Commission to Promote
Sustainable Child Welfare

Commission de promotion de la viabilité
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Serious Occurrence Reporting

Background Paper #2

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Background Paper prepared by

The Commission to Promote Sustainable Child Welfare

Introduction

The Commission has identified the removal of administrative obstacles and streamlining of administrative processes as one of its priorities. Activities that divert the time and attention of staff from direct service should be examined to ensure that they are necessary, efficient, and add value.

Serious Occurrence Reporting represents an important early opportunity to reduce administrative demands while ensuring effective monitoring of child safety.

After careful consideration and consultation with MCYS and the field, the Commission has prepared a series of recommendations to simplify and streamline the use of Serious Occurrence Reports (SORs). It is important to note that the Commission is making recommendations for the child welfare sector only; however, in some instances the Ministry will need to examine the implications in other service sectors that have SOR requirements.

The analysis and recommendations in this document arise from a review of SOR documentation; discussions with individual CASs, Regional Offices, and representatives of the private residential care sector; and two separate focus groups with CAS and MCYS representatives.

Background Information

Service providers who deliver any direct service to children and youth under the Child and Family Services Act must inform MCYS when there is an incident involving a child in care that is deemed by the provider to be serious. The procedures that must be followed are set out in *Serious Occurrence Reporting: Procedures for Service Providers* (revised August 2009). The same requirements apply to service providers caring for children under *the Day Nurseries Act.* In the adult services sectors providers must report serious occurrences to the Ministry of Community and, Social Services if they serve clients under *the Developmental Services Act* or if they provide Violence Against Women services to clients under *the Ministry of Community and Social Services Act*.

The stated purpose of SORs is to provide the two ministries and service providers with an effective means of reviewing and monitoring the quality of service delivery. Over time, the purpose has become more complex and SORs are now also used for issue management and case management by the Ministry. As well, SOR data is used by the Ministry in the licensing process by notifying licensing staff if there have been SORs that may have licensing implications.

The volume of SORs is large. Approximately 40,000 SORs are filed each year across all service providers covered by the requirements. It is estimated that 50% of these relate to the use of approved physical restraints on children in residential care. CASs filed 9631 SORs in 2008 and 9397 in 2009.

Shortcomings with the Serious Occurrence Reporting Process

There is consensus among CAS and MCYS staff that Serious Occurrence Reporting could be useful in helping to monitor service. However, there is also consensus that the current Serious Occurrence Reporting process is a significant administrative burden and a major irritant.

Ministry and CAS staff have identified multiple deficiencies in the current SOR process:

First, there is wide variation in the interpretation of the word "serious," leading to inconsistency and excessive reporting of trivial matters. CASs often file SORs for minor incidents that are normal occurrences of childhood (e.g. a child scraping her knee on the playground). Service providers need to exercise judgement in determining what constitutes a serious incident, as set out in the guidelines. CASs report that they believe they are following the expectations of their Regional offices and of Crown Ward Reviewers, who overrule CAS staff judgement when they issue directives to file SORs on individual cases they have reviewed.

Second, the purpose of SORs has become obscured. SORs were originally intended to serve as a tool for quality assurance by helping to ensure that service providers provided a safe environment for children in care. With the addition of the requirement to submit SORs every time a restraint is used, SORs have taken on a role in case management. Enhanced Serious Occurrence Reports (ESORs) are completed to identify potentially sensitive issues (public, controversial situations) that may require a Contentious Issue report by the Ministry—and these ESORs are therefore used for Issues Management.

Third, the SOR process is duplicative, further contributing to excess volume and workload. It is common for CASs to submit an SOR even though another service provider has already done so. In addition, submitting SORs for reporting missing children duplicates the existing, mandatory process for Missing Person Reports (MPRs).

Fourth, the volume of reports is excessive. In addition to being time consuming, with over 9000 reports filed by CASs each year, there is a real risk that serious matters reported as Serious Occurrences will be overlooked or missed by Regional staff in their efforts to process the large volume of reports. In fact, SORs are only one mechanism for ensuring quality and CASs have internal mechanisms to track and respond to adverse incidents. SORs should be reserved only for incidents that constitute sufficient risk / adverse impact to be elevated beyond the agency to MCYS.

Fifth, the information gathered is not routinely analyzed with feedback provided to the field. In order for the reporting process to improve service delivery, CAS and Regional staff must receive analytical feedback from the information gathered.

Sixth, there is a lack of coordination in the field. The expectations of Regional Offices vary across the province, and the processes Regional Offices use for dealing with SORs do not always follow the recommended best practice outlined in the document, *Serious Occurrence Reporting: Guidelines for Regional Staff* (revised August 2009). Different interpretations and processes lead to inconsistent reporting by service providers. Additionally, when CASs receive reports from an outside paid resource (OPR), they do not usually inform other CASs that also have children placed in that facility. This lack of communication can undermine the usefulness of SORs for quality assurance purposes.

SOR Reporting Requirements

Section 2.2 of *Serious Occurrence Reports: Procedures for Service Providers* (revised August 2009) outlines the categories and definitions governing the reporting of serious occurrences. For CASs, each category applies only to children in care (except for category 1, death of a client). There are eight categories of serious occurrences to be reported by the service provider to the Ministry. In brief, these categories are:

1. Any death of a client which occurs while participating in a service. For CASs, this applies only to children in care at the time of death and children who received service in the prior year.
2. Any serious injury to a client.
3. Any alleged abuse or mistreatment of a client by staff, volunteers or others associated with providing the service which occurs while participating in a service.
4. Any situation where a client is missing in accordance with ministry requirements and any applicable legislative requirements.
5. Any disaster on the premises where a service is provided, that interferes with daily routines (e.g., fire, flood, etc.)
6. Any complaint about the operational, physical or safety standards of the service that is considered serious by the service provider.
7. Any complaint made by or about a client, or any other serious occurrence involving a client that is considered by the service provider to be of a serious nature.
8. Any use of a physical restraint of a client in a residence licensed as a children's residence under the *Child and Family Services Act* or that results in a) no injury, b) injury, c) allegation of abuse.

SO Reporting Process

The document, *Serious Occurrence Reporting: Guidelines for Regional Staff* (revised August 2009) outlines the steps, responsibilities, and timeframes for the SO reporting process. In brief, the SO reporting process is presented below.

Timeframe	Responsibility
Immediately	Service Provider will: • Address health & safety of client(s) • Notify coroner of any death • Notify Children's Aid Society, as appropriate
Within 24 hours	Service Provider will: • Submit SO Initial Notification Report (INR) to the regional office
Within 7 business days	Service Provider will: • Submit SO Inquiry Report (IR) to the regional office

Upon receipt of IR	Regional Office will: • Review all information and determine if the necessary actions has been taken by the service provider • Determine if further ministry follow-up is required (if so, Ministry staff will work with the service provider until satisfied with the outcome) • Acknowledge receipt of IR to Service Provider
Every six months	Regional Office will: • Review all SORs for each service provider received during this period
Annually	Service Provider will: • Submit "Annual Summary & Analysis Report" to the region by the date identified in the annual reporting cycle for all SORs submitted the previous year, noting emerging issues and/or trends Regional Office will: • Complete the regional response to the "Annual Summary & Analysis Report", reconciling service provider and regional numbers • Forward package to program supervisor for review, action and sign-off
Ongoing	Regional Office will: • Monitor SO reporting and identify issues to program supervisor/adviser • Notify Compliance Review Services of any SORs with licensing implications

Conclusions: General

- The purpose of SORs needs to be refocused on quality assurance, not issues management or case management.
- SORs should be filed only for serious incidents affecting children in care (except for category 1, death of a client). For example, SORs should not be filed by CASs for incidents affecting guardians, parents, or children out of care as per the MCYS requirements.
- CASs should exercise reasonable judgement in determining whether an incident is a serious occurrence and should contact the ministry Regional Office to discuss an incident if they are unclear whether the incident is serious or not.

- Crown Ward Reviewers should be restricted to making recommendations within their mandate and should stop issuing directives regarding compliance with SOR reporting on individual cases.
- SORs should be clearly distinguished from ESORs which deal with Critical Incidents (CIs) by renaming them as Contentious Issues reports or some similar name.
- CASs should cease submitting an SOR when another organization is obliged do so but should ensure that they receive a copy of any SOR submitted by another organization relating to children in their care.
- A CAS receiving SORs from a residence facility should inform other CASs that also have children placed in the facility if the other CASs could benefit from that information.
- The Ministry should take steps to ensure consistency in Regional Office communication and interpretation regarding SORs, to the field
- Regional Offices should be encouraged to adopt the practices set out in the document, *Serious Occurrence Reporting: Guidelines for Regional Staff* (revised August 2009). In particular, one staff member should be identified in each Regional Office to oversee the SOR process and serve as the primary contact for CASs in the Region.
- The Ministry should regularly provide feedback to the CASs on the analysis of SOR data

Conclusions Specific to the SOR Categories and Definitions

The Commission has no recommendations regarding categories 1, 3, 6, or 7. With respect to the other categories, the Commission recommends that the following actions be taken:

1. Serious injury (Category 2)
    - the definition of "serious" as an occurrence which "falls within the definitions in [the] guidelines **and has important or possibly dangerous consequences**" (emphasis added), should be reaffirmed.
    - CASs should be encouraged to exercise appropriate judgement in determining if an injury is serious or not.
2. Missing client (Category 4)
    - The requirements set out in the guidelines are appropriate and need to be followed: When a child is missing from a residence a Missing Persons Report (MPR) shall be filed. Only when this same child poses a serious risk to self and/or others shall it be appropriate for the CAS/licensee to also file a SOR.
    - CASs should ensure that they receive a copy of the MPR when another agency is obliged to submit the MPR.
3. Disaster on premise (Category 5)
    - The definition of "disaster" in the guidelines should be clarified and modified so that category 5 clearly applies only to incidents of great consequence. Not all disruptions to daily routines are necessarily serious occurrences, and staff discretion is required to determine the severity of a disruption.
4. Use of physical restraint (Category 8)
    - SORs should not be required for the use of approved physical restraint unless the use of the restraint causes injury to a client, leads to an allegation of abuse, or if the service

provider determines that the restraint did not comply with regulations (e.g. improperly applied).

- The use of approved restraints should be logged, and these logs should be reviewed by CASs with children placed in the facility and by licensing authorities during annual reviews.

Benefits of These Measures

Through implementing the measures set out in this document, SORs and the reporting process can be streamlined and simplified. The Commission estimates that a 50% reduction in the volume of SORs can be achieved.

Assuming 2.5 hours total time per SOR for the entire process (completing the form, review by the supervisor, approval by the Manager and Senior Management, filing it with the Regional Office, and receiving any feedback and revising the SOR), the equivalent of approximately 10 FTEs time can be redirected to direct service. Significant time would also be saved in Ministry Regional Offices by reducing the number of times that an SOR must be reviewed and approved by Regional staff up to and including the Regional Director.

Clarifying the purpose of SORs also reduces the risk of serious matters being overlooked. Additionally, ensuring that the data collected from SORs is analyzed with feedback provided to CASs will further enhance service delivery.

The key steps to achieving these outcomes include reaffirming the use of judgement by service providers, clarifying the purpose of SORs, effectively using the data collected from SORs, eliminating duplication, clarifying the circumstances under which SORs are required in relation to the use of approved physical restraints and missing persons, and standardizing MCYS practices.

Progress in meeting the goal of reducing the numbers by 50% should be monitored at both the agency and Regional level and summarized quarterly.