Book	A. SEFBHN Policy and Procedures
Section	300.00 Operations
Title	Incident Reporting
Code	302.00
Status	Active
Adopted	October 31, 2013
Last Revised	August 20, 2021
Last Reviewed	August 1, 2021

Reason for Policy:

To establish the process to manage Department of Children and Families (the Department) Critical Incident Reporting in referencing the Florida Department of Children and Families Operating Procedure (CFOP) 215-6. This policy establishes the requirements governing the accurate reporting and dissemination of information regarding occurrences.

Definitions:

Abuse: Any willful or threatened act or omission that causes or is likely to cause significant impairment to a child or vulnerable adult's physical, mental or emotional health.

Department: The Department of Children and Families.

Adult Death: An individual 18 years or older, whose life terminates while receiving services, during an investigation, when it is known that a client died within thirty (30) days of discharge from a residential program,

Child Death: An individual 18 years or less whose life terminates while receiving services, during an investigation, or when it is known that a child died within thirty (30) days of discharge from a residential program or treatment facility or when a death review is required pursuant to CFOP 175-17, Child Fatality Review Procedures. The manner of death is the classification of categories used to define whether a death is from intentional causes, unintentional causes, natural causes, or undetermined causes.

(1) The final classification of an individual's death is determined by the medical examiner. However, in the interim, the manner of death will be reported as one of the following:

(a) Accident - A death due to the unintended actions of one's self or another.
(b) Homicide - A death due to the deliberate actions of another.
(c) Natural Expected - A death that occurs as a result of, or from complications of a diagnosed illness for which the prognosis is terminal.
(d) Natural Unexpected - A sudden death that was not anticipated and is attributed to an underlying disease either known or unknown prior to the death.
(e) Suicide - The intentional and voluntary taking of one's own life.
(f) Undetermined - The manner of death has not yet been determined.
(g) Unknown - The manner of death was not identified or made known.

(2) If an individual's death involves a suspected overdose from alcohol and/or drugs, or seclusion and/or restraint, additional information about the death will need to be reported in IRAS.

Hospital: A facility licensed under Chapter 395, Florida Statutes (F.S.). This includes facilities licensed as specialty hospitals under Chapter 395, F.S.

Critical Incident Coordinator: The designated Department or provider/agency staff whose role is to add and update Critical Incidents, create and send initial and updated notifications and change the status of a Critical Incident. Department Critical Incident Coordinators are designated by their respective Circuit/Region /Headquarters leadership.

Critical Incident Reporting and Analysis System (IRAS): Operating procedure that establishes the guidelines for reporting and analyzing Critical Incidents.

Managing Entity: Corporations contracted by the Department to manage the daily delivery of behavioral health services (i.e., substance abuse prevention and treatment, and mental health services) through the establishment of local networks.

Neglect: The failure or omission on the part of the caregiver to provide the care, supervision and services necessary to maintain the physical and mental health of a child or vulnerable adult; or the failure of a caregiver to make reasonable efforts to protect a child or vulnerable adult from abuse, neglect, or exploitation by others.

Restraint: Any manual method or physical or mechanical device, materials, or equipment attached or adjacent to the individual's body so that he or she cannot easily remove the restraint, and which restricts freedom of movement or normal access to one's body.

Seclusion: The physical segregation of a person in any fashion, or involuntary isolation of a person in a room or area from which the person is prevented from leaving. The prevention may be by physical barrier or by a staff member who is acting in a manner, or who is physically situated, so as to prevent the person from leaving the room or area.

Policy Statement:

This policy is related to Florida Department of Children and Families Operating Procedure (CFOP) 215-6, wherein the Managing Entities shall establish a Critical Incident reporting process to protect and ensure the safety and security of the clients and staff served through Department funding, and the public. As a Managing Entity, Southeast Florida Behavioral Health Network (SEFBHN) is required, and requires its contracted providers, to be subject to (CFOP) 215-6. This Critical Incident Report process shall include standards for all programs and services within the Network and subcontracted with the DCF Substance Abuse and Mental Health Services Managing Entity. This policy will ensure adherence to uniform procedures for Critical Incident Reporting in accordance with applicable federal and state laws, rules, and regulations; the terms and conditions of the contract; and policies, and procedures established by SEFBHN and the Department of Children and Families. SEFBHN shall receive, review, and report all subcontracted provider reported Critical Incidents.

Procedure:_____

a. All SEFBHN contracted providers shall identify staff responsible for the report of Critical Incidents to SEFBHN and the Department via the Department's Incident Reporting and Analysis System (IRAS). The provider shall ensure all staff, including volunteers, successfully completes Critical Incident reporting training prior to contact with clients.
b. Upon notification and/or identification of the occurrence of a Critical Incident that meets CFOP 215-6 criteria, the provider shall input record of the Critical Incident into IRAS. Providers shall complete the CBH Critical Incident Report Template when access to IRAS is not available.
c. This procedure does not replace the mandatory reporting requirements to the Florida Abuse Hotline for abuse, neglect and exploitation as required by law. Allegations of abuse, neglect or exploitation must always be reported immediately to the Florida Abuse Hotline.
d. If access to IRAS is not available, the Provider shall email the incident details in a password protected document to the Incident Reporting Coordinator at lindsay.slattery-cerny@sefbhn.org.
e. Provider will make a phone call to dedicated phone for those Critical Incidents defined as category A below.
f. The employee's first obligation is to ensure the health, safety and welfare of all individuals involved.
g. The employee must immediately ensure contacts are made for assistance as dictated by the needs of the individuals involved. These types of contacts may include but are not limited to: emergency medical services (911), law enforcement or the fire department. When the incident involves suspended abuse, neglect or exploitation, the employee must call the Florida Abuse Hotline to report the incident. The employee must ensure that the client's guardian, representative or relative is notified, as applicable.

II. **Reporting Timeframes and Reportable Critical Incident Definitions:**

a. **Category A**: The Provider must report within two (2) hours of becoming aware of any of the following Critical Incidents that occurs at its facility or to a client. Reports defined in Category A must be reported with a phone call to the Critical Incident Reporting Coordinator at 772-812-7037. Category A Critical Incidents must be reported via IRAS in addition to the notification to the Incident Reporting Coordinator.

The Critical Incidents included in this category are:

- **Child on child sexual abuse:** Any sexual behavior between children which occurs without consent, without equality, or as a result of coercion. This applies only to children receiving services from the Department or by a licensed contract provider, e.g., children in foster care placements or residential treatment.
- **Sexual abuse / Sexual Battery:** Any unsolicited or no-consensual sexual activity or battery* by one client to another; a DCF or service provider employee or other individual; to a client; or a client to an employee regardless of the consent of the client. *Sexual battery may be defined by Chapter 794 of the Florida Statutes.
- **Adult or Child Death:** Any death determined as unnatural, unless the death happens within or under the direct care of the provider and/or its staff.
- **Media Event:** Any Critical Incident resulting in media coverage due to circumstances that meet the threshold for a report to the DCF/ME. That includes press inquiries, broadcast and written media coverage.

b. **Category B:** The following Critical Incidents must be reported via the IRAS system within twelve (12) hours. Unlike Category A Critical Incidents, a telephone call is not required:

- **Youth Interaction with Law Enforcement (Child Arrest):** When a person under the age of 18 is taken into custody by law enforcement for allegedly committing an act considered a law violation, while in the custody of the department
- **Death:** Any death determined of natural causes and DOES NOT occurs within or under the direct care of the provider and/or its staff, or while in the physical or legal custody of the department.)
- **Elopement:** (1) The unauthorized absence beyond four hours of an adult during involuntary civil placement within a Department-operated, Department-contracted or licensed service provider; or (2) The unauthorized absence of a forensic client on conditional release in the community; or (3) The unauthorized absence of any individual in a Department contracted or licensed residential substance abuse and/or mental health program.
- **Employee Arrest:** The arrest of an employee of the Department or its contracted or licensed service provider for a civil or criminal offense.
- **Employee Misconduct:** Work-related conduct or activity of an employee of the Department or its contracted or licensed service provider that results in potential liability for the Department; death or harm to a client; abuse, neglect or exploitation of a client; or results in a violation of statute, rule, regulation, or policy. This includes, but is not limited to, misuse of position or state property; falsification of records; failure to report suspected abuse or neglect; contract mismanagement; or improper commitment or expenditure of state funds.
- **Escape:** The unauthorized absence of a client who is committed by the court to a state mental health treatment facility pursuant to Chapter 916 or Chapter 394, Part V, Florida Statutes.
- **Missing Child:** When the whereabouts of a child in the custody of the Department are unknown and the attempts to locate he child have been unsuccessful.
- **Security Critical Incident – Unintentional:** Unintentional action or event that results in compromised data confidentiality, danger to the physical safety of personnel, property, or technology resources; this excludes instances of compromised client information.
- **Significant Injury to Clients:** Severe bodily trauma to a client in a treatment/service program that requires immediate medical care or treatment at a hospital.
- **Significant Injury to Staff:** Severe bodily trauma to a staff member in a treatment/service program that requires immediate medical care or treatment at a hospital.
- **Suicide Attempt:** Potentially lethal act which reflects an attempt by a an individual to cause their own death

    - **Other:**

        - Human acts that jeopardize health, safety or welfare of clients such as kidnapping, riot, or hostage situation.
        - Bomb or biological/chemical threat
        - Death or significant injury of an employee or visitor on the grounds of the Department or one of its contracted or licensed providers.
        - Human acts that jeopardize health, safety or welfare of clients
        - Theft, vandalism, damage, fire, sabotage, or destruction of state or private property of significant value or importance.

III. **ME Tasks**

1. When an email is received by the IRAS system to SEFBHN staff the following occurs:
2. SEFBHN (Critical Incident Report Coordinator) reviews the Critical Incident Report and:

    a. Identifies the appropriate level of action for the Critical Incident reported as per the CBH Critical Incident Report Response Grid. This level may be modified based on further information obtained and/or follow up received about the Critical Incident.
    b. SEFBHN (Critical Incident Report Coordinator) will contact Provider for clarification, when required.
    c. SEFBHN (Critical Incident Report Coordinator) will monitor reported Critical Incidents and determine any required follow up with QI or Provider Relations staff when applicable.

    d. Provider Relations will be engaged for Critical Incidents directly related to or impacting the provider's ability to meet its contractual obligations.
    e. SEFBHN (Critical Incident Report Coordinator) will complete preliminary review for Critical Incident reports.
    f. When further in-depth review is deemed necessary SEFBHN (Critical Incident Report Coordinator) will lead this process and will engage the support of the Provider Relations Specialist if needed.
3. SEFBHN (Critical Incident Report Coordinator) will update provider regarding status on Critical Incident Review Process
4. SEFBHN (Critical Incident Report Coordinator) will track the Critical Incident Report for further analysis.
5. SEFBHN (Critical Incident Report Coordinator) will inform Provider Relations Specialists on an as needed basis, of any report that has been non-compliant with the procedures,
6. SEFBHN (Critical Incident Report Coordinator) will generate a monthly report of all Critical Incident reports received during the previous month, to be submitted to the SEFBHN by the 10th of the following month. This report will be made available at the Quality Improvement Committee Meetings.
7. When the provider has no IRAS access, SEFBHN (Critical Incident Report Coordinator) will input the Critical Incident report in the IRAS within the time frames established with DCF.

Forms/Regulations:

DCF CFOP 215-6, IRAS System