

Family Services Division Policy Manual: Appendix 11
Response to Critical Incidents
August 2017

Premise

To create a comprehensive framework to respond to critical incidents in the context of a learning culture, it is necessary to fully understand the incident and how it can inform:

- ❖ Providing support to those affected
- ❖ Response to performance
- ❖ Reflection for organizational and wider systems changes

In the field of child protection, critical incidents can be expected and should be anticipated as risk and danger is inherent in the work that we do. While tragic, we consider these critical incidents to be an opportunity for reflection and learning to improve the system. Awareness of risk cannot always prevent the consequences of risk, and the severity of risk cannot always be predicted. To be effective, social workers must have a highly developed awareness of risk without working in fear of what cannot be known and what cannot be controlled. Not all risk can be eliminated and the reduction of risk is the goal of our work. Response to critical incidents must recognize the complex family, social work, system, and community contexts in which they occur.

We believe that open communication is a critical part of any learning culture. We also recognize that the review of critical incidents takes time, requires the balancing of many elements (possibly including sensitive personnel matters) and that these things can impact the free flow of information.

Cases Requiring Formal Review

Critical incidents happen each and every day in the field of child welfare. Examples include threats made toward social workers, social workers dealing with difficult subject matter, social workers managing aggressive and hostile clients, etc. Support is needed to deal effectively with all of these situations.

The Family Services Operations Director will determine which cases will be the subject of a critical incident review and who will conduct that review. For the purpose of this critical incident response process, the following are examples of situations that may be reviewed:

- Situations involving the death or serious, inflicted injury of a child where information suggests that it was caused by a caretaker's actions and/or inactions and the family is currently being served in any capacity by the division or has been within the prior 6 months. This includes situations where a child has been the subject of a child abuse / neglect report during the prior 6 months regardless of acceptance decision AND the information reported is related to the current caretaker and a similar concern.

- The death or serious injury of a youth in our custody that is not natural or accidental or information suggests that an accident was the result of a lack of appropriate supervision or services/support.

Procedure for Review

Non-Accepted Intake Involvement: Operations Manager will review the intake and determine if the decision to not accept was appropriate given policy. If there appears to be a violation of policy, official warning of a personnel investigation will occur prior to an interview of staff so that the staff person(s) can elect to have union representation present for any interview.

Open Case Involvement: Operations Manager will communicate with the district to plan for the review. The Operations Manager will offer to have a phone conversation with the district director, supervisor and worker involved to answer any questions they may have about the process. In some situations, it may be possible for the Operations Manager and District Director to jointly review the file. In other situations, the Operations Manager will review the case file and determine if there are any concerns about policy violations. If there appears to be a violation of policy, official warning of a personnel investigation will occur prior to an interview of staff so that the staff person(s) can elect to have union representation present for any interview.

Providing Support to Those Affected

Ensure the benefits of reflection and supervision regarding the social worker process are provided (professional judgment, deep understanding of human behavior and reflective thinking are the most critical drivers of skilled social work practice, not a checklist of tools followed).

Participate in efforts, both internal to the office and to the community more broadly, to provide training and education that helps people understand that the practice of child protection is fundamentally uncertain. These efforts should assist people in understanding that although death or serious injury by assault is relatively rare, it does occur, and when it does, there is vicarious trauma for the social worker concurrent to the impact on the child's family, public outcry, and systemic review to address accountability.

Support to the social worker/team / supervisor should focus not only on the conduct of the individual social worker / team /supervisor but focus on other factors including the more complex factors and interrelationship that invariably surround a child at risk including the community, political pressures, availability of resources, relationships with family and community partners, the social worker's belief system, and the boundaries within the family system. These are all examples of factors that could be beneficial to reflect on.

Support to the social worker / supervisor should include a referral to EAP. The District Director will contact EAP to discuss the best next steps for the worker / team /

supervisor / staff. This may include a group critical incident stress debrief. The District Director will convey this information to the worker / team / supervisor / staff so that they understand what is available to them for support. The District Director will discuss this information with their Operations to ensure that there is an adequate plan in place to support all staff – individually and as a group.

Response to Performance

Recognizing that certain procedures exist for the protection of our workforce in the form of the VSEA Collective Bargaining Agreement and that agreements about personnel inquiries are contained therein, these procedures set forth how our response will interface with the current personnel investigation process.

If division staff becomes aware that a critical incident has occurred, it will be brought to the attention of the District Director and Operations Manager. The Operations Manager will determine what type of involvement the division had with the family.

In keeping with the VSEA Collective Bargaining Agreement, the reviewer will attempt to determine if the issue is a performance or misconduct issue. Professional judgment within the existing policy framework will be viewed, generally, as performance inquiries and any resulting action will focus on feedback. Performance feedback or disciplinary action may occur as a result of a critical incident review.

Operations will work to conclude their portion of any personnel investigation, including the file review and written report, within 60 days.

Reflection for System Change

We are committed to building strong systems of support for children, youth and families. To that end, the leadership team of this division will have a discussion following the issuance of a report that documents the file review that occurs after a critical incident. The goal of these discussions is to reveal improvements that we might be able to address either because we have direct control or the ability to influence a practice. We believe that a multi-level review is the best way to achieve that goal. Our discussion will be structured as follows:

Family System: We recognize that the harm that was caused is the responsibility of the perpetrator of that harm. We will discuss factors that led to a child being unsafe in their family system: boundaries, history, attachment, values, communication patterns, receptivity to help, etc, as what the family brings provides insight into how professionals respond.

Social Worker System: How does the worker understand what is happening in the family? The following factors influence how the worker understands the family: his/her belief system, experience, values. What were the dynamics between the social worker and the family?

Organizational System: We will discuss the situation in the context of what our organization can learn, to include: statute, policy, supervision, team, training, supports, practice reflection opportunities. Did what the organization focused on for work priorities affect this situation?

Wider System: We will review whether or not circumstances outside of our organization affected the outcome to include: political pressure, community, professional input from service providers and others - did everyone work effectively together? This will include a look at the network of people and systems surrounding the child, youth and family.