

UNUSUAL INCIDENT INJURY and DEATH REPORTING

CERTIFIED OUT OF STATE GROUP HOMES



CA Family Code Section 7911.1(a)

Certified Out of State Group Homes are required to comply with California Reporting requirements for each child in care regardless of whether or not the child is a California placement.

Other Applicable Reporting Statutes And Regulations

- Health & Safety Code (H&SC) Section 1502.4
- California Code Of Regulations (CCR), Title 22 Division 6, Sections 80061 and 84061(a) – (H)(7)

MANDATED CHILD ABUSE REPORTERS

Licensees, Administrators and facility staff are mandated reporters, who in their professional capacity or within the scope of employment, have knowledge of or observes a person under the age of 18 years whom he/she knows or reasonably suspects has been the victim of child abuse or neglect must report the suspected incident. The mandated reporter must contact a designated agency immediately or as soon as practically possible by telephone, and shall prepare and send a written report within 36 hours of receiving the information concerning the incident. [PC 11166(a)]

PURPOSE OF REPORTING

To promote the health, safety, and quality of life of each person in community care through the administration of an effective collaborative regulatory enforcement system.

- Collaborative efforts promoting continuous improvement and efficiency
- Training and technical assistance to increase voluntary compliance

PURPOSE OF REPORTING

The California reporting requirement is to provide an opportunity to explain:

- How or why an incident occurred
- What preceded (antecedent) the incident and what could have been done to deescalate the situation
- What action is being taken to protect clients, and prevent further incidents

STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT CHILD ABUSE*NOTE: RETAIN IN EMPLOYEE/LICENSEE FILE*

NAME

POSITION

FACILITY NUMBER

California law **REQUIRES** certain persons to report known or suspected child abuse. As a licensee or an employee at a licensed facility or a child care institution, **YOU** are one of those persons - a "mandated reporter."

PERSONS WHO ARE REQUIRED TO REPORT ABUSE

Mandated reporters include a licensee, an administrator, or an employee of a licensed community care or child day care facility. [Penal Code ("PC") § 11165.7(a)(10)] Mandated reporters also include an employee of a child care institution, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities. [PC § 11165.7(a)(14)] No supervisor or administrator may impede or inhibit an individual's reporting duties or subject the mandated reporter to any sanction for making the report. [PC § 11166(h)]

WHEN REPORTING ABUSE IS REQUIRED

A mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has knowledge of or observes a person under the age of 18 years whom he or she knows or reasonably suspects has been the victim of child abuse or neglect must report the suspected incident. The reporter must contact a designated agency immediately or as soon as practically possible by telephone, and shall prepare and send a written report within 36 hours of receiving the information concerning the incident. [PC § 11166(a)]

ABUSE THAT MUST BE REPORTED

Physical injury inflicted by other than accidental means on a child. [PC § 11165.6]

Sexual abuse meaning sexual assault or sexual exploitation of a child. [PC § 11165.1]

Neglect meaning the negligent treatment, lack of treatment, or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. [PC § 11165.2]

Willful harming or injuring or endangering a child meaning a situation in which any person inflicts, or willfully causes or permits a child to suffer, unjustifiable physical pain or mental suffering, or causes or permits a child to be placed in a situation in which the child or child's health is endangered. [PC § 11165.3]

Unlawful corporal punishment or injury willfully inflicted upon a child and resulting in a traumatic condition. [PC § 11165.4]

SUSPECTED CHILD ABUSE REPORT

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

CASE NAME: _____

PLEASE PRINT OR TYPE

CASE NUMBER: _____

A.	REPORTING PARTY	NAME OF MANDATED REPORTER		TITLE		MANDATED REPORTER CATEGORY			
		REPORTERS BUSINESS/AGENCY NAME AND ADDRESS				Street	City	Zip	
		REPORTERS TELEPHONE (DAYTIME) ()		SIGNATURE		DID MANDATED REPORTER WITNESS THE INCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
				TODAY'S DATE					
B.	REPORT NOTIFICATION	<input type="checkbox"/> LAW ENFORCEMENT <input type="checkbox"/> COUNTY PROBATION		AGENCY					
		<input type="checkbox"/> COUNTY WELFARE / CPS (Child Protective Services)							
		ADDRESS				Street	City	Zip	
		OFFICIAL CONTACTED - TITLE		TELEPHONE		()			
C.	VICTIM <small>One report per victim</small>	NAME (LAST, FIRST, MIDDLE)				BIRTHDATE OR APPROX. AGE		SEX	ETHNICITY
		ADDRESS				Street	City	Zip	TELEPHONE ()
		PRESENT LOCATION OF VICTIM				SCHOOL		CLASS	
		PHYSICALLY DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO		DEVELOPMENTALLY DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO		OTHER DISABILITY (SPECIFY)		PRIMARY LANGUAGE SPOKEN IN HOME	
		IN FOSTER CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: <input type="checkbox"/> DAY CARE <input type="checkbox"/> CHILD CARE CENTER <input type="checkbox"/> FOSTER FAMILY HOME <input type="checkbox"/> FAMILY FRIEND <input type="checkbox"/> GROUP HOME OR INSTITUTION <input type="checkbox"/> RELATIVE'S HOME				TYPE OF ABUSE (CHECK ONE OR MORE) <input type="checkbox"/> PHYSICAL <input type="checkbox"/> MENTAL <input type="checkbox"/> SEXUAL <input type="checkbox"/> NEGLECT <input type="checkbox"/> OTHER (SPECIFY)	
		RELATIONSHIP TO SUSPECT				PHOTOS TAKEN? <input type="checkbox"/> YES <input type="checkbox"/> NO		DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK	
D.	INVOLVED PARTIES <small>VICTIMS PARENTS/GUARDIANS SUSPECT</small>	VICTIMS							
		SUSPECTS							
		1. NAME		BIRTHDATE		SEX		ETHNICITY	
		2. _____		_____		_____		_____	
		3. NAME		BIRTHDATE		SEX		ETHNICITY	
		4. _____		_____		_____		_____	
		NAME (LAST, FIRST, MIDDLE)				BIRTHDATE OR APPROX. AGE		SEX	ETHNICITY
		ADDRESS				Street	City	Zip	HOME PHONE ()
						BUSINESS PHONE ()			
		NAME (LAST, FIRST, MIDDLE)				BIRTHDATE OR APPROX. AGE		SEX	ETHNICITY
ADDRESS				Street	City	Zip	HOME PHONE ()		
				BUSINESS PHONE ()					
SUSPECT'S NAME (LAST, FIRST, MIDDLE)				BIRTHDATE OR APPROX. AGE		SEX	ETHNICITY		
ADDRESS				Street	City	Zip	TELEPHONE ()		
OTHER RELEVANT INFORMATION									
E.	INCIDENT INFORMATION	IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX <input type="checkbox"/>						IF MULTIPLE VICTIMS, INDICATE NUMBER: _____	
		DATE / TIME OF INCIDENT				PLACE OF INCIDENT			
		NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)							

SS 8572 (Rev. 12/02)

DEFINITIONS AND INSTRUCTIONS ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY- District Attorney's Office; YELLOW COPY-Reporting Party

California Certified Group Homes

Report within 24 hours, or next business day; and a written report within 7 days

Report Unusual Incident/Injury and Death to:

CDSS

Children & Family Services Division

Out-of-State Placement Policy Unit

Interstate Compact Administrator

744 P Street, MS 8-12-90

Sacramento, CA 95814

Fostercare.incidencereport@dss.ca.gov

FAX: (916) 651-8144

- In State Licensing Authority
- Authorized Representatives
- Placement Agencies

WHAT SHOULD BE REPORTED?

What constitutes a serious incident?

- Any incident that threatens the physical or emotional health or safety of any client including sexual or physical abuse and/or assaults
- The death of any child in care from any cause
- Serious injuries requiring non-routine medical treatment
- Unusual pain or limited mobility from unknown sources
- Illegal drugs or alcohol
- Criminal activity
- Unauthorized absence
- Use of manual restraints/physical escort
- Epidemic out breaks, poisoning, catastrophes, fires, evacuations or explosions

...Reporting Requirements...

ADMINISTRATIVE CHANGES WITHIN 10 DAYS

- Organizational changes
- New Chief Executive or Administrator
- Plan of Operation changes affecting client services

Incident Reports Must Include:

- Facility Name, Address, Phone Number
- Reporter's and Reviewer's Name
- Administrator's Signature
- Placement Worker's Name, Address, Phone Number
- Agencies Notified - Who and When
- Description of the Incident
 - Who, what, when, where, why and how
 - Actions taken and follow up plan
 - Preventive measures
 - Witnesses, medical treatment

**UNUSUAL INCIDENT/INJURY
REPORT****INSTRUCTIONS :** NOTIFY LICENSING AGENCY, PLACEMENT AGENCY AND
RESPONSIBLE PERSONS, IF ANY, BY NEXT WORKING DAY.SUBMIT WRITTEN REPORT WITHIN 7 DAYS OF OCCURRENCE.
RETAIN COPY OF REPORT IN CLIENT'S FILE.

NAME OF FACILITY	FACILITY FILE NUMBER	TELEPHONE NUMBER ()
ADDRESS	CITY, STATE, ZIP	

CLIENTS/RESIDENTS INVOLVED	DATE OCCURRED	AGE	SEX	DATE OF ADMISSION

TYPE OF INCIDENT

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Unauthorized Absence | <input type="checkbox"/> Alleged Client Abuse | <input type="checkbox"/> Rape | <input type="checkbox"/> Injury-Accident | <input type="checkbox"/> Medical Emergency |
| <input type="checkbox"/> Aggressive Act/Self | <input type="checkbox"/> Sexual | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Injury-Unknown Origin | <input type="checkbox"/> Other Sexual Incident |
| <input type="checkbox"/> Aggressive Act/Another Client | <input type="checkbox"/> Physical | <input type="checkbox"/> Suicide Attempt | <input type="checkbox"/> Injury-From another Client | <input type="checkbox"/> Theft |
| <input type="checkbox"/> Aggressive Act/Staff | <input type="checkbox"/> Psychological | <input type="checkbox"/> Other | <input type="checkbox"/> Injury-From behavior episode | <input type="checkbox"/> Fire |
| <input type="checkbox"/> Aggressive Act/Family, Visitors | <input type="checkbox"/> Financial | | <input type="checkbox"/> Epidemic Outbreak | <input type="checkbox"/> Property Damage |
| <input type="checkbox"/> Alleged Violation of Rights | <input type="checkbox"/> Neglect | | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Other (explain) |

DESCRIBE EVENT OR INCIDENT (INCLUDE DATE, TIME, LOCATION, PERPETRATOR, NATURE OF INCIDENT, ANY ANTECEDENTS LEADING UP TO INCIDENT AND HOW CLIENTS WERE AFFECTED, INCLUDING ANY INJURES:

PERSON(S) WHO OBSERVED THE INCIDENT/INJURY:

EXPLAIN WHAT IMMEDIATE ACTION WAS TAKEN (INCLUDE PERSONS CONTACTED):

IF DEATH OCCURS

- Must Report Regardless of Where It Occurred
- Describe the Immediate Cause of Death
- Conditions Contributing to Death
- What Action Was Taken
- Name of Attending Physician
- Name of Coroner
- Copy of Death Certificate
- (Send Coroner Report if available within 30 days)

DEATH REPORT

LICENSEE MUST REPORT THE DEATH OF A CLIENT OF ANY CAUSE, REGARDLESS OF WHERE THE DEATH OCCURRED.

INSTRUCTIONS: NOTIFY LICENSING AGENCY, PLACEMENT AGENCY AND RESPONSIBLE PERSONS, IF ANY, BY NEXT WORKING DAY.
SUBMIT WRITTEN REPORT WITHIN 7 DAYS OF OCCURRENCE.
RETAIN COPY OF REPORT IN CLIENT'S FILE.

NAME OF FACILITY	FACILITY FILE NUMBER	TELEPHONE NUMBER ()	
ADDRESS	CITY, STATE, ZIP		
CLIENT'S NAME	D.O.B.	SEX	DATE OF ADMISSION
DATE AND TIME OF DEATH	PLACE OF DEATH		

DESCRIBE IMMEDIATE CAUSE OF DEATH (IF CORONER REPORT MADE, SEND COPY WITHIN 30 DAYS):

DESCRIBE CONDITIONS PRIOR TO OR CONTRIBUTING TO DEATH:

EXPLAIN WHAT IMMEDIATE ACTION WAS TAKEN (INCLUDE PERSONS CONTACTED):

MEDICAL TREATMENT NECESSARY? YES NO IF YES, GIVE NATURE OF TREATMENT:

NAME OF ATTENDING PHYSICIAN	NAME OF MORTICIAN
REPORT SUBMITTED BY:	DATE
REPORT REVIEWED/APPROVED BY:	DATE

AGENCIES/INDIVIDUALS NOTIFIED (SPECIFY NAME AND TELEPHONE NUMBER)

- LICENSING _____ ADULT/CHILD PROTECTIVE SERVICES _____
- LONG TERM CARE OMBUDSMAN _____ PARENT/GUARDIAN/CONSERVATOR _____
- LAW ENFORCEMENT _____ PLACEMENT AGENCY _____

California Department of Social Services (CDSS)

744 P Street, Sacramento 95814

Children & Family Services Division

Out-of-State Placement Policy Unit

Interstate Compact Administrator

744 P Street, MS 8-12-90

Fostercare.incidencereport@dss.ca.gov

FAX: (916) 651-8144

Community Care Licensing Division

Children's Residential Program

Out of State Certification Unit

744 P Street, M.S. 8-3-54

(916) 651-5380

FAX: (916) 657-1657

Thank You

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