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Service Stream	Families and Young People Services	Category	Residential Care and Transition Services
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What is a Critical Incident?

A Critical Incident is an incident that indicates that harm, potential harm, breaches of the Statement of Standards, breaches to legislation, the license has been placed at risk or other significant impacts may have occurred. A critical incident can have an impact on a person we support, employee, the service and/or Mercy Community (MC).

All Critical Incidents must be reported as per Incident Reporting timeframes, dependent on assessed category (i.e., 1 or 2), at the time that the employee or the service becomes aware of, or reasonably suspects, that an incident is a Critical Incident. For further information regarding incident reporting timeframes and process, refer to *FS PROC RCaTS Incident Reporting*, *FS WF RCaTS Incident Reporting Process* and *Department's Incident Reporting Guide for Residential Care Services*.

Recording an Incident

To provide a full picture of the incident, including the context, the following details are required to be recorded in the CTARS Incident Log form:

- The date and time of the incident;
- The place of the incident;
- Details of the client/s – name, age and gender;
- Details of the worker and/or persons who reported/witnessed the incident;
- Details of emergency services involvement;
- Details of any Police involvement related to the incident;
- The type of incident, including identified level of risk and category;
- Name of the MC Line Manager/On-call Worker the incident is reported to;
- Description of the incident, including antecedents, behaviour, de-escalation, consequence, and possible function; and
- Details of the person preparing the report.

When writing an Incident Log, ensure that:

- All information provided in the Incident Log is factual and concise;
- The information in the Incident Log is described in detail, time lined and written clearly to reduce any confusion or misconception by the reader of the report; dot points are appropriate
- The report is written in third person, noting role e.g., Residential Care Worker (RCW) Joe Blog;
- Names of the person we support, employee/s and any other people are provided in the description of the incident, not initials;
- Firsthand descriptions of what was seen or heard by the person completing the report are used;

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- If the incident concerns a disclosure by a person we support, write the words actually used by the person we support;
- If the incident concerns a disclosure, the time and date of the incident as recorded within the report is the time and date on which the disclosure occurred – not the time and date of the alleged event; and
- **For disclosures that fall under Category 1 – Alleged or suspected unmet standard/s of care (*Child Protection Act 1999*) or duty of care including the use of a prohibitive practice, refer to *FS PP Responding to Disclosures*.**

Processing an Incident Log within the CTARS Incident Register

1. Immediate Intervention Section

This section provides an overarching assessment of the incident and places the incident in the context of the person we support's behaviour and the whole program.

- Is this behaviour/ presentation known or a new behaviour?
- Did the care team follow the current therapeutic plans in place to respond to the presenting behaviour?
- Did the interventions work successfully?
- Has there been any new learning from this incident?
- Will the interventions in place need to change, and why?
- Is the incident an indication of progression or regression?
- Comment on relationship repair and co-tenant dynamic if relevant?

2. Actions, Investigations and Comments Section

This section outlines the actions that will be undertaken as a result of the incident. Ensure the following aspects are covered off if required:

- Response to property damage/need to replace items;
- Debriefing with the person/people we support (include who and when);
- Debriefing with the team members (include who and when);
- Clear changes to the intervention strategies (what and by when);
- Additional care team training that has been identified as required;
- Additional or different psychoeducation for the young people;
- Review of other CTARS data, such as Behaviour Logs, Sleep Disturbance Logs, any Specialist Forms;
- Informal and formal investigations that will take place as a result of the incident.
- Include commentary regarding delays to verbal and written reporting.

For example: *Care Team Leader (CTL) notes that the incident report has been submitted outside of timeframes. This is due to the Residential Care Worker (RCW) being required to remain on the floor to support the person we support to reengage, and incident being written after business hours.*

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3. Incident Notification and Distribution Section

This section lists the date, time, contact details and methods required reporting occurred. This can include both verbal reporting (incidents that are Critical, and High must have verbal reporting to the Department at the time of the incident) and written reporting (PDF copy of the incident report for all incidents).

There is to be one line entered with details of verbal reporting of incident and one line entered for the written reporting details of the incident.

The required recipients of the incident report are listed in the External Client Link section of the CTARS Client Profile.

When to contact police

At Mercy Community, we need to provide people we support with care that responds to trauma in way that does not necessarily criminalise actions and behaviour.

Police should be called to respond to incidents where there is an immediate safety risk or a criminal complaint. This must then involve follow up support for each person we support involved or present, including access to legal services.

The purpose of the Queensland Police Service (QPS) is to provide timely, high quality and efficient policing services to make the community safer and to stop crime. Prior to contacting police, consideration should be given as to whether police are the appropriate emergency service to provide a response to incidents at the residential care service.

Police have no powers in relation to issues including:

- Behaviour management;
- Returning a person we support to a placement, or otherwise transporting them; or
- Potential criminality (e.g., property damage) but where no criminal complaint will be made.

Officers responding to calls for service are more likely to be uniformed officers. These officers are unlikely to have had significant exposure to person we support who have experienced trauma. Their priority will be to ensure the physical safety of all persons present, and to determine whether a criminal offence has occurred.

Expanded descriptors for Incident Categories

(as per the Department's Incident Reporting Guide for Residential Care Services)

Category 1 – Critical Risk Incidents (risk is labelled as 'Critical' or 'High' in CTARS)

Critical Level of Risk:

- Death or fatal injury of a person we support
- Death or fatal injury of a carer or community member
- Alleged or suspected unmet standard/s of care (*Child Protection Act 1999*) or duty of care including the use of a prohibitive practice
- Incident to cause reputation risk or attract media attention (inc. demonstrations)
- Major security incident

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Category 1 – Critical Risk Incidents (risk is labelled as ‘Critical’ or ‘High’ in CTARS)					
<ul style="list-style-type: none"> Serious public health risk Abduction or hostage of person we support 					
Death or fatal injury of a person we support					
A person we support has died, regardless of the cause of death.					
Death or fatal injury of a carer or community member					
A person we support witnesses or is involved in the death of a carer/community member.					
Alleged or suspected unmet standard/s of care (<i>Child Protection Act 1999</i>) or duty of care including the use of a prohibitive practice					
<p>A person we support has experienced, or is alleged to have experienced, harm or compromised care that has been caused by an MC employee or a carer supported by MC and is in direct opposition to legal or moral care standards and/or the matter may affect MC’s ability to continue providing services.</p> <p>This includes where a prohibitive practice has been used without the prior authorisation as per the Department’s Positive Behaviours Support Policy.</p>					
Concern requiring immediate response – use of prohibited practice					
<p>Prohibited practices are unlawful and unethical practices and practices which cause a high level of discomfort and trauma. Any action which is contrary to section 122 of the <i>Child Protection Act 1999 (Qld)</i> because it frightens, threatens or humiliates a child or young person is a prohibited practice. Prohibited practices must not be used in responding to the behaviour of children who are placed in care under section 82(1) of the Act.</p> <p>Physical restraint</p> <p>Physical restraint can result in injury, trauma, and death. The following types of physical restraint are prohibited by Child Safety as either an emergency, or as a planned response:</p> <ul style="list-style-type: none"> Prone restraint – holding a person we support on their stomach in a face down position; Supine restraint – holding a person we support on their back in a face-up position; Basket holds – holding a person we support with the intent to restrict their movement by wrapping your arms around their upper and/or lower body; Take down techniques – where the person we support is taken to the floor in either a controlled or uncontrolled manner; Any restraint which covers the person we support’s mouth or nose or any other way restricts breathing; Pushing the person we support’s head to their chest or bending the person we support forwards at the waist; Restraint involving the hyperextension or hyperflexion of joints; The application of pain for compliance; and Having a carer sitting or kneeling on the person we support. <p>The planned use of physical restraint is not supported by Child Safety.</p>					
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Category 1 – Critical Risk Incidents (risk is labelled as ‘Critical’ or ‘High’ in CTARS)

Seclusion

Seclusion is the sole confinement of a person we support in a room where the person we support is not able to leave or believes that they are not able to leave. Rooms or areas designed specifically for the purpose of seclusion, or which are used primarily for the purpose of seclusion are not permitted.

This does not include steps taken by a carer or member of direct care workers in a parenting role to discipline and respond to developmentally appropriate behaviour. For example, the short periods of ‘time out’ type strategies consistent with accepted parenting practices such as those promoted through the Triple P Program. Care will be taken that these strategies do not continue as the person we support becomes older and that they do not become seclusion.

Containment

Containment is a type of environmental restraint where the person we support is unable to freely leave the home in order to manage responses to their behaviour which causes harm to themselves or others.

It does not include everyday safety responses such as locking the front door to prevent intruders however if a person we support has appropriate independence skills and is able to safely leave the home, they should be able to do so freely.

Environmental restraints – ongoing use of restricted access to items

The ongoing use of restricting access to items in a person we support’s home is not supported as a strategy to manage behaviour, particularly if it is considered problematic behaviour. For example, restricting access to food or hygiene items like soap to prevent people we support making a mess.

Chemical restraint

Chemical restraint is the use of medication to manage a person we support’s behaviour where they are prescribed it for the primary purpose of controlling the person we support’s behaviour. This does not include the prescription and application of medication in response to a specific medical/mental condition. For example, Epilim when prescribed for epilepsy manages seizures. This is not considered a chemical restraint. Where Epilim is prescribed in the absence of epilepsy for the purposes of managing behaviour, it would be considered a chemical restraint; and a prohibited practice. The use of routine or as required (PRN) chemical restraint is not supported by Child Safety.

Mechanical restraint

Mechanical restraint is the use of materials or items to manage a person we support’s behaviour such as helmets, clothing, and splints. These aids restrict the free movement of the person we support with the intent to prevent injury.

Mechanical restraint does not include:

- Therapeutic items that have been prescribed with a therapeutic intent for example, postural support and is used within the parameters of the recommendations of the prescribing therapist;
- Developmentally appropriate aids and support devices for example, a cot; or

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Category 1 – Critical Risk Incidents (risk is labelled as ‘Critical’ or ‘High’ in CTARS)

- The use of devices to facilitate medical treatment for example a wrap around the person we support’s waist to cover a feeding tube to prevent the person we support pulling it out.

These items will be monitored to ensure that they:

- Do not convert to being used as a mechanical restraint for example, a stroller with straps for postural support that had been prescribed for when a person we support fatigues in the community starts being used in their home as a way to manage the person we support’s behaviour; and
- Are not used in a way to punish a person we support or used for lengthy periods of time for example placing a person we support in a cot for lengthy periods as a form of discipline.

Corporal punishment

Corporal or physical punishment is the use of physical force intended to cause some degree or discomfort for discipline, correction, control, changing behaviour or in the belief of educating the person we support. For example, hitting, slapping, whipping, kicking, pinching, punching, pushing, or shoving.

Aversive strategies

The application of painful or noxious conditions on a person we support’s face or body parts. Examples including unwanted cold or hot bath, application of chilli powder on a food or body parts, unwanted squirting of liquid.

Unethical practices

Practices that may be considered unethical include:

- Rewarding people we support with cigarettes or other substances;
- Using family contact as a reward or the withdrawal of family contact as punishment;
- Deprivation of meals, sleep, clothes, shelter, personal hygiene;
- Restricting access to everyday items for example food, personal hygiene, on an ongoing basis; and
- Psychosocial restraint which usually involves ‘power-control’ strategies.

Incident to cause reputation risk or attract media attention (including demonstrations)

An incident has occurred that has peaked, or is likely to peak, interest from the media or other stakeholders that may have a detrimental bearing on MC’s reputation in the community.

Major security incident

An incident has occurred that has peaked, or is likely to peak, interest from the media or other stakeholders that may have a detrimental bearing on MC’s reputation in the community. This includes an incident, issues or event that has occurred that poses a credible threat to the safety of a person supported by MC, including bomb, biological or chemical and, at the time of reporting, the threat is not realised. For example, joyriding in stolen vehicles which has attracted media attention.

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Category 1 – Critical Risk Incidents (risk is labelled as ‘Critical’ or ‘High’ in CTARS)

Serious public health risk

A person supported by MC is medically diagnosed with a condition that is identified as a serious risk to public health. For example, a person diagnosed with a serious highly contagious illness and the Medical Officer or General Practitioner makes the notification.

Abduction or hostage of a person we support

A person we support has become involved in a hostage situation where there is an imminent threat to their life or safety.

Category 1 – High Risk Incidents (risk is labelled as ‘Critical’ or ‘High’ in CTARS)

High Level of Risk:

- Missing person we support
- Serious medical situation/life threatening injury to a person we support or staff member
- Serious mental health episode/self-injurious behaviour/suicidal ideation
- Emergency use of restrictive practice
- Immediate risk of harm, neglect, or exploitation (not by a carer)
- High risk illicit substance or alcohol possession/use
- Serious assault (including alleged) to person we support including physical and sexual assault
- Alleged or confirmed criminal activity with legal or police action

Missing person we support

A person we support is considered missing when:

- Their whereabouts are unknown and there are serious concerns in relation to their safety and well-being - for example, they are vulnerable because they are under 12 years of age, are at significant risk, engage in high-risk behaviours or have a significant intellectual or physical disability; and/or
- A reasonable search has been undertaken and the person we support cannot be located.

Identifying and assessing risks

Judgment must be applied in determining potential risk and an appropriate response, considering factors such as the person we support’s age, developmental level and vulnerability. When unsure about the appropriate response or level of incident, the carer or worker should contact their line manager or appropriate on call person to discuss.

Consideration should be given to the following in deciding whether the event requires immediate reporting to the Department:

- Is the person we support particularly vulnerable due to their age or a recent event?
- Is the person we support’s location known? Is this place safe?

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- Does the person we support regularly leave placement and return within a certain timeframe?
- Has contact been made with known friends, family other people who may know where the person we support is?
- If the location of the person we support is known, have they been encouraged to return to the placement?
- If it is after hours, has consultation occurred with the line manager, or On-call support, to determine whether the incident/matter warrants immediate reporting or support from the Department?
- Is it appropriate for the matter or incident to be raised with the person we support's Child Safety Officer (CSO) the following business day?

Contact with QPS about a missing person we support

The police are to be advised of a person we support's absence from their placement where their location is unknown and there are concerns for their safety and/or welfare due to their vulnerability. **There is no minimum time period** on making a missing person report to police. Workers must, however, have made all reasonable attempts to find and locate the person we support who you consider is missing.

- In this case, the police should be contacted to lodge a missing person's report. This is to be done by attending the police station.
- If there are extenuating circumstances that prevent attendance at the police station, as the carer, you must contact QPS to discuss an alternative process to facilitate the lodging of the missing person report.
- Workers are required to complete the *QPS Reporting Missing Children Form* (link available on the MercyNet Portal page).
- Workers should attempt to complete all fields in the checklist.
- Workers should provide a current and up to date photo of the missing person we support.

After completing the missing person report, as a carer you are required to ask and record the following:

- The date and time of the missing person report was made;
- The name of the police officer who received the missing person report; and
- The QPRIME number obtained from the police officer taking the information from you.

This information is then reported to the on-call representative, who will notify Child Safety After Hours (CSAH) and then recorded within the Incident Log.

Media authorisation

The police may decide to release information to mainstream media to assist in locating the missing person we support. To do this, they require the signature on the Missing Person Media Authorisation form. Child Safety Team Leaders or CSAH can sign this form. This form does not identify the person we support as being subject to a child protection intervention.

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In the event that police need to release additional information that does disclose the person we support is currently under an intervention order, the police must secure written authorisation from the Chief Executive of the Department.

Responding when the person we support returns to placement

It is important that the Department and QPS are advised immediately when the person we support returns to the placement. The appropriate Child Safety Service Centre (CSSC) is to be advised during business hours and CSAH are to be advised after business hours. Police are no longer required to sight the person we support upon return to placement. This can be confirmed by the carer or CSO.

Serious medical situation/life threatening injury to a person we support or staff member

A life-threatening medical situation may be a situation where a person we support's or staff members life is at risk, and they require medical support.

For example:

- A person we support is hospitalised due to injury and are in a critical condition; or
- Critical health situation (e.g., person we support has serious health issue or injury that requires admission to hospital or emergency medical support).

A worker has been injured on shift whilst performing their duties or injured during an incident with a person we support and requires emergency services or hospitalisation. Workers are also required to complete a WHS Incident Report via RiskMan.

Serious mental health episode/self-injurious behaviour/suicidal ideation

"Distinguishing between 'self-harm without suicidal intent' and 'attempted suicide' can at times be difficult. Regardless of motivation or intention, both are dangerous behaviours associated with a heightened risk of dying. Self-harm is a maladaptive behaviour that reflects severe internal distress (which may not always be evident in the external demeanour) and a limited ability to develop effective coping strategies to deal with difficulties."

- (NSW Department of Health, 2004, p.05)

People we support may experience episodes of mental health concerns which need to be assessed to ascertain the appropriate level of responses. This is considered serious/high-risk if it places their life, or others, at risk, or requires immediate medical attention. In undertaking this assessment, workers should consider the following current diagnosis and treatment plans – this must be detailed in their CTARS Client Information.

It is important to distinguish the difference between self-harm, suicidal ideation and attempted suicide. If a person we support is displaying self-harming behaviour, has previously attempted suicide or is displaying suicidal ideation, it is important for the level of risk to be assessed by the worker on shift.

In order to assess risk, the following questions may be asked:

- Have things been so bad lately that you would rather not be here?
- Have you ever been feeling so bad that you have thought about suicide?

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- Are you thinking of committing suicide?
- How often have you had these thoughts about killing yourself?
- Have you made any current plans?
- Do you have the means to carry out these plans?
- Have you decided when you are going to carry out these plans?

Risk levels and response to suicide ideation/mental health issues

Level of risk	Suggested response
Low risk Some thoughts but minimal risk factors, no previous attempts, no specific plan, intention or means, evidence of minor self-harm, protective factors (e.g., available supports).	<ul style="list-style-type: none"> • Monitor closely and agree on a verbal or written safety plan with the person we support; • Discuss protective factors with the person we support; • Assist the person we support to identify support person/s; • Provide the person we support access to support, for example, support numbers such as: <ul style="list-style-type: none"> ○ Lifeline 13 11 14; or ○ KidsHelpline 1800 55 1800; • Follow the strategies contained within the Positive Behaviour Support Plan or any other Safety Plan – the person we support should be aware of these plans; • Obtain commitment to follow the plan should feelings escalate; and • Organise appropriate follow up (e.g., consultation with CSO, mental health professional, etc.).
Moderate risk Thoughts, some risk factors, plan has some specific detail, means are available, intention to act in near future but not immediately, some protective factors (e.g., inconsistent supports).	<ul style="list-style-type: none"> • Offer or refer for further assessment/contact with mental health or other appropriate service; • Agree on a written safety plan with the person we support, clearly outlining relevant supports to be contacted if feelings escalate; • Follow the Positive Behaviour Support Plan; • Consult with line manager, as necessary; • Seek appropriate mental health support specialist input regarding required supports; • Negotiate with the person we support to attend specialist support, if required, and provide transport; and • Organise appropriate further follow up (e.g., consultation with CSO, mental health professional, etc.).

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High risk

Thoughts, previous attempts, risk factors, clear and detailed plan, immediate intent to act, means are available (and lethal), social isolation.

- Follow the Positive Behaviour Support Plan;
- Limit confidentiality;
- Immediately refer to hospital mental health services or emergency mental health team;
- If risk is high and the person we support has the intention to act, contact ambulance immediately and ensure that the person we support is not left alone;
- Consult with supervisor/on-call; and
- Organise appropriate follow up (e.g., consultation with CSO, mental health professional, etc.).

Adapted From: Psycheck, Screening Tool Users Guide, n.d, p.13

If the person we support is likely to become aggressive or is likely to refuse support, it may be necessary to contact police also, but it is preferable to allow Ambulance staff to make this assessment.

All self-harming behaviour, suicide or attempted suicide is to be reported as per the appropriate level as assessed in accordance with the above guide. If suspected that a person we support has implements to harm themselves in their room; a room search may be conducted to aid in reducing risk and maintaining the safety of all people we support in the residential home.

Self-injury

Self-injury or self-harm can be a way of coping with unbearable feelings, an important survival function. The physical act of self-injury can give a person an immediate sense of relief in the form of calmness, joy or wellbeing due to the endorphins released by the body to mask the feelings of pain. Due to the endorphins, this can become physically and mentally addictive, however, the feeling is short-lived and the need to self-injure increases. This results in a vicious cycle of addiction which can only be broken if the feelings behind the self-injury are treated.

Self-injury generally has meaning for the person themselves. Specific reasons can vary but they may do so:

- To alter their mood when they are depressed or angry;
- Because they are frustrated and don't know what else to do; or
- It's a sign that the person is not coping with their surroundings or the situation.

Supporting a person who self-injures can be challenging and difficult. People who self-injure should be treated with care and given appropriate physical treatment for their injuries. Any intervention or treatment should aim at reduction of the harm and promote emotional and physical safety. This may include medical treatment, intervention from a mental health professional, therapy, medication, support groups, etc. There are also a range of short and long term practical and supportive responses which should be explored.

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Emergency use of restrictive practice

At times, people we support may engage in behaviours of such intensity, frequency and duration they present immediate risk to themselves and/or others without intervention. In these limited instances, the emergency use of a restrictive practice may be required to manage risk.

Guiding principles for the emergency use of restrictive practices

The situation in which an emergency use of restrictive practices may be appropriate is when:

- The person we support is behaving in a way that poses immediate foreseeable risk of harm or actual risk of harm to themselves or others;
- The practice is reasonable in all the circumstances of the behaviour;
- Where there is no less restrictive measure available to respond the person we support's behaviour in the circumstances; and
- Paramount consideration must be given to the best interests of the person we support.

When responding to unsafe behaviour of people we support, carers and direct care workers may be required to intervene, as a last resort, proportionate to the behaviour displayed and with reasonable force to protect the person we support, themselves and others. Reasonable force is defined as the minimum force necessary to protect the person we support, oneself and others from injury or harm.

Where reasonable force is used, this must only be in conjunction with the use of an emergency use of restrictive practice, and not prohibited practice.

Emergency use of physical restraint

Physical restraint is the sustained or prolonged use or action of physical force to prevent or restrict the movement of a person we support, or any part of their body, for the primary purpose of managing their behaviour that causes risk of or actual harm to themselves or others. It is distinct to a hands-on technique to guide the person we support away from potential harm or injury consistent with what would be considered as exercising duty of care towards a person we support.

People we support in care arrangements are not to be physically restrained by workers or carers except in emergency circumstances. In all circumstances where physical restraint is used in an emergency, workers or carers are required to ensure that the physical restraint:

- Is reasonable and necessary to prevent the person we support from harming themselves or others; and
- Is the least restrictive option, in that it is the minimum level of force which is reasonable and necessary to protect the person we support against danger; and
- Is applied for the shortest amount of time possible, and is removed as soon as the risk has reduced; and
- Is only used where the risk of not using the restraint outweighs the risk for using the restraint.

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There is a serious risk that physical restraint can result in physical and/or emotional harm to the person we support, the person applying the restraint, and those that witness the restraint. Any emergency use of physical restraint will consider the person we support's individual needs and circumstances, including:

- The age and size of the person we support;
- Past behaviours;
- Any impairment, disability or health condition the person we support may have for example obesity, epilepsy, medications or the side effects of drug use;
- The person we support's cultural background;
- Any history of trauma, including physical and sexual abuse or exposure to domestic and family violence; and
- The environment in which the physical restraint is taking place.

If the emergency use of physical restraint is required, the person we support will be carefully and continuously monitored and must never reach the stage where:

- The person we support subject to the restraint says they cannot breathe, vomits, demonstrates signs of physical or psychological distress, starts to change colour or has a medical emergency such as a seizure; or
- The worker administering the restraint is observed to be injured, unwell or unable to continue to safely monitor the situation.

After any use of emergency physical restraint, the person we support will be:

- Supported to access any required medical attention;
- Provided the opportunity to debrief about the incident once they are calm.

Prohibited physical restraints are listed in the prohibited practices section of this policy and cannot be used under any circumstance. These specific restraints are recognised as high-risk physical restraints.

An example of an emergency use of physical restraint is:

- A person we support is hitting another person we support, and it may be necessary for the safety of both people we support that you, as the worker on shift, intervene. In this instance a worker may need to place their hands on the person we support's arm to prevent him from continuing to hit the other person we support and to allow the other person we support time to get away.
- A person we support may be threatening to step in front of a car, it may be appropriate to place your hands on the person we support's waist to move them away and prevent them from being harmed.

Emergency use of Environmental Restraint – Emergency removal of an object that may cause harm

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Environmental restraints restrict a person we support's free access to all parts of their environment, including objects.

People we support have the right to access all everyday items and areas in their house. There may be instances where a person we support using an object in a way that creates imminent risk or actual harm to themselves or others. In these situations, an object may need to be removed until the risk reduces or to prevent ongoing actual harm. If there is need to remove an object when there is imminent risk or actual harm:

- It will be removed for the shortest amount of time possible; and
- Will be returned to the person we support's environment once the risk has reduced
- The removal of the object may be accompanied by the emergency use of physical restraint and the principles related to this will be considered.

The ongoing restriction of access to objects, particularly as the sole behavioural management strategy is not supported by Child Safety. Where the person we support continues to use objects in a way that presents a risk of or actual harm to themselves or others, a Positive Behaviour Support Plan will be developed with a focus on reducing the behaviours of harm.

Emergency removal of an object does not include removal:

- Due to the person we support not having the relevant safety skills, as appropriate to their developmental age for example locking chemicals up when there are young children in the house; or
- Items that may be used for illegal purposes such as weapons; or
- Items that need to be locked away to ensure carers are compliant with relevant licensing requirements.

An example of Emergency use of Environmental restraint:

Remove illegal or harmful objects that may be used to harm self or others (with consideration to your own safety).

Emergency use of restrictive practices may only be used where there is a high risk of immediate harm to the person we support or others. When emergency use of restrictive practices is used, paramount consideration must be given to the best interests of the person we support.

The use of emergency use of restrictive practices must be reported as a Category 2 Critical Incident and be reported to the Department as soon as possible (as per *FS PROC RCaTS Incident Reporting* and *FS IP RCaTS Incident Category Definitions*).

It is important when including the use of an emergency use of restrictive practice in an Incident Log that as much detail as possible is given to the description of the incident. The following information should be included:

- What happened that necessitated the emergency use of restrictive practices being used?
- When and for how long the emergency use of restrictive practice was used?

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- Where and how physical contact was made with the person we support?
- Specific details of harm (if any) caused by emergency use of restrictive practices (e.g., there was a red mark on Johnny's right wrist where I held his arm to prevent him from hitting Mark).

When possible, the worker should discuss with the person we support the reason for the emergency use of restrictive practices. This should be included in Life Space Interview (LSI).

Immediate risk of harm, neglect, or exploitation (not by a carer)

What is Harm?

Harm is any detrimental effect of a *significant* nature on the person we support's physical, psychological or emotional wellbeing. Harm can be caused by physical, psychological or emotional abuse, neglect or sexual abuse or exploitation (it is immaterial how the harm is caused). Harm or risk of harm is something that has occurred or is at risk of occurring.

Harm can be caused by a single act, omission or circumstance, or a series or combination of acts, omissions, or circumstances.

It is important to remember that all disclosures, allegations of harm or suspected harm to a person we support or Standards potentially not met that a worker or the service becomes aware of must be reported to the Department, regardless of the source of the information, unless the report is received directly from the Department.

Disclosure of past harm where risks are present

A person we support in care may disclose harm that has occurred to them in the past. Whether it be a family member or previous carer, the safety and wellbeing of the person we support is the primary concern.

- If action is required to secure the person we support's immediate safety, this must be taken as priority;
- Be aware that the people we support who disclose harm are particularly emotionally vulnerable;
- Ensure that the people we support are supported throughout the process; and
- If people we support disclose abuse, do not attempt to investigate it. For example, instead of questioning them, support them to report the matter to an appropriate person in authority (e.g., the Departmental Community Visitor, CSAH).

Do not collude with a person we support about not reporting the incident. This applies even if a person we support tells you something in 'confidence'. Remind them that you are legally bound to report concerns about them.

Abuse and Harm Types

Neglect

The person we support's necessities of life are unmet by his/her parent/carers to such an extent that the person we support's health and development are affected, causing harm, or likely to cause an unacceptable risk of harm to the person we support.

Physical Harm

A person we support has suffered, or is at an unacceptable risk of, suffering, serious physical trauma or injury.

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Sexual Abuse	Child/young person sexual abuse refers to any sexual activity or behaviour that is imposed on a person we support by his/her parent, carer or a household member (including other people we support). It includes the inducement or coercion of a person we support to engage in, or assist any other person to engage in, sexually explicit conduct or behaviour for the sexual gratification or profit of the person responsible. It also includes circumstances where there is an unacceptable risk that the person we support may be sexually abused.
Emotional Harm	The person we support's social, emotional, cognitive, or intellectual development is impaired or seriously threatened as a direct result of persistent parental behaviour or attitude toward the person we support. This includes significant emotional deprivation due to persistent rejection or hostility. The harm to the person we support may be observable in behaviour such as severe anxiety, depression, withdrawal, self-harming behaviour or aggressive behaviour towards others.

High risk illicit substance or alcohol possession/use

Disclosure of substance abuse

If a person we support discloses that they have been using substances, it is important to ask the person we support the following questions to establish an assessment of risk as to whether the substance presents a significant risk to their safety and/or is significantly impacting on their functioning:

- What substance/s they have been using?
- How much of the substance/s have they taken?
- How long ago did they take the substances?
- How do they feel?
- Observe the person we support, how they present physically and emotionally and what they sound like.

Consult the Safety Plan for guidance and use observations to determine appropriate action.

It may be necessary to contact 13 HEALTH or other health professionals in order to obtain advice in assessing risk. Depending on advice determine the appropriate level of incident and report accordingly. It may be necessary to contact the Ambulance if immediate concerns are held for the person we support's wellbeing.

If it is suspected that a person we support has substances on the property, they must be given the opportunity to dispose of these. A room or bag search may be necessary to aid in maintaining the safety and legality of all people we support and workers in the residential home. It is always best practice to inform the person we support of this where it is safe to do so. Workers should avoid removing or storing illegal substances themselves due to potential for prosecution.

Suspected substance use without disclosure

If it is suspected that a person we support has arrived home under the influence, discuss the issue with the person we support, when possible, and attempt to get them to disclose that they

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have used substances (ask questions above). If the person we support discloses their use of substances follow the above process.

If the person we support does not disclose that they have been using substances, however, there remains concerns for their health and wellbeing, contact 13 HEALTH for advice.

If there is any concern regarding possible overdose or poisoning, the person we support must receive immediate medical attention and the line manager/on-call representative must be contacted immediately. They will then immediately advise the Department.

If people we support are under the influence of substances, discuss with 13 HEALTH and the on-call representative as to the frequency of monitoring.

Medication and alcohol/other drugs

If there is suspicion that a person we support has consumed alcohol or other medication/drugs, do not administer any medication prior to receiving advice or instruction from a doctor, an after-hours medical service/ 13 HEALTH, or the emergency department of the local hospital.

Call an Ambulance if the person we support is in distress or showing signs described by the doctor as requiring hospitalisation. **If in doubt, call an Ambulance.**

Serious assault (including alleged) to a person we support or staff including physical, sexual assault and rape

Person we support

When a person we support has been subject to serious physical injury (including accidental), an assessment must be made as to what type of medical assistance is required and help rendered immediately.

Sexual assault and rape

If a person we support discloses sexual assault or rape (including alleged) it is important to provide support to the person we support. Workers have mandated responsibility to report, and it would be necessary to discuss with the person we support going to the doctor's or hospital for a health check, as well as reporting the incident to the police.

Employee

Where an employee is allegedly raped or sexually assaulted whilst performing their duties. Worker to complete a WHS Incident Report through RiskMan.

Alleged or confirmed criminal activity with legal or police action

People we support may engage in high-risk behaviours which constitute potential criminal offences. This may include, but not limited to, a person we support engaging with an adult and communicating in a sexual nature, possessing, or sending images of a sexual nature on a mobile device.

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Person we support leaves the premises with police due to investigation into their criminal behaviour

If a person we support encounters contact with police or the court system, it is essential that MC assists the person we support to access appropriate legal advice prior to consenting to an interview. This support person must ensure the person we support understands the process and their rights, that they can exercise those rights, and to ensure that the police conduct the interview fairly. If the person we support agrees to an interview, the best way to support them is to organise for the interview to take place after they have sought legal advice. A support person cannot be a Residential Care Worker (RCW) involved in the incident.

As Child Safety is the guardian, they should be contacted to support the interview process.

Workers must ensure that they contact their line manager/on-call representative, who will consult with the Department and seek appropriate guidance ahead of seeking legal advice.

Useful contacts include:

- Youth Advocacy Centre – call 07 3356 1002 or visit <http://www.yac.net.au/>;
- Logan Youth Legal Service – call 07 3826 1599;
- Legal Aid Queensland – call 1300 651 188;
- Aboriginal and Torres Strait Islander Legal Service (ATSILS) – call 1800 012 255;
- Community Legal Centres (CLCs) – visit www.naccl.org.au for your nearest CLC; and
- Youth Legal Advice Hotline – 1800 527 527.

Category 2 – Medium Risk Incidents (risk is labelled as 'Medium' in CTARS)

Medium Level of Risk:

- Medical situation/injury
- Alleged historical/past harm, neglect or exploitation
- Self-injurious behaviour or plausible threats
- Illicit substance or alcohol possession/use
- Escalating risk taking behaviour
- Alleged or confirmed criminal activity
- Medication error/refusal/unable to administer which has serious consequences
- Absence from placement
- Significant property damage (destruction of premises)
- Problematic sexually reactive behaviour

Medical situation/injury

A non-critical medical situation is where a person we support has suffered a serious injury or illness which is not life-threatening or experiences a mental health episode that requires medical treatment but does not result in hospital admission (e.g., broken arm).

Alleged historical/past harm, neglect, or exploitation

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There may be situations where it has been identified that there is a serious and credible risk of the person we support experiencing significant harm or injury, however, their immediate safety is not threatened. This may occur when the person we support has unauthorised contact with any person who has not been approved by the Department, such as their parents due to previous child protection issues and risk of harm. If the person we support is to meet with the parents, regardless of if whereabouts are known, this would be reported as a Medium Risk Category 2 Incident.

The list of approved contacts does not form an exhaustive list of approved contact people. Workers can assess suitability of people outside of the approved list for contact up to 48 hours. Decisions should be based on a range of information to inform the assessment of risk including phone calls, visits to location and other reasonable measures to ensure safety and appropriateness of contact arrangements.

Self-injurious behaviour or plausible threats

A person we support has caused intentional harm to themselves requiring medical support or treatment or has expressed an intention to cause physical harm to themselves without conscious intention to die.

Illicit substance or alcohol possession/use

A person we support engages in substance misuse or the effect of such is observed but does not appear seriously impacted and does not require medical attention or hospitalisation.

This can include a disclosure of past use or a person we support who is in possession of illicit substances or paraphernalia.

A person we support has disclosed the use of substances or substance use is suspected. An assessment is undertaken to determine the severity of impact upon their safety and functioning. If this has been assessed as low risk as it is considered to have a minor effect on their day-to-day functioning, but this is a new or emerging behavior, further action may be necessary to ensure that the risk does not increase.

Escalating risk-taking behaviour

The person we support is displaying increased risk-taking behaviour, which poses an increased risk to themselves or others or property. This may include but is not limited to:

- **Assault/injury to another person we support or worker**

An assault or injury has occurred to a person we support or worker/carer that does not require medical attention. Care and concern including First Aid where required should be provided. Where this involves a worker, an Incident Report must be completed in RiskMan.

- **Verbal abuse, threats or intimidating behaviour**

Behaviour, harmful language, or a threat has been used that has caused significant distress or disruption to workers or other people we support in the house.

Alleged or confirmed criminal activity

A person we support has been charged with an offence and there is a pending court appearance OR is alleged to have been involved in criminal actions warranting police investigation.

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Medication error/refusal/unable to administer which has serious consequences

Administration of Medication

If a worker has incorrectly administered medication, has forgotten to administer medication or the person we support refuses to take their medication, and this will have potential serious consequences on the health or wellbeing of the person we support. Prior to consulting and reporting to the line manager or the on-call representative, contact 13 HEALTH to seek advice regarding the effect that the medication error is likely to have on the person we support and support the assessment of risk.

Examples of reportable medication errors are as follows:

- Any need for emergency services or hospital visits due to medication errors; and
- Medication errors that have detrimental effects on the person we support.

Refusal to take medication

If a person we support refuses to take medication, the worker should:

- Talk with the person we support about the reasons for refusal;
- Talk with the person we support about the reason why he or she needs the medication; and
- Continue to offer at regular intervals for up to one (1) hour. Contact 13 HEALTH to discuss if a delay in medicating will cause the person we support to suffer acute symptoms and follow advice given. Details of the advice and the actions taken must be recorded in the Incident Log.

Medication errors or adverse reactions

Overdose and poisoning can occur accidentally or as a deliberate attempt to self-harm. Vigilance regarding the storage and administration of all medications is necessary to minimise the risk of harm to people we support.

If the worker makes a mistake in administering the medication or notices a mistake in self-medication (i.e., dosage error), the following instructions must be followed:

- Inform the doctor immediately and follow the doctor's instructions. Where the doctor's instructions involve a change to the original medication schedule, the instructions from the doctor must be in writing;
- Contact 13 HEALTH (13 43 25 84) immediately and follow any advice provided; and
- The person we support must always be observed for a short time after taking medication for any adverse effects of medication. If any adverse reactions are observed, these should be carefully noted and reported to the medical service or doctor who attends to the person we support.

Absence from placement

A person we support who is absent from placement is defined as a person we support who has left the placement without permission and are assessed as not being at significant risk of harm;

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their location is known or can be quickly established, or they display patterns of behaviour of leaving the placement without permission but usually returns within a reasonable timeframe.

Workers should make all reasonable attempts to locate the person we support and make a judgement about the seriousness of the situation and respond like any reasonable parent. This would include:

- Attempting to contact the person we support;
- Searching the house/garage/grounds/yards;
- Asking friends and neighbours if they have seen them;
- Contacting the person we support's school
- Checking highly frequented environments (shops/parks/friends or other 'special' places); and
- Engaging with the other members of the person we support's Care Team (this may include parents or family members).

Identifying risks

Judgment must be applied in determining potential risk and an appropriate response, considering factors such as the person we support's age, developmental level and vulnerability. When unsure about the appropriate response or level of incident, the carer or worker should contact their line manager or appropriate on-call person to discuss.

Consideration should be given to the following in deciding whether the event requires immediate reporting to the Department:

- Is the person we support particularly vulnerable due to their age or a recent event?
- Is the person we support's location known? Is this place safe?
- Does the person we support regularly leave and return within a certain timeframe?
- Has contact been made with known friends, family other people who may know where the person we support is?
- If the location of the person we support is known, have they been encouraged to return to the placement?
- If it is after hours, has consultation occurred with the line manager or the on-call support to determine whether the incident/matter warrants immediate reporting or support from the Department?
- Is it appropriate for the matter or incident to be raised with the person we support's CSO the following business day?

Significant property damage (destruction of premises)

If a person we support has caused or contributed to destruction of property and that damage requires extensive repairs or would be in excess of \$5000, this must be immediately reported to the line manager/on-call representative. Where this damage presents a risk to health and safety, actions must be taken to make the area safe, and repairs prioritised.

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Willful damage should not be reported to police without consulting with the Senior Program Manager or On-call Manager.

Problematic sexually reactive behaviour

Due to trauma and lack of appropriate socialisation skills, people we support in care may display sexualised behaviours. Sexual behaviour becomes a problem for the person we support when it interferes with social, cognitive, emotional and/or physical development. It is a problem for others when it involves:

- Coercion, bribery, aggression, clandestine behaviour and/or violence;
- Behaviour that is abnormal for age/developmental capability;
- Behaviour that is compulsive, excessive and or/degrading; and
- A substantial difference in age or developmental ability between participants.

Problematic sexual behaviour may be a coping mechanism for controlling emotions. Problematic sexual behaviour may be due to trauma or lack of education and boundaries regarding age-appropriate sexual behaviour. The Traffic Light Framework is used to gain an understanding of healthy sexual behaviour from birth to 18 years of age. Problematic sexual behaviour can generally be assessed as those behaviours which sit within the “Red” and “Orange” descriptors. Behaviours which sit within the “normal” range (i.e., “Green light”) descriptors should be recorded within Shift Logs and do not meet the threshold for incident reporting.

Traffic Light Framework – sexual behaviours from birth to 18 years



Red sexual behaviours that are outside what is “normal” behaviour, which is excessive, secretive, compulsive, coercive or degrading.

Indicates a need for immediate intervention and action.



Orange sexual behaviours that are outside “normal” behaviour in terms of persistence, frequency or inequality in age or developmental abilities.

Signal the need to take notice and gather information to assess the appropriate action.



Green sexual behaviours that are “normal”, considered healthy, spontaneous, curious, light-hearted, easily distracted, experimentation and equality of age, size and ability levels.

Provide opportunities to give the person we support positive feedback/information.

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Red Light Behaviour is...

- Behaviour that is excessive, secretive, compulsive, coercive, degrading or threatening;
- Significant age, developmental and/or power difference between the children involved; and
- Of concern because of the nature of the activities and the way they occur.

These indicate a need for immediate intervention and action.

Birth to 5 years	5 to 9 years	9 to 12 years	13 to 18 years
<ul style="list-style-type: none"> • Simulation of explicit foreplay or sexual behaviour in play; • Persistent masturbation; • Persistent touching of the genitals of other children; • Persistent attempts to touch the genitals of adults; • Sexual behaviour between young children involving penetration with objects; and • Forcing other children to engage in sexual play. 	<ul style="list-style-type: none"> • Persistent masturbation, particularly in front of others; • Sexual behaviour engaging significantly younger or less able children; • Sneaking into the rooms of sleeping younger children to touch or engage in sexual play; • Simulation of sexual acts that are sophisticated for their age (e.g. oral sex); and • Persistent sexual themes in talk, play, art, etc. 	<ul style="list-style-type: none"> • Persistent masturbation, particularly in front of others; • Sexual activity (e.g. oral sex or intercourse); • Arranging a face to face meeting with an online acquaintance; • Sending nude or sexually provocative images of self or others electronically; • Coercion of others, including same age, younger or less able children, into sexual activity; and • Presence of Sexually Transmitted Infection (STI). 	<ul style="list-style-type: none"> • Compulsive masturbation (especially chronic or public); • Degradation/humiliation of self or others with sexual themes, e.g. threats, phone, email, touch attempt/force others to expose genitals; • Preoccupation with sexually aggressive pornography; • Sexually explicit talk with younger children; • Sexual harassment, forced sexual contact; • Sexual contact with others of significant age and/or developmental difference; • Sending nude or sexually provocative images of self or others electronically;

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			<ul style="list-style-type: none"> • Joining adults only online dating service; • Sexual contact with animals; and • Genital injury to others/self.
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Orange Light Behaviour is:

- Outside “normal” sexual behaviour in terms of persistence, frequency or inequality in age or developmental abilities;
- Outside normal in either type or persistence of activities;
- Of concern due to frequency and duration of the behaviour; and
- Behaviour which is ‘unusual’ or different for a particular child or children.

These signal the need to take notice and gather information to assess the appropriate action.

Birth to 5 years	5 to 9 years	9 to 12 years	13 to 18 years
<ul style="list-style-type: none"> • Preoccupation with adult sexual type behaviour; • Pulling other children’s pants down/skirts up against their will; • Explicit sexual conversation using sophisticated or adult language; • Preoccupation with touching another’s genitals (often in preference to other child focussed activities); • Chronic peeping; and • Following others into toilets to look at them or touch them. 	<ul style="list-style-type: none"> • Questions about sexual activity which persist or are repeated frequently, despite an answer being given; • Writing sexually threatening notes; • Engaging in mutual masturbation; and • Use of adult language to discuss sex (e.g. “Do you think I look sexy?” or “Look at my dolls – they’re screwing.”). 	<ul style="list-style-type: none"> • Uncharacteristic behaviour (e.g. sudden provocative changes in dress, mixing with new or older friend, consistent bullying involving sexual aggression); • Pseudo maturity, including inappropriate knowledge and discussion of sexuality; • Giving out identifying details to online acquaintances; • Preoccupation with chatting online; and 	<ul style="list-style-type: none"> • Sexual preoccupation/anxiety which interferes with daily functioning; • Preoccupation with pornography; • Giving out identifying details to online acquaintances; • Preoccupation with chatting online; • Giving false gender, age, sexuality details online in adult chat room; • Arranging a face to face meeting with an online acquaintance;

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		<ul style="list-style-type: none"> Persistent expression of fear of pregnancy/STIs. 	<ul style="list-style-type: none"> Sexually aggressive themes/obscenities; Sexual graffiti (chronic/impacting on others); Violation of others' personal spaces; Single occurrence of peeping, exposing, non-consenting sexual touch with known peers; pulling skirts up/pants down; mooning and obscene gestures; Unsafe sexual behaviour, including unprotected sex, sexual activity while intoxicated, multiple partners and frequent changes of partner; and Oral sex and/or intercourse (age and developmental ability to give consent must be considered).
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Green Light Behaviour is:

- “Normal” sexual development, which is spontaneous, curious, light-hearted, mutual and easily distracted;
- Play or activities among equals in terms of age, size and ability levels; and
- Behaviour that reflects information gathering, balanced with curiosity about other parts of life.

These provide opportunities to give the person we support positive feedback and information.

Birth to 5 years	5 to 9 years	9 to 12 years	13 to 18 years
<ul style="list-style-type: none"> Thumb sucking, body stroking and holding of genitals; 	<ul style="list-style-type: none"> Masturbation to self soothe; 	<ul style="list-style-type: none"> Use of sexual language; 	<ul style="list-style-type: none"> Sexually explicit conversations with peers;

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<ul style="list-style-type: none"> • Wanting to touch other children's genitals; • Asking about or wanting to touch the breasts, bottoms or genitals of familiar adults (e.g. when in the bath); • Games – 'doctor/nurse', 'show me yours and I'll show you mine'; • Enjoyment of being nude; and • Interest in body parts and functions. 	<ul style="list-style-type: none"> • Increased curiosity in adult sexuality (e.g. questions about babies, gender differences); • Increased curiosity about other children's genitals (e.g. playing mutual games to see or touch genitals); • Telling stories or asking questions, using swear words, 'toilet' words or names for private body parts; and • Increased sense of privacy about bodies. 	<ul style="list-style-type: none"> • Having girl/boyfriend's exhibitionism (e.g. flashing or mooning amongst same age peers); • Increased need for privacy; • Consensual kissing with known peers; and • Use of internet to chat online. 	<ul style="list-style-type: none"> • Obscenities and jokes within the cultural norm; • Flirting; • Interest in erotica; • Use of internet to chat online; • Solitary masturbation; • Interest and/or participation in a one-on-one relationship (with or without sexual activity); • Sexual activity including hugging, kissing, holding hands, foreplay, mutual masturbation; • Consenting oral sex and/or intercourse with a partner of similar age and developmental ability (age and developmental ability to give consent must be considered).
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Do...

Establish safety

- Intervene immediately and stop the behaviour (early intervention is best);
- Remain calm, have a non-blaming approach, and separate the behaviour from the person we support;
- Teach people we support touching rules and protective behaviours; and
- Let them know they can ask for help.

Redirect

- Explain to person we support why the behaviour is not O.K.;

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- Allow person we support to talk openly about what happened; and
- Introduce enjoyable/relaxing activity.

Education/boundary setting

- Teach touching rules/protective behaviours;
- Teach people we support alternate ways to express emotions; and
- Explain to person we support that their play with other people we support will be supervised.

Get support

- Acknowledge this is a difficult situation;
- Develop list of safe people the person we support can speak to; and
- Contact counselling or specialist support services.

Don't...

Shame

- Don't deal with situation in public;
- Don't blame/threaten the person we support;
- Don't label the person we support a molester or sex offender; and
- Don't label the person we support as being homosexual.

Don't ignore, cover up or overreact to the behaviour

Don't make promises you cannot keep

If sexualised behaviour is ongoing and presents a risk of safety to self or others, a *Positive Behaviour Support Plan* is to be developed.

Traffic lights adapted from the Child at Risk Assessment Unit (2000). *Age-Appropriate Sexual Play and Behaviour in Children*. Canberra: Australian Capital Territory Government Community Care. 5-11.) When Problem sexualised behaviour has been identified it is important that intervention occurs in order to establish safety. **Galileo House Child and Youth Trauma Recovery Centre** (Formerly SASS Child and Adolescent Service discuss the Do's and Don'ts for dealing with Problem Sexual Behaviour).

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References

Child Protection Act 1999 (Qld)
 Child Safety Policy 646.2- Managing High Risk Behaviour
 Department's Incident Reporting Guide for Residential Care Services
 NSW Department of Health (2004) Suicide Risk Assessment and Management Protocols.
 Retrieve from http://www.health.nsw.gov.au/pubs/2004/pdf/community_mental_hlt.pdf
 Psycheck, Responding to Mental Health Issues Around Drug and Alcohol Treatment. (n.d).
 Screening Tool Users Guide. Retrieved from
[http://www.psycheck.org.au/RESOURCES/DOCUMENT_PDFS/02_Psycheck_user's_guide.p
 df](http://www.psycheck.org.au/RESOURCES/DOCUMENT_PDFS/02_Psycheck_user's_guide.pdf)
 QPS Reporting Missing Children Form

Relating Documents

FS IP RCaTS Incident Category Definitions
 FS IP Responding to Disclosures
 FS PROC RCaTS Incident Reporting
 FS PROC FKC RCaTS Employee Standard of Care Matters
 FS WF RCaTS Incident Reporting Process
 GOV SOP Incident Management – Clients
 WHS SOP Incident Management – Employees and Visitors

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