Quality Assurance Investigation Case Review Findings
Summary of Circuit Practice Trends
FY 2011/2012

Circuit 12

The first quarter Quality Assurance review for Circuit 12, Sarasota and Desoto Counties, was conducted on-site from August 15 through August 18, 2011. Case files were reviewed August 15 – 16 and de-briefings were held on August 17 – 18, 2011. One investigative record closed within the last 30 days was randomly selected from each of the five units. De-briefing participants included the investigator, supervisor, operations review administrator and QA review specialist for each of the investigations reviewed. Overall performance for the Circuit is rated at 93%. A summary for each of the four practice trends is detailed below.

Conducting Thorough Assessments

Overall performance for this practice trend is rated at 93%. Child Protective Investigators did an excellent job overall in assessing child safety. In three of the five investigations reviewed all required background checks were completed timely and the information was appropriately used to assess immediate safety, short and long term risks to each child and the need for services. In one of the remaining two investigations, although all the required background checks were obtained; there was a delay in requesting the records; however it was determined not to have an impact on child safety as neither parent was found to have any abuse/neglect or criminal history. In the second case, the investigator failed to consider the extensive criminal history of the maternal aunt who lived in the home with the child when determining risk; however she was found to have limited contact with the child and was not the caretaker responsible. Similarly, the safety assessment process was completed with sufficient thoroughness to identify risks in three of the five investigations with a rating of “9” indicating that the specific requirements of the review element were met and the remaining two cases were rated at “7” because the initial assessments had limited supporting documentation in the implications sections. The updated assessments could also have been strengthened with additional supporting documentation; however did support the maltreatment findings. One investigation required a safety plan and the plan was completed with sufficient thoroughness and reflected the information obtained through the investigative process. The safety plan was also documented in Florida Safe Families Network (FSFN). Relevant collateral contacts were completed in all five cases; however in two of the five cases reviewers felt there were additional collaterals who should have been contacted. In one case the allegations concerned substance misuse and the mother’s treating physician was stated to be aware of the mother’s prescribed medications; however contact was not attempted. In the other investigation, the mother provided two collaterals, a friend and a maternal relative, and although the investigator was aware that the paternal side of the family was hostile toward the mother, there was no attempt
made to contact the maternal aunt. The reviewer felt this may have shown bias towards the mother. Pertinent information was obtained from the collateral contacts and was considered when assessing the overall safety of the child and the need for services in all the cases reviewed; however there was a missed opportunity in one investigation to verify information obtained from collateral contacts by asking more probative questions. Only one of the five investigations met the criteria for a Children’s Legal Staffing. A multi-disciplinary staffing was held and it was determined that there was no legal basis for a dependency petition. The sample for this review did not include any investigations resulting in the removal of the children.

**Observing and Interviewing Children, Parents, Others**

Overall performance for this practice trend is rated at 94%. All child victims were seen immediately or within 24 hours of report receipt and all child victims, with the exception of one 4 year old, were not age appropriate to interview. The four year old was very verbal and responsive to the investigator who addressed all maltreatments with her. The investigator noted that the maternal great grandmother kept interrupting the interview by coming into the room and the child eventually lost focus. There were no “other” age appropriate children for an interview included in the sample. In one case where the child victim was an infant, the investigator documented how the child warmed up to her and allowed her to pick her up and play with her to build a rapport. Interviews were conducted with the parents, and other adults in the home in all cases; however in two of the five investigations there could have been more effort made to engage them. In both situations it would have proved valuable to ask additional questions to get a better picture of the family dynamics. The investigator in one of these cases did have a great deal of difficulty keeping the maternal great grandmother on track as she attempted to keep addressing things from the past; however the investigator eventually was able to address all the maltreatments with her and missed obtaining necessary information from the aunt who lived in the home. Ratings for documenting substantive observations and interactions of the children with family members reveal this review element was met in all but one investigation. In this case, the investigator failed to document the interaction between the child and parent or with the other relatives in the household. Documentation was much improved from the prior reviews and painted a clear picture of the investigative activities so that the reviewers could understand exactly what occurred. One of the investigators also took photographs of the home and children which is a valuable tool during an investigation and further evidence to substantiate the findings.

**Determining Maltreatment Findings, Family Needs and Services**

Overall performance for this practice trend is 97%. One of the five investigations reviewed required a mandatory referral to the Child Protection Team (CPT) and CPT was contacted immediately; however since the child was examined by the Emergency Room physician who confirmed the child was not sexually abused, it was determined that there was no need for CPT to complete a medical evaluation. In each of the investigations reviewed, all maltreatment findings were supported by the information gathered and appropriately documented in the investigative record. None of the investigations resulted in a child being removed from the home. Based on the child and family needs, immediate and ongoing service needs were identified in all cases and referrals for services were provided in all cases. Unfortunately one investigator required the parents to obtain a door lock and/or a safety door knob to restrict the child’s access
to leaving the home unattended; and the investigation closed without ensuring the
parent’s obtained a safety device. Evidence was reflected that services were engaged
prior to case closure in all applicable cases.

Planning for Safe Investigation Case Closure

Overall performance for this practice trend is 89%. The plan for closing the investigation
was thoughtful, individualized and matched to the child and family’s present situation,
preferences and long-term view for child safety in all the investigations reviewed in this
sample. In one investigation the reviewer noted documentation was lacking to support
evidence that the investigator had followed through with the supervisor’s directives;
however verification of follow up was discovered through the interviews conducted
during the Quality Service Review (QSR). Overall results reveal that the
investigations reviewed were considered to be thorough and appropriate steps
were taken to ensure child safety. This standard is evaluated based on the
ratings assigned to standards 1, 4, 5, 7, 10 and 22 which are considered the key
factors of for a qualitative investigation. One of the five investigations scored a
“9” rating which indicates that all necessary investigative activities are completed
and the specific requirements of the review element are met. For example, in
this investigation it was determined that there were no findings for sexual abuse;
the child victim’s parents are protective, the child’s extended family is supportive
and service interventions were not needed. The remaining investigations were
given a “7” rating which indicates that the requirement was mostly achieved. In
these cases the file contained evidence most of the necessary investigative
activities were completed, child safety was not compromised and the disposition
of the case was appropriate. In one situation, although the investigation was
thorough and obtained information to support or refute the alleged maltreatment;
additional information may have assisted with closing some of the gaps through
interviewing and collateral contacts. In another investigation, a local law
enforcement check was not documented and additional supporting information in
the child safety assessment would have enhanced the assessment; however
neither of these issues had an impact on child safety or the outcome of the
investigation. In three of the five investigations, appropriate supervisory
guidance and direction were provided that ensured a thorough investigation was
completed. The child protective investigations supervisor provided relevant and
specific feedback, requested further action be taken and explained why it was
necessary. Supervisors were found to routinely conduct file reviews at the 30 day
mark during the investigation. The remaining two investigations noted some
deficiencies such as the supervisor giving concrete, but general directives. For
example: complete collaterals, rather than assisting with the identification of
appropriate collaterals. Also, it appeared that the supervisor had not read the
notes before conducting the case conference with the investigator as
documentation revealed that more information was documented in the
conference than was documented in notes. In all but one case, the investigative
file verified that follow through occurred on the supervisory guidance and
direction provided, or there was documentation that was no longer necessary. In
the one exception, the case file did not include documentation to verify that the
child was referred to day care or if the mother had complied with Diversion services. However, this particular case was chosen for the QSR and findings from the interviews revealed that the child was referred to daycare and continues to attend daycare in the afternoon after she attends a pre-k program. Additionally, it was discovered that the mother is complying with Diversion services and expressed how grateful she is to receive the intervention services.