Circuit 12

The second quarter Quality Assurance review for Circuit 12, Sarasota and Desoto Counties, was conducted on-site from November 15 through November 18, 2011. Case files were reviewed November 15 – 16 and de-briefings were held on November 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 Program Administrator, SunCoast Region CPI Specialist, Program Supervisor and QA review specialists for each of the investigations reviewed. Overall performance for the Circuit is rated at 90%. A summary for each of the four practice trends is detailed below.

Conducting Thorough Assessments

Were thorough assessments completed throughout the investigative process to include the development of realistic safety plans when needed?

Overall performance for this practice trend is rated at 91% as compared to 93% during the first quarter. There were noted improvements in obtaining background checks and assessing child safety. In four of the five investigations reviewed, child protective investigators obtained the required background checks timely and used the information collected to appropriately assess immediate child safety and the need for services. The one exception was given a rating of “7” (requirement mostly achieved) as there was a delay in requesting local law enforcement checks on all family members and the FCIC and NCIC checks were not completed on the caretaker of the victim child until three days prior to case closure. However, it should be noted that the results of the background checks did not impact child safety. Equally impressive is the improvement seen in the safety assessment process. The reviewers found this standard was met and no improvements were needed with a rating of “9” (requirement achieved) in all five investigations for the initial child safety assessment; and except for one investigation all updated child safety assessments met the specific requirements of the review element. Reviewers saw evidence of investigators using a longitudinal approach when assessing child safety and identifying all prior family abuse/neglect history. For example, one investigator considered critical factors such as a second report concerning the mother’s drug use during pregnancy and that she appeared to be overwhelmed with caring for three children under the
age of four years. The updated assessment also addressed the mother and father’s breakup, the mother’s depression and her positive support system. Risk was appropriately assessed as intermediate. Another investigator noted an escalating pattern of concern relative to the priors that dealt with similar allegations as the current report and the updated safety assessment contained specific details as to what had been done to mitigate the risk of harm to the child. In the one instance where the updated assessment did not meet the standard, it was noted that the investigator did not include the most current information obtained from a collateral contact prior to closure; and although a safety plan was signed by the family; it was not documented that the safety plan was shared with the Diversion worker. Although relevant collaterals were completed in all but one investigation; pertinent information was obtained and considered when assessing safety and/or the need for services in only two of the four investigations. In one instance information was obtained from the mental health therapist regarding the mother and this information was not used when considering the mother’s service needs. Another opportunity to gain pertinent information from the apartment manager to assess the condition of the home and the supervision of the children was not documented in the record. One investigation met the criteria for a staffing with Children’s Legal Services (CLS) and the investigator contacted the attorney for a consult while on-site as this was an emergency where the caretakers were assessed as being unable to care for the children. After CLS heard all of the evidence presented, it was determined that there was legal sufficiency for removal; and a dependency petition was filed. The investigator made appropriate inquiry to determine if the children were of American Indian or Native Alaskan descent, and the court was made aware of the findings.

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

Were thorough interviews with children and other participants conducted and substantive observations made of behaviors and interactions between the children and family members?

Overall performance for this practice trend is rated at 83% compared to 94% in quarter one. All child victims were seen immediately or within 24 hours of report receipt. Last quarter it was reported that there was only one age appropriate child victim to interview and no age appropriate other children included in the sample. This may have had a bearing on the sudden decrease in performance this quarter. Thorough interviews with children and other participants have been identified as an area in need of improvement. Only one of the five investigations documented thorough and detailed interviews of the victim child and other children who witnessed the incident. In this case all the maltreatments were addressed with the child victim, the mother and her paramour who were interviewed in the Sarasota County jail and documented in the record. The remaining investigations noted attempts in most instances to interview the child victims and other children residing in the home if age appropriate. However the investigator in one case failed to address all the maltreatments with the five year
old child who had provided detailed information in prior investigations; and did not interview the father, who was the alleged perpetrator, prior to closure or address all the maltreatments with the mother who was interviewed. Older children were interviewed, however a four year old in an investigation was not interviewed and it appears that he was present when his mother attempted suicide. The paramour and mother in this investigation were interviewed and the investigator’s efforts to engage them provided substantial information. Another investigator did not document if the four year old victim child’s verbal skills were assessed to interview him regarding the maltreatments. Although an investigator in another investigation documented her interview with a ten year old; they discussed whether the family was moving and a recent family trip to Sea World; and not the ongoing condition of the home or who cares for the child when the mother is not home. Observations of children’s behaviors while in the home were noted and interactions between siblings were documented in most instances; however there was a considerable lack of documentation of the interactions between the children and their caretakers or other adult household members. One of the five investigations provided documentation that supported good interaction between the adults and child victims and evidence of bonding between the child and mother. There was also descriptive documentation of each child’s physical appearance and behavior. Additional training in interviewing and engaging young children and documentation of children’s developmental skills would prove helpful to improve performance in this area.

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

Were appropriate maltreatment findings reached and needed services provided to children and families to promote positive outcomes and improve child well-being?

Overall performance for this practice trend is 97% which remained consistent with the first quarter performance data. The investigators worked in partnership with the Child Protection Team (CPT) to identify child maltreatment, current and long term concerns and child and family service needs in two applicable investigations. In the first investigation, the investigator contacted CPT regarding injuries to the child’s head. A CPT therapist was involved in individual therapy with the victim child and his sister and has plans to provide family therapy when deemed appropriate. The investigator obtained medical records from the emergency room for CPT and continued to work with the therapist to coordinate additional services. The investigator also advised that a Multidisciplinary Staffing was warranted. The second investigation involved a fourteen year old who was seen by CPT and determined to have been physically abused by his father’s paramour based on the CPT interview and medical exam. This investigation was later compounded by the paramour’s suicide attempt and substance misuse, which may have occurred in the presence of at least one child victim. Due to the complex nature of this family, a multidisciplinary staffing may have assisted with determining further service and/or legal interventions for this family; however this
was not considered by the investigator or supervisor. All maltreatment findings were supported by the information gathered and appropriate documentation in the investigative record in each of the investigations reviewed. Only one of the five investigations resulted in the removal of the children from the home and was staffed at an Early Services Intervention (ESI) staffing with the Safe Children Coalition. This family had refused family preservation services in the past and refused to cooperate with the investigator and law enforcement. The adult caregivers were assessed as being unable to care for the children and the children were placed in licensed foster care. Based on the child and family needs, the immediate and/or ongoing service needs were appropriately identified for all family members in four of the five applicable investigations. In one investigation, the investigator failed to refer the mother for a substance abuse evaluation although her therapist stated she had substance abuse issues. For all identified service needs there was evidence in the record that referrals for services were completed; however the investigative record noted services were engaged in only three of the five applicable investigations. Notes indicate the investigator left a message for Diversion staff with no further efforts to contact the program and discuss the status of the referral. In the second investigation, there was no documentation to confirm whether the four year old was attending day care. Once the decision was made to remove the children in the one applicable investigation, placement priority was given to relatives rather than licensed care. When the investigator completed criminal record checks on the maternal grandparents, he discovered a recent domestic violence charge between the maternal grandfather and his wife; and decided not to complete a home study for possible placement. The children were provided a child health check-up within 48 hours of removal and the investigator visited the children in shelter care on a weekly basis until the case was transferred and accepted by the Safe Children Coalition who agreed to conduct the required visits.

Planning for Safe Investigation Case Closure

Was information gathered during investigations appropriately shared between and among all parties including supervisors, case managers, substitute caregivers, etc., and acted upon as necessary?

Overall performance for this practice trend is 83% compared to 89% for the first quarter. 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 four of the five investigations reviewed. The exception was an investigation where closure was thoughtful; however the family needed a more lengthy provision of services than that provided by the Diversion program. The thoroughness of investigation is evaluated based on the ratings assigned to standards 1, 4, 5, 7, 10 and 22 which are considered key factors for a qualitative investigation. All of the investigations reviewed were given a “7” rating which indicates that the requirement was mostly achieved. In these cases there was evidence that most of the investigative activities were completed, child safety
was not compromised and the disposition of the case was appropriate. In one situation the investigation concerning the physical altercation between the fourteen year old and the paramour was thorough; however with the added dynamics of the paramour’s suicide attempt and substance abuse; additional efforts should have been made to completely investigate these issues and determine the impact on child safety. In another investigation, deficits included the lack of assessing the four year old child victim’s verbal skills in order to interview her as to the alleged maltreatments, and a seven and a half week lapse in contacting the mother which contributed to the delay in determining the engagement with services prior to closure. Initial supervisory guidance and direction was provided and was rated as “9” with the specifics of the review element met in all investigations. Ongoing supervisory oversight was provided in most instances; however 30 day supervisory reviews were not routinely conducted in all cases as was evidenced in quarter one. Follow through occurred on the supervisory directives provided in all but one investigation. This investigation resulted in judicial action and the transfer from the initial investigator assigned to the court unit investigator, with two supervisors involved, may have played a role in why the investigative actions were not completed per the supervisory and second party directives prior to closure. Although the children and family were provided ongoing protective services supervision through case management, many of the supervisor and second party directives went undone without evidence that they were no longer necessary. When the investigation was being closed, the investigative file did not document the investigator or the supervisor ensured the receiving case management agency, Safe Children’s Coalition, was notified of the closure, and the completed transfer of responsibilities from investigator to case management was clearly communicated. The investigator did ensure that Emergency Intake Forms were completed on all the children and shared the necessary information with the substitute caregivers.