Quality Assurance Investigation Case Review Findings
Summary of Circuit Practice Trends
FY 2011/2012
1st Quarter

Circuit 20

The first quarter Quality Assurance review for Circuit 20 was conducted from September 1 through September 12, 2011. Debriefings for each investigation were held on September 22 – 23, 2011 with the Supervisor, Operations Program Administrator and Operations Manager. One investigative record closed within the last 30 days was randomly selected from each of the thirteen units. Overall performance for the Circuit is rated at 83%. A summary for each of the four practice trends is detailed below.

Conducting Thorough Assessments

Overall performance for this area is rated at 80%. The safety assessment process was completed with sufficient thoroughness in slightly over a third of the investigations. Each of these records contained documentation that the initial and updated safety assessments were thorough and information obtained during the course of the investigation was utilized to accurately assess risk. A safety plan was developed when appropriate for these investigations.

In the remaining investigations the safety assessment process could have been enhanced by obtaining criminal records within required timeframes, conducting interviews with all household members, reviewing prior abuse/neglect reports for trends, and making additional collateral contacts or obtaining medical/mental health records to assess the impact on child safety. In one investigation safety assessments stated “there were prior abuse/neglect reports closed with no indicators”, when there were actually fourteen prior reports on the family (8 closed with no indicators; 4 closed with some indicators; and 2 closed with verified findings). Half of the investigations contained documentation of relevant collateral contacts, while the remaining investigations were identified to need additional contacts with entities such as the child’s school, mental health workers, relatives, probation officer, and neighbors. Three investigations documented no collateral contacts. In all cases where collateral contacts were completed the information obtained was considered when assessing the overall safety of the child and need for services.

When appropriate, investigations were staffed with Children’s Legal Services (CLS) and a walk-in petition was filed for one of the investigations. Two other investigations held a multi-disciplinary staffing that included CLS. Rather than legal action being pursued diversion, mental health and/or substance abuse services were recommended for the families. If the parents did not comply the cases were to be re-staffed with CLS. In one of these investigations the CPI determined the parents had not followed through with
substance abuse services; however this information was not brought to the attention of CLS prior to the investigation closing. The term multi-disciplinary staffing appears to be used as a generic term for an in-house staffing that may include the OPA, CLS, CPI and CPIS only, rather than a staffing inclusive of DCF staff as well as providers who have direct knowledge of family functioning and engagement with services. It is very important to have communication and collaboration with all parties who have involvement with the family in order to ensure an appropriate course of action is taken to ensure child safety.

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

Overall performance for this area is also rated at 80%. Most child/victims were seen immediately or within twenty-four hours and in two of the five investigations where victims were not seen there were diligent daily attempts until they were seen. In the remaining three investigations there was a gap of two to three days between the initial attempt to see the victim(s) and a second attempt. One of the investigations where the victim was finally interviewed at school revealed there was an infant in the home and no attempt was made to conduct a home visit for approximately three months.

Interviews that addressed all maltreatments were conducted with victims and other children residing in the home in six of the ten applicable investigations. CPI's attempted to engage those victims' commensurate with their age, developmental level and primary language. There was evidence that probing questions were asked which resulted in additional maltreatments being added in some instances. In three of the investigations young children were not interviewed, while in the fourth investigation the child/victims were initially interviewed, but there was no documentation they were interviewed again when an additional report was received. One investigation provided documentation of substantive observations and interactions of the children with family members. All other investigations contained observations of the children's physical appearance; however lacked documentation of interaction between all or some of the adults, household members and children. In some cases there was also a lack of documentation concerning whether the children appeared to be developmentally on target.

Approximately two-thirds of the investigations documented that all maltreatments were addressed with the mother, father, caregiver and other household members, if appropriate. FSFN notes reflected that these adults were engaged by the CPI and provided detailed information concerning their use of prescribed or illegal substances, the care of their children (or lack thereof), family functioning and relationships. In the remaining investigations either there was no evidence of an attempt to discuss the maltreatments with an adult such as a parent or alleged perpetrator or all maltreatments were not thoroughly addressed. One investigation contained well documented observations of the home such as it was filled with trash, had a roach infestation and was in general filthy; however there was no documented discussion with the parents regarding the home conditions.

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

Overall performance for this practice trend is 95%. There were four investigations where it was required that the victim(s) be referred to the Child Protection Team. All referrals were completed and a medical exam was conducted for children in three of the four
investigations. It was determined the child in the fourth investigation did not need an examination as there were no marks bruises, or noted injuries observed by the CPI.

There were four investigations where information and evidence gathered through interviews and observations indicated an additional alleged maltreatment might have occurred. The CPI ensured the new information was processed appropriately in three cases. Additional maltreatments of Family violence Threatens Child, Threatened Harm, Inadequate Supervision, Mental Injury and Substance Misuse were added to these investigations with not substantiated or verified findings at closure. One investigation was initially received with Substance Abuse and Inadequate Supervision as the only maltreatments. Additional information alleging environmental hazards was received approximately a week after the initial report was received. While the narrative of the investigation summary states the household was initially observed to have environmental hazards, but had been cleaned up since the initial report, an environmental hazards maltreatment was not added. In general the maltreatment findings for all investigations were supported by the information gathered.

There were two investigations where the CPI requested an Early Services Intervention staffing to determine if there were family preservation services that would allow the child to safely remain in the family home. Diversion services were provided to both families. Appropriate immediate or ongoing service needs were identified for all parents and most children in the nine applicable investigations. Referrals were provided for mental health services, quality living services, housekeeping, Healthy Start, day care, substance abuse treatment and domestic violence services. There was no documentation that an infant with Down syndrome who was named as a victim had been referred for social security disability or services through the Agency for Persons with Disabilities. There was documentation that the CPI obtained information regarding whether the parents were engaged with services in three of eight applicable investigations. The remaining five investigations either did not contain documentation the CPI had followed-up with service providers to determine whether services were engaged or contacted some, but not all providers. It is important to determine parent’s compliance with services to determine if further action, such as legal intervention needs to occur to ensure safety for the victim(s).

**Planning for Safe Investigation Case Closure**

Overall performance for this practice trend is 74%. Two of the thirteen investigations reviewed were considered to be thorough with appropriate steps taken to ensure child safety. Both case files contained evidence all necessary investigative activities were completed and child safety was accurately assessed and addressed. One of these investigations was initiated as the result of a physical injury to a child thought to be the result of inadequate supervision. The CPI along with the Supervisor carefully reviewed the prior abuse/neglect history and although many were closed with no indicator findings they suggested the parents had a long standing substance abuse problem that impacted their ability to parent their children. By identifying these trends, using information gathered from interviews with the children and the parent’s lack of follow through with services in the past, a case was built so that legal action could be initiated to protect the children. Areas that might have assisted the other investigations in
being thorough were obtaining timely background checks on parents and other household members and using the information to assess the impact on child safety; making appropriate collateral contacts and obtaining medical/mental health records; documenting interactions between the victim(s) and other household members; conducting investigative activities continuously without gaps; asking probing questions during interviews and contacting providers to determine parent’s progress prior to closure.

Appropriate supervisory guidance and direction throughout the investigation was provided in approximately a third of the cases. These supervisors provided specific direction and timeframes for completion with some having multiple reviews which were face to face with the CPI. The majority of the remaining investigations documented a thorough initial supervisory review; however some were not reviewed again until closure and regardless of the number of supervisory reviews some were closed without all investigative activities being completed to ensure a thorough investigation. In particular there were three investigations where subsequent reports have been received two of them initiating a Request for Action by Quality Assurance staff due to safety concerns. There were several complex investigations that required more intense scrutiny and guidance by supervisors in particular when parents have multifaceted needs such as mental health and substance abuse issues where young children are involved. Follow-up on supervisory guidance and direction was inconsistent with approximately half the investigations having all recommendations completed and the other half having some to very few recommendations completed without documentation from the supervisor that they were no longer necessary. If the supervisory recommendations had been completed many of the investigations would have been considered thorough. Most 2nd party recommendations were completed by CPI staff, although additional efforts are needed to come to a consensus with 2nd party reviewers prior to determining their recommendations are no longer necessary.

The plan for closing most investigations was thoughtful, individualized and matched to the family’s present situation and long-term to ensure child safety despite the previously identified opportunities for improvement. There has been a response for each of the Requests for Action and Quality Assurance staff will continue to monitor them until all safety issues have been satisfactorily resolved.