Central Region
Quality Assurance Review

Circuits 5, 9, 10, 18 & 19
Child Protective Investigations
Quarter 4 Report Fiscal Year 2011-2012
Date of Review: May 2012 for Quarter 4.

Region’s Overall performance achieved: 89%

Sample Period: Investigative reports closed March 2012- April 2012.

Methodology

Region QA staff randomly selected one closed investigation between March 1, 2012 and April 30, 2012, from each of the Department’s 67 Child Protective Investigation units located in the Central Region using the Florida Safe Families Network (FSFN) “Child Investigation and Special Condition Status Report District-Daily”. The sample excluded “Special Conditions”, Institutional Investigations and investigations closed as “No Jurisdiction” or “Duplicate”. Eight of the randomly selected investigations included an emergency removal. Following the reviews, the QA reviewer conducted a debriefing to discuss review findings. The debriefing included the Child Protective Investigator Supervisor and when possible the Child Protective Investigator (CPI), the Program Administrator and OMC II. Any concerns or disputes were resolved during the debriefings.

The Central Region consists of five circuits. The Department maintains investigative responsibility throughout the Central Region with the exception of the Citrus County Sheriff’s Office in Circuit 5 and the Seminole County Sheriff’s Office in Circuit 18.

The distribution of the final sample of 67 reports, based upon one report per CPI unit, was as follows: Circuit 5- 15 reports (22%), Circuit 9- 23 reports (34%), Circuit 10- 12 reports (18%), Circuit 18- 10 reports (15%) and Circuit 19- 7 reports (11%).

Central Region Sample by Circuit
February 2012 - March 2012

- Circuit 5 (15)
- Circuit 9 (23)
- Circuit 10 (12)
- Circuit 18 (10)
- Circuit 19 (7)

N=67
Analysis of Review Findings

Investigations were reviewed using the Quality of Practice Standards (QPS) for Child Protective Investigations (revised August 2011) to focus on qualitative standards. Review elements were grouped into four specific practice trend areas to focus on assessing quality and family centered practices:

- Conducting Thorough Assessments
- Observing and Interviewing Children, Parents and Others
- Determining Maltreatment Findings, Family Needs and Services
- Planning for Safe Investigation Case Closure

At the conclusion of the exit conference held in each circuit in June 2012, the Quality Assurance Specialist in collaboration with operations leadership in each circuit developed a circuit specific Corrective Action Plan to address any identified opportunities for improvement. The opportunities were identified based upon cumulative data from January through June 2012, and included the quarter 3 and quarter 4 CPI QA reviews, as well as the region’s monthly Real Time Reviews completed. These plans will continually be reviewed after each quarterly review completed for fiscal year 2012-2013.

Chart 2 below illustrates the Central Region’s performance level as it relates to each of the four practice trend areas. Each circuit will be addressed below.
Region Fiscal Year 2011-2012 Performance

Chart 3 below illustrates the Central Region’s performance level as it relates to each of the four quarters.

Chart 3

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<tr>
<th>Region Overall Performance Quarters 1-4</th>
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<td>1st Quarter</td>
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<td>Overall</td>
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Circuit 5

Conducting Thorough Assessments
Completing thorough assessments throughout the investigative process to include developing realistic safety plans when needed achieved a rating of 88%.

1.0 Timely completion of required background checks and appropriately using the information to assess immediate safety and short/long term risks to each child and the need for services achieved a rating of 82%.

- Untimely background checks and rechecks were indicated in six investigations.
- Five reports reviewed did not adequately complete person searches.
- In four cases, local law enforcement checks were not completed.
- Three reports did not accurately assess the implications of the prior service reports or criminal history results. One report only indicated a prior history existed, one report did not consider the father’s prior verified report of family violence and injunction, and one report did not consider the mother’s prior Protective Service history as a child.
- Out of State criminal or child welfare history was not requested in one report reviewed.
- Florida Department of Law Enforcement (FDLE) checks were not completed on all subjects of the report in two cases when required.
• Calls for service were not completed in one report.

7.0 Completing the safety assessment process with sufficient thoroughness to identify risk and develop a safety plan if needed achieved a rating of 84%.
• Six cases did not fully indicate or describe the family’s circumstances in the initial assessment.
• Two safety assessments were not updated and resubmitted when required.
• The development of a Safety Plan was required in two cases to address appropriate discipline with the parent and/or caregivers.
• A written and signed Safety Plan that was developed with the mother was not located in the case file in one case.
• The father residing in the home was not included in the Safety Plan in one case that involved family violence.
• The Safety Plans was not entered into FSFN in one of the six applicable cases.
• One safety assessment did not consider findings and recommendations from the Child Protection Team (CPT).
• All subjects of the report were not added to the report in one case reviewed, thus, the case was not identified for a completion of a second party review.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 87%.
• Examples of collateral contacts that would have been appropriate to contact included neighbors, extended family members, pediatrician, service providers, biological mother not residing in the home, and school personnel.

10.0 Considering pertinent information obtained from the collateral contacts when assessing the overall safety of the child and/or the need for services achieved a rating of 100%.

12.0 Presenting the case to Children’s Legal Services (CLS) for a staffing when warranted and filing a petition when the investigation was legally sufficient or documenting a valid reason for not filing a petition achieved a rating of 100%.

30.0 Upon removing a child from his/her home, the investigative file contained a completed Indian Child Welfare Act (ICWA) Eligibility Form and achieved a rating of 78%.
• In one case the mother refused to sign the ICWA eligibility form. An inquiry was not completed with the maternal grandmother with whom the child was placed.

32.0 Completing background checks and physically inspecting the home prior to placing the child with relatives/non-relatives achieved a rating of 78%.
• Sections in the relative home study were left incomplete (Background History and Descriptive Narrative of Overall Functioning and Capacity) and Firearm Safety was not signed in one applicable case reviewed.

Observing and Interviewing Children, Parents, Others
Completing thorough interviews with children and other participants, making substantive observations of behaviors and documenting interactions between children and family members achieved a rating of 89%.
2.0 Diligent attempts to see the child victim immediately or within 24 hours of report receipt achieved a rating of not applicable as all child victims were seen immediately or within 24 hours of the report receipt.

4.0 Conducting interviews with the alleged child victim(s) and “other” child (ren) named in the report and/or residing in the home that addressed all maltreatments achieved a rating of 92%.
   - Three of the fourteen applicable cases reviewed did not interview the victims independently or away from the parents or alleged perpetrator.
   - In one case, the child/sibling was minimally interviewed as to the allegations.
   - The investigator documented the father had a drug abuse criminal history. There was no documentation the child victim was interviewed as to possible drug use by the father.

5.0 Conducting interviews with the mother, father, other caregiver, alleged perpetrator (if other than the mother or father), and other adult household members achieved a rating of 93%.
   - Three cases did not sufficiently interview the mother as to the allegations of the report.
   - In one case both parents were not fully interviewed as to the alleged maltreatments.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 84%
   - Six reports had no interactions and/or physical descriptions of the children were not specific in relation to the alleged maltreatment.
   - The development of three children ages one and two (two of the children were the same age) was not documented in two cases reviewed.

**Determining Maltreatment Findings, Family Needs and Services**
Making appropriate maltreatment findings, identifying, making appropriate referrals and engaging needed services for children and families achieved a rating of 94%.

13.0 Working in partnership with the CPT to identify child maltreatment, current and long-term concerns and needed services achieved a rating of 97%.
   - In one case there was no documentation the following CPT recommendations were considered or a rationale as to why they were not considered: parenting for both parents, anger management for the mother, counseling for the seven year old victim.

17.0 Information and evidence gathered warranted the consideration of additional maltreatments achieved a rating of 78% during this review.
   - Consideration of adding the maltreatment of Inadequate Supervision was warranted in one case. The mother was incarcerated until September 2012, and did not make appropriate arrangements for the care of the child.

18.0 Supporting maltreatment findings through appropriate documentation and information gathering achieved a rating of 97%.
   - One report was closed with Not Substantiated findings for Asphyxiation, but the Summary/Findings Implications documented Verified findings.
• In one report, the Summary/Findings only referenced the allegation matrix and not the specific factors of the report in determining Not Substantiated findings for Environmental Hazards. The Summary/Findings indicated the investigation is pending.

19.0 Requesting an Early Services Intervention (ESI) Staffing, to determine if Community Based Care (CBC) should provide family preservation services to allow the child to remain safely in the home achieved a rating of 100%.

20.0 Identifying appropriate services based on the child/family needs achieved a rating of 98%.

• In one case, the seven year old child was assuming chores and a parental role regarding her two year old sibling that was beyond the norm of what would be expected for a child of her age. Also, the child was involved in a previous child-on-child report in which she was to receive counseling. There was no documentation that counseling for either of these two issues was identified or assessed. The parents were also recommended to be referred for parenting. There was no documentation that these services were discussed with the parents.

21.0 Making appropriate service referrals based on the child/family needs achieved a rating of 97%.

• In one case, the CPT report indicated there was discussion with the mother regarding the child’s dental needs (the CPI was present for the CPT examination). There was no documentation that the mother was apprised of local dental health care providers or how she was going to obtain the dental treatment.

22.0 Ensuring service engagement achieved a rating of 89%.

• The diversion staffing was not held timely in one case reviewed and the report was closed without determining if the mother was going to follow through and comply with the Family Intervention Services (FIS) program.

31.0 Giving placement priority to responsible relatives/non-relatives rather than licensed care achieved a rating of 100%.

34.0 Ensuring that children receive a Child Health Check-Up within 72 hours of removal achieved a rating of 78%.

• The Child Health Examination was completed 8 days after shelter due to Medicaid complications.

37.0 Visiting children in shelter care on a weekly basis until the case transfer and acceptance by the CBC provider achieved a rating of 0%.

• In one case, the ESI staffing occurred fourteen days after shelter and placement. Prior to the ESI, there was no documentation the child was visited by the CPI.

Planning for Safe Investigation Case Closure
Gathering and sharing information between and among all parties including supervisors, case managers, substitute caregivers, etc., and appropriately acting upon information as necessary achieved a rating of 92%.

23.0 Timely and appropriate communication and collaboration between the CPI and the Case Manager occurred when active case management services existed when the CPI received the investigative report achieved a rating of 78%.
• In the one applicable case reviewed, contact with the case manager did not occur until two days after the report was received.

24.0 Completing a thorough investigation and taking appropriate steps to ensure child safety achieved a rating of 88%.
• Two cases had gaps in investigative activity more than thirty days.
• A change in placement occurred in one case reviewed with open Protective Services, a home study was completed; however, local law enforcement checks were not documented, had no caregiver, CPI, or CPIS signatures, and the water safety addendum and firearm policy statement were not completed.
• One case did not complete a timely diversion staffing.
• Collateral contact was not completed with a witness of the alleged injury in one case reviewed.
• In one case, the parents were not interviewed as to the additional maltreatments.
• A Safety Plan was not developed to address appropriate discipline with the parents in one case.

26.0 Providing appropriate supervisory guidance and direction; and ensuring the completion of a thorough investigation achieved a rating of 94%.
• The supervisor disposition review was not completed in two cases as an updated safety assessment.
• In one case, the CPIS did not add the directive to add additional household members to the report. Also, the CPIS did not indicate to see and interview the other child and his father.
• The supervisor directed the CPI in the initial safety assessment to resubmit an updated safety assessment but did not indicate when this was to occur. The updated safety assessment was updated at case closure.

27.0 Following through on the supervisory guidance and direction or documenting it was no longer necessary achieved a rating of 88%.
• In seven of 14 cases, the CPI followed through on all CPIS and second party review directives.

28.0 Notifying the receiving case management agency of case closure to clearly communicate case transfer responsibilities achieved a rating of 100%.

35.0 Obtaining medical information, including prescribed medicines, and/or other needs of the child as known by the parent, guardian or legal custodian and sharing the necessary information with the substitute caregiver achieved a rating of 78%.
• In one applicable case, the child's Resource "Blue" book was provided and signed for (not in the notes) but not the emergency intake form. There was no documentation as to the medical information shared, but the grandparents were aware of the child's head lice and that she had not received routine health or dental care in years.

Circuit 9

Conducting Thorough Assessments
Completing thorough assessments throughout the investigative process to include developing realistic safety plans when needed achieved a rating of 88%.
1.0 Timely completion of required background checks and appropriately using the
information to assess immediate safety and short/long term risks to each child and
the need for services achieved a rating of 86%.
   • Eight cases did not complete required criminal checks timely.
   • In five cases, out of state child welfare checks were not obtained.
   • In three cases, the FDLE checks were not completed on all household members.
   • One case lacked documentation of a local law enforcement check.

7.0 Completing the safety assessment process with sufficient thoroughness to identify
risks and develop a safety plan if needed achieved a rating of 80%.
   • In seven cases, the initial assessment was submitted with no or incomplete
chronological notes.
   • Six cases rated a level of risk levels, rather than indicating risk was low,
moderate or high. For example, “low to moderate risk”.
   • Five of the safety plans developed were simply statements regarding a task the
parent shall complete. For example, “Will monitor [the child’s] behavior and if any
suspicion arise I will contact DCF”. The safety plans did not include long term
actions to keep the child safe from harm.
   • In three of the applicable 14 cases in which a safety plan was developed, the
safety plan was not entered into FSFN.
   • Two cases rated risk as low. One of these cases involved a child that was
hospitalized due to a near drowning at the time of initial assessment. The second
case was completed with numerous unknowns since the home had not been able
to be observed, but the victim was seen the next day at school. The rating of low
did not appear correct as the home and remaining household members had not
been seen.
   • In two cases reviewed, the chronological notes were not updated at the time the
updated safety assessment was submitted.
   • Upon submission of the updated safety assessment risk factors continued as
unknown or “no update” in two cases.
   • In one of the investigations reviewed, a signed safety plan was not found in the
case file; however, the safety plan was developed and entered into FSFN.
   • In one case reviewed, a safety plan was not developed when needed as to the
father due to concerns with the child’ height and weight. The development of a
safety plan was also directed in the supervisor review.
   • In one case, the initial assessment was completed by the supervisor solely for
the purposes of meeting time frames until the CPI could complete the update.

9.0 Completing relevant collateral contacts during the course of the investigation
achieved a rating of 83%.
   • There were no collateral contacts completed in one case reviewed.
   • Collateral contacts that should have made included neighbors, reporters,
therapist, medical providers, extended family members, and daycare/school
personnel.

10.0 Considering pertinent information obtained from the collateral contacts when
assessing the overall safety of the child and/or the need for services achieved a
rating of 98%.
• In one case, the CPI spoke to the receptionist at the office where the child was attending for medication management and therapy. There was no follow up with the therapist to ascertain progress for the child.

12.0 Presenting the case to CLS for a staffing when warranted and filing a petition when the investigation was legally sufficient or documenting a valid reason for not filing a petition achieved a rating of 100%.

30.0 Upon removing a child from his/her home, the investigative file contained a completed ICWA Eligibility Form and achieved a rating of 100%.

32.0 Completing background checks and physically inspecting the home prior to placing the child with relatives/non-relatives achieved a rating of 93%.

• In one case reviewed, local law enforcement checks were not obtained for the aunt and uncle with whom the child was placed.

Observing and Interviewing Children, Parents, Others
Completing thorough interviews with children and other participants, making substantive observations of behaviors and documenting interactions between children and family members achieved a rating of 91%.

2.0 Diligent attempts to see the child victim immediately or within 24 hours of report receipt was not applicable.

4.0 Conducting interviews with the alleged child victim(s) and “other” child (ren) named in the report and/or residing in the home that addressed all maltreatments achieved a rating of 92%.

• In two cases, the allegations of the report were not thoroughly addressed with the victims.
• There was no attempt to interview the “children” in two cases.
• In one case, the CPI interviewed the child timely but did not address all maltreatments. The child was again seen 53 days later and was sufficiently interviewed at that time, which would have impacted the initial assessment had the information been known at that time.

5.0 Conducting interviews with the mother, father, other caregiver, alleged perpetrator (if other than the mother or father), and other adult household members achieved a rating of 97%.

• Five cases did not sufficiently address the maltreatments with the father.
• Two cases did not sufficiently address the maltreatments with the mother.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 85%.

• In 12 of the 23 applicable cases, familial interactions were either not documented or minimally documented.
• One case described the child in the home as “friendly”.
• The clothing of the child was only observed in one case. Observations regarding the child’s physical appearance or development were not documented.
• There were no observations of two of the children in the home in one case.

Determining Maltreatment Findings, Family Needs and Services
Making appropriate maltreatment findings, identifying, making appropriate referrals and engaging needed services for children and families achieved a rating of 93%.

13.0 Working in partnership with the CPT to identify child maltreatment, current and long-term concerns and needed services achieved a rating of 69%.
- Twelve applicable cases warranted CPT referrals. In one case, the child was Baker Acted therefore a referral to CPT was required. This is based upon the child potentially suffering adverse emotional effects due to a plausible suspicion of abuse or neglect.
- In one case, CPT was required based upon the fact a child was observed to have a mark on the head. The CPI described the injury as a slight scratch along the child’s hairline.
- The child was reported to have been hit in the head. The child’s mother and AP reported that he had been hit in the head. No referral to CPT was completed.
- A referral although completed, was not completed timely. CPT refused to accept the referral based upon the fact that the referral was not completed until the day the case was closed.

17.0 The consideration of additional maltreatments achieved a rating of 78%.
- In one case, the mother was noted as being intoxicated at the time of the incident, which may have contributed to the overall incident and her ability to care for the child. Substance Misuse could have been further explored as part of the investigation.
- In one case, the CPI did not add a field narrative with regard to the substance misuse being added to the maltreatments and findings.

18.0 Supporting maltreatment findings through appropriate documentation and information gathering achieved a rating of 100%.

20.0 Identifying appropriate services based on the child/family needs achieved ratings of 96%.
- In one of the seventeen applicable cases, there was no documentation that the father was offered a parenting class to assist with parenting difficult teens.
- The mother was not offered domestic violence services to address alleged Family Violence, which was closed with not substantiated findings.
- The father was not documented as being offered any services in the case. This was also noted in the CPIS directives to be completed based upon the domestic violence incident that was alleged to have occurred in the mother's home.

21.0 Making appropriate service referrals based on the child/family needs achieved ratings of 100%.

22.0 Ensuring service engagement achieved a rating of 94%.
- In one case, child care and domestic violence service referrals were not determined to have been engaged.

29.0 Making concerted efforts to provide appropriate services that would allow the child to remain safely in his/her own home was not applicable.

31.0 Giving placement priority to responsible relatives/non-relatives rather than licensed care achieved a rating of 100%.

34.0 Ensuring that children receive a Child Health Check-Up within 72 hours of removal achieved a rating of 100%.
Planning for Safe Investigation Case Closure
Gathering and sharing information between and among all parties including supervisors, case managers, substitute caregivers, etc., and appropriately acting upon information as necessary achieved a rating of 84%.

24.0 Completing a thorough investigation and taking appropriate steps to ensure child safety achieved a rating of 77%.
- Review elements impacting the thoroughness of the investigation included: incomplete chronological notes, additional maltreatments not addressed during the investigation, background checks not completed or completed timely, child interactions, incomplete interviews, collateral contacts, and no completion of a CPT when required.

26.0 Providing appropriate supervisory guidance and direction; and ensuring the completion of a thorough investigation achieved a rating of 84%.
- In 15 of 23 applicable reports, supervisory guidance and ongoing direction did not thoroughly identify all needed follow up tasks to be completed prior to case closure or were not given during the course of the investigation.

27.0 Following through on the supervisory guidance and direction or documenting it was no longer necessary achieved a rating of 85%.
- In 10 cases, CPI followed through on all supervisory directives, and in 13 cases, the CPI followed through on the majority of directives.
- In five of eight cases, the second party review directives were not completed and the supervisor did not ensure follow-up communication and consensus with the second party reviewer prior to determining the second party recommendations were no longer necessary.

28.0 Notifying the receiving case management agency of case closure to clearly communicate case transfer responsibilities achieved a rating of 67%.
- In one of three applicable cases, there was no documentation to support the case manager was notified of the investigation's closure.

35.0 Obtaining medical information, including prescribed medication, and/or other needs of the child as known by the parent, guardian or legal custodian and sharing the necessary information with the substitute caregiver achieved a rating of 100%.

Circuit 10

Conducting Thorough Assessments
Completing thorough assessments throughout the investigative process to include developing realistic safety plans when needed achieved a rating of 83%.

1.0 Timely completion of required background checks and appropriately using the information to assess immediate safety and short/long term risks to each child and the need for services achieved a rating of 76%.
- In six cases background checks, specifically re-checks were not requested timely.
- In five cases all prior abuse reports were not identified and assessed.
• A search for priors was not completed timely in one case reviewed.
• In three cases, local law enforcement checks for all subjects of the abuse report were not completed.
• Person searches were not completed on all household members in one report.
• In one case an FDLE check was not completed.
• Calls for service to the home were not completed in one case reviewed.

7.0 Completing the safety assessment process with sufficient thoroughness to identify risks and develop a safety plan if needed achieved a rating of 76%.
• Six cases did not adequately account for all prior reports or required criminal checks.
• In four cases, the initial child safety assessment did not include pertinent information necessary to complete the safety assessment.
• In one case, an updated child safety assessment was not completed after the mother and children were seen and interviewed.
• An appropriate safety plan was developed in five of six applicable cases. In one case a safety plan appeared warranted to establish the grandmother as a safeguard and to address the substance misuse of the parent. The safety plan was created in FSFN in two cases of the five applicable cases where safety plans were developed.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 89%.
• In one case, case file documentation doesn’t reflect the CPI ever made contact with the reporter after the initial attempt prior to commencement.
• Relevant collateral contacts that should have been made included neighbors, non custodial parents, and extended family members.

10.0 Considering pertinent information obtained from the collateral contacts when assessing the overall safety of the child and/or the need for services achieved a rating of 98%.
• Collateral contact completed by the investigator with a relative did not adequately address the alleged injury to the child’s arm.

12.0 Presenting the case to CLS for a staffing when warranted and filing a petition when the investigation was legally sufficient or documenting a valid reason for not filing a petition achieved a rating of 100%.

30.0 Upon removing a child from his/her home, the investigative file contained a completed ICWA Eligibility Form achieved a rating of 50%.
• In one case, the ICWA form was not completed. Case file documentation reflected the mother refused to sign forms on the date of commencement. There is no documentation of follow up with the mother in regards to signing forms, such as at the Shelter Hearing she attended. The maternal grandmother could have also been used as an "informant" for the purpose of identifying ICWA eligibility.

32.0 Completing background checks and physically inspecting the home prior to placing the child with relatives/non-relatives achieved a rating of 56%.
• All local law enforcement checks, call outs and prior abuse history searches were not completed in one case reviewed.
Observing and Interviewing Children, Parents, Others
Completing thorough interviews with children and other participants, making substantive observations of behaviors and documenting interactions between children and family members achieved a rating of 90%.

2.0 Cases requiring diligent attempts to see the child victim immediately or within 24 hours of report as all investigations reviewed had child victims seen either immediately or within 24 hours achieved a rating of 78%.
   • In the one applicable case, the children were not seen until fourteen days after report receipt. Although, some attempts were made during those fourteen days, they were not completed daily as required.

4.0 Conducting interviews with the alleged child victim(s) and “other” child (ren) named in the report and/or residing in the home that addressed all maltreatments achieved a rating of 96%.
   • In two of ten applicable cases, all victims were not interviewed as to all of the maltreatments.

5.0 Conducting interviews with the mother, father, other caregiver, alleged perpetrator (if other than the mother or father), and other adult household members achieved a rating of 87%.
   • The alleged perpetrator was not interviewed in one case.
   • In one case, the father was only notified of the shelter hearing occurring and was not interviewed as to the allegations of the report.
   • In three of 12 cases, there was no documentation that an interview addressing the allegations of the report with the mother occurred. The mother was interviewed by phone in one case reviewed.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 91%.
   • In five cases, familial interactions were either not documented or minimally described. In all of these cases the child victims were observed in their homes.
   • One case did not document observations or development of the child.

Determining Maltreatment Findings, Family Needs and Services
Making appropriate maltreatment findings, identifying, making appropriate referrals and engaging needed services for children and families achieved a rating of 96%.

13.0 Working in partnership with the CPT to identify child maltreatment, current and long-term concerns and needed services achieved a rating of 100%.

17.0 The consideration of additional maltreatments achieved a rating of 87%.
   • In two of the five applicable cases, additional maltreatments were appropriately added to the Investigation; however, a field narrative was not added to the Investigation to support the addition of the maltreatments.
   • In one case, the injunction reported the father has been locking the two younger boys (ages 2 and 5) in their room for an hour at a time. There is no documentation reflecting that this information was explored with the participants of the Investigation.
18.0 Supporting maltreatment findings through appropriate documentation and information gathering achieved a rating of 96%.
   • In one case, the CPI’s assessment of Inadequate Supervision cannot be determined as there is no documentation supporting this maltreatment was addressed.
   • In one case, the Not Substantiated findings of Family Violence was applied to the wrong child victim.
20.0 Identifying appropriate services based on the child/family needs achieved ratings of 100%.
21.0 Making appropriate service referrals based on the child/family needs achieved ratings of 100%.
22.0 Ensuring service engagement achieved a rating of 85%.
   • In two applicable cases, engagement with substance abuse services referred for the parents was not documented.
31.0 Giving placement priority to responsible relatives/non-relatives rather than licensed care achieved a rating of 100%.
34.0 Ensuring that children receive a Child Health Check-Up within 72 hours of removal achieved a rating of 100%.

Planning for Safe Investigation Case Closure
Gathering and sharing information between and among all parties including supervisors, case managers, substitute caregivers, etc., and appropriately acting upon information as necessary achieved a rating of 86%.

23.0 Initiating timely communication with case management services applied to two cases and achieved a rating of 100%.
24.0 Completing a thorough investigation and taking appropriate steps to ensure child safety achieved a rating of 69%.
   • In seven cases, required background checks were either not completed, not completed timely or were not appropriately assessed.
   • In five cases the subjects of the report were not interviewed as to the maltreatments.
   • One case reviewed indicated there was no safety plan developed when needed.
   • One case reviewed indicated there were no diligent attempts to see and locate the victims.
26.0 Providing appropriate supervisory guidance and direction; and ensuring the completion of a thorough investigation achieved a rating of 96%.
   • In two cases, the ongoing supervisory guidance did not ensure the completion of a thorough investigation.
27.0 Following through on the supervisory guidance and direction or documenting it was no longer necessary achieved a rating of 85%.
   • In eight of the 12 applicable cases, the supervisor did not ensure all guidance was completed or documented it was no longer necessary prior to closure.
   • In two of the six applicable cases reviewed, second party guidance and recommendations were not completed or justification existed that the guidance was no longer necessary.
28.0 The CPI documented notifying the receiving case management agency of case closure to clearly communicate case transfer responsibilities in the two applicable cases 50%.

- In one of two applicable cases, a case chronological note reflects the CPI called the Case Manager but was not able to speak with the Case Manager and requested a returned phone call. There is no further documentation to support that communication occurred between the CPI and Case Manager.

**Circuit 18**

**Conducting Thorough Assessments**
Completing thorough assessments throughout the investigative process to include developing realistic safety plans when needed achieved a rating of 91%.

1.0 Timely completion of required background checks and appropriately using the information to assess immediate safety and short/long term risks to each child and the need for services achieved a rating of 87%.

- Background checks and rechecks were not completed timely in three applicable cases.
- Three cases did not document the completion of local law enforcement checks of all subjects of the report.
- One case did not document the completion of an out-of-state child welfare check.
- In one case, calls for service were not completed.

7.0 Completing the safety assessment process with sufficient thoroughness to identify risks and develop a safety plan if needed achieved a rating of 82%.

- The initial child safety assessment was not completed with sufficient thoroughness in three cases reviewed.
- In three cases, the safety plan did not adequately document immediate safety actions and long term actions to ensure the safety of the children.
- In two cases, the initial child safety assessment was submitted without the support of chronological notes or had missing chronological notes.
- In two of eight applicable cases, the safety plan was not created in FSFN.
- In one case, the CPIS completed the initial safety assessment due to the CPI being ill. The initial safety assessment documented safety factors as pending with limited information in the assessment.
- The father and grandfather were not involved in the safety plan development or process in one case.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 98%.

- In one of the applicable ten cases reviewed, collateral contact was not completed with a relative.

10.0 Considering pertinent information obtained from the collateral contacts when assessing the overall safety of the child and/or the need for services achieved a rating of 100%.
12.0 Presenting the case to CLS for a staffing when warranted and filing a petition when the investigation was legally sufficient or documenting a valid reason for not filing a petition achieved a rating of 67%.
   • In one of the three applicable cases, the grandparents refused the CPI access to the home in a report which alleged black mold was growing in the home. A court order was not pursued to allow the CPI access to the home.

30.0 Upon removing a child from his/her home, the investigative file contained a completed ICWA Eligibility Form achieved a rating of 78%.
   • In one case, the CPI determined the ICWA eligibility of the female child through her biological father. The step father signed regarding the male child’s ICWA eligibility; however the step father is not biologically related to the victim. The mother was seen in court; however, the documentation does not support ICWA eligibility determination was made by the mother who is the only biological participant to the male victim.

32.0 Completing background checks and physically inspecting the home prior to placing the child with relatives/non-relatives achieved a rating of 78%.
   • Local law enforcement checks were completed in two cases in which removal and placement with a relative or non-relative occurred.
   • In one case, calls for services were not obtained as part of the home study approval process.

Observing and Interviewing Children, Parents, Others
Completing thorough interviews with children and other participants, making substantive observations of behaviors and documenting interactions between children and family members achieved a rating of 92%.

2.0 Diligent attempts to see the child victim immediately or within 24 hours of report receipt was not applicable.
4.0 Conducting interviews with the alleged child victim(s) and “other” child (ren) named in the report and/or residing in the home that addressed all maltreatments achieved a rating of 97%.
   • The attempted interview with the biological mother's children who were ages 4 and 5 did not document attempts to engage the children in the home. The children were not described as non verbal they were described as non compliant.

5.0 Conducting interviews with the mother, father, other caregiver, alleged perpetrator (if other than the mother or father), and other adult household members achieved a rating of 98%.
   • One case did not document an interview with the adult son also residing in the home.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 82%.
   • Interactions were not documented in four of the 10 cases.
   • Observations were minimally described as “no marks and bruises” in two cases.

Determining Maltreatment Findings, Family Needs and Services
Making appropriate maltreatment findings, identifying, making appropriate referrals and engaging needed services for children and families achieved a rating of 90%.

13.0 Working in partnership with the CPT to identify child maltreatment, current and long-term concerns and needed services achieved a rating of 93%.
   • In one case, the CPT recommendations were not utilized when addressing child safety. A safety plan was not developed with the mother to address the grandfather being in a caregiver role to the victim child when he is visiting the home.

17.0 The consideration of additional maltreatments achieved a rating of 0%.
   • In three applicable cases, identified maltreatments were not added to the investigation when required. Additional maltreatments to be added included environmental hazards, threatened harm, and family violence threatens child.

18.0 Supporting maltreatment findings through appropriate documentation and information gathering achieved a rating of 98%.
   • In one case, the reviewer disagreed with the finding of not substantiated for inadequate supervision as the children resided in the home of the aunt and uncle. There were appropriate caregivers readily available to the child and the child was reported to be adequately supervised at all times.

19.0 Identifying appropriate services based on the child/family needs achieved ratings of 88%.
   • In one case, there is no documentation to support the family being offered any services. Services the family could benefit from included: individual/family therapy, parenting for both parents, and targeted case manager based upon the child having ADHD.

21.0 Making appropriate service referrals based on the child/family needs achieved ratings of 100%.

22.0 Ensuring service engagement achieved a rating of 96%.
   • In one case, there was no documentation to indicate contact was made with the mother inquiring her refusal to ensure the child attends counseling.

29.0 Making concerted efforts to provide appropriate services that would allow the child to remain safely in his/her own home achieved a rating of 100%.

31.0 Giving placement priority to responsible relatives/non-relatives rather than licensed care achieved a rating of 100%.

34.0 Ensuring that children receive a Child Health Check-Up within 72 hours of removal achieved a rating of 100%.

37.0 Visiting children in shelter care on a weekly basis until the case transfer and acceptance by the CBC provider achieved a rating of 100%.

**Planning for Safe Investigation Case Closure**
Gathering and sharing information between and among all parties including supervisors, case managers, substitute caregivers, etc., and appropriately acting upon information as necessary achieved a rating of 87%.

23.0 Initiating timely communication with case management services was not applicable.
24.0 Completing a thorough investigation and taking appropriate steps to ensure child safety achieved a rating of 84%.
   - In seven cases, background checks were either not completed on all subjects of the abuse report or not completed timely.
   - In one case, services were not offered to the family when needed.
   - Prior abuse reports were not considered and assessed as to the risk and safety to the children in one case reviewed.
   - The residence of the victims was not observed in one case, as the CPI was refused access and a court order for access was not pursued.

26.0 Providing appropriate supervisory guidance and direction; and ensuring the completion of a thorough investigation achieved a rating of 89%.
   - Appropriate supervisor guidance was provided in five of the ten cases reviewed.

27.0 Following through on the supervisory guidance and direction or documenting it was no longer necessary achieved a rating of 89%.
   - In four of the ten applicable cases initial supervisor directives were not followed.
   - In the one applicable case, second party directives were followed.

28.0 Notifying the receiving case management agency of case closure to clearly communicate case transfer responsibilities achieved a rating of 50%.
   - In one of two applicable cases, there was no documentation the Case Manager was notified of investigative closure

Circuit 19

Conducting Thorough Assessments
Completing thorough assessments throughout the investigative process to include developing realistic safety plans when needed achieved a rating of 92%.

1.0 Timely completion of required background checks and appropriately using the information to assess immediate safety and short/long term risks to each child and the need for services achieved a rating of 87%.
   - Two cases did not document the completion of out of state check results although requests were completed).
   - In one case, FDLE and local checks were not completed for all subjects of the report.
   - The timely request for local checks for other adult household members was not completed in one case.

7.0 Completing the safety assessment process with sufficient thoroughness to identify risk and develop a safety plan, if needed achieved a rating of 87%.
   - In one case, there is limited information regarding the implications to child safety in the protective capacities and child vulnerability section in the initial assessment. The safety assessment process was not completed with sufficient thoroughness based on the lack of information documented in the initial and updated assessment.
   - Chronological notes were not entered at the time the initial safety assessment was submitted for supervisor review in one case reviewed.
• In one case, the safety plan did not identify immediate action regarding the mother's excessive use of physical discipline. The documentation does not support the mother was involved in the safety planning process. The Safety Plan was not entered into FSFN.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 90%.
• Three reports did not document relevant collateral contacts with the following: reporter, property owners, and neighbors.

10.0 Considering pertinent information obtained from the collateral contacts when assessing the overall safety of the child and/or the need for services achieved a rating of 100%.

12.0 Presenting the case to CLS for a staffing when warranted and filing a petition when the investigation was legally sufficient or documenting a valid reason for not filing a petition achieved a rating of 100%.

30.0 Upon removing a child from his/her home, the investigative file contained a completed ICWA Eligibility Form achieved a rating of 100%.

Observing and Interviewing Children, Parents, Others
Completing thorough interviews with children and other participants, making substantive observations of behaviors and documenting interactions between children and family members achieved a rating of 90%.

2.0 Diligent attempts to see the child victim immediately or within 24 hours of report receipt achieved a rating of 89%.
• In one of the two applicable cases, one effort was completed to locate three of the child victims 22 hours after the receipt of the intake. Two victims were located within the twenty four hours. The other victim was located the next day.

4.0 Conducting interviews with the alleged child victim(s) and “other” child (ren) named in the report and/or residing in the home that addressed all maltreatments achieved a rating of 94%.
• In one of the seven applicable cases, the investigator did not interview the victim regarding additional maltreatment information received during the investigation.
• One report did not attempt to interview one of the child victims.

5.0 Conducting interviews with the mother, father, other caregiver, alleged perpetrator (if other than the mother or father), and other adult household members achieved a rating of 94%.
• In two of the applicable seven cases the father was not interviewed in one case, and the alleged perpetrator (father’s paramour) was not interviewed as to the second case.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 83%.
• One of the applicable seven cases reviewed did not document the physical appearance or interaction of the children identified in the report.
• Interactions of the children with the parents were not documented in one of the applicable seven cases.
Determining Maltreatment Findings, Family Needs and Services
Making appropriate maltreatment findings, identifying, making appropriate referrals and engaging needed services for children and families achieved a rating of 93%.

13.0 Working in partnership with the CPT to identify child maltreatment, current and long-term concerns and needed services achieved a rating of 100%.
17.0 The consideration of additional maltreatments achieved a rating of 100%.
18.0 Supporting maltreatment findings through appropriate documentation and information gathering achieved a rating of 100%.
20.0 Identifying appropriate services based on the child/family needs achieved ratings of 100%.
21.0 Making appropriate service referrals based on the child/family needs achieved ratings of 100%.
22.0 Ensuring service engagement achieved a rating of 60%.
  • Two of the five applicable cases, there was no verification of engagement with service referrals that were provided.
34.0 Ensuring that children receive a Child Health Check-Up within 72 hours of removal achieved a rating of 100%.

Planning for Safe Investigation Case Closure
Gathering and sharing information between and among all parties including supervisors, case managers, substitute caregivers, etc., and appropriately acting upon information as necessary achieved a rating of 86%.

24.0 Completing a thorough investigation and taking appropriate steps to ensure child safety achieved a rating of 84%.
  • Two cases reviewed did not complete all background checks to include results from out of state child welfare inquiries.
  • Two cases reviewed did not document an interview with children.
  • Two cases reviewed did not determine if service referrals were engaged.
  • One case did not complete timely entry of chronological notes.
  • One case did not develop a safety plan when required.
26.0 Providing appropriate supervisory guidance and direction; and ensuring the completion of a thorough investigation achieved a rating of 78%.
  • All seven applicable cases did not provide appropriate initial or ongoing guidance based upon information documented in the case file.
27.0 Following through on the supervisory guidance and direction or documenting it was no longer necessary achieved a rating of 84%.
  • Five of seven applicable cases did not ensure follow through with supervisory and second party review guidance.
28.0 Notifying the receiving case management agency of case closure to clearly communicate case transfer responsibilities achieved a rating of 100%.
35.0 Obtaining medical information, including prescribed medicines, and/or other needs of the child as known by the parent, guardian or legal custodian and sharing the necessary information with the substitute caregiver achieved a rating of 100%.
Additional Review Elements

Central Region QA has incorporated the following additional review elements during CPI reviews. No changes to the additional review element questions were adopted for the Quarter 4 review.

These additional review elements for the region are summarized below in Table 1.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. TANF is accurately completed in FSFN for the investigation (all household members).</td>
<td>25%</td>
</tr>
<tr>
<td>2. If the investigator documented taking pictures of the home, children, etc. the pictures were located in the case file.</td>
<td>81%</td>
</tr>
<tr>
<td>3. There was no “gap” in time (30 days or more) during the investigation of investigative tasks completed by the investigator.</td>
<td>80%</td>
</tr>
<tr>
<td>4. If the reporter narrative indicated a subject of the abuse report was hearing impaired or it was determined by the investigator a subject of the abuse report was hearing impaired, the investigator arranged for certified interpreter, TTY communications device or amplified hearing device, or there is documentation the subject of the report declined services and the appropriate forms were completed.</td>
<td>N/A</td>
</tr>
<tr>
<td>5. The CPI did not leave a business card at commencement, or contacted the family via telephone, prior to making an unannounced visit and contact with the child victim/family.</td>
<td>99%</td>
</tr>
<tr>
<td>6. The supervisor did not conduct the initial and/or the final supervisory review(s) using only the electronic file in FSFN.</td>
<td>97%</td>
</tr>
<tr>
<td>7. Removal only: If placement occurred with a relative or non-relative, there is documentation in the case file that the completed home study (positive or negative) was filed with the court.</td>
<td>50%</td>
</tr>
</tbody>
</table>

- In 50 of the 67 reports reviewed TANF was incorrectly completed in FSFN. Errors in TANF were attributed to the "applies to" was also checked for adults instead of just children in the household information section and the citizenship box was not checked for the adults in the person module of FSFN.
- Thirteen reports had a gap in time (30 days or more) of investigative activity.
- In three of six reports reviewed, there was no documentation that the completed relative or non-relative home study was filed with the court.
- There were no applicable reports in which a subject of the report was possibly hearing impaired.

Institutional Reports Review

Central Region QA has incorporated the completion of Institutional Reports Reviews beginning with the 4th Quarter CPI review. A QA review tool was developed with specific criteria for institutional investigations. Five cases per circuit (25 cases reviewed total for the region) were selected for review. Review results for the region for are summarized below in Table 2.

Table 2
## Institutional Investigative Response

<table>
<thead>
<tr>
<th><strong>Background Checks</strong></th>
<th>87%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diligent Attempts to See Child Victims</strong></td>
<td>100%</td>
</tr>
<tr>
<td><strong>Interviewing Children</strong></td>
<td>100%</td>
</tr>
<tr>
<td><strong>Interviews with Caregivers</strong></td>
<td>100%</td>
</tr>
<tr>
<td><strong>Observations of the Children</strong></td>
<td>71%</td>
</tr>
<tr>
<td><strong>Safety Assessment and Safety Plan</strong></td>
<td>100%</td>
</tr>
<tr>
<td><strong>Collateral Contacts</strong></td>
<td>100%</td>
</tr>
<tr>
<td><strong>Obtaining Pertinent Information from Collaterals</strong></td>
<td>100%</td>
</tr>
</tbody>
</table>

### Background Checks

1. Required background checks were completed timely and the information was appropriately used to assess immediate safety and short/long term risks to each child and the need for services. (Alleged victim and alleged caregiver)

### Diligent Attempts to See Child Victims

2. Diligent attempts to see the child victim were made at least daily if the child victim was not seen immediately or within 24 hours of report receipt from the Florida Abuse Hotline. If the initial attempt to contact the child victim was unsuccessful, regular attempts (daily and at varying locations and times of the day) are required until all child victims are seen.

### Interviewing Children

3. An interview was conducted and addressed all maltreatments with the alleged child victim(s) named in the report.

3.1 Interview(s) with child victim(s)

3.2 The CPI made appropriate attempts to engage with child victim(s).

### Interviews with Caregivers

4. Interviews that addressed all maltreatments were conducted with alleged perpetrator.

4.1 Interview with alleged caretaker(s) responsible.

4.2 Interview with parents (pending HB 803).

4.3 The CPI made appropriate attempts to engage with the parents and alleged caretaker(s) responsible during the investigative process.

### Observations of the Children

5. Observations of the children were completed and documented during the course of the investigation.

### Safety Assessment and Safety Plan

6. The safety assessment process was completed with sufficient thoroughness to identify risks and develop a safety plan if needed.

6.1 The initial safety assessment was completed with sufficient thoroughness to identify risk.

6.2 The updated safety assessment(s) was completed with sufficient thoroughness to identify risks and accurately reflected information obtained during the course of the investigation.

6.3 The safety plan, when needed, must be sufficient and identify the immediate and long term actions required to keep the child safe from harm.

6.4 The safety plan was documented in FSFN.

### Collateral Contacts

7. Relevant collateral contacts were completed during the course of the investigation.

### Obtaining Pertinent Information from Collaterals

8. Pertinent information was obtained from the collateral contacts and was considered when assessing the overall safety of the child.
<table>
<thead>
<tr>
<th>General Counsel Staffing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9 The CPI presented the case to General Counsel for a staffing when warranted (for the purpose of but not limited to limiting facility operations, denial of access to the investigator and/or removing the alleged perpetrator from the facility).</td>
<td>NA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referral to the Child Protection Team</th>
<th>94%</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 The CPI worked in partnership with the Child Protection Team (CPT) to identify child maltreatment, current and long term concerns and child and service needs.</td>
<td></td>
</tr>
<tr>
<td>10.1 A referral was made to the Child Protection Team (CPT) when required.</td>
<td></td>
</tr>
<tr>
<td>10.2 The CPI appropriately considered CPT recommendations in the identification of child maltreatment, current and long term concerns, and child service needs.</td>
<td>NA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Added Maltreatments</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>11 When the information and evidence gathered through interviews and observations indicated an additional alleged maltreatment might have occurred, the CPI ensured this new information was processed appropriately.</td>
<td>NA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maltreatment Findings</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 All maltreatment findings were supported by the information gathered and appropriately documented in the investigative record.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Communication Between the Child Protection Investigator, Licensing and Case Manager</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>13 If there was an active services case when the investigative report was received, timely and appropriate communication and collaboration between the CPI and Case Manager occurred to assure mutual understanding of history and current events.</td>
<td>NA</td>
</tr>
<tr>
<td>14 Institutional staffing occurred for a child in out of home care. The recommendations of the institutional staffing were documented in the case file. The recommendations of the institutional staffing were followed by the investigator.</td>
<td>NA</td>
</tr>
<tr>
<td>14.1 Institutional staffing occurred for a child in out of home care.</td>
<td>NA</td>
</tr>
<tr>
<td>14.2 The recommendations of the institutional staffing were documented in the case file.</td>
<td>NA</td>
</tr>
<tr>
<td>14.3 The recommendations of the institutional staffing were followed by the investigator.</td>
<td>NA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Thoroughness of the Investigation</th>
<th>78%</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 The investigation was thorough and appropriate steps were taken to ensure child safety.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supervisory Guidance and Direction</th>
<th>82%</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 Appropriate supervisory guidance and direction were provided and ensured a thorough investigation was being completed.</td>
<td></td>
</tr>
<tr>
<td>16.1 Initial supervisor guidance</td>
<td>96%</td>
</tr>
<tr>
<td>16.2 On-going supervisor guidance</td>
<td>78%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Follow Through</th>
<th></th>
</tr>
</thead>
</table>
Follow through occurred on the supervisory guidance and direction provided, or there was documentation it was no longer necessary. | 82%
---|---
The CPI followed through on the supervisory guidance and direction. | 82%
The CPI supervisor ensured CPI followed through on supervisory guidance and direction provided or the reason(s) the guidance and direction provided was no longer necessary was documented. | 82%
The CPI supervisor ensured the CPI followed through on the 2nd party reviewer guidance and direction, or documented justification that actions were no longer necessary. | 89%
The CPI Supervisor ensured follow-up communication and consensus with the 2nd party reviewer prior to determining 2nd party review recommendations were no longer necessary. | NA

Investigation Closure Notification

The plan for closing the investigation case was thoughtful, individualized and matched to the child present situation, preferences, and long-term view for child safety with regard to remain in the same institution. | 96%

Overall Total | 91%
Conducting Thorough Assessments | 97%
Observing & Interviewing Children, Parents, Others | 90%
Determining Maltreatment Findings, Family Needs & Services | 98%
Planning for Safe Case Closure | 84%

Requests for Action
There was one Requests for Action (RFA) completed during the review.

On February 23, 2012 the Department of Children and Families received an abuse report alleging “The children live with the mother, who does not supervise them. It is unknown if the mother is depressed, or if she is abusing drugs. Recently, the mother stayed in her room for two days. During that time, she would not leave her room or let the children in. [The child victim] did not eat for those two days, and [child victim] had to care for [child victim] around the clock. There was a time that a neighbor had to buy the children some groceries, because the mother had no food in her home. [The child victim] routinely is filthy, and hewears the same clothing for days in a row until an outsider washes them. In addition, his feet and hand are always filthy. Inside the home, there is filth and garbage around. [The child victim] has easy access to the small, choking hazards and cleaning supplies that are all over the floors. [The child victim] once fell and hurt himself, and he went for two weeks in pain. After the father finally took [the child victim] to the doctor's office, it was discovered that he had a fractured collarbone. On two occasions, [the child victim] fell out of bed and obtained a black eye.”

The investigation determined the children were not residing in a hazardous home based upon the observations of the CPI. Information with regard to the collar bone fracture was obtained from the listed subjects and the grandmother who was present. (It is unclear from the notes if the entire family was in Georgia or if the grandmother was in a caregiver role).
The child victim reported her brother had sustained an injury during Christmas break which he began to complain about once they had returned to Florida. The child victim reported that he was taken to the physician once he began complaining. The child victim reported that he injured his shoulder meanwhile on the Christmas break and he was with his grandmother. He reported when he returned he complained about pain to his father and he took him to the physician. The mother reported the child victim sustained the injury meanwhile in Georgia and was taken to the physician upon his return. She denied the allegations of using drugs or being depressed. The mother was not offered a drug screen during the investigation. The grandmother reported the injury was sustained in Georgia meanwhile the child was sledding over Christmas break.

CPT was contacted on April 23, 2012 and declined the referral based upon the referral being late (which does not appear correct as the injury was historical and occurred two months prior to the referral).

The second party review which was completed on April 23, 2012 stated a new report was to be called into the hotline. A new report was generated with regard to the above listed investigation due to the allegation of medical neglect not being assessed by CPT and what appears to be to avoid the case remaining open longer than 60 days (thus becoming backlog).

Recommended actions included:

1. Child Protective Investigators and Supervisors to ensure CPT referrals are completed in a timely manner in accordance with Operating Procedure 175-21 6. b. which states “Some cases will require an immediate referral to assure the safety of the child and/or to preserve forensic evidence. In all cases, early consideration and when indicated, early referral, is necessary in order to allow for timely response by the team”. The CPIS shall ensure the referral to CPT is completed and documented in the chronological notes in this case.

2. DCF Operations staff to meet with members of the Child Protection Team to discuss the referral of mandated referrals in which injuries or neglect is considered “historical”.

3. Gaps in casework shall be addressed with investigation staff in regards to the new abuse report. Chronological notes had not been updated, which was a directive from the initial child safety assessment review to include the initial face-to-face contact with the child victims.

4. The practice of closing cases by generating new cases with the same maltreatments to avoid the case being opened longer than the allowed 60 days should be discontinued.

A written response was received, which addressed each of the concerns noted above indicating:
1. The timeliness of CPT referrals was addressed with the investigator. The Operations Manager has addressed the issue with CPT, that when a referral is made late, specifically at closure of the intake, and when CPT declines the referral, that notification is made to the Supervisor of the CPI making the referral, if not the Program Administrator. Reported historical injury allegation referrals were also addressed with the CPT Manager.

2. Gaps in casework have been addressed with both the CPI and the CPIS. The CPT referral was completed and additional updating of chronological notes would be completed.

3. Generating a new intake for the purpose of not having a case roll into backlog will no longer take place and was communicated to investigation staff

**Summary and Recommendations**

The Central Region should focus improvement strategies on the following recommendations that present opportunities for qualitative improvement. Administrative and operations staff, in conjunction with the Family Safety Program Office staff, will develop action plans, develop and conduct in-service training and provide supervisory oversight to address the following elements:

- Ensuring the completion of required background checks timely and using the information to assess immediate safety and short/long term risks to each child and the need for services. 39.301(9) (b) 3 F.S.; 65C-29.003 (j) and 65-29.009, F.A.C.
- The sufficient completion of safety plans, when required, that appropriately identify the immediate and long term actions required to keep the child safe from harm to include the documentation of the safety plan in FSFN. 39.301(9) (b) 5 and 6, F.S.; 65C-29.003(5) (a), F.A.C.
- Ensuring the observations and interactions of the children with family members are completed and documented during the course of the investigation. 39.301(10) (b), F.S.; 65C-29.003(3) (c), F.A.C.
- To appropriately consider CPT recommendations in the identification of child maltreatment, current and long term concerns, and child and family service needs 39.303 (2-4), F.S.
- Ensuring when information and evidence gathered through interviews and observations indicated an additional alleged maltreatment might have occurred the CPI ensures this new information was investigated, included in the assessment process and documented. A field narrative should also be added to support the addition of any maltreatments discovered during the course of the investigation in accordance with the FSFN policy.
• Timely and appropriate communication and collaboration between the CPI and Case Manager occurred to assure mutual understanding of history and current events 65C-30.015(1), F.A.C.

• Completion of ongoing supervisory guidance and direction to include documentation of supervisory disposition reviews to avoid/detect gaps in the investigative process and ensure timely completion of supervisory directives. 39.301(4), F.S.; 65C-29.003(6) (b), F.A.C.; CFOP 175-17 & 42; Central Region CPI Initiatives and Strategies- Quality, Practice, Performance.

• Ensure the CPI or CPIS notifies the receiving case management of closure of the investigation, and the completed transfer of responsibilities from CPI to case management was clearly documented.

• Completion of weekly child visits with the child by the CPI while in out-of-home care until the case is transferred to and accepted by the CBC provider who subsequently agrees to conduct the required visits. 394.455, F.S.; 65C-35.007 and 65C-28.016, F.A.C. CFOP 175-98.

• Continue training to investigations staff regarding the accurate completion and approval of TANF forms in FSFN. CFOP 175-39.

<table>
<thead>
<tr>
<th>Question</th>
<th>9</th>
<th>7</th>
<th>5</th>
<th>0</th>
<th>NA</th>
<th># Cases</th>
<th>% achieved 4th Qtr FY 2011-2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Required background checks were completed timely and the information was appropriately used to assess immediate safety and short/long term risks to each child and the need for services.</td>
<td>24</td>
<td>36</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>67</td>
<td>83%</td>
</tr>
<tr>
<td>2 Diligent attempts to see the child victim were made at least daily if the child victim was not seen immediately or within 24 hours of report receipt from the Florida Abuse Hotline. If the initial attempt to contact the child victim was unsuccessful, regular attempts (daily and at varying locations and times of the day) are required until all child victims are seen.</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>64</td>
<td>67</td>
<td>85%</td>
</tr>
<tr>
<td>3 BLANK</td>
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</tr>
<tr>
<td>4</td>
<td>An interview was conducted and addressed all maltreatments with the alleged child victim(s) and other child(ren) named in the report and/or residing in the home.</td>
<td>43</td>
<td>13</td>
<td>2</td>
<td>0</td>
<td>9</td>
<td>67</td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>4.1</td>
<td>Interviews with child victim(s) were conducted and addressed all maltreatments.</td>
<td>44</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>67</td>
</tr>
<tr>
<td>4.2</td>
<td>Interviews with “other” child(ren) were conducted and addressed all maltreatments.</td>
<td>10</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>53</td>
<td>67</td>
</tr>
<tr>
<td>4.3</td>
<td>The CPI made appropriate attempts to engage with child victim(s) and &quot;other children&quot; in the investigative process.</td>
<td>52</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>9</td>
<td>67</td>
</tr>
<tr>
<td>5</td>
<td>Interviews that addressed all maltreatments were conducted with the mother, father, other caregiver, alleged perpetrator (if other than the mother or father), and other adult household members.</td>
<td>49</td>
<td>16</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>67</td>
</tr>
<tr>
<td>5.1</td>
<td>Interview with mother;</td>
<td>49</td>
<td>9</td>
<td>2</td>
<td>0</td>
<td>7</td>
<td>67</td>
</tr>
<tr>
<td>5.2</td>
<td>Interview with father</td>
<td>38</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>20</td>
<td>67</td>
</tr>
<tr>
<td>5.3</td>
<td>Interview with alleged perpetrator (if other than the mother or father) and;</td>
<td>8</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>56</td>
<td>67</td>
</tr>
<tr>
<td>5.4</td>
<td>Interviews with other adult household members</td>
<td>27</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>37</td>
<td>67</td>
</tr>
<tr>
<td>5.5</td>
<td>The CPI made appropriate attempts to engage with the parents and other adults during the investigative process.</td>
<td>58</td>
<td>5</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>67</td>
</tr>
<tr>
<td>6</td>
<td>Substantive observations and interactions of the children with family members were completed and documented during the course of the investigation.</td>
<td>30</td>
<td>31</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>67</td>
</tr>
<tr>
<td>7</td>
<td>The safety assessment process was completed with sufficient thoroughness to identify risks and develop a safety plan if needed.</td>
<td>13</td>
<td>51</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>67</td>
</tr>
<tr>
<td>7.1</td>
<td>The initial safety assessment was completed with sufficient thoroughness to identify risks.</td>
<td>27</td>
<td>33</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>67</td>
</tr>
<tr>
<td>7.2</td>
<td>The updated safety assessment(s) was completed with sufficient thoroughness to identify risks and accurately reflected information obtained during the course of the investigation.</td>
<td>45</td>
<td>19</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>67</td>
</tr>
<tr>
<td>7.3</td>
<td>The safety plan, when needed, was sufficient and appropriately identified the immediate and long term actions required to keep the child safe from harm.</td>
<td>21</td>
<td>12</td>
<td>4</td>
<td>5</td>
<td>25</td>
<td>67</td>
</tr>
<tr>
<td>7.4</td>
<td>The safety plan was documented in FSFN.</td>
<td>27</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>30</td>
<td>67</td>
</tr>
<tr>
<td>8</td>
<td>BLANK</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Count</td>
<td>Count</td>
<td>Count</td>
<td>Count</td>
<td>Count</td>
<td>Value</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>9</td>
<td>Relevant collateral contacts were completed during the course of the investigation.</td>
<td>37</td>
<td>25</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>67</td>
</tr>
<tr>
<td>10</td>
<td>Pertinent information was obtained from the collateral contacts and was appropriately considered when assessing the overall safety of the child and/or need for services.</td>
<td>64</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>67</td>
</tr>
<tr>
<td>11</td>
<td>BLANK</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>The CPI presented the case to CLS for a staffing when warranted and when the investigation was legally sufficient, a petition was filed or a valid reason for not filing a petition was documented.</td>
<td>13</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>53</td>
<td>67</td>
</tr>
<tr>
<td>13.1</td>
<td>A Children’s Legal Services staffing was held when warranted.</td>
<td>13</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>53</td>
<td>67</td>
</tr>
<tr>
<td>13.2</td>
<td>A dependency petition was filed or a valid reason for not pursuing a dependency action was documented, when the CLS staffing documented legal sufficiency.</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>57</td>
<td>67</td>
</tr>
<tr>
<td>13</td>
<td>The CPI worked in partnership with the Child Protection Team (CPT) to identify child maltreatment, current and long term concerns and child and family service needs.</td>
<td>19</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>42</td>
<td>67</td>
</tr>
<tr>
<td>13.1</td>
<td>A referral was made to the CPT when required.</td>
<td>21</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>42</td>
<td>67</td>
</tr>
<tr>
<td>13.2</td>
<td>The CPI appropriately considered CPT recommendations in the identification of child maltreatment, current and long term concerns, and child and family service needs.</td>
<td>9</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>53</td>
<td>67</td>
</tr>
<tr>
<td>14</td>
<td>BLANK</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>BLANK</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>BLANK</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>When the information and evidence gathered through interviews and observations indicated an additional alleged maltreatment might have occurred, the CPI ensured this new information was processed appropriately.</td>
<td>6</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>52</td>
<td>67</td>
</tr>
<tr>
<td>18</td>
<td>All maltreatment findings were supported by the information gathered and appropriately documented in the investigative record.</td>
<td>62</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>67</td>
</tr>
<tr>
<td>19</td>
<td>If at any point during the investigation placement of the child outside of the home was a possibility, the CPI requested an Early Services Intervention (ESI) Staffing to determine if the Community Based Care (CBC) should provide family preservation services that would allow the child to remain safely in</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>64</td>
<td>67</td>
</tr>
</tbody>
</table>
the home.

20 Based on the child/family needs, the immediate service and/or ongoing supervision needs were identified for the child, mother, father, other caregiver and/or caretaker responsible, if other than the mother or father.

<p>| | | | | | | |</p>
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</thead>
<tbody>
<tr>
<td>41</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>20</td>
<td>67</td>
<td>96%</td>
</tr>
</tbody>
</table>

20.1 Child (Not restricted to focus child or child identified as the victim in the abuse hotline report)

<p>| | | | | | | |</p>
<table>
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</thead>
<tbody>
<tr>
<td>36</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>29</td>
<td>67</td>
<td>95%</td>
</tr>
</tbody>
</table>

20.2 Mother

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>29</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>35</td>
<td>67</td>
<td>93%</td>
</tr>
</tbody>
</table>

20.3 Father

<p>| | | | | | | |</p>
<table>
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<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>19</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>42</td>
<td>67</td>
<td>84%</td>
</tr>
</tbody>
</table>

20.4 Other Caregiver or Caretaker Responsible (if other than the mother or father and has access or ongoing contact with the child)

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</thead>
<tbody>
<tr>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>59</td>
<td>67</td>
<td>89%</td>
</tr>
</tbody>
</table>

21 If immediate services or ongoing supervision was needed, referrals for these services were completed for the child, mother, father and other caregiver or caretaker responsible (if other than the mother or father).

<p>| | | | | | | |</p>
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</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>36</td>
<td>67</td>
<td>99%</td>
</tr>
</tbody>
</table>

21.1 Child (Not restricted to the focus child or child identified as the victim in the abuse hotline report).

<p>| | | | | | | |</p>
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</thead>
<tbody>
<tr>
<td>21</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>45</td>
<td>67</td>
<td>99%</td>
</tr>
</tbody>
</table>

21.2 Mother

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>48</td>
<td>67</td>
<td>100%</td>
</tr>
</tbody>
</table>

21.3 Father

<p>| | | | | | | |</p>
<table>
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<tr>
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<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>53</td>
<td>67</td>
<td>100%</td>
</tr>
</tbody>
</table>

21.4 Other Caregiver or Caretaker Responsible (if someone other than the mother or father and has access or ongoing contact with the child)

<p>| | | | | | | |</p>
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</thead>
<tbody>
<tr>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>61</td>
<td>67</td>
<td>100%</td>
</tr>
</tbody>
</table>

22 If documentation reflects the need for immediate services and/or ongoing supervision, the investigation record contained evidence the services were engaged.

<p>| | | | | | | |</p>
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</thead>
<tbody>
<tr>
<td>18</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>42</td>
<td>67</td>
<td>85%</td>
</tr>
</tbody>
</table>

23 If there was an active services case when the investigative report was received, timely and appropriate communication and collaboration between the CPI and Case Manager occurred to assure mutual understanding of history and current events.

<p>| | | | | | | |</p>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>64</td>
<td>67</td>
<td>59%</td>
</tr>
</tbody>
</table>

24 The investigation was thorough and appropriate steps were taken to ensure child safety.

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>44</td>
<td>8</td>
<td>0</td>
<td>1</td>
<td>67</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Count</td>
<td>Rate</td>
<td></td>
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<td>----------------------------------------------------------------------------------------------</td>
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<tr>
<td>25</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Appropriate supervisory guidance and direction were provided and ensured a thorough investigation was completed.</td>
<td>33</td>
<td>32</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>26.1</td>
<td>Initial supervisory guidance</td>
<td>52</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>26.2</td>
<td>On-going supervisory guidance</td>
<td>27</td>
<td>17</td>
<td>3</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>27</td>
<td>Follow through occurred on the supervisory guidance and direction provided, or there was documentation it was no longer necessary.</td>
<td>26</td>
<td>39</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>27.1</td>
<td>The CPI followed through on the supervisory guidance and direction.</td>
<td>27</td>
<td>38</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>27.2</td>
<td>The CPI supervisor ensured CPI followed through on supervisory guidance and direction provided or the reason(s) the guidance and direction provided was no longer necessary was documented.</td>
<td>28</td>
<td>37</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>27.3</td>
<td>The CPI supervisor ensured the CPI followed through on the 2nd party reviewer guidance and direction, or documented justification actions were no longer necessary.</td>
<td>19</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>40</td>
</tr>
<tr>
<td>27.4</td>
<td>The CPI Supervisor ensured follow-up communication and consensus with the 2nd party reviewer prior to determining 2nd party review recommendations were no longer necessary.</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>54</td>
</tr>
<tr>
<td>28</td>
<td>When the investigation was being closed, the case file documents the CPI or CPI Supervisor ensured the receiving case management agency was notified of the closure, and the transfer of responsibilities from CPI to case management was clearly communicated.</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>57</td>
</tr>
<tr>
<td>28.1</td>
<td>The plan for closing the investigation case was thoughtful, individualized and matched to the child and family's present situation, preferences, and long-term view for child safety.</td>
<td>52</td>
<td>13</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>29</td>
<td>Prior to the removal, the CPI made concerted efforts to provide appropriate services that would allow the child to remain safely in his/her own home.</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>65</td>
</tr>
<tr>
<td>30</td>
<td>Upon removing the child from his/her home, the CPI made the appropriate inquiries to determine if the child was of American Indian or Native Alaskan descent so that the appropriate tribe could be contacted regarding the need for an alternative placement.</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>58</td>
</tr>
</tbody>
</table>
31 Once the decision was made to remove the child, placement priority was given to responsible relatives/non-relatives rather than licensed care.

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</thead>
<tbody>
<tr>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>59</td>
<td>67</td>
<td>100%</td>
</tr>
</tbody>
</table>

32 When the CPI placed the child with relatives or non-relatives, the case file contained evidence required background checks and a physical inspection of the home were completed prior to the child’s placement.

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</thead>
<tbody>
<tr>
<td>2</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>60</td>
<td>67</td>
<td>81%</td>
</tr>
</tbody>
</table>

32.1 The required background checks were completed during the home study process prior to the child’s placement.

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</thead>
<tbody>
<tr>
<td>2</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>60</td>
<td>67</td>
<td>87%</td>
</tr>
</tbody>
</table>

32.2 A physical inspection of the home was completed during the home study process prior to the child’s placement.

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</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>67</td>
<td>100%</td>
</tr>
</tbody>
</table>

32.3 An evaluation of the prospective caregiver’s capacity to protect was completed during the home study process prior to the child’s placement.

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</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>60</td>
<td>67</td>
<td>94%</td>
</tr>
</tbody>
</table>

33 BLANK

34 If the child was removed and placed in a licensed home or with a relative or non-relative caregiver, a Child Health Check-Up was completed within 72 hours of removal.

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</thead>
<tbody>
<tr>
<td>8</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>58</td>
<td>67</td>
<td>98%</td>
</tr>
</tbody>
</table>

34.1 The Child Health Check-Up was completed within 72 hours of the child's removal and a copy is in the case file.

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>8</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>58</td>
<td>67</td>
<td>89%</td>
</tr>
</tbody>
</table>

34.2 If the Child Health Check-Up was not completed within 72 hours of the child’s removal, the Child Health Check-Up was completed at some point thereafter and a copy was in the case file.

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>66</td>
<td>67</td>
<td>100%</td>
</tr>
</tbody>
</table>

35 The CPI obtained medical information, including prescribed medicines, and/or other needs of the child as known by the parent, guardian or legal custodian and shared the necessary information with the substitute caregiver.

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</thead>
<tbody>
<tr>
<td>8</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>58</td>
<td>67</td>
<td>98%</td>
</tr>
</tbody>
</table>

36 If the removed child was prescribed psychotropic medications prior removal or prior to case responsibility being transferred to the case management agency, the CPI obtained written authorization from the parents to continue administration where appropriate and properly initiated the process to obtain written express and informed consent by the parents, or where necessary, a court order.

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</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>66</td>
<td>67</td>
<td>0%</td>
</tr>
</tbody>
</table>
37 The CPI visited the child in shelter care on a weekly basis until the case was transferred to and accepted by the CBC provider who subsequently agreed to conduct the required visits.

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>89%</td>
<td></td>
</tr>
<tr>
<td>Response</td>
<td>89%</td>
<td></td>
</tr>
<tr>
<td>Removal</td>
<td>88%</td>
<td></td>
</tr>
<tr>
<td>Conducting Thorough Assessments</td>
<td>88%</td>
<td></td>
</tr>
<tr>
<td>Observing &amp; Interviewing Children, Parents, Others</td>
<td>91%</td>
<td></td>
</tr>
<tr>
<td>Determining Maltreatment Findings, Family Needs &amp; Services</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td>Planning for Safe Case Closure</td>
<td>87%</td>
<td></td>
</tr>
</tbody>
</table>