**Date of Review:** August 2012 for Quarter 1.

**Region’s Overall performance achieved:** 91%

**Sample Period:** Investigative reports closed June 2012- July 2012.

**Methodology**

Region QA staff randomly selected one closed investigation between June 1, 2012 and July 31, 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”. Nine 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%).

**Chart 1**

![Central Region Sample by Circuit Chart](image)
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 September 2012, the Quality Assurance Specialist in collaboration with operations leadership in each circuit reviewed the circuit specific Corrective Action Plan to measure current progress and address any identified opportunities for improvement. The opportunities were previously 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 2012-2013 Performance

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

Chart 3

Region Overall Performance 1st Quarter 2012-13

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>91%</td>
<td>Overall</td>
</tr>
<tr>
<td>92%</td>
<td>Initial Response</td>
</tr>
<tr>
<td>84%</td>
<td>Emergency Removal</td>
</tr>
</tbody>
</table>

Circuit 5

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 88%.
- In five cases, local law enforcement checks were not completed.
- Untimely background checks and rechecks were indicated in three investigations.
- Three reports reviewed did not adequately complete person searches.
- Calls for service were not completed in two reports.
- Out of State criminal or child welfare history was not requested in one report reviewed (New York).
- Florida Department of Law Enforcement (FDLE) checks were not completed on all subjects of the report in two cases when required.

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%.
- In four cases, the updated safety assessments were not completed when required and were not updated until closure.
• Two safety assessment safety factors were entered as all “unknowns” with the instruction to resubmit the safety assessment. In one of these cases, the safety assessment was not updated and submitted until closure.
• One initial safety assessment did not consider the other child in the home that was presently out of state.
• The supervisor review of one updated safety assessment did not occur until three weeks after submission.
• One initial child safety assessment was submitted without chronological notes.
• The development of a Safety Plan was required in one case of eight applicable cases to address the mother’s substance misuse, her continued cooperation with “FIS”, her use of her prescription medication as prescribed and could include the mother's roommate and the maternal grandmother as sources of support.
• All seven safety plans developed were entered into FSFN.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 91%.
• Examples of collateral contacts that would have been appropriate to contact included neighbors, extended family members, medical provider, and the biological father not residing in the home.

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 100%.
• 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 was not applicable.

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 95%.

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 95%.
• One of the fourteen applicable cases reviewed did not interview the victims independently or away from the parents or alleged perpetrator. In the same case,
the child victim was not interviewed as to his broken/chipped tooth and if his mother ever struck him on the head.

- In two cases, the victim was not interviewed as to the allegations of the report.

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 99%.

- One case did not sufficiently interview the mother as to the allegations of the domestic violence to determine if she was planning on following through with filing an injunction or would be maintaining a relationship with her paramour.
- 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 91%

- Four reports had no interactions documented between the children and their parents/caregivers.
- In one report, the overall physical and developmental observations of the two year old child were not sufficiently documented, as she was described as playing and sharing toys with another child and they appeared comfortable and responded to direction.
- The observations and development of the two children in one report was not sufficiently documented.
- One report did not sufficiently document the injury to the child's alleged chipped tooth.
- In one report, the observations of the children were limited to the children's appearance and did not include developmental observations.

**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 97%.

13.0 Working in partnership with the Child Protection Team (CPT) to identify child maltreatment, current and long-term concerns and needed services achieved a rating of 96%.

- In one case the abuse report was received on May 24, 2012 where the child was committed under the Baker Act with facial injuries and marks on his neck. The May 26, 2012 supervisory review directed a CPT referral. The CPT referral was not made until June 6, 2012.

17.0 Information and evidence gathered warranted the consideration of additional maltreatments achieved a rating of 89% during this review.

- In one report, Threatened Harm and Inadequate Supervision were appropriately added and the substantiated maltreatment findings supported, but a field narrative supporting the addition maltreatments was not added.

18.0 Supporting maltreatment findings through appropriate documentation and information gathering achieved a rating of 96%.

- One report was closed with Not Substantiated findings of Physical Injury findings. The supporting documentation for the findings was limited to the child's
statement that the incident occurred, that it hurt for awhile but didn't leave a mark, and the father stating they "horse around" but he does not remember elbowing the child. The rationale should have also included, the lack of observed physical injury by the investigator, the CPT findings, and the pattern of reports alleging the same maltreatment (both received in 2011 regarding the oldest sibling, one verified and the other Not Substantiated).

- In one case the summary/findings does not document the maltreatment findings or a rationale for the finding of Substance Misuse as to one of the child victims.

20.0 Identifying appropriate services based on the child/family needs achieved a rating of 100%.

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

22.0 Ensuring service engagement 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 was not applicable.

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 94%.

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 was not applicable.

24.0 Completing a thorough investigation and taking appropriate steps to ensure child safety achieved a rating of 94%.

- Two cases did not sufficiently document investigative activities that had occurred in the child safety assessment.
- One case had a gap in investigative activity more than thirty days.
- One case had a delay in the transfer of the case to an investigative unit within Circuit 5.

26.0 Providing appropriate supervisory guidance and direction; and ensuring the completion of a thorough investigation achieved a rating of 94%.

- In two cases, the initial assessment was reviewed out of county and included several specific follow-up directives but it was not reviewed again following transfer until it was reviewed for closure.
- In one case, the supervisor submitted the initial assessment on June 4, 2012 and directed the investigator to resubmit an updated assessment within 24 hours with updated notes. The assessment was not updated until prior to closure on July 10, 2012.
- The initial supervisory review was completed on May 31, 2012. An updated child safety assessment was to be resubmitted after all subjects were interviewed as
directed by the CPIS. A supervisor review was not completed until prior to closure on July 18, 2012.

27.0 Following through on the supervisory guidance and direction or documenting it was no longer necessary achieved a rating of 90%.

- In eight of 15 cases, the CPI followed through on all CPI Supervisor 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 Upon removal, 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 was placed from the hospital to the foster home, therefore it is unknown what information the foster parent received regarding the child’s medical needs at discharge. The case manager documented giving the foster parent the child's resource "Blue Book". An Emergency Intake form was appropriately completed.

## Circuit 9

### Conducting Thorough Assessments

Completing thorough assessments throughout the investigative process to include developing realistic safety plans when needed achieved a rating of 90%.

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%.

- Seven cases did not complete required criminal checks timely.
- In four cases, all background checks were not completed on all household members.
- In three cases, out of state child welfare checks were not obtained (Kentucky, New York, and Virginia).
- The assessment of background checks results were not completed in two cases reviewed.
- One case lacked documentation of the completion of call outs to the home.
- One case lacked documentation of the completion local checks.

7.0 Completing the safety assessment process with sufficient thoroughness to identify risks and develop a safety plan if needed achieved a rating of 87%.

- Eleven cases rated a level of risk levels, rather than indicating risk was low, moderate or high or the level of risk was documented inconsistently in the investigation. For example, “low to moderate risk” and indicated moderate risk when case file documentation indicated the risk to the children was high.
- In four cases, safety factors in the child safety assessment were incorrectly answered based upon other documentation located in the case file.
- In three of thirteen applicable cases, the safety plan was not created in FSFN.
• In one case, there was no updated level of risk indicated in the Overall Safety Assessment.
• In one case criminal record results were not considered in the safety assessment.
• The mother’s engagement in services was not considered in the updated safety assessment in one case.
• The “unknowns” identified in the safety factors were not updated in the updated safety assessment in one case.
• In one case, the signed safety plan stated that the mother and children would move to her friend’s home if the paramour was to return to the home, and that she would call 911 if needed. There was nothing in the plan as to her obtaining housing through the information she was provided.
• In one case the family was not in receipt of any services therefore service providers were not added as parties to the safety planning process.
• In one case the investigator advised the mother that if the patterns continue the Department "may take judicial actions".
• The father was not involved in the safety plan process when required.
• A safety plan was not created with the mother or the father in one case due to ongoing domestic violence.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 89%.
• Collateral contacts that should have made included neighbors, reporters, 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 investigator spoke to the pediatrician's office. The pediatrician was not asked specifically about the alleged hand injury.
• In one case the mother was described as somewhat irresponsible by one maternal relative. This information was not fully considered in the safety assessment.

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 86%.
• In one report, the case warranted a CLS staffing to seek further action to protect the child due to a pattern of domestic violence, the mother’s mental health, child vulnerability due to being autistic, and the child's emotional distress due to the domestic violence.

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 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 93%.

2.0 Diligent attempts to see the child victim immediately or within 24 hours of report receipt achieved a rating of 56%.
   - In one case, a home visit was attempted within the required time frames and the mother indicated the children were in Kentucky. A telephone call to relatives in Kentucky was completed to validate the mother’s statement was attempted, but there was no response. A neighbor inferred that the mother stated they were going on vacation, but there was no indication this statement was validated. Four days passed without attempts to contact relatives in Kentucky. There was another sixteen day gap prior to the children being seen.

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 100%.

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%.
   - One case did not sufficiently address the maltreatments with the father.
   - One case did not sufficiently address the maltreatments with all household members.
   - The mother and paramour were not interviewed in person and were only interviewed by telephone in one case reviewed.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 84%.
   - In seven of the 23 applicable cases, familial interactions were either not documented or minimally documented.
   - In six of 23 cases, the children’s appearance was only minimally described. For example, the children were described with “no marks or bruises”.
   - There were no observations of the children 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 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 100%.

17.0 The consideration of additional maltreatments achieved a rating of 51%.
   - In two cases, the CPI did not add a field narrative with regard to the substance misuse being added to the maltreatments and findings.
   - In one case, the children were consistent in their statements that they would be left in the car to sleep at night while the mother was in other residences, inadequate supervision should have been fully investigated to determine findings.
   - In one case, the investigator should have added threatened harm based upon the mother placing the child at risk due to her ongoing behaviors which are
directly linked to her unstable mental health. The mother was not taking her medications on a regular basis. Without her medications, the mother became hostile and tried to run the paramour over with her car with the child in the vehicle at the time.

18.0 Supporting maltreatment findings through appropriate documentation and information gathering achieved a rating of 94%.

- In one case, the CPI verified substance misuse with a positive drug screen. The adverse effect upon the children was not assessed to support a verified finding.
- In one report, although the case was closed verified for Family Violence Threatens Child the documented evidence did not support the verified finding. The father was not arrested, has no prior verified history of domestic violence, and there was no evidence to support the child suffered any adverse effects of the incident. The child did not report seeing any violence in the home. A police report was not located to support the incident.

20.0 Identifying appropriate services based on the child/family needs achieved ratings of 94%.

- In one case, medical services were not identified to address the child’s medical needs.
- Harbor House services were not identified for the mother in one case.

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

- In one case, the child’s medical needs remained unaddressed and no service referrals were provided.

22.0 Ensuring service engagement achieved a rating of 94%.

- In one case, there was no determination made the service referrals for the mother had 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 50%.

- In one of two applicable cases, the child was placed in licensed care at removal. At the shelter hearing, the judge ordered a home study be completed on the paternal grandparents. The paternal grandparents were not documented as being considered by the CPI prior to the shelter hearing.

34.0 Ensuring that children receive a Child Health Check-Up within 72 hours of removal achieved a rating of 89%.

- In one of two applicable cases, the Child Health Check-Up was completed at a time which was later than within 72 hours of removal.

37.0 Visiting children in shelter care on a weekly basis until the case transfer and acceptance by the CBC provider was rated as not applicable.

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 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 100%.

24.0 Completing a thorough investigation and taking appropriate steps to ensure child safety achieved a rating of 78%.
   - Review elements impacting the thoroughness of the investigation included: additional maltreatments not addressed during the investigation, background checks not completed or completed timely, incomplete interviews, and the completion of collateral contacts.

26.0 Providing appropriate supervisory guidance and direction; and ensuring the completion of a thorough investigation achieved a rating of 93%.
   - In 11 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 11 cases, CPI followed through on all supervisory directives, and in 12 cases, the CPI followed through on the majority of directives.
   - In two of seven 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 100%.

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 0%.
   - In the two applicable cases, the Emergency Intake form was not completed, nor was there case file documentations medical information was shared with the substitute caregiver.

**Circuit 10**

**Conducting Thorough Assessments**
Completing thorough assessments throughout the investigative process to include developing realistic safety plans when needed achieved a rating of 86%.

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 83%.
   - In six cases background checks, specifically re-checks were not requested timely.
   - In three cases, local law enforcement checks for all subjects of the abuse report were not completed.
   - In two cases all prior abuse reports were not identified and assessed.
• Person searches were not completed on all household members in one report.
• In one case, an out of state child welfare check was not completed (Ohio).
• 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%.
• In seven cases, the initial safety assessment was submitted without all chronological notes entered to document investigative activities that had occurred up to the submission of the initial assessment.
• Three cases did not adequately identify all prior reports or the completion of all required criminal checks.
• In three cases, an updated child safety assessment was not completed after the subjects of the report were seen and interviewed.
• An appropriate safety plan was developed in three of five applicable cases. In one case a safety plan appeared warranted due to the mother's history of domestic violence with the paramour, and the paramour's extensive history of domestic violence which includes incidents with other women. In one case, a safety plan was warranted due to the mother's history of domestic violence as the aggressor. The safety plan was created in FSFN in three cases of the four applicable cases where safety plans were developed.
• In two cases, the initial child safety assessment did not include pertinent information necessary to complete a thorough safety assessment.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 89%.
• In one case, case file documentation does not reflect the CPI made contact with the reporter.
• Relevant collateral contacts that should have been made included neighbors, extended family members and medical staff responsible for the treatment of the child.

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 50%.
• In one case, the ICWA form in the file reflects the mother refused to sign. Inquiry of the maternal grandparents could have occurred.

32.0 Completing background checks and physically inspecting the home prior to placing the child with relatives/non-relatives achieved a rating of 78%.
• In one case, the grandfather was not included in the home study process, thus his capacity to protect and care for the child was not assessed.

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 93%.

2.0 Diligent attempts to see the child victim immediately or within 24 hours of report was not applicable, as all investigations reviewed had child victims seen either immediately or within 24 hours of 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 91%.
   • In one of eleven applicable cases, all victims were not interviewed as to all of the maltreatments.
   • In two of the seven applicable cases, all children 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 94%.
   • In three of eight applicable cases, there was no documentation that an interview addressing the allegations of the report with all household members occurred.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 94%.
   • In two cases, familial interactions were either not documented or minimally described. In all of these cases the child victims were observed in their homes.

**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 91%.

13.0 Working in partnership with the CPT to identify child maltreatment, current and long-term concerns and needed services achieved a rating of 89%.
   • In one case, the CPT referral was completed, but was completed at the conclusion of the investigation.

17.0 The consideration of additional maltreatments achieved a rating of 58%.
   • In one 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, medical neglect was not added to the report when required. The additional intake alleged the child victim was born premature and was to have surgery. However, the parents failed to have the child taken for surgery and did not reschedule her appointment. In the same case, domestic violence was not fully explored when suspected.
   • In two cases, suspected maltreatments of substance misuse and domestic violence where not fully investigated.

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 83%.
   • In one case, domestic violence and anger management services were not identified for the mother and paramour.
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 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 was rated as not applicable.

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 72%.
   • 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, incomplete interviews, and the completion of relevant collateral contacts.
26.0 Providing appropriate supervisory guidance and direction; and ensuring the completion of a thorough investigation achieved a rating of 96%.
   • In one case, the case was not accurately identified for the completion of a second party review as the supervisory review did not identify the existence of prior reports.
   • In one case, the supervisor did not indicate the child victim had not been interviewed and the requirement to have the child interviewed prior to case closure.
27.0 Following through on the supervisory guidance and direction or documenting it was no longer necessary achieved a rating of 83%.
   • 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 three of the five 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 100%.
Circuit 18

Conducting Thorough Assessments
Completing thorough assessments throughout the investigative process to include developing realistic safety plans when needed achieved a rating of 89%.

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 89%.
   - Three cases did not document the completion of local law enforcement checks of all subjects of the report.
   - In one case, prior reports were not identified for all subjects of the report. The CPI reviewed and assessed five prior reports in the background history and implications section of FSFN, however, there were nine total prior reports.
   - One case did not complete any required background checks on the alleged perpetrator.

7.0 Completing the safety assessment process with sufficient thoroughness to identify risks and develop a safety plan if needed achieved a rating of 91%.
   - In one case, the indicated risk to the children was assessed as intermediate. The case file documentation indicated there being no criminal history, no prior reports, older children, and the mother was protective. Additionally, CPT findings were “indeterminate” for physical abuse and the investigation was closed with no indicators.
   - The father was not interviewed as to the two additional reports received during the investigation in one report reviewed.
   - In one case, a safety plan was not developed with the mother to address substance misuse concerns and to increase visibility of the child through utilizing a daycare referral.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 89%.
   - In two cases, collateral contact was not completed with the reporter.
   - The mother’s mental health provider was not contacted in one case.
   - In one case, the maternal grandmother was not contacted as a collateral source as she was identified as a frequent visitor to the home.

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, a CLS staffing would have been appropriate as there was a pattern of drug arrests, substance abuse history, prior removal, trespass for theft with allegedly using the child as a accomplice, refusal of drug screen and the mother appeared to be under the influence of substances at the
time of her trespass and when the investigator completed face to face contact. The biological father was incarcerated for drug charges.

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, there was no documentation that ICWA eligibility was determined and the ICWA form was not located in the case file.

32.0 Completing background checks and physically inspecting the home prior to placing the child with relatives/non-relatives 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 95%.

3.0 Diligent attempts to see the child victim immediately or within 24 hours of report receipt achieved a rating of 56%.
- In one case, there were two victims identified at the time the intake was received. Upon contact with the family, the investigator identified an additional two victims (total of four child victims). The documentation supports the investigator completed three attempts within the first twenty four hours to locate two victims and located them at school after the twenty four hours expired. Attempts were not made to locate the additional victims for three days. The victims were then not seen until seven days later. The documentation does not support daily and diligent efforts were made to locate and see the two additional victims identified.

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 100%.

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 96%.
- One case did not document the father (who was also identified as the alleged perpetrator) was interviewed regarding the two additional reports received.
- In one case, the documentation supports two fathers were identified. There is no documentation of attempts to contact, notify, or interview either of the fathers.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 93%.
- Interactions were not documented in one of the 10 cases.
- Observations were minimally described as “no marks and bruises” and no appearance was documented 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 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 96%.
   • In one applicable case, the identified maltreatment was added to the investigation when required; however, a field narrative was not added to the report.

18.0 Supporting maltreatment findings through appropriate documentation and information gathering achieved a rating of 98%.
   • In one case, the finding of no indicators for substance misuse was not consistent with documentation in the file, which included law enforcement observations of the mother impaired, the investigator’s observations of the mother’s impairment at the time of commencement, a pattern of arrests and prior reports alleging substance misuse.

20.0 Identifying appropriate services based on the child/family needs achieved ratings of 83%.
   • In one case, there is no documentation to support the family being offered any services. Services the family could have benefitted from included: daycare, substance abuse evaluation and treatment and parenting.

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 100%.

29.0 Making concerted efforts to provide appropriate services that would allow the child to remain safely in his/her own home was rated as 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 89%.
   • In the two applicable cases, the children did receive the check up as required. In one case, it occurred eleven days after removal.

37.0 Visiting children in shelter care on a weekly basis until the case transfer and acceptance by the CBC provider was rated as not applicable.

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 88%.

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 87%.
   • In three cases, background checks were either not completed on all subjects of the abuse report or not completed timely.
   • In two cases, the fathers of the children were not interviewed as to the allegations of the report and/or additional reports.
   • In one case, services were not offered to the family when needed.
   • The reporter was not contacted in one investigation reviewed.
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 six 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 91%.
   • In four cases the initial supervisor directives were not followed.
   • In six applicable cases, 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 97%.

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 94%.
   • Two cases did not document the completion of local criminal check results, although a request was completed in one case.
   • In one case, calls for service were not requested or obtained.
7.0 Completing the safety assessment process with sufficient thoroughness to identify risk and develop a safety plan, if needed achieved a rating of 97%.
   • In one case, the initial child safety assessment was completed without sufficient information entered into the child safety assessment when known. The CPI documented an unknown criminal history; however, the criminal history was received the date the report was received. The CPI indicated “no immediate action” was needed and a victim child was unseen. The documentation in the child safety assessment indicated no pattern of reported incidents however, the prior report indicated concerns of the mother not meeting the children's immediate needs.
9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 94%.
   • Two reports did not document relevant collateral contacts with the following: reporter and church staff that assisted the family with food and transportation services.
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 96%.

2.0 Diligent attempts to see the child victim immediately or within 24 hours of report receipt achieved a rating of 78%.
   • In one of the two applicable cases, there were four identified victims. The documentation supports the CPI completed contact with three victims within the first twenty four hours. The documentation does not support the fourth victim was seen within twenty four hours. There were no documented attempts made to locate the victim for eight days after the initial attempts.

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 100%.

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 100%.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 94%.
   • Interactions of the children with the parents or caregivers were not documented 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 99%.

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 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 89%.
   • In one of the two applicable removal cases, the CPI set up the out of county Child Health Check-Up for the children within the required timeframes. The
placement provider failed to make the appointment and failed to notify the Department the Child Health Check-Up was not completed. The CPI proceeded to make another appointment. The Child Health Check-Up checks were not completed within the 72 hour timeframe; however, were completed after the timeframe and were documented in the file.

37.0 Visiting children in shelter care on a weekly basis until the case transfer and acceptance by the CBC provider was rated as not applicable.

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 95%.

24.0 Completing a thorough investigation and taking appropriate steps to ensure child safety achieved a rating of 94%.
- Two cases reviewed did not complete all background checks to include local law enforcement checks.
- In one case, the CPI did not sufficiently complete the Initial Child Safety Assessment. The CPI documented an unknown criminal history in the safety assessment; however, the criminal history was received the date the report was received. The CPI documented in the initial child safety assessment no immediate action was needed and a victim child remained unseen.

26.0 Providing appropriate supervisory guidance and direction; and ensuring the completion of a thorough investigation achieved a rating of 90%.
- Three 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 97%.
- One case 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. There were no changes made to the additional review element questions for the Quarter 1 review.

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

<table>
<thead>
<tr>
<th>Standard</th>
<th>Percent</th>
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<tbody>
<tr>
<td>1. TANF is accurately completed in FSFN for the investigation (all household members).</td>
<td>58%</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>94%</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>91%</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>100%</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>96%</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>57%</td>
</tr>
</tbody>
</table>

- In 28 of the 67 reports reviewed TANF was incorrectly completed in FSFN. Errors in TANF were attributed to supporting comments/documentation not entered into the “eligibility notes” section of the TANF form, “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.
- Six reports had a gap in time (30 days or more) of investigative activity.
- In three of seven reports reviewed, there was no documentation that the completed relative or non-relative home study was filed with the court.

Environmental Hazards Reports Review

For the 1<sup>st</sup> Quarter Review, the Central Region QA incorporated the completion of Environmental Hazards Reviews. The purpose of the review was to determine if the investigator utilized a Trauma Informed Care approach to the assessment of the causes of the “dirty house’ or hazardous environment. Examples of possible causes of Environmental Hazards could be attributed to substance misuse, mental health, and parental capacity. The QA review tool was developed with specific criteria for Environmental Hazards investigations. Ten cases per circuit (50 cases reviewed total for the region) were selected for review. Review results for the region for are summarized below in Table 2.
Table 2

<table>
<thead>
<tr>
<th>Standard</th>
<th>Percent</th>
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</thead>
<tbody>
<tr>
<td>1. Was a Trauma Informed Care approach taken by the investigator when determining the causes of the environmental hazards (substance misuse, mental health, parental capacity, generational, etc)?</td>
<td>84%</td>
</tr>
<tr>
<td>2. Were referrals provided for mental health/substance abuse/parenting services that were identified as the causes of the environmental hazards?</td>
<td>67%</td>
</tr>
<tr>
<td>3. Was a Homemaker service offered to the family to assist with teaching the family how to properly clean and maintain the home?</td>
<td>32%</td>
</tr>
<tr>
<td>4. If the investigator documented taking pictures of the home, children, etc., the pictures were located in the case file.</td>
<td>73%</td>
</tr>
<tr>
<td>5. Did the pictures located in the case file match the observations of the home documented by the investigator in the chronological notes?</td>
<td>100%</td>
</tr>
<tr>
<td>6. Did the investigator revisit the home prior to case closure to determine if the conditions of the home improved?</td>
<td>80%</td>
</tr>
<tr>
<td>7. Was collateral contact completed with the children’s pediatrician/health care collaterals to identify if consistent pediatric care has been obtained and/or if there were any “neglect” related concerns?</td>
<td>25%</td>
</tr>
</tbody>
</table>

- In 14 of the 21 applicable cases, referrals were provided for mental health/substance abuse/parenting services that were identified as the causes of the environmental hazards.
- The investigator offered the parent or caregiver cleaning services in six of the 19 applicable cases.
- In 13 of the 50 applicable cases, photographs were not taken to support the alleged Environmental Hazards maltreatment.
- The investigator documented taking photographs of the home in 37 cases reviewed. Of the 37 applicable cases, photographs of the home were found in 27 cases.
- In seven applicable cases, the investigator did not revisit the home prior to case closure to determine if the conditions of the home improved.
- Collateral contact was completed with the children’s pediatrician/health care provider to identify if consistent pediatric care has been obtained and/or if there were any “neglect” related concerns in six of the 24 applicable cases reviewed. Cases were only rated in this standard if there was indication Environmental Hazards or unhealthy conditions existed.

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

On May 3, 2012 the Department of Children and Families received a report alleging “The mother hit the father and the father hit the mother. The mother tried to hit the father with a car. [The child] witnessed the violence and has cried about it. The parents have a history of domestic violence. [The child] is autistic.”
The prior history indicates a concerning pattern for the mother’s mental health (possible diagnosis of Bi-Polar based on the prior report history documentation) and her inability to remain consistent with medication management. In eight of the 10 prior reports the mother is documented as not taking her medications as prescribed. The mother has received prior In Home Non-judicial cases in 2006. It is not known if she was successful in the completion of services or the circumstances of the case closure. The mother was provided community service referrals on several occasions in 2008 (to include daycare, mental health services, in home mental health services, Lakeside Alternatives, anger management) though there is no documentation to ascertain if she engaged in these services.

In the current investigation, the mother engaged in a domestic violence incident at the paramour’s home in which she was physically fighting with the paramour and then attempted to run him over with her car. The eight year old autistic child witnessed the incident as she was in the car with the mother. The child stated she was upset and crying asking her mother to stop. The incident occurred on May 2, 2012. The abuse report was received on May 3, 2012 as the child was still suffering adverse emotional effects. The school bus driver reported seeing the child crying as she got on the school bus due to the incident that had occurred the day prior. The grandmother reported to the investigator at case commencement the mother had only recently resumed taking her medications on May 3, 2012. The mother would not speak to the investigator at that time. The mother was later interviewed at the home of the paramour and confirmed she was in a physical confrontation with the paramour in the presence of the child and she had attempted to run over the paramour with her car while the child was inside the car.

Referrals were made to Behavioral Support Services on behalf of the child and to the Invest Program for mental health services on behalf of the mother at the closure of the case. There was no verification that the referred services were engaged by the family. Services have been implemented historically with the mother though contact was not made with the prior service providers in order to ascertain her compliance and the effectiveness of the services. Nor was collateral contact completed with the current prescribing physician to determine if the mother is taking her medications and the frequency of prescriptions.

The case was closed with some indicators of Family Violence Threatens Child. Based upon the information obtained in the interviews as well as documented pattern of family violence and adverse emotional effect on the child, a verified finding of Family Violence Threatens Child would have been supported. In addition, the Threatened Harm maltreatment could have been added to the report based upon the circumstances of the incident.

Recommended Actions included:

1) The Program Administrator to complete an administrative review of the case file, safety assessments, chronological notes, prior abuse history, current law enforcement report, criminal history and calls for services.
2) Determine the mother’s current engagement and compliance with the service referral to the Invest Program mental health services provider.
3) Determine the child’s current engagement and compliance with Behavioral Support Services referral completed on behalf of the child.
4) Complete collateral contact with the mother’s prescribing physician to determine her compliance with medication management.
5) Conduct a recent call for service request at the home of the mother/maternal grandmother and the home of the paramour to determine the existence of new incidents of violence.
6) The Program Administrator to review the “not substantiated” Family Violence Threatens Child maltreatment findings to determine if the maltreatment findings are accurate and will determine the need to add Threatened Harm as an additional maltreatment.
7) The Program Administrator in conjunction with the investigator and supervisor will determine the need for judicial intervention if mother is found not engaged with mental health services and medication management.

A response to the RFA was received on August 27, 2012. A new criminal check was completed which determined the mother had been arrested two more times involving domestic violence since this report was closed. A new abuse report was generated and the investigator made contact with the family. The mother reported that the incidents did occur. She also reported that she was not taking her medications nor did she follow through with service referrals completed during the prior report. The child was sheltered from the mother and placed with the maternal grandparents. A data change request was completed to change the findings of Family Violence Threatens Child during the prior report from Not Substantiated to Verified. The Threatened Harm maltreatment was added to the current investigation.

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 65C-29.009, F.A.C.
- Ensuring the completion of 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. 39.201(5) F.S. and 65C-29.013 (2) (a), 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 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.

- Upon removing a child from his/her home, the investigator shall complete the appropriate inquires 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 and other possible services available. 65C-28.013(1) (7), F.A.C., 65C-30.001(67-69) and 65C-30.002(1) (a) & (1) (e) 4, F.A.C.

- Ensure the completion of the Child Health Check-Up is completed within 72 hours of the child’s removal and a copy is in the investigation file. 39.407, F.S. and 65C-29.008 (1) & 65C-30.001(17) and 65C-30.002(1) (g) 1& 4, F.A.C.

- Ensure the investigator obtains 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. 39.402(11), F.S. and 65C-29.003(6) (a) 1.d., F.A.C.

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

Recommendations based on the results of the Environmental Hazards review include:

- The CPI and CPI Supervisor to ensure homemaker type services are offered and provided when needed. If a homemaker type service is not available within a circuits system of care, the need for this service will be explored by the Operations Manager with the CBC Lead Agency. Home cleaning programs are available in the following Circuits: Circuit 5- Chores. Circuit 9-ABESS. Circuit 10-Maid Pro. Circuit 18-Maid Pro. Circuit 19-none available.

- In cases in which environmental hazards exist, a collateral contact should be completed with the child's pediatrician to determine the child is receiving routine health care and to determine if the existing environmental hazards had any effects on the children's health. While not required to be completed in every case, collateral contact with the children’s pediatrician appears relevant per Chapter 65C-29.003 (9), F.A.C. when environmental hazards exist that could affect the child's health.

- CPI and CPI Supervisor shall ensure photographs taken of the conditions of the home are printed and located in the investigation case file. Program Administrators shall determine if any barriers exist to downloading and printing photographs from the investigator's cameras or telephones.

- If the CPI communicated to the parent action needed to be taken to resolve the hazardous conditions and the CPI would be returning to the home, the CPI and CPI Supervisor must ensure this occurs timely, when the CPI said they would return.
<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 1st Qtr FY 2012-2013</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></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>32 32 3 0 0 67</td>
<td>87%</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></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 0 3 0 62 67</td>
<td>67%</td>
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<tr>
<td>4 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></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>58 4 2 0 3 67</td>
<td>97%</td>
</tr>
<tr>
<td>4.1 Interviews with child victim(s) were conducted and addressed all maltreatments.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>58 3 0 1 5 67</td>
<td>97%</td>
</tr>
<tr>
<td>4.2 Interviews with “other” child(ren) were conducted and addressed all maltreatments.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>20 0 0 2 45 67</td>
<td>91%</td>
</tr>
<tr>
<td>4.3 The CPI made appropriate attempts to engage with child victim(s) and “other children” in the investigative process.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>61 3 1 0 2 67</td>
<td>98%</td>
</tr>
<tr>
<td>5 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></td>
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<td></td>
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<td>57 10 0 0 0 67</td>
<td>97%</td>
</tr>
<tr>
<td>5.1 Interview with mother;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>62 4 0 0 1 67</td>
<td>99%</td>
</tr>
<tr>
<td>5.2 Interview with father</td>
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<td></td>
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<td></td>
<td></td>
<td>39 2 1 1 24 67</td>
<td>95%</td>
</tr>
<tr>
<td>5.3 Interview with alleged perpetrator (if other than the mother or father) and;</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>17 0 0 0 50 67</td>
<td>100%</td>
</tr>
<tr>
<td>5.4 Interviews with other adult household members</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>27 4 1 0 35 67</td>
<td>96%</td>
</tr>
<tr>
<td>5.5 The CPI made appropriate attempts to engage with the parents and other adults during the investigative process.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>61 6 0 0 0 67</td>
<td>98%</td>
</tr>
</tbody>
</table>
6 Substantive observations and interactions of the children with family members were completed and documented during the course of the investigation.  
<p>| | | | | | |</p>
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<tr>
<td>63</td>
<td>17</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>67</td>
</tr>
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</table>

7 The safety assessment process was completed with sufficient thoroughness to identify risks and develop a safety plan if needed.  
7.1 The initial safety assessment was completed with sufficient thoroughness to identify risks.  
<p>| | | | | | |</p>
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<tr>
<td>60</td>
<td>20</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>67</td>
</tr>
</tbody>
</table>

7.2 The updated safety assessment(s) was completed with sufficient thoroughness to identify risks and accurately reflected information obtained during the course of the investigation.  
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<tbody>
<tr>
<td>54</td>
<td>31</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>67</td>
</tr>
</tbody>
</table>

7.3 The safety plan, when needed, was sufficient and appropriately identified the immediate and long term actions required to keep the child safe from harm.  
<p>| | | | | | |</p>
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</thead>
<tbody>
<tr>
<td>48</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>33</td>
<td>67</td>
</tr>
</tbody>
</table>

7.4 The safety plan was documented in FSFN.  
<p>| | | | | | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>46</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>37</td>
<td>67</td>
</tr>
</tbody>
</table>

8 BLANK

9 Relevant collateral contacts were completed during the course of the investigation.  
<p>| | | | | | |</p>
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<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>58</td>
<td>26</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>67</td>
</tr>
</tbody>
</table>

10 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.  
<p>| | | | | | |</p>
<table>
<thead>
<tr>
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<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>67</td>
</tr>
</tbody>
</table>

11 BLANK

12 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.  
12.1 A Children’s Legal Services staffing was held when warranted.  
<p>| | | | | | |</p>
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<thead>
<tr>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>55</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>50</td>
<td>67</td>
</tr>
</tbody>
</table>

12.2 A dependency petition was filed or a valid reason for not pursuing a dependency action was documented, when the CLS staffing documented legal sufficiency.  
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>51</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>56</td>
<td>67</td>
</tr>
</tbody>
</table>

13 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.  
13.1 A referral was made to the CPT when required.  
<p>| | | | | | |</p>
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<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>53</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>47</td>
<td>67</td>
</tr>
</tbody>
</table>
13.2 The CPI appropriately considered CPT recommendations in the identification of child maltreatment, current and long term concerns, and child and family service needs.

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</thead>
<tbody>
<tr>
<td></td>
<td>10</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>56</td>
<td>67</td>
</tr>
</tbody>
</table>

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17 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.

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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9</td>
<td>7</td>
<td>0</td>
<td>3</td>
<td>47</td>
<td>67</td>
</tr>
</tbody>
</table>

18 All maltreatment findings were supported by the information gathered and appropriately documented in the investigative record.

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<thead>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>58</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>67</td>
</tr>
</tbody>
</table>

19 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 the home.

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</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>65</td>
<td>67</td>
</tr>
</tbody>
</table>

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.

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</thead>
<tbody>
<tr>
<td></td>
<td>22</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>41</td>
<td>67</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>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>17</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>48</td>
<td>67</td>
</tr>
</tbody>
</table>

20.2 Mother

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
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<th></th>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>21</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>43</td>
<td>67</td>
</tr>
</tbody>
</table>

20.3 Father

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
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<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>54</td>
<td>67</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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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>61</td>
<td>67</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>
<table>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>21</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>45</td>
<td>67</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>
<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>49</td>
<td>67</td>
</tr>
</tbody>
</table>

21.2 Mother

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>47</td>
<td>67</td>
</tr>
</tbody>
</table>
21.3 Father | 10 0 0 0 57 67 | 100%
21.4 Other Caregiver or Caretaker Responsible (if someone other than the mother or father and has access or ongoing contact with the child) | 5 0 0 0 62 67 | 100%
22 If documentation reflects the need for immediate services and/or ongoing supervision, the investigation record contained evidence the services were engaged. | 18 0 1 0 48 67 | 98%
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. | 3 0 0 0 64 67 | 100%
24 The investigation was thorough and appropriate steps were taken to ensure child safety. | 27 31 9 0 0 67 | 83%
25 BLANK
26 Appropriate supervisory guidance and direction were provided and ensured a thorough investigation was completed. | 48 17 2 0 0 67 | 93%
26.1 Initial supervisory guidance | 56 8 3 0 0 67 | 95%
26.2 On-going supervisory guidance | 21 17 1 2 26 67 | 85%
27 Follow through occurred on the supervisory guidance and direction provided, or there was documentation it was no longer necessary. | 34 32 0 1 0 67 | 88%
27.1 The CPI followed through on the supervisory guidance and direction. | 35 30 0 1 1 67 | 89%
27.2 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. | 35 30 0 0 2 67 | 90%
27.3 The CPI supervisor ensured the CPI followed through on the 2nd party reviewer guidance and direction, or documented justification actions were no longer necessary. | 20 5 1 0 41 67 | 95%
27.4 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. | 0 2 1 0 64 67 | 78%
<p>| 28 | 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. | 10 | 0 | 0 | 1 | 56 | 67 | 91% |
| 28.1 | 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. | 55 | 9 | 3 | 0 | 0 | 67 | 95% |
| 29 | 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. | 2 | 0 | 0 | 0 | 65 | 67 | 100% |
| 30 | 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. | 7 | 0 | 0 | 2 | 58 | 67 | 78% |
| 31 | Once the decision was made to remove the child, placement priority was given to responsible relatives/non-relatives rather than licensed care. | 8 | 0 | 0 | 1 | 58 | 67 | 78% |
| 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. | 5 | 2 | 0 | 0 | 60 | 67 | 94% |
| 32.1 | The required background checks were completed during the home study process prior to the child's placement. | 6 | 1 | 0 | 0 | 60 | 67 | 97% |
| 32.2 | A physical inspection of the home was completed during the home study process prior to the child's placement. | 7 | 0 | 0 | 0 | 60 | 67 | 100% |
| 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. | 6 | 0 | 1 | 0 | 60 | 67 | 94% |
| 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. | 5 | 3 | 1 | 0 | 58 | 67 | 93% |</p>
<table>
<thead>
<tr>
<th>Requirement</th>
<th>Yes</th>
<th>No</th>
<th>Partly</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>67</td>
<td>67%</td>
</tr>
<tr>
<td>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.</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>67</td>
<td>100%</td>
</tr>
<tr>
<td>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.</td>
<td>5</td>
<td>2</td>
<td>0</td>
<td>67</td>
<td>73%</td>
</tr>
<tr>
<td>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.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>67</td>
<td>100%</td>
</tr>
<tr>
<td>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.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>67</td>
<td>N/A</td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>91%</td>
</tr>
<tr>
<td>Response</td>
<td></td>
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<td></td>
<td>92%</td>
</tr>
<tr>
<td>Removal</td>
<td></td>
<td></td>
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<td></td>
<td>84%</td>
</tr>
<tr>
<td>Conducting Thorough Assessments</td>
<td></td>
<td></td>
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<td></td>
<td>90%</td>
</tr>
<tr>
<td>Observing &amp; Interviewing Children, Parents, Others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>94%</td>
</tr>
<tr>
<td>Determining Maltreatment Findings, Family Needs &amp; Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>93%</td>
</tr>
<tr>
<td>Planning for Safe Case Closure</td>
<td></td>
<td></td>
<td></td>
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<td>89%</td>
</tr>
</tbody>
</table>