Central Region
Quality Assurance Review

Circuits 5, 9, 10, & 18
Child Protective Investigations
Quarter 1 Report Fiscal Year 2013-2014
Date of Review: August 2013 for Quarter 1.

Region’s Overall performance achieved: 89%


Methodology

Region QA staff randomly selected one closed investigation between June 1, 2013 and July 31, 2013, from each of the Department’s 63 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 four circuits. The Department maintains investigative responsibility throughout the Central Region with the exception of the Seminole County Sheriff’s Office in Circuit 18.

The distribution of the final sample of 63 reports, based upon one report per CPI unit, was as follows: Circuit 5- 18 reports (28.5%), Circuit 9- 23 reports (36.5%), Circuit 10- 12 reports 19(%), and Circuit 18- 10 reports (16%).

Chart 1
Analysis of Review Findings

Investigations were reviewed using the Quality of Practice Standards (QPS) for Child Protective Investigations (revised August 2013) 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

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.

Chart 2
Region Fiscal Year 2013-2014 Performance

Chart 3 below illustrates the Central Region’s performance level for quarter 1.

Chart 3

Region Overall Performance Quarters 1

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<thead>
<tr>
<th>1st Quarter</th>
<th>Overall</th>
<th>Initial Response</th>
<th>Emergency Removal</th>
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Central Region Practice Trends

<table>
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<tr>
<th>Service Area</th>
<th>Region</th>
<th>Circuit 5</th>
<th>Circuit 9</th>
<th>Circuit 10</th>
<th>Circuit 18</th>
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<tr>
<td>Thorough Assessments</td>
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<td>91%</td>
<td>88%</td>
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<tr>
<td>Observing &amp; Interviewing</td>
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<td>87%</td>
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<tr>
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<tr>
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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 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 81%.
   - Untimely background checks and rechecks were indicated in seven investigations.
   - Untimely requests for call outs and local criminal history checks were indicated in four investigations.
   - In four cases, rechecks were not completed as to additional subjects identified and added to the report.
   - In three cases, local law enforcement checks were not completed.
   - In two reports, implications for child safety based on the family’s prior abuse history with supporting documentation was not indicated.

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%.
   - Chronological notes were not entered at the time of the submission of the initial safety assessment in three cases reviewed.
   - In one case “no immediate action” was incorrectly selected as the initial safety action, however, a safety plan had been developed with the child and the mother/alleged perpetrator still needed to be interviewed.
   - In one case “no immediate action” was incorrectly selected as the initial safety action, however, additional safety actions were needed. The mother was incarcerated, the father declined a drug screen and there were questions regarding his ability to care for the children because of his work. Both parents had a concerning substance abuse history and were on probation. The maternal grandmother had no temporary guardianship and Children’s Legal Services had not been contacted.
   - In one case “no immediate action” was incorrectly selected as the initial safety action, however, the mother had not been located and interviewed. Safety planning appeared necessary as it was not documented where the children ages 12 and 14 planned to stay other than with an unspecified friend. When the report was received, parts of the home had been flooded with sewage due to septic back up and with water from toilet over that originated three months prior. Law enforcement described conditions that were hazardous for children to reside there to include ant and roach infestations, extensive mold and broken windows and doors exposing the inside of the home to outside elements. When the report was commenced, there was some repairs started, but still environmental hazards that made the home unsuitable for children.
• In one case, the safety actions indicate no immediate action, but a safety plan was needed to address the child's living arrangements, how her needs would be met, contact with the mother and actions to take if court injunction was violated.
• In one case, the safety assessment did not document the observations of the home, the child's ADHD diagnosis or the services that were identified. The updated assessment did not update safety factors #18 (child vulnerability) and #19 (behaviors) from unknown.
• In one case, the Child Vulnerability section documented the child's developmental delays and behaviors that put him at risk, however, safety factor question #18 was not updated from unknown.
• In one case, family members had criminal and prior report histories, but there was no assessment of the histories in the safety assessments.
• The Safety Actions did not reflect the safety planning which had been completed with the family members in an attempt to limit the child's unsupervised contact with the dog that bit him.
• In one case, no attempts were made to contact the reporter prior to the completion of the initial child safety assessment.
• In one case a safety plan was not developed to address domestic violence. In the same case, the mother remained incarcerated with the grandmother providing care for the child. There was no safety planning regarding the long term care of the child.
• In one case, based upon the environmental observed, a safety plan was needed to address the immediate dangers of the conditions of the home and determine where the children were going to stay. Prior to closure, safety planning was needed with both the mother and children as to the actions they would take to keep the home from deteriorating to such a condition again.
• In one case, the child continued to reside in the family home with the child’s boyfriend and boyfriend’s mother. A safety plan was needed to address the child's living arrangements, contact with the mother and actions to take if the court injunction was violated. Without any written permission, it is unknown how the boyfriend's mother will act on the child's behalf.
• One safety plan was developed indicating the aunt would not leave the children unsupervised, not “use any form of physical discipline and the aunt agrees not to us any object to discipline” and not use drugs around the children. The safety plan did not appear to include the parent.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 93%.
• Examples of collateral contacts that would have been appropriate to contact included relatives, neighbors, non custodial parent, medical provider, probation officer, and the family's service providers.

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%.

12.2 A dependency petition was filed or a valid reason for not pursuing dependency was documented, when the Children's Legal Services staffing documented legal sufficiency 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%.

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 91%.

2.0 Diligent attempts to see the child victim immediately or within 24 hours of report receipt was not applicable as all victims were either seen immediately of 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 96%.
- In one case, the victims were not interviewed as to who or where they were staying, other than an unspecified friend, or if this was with the mother's approval (environmental hazards case).
- In one case, there was no attempt to interview the “child” identified in the home. The child was in the process of being arrested at the time the investigator was present.

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 or additional information that was received during the investigation.
- In one case, the alleged perpetrator/paramour was not interviewed.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 85%
- Five reports had no interactions documented between the children and their parents/caregivers.
- In five reports, the observations of the children were limited to the children’s appearance and were not specific as to the allegations.
- In two reports, there were no or limited documented observations of the "other" children in the home.
- In one report, the observation of the child was not specific as to the allegation of the report (physical injury due to spanking with a belt).

**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 88%.
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 achieved a rating of 92%.

- The recommendations of CPT were not followed in two case reviewed. Recommendation not followed included having the children placed in a safe and nurturing environment in one case and follow up contact with the child's primary care physician or obtain the dogs vaccine records.
- In one case, the discussion and information shared with CPT was not documented.

17.0 Information and evidence gathered warranted the consideration of additional maltreatments achieved a rating of 0% during this review.

- In one case Inadequate Supervision should have been identified and added as an additional maltreatment due to statements by child to the investigator and CPT indicating she is choked by her brother and has several bruises from her brother.

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

- In one of the applicable cases, the evidence gathered did not support a No Indicator finding of Substance Misuse. Drug tests were not requested and the findings were supported based on observations only. The investigator’s supervisor gave directives to re-interview the subjects and request drug screens. A pill count would have also supported the finding.
- In one case, the FSFN Summary/Findings did not thoroughly document the rationale for the maltreatment findings. The documentation indicates there was no evidence to support Family Violence Threatens Child, but did not state what the evidence was including the participants statements.
- In one case, the rationale to support the maltreatment findings of Substance Misuse and Family Violence Threatens Child was limited to a statement indicating the findings were based on all participants account of the incident and the mother's arrest.

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 0%.

- In one report, FSFN indicates the child was seen at Premier Pediatrics in Ocala on 8/15, but a copy of the check up was not in the file or the FSFN file cabinet.
- In one case, the child was sheltered on June 14, 2013. A chronological note documenting completion of the 72 hour health screening on June 17, 2013. A copy of the check up was not in the file.

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 children were placed in a Marion County licensed home on June 28, 2013. The ESI staffing occurred on July 9, 2013. There was no documentation that the children were seen during this timeframe.

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 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 80%.

• Review elements impacting the thoroughness of the investigation included: background checks not completed or completed timely, incomplete interviews, insufficient safety planning 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 93%.

• Five of 18 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 93%.

• In six of 18 cases, the CPI followed through on all CPI Supervisor review directives.

28.0 Notifying the receiving case management agency of case closure to clearly communicate case transfer responsibilities achieved a rating of 52%.

• In two of four applicable reports reviewed, the receiving case management agency was not notified of the investigations case closure. In one of the two applicable cases, the case management agency was advised at the ESI staffing on July 9, 2013 the report was closing. However the report did not close until July 21, 2013.

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 case, the investigator documented completing the blue book resource record and the emergency intake form, but neither the blue book receipt or emergency intake form were in the file or what information was shared with the foster parent when the child was placed.

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%.
   - In seven cases, all FCIC/NCIC checks were not completed on all household members.
   - In six cases, all local checks were not completed on all household members.
   - Five cases did not complete required criminal checks rechecks timely.
   - The assessment of background checks results were not completed in one case reviewed.
   - In one case, call outs were not requested timely.

7.0 Completing the safety assessment process with sufficient thoroughness to identify risks and develop a safety plan, if needed achieved a rating of 89%.
   - Two applicable cases had limited or no chronological notes entered at the time the initial safety assessment was submitted.
   - Two applicable cases were submitted with incorrectly answered safety factors.
   - In one case, the safety plan was a directive for the parents to comply with (written pledge to not drink alcohol while driving and have a cooling off period due to domestic violence).
   - One case did not have the submission of an updated child safety assessment when required.
   - In one case, the safety plan was described as a promissory note (addressing domestic violence) in which the mother did not comply with prior to case closure. The safety actions in FSFN state the mother “entered a safety plan”.
   - While one safety plan was developed with both parents, it only included information indicating neither would allow the maternal grandmother to care for the child alone.
   - In one case, the safety plan noted the parents were to refrain from physical altercations around the child and to ensure child safety at all times. There was no requirement for service involvement. The father was not involved in the development of the safety plan.
   - One safety plan stated “the mother will continue not to engage in any DV in the child present”. The safety plan is a directive not a plan.
   - In one case, the Safety plans did not describe safety concerns that would pose immediate or serious harm or threats of harm.
   - In one case, the safety plan stated “caregiver will use alternative methods to help with morning sickness. Caregiver will enroll in early head start”. It should be noted that the mother had given birth and would no longer suffer from morning sickness.
   - In one case, the initial child safety assessment was submitted with the safety factors properly completed, but the risk was noted throughout as low to intermediate instead selecting the appropriate risk level.
• The initial safety assessment was submitted with no documentation in the assessment (safety factors indicated as unknown and information pending). The supervisor, however, properly instructed the investigator to input the data and then to staff the case.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 92%.

• Collateral contacts that should have been made included reporters, extended family members, and sources identified by the reporters.

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 97%.

• In one case, information received from the adult sister revealed the adult brother was not aware of the current residence, but there was nothing asked of the adult sister as to whether she knew any details of the listed incident.

12.2 A dependency petition was filed or a valid reason for not pursuing dependency was documented, when the Children’s Legal Services staffing documented legal sufficiency 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 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 89%.

2.0 Diligent attempts to see the child victim immediately or within 24 hours of report receipt was not applicable as all child victims were seen either immediately or within 24 hours.

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 98%.

• In one cases, it did not appear the specific allegation pertaining to the abuse report was addressed with the child victim regarding the conditions of her home.

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%.

• Four cases did not sufficiently address the maltreatments with the mother.
• Three cases did not sufficiently address the maltreatments with the father.
• Three cases did not sufficiently address the maltreatments with all household members.
• One case did not sufficiently address the maltreatments with the alleged perpetrator (paramour).

6.0 Documenting observations and interactions of the children with family members achieved a rating of 89%.
• In seven of 23 cases, the children’s appearance was minimally described. For example, the children were described with “no marks or bruises”.
• In six of the 23 applicable cases, familial interactions were either not documented or minimally documented.

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%.

13.2 The CPI appropriately considered CPT recommendations in the identification of child maltreatment, current and long term concerns, and child and family service needs achieved a rating of 80%.
• In one case, despite the child having no current marks or bruises, denying ever receiving any injuries from the incident and the allegations being from almost three months earlier, the mother stated she saw a small bruise on the child following the incident. CPT should have been contacted although it would have likely resulted in a deferral.

17.0 The consideration of additional maltreatments achieved a rating of 50%.
• In one case, the child stated the mother's old boyfriend had punched her in the thigh in the past and left a bruise, so the field narrative and Physical Injury maltreatment should have been added to the investigation.

18.0 Supporting maltreatment findings through appropriate documentation and information gathering achieved a rating of 94%.
• In one case, Not Substantiated findings for Environmental Hazards findings appears to be the appropriate finding as the electricity was validated as being off for one day due to non-payment of the bill, reporter information and the investigator was not provided access to the home.
• In one case, there appeared to be enough information to consider Not Substantiated for Substance Misuse as the paramour cared for the children after drinking multiple beers, with him being labeled as "mean" by the children when he drank.
• One case was closed Verified for Family Violence Threatens Child with the lack of supporting evidence obtained. The father was not arrested or interviewed in the case. The children were unable to provide an account of the incident which had occurred in the home and were described as crying as the father was shouting and kicked the master bedroom door open and made his way to the bathroom door where he banged on the door and was shouting through the door.

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%.
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 78%.
   • In one applicable case, the Child Health Check-Up was completed at a time which was later than within 72 hours of removal (17 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 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 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: background checks not completed or completed timely, incomplete interviews, delay in chronological note entry, 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 87%.
   • In 12 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 93%.
   • In seven of 23 cases, the CPI followed through on all supervisory 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 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 89%.
   • It could not be determined in one case if the father was asked about the child’s medications or medical history, or if he would have known since he wasn’t allowed contact with the child.

Circuit 10

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 78%.

- In five cases background checks, specifically local checks and FDLE re-checks were not requested timely.
- Person searches were not completed for all subjects of the report were completed in four cases.
- In two cases, out of state child welfare checks were not obtained.
- Criminal and abuse report history was not considered in two cases.
- In one case, FDLE checks for all subjects of the abuse report were not completed.
- In one case, all background checks for a household member/roommate were not completed.
- In one case, local law enforcement checks for all subjects of the abuse report 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 83%.

- An appropriate safety plan was developed in one of the four applicable cases. In one case, the safety plan was developed with the grandmother only and was not complied with. An updated safety plan was not completed. One safety plan included the family’s relatives but it did not appear the relatives were aware of the safety plan and the safety plan did not identify adequate safety resources. One safety plan did not include the mother’s Early Steps worker.
- In four cases, chronological notes were not entered at the time of the initial assessment or timely throughout the investigation.
- In one case, the household member’s background checks were not completed or assessed.
- In one case, the safety factors were incorrectly answered as factors five and 11 could have been yes with the information obtained at initial assessment even if the parents were yet not located for interview.
- There was no attempt to contact the mother to determine her short and long term plans for the care of the children.
- In one case, the Initial Child Safety Assessment was completed with no information just, "cpi to update".
- The safety factors were answered appropriately; however, the supporting information documented in the CSA was minimally completed and did not identify long term risk to the children.
- In one case, there was insufficient documentation to indicate the child’s development was appropriately assessed. Additionally, there was insufficient information to indicate drug use was sufficiently assessed.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 94%.

- Relevant collateral contacts that should have been made included service providers, neighbors, and the child’s primary care physician.
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 school collateral contact reported concerns of the child victim’s knowledge of marijuana which was not addressed with the parents.

12.2 A dependency petition was filed or a valid reason for not pursuing dependency was documented, when the Children’s Legal Services staffing documented legal sufficiency achieved a rating of 67%.
   - In one report, a CLS staffing was needed as the child victim had an arm fracture with an unknown history. The CPT consult concluded the injury was positive for physical abuse on. The mother did not accept any services. The mother also has no sense of urgency in following up with medical appointments.

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

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 87%.

2.0 Diligent attempts to see the child victim immediately or within 24 hours of report achieved a rating of 56%.
   - In one case, one child victim was seen within 24 hours. However, there was no attempt to see the second child victim until 30 days later.

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 90%.
   - In two of seven applicable cases, all victims were not interviewed as to all of the maltreatments.
   - In one of the two 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 91%.
   - In three of 10 applicable cases, there was no documentation that an interview addressing the allegations of the report with the children’s mother.
   - In one case, the maternal grandmother was identified as the alleged perpetrator. There was no documentation to indicate she was interviewed regarding her drug history nor was she requested to submit to a drug screen.
   - In one case, the paramour was identified as the alleged perpetrator. There was no documentation to indicate he was interviewed regarding his drug history.
   - In one of four applicable cases, there was no documentation that an interview addressing the allegations of the report with the children’s father.
6.0 Documenting observations and interactions of the children with family members achieved a rating of 83%.
- In seven cases, observations of the children were minimal and limited to “no marks or bruises” or not including development.
- In one case, familial interactions were not documented.

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 84%.

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 achieved a rating of 78%.
- In one case, the CPT referral, examination and consult were completed. The CPT’s findings were positive for physical abuse for an unexplained fracture in a young child who is nonverbal and non-mobile. The investigation was closed with not substantiated findings of physical injury.

17.0 The consideration of additional maltreatments achieved a rating of 0%.
- In one report, medical neglect should have been added as maltreatment to the report. The mother showed a pattern of not following through with appointments and filling prescriptions. The mother was given a prescription for the child for wheezing and did not fill it because her insurance did not cover it and the child was hospitalized.

18.0 Supporting maltreatment findings through appropriate documentation and information gathering achieved a rating of 86%.
- In two cases, the findings needed additional supporting documentation to include a request for drug test and obtaining medical records for CPT review.
- In one case, the findings for substance misuse appear to be verified. The law enforcement report indicated marijuana was located on the floor of the home that could have been picked up by either of the children. Also, the children were sitting with the mother and a burnt hand rolled marijuana cigarette was located on the floor next to the couch the defendant was observed sitting on. The mother was in primary caregiver role and does have drug related criminal history. Neighbor witnesses also reported marijuana smell stemming from the home frequently and traffic in and out of the home. The mother was not drug tested as she was arrested for possession of marijuana, drug paraphernalia and child neglect.

20.0 Identifying appropriate services based on the child/family needs achieved ratings of 96%.
- In one case, a substance evaluation should have been identified for the father as there is documentation back to 2004 which indicates alcohol has been a contributing factor to the family violence.

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 achieved a rating of 0%.
   • In one case, the child was sheltered on July 2, 2013 and case was staffed to services on July 29, 2013. Shelter visits were no completed weekly until the case was received by the CBC provider.

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 76%.
   • Review elements impacting the thoroughness of the investigation included: background checks not completed or completed timely, incomplete interviews, insufficient safety planning 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 94%.
   • Three of 12 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 88%.
   • In five of the 12 applicable cases, the supervisor did not ensure all guidance was completed or documented it was no longer necessary prior to closure.
28.0 The CPI documented notifying the receiving case management agency of case closure to clearly communicate case transfer responsibilities achieved a rating of 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 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 78%.
• Four cases did not document the completion of local criminal history checks for all household members.
• Two cases did not identify all prior reports associated with the all household members.
• One case did not complete an out of state welfare check when required.
• In one cases, prior reports were not identified and assessed for all subjects of the report.
• In one case, the mother relocated to another residence in which there was a male roommate. There is no documentation he was added to the investigation or checks were completed for him.
• FDLE/NCIC checks were not completed on all subjects of the investigation in one report.
• Local law enforcement reports pertaining to the parent’s prior child abuse arrests were not obtained in one report.
• The criminal history of the father (prior drug arrests) was not considered when determining implications for child safety based on criminal history results.
• Untimely criminal checks occurred in one investigation.
• In one case, a copy of the mother’s injunction was not obtained once identified.

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 three cases, the chronological notes were not entered prior to the submission of the child safety assessment.
• In two cases, the safety factors were incorrectly entered.
• In two cases, the prior reports were not accurately assessed.
• In one case, the updated safety assessment was not completed with sufficient thoroughness as the allegation of mental injury was not fully investigated. The documentation supports the children both expressed fear of their father and the younger child refused to visit, the children reported the father threatened to stab them with a knife.
• In one case, additional information from the victim was obtained which was not appropriately addressed with the parents to ensure a thorough safety assessment was completed to identify specific needs for the family.
• In one case, the father was involved in the safety planning process although he was identified as the alleged perpetrator.
• The safety plan did not identify all necessary actions to ensure the safety of the children to include identified service needs and compliance with services identified in one case reviewed.
• In one case, the safety plan entered into FSFN was a safeguard with relatives in which the parents were not included. The written safety plan in the case file was incomplete.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 91%.
• Appropriate collateral contacts not completed included neighbors, law enforcement, the prior case manager, and the prior Healthy Start worker.
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 chronological documenting contact with the reporter only stated “discussed allegations”.

12.2 A dependency petition was filed or a valid reason for not pursuing dependency was documented, when the Children’s Legal Services staffing documented legal sufficiency 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%.

32.0 Completing background checks and physically inspecting the home prior to placing the child with relatives/non-relatives achieved a rating of 89%.

- Local criminal records checks of the non-relatives were not completed and calls for service of the child’s placement were not obtained in one case.

**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 when the child victim was not seen either immediately or within 24 hours of receipt achieved a rating of 56%.

- In one case, there were two victims initially identified on the intake, contact with those victims was completed within 24 hours. The CPI documented a third victim child visiting an uncle. There is no documented attempt to locate the victim within 24 hours. The child victim was seen within 48 hours.

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 98%.

- In one cases, a thorough interview did not occur with the child victim addressing the inadequate supervision maltreatment.

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 84%.

- In three cases, there was no interview with the biological father although his location was known.
- Two cases did not document the mother or father was interviewed regarding the reported allegations or additional information received.
- In two cases, a household member was not interviewed.
- In one case, alleged perpetrator was not interviewed as to the maltreatments.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 98%.

- Observations were minimally described as “no marks or bruises” 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 86%.

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 achieved a rating of 80%.

- In one case, the children were experiencing serious emotional conditions which required counseling due to the reported incident of mental injury. The documentation does not support a CPT referral was completed.

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 70%.

- In one case, the documentation does not support the evidence gathered supported No Indicators of Mental Injury and Physical Injury. Both children reported the father threatened to stab them, the mother reported seeking counseling for the children due to the incident and the youngest child victim was refusing to go to the father’s residence.

- One case was closed with No Indicators of Family Violence Threatens Child. The documentation supports verified findings of family violence as the child victim witnessed the incident and was pushed by the uncle during the incident.

- In one case, No Indicators of Inadequate Supervision was not supported by the information gathered. Additional information from the 13 year old indicated there was a previous incident where he perpetrated on his sister and the parents were aware.

20.0 Identifying appropriate services based on the child/family needs achieved ratings of 93%.

- In one case, the father was receiving substance abuse services there is no documentation regarding identified service needs for the father to include parenting, healthy start, and ongoing case management for the father.

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 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 86%.
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 78%.
   • Review elements impacting the thoroughness of the investigation included:
     background checks not completed or completed timely, incomplete interviews,
     insufficient safety planning 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 80%.
   • Appropriate supervisor guidance was provided in all 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 96%.
   • In two cases the initial supervisor directives were not followed.
28.0 Notifying the receiving case management agency of case closure to clearly communicate case transfer responsibilities achieved a rating of 100%.

Additional Review Elements

Central Region QA has incorporated the following additional review elements during CPI reviews. There were five additional questions (questions 5-9) added to the additional review element questions for the Quarter 1 review. Questions pertaining to photographs of the home, gaps in case work activities and business cards left at case commencement were removed from the review tool.

These additional review elements for the region are summarized below in 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>68%</td>
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<td>2. The supervisor documented reviewing TANF for accuracy prior to report closure (in the review or in case notes).</td>
<td>76%</td>
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<tr>
<td>3. ICWA CF-FSP 5323 was uploaded into the FSFN filing cabinet prior to closure of the investigation (all reports resulting in either in-home or out-of-home judicial action after July 9, 2012).</td>
<td>67%</td>
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<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 a 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>
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<td>5. A water safety survey was completed by the CPI and located in the case file.</td>
<td>52%</td>
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<td>6. A sleeping survey was completed by the CPI for households in which a child under two years of age is residing.</td>
<td>71%</td>
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<td>7. The family’s demographics and addresses were updated in the FSFN person management screen.</td>
<td>48%</td>
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<tr>
<td>8. If the results of the Child Health Check-Up indicated any health concerns, the information was shared with the DCM and caregivers for follow up (removal only).</td>
<td>80%</td>
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</table>
9. A Sexual Safety Plan was developed when applicable (removal only).

- In 20 of the 63 reports reviewed TANF was incorrectly completed in FSFN. Errors in TANF were attributed to the "child eligibility" was also checked for adults instead of just children in the household information section, including parents that were not part of the economic unit, citizenship not checked for children and the citizenship box was not checked for the adults in the person module of FSFN.
- The supervisor documented reviewing TANF for accuracy prior to report closure (in the safety assessment supervisor review or in the case notes) in 48 of the 63 reports reviewed.
- In six of the nine applicable judicial cases, the ICWA form was uploaded into the FSFN filing cabinet prior to closure of the investigation. (Central Region requirement.
- A Sexual Safety Plan was developed when applicable (removal only) in the one applicable case.

**Requests for Action**

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

On April 12, 2013, the Department of Children and Families received a report alleging "[Child victim] has a healing right elbow and forearm fracture. It is unknown how old the fracture is and the mother does not know what happened. The child is very fussy when the right arm is moved. There is a concern that the fracture is old and could be infected."

In the current investigation, the mother took her twin children for their six month check up on April 9, 2013. The mother indicated to the nurse practitioner one of the children was favoring her right arm and was exhibiting pain when moving her arm. The mother gave no history of injury. The mother is unemployed and resides with her twin daughters, the maternal aunt (the mother’s sister) and the maternal aunt’s daughter. The nurse practitioner ordered an X-ray of the right arm. The doctor’s office reported the results from the X-rays indicated a healing fracture or osseous infection of right arm. The mother reported to medical staff that last month her child had fallen off the swing while at the babysitter’s home. The child was provided a referral for an Orthopedist.

The child was brought to the Child Protection Team (CPT) for a physical exam and a medical consult was also completed. The CPT findings were positive for physical abuse.

The child’s doctor reported the mother had contacted the Orthopedist to reschedule the appointment. The mother indicated to the investigator, the maternal grandfather was the only one who could transport and he was unavailable. The CPI indicated to the mother she can arrange a transport but she must keep appointment. The appointment was rescheduled on two occasions as the child was hospitalized for wheezing. The orthopedic appointment was completed on May 13, 2013. The results from the children’s Orthopedic were the following: the child has an irregularity of the distal humerus. It is
most consistent with a fracture, but is hard to tell without seeing the previous films. An infectious etiology cannot be ruled out. A follow up clinical exam is recommended for follow up X-ray.

The final CPT report completed on July 26, 2013 indicated a medical examination of [the child] was conducted by CPT. The assessment indicated “positive findings for physical abuse. Unexplained fracture in a young child who is non verbal and non mobile. Further testing is pending, however this fracture appears to be a CML, which is virtually pathognomonic for child abuse. Review of primary records shows a pattern of failing to follow through with recommendations and difficulty reaching the mother due to non working numbers. Medical records from PCP indicated the mother failed to follow up in February when the child had an abscess on buttocks and on May 2nd [the child] was prescribed Pulmicort for wheezing and the mother did not fill it because Medicaid did not cover it. is recommending the original X-Rays be provided to to ensure child receives appropriate follow up care.

The mother was offered Parenting and a Healthy Start referral several times during the investigation but refused as she reported that Early Steps is already involved with her family.

A safety plan was completed indicating the following, “Mother states that she will attend all doctor appointments for [the children] including all follow up to the pediatrician’s and CPT recommendations as well as continue to stay engaged with Early Steps services. Mother states that she will continue to keep her children safe and in the care of those she can trust such as her sister, aunts and her father. [The mother] advises that she can rely on her father, sister and friends for transportation to appointments”.

Case file documentation reflects one unsuccessful attempt to contact the Early Steps case manager on the same day the investigation was closed. Therefore, there was no verification the mother is working with Early Steps, the level of compliance and what the program goals/task entail. Medical records enclosed from April 12, 2013 written by NP indicted the following when talking to the investigator, “I was informed today it was due to a fall out of a swing a month ago while under a babysitter’s care, per Connie no disclosure about her falling out of a swing occurred at the home visit. There is no indication of any further follow up about the history given by the nurse practitioner regarding a fall while with a babysitter being discussed with the mother. No documentation of CPT recommendations being discussed with the mother as per safety plan.

**Recommended Action(s):**

1) The Program Administrator to complete administrative review of case file, safety assessments, chronological notes, prior abuse history, current law enforcement report, criminal history and calls for services.
2) Contact the Early Step case manager to verify if the mother is engaged in services, length of involvement, how often is the family visited, what is being addressed and concerns if any.

3) Follow up with the mother as to history given to the child’s doctor about the child falling from a swing while at the babysitter’s home. Talk to the babysitter regarding the alleged incident.

4) Determine if the X-rays were received by [redacted] office and determine if the mother and child attended up with the August appointment.

5) Request the results of the “further testing” to be completed on August 14, 2013.

6) Offer the mother daycare for her children.

A response to the RFA was received on August 30, 2013. Contact was completed by the investigator with the case manager from Early Steps that was working with the family. According to the case manager, the mother was engaged with the program and attending the weekly meetings. Several weeks into July, the mother became non compliant and her case closed due to missing three appointments. The case manager indicated the mother was doing well when participating in the program and appeared to be gaining understanding of the concepts being taught to her.

Follow up contact was completed by the investigator with the mother. The mother stated the children are doing well. She stated she discontinued participating in the Early Steps program due to wanting to get the girls in daycare. The mother denied remembering she provided the babysitter/swing scenario to the child’s doctor.

The mother did not attend the child’s appointment August 14, 2013. The mother disclosed that she did not remember about the appointment until she received a no call/no show letter in the mail. The mother contacted [redacted] office and make arrangements to be seen on September 4, 2013. The Department will transport the mother and children to the appointment to ensure attendance. The investigator completed a follow up call to the doctor’s office to determine if they were in need of any documentation or requested any in the past. The investigator was informed the doctor’s office did not request any additional records during the course of the investigation and is not currently requesting any records.

The mother accepted a referral for day care by the investigator.

**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:
• Ensure the completion of required background checks are timely and the information is being used 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.

• Ensure 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. 39.201(5) F.S. & 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.

• When information and evidence gathered through interviews and observations indicate an additional alleged maltreatment might have occurred the CPI will ensure this new information is 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.

• Ensure the completion of the Child Health Check-Up 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.

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

• Ensure the CPI visits the child in shelter care on a weekly basis until the case was transferred to and accepted by Community Based Care provider who subsequently agreed to conduct the required visits. 39.402(11), F.S. &65C-29.003(6)(a)1.d., F.A.C

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<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 2013-2014</th>
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<tbody>
<tr>
<td>1 Required background checks were completed timely and the information</td>
<td>18</td>
<td>40</td>
<td>5</td>
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<td>was appropriately used to assess immediate safety and short/long term</td>
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<td>risks to each child and the need for services.</td>
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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.

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<td>2</td>
<td>0</td>
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<td>63</td>
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3. BLANK

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.

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<td>42</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>14</td>
<td>63</td>
<td>96%</td>
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4.1 Interviews with child victim(s) were conducted and addressed all maltreatments.

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<td></td>
<td>35</td>
<td>4</td>
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<td>0</td>
<td>23</td>
<td>63</td>
<td>97%</td>
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4.2 Interviews with “other” child(ren) were conducted and addressed all maltreatments.

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<td>13</td>
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<td>1</td>
<td>48</td>
<td>63</td>
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4.3 The CPI made appropriate attempts to engage with child victim(s) and “other children” in the investigative process.

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<td>43</td>
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<td>0</td>
<td>14</td>
<td>63</td>
<td>97%</td>
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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.

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<td></td>
<td>41</td>
<td>18</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>63</td>
<td>91%</td>
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5.1 Interview with mother;

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<td>47</td>
<td>10</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>63</td>
<td>95%</td>
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5.2 Interview with father

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<td></td>
<td>27</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>27</td>
<td>63</td>
<td>87%</td>
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5.3 Interview with alleged perpetrator (if other than the mother or father) and;

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<td></td>
<td>9</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>48</td>
<td>63</td>
<td>81%</td>
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5.4 Interviews with other adult household members

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<td></td>
<td>26</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>28</td>
<td>63</td>
<td>86%</td>
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5.5 The CPI made appropriate attempts to engage with the parents and other adults during the investigative process.

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<td></td>
<td>45</td>
<td>15</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>63</td>
<td>93%</td>
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6. Substantive observations and interactions of the children with family members were completed and documented during the course of the investigation.

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<td></td>
<td>36</td>
<td>21</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>63</td>
<td>88%</td>
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7. The safety assessment process was completed with sufficient thoroughness to identify risks and develop a safety plan if needed.

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<td></td>
<td>21</td>
<td>37</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>63</td>
<td>84%</td>
</tr>
</tbody>
</table>

7.1 The initial safety assessment was completed with sufficient thoroughness to identify risks.

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<td></td>
<td>35</td>
<td>21</td>
<td>5</td>
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<td>63</td>
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<td>Section</td>
<td>Description</td>
<td>Score</td>
<td>Total</td>
<td>Pass Rate</td>
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<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>30 24 3 1 5 63</td>
<td>87%</td>
<td></td>
<td></td>
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</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>12 7 3 7 34 63</td>
<td>65%</td>
<td></td>
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<td>7.4</td>
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<tr>
<td>9</td>
<td>Relevant collateral contacts were completed during the course of the investigation.</td>
<td>42 21 0 0 0 63</td>
<td>93%</td>
<td></td>
<td></td>
<td></td>
<td></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>59 3 1 0 0 63</td>
<td>98%</td>
<td></td>
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<tr>
<td>11</td>
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<tr>
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<td>12.1</td>
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</tr>
<tr>
<td>12.2</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>10 0 0 1 52 63</td>
<td>90%</td>
<td></td>
<td></td>
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<tr>
<td>13</td>
<td>BLANK</td>
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<td>13.1</td>
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</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>14 3 1 2 43 63</td>
<td>84%</td>
<td></td>
<td></td>
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<tr>
<td>14</td>
<td>BLANK</td>
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<tr>
<td>16</td>
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</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>4 0 0 4 55 63</td>
<td>43%</td>
<td></td>
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</tr>
<tr>
<td>18</td>
<td>All maltreatment findings were supported by the information gathered and appropriately documented in the investigative record.</td>
<td>51 6 1 5 0 63</td>
<td>90%</td>
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<tr>
<td><strong>19 BLANK</strong></td>
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</tr>
<tr>
<td><strong>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.</strong></td>
<td>13</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>48</td>
<td>63</td>
<td>97%</td>
</tr>
<tr>
<td><strong>20.1 Child (Not restricted to focus child or child identified as the victim in the abuse hotline report)</strong></td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>49</td>
<td>63</td>
<td>100%</td>
</tr>
<tr>
<td><strong>20.2 Mother</strong></td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>51</td>
<td>63</td>
<td>100%</td>
</tr>
<tr>
<td><strong>20.3 Father</strong></td>
<td>7</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>54</td>
<td>63</td>
<td>86%</td>
</tr>
<tr>
<td><strong>20.4 Other Caregiver or Caretaker Responsible (if other than the mother or father and has access or ongoing contact with the child)</strong></td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>62</td>
<td>63</td>
<td>100%</td>
</tr>
<tr>
<td><strong>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).</strong></td>
<td>13</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>50</td>
<td>63</td>
<td>100%</td>
</tr>
<tr>
<td><strong>21.1 Child (Not restricted to the focus child or child identified as the victim in the abuse hotline report).</strong></td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>51</td>
<td>63</td>
<td>100%</td>
</tr>
<tr>
<td><strong>21.2 Mother</strong></td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>53</td>
<td>63</td>
<td>100%</td>
</tr>
<tr>
<td><strong>21.3 Father</strong></td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>56</td>
<td>63</td>
<td>100%</td>
</tr>
<tr>
<td><strong>21.4 Other Caregiver or Caretaker Responsible (if someone other than the mother or father and has access or ongoing contact with the child)</strong></td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>62</td>
<td>63</td>
<td>100%</td>
</tr>
<tr>
<td><strong>22 If documentation reflects the need for immediate services and/or ongoing supervision, the investigation record contained evidence the services were engaged.</strong></td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>51</td>
<td>63</td>
<td>100%</td>
</tr>
<tr>
<td><strong>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.</strong></td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>61</td>
<td>63</td>
<td>100%</td>
</tr>
<tr>
<td><strong>24 The investigation was thorough and appropriate steps were taken to ensure child safety.</strong></td>
<td>3</td>
<td>56</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>63</td>
<td>78%</td>
</tr>
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</tr>
<tr>
<td><strong>26</strong> Appropriate supervisory guidance and direction were provided and ensured a thorough investigation was completed.</td>
<td>34</td>
<td>27</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>63</td>
<td>89%</td>
</tr>
<tr>
<td><strong>26.1</strong> Initial supervisory guidance</td>
<td>50</td>
<td>13</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>63</td>
<td>95%</td>
</tr>
<tr>
<td><strong>26.2</strong> On-going supervisory guidance</td>
<td>16</td>
<td>15</td>
<td>3</td>
<td>4</td>
<td>25</td>
<td>63</td>
<td>77%</td>
</tr>
<tr>
<td><strong>27</strong> Follow through occurred on the supervisory guidance and direction provided, or there was documentation it was no longer necessary.</td>
<td>42</td>
<td>19</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>63</td>
<td>92%</td>
</tr>
<tr>
<td><strong>27.1</strong> The CPI followed through on the supervisory guidance and direction.</td>
<td>42</td>
<td>18</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>63</td>
<td>92%</td>
</tr>
<tr>
<td><strong>27.2</strong> 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>33</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>63</td>
<td>91%</td>
</tr>
<tr>
<td><strong>27.3</strong> BLANK</td>
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<tr>
<td><strong>27.4</strong> BLANK</td>
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<tr>
<td><strong>28</strong> 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>9</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>52</td>
<td>63</td>
<td>86%</td>
</tr>
<tr>
<td><strong>28.1</strong> 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>46</td>
<td>15</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>63</td>
<td>93%</td>
</tr>
<tr>
<td><strong>29</strong> 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>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>63</td>
<td>100%</td>
</tr>
<tr>
<td><strong>30</strong> 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>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>55</td>
<td>63</td>
<td>100%</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. | 8 | 0 | 0 | 0 | 55 | 63 | 100%

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. | 3 | 1 | 0 | 0 | 59 | 63 | 94%

32.1 The required background checks were completed during the home study process prior to the child's placement. | 3 | 0 | 1 | 0 | 59 | 63 | 89%

32.2 A physical inspection of the home was completed during the home study process prior to the child's placement. | 4 | 0 | 0 | 0 | 0 | 63 | 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. | 4 | 0 | 0 | 0 | 0 | 63 | 100%

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 | 0 | 1 | 2 | 55 | 63 | 69%

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. | 5 | 0 | 0 | 3 | 55 | 63 | 63%

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. | 1 | 0 | 0 | 2 | 60 | 63 | 33%

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. | 7 | 1 | 0 | 0 | 55 | 63 | 92%

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. | 1 | 0 | 0 | 0 | 62 | 63 | 100%
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>Activity</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>2</th>
<th>62</th>
<th>63</th>
<th>Overall</th>
<th>89%</th>
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<tr>
<td>Response</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>89%</td>
</tr>
<tr>
<td>Removal</td>
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<td></td>
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<td>88%</td>
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<tr>
<td>Conducting Thorough Assessments</td>
<td></td>
<td></td>
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<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></td>
<td></td>
<td></td>
<td>91%</td>
</tr>
<tr>
<td>Determining Maltreatment Findings, Family Needs &amp; Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>88%</td>
</tr>
<tr>
<td>Planning for Safe Case Closure</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td>88%</td>
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</table>