Date of Review: November 2012 for Quarter 2.

Region’s Overall performance achieved: 89%

Sample Period: Investigative reports closed September 2012- October 2012.

Methodology

Region QA staff randomly selected one closed investigation between September 1, 2012 and October 31, 2012, from each of the Department’s 67 Child Protective Investigation units (with the exception of Citrus Count units which recently transitioned back to the Department during October 2012) 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 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
September 2011 - October 2012

[Diagram showing distribution by circuit]

N=67
Analysis of Review Findings

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

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

At the conclusion of the exit conference held in each circuit in December 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.

![Central Region Practice Trends Chart]

<table>
<thead>
<tr>
<th>Practice Trend</th>
<th>Region</th>
<th>Circuit 5</th>
<th>Circuit 9</th>
<th>Circuit 10</th>
<th>Circuit 18</th>
<th>Circuit 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thorough Assessments</td>
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<td>88%</td>
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<td>Observing &amp; Interviewing</td>
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<td>87%</td>
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<tr>
<td>Planning Safe Case Closure</td>
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<td>92%</td>
<td>83%</td>
<td>89%</td>
<td>86%</td>
<td>89%</td>
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</tbody>
</table>
Region Fiscal Year 2012-2013 Performance

Chart 3 below illustrates the Central Region’s performance level for quarters 1 and 2.

Chart 3

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.
- Out of State criminal or child welfare history was not requested in four reports reviewed.
- Four reports reviewed did not adequately complete person searches.
- Untimely background checks and rechecks were indicated in two investigations.
- Calls for service were not completed in two reports.
- Florida Department of Law Enforcement (FDLE) checks were not completed on all subjects of the report in one case 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 88%.
- Five cases inaccurately indicated “No Immediate Action” in the safety actions of the child safety assessment when additional actions or follow up was required.
- Four initial child safety assessments were submitted without chronological notes.
• In one case reviewed, the initial overall level of risk was assessed to be moderate to high. The determination of a level of risk shall be determined as either low, moderate/intermediate, or high but not as a combination of levels.

• In one initial child safety assessment, the Signs of Present Danger factors #5 did not reflect the mother's 2011 arrest for domestic battery. The other two children residing in the home, who were seen prior to submission, were not reflected as seen and interviewed in the initial assessment.

• In one case, a safety plan was developed with the mother and documented in the chronological notes to address domestic violence; however, the safety plan was not found in the case file or FSFN.

• In one case, the initial assessment was completed by Orange County on August 30, 2012 with all unknown safety factor implications, which was appropriate at that time because no one had been seen or the home observed. The children, adults and home were observed in Lake County on August 30, 2012, an updated child safety assessment was not completed until September 19, 2012.

• In one case reviewed, the CPI was directed to resubmit the CSA with updated chronological notes by August 8, 2012. The updated child safety assessment was not resubmitted until September 21, 2012.

• The initial assessment was submitted on September 8, 2012, before the child victim had not been seen. The victim was seen on September 10, 2012, but an updated assessment was not resubmitted until September 26, 2012, following contact with the mother and her significant other.

• The development of a safety plan was required in one of seven applicable cases to address the mother's alcohol consumption, domestic violence and follow through with FIS services; however, was not completed.

• Three of the seven safety plans developed were entered into FSFN.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 90%.

• Examples of collateral contacts that would have been appropriate to contact included reporters, sources identified by the reporters, medical provider, 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%.

12.0 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 85%.

• In two cases, the CLS staffing and/or consultation was warranted but not completed or documented by the completion of a CLS staffing form or in the chronological notes.

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 achieved a rating of 78%.
• In one case in which a removal occurred, all record checks were completed except there were no person searches documented on household members.

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 receipt achieved a rating of 67%.
  • In one case, two additional child victims were identified to be residing in the home in the intake. The child victims were seen five days after the report was received with only one attempt to see and interview the victims until that time.
  • Upon receipt of the report, one attempt to locate the child victims occurred on Saturday and again on Sunday. The attempts to locate the child victims occurred at the same time on both of the days.

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 89%.
  • Four of the fourteen applicable cases reviewed did not interview the victims or children independently or away from the parents or alleged perpetrator.
  • In one case, the victim was not interviewed as to the allegation of the additional report.
  • In one case, there was no attempt to interview the three year old victim and no attempt to ascertain his verbal ability.
  • In one case, the child victim was asleep and there is no documented attempt to interview him.

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 90%.
  • Three cases did not sufficiently interview the mother as to the allegations of the report or additional information that was received during the investigation.
  • Three cases did not thoroughly interview the household members who included the maternal grandmother, adult sibling, and the mother’s paramour.
  • In one case the father was not fully interviewed as to the alleged maltreatments.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 87%
  • In four reports, the observations of the children were limited to the children’s appearance and did not include developmental observations.
  • Three reports had no interactions documented between the children and their parents/caregivers.

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 95%.
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 93%.

- In one case, the CPT referral was not completed as the CPI did not observe any injuries at case commencement. A CPT referral was warranted; however, based upon law enforcement’s observations earlier that morning the 13 year old had a small knot on her forehead and her sibling had several red marks on his face from being struck by their mother.

- The recommendations of CPT were followed in one case reviewed. Recommendation not followed included in home services, counseling and discussion with the parents regarding visitation exchanges and the sexual activity of the fifteen year old victim.

17.0 Information and evidence gathered warranted the consideration of additional maltreatments achieved a rating of 69% during this review.

- In one report, Substance Misuse should have been added due to the mother being intoxicated and engaging in domestic violence in which she was arrested. The father and collateral contacts also reported the mother’s behavior changes and she becomes violent when she is using alcohol.

- Family Violence Threatens Child was appropriately added to one report; however, a field narrative was not entered into FSFN supporting the maltreatment.

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 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 78%.

- In one report, the child victim was sheltered on August 7, 2012. An attempt to obtain the 72 hour health screening was made on August 10, 2012 but there was trouble with the HMO Medicaid. The Child Health Check-Up occurred on August 13, 2012.

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

**Planning for Safe Investigation Case Closure**
Gathering and sharing information between and among all parties including supervisors, case managers, substitute caregivers, etc., and appropriately acting upon information as necessary achieved a rating of 92%.
23.0 Timely and appropriate communication and collaboration between the CPI and the Case Manager occurred when active case management services existed when the CPI received the investigative report was not applicable.

24.0 Completing a thorough investigation and taking appropriate steps to ensure child safety achieved a rating of 99%.
- In one report, the mother's paramour who resided in the home was not added to the report, record checks were not completed, nor was an interview documented.

26.0 Providing appropriate supervisory guidance and direction; and ensuring the completion of a thorough investigation achieved a rating of 97%.
- Two of 15 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 90%.
- In seven 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 40%.
- In three of five applicable reports reviewed, the receiving case management agency was notified of the investigations case closure.

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 100%.

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**Circuit 9**

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

1.0 Timely completion of required background checks and appropriately using the information to assess immediate safety and short/long term risks to each child and the need for services achieved a rating of 87%.
- Six cases did not complete required criminal checks timely.
- The assessment of background checks results were not completed in five cases reviewed.
- In four cases, all background checks were not completed on all household members.
- In two cases, out of state child welfare checks were not obtained.
- Two cases lacked documentation of the completion of call outs to the home.
- Two cases lacked documentation of the completion of local law enforcement checks.
• One case did not identify and assess all prior reports regarding the subjects of the report.

7.0 Completing the safety assessment process with sufficient thoroughness to identify risks and develop a safety plan, if needed achieved a rating of 78%.
• Seven applicable cases had limited or no chronological notes entered at the time the initial safety assessment was submitted.
• One 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 one case, the signs of present danger narrative were a copy/paste of the mother’s interview, which included a lot of the information but did not particularly address safety factor #4 as it relates to the paramour. Also, protective capacities notes there are no priors, which was not accurate. The Overall Safety Assessment narrative was a reiteration of the chronological notes.
• The initial safety assessment was limited in detail in one case reviewed, particularly pertaining to safety factors, with the supervisor correctly noting disagreement in several areas. Some of the information had been obtained that should have changed the listed unknowns.
• In one case, the initial child safety assessment was completed on September 30, 2012 with all unknowns and no relevant information or thoroughness to identify risk. An updated assessment was completed three days later on October 3, 2012. The update did not accurately reflect all information obtained during the course of the investigation. Information obtained regarding the interview with the father is not documented in the updated safety assessment. The updated assessment did not identify a risk level at closure.
• In one case, the mother agreed with a safety plan to abide by any court orders in place and to ensure no domestic violence occurred in the presence of the child. The father was not involved in the development of the plan. The safety plan did not include identified services to assist the family should new circumstances arise.
• The safety plan in one applicable case stated the child will remain with the paternal grandmother until the mother is stable and able to take care of the children. There was no elaboration or detailed plan as to what the mother’s situation would be when she is stable. For example, compliant with drug treatment, stable employment, etc.
• Five of the applicable safety plans were not created in FSFN.
• Four safety plans did not include or involve the father in its development.
• Three safety plans did not accurately identify safety resources and services to address the issues that led to the development of the safety plan.
• One safety plan was created in FSFN; however, there was no signed safety plan found in the case file.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 87%.
• Collateral contacts that should have been made included neighbors, reporters, sources identified by the reporters, law enforcement, 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 96%.

• In one case, the school counselor’s assertion that there was no follow-up by the parents when she suggested counseling for the child was not fully considered in the assessment process.

• The information obtained from a neighbor collateral contact indicated the family smokes marijuana outside the home was not addressed in one case reviewed.

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

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

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

• One home study for relative placement did not complete person searches or local criminal checks for all household members of the home where the child was placed.

Observing and Interviewing Children, Parents, Others
Completing thorough interviews with children and other participants, making substantive observations of behaviors and documenting interactions between children and family members achieved a rating of 87%.

2.0 Diligent attempts to see the child victim immediately or within 24 hours of report receipt was not applicable, as all victims were seen 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 90%.

• In one case, two of the child victims were observed, but not interviewed due to not awakening sufficiently enough when seen to adequately respond to questioning. An attempt to interview the child victims at another time did not occur.

• In one case, the three year old child victim responded to questions but it could not be determined if the three year old had anything addressed with her pertaining to the actual maltreatments.

• Additional information from the oldest child victim regarding her prior removal and placement in the State of New York was not obtained.

• In one case, the child victim was not interviewed.

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 89%.

• Eight cases did not sufficiently address the maltreatments with the father.
• Five cases did not sufficiently address the maltreatments with the mother.
• Three cases did not sufficiently address the maltreatments with all household members.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 82%.
• In eight of the 23 applicable cases, familial interactions were either not documented or minimally documented.
• In ten of 23 cases, the children’s appearance was 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 93%.

13.0 Working in partnership with the CPT to identify child maltreatment, current and long-term concerns and needed services achieved a rating of 83%.
• In one case, a CPT referral was not completed when mandated due to the child victim's apparent emotional issues that resulted in her prior Baker Act.

17.0 The consideration of additional maltreatments achieved a rating of 37%.
• In one cases, the child victim noted seeing the father smoke something green that came out of a plastic bag. The Substance Misuse maltreatment was added, but there was no field narrative added in FSFN.
• In one case, it does not appear the information regarding Substance Misuse was appropriately addressed. Substance Misuse maltreatment should have been added as the neighbor collateral reported that the family smokes marijuana outside. This was never addressed, nor was there any assessment as to whether the children are around or not. Also, the CPI documented smelling a "distinct odor" in the household member’s bedroom.
• In one case, the father has prior arrest history for marijuana possession. The father stated on the day of the incident he had "smoked a joint" prior to the alleged incident. Substance Misuse maltreatment was not considered to be added as a maltreatment.

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%.

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 93%.
• In one of three applicable cases, it is not documented whether any relatives or friends were considered for placement. There is documentation as to why the
father does not believe any maternal relatives should have the child, but the consideration of paternal relatives is not documented.

34.0 Ensuring that children receive a Child Health Check-Up within 72 hours of removal achieved a rating of 67%.
   • In one of three 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 83%.

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 76%.
   • 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, 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 78%.
   • In 20 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 75%.
   • In 12 of 23 cases, the CPI followed through on all supervisory or second party directives.

28.0 Notifying the receiving case management agency of case closure to clearly communicate case transfer responsibilities achieved a rating of 75%.
   • The case management agency was not notified of case closure in two cases reviewed.

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 93%.
   • In one applicable case, the Emergency Intake form was not completed, nor was there case file documentation that 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 70%.
   - In five cases, local law enforcement checks for all subjects of the abuse report were not completed.
   - In five cases, FDLE checks for all subjects of the abuse report were not completed.
   - In four cases background checks, specifically re-checks were not requested timely.
   - In two cases all prior abuse reports were not identified and/or assessed.
   - In two cases, out of state child welfare checks were not obtained.
   - Calls for service to the home were not completed in two cases 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 85%.
   - An appropriate safety plan was developed in four of the nine applicable cases. Three of the safety plans were developed without indicating appropriate safety resources or services. Extended family resided in the home was included in the development of the safety plan in two case reviewed.
   - Two initial child safety assessments were completed and submitted while there were no chronological notes entered.
   - In two of the applicable nine cases, the safety plan was not entered into FSFN.
   - In one case, the overall safety assessment of the initial child safety assessment was minimally completed. The risk was indicated as low; however, based upon recent prior report of the same situation and the young ages of children this level may have been assessed as intermediate.
   - At closure in one case reviewed, the risk was identified as moderate. However, risk appears to be low as the children were residing with relatives with the mother having supervised contact. The mother also was agreeable to non-judicial services.
   - One case was identified as low risk; however, intervention services to include daycare, parenting, speech therapy, and employment services were not identified.
   - At closure, risk was assessed as low to moderate. Based upon the fact that there was not any evidence to support the maltreatments the risk appeared to be low.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 91%.
   - In three cases, case file documentation does not reflect contact was made with the reporter.
Relevant collateral contacts that should have been made included neighbors, paramour and a source identified by the reporter.

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 maternal grandmother indicated the mother was working with the oldest child regarding her speech concerns. She also reported the child was previously working with a speech therapist but the service was discontinued. There is no other information known regarding re-engaging the child in speech therapy.

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 80%.

- In one case, a CLS staffing appeared necessary due to collateral information that was received from reliable reporters that indicated concerns of drug use and domestic violence, the mother’s refusal of services and the child’s frequent absences from school.

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 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%.

3.0 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 96%.

- In two of nine applicable cases, all victims were not interviewed as to all of the maltreatments.
- In one of the four 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 96%.

- In one of seven applicable cases, there was no documentation that an interview addressing the allegations of the report occurred with the children’s uncle.
- In one of five 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 87%.
• In four cases, familial interactions were either not documented or minimally described. In all of these cases the child victims were observed in their homes.
• In one case, a photograph of the child's injury was in the file. The child's injury was documented in the chronological notes. The appearance of the other children was not documented in the chronological notes.
• In one case, the observations of the children were minimal with the exception of one of the eight children, who was described as “down syndrome”.

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

13.0 Working in partnership with the CPT to identify child maltreatment, current and long-term concerns and needed services achieved a rating of 56%.
• In one case, the CPT referral was completed; however, the mother refused to allow the child to be seen at CPT. CPT was not provided the photographs of the child’s injury along with explanation for the injury. There was no additional documented follow up with CPT.
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 90%.
• In one report, the allegation of substance misuse was not indicated; however, there was some evidence to support a not substantiated finding. The mother reported she did not have any of her prescription medications left and her brother reported she had been taking his medications as well. There was evidence as reported by local law enforcement that methamphetamine was being made at the home. Collateral information obtained also supported ongoing substance abuse.
• In one case, the case was closed not substantiated for physical injury. Based upon the information obtained from witnesses and collateral contacts with the addition of no marks or bruises on the child the case should have been closed with no indicators.
20.0 Identifying appropriate services based on the child/family needs achieved ratings of 89%.
• In one case, services were not identified for the mother (substance abuse) and child (school and protective services).
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 89%.

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: incomplete chronological notes, an incomplete CPT referral, 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 91%.
- 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 94%.
- In three 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 one of the six applicable cases reviewed, second party guidance and recommendations were not completed or justification existed that the guidance was no longer necessary.

28.0 The CPI documented notifying the receiving case management agency of case closure to clearly communicate case transfer responsibilities in the two applicable cases 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 82%.
- Four cases did not document the completion of local law enforcement checks of all subjects of the report.
- In two cases, prior reports were not identified and assessed for all subjects of the report.
- Call outs were not completed in three cases.
• One case did not complete any required background checks on the paternal aunt and uncle.
• One case did not complete an out of state welfare check when required.

7.0 Completing the safety assessment process with sufficient thoroughness to identify risks and develop a safety plan if needed achieved a rating of 84%.
• In two cases, the implications of all prior reports were not assessed.
• In two cases, the safety plans were determined to be insufficient. In one case, the safety plan was completed with the grandparents to contact the appropriate authorities and not allow parents to have the child if they were under the influence. The safety plan is not appropriate as it restricts the parent's access to the child and did not include the parents in its development. In the second case, the safety plan stated "Mother and father will not engage in arguments or domestic violence in the presence of the children." The safety plan did not document immediate or long term specific actions required to keep the children safe from harm.
• In one case, the initial safety assessment was submitted without chronological notes.
• The initial child safety assessment was not completed without thoroughness due to documentation indicating “technical issues” (computer problems) in one case reviewed. A thorough updated assessment was subsequently completed within 48 hours of the time the report was received. The assessment indicated there were no prior reports when the family was the subject of one prior report.
• The overall safety assessment and risk was not sufficiently documented in FSFN as it appeared to be “cut off” or incomplete in one case.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 91%.
• In three cases, law enforcement that responded to the home was not contacted as a collateral source.
• In one case, collateral contact was not completed with the reporter.

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 father refused to cooperate with completing the ICWA inquiry. The child was placed with an adult sibling who was biologically related to the child, and there is no documentation an ICWA inquiry was made with the adult sibling to determine the child’s eligibility.

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 for the sibling’s paramour or calls for service to 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 was not applicable, as all investigations reviewed had child victims seen either immediately or within 24 hours of receipt.

3.0 Conducting interviews with the alleged child victim(s) and “other” child (ren) named in the report and/or residing in the home that addressed all maltreatments achieved a rating of 97%.
   • In one case, a thorough interview did not occur with one of the two child victims which addressed the specific maltreatments of substance misuse and environmental hazards.

4.0 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%.
   • Two cases did not have case file documentation indicating household members were interviewed.
   • One case did not document the mother was interviewed regarding the reported allegations.
   • In one case, the documentation supports two fathers were identified. There is no documentation of attempts to contact, notify, or interview one of the fathers.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 87%.
   • Interactions were not documented in five of the 10 cases.
   • Observations were minimally described as “clean and free of marks and 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 90%.

13.0 Working in partnership with the CPT to identify child maltreatment, current and long-term concerns and needed services achieved a rating of 93%.
   • There is no documentation that CPT’s recommendation to assess failure to protect as to the mother was considered in one case.

17.0 The consideration of additional maltreatments achieved a rating of 33%.
   • In one applicable case, the investigation indicated concerns for the mother abusing substances. The documentation supports the mother was provided a drug screen and according to a med count one prescription count was short based upon the prescription provided. There is no documentation the allegation of substance misuse was added (to include a field narrative) to the investigation.
   • In one case, CPT’s recommendation that the Department evaluate concerns for Failure to Protect as to the mother was not considered. Also, the investigation indicated the adult sibling disclosing an incident of family violence between the
sibling and the father. The maltreatment of Family Violence Threatens Child (to include a filed narrative) was not added to the investigation.

18.0 Supporting maltreatment findings through appropriate documentation and information gathering achieved a rating of 98%.
   • In one case, the finding of no indicators of Family Violence Threatens Child was not adequately supported or documented as the incident occurred in the past and out of state.

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 83%.
   • In one case, the father’s engagement with anger management services was not confirmed.

24.0 Completing a thorough investigation and taking appropriate steps to ensure child safety achieved a rating of 80%.
   • In five cases, background checks or call outs were either not completed on all subjects of the abuse report or were not completed timely.
   • Law enforcement was not contacted in three investigations reviewed.
   • Two cases did not have case file documentation indicating household members were interviewed.
   • One case did not document the mother was interviewed regarding the reported allegations.
   • In one case, the father of the child victims was 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.

26.0 Providing appropriate supervisory guidance and direction; and ensuring the completion of a thorough investigation achieved a rating of 78%.
   • Appropriate supervisor guidance was provided in none of the ten cases reviewed.

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 80%.
   • In five cases, background checks or call outs were either not completed on all subjects of the abuse report or were not completed timely.
27.0 Following through on the supervisory guidance and direction or documenting it was no longer necessary achieved a rating of 93%.
   • In three cases the initial supervisor directives were not followed.
   • In two 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 100%.

Circuit 19

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

1.0 Timely completion of required background checks and appropriately using the information to assess immediate safety and short/long term risks to each child and the need for services achieved a rating of 81%.
   • In two reports reviewed, out of state welfare checks were requested but not obtained. One report did not document the request of an out of state welfare check when needed.
   • One case did not document the request for local criminal check on all subjects of the report.
   • 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 87%.
   • In one case, the initial child safety assessment was completed without sufficient information as safety factors were not accurately assessed. The assessed signs of present danger safety factors indicated the parent/caregiver did not have a criminal history that would negatively affect the child, did not have a history of violence, was not likely to flee, did not have substance abuse that would negatively affect the child, and there was no pattern of incidents. Based on required checks this was inaccurate as the mother and grandmother had a history of violence, history of criminal offenses that could negatively impact the child, the mother reported current and past substance abuse, and there was a significant pattern of the mother using substances.
   • In one case, it was documented that no immediate safety actions identified; however, the documentation reflects immediate safety action was needed to complete identified service needs, referrals and ensure engagement.
   • In one case, the implications to child safety based on the assessment of the risk factors were not documented.
9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 97%.
   • One report did not document relevant collateral contact with the school staff where the children attended.
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 regarding the mother’s substance misuse provided by a collateral source was not adequately addressed.

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 91%.

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 96%.
   • The alleged maltreatment was not addressed with one of the children in the home in one case reviewed.

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 90%.
   • In two reports, the father was not adequately interviewed as to the allegations of the report.
   • In one report, there was no attempt to engage the mother in the interview process. In the same case, a thorough interview was not completed with the adult brother residing in the residence.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 87%.
   • In one report, case file documentation does not support the children’s physical appearance was observed, this was pertinent as the children disclosed being disciplined by a show, hanger, and belt.
   • Interactions of the children with the parents or caregivers were not documented in two additional cases.

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

13.0 Working in partnership with the CPT to identify child maltreatment, current and long-term concerns and needed services achieved a rating of 100%.
17.0 The consideration of additional maltreatments achieved a rating of 69%.
   • In one report, the child disclosed an incident of family violence in the home, the maltreatment of Family Violence Threatens Child was not fully addressed, added to the report nor was a field narrative entered.
   • In one report, the grandmother (who had custody) reported knowledge of the mother abusing substances for months and knowledge of previous incidents where the mother would drive with the children while under the influence. There is no documentation the maltreatment of failure to protect or a field narrative was added to the investigation.

18.0 Supporting maltreatment findings through appropriate documentation and information gathering achieved a rating of 94%.
   • One report was closed with not substantiated findings of Family Violence Threatens Child and Substance Misuse based on parent's refusal to complete a substance screen and call outs to the home. The call outs to the home were due to "verbal altercations". Based on the documentation there is a lack of evidence to support not substantiated findings.

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 75%.
   • In one case, a referral for substance abuse services on behalf of the mother appeared warranted.

22.0 Ensuring service engagement with services was rated as 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 89%.

24.0 Completing a thorough investigation and taking appropriate steps to ensure child safety achieved a rating of 78%.
   • Four cases reviewed did not complete all background checks to include local criminal checks, call outs, and out of state welfare checks.
   • In three cases, the initial child safety assessment was not sufficiently completed.
   • In one case, the relevant collateral contact with the children's school staff was not documented.

26.0 Providing appropriate supervisory guidance and direction; and ensuring the completion of a thorough investigation achieved a rating of 81%.
   • Six 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 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%.

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**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>
</tr>
</thead>
<tbody>
<tr>
<td>1. TANF is accurately completed in FSFN for the investigation (all household members).</td>
<td>51%</td>
</tr>
<tr>
<td>2. The supervisor documented reviewing TANF for accuracy prior to report closure (in the review or in case notes).</td>
<td>72%</td>
</tr>
<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>33%</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>97%</td>
</tr>
<tr>
<td>5. There was no “gap” in time (30 days or more) during the completion of investigative tasks by the investigator.</td>
<td>97%</td>
</tr>
<tr>
<td>6. 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>
</tr>
<tr>
<td>7. The CPI did not leave a business card at commencement, or contact the family via telephone, prior to making an unannounced visit and contact with the child victim or family.</td>
<td>97%</td>
</tr>
</tbody>
</table>

• In 33 of the 67 reports reviewed TANF was incorrectly completed in FSFN. Errors in TANF were attributed to incorrect financial information, "applies to" was also checked for adults instead of just children in the household information section, citizenship not checked for children included 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 67 reports.
reports reviewed. This is an action item in each of the circuit’s individual Corrective Action Plan.

- In eight of the 12 applicable judicial cases, the ICWA form was uploaded into the FSFN filing cabinet prior to closure of the investigation. (Central Region requirement)

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

On August 8, 2012, the Department of Children and Families received a report alleging Family Violence Threatens Child; Environmental Hazards; Substance Misuse and Inadequate Supervision of a 9 year old child while in the care of mother, grandparents and other household members. Allegations included manufacturing, use of and selling methamphetamine in the home, as well as prescription pain medication; guns in the home; child wandering neighborhood by self while family uses drugs and fighting amongst the adults in the home.

The report was closed on September 14, 2012, with not substantiated findings of Environmental Hazards; and no indicators of Family Violence Threatens Child, Inadequate Supervision or Substance Misuse.

In the current investigation, the home was described by the investigator as filthy with dirty clothing throughout the entire home. A total of three large dogs live in the home, two are pit-bulls. There are papers and piles of clutter everywhere. The vacant bedroom has a broken door that sits on top of a pile of clothing directly in the doorway. The room was dark but the room was full of clutter and smelled of dog poop. The kitchen was clean. The dishes were washed and placed in the cabinet. Most of the cabinets did not have doors. CPI observed plenty of dry and refrigerated goods. Appliances and utilities were present and operational. The home had running water, power, and a central air / heating unit was running during the CPI’s visit. The child reported that sleeping in the living room with the mother on the couch and recliner.

The mother declined a drug screen and reported that she would only complete one if she was court ordered to do so. During the 2010 prior abuse report, the mother and grandmother completed a drug screen in which they both tested positive for methamphetamines.

Law enforcement conducted a search of the home and surroundings. A gun was found between two mattresses in one of the bedrooms. There were no drugs found but law enforcement stated it appears someone has manufactured methamphetamine in or around the home.

Collateral information obtained from three neighbors reported ongoing concerns for the child in the home due to a high volume of traffic in and out of the home. The neighbors reported knowledge of ongoing prescription abuse and illegal drug abuse in the home.
The neighbors also reported that there was ongoing domestic violence. The child’s aunt reported ongoing concerns with substance abuse in the home and ongoing violence with the adults in the home.

Recommended Action(s):

1) The Program Administrator to complete administrative review of case file, safety assessments, chronological notes, prior abuse history, law enforcement reports, criminal history and calls for services to the home.
2) Complete collateral contact with the child’s school to ascertain if the child has been attending and if there are any ongoing concerns.
3) Complete collateral contacts with the neighbors, as per the last 2 reports the neighbors appear to have an ongoing knowledge of the family.
4) Obtain and review any law enforcement reports regarding any drug or violent related arrests at the home.
5) Complete an updated calls for service check to the home. Assess for drug or violence related call outs and obtain reports if available.
6) Complete a home visit, attempt to drug screen mother and caregivers. Assess for any adverse effects to the child due to possible substance exposure.
7) Complete a legal staffing to address the need for ongoing services in the home with the family.

A response to the RFA was received on November 13, 2012. An additional school collateral contact was completed. The child’s teacher stated her only concern was with the child’s growing number of absences. She stated this concern has not been addressed with the child’s parents.

A neighbor collateral contact stated the fighting at the home has “calmed down”; however, there is still a large volume of traffic coming to and from the home. The neighbor could not confirm drug manufacturing or usage at the home, but suspected it. Another neighbor stated there is still fighting in the home and still suspected drug use and sales occurring. The neighbor stated sometimes the child is outside the home for long periods of time.

An updated calls for service check was completed revealing an additional call out for a “narcotics violation”. Law enforcement indicated there was no law enforcement report regarding this call out.

A home visit was completed on November 6, 2012. The mother and household members refused to submit to a drug screen. The child stated feeling safe at home and reported there is no fighting in the home. The child denied knowledge of any drug use in the home. The conditions of the home were not documented during this follow up visit.

The case was staffed with Children’s Legal Services (CLS) on November 7, 2012. It was determined that no legal sufficiency existed to pursue dependency, as there was no adverse effect to the child.
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 the completion of diligent attempts to see the child victim are made at least daily if the child victim was not 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.
- Ensure the CPT recommendations are appropriately considered in the identification of child maltreatment, current and long term concerns, and child and family service needs 39.303(2-4), F.S.
- 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 appropriate ongoing supervisory guidance and direction are provided and a thorough investigation is being completed. 65C-29.003(6) (b) 1, F.A.C.
- Ensure when the investigation is being closed, the case file documents the CPI or CPI Supervisor ensured the receiving case management agency was notified of the closure, and the completed transfer of responsibilities from CPI to case management was clearly communicated. Effective practices.
- Upon removing a child from his/her home, the investigator shall complete the appropriate inquires to determine if the child is of American Indian or Native Alaskan descent so that the appropriate tribe can 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 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.
# Central Region Family Safety Program Office Quality Assurance

## Attachment 1

<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 2nd 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>NA</td>
<td>67</td>
<td>83%</td>
</tr>
<tr>
<td>2 Diligent attempts to see the child victim were made at least daily if the child victim was not seen immediately or within 24 hours of report receipt from the Florida Abuse Hotline. If the initial attempt to contact the child victim was unsuccessful, regular attempts (daily and at varying locations and times of the day) are required until all child victims are seen.</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>64</td>
<td>67</td>
<td>78%</td>
</tr>
<tr>
<td>3 BLANK</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<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>46</td>
<td>12</td>
<td>2</td>
<td>1</td>
<td>6</td>
<td>67</td>
<td>92%</td>
</tr>
<tr>
<td>4.1 Interviews with child victim(s) were conducted and addressed all maltreatments.</td>
<td>46</td>
<td>7</td>
<td>2</td>
<td>2</td>
<td>10</td>
<td>67</td>
<td>92%</td>
</tr>
<tr>
<td>4.2 Interviews with “other” child(ren) were conducted and addressed all maltreatments.</td>
<td>19</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>43</td>
<td>67</td>
<td>94%</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>54</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>8</td>
<td>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>40</td>
<td>25</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>67</td>
<td>91%</td>
</tr>
<tr>
<td>5.1 Interview with mother;</td>
<td>49</td>
<td>8</td>
<td>0</td>
<td>2</td>
<td>8</td>
<td>67</td>
<td>94%</td>
</tr>
<tr>
<td>5.2 Interview with father</td>
<td>37</td>
<td>7</td>
<td>2</td>
<td>4</td>
<td>17</td>
<td>67</td>
<td>87%</td>
</tr>
<tr>
<td>5.3 Interview with alleged perpetrator (if other than the mother or father) and;</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>61</td>
<td>67</td>
<td>83%</td>
</tr>
<tr>
<td>5.4 Interviews with other adult household members</td>
<td>21</td>
<td>7</td>
<td>1</td>
<td>2</td>
<td>36</td>
<td>67</td>
<td>86%</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>51</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>67</td>
<td>95%</td>
</tr>
<tr>
<td>6</td>
<td>Substantive observations and interactions of the children with family members were completed and documented during the course of the investigation.</td>
<td>32</td>
<td>25</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>67</td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
</tr>
<tr>
<td>7</td>
<td>The safety assessment process was completed with sufficient thoroughness to identify risks and develop a safety plan if needed.</td>
<td>19</td>
<td>46</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>7.1 The initial safety assessment was completed with sufficient thoroughness to identify risks.</td>
<td>36</td>
<td>26</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td>35</td>
<td>29</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td>13</td>
<td>14</td>
<td>5</td>
<td>3</td>
<td>32</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>7.4 The safety plan was documented in FSFN.</td>
<td>23</td>
<td>0</td>
<td>1</td>
<td>10</td>
<td>33</td>
<td>67</td>
</tr>
<tr>
<td>8</td>
<td>BLANK</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>67</td>
<td>67</td>
</tr>
<tr>
<td>9</td>
<td>Relevant collateral contacts were completed during the course of the investigation.</td>
<td>43</td>
<td>20</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>67</td>
</tr>
<tr>
<td>10</td>
<td>Pertinent information was obtained from the collateral contacts and was appropriately considered when assessing the overall safety of the child and/or need for services.</td>
<td>60</td>
<td>6</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>67</td>
</tr>
<tr>
<td>11</td>
<td>BLANK</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>67</td>
<td>67</td>
</tr>
<tr>
<td>12</td>
<td>The CPI presented the case to CLS for a staffing when warranted and when the investigation was legally sufficient, a petition was filed or a valid reason for not filing a petition was documented.</td>
<td>13</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>51</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>12.1 A Children’s Legal Services staffing was held when warranted.</td>
<td>13</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>51</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>55</td>
<td>67</td>
</tr>
<tr>
<td>13</td>
<td>The CPI worked in partnership with the Child Protection Team (CPT) to identify child maltreatment, current and long term concerns and child and family service needs.</td>
<td>14</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>48</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>13.1 A referral was made to the CPT when required.</td>
<td>17</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>48</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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</tr>
</thead>
<tbody>
<tr>
<td>14 BLANK</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>15 BLANK</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>16 BLANK</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

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.

<p>| | | | | | | |</p>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>52</td>
<td>67</td>
</tr>
</tbody>
</table>

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

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>63</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</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>19</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>64</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>
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</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>23</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>43</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>
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</tr>
</thead>
<tbody>
<tr>
<td>20.1</td>
<td>18</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>48</td>
<td>67</td>
</tr>
</tbody>
</table>

20.2 Mother

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>20.2</td>
<td>16</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>50</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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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>20.3</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>52</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)

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>20.4</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>63</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>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>46</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>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>21.1</td>
<td>17</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>50</td>
<td>67</td>
</tr>
</tbody>
</table>

21.2 Mother

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
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<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>21.2</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>51</td>
<td>67</td>
</tr>
</tbody>
</table>
21.3 Father | 14 | 0 | 0 | 0 | 53 | 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) | 3 | 0 | 0 | 0 | 64 | 67 | 100%
---|---|---|---|---|---|---|---
22 If documentation reflects the need for immediate services and/or ongoing supervision, the investigation record contained evidence the services were engaged. | 19 | 0 | 0 | 0 | 64 | 67 | 90%
---|---|---|---|---|---|---|---
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. | 0 | 0 | 0 | 0 | 67 | 67 | N/A
---|---|---|---|---|---|---|---
24 The investigation was thorough and appropriate steps were taken to ensure child safety. | 16 | 47 | 4 | 0 | 0 | 67 | 82%
---|---|---|---|---|---|---|---
25 BLANK | 0 | 0 | 0 | 0 | 0 | 0 | 0
---|---|---|---|---|---|---|---
26 Appropriate supervisory guidance and direction were provided and ensured a thorough investigation was completed. | 23 | 42 | 2 | 0 | 0 | 67 | 85%
---|---|---|---|---|---|---|---
26.1 Initial supervisory guidance | 45 | 21 | 0 | 1 | 0 | 67 | 92%
---|---|---|---|---|---|---|---
26.2 On-going supervisory guidance | 5 | 25 | 5 | 8 | 24 | 67 | 63%
---|---|---|---|---|---|---|---
27 Follow through occurred on the supervisory guidance and direction provided, or there was documentation it was no longer necessary. | 40 | 26 | 0 | 0 | 1 | 67 | 91%
---|---|---|---|---|---|---|---
27.1 The CPI followed through on the supervisory guidance and direction. | 41 | 25 | 0 | 0 | 1 | 67 | 91%
---|---|---|---|---|---|---|---
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. | 41 | 24 | 0 | 0 | 2 | 67 | 92%
---|---|---|---|---|---|---|---
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. | 17 | 5 | 0 | 0 | 45 | 67 | 93%
---|---|---|---|---|---|---|---
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. | 2 | 3 | 1 | 0 | 61 | 67 | 83%
<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 When the investigation was being closed, the case file documents the</td>
<td></td>
<td>76%</td>
</tr>
<tr>
<td>CPI or CPI Supervisor ensured the receiving case management agency was</td>
<td></td>
<td></td>
</tr>
<tr>
<td>notified of the closure, and the transfer of responsibilities from CPI to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>case management was clearly communicated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28.1 The plan for closing the investigation case was thoughtful,</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td>individualized and matched to the child and family's present situation,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>preferences, and long-term view for child safety.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29 Prior to the removal, the CPI made concerted efforts to provide</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>appropriate services that would allow the child to remain safely in his/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>her own home.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Upon removing the child from his/her home, the CPI made the</td>
<td>91%</td>
<td></td>
</tr>
<tr>
<td>appropriate inquiries to determine if the child was of American Indian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>or Native Alaskan descent so that the appropriate tribe could be</td>
<td></td>
<td></td>
</tr>
<tr>
<td>contacted regarding the need for an alternative placement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 Once the decision was made to remove the child, placement priority</td>
<td>98%</td>
<td></td>
</tr>
<tr>
<td>was given to responsible relatives/non-relatives rather than licensed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32 When the CPI placed the child with relatives or non-relatives, the</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td>case file contained evidence required background checks and a physical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>inspection of the home were completed prior to the child’s placement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.1 The required background checks were completed during the home study</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td>process prior to the child’s placement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.2 A physical inspection of the home was completed during the home</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>study process prior to the child's placement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.3 An evaluation of the prospective caregiver’s capacity to protect</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>was completed during the home study process prior to the child's</td>
<td></td>
<td></td>
</tr>
<tr>
<td>placement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33 BLANK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34 If the child was removed and placed in a licensed home or with a</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td>relative or non-relative caregiver, a Child Health Check-Up was</td>
<td></td>
<td></td>
</tr>
<tr>
<td>completed within 72 hours of removal.</td>
<td></td>
<td></td>
</tr>
<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>9</td>
<td>0</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------------------------------</td>
<td>----</td>
<td>----</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>2</td>
<td>0</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>10</td>
<td>1</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>1</td>
<td>0</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>2</td>
<td>0</td>
</tr>
</tbody>
</table>

Overall 89%
Response 89%
Removal 94%
Conducting Thorough Assessments 89%
Observing & Interviewing Children, Parents, Others 89%
Determining Maltreatment Findings, Family Needs & Services 92%
Planning for Safe Case Closure 87%