Central Region
Quality Assurance Review

Circuits 5, 9, 10, & 18
Child Protective Investigations
Quarter 3 Report Fiscal Year 2012-2013
**Date of Review:** February 2013 for Quarter 3.

**Region’s Overall performance achieved:** 90%

**Sample Period:** Investigative reports closed December 2012- January 2013.

**Methodology**

Region QA staff randomly selected one closed investigation between December 1, 2012 and January 31, 2013, from each of the Department’s 63 Child Protective Investigation units (with the exception of the Circuit 19 Child Protective Investigation units which recently transitioned back to the Southeast Region on February 1, 2013) 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 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 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 March 2013, 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

Region Fiscal Year 2012-2013 Performance

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

Region Overall Performance Quarters 1, 2 and 3

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

1st Quarter | 2nd Quarter | 3rd Quarter
Overall | 90% | 92% | 90%
Initial Response | 90% | 92% | 89%
Emergency Removal | 69% | 90% | 95%
Circuit 5

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 86%.
   - Untimely background checks and rechecks were indicated in five investigations.
   - Four reports reviewed did not adequately complete person searches.
   - In three reports, implications for child safety based on the family’s prior abuse history with supporting documentation was not indicated.
   - Calls for service were not completed in one report.
   - Department of Juvenile Justice checks were not documented for a 15 year old subject of the report in one case.
   - Person searches were not documented as completed in one report.
   - In one case, local law enforcement checks was not completed.

7.0 Completing the safety assessment process with sufficient thoroughness to identify risk and develop a safety plan if needed achieved a rating of 91%.
   - Chronological notes were not entered at the time of the submission of the initial safety assessment in five cases reviewed.
   - In one case, the initial overall level of risk was identified as intermediate but based upon the circumstances of the case was high. One safety factor question was misidentified but both of these issues were identified and addressed by the supervisor.
   - In one case, the initial safety assessment was not completed with sufficient thoroughness to identify risk. The background checks were not completed for the grandparents and aunt and the prior history was not taken into consideration. The safety factors did not document the prior history.
   - In one case, the grandmother's non-functioning green swimming pool and what locking/safety devises were present, if any should have been reflected in the initial assessment (the supervisor directed this issue be addressed through review of the chronological notes).
   - The Overall Safety Assessment did not include an overall level of risk in two cases reviewed.
   - In one case, the initial assessment reflected the interview and observations of the child but did not include the child's statements that the father's girlfriend also resided in the home. Additionally, the father had not been interviewed nor the home observed. As a result, most of the safety implications were unknown. Neither the assessment nor chronological notes documented the efforts taken to interview the father or see the home.
   - One safety plan was completed with both parents indicating they would refrain from using corporal punishment. The safety plan did not document alternative forms of discipline the parent's agreed to utilize. Additionally, the safety plan did
not address the Child Protection Team (CPT) recommendation related to appropriate supervision of the children.

- In one case a safety plan was needed to develop safety precautions to address supervision of the child as the four year old child was sneaking out of the home.
- In one case reviewed, no Immediate Action was identified upon completion of the Initial Safety Assessment, however, identifying a safety plan to address the children's access to guns and adequate supervision when using firearms would have been necessary.
- All six safety plans developed were entered into FSFN.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 88%.

- Examples of collateral contacts that would have been appropriate to contact included reporters, school staff, relatives, neighbors, non custodial parent, 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 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 achieved a rating of 89%.

- In one case, the home study reflected that all record checks were completed. It assessed the criminal and prior report histories and neither caregiver had a disqualifying criminal record. There were no record checks located in the file to support this for the relatives the child was placed with.

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 85%.

2.0 Diligent attempts to see the child victim immediately or within 24 hours of report receipt achieved a rating of 89%.

- In one case, the child victim in the report was seen prior to report receipt as part of an Out of Town Inquiry (OTI) requested from another county regarding an open report being investigating. This was the only documented contact with the child. A new abuse report was received in the county were the child was located; however, the contact that occurred during the OTI request was used as the commencement.

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 78%.
• Four of the sixteen 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 reports.
• In one case, there was no attempt to interview two of the "children" identified in the home where the mother relocated. The two children were added as subjects of the report.
• In one case, the three year old child in the home was observed on two occasions but there was no attempt to interview or discussion documented.
• In one case, the initial assessment and chronological note stated that all of the children in the home were interviewed, but the chronological notes do not document the victim's statements.

5.0 Conducting interviews with the mother, father, other caregiver, alleged perpetrator (if other than the mother or father), and other adult household members achieved a rating of 94%.
• 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 adoptive grandmother was not interviewed regarding her participation in counseling and prescription medications.
• In one case, the mother’s paramour was interviewed, but his specific statements were not documented in the chronological notes.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 81%
• Eight 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 documented observations of the "other" children in the home.
• In two reports, there were no developmental observations of the child 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 97%.

13.0 Working in partnership with the Child Protection Team (CPT) to identify child maltreatment, current and long-term concerns and needed services achieved a rating of 90%.
• In two cases, the discussion and information shared with CPT was not documented.
• The recommendations of CPT were not followed in one case reviewed. Recommendation not followed included safety planning to address appropriate supervision of the children and a day care referral for the younger sibling.

17.0 Information and evidence gathered warranted the consideration of additional maltreatments achieved a rating of 100% during this review.
18.0 Supporting maltreatment findings through appropriate documentation and information gathering achieved a rating of 99%.
   - In one of the applicable 18 cases, the maltreatment Index did not support a Verified finding of Substance Misuse as to the mother or father. The mother tested positive for marijuana when screened and stated she had smoked marijuana two weeks ago. The father admitted to smoking marijuana but refused to drug screen. Both parents denied using marijuana in the presence of the children and the children did not appear to have any knowledge of drug use. Household members could not corroborate the parents using drugs in the presence of the children, there were no signs of drug use in the home, and no evidence the parents were abusing drugs.

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 December 27, 2012. A 72 hour health screening for the child was not completed until January 14, 2013.

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 89%.
   - In one case, the child was sheltered on December 27, 2012. The child was seen again on December 28, 2012. Contact with the child was to occur again by January 4, 2013. The child was not seen again prior to ESI transfer on January 8, 2013.

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 90%.

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 86%.
   - In three reports, significant gaps in investigative activities occurred.
   - In one report, the child victim was residing with her mother who had moved into another home with her paramour prior to case closure. There was no documentation the paramour’s home was observed nor was the determination made of the household members residing in the home.
- In one report, background checks were not completed timely, collateral contacts completed were not determined to be relevant, and diligent efforts to contact and interview the parents did not occur.
- In two reports, the allegations of the report were not addressed with the children or victims in the home.
- In one report, the interviews with the parents did not include discussion of services related to housing, local housing services or a list of local agencies to contact as housing was an issue leading to the Department’s involvement.
- One case had incomplete background checks.
- In one case, the commencement occurred the day prior to the report being received. The incident involving the child occurred at the friend of the family's home with other adults present. Collateral contacts were not completed with the adults present.

26.0 Providing appropriate supervisory guidance and direction; and ensuring the completion of a thorough investigation achieved a rating of 90%.
- Seven 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 96%.
- In three of 18 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 51%.
- In three of five applicable reports reviewed, the receiving case management agency was not 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%.

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%.
- Six cases did not complete required criminal checks rechecks timely.
- In four cases, all background checks were not completed on all household members.
• The assessment of background checks results were not completed in one case reviewed.
• One case 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 84%.
• In three cases, the safety plan did not include any service provisions.
• In three cases, the safety plan contained directives (what the parents cannot do) with no actions the parents could take in order to achieve the actions that would facilitate child safety.
• Two of the applicable 14 safety plans were not created in FSFN.
• Three applicable cases had limited or no chronological notes entered at the time the initial safety assessment was submitted.
• In two cases, safety factors related to criminal history results were incorrect. The safety factor remained unchanged upon the completion of the updated safety assessment.
• In one case, the overall safety assessment indicated a low level of risk; however, criminal check results had not yet been received and the father had not been interviewed. Based on this, the risk level should have been moderate.
• In one case, the initial child safety assessment assessed risk as "overall risk to the child is low-moderate. The child was observed with a bump underneath his left eye and a few scratches. The child stated he was hit by the belt by his father". Low to moderate risk does not represent an accurate assessment of safety with the presenting factors.
• One case did not identify a level of risk in the overall safety assessment.
• In one case, the safety plan included the mother agreeing to not engage in verbal or physical altercations in the presence of the children, and if this was to occur, she would relocate the children to a safe location. There were no other steps included in the safety plan. The father was not included in the development of the plan. No specific safety resources were identified in the safety plan.
• In one case, the grandparents could have been involved in the safety plan development, as well as the child being placed in daycare thus reducing the risk to the child.
• In one case, the safety plan was developed with the family’s roommate and did not include the parents.
• In one case, the safety plan did not include tasks aimed specifically to address co-sleeping that was occurring and discussed with the mother. The safety plan did indicate to obtain furniture from the Mustard Seed.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 90%.
• Collateral contacts that should have been made included neighbors, reporters, medical providers, extended family members, case managers, service providers, 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 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 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 achieved a rating of 78%.
   • In one case, the child victim was seen within the required time frames on the initial report and the 03 additional report but while the mother was seen timely on the 02, the victim was not documented as being seen for five days. There were no attempts documented in the file.

4.0 Conducting interviews with the alleged child victim(s) and “other” child (ren) named in the report and/or residing in the home that addressed all maltreatments achieved a rating of 97%.
   • In two cases, it did not appear the specific allegation pertaining to the abuse report was addressed with the child victims.

5.0 Conducting interviews with the mother, father, other caregiver, alleged perpetrator (if other than the mother or father), and other adult household members achieved a rating of 91%.
   • Eight cases did not sufficiently address the maltreatments with the father.
   • Five cases did not sufficiently address the maltreatments with the mother.
   • Four 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 79%.
   • In 12 of the 23 applicable cases, familial interactions were either not documented or minimally documented.
   • In eight 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 child 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 89%.
   • In one case, a CPT referral was not completed when mandated due to the child victim's alleged injuries.
   • In one case, CPT recommended to offer specific services to the family though the case was closed with no indicators and low risk to the family.
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 94%.
   • In three cases, Substance Misuse findings were indicated upon self disclosures and positive drug screens for marijuana. A positive drug does not itself support findings of abuse or neglect if there is no other supporting evidence to indicate effects to the children.
20.0 Identifying appropriate services based on the child/family needs achieved ratings of 96%.
   • In one case, a referral on behalf of the child to the Agency for Persons with Disabilities would also have been appropriate.
21.0 Making appropriate service referrals based on the child/family needs achieved ratings of 96%.
   • In one case, a referral on behalf of the child to the Agency for Persons with Disabilities would also have been appropriate.
22.0 Ensuring service engagement achieved a rating of 91%.
   • In one case, a determination was not made as to whether the child's autistic needs were being addressed.
   • In one case, the family was referred to services through ABESS, although ABESS had a waiting list at the time of the referral, it was indeterminate as to whether the agency could assist the family.
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 two applicable cases, the Child Health Check-Up was completed at a time which was later than within 72 hours of removal.
37.0 Visiting children in shelter care on a weekly basis until the case transfer and acceptance by the CBC provider was rated as not applicable.

Planning for Safe Investigation Case Closure
Gathering and sharing information between and among all parties including supervisors, case managers, substitute caregivers, etc., and appropriately acting upon information as necessary achieved a rating of 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 79%.
- 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 83%.
- In 10 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 89%.
- In 12 of 23 cases, the CPI followed through on all supervisory directives.
- In all five applicable cases, the CPI followed through on all second party directives.

28.0 Notifying the receiving case management agency of case closure to clearly communicate case transfer responsibilities achieved a rating of 50%.
- The case management agency was not notified of case closure in one of the two applicable 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 100%.

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**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 80%.
- In three cases, FDLE checks for all subjects of the abuse report were not completed.
- In two cases background checks, specifically re-checks were not requested timely.
- In two cases all prior abuse reports were not identified and/or assessed.
- Calls for service to the home were not assessed or addressed with the family in two cases reviewed.
- In one case, local law enforcement checks for all subjects of the abuse report were not completed.
- In one case, out of state child welfare checks were not obtained.

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 four of the eight 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.
• In five of the applicable six cases, the safety plan was not entered into FSFN.
• In one case, the home was not in condition for the children to reside in. The CPI immediately asked for the children to be removed from the situation. The grandmother identified the neighbors as a temporary placement. The neighbor’s backgrounds were not completed. In the same case, the prior history protective capacities section in which there was no mention that the mother was raped as a child and her involvement in a judicial dependency case as a child.
• In one case, the CPI did not the address the father “popping” the child in the mouth or face as a form of discipline.
• In one case, the mother refused access to the home. CLS or law enforcement was not contacted to explore methods to gain access to the home.
• One case did not accurately assess the parent’s inadequate supervision as reported by a neighbor.
• There was considerable delay regarding contact with the mother to address the allegations of the report in one case.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 93%.
• Relevant collateral contacts that should have been made included service providers, extended family, non custodial father, family’s pastor, and school staff.

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, collateral contact was completed with the father’s probation officer. The probation officer was not questioned regarding which services the father is to complete as a requirement of his probation.
• In one case, information obtained from the neighbor regarding inadequate supervision was not addressed with the parents.

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%.

32.0 Completing background checks and physically inspecting the home prior to placing the child with relatives/non-relatives achieved a rating of 78%.
• In one case, the background checks required for placement were not located in the file. However, the home study documentation indicates the background checks were requested as the home study stated the participants do not have a criminal history.
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 88%.

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 87%.
   • In one of seven applicable cases, all victims were not interviewed as to all of the maltreatments.
   • In three of the six 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 93%.
   • In two of 12 applicable cases, there was no documentation that an interview addressing the allegations of the report with the children’s mother.
   • In two of five applicable cases, there was no documentation that an interview addressing the allegations of the report occurred with the children’s paternal grandmother in one case and the all household members in the second case.
   • In two of ten 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 85%.
   • In four cases, observations of the children were minimal and limited to “no marks or bruises”.
   • There were no observations of one of the children in the home in two cases reviewed.
   • 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 93%.

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

17.0 The consideration of additional maltreatments achieved a rating of 67%.
   • In one report, Inadequate Supervision should have been added to the report with verified findings. During this report, there was no one providing care for the children for four and a half hours, according to the parents statements, Additionally, there was marijuana use and possible other substance use at the party during that time so the children would have been inadequately supervised if watched by the parents and their friends.
18.0 Supporting maltreatment findings through appropriate documentation and information gathering achieved a rating of 88%.
   • In one report, Physical Injury was incorrectly founded as no indicators. The child reported having soreness and being popped in the past. The father admitted to doing it out of frustration and that the child did have some redness afterwards.
   • In one report, Not Substantiated for Medical Neglect does not appear correct as the father never denied the importance of the child needing the medication. He stated the mother did not give him a chance to go and pick up the medication. The child missed one dose as a result of this incident.
   • In one case, the finding of not substantiated for Inadequate Supervision was not supported with the information obtained during the investigation. The child was picked up by law enforcement on the road without supervision.

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

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

22.0 Ensuring service engagement achieved a rating of 100%.

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

34.0 Ensuring that children receive a Child Health Check-Up within 72 hours of removal achieved a rating of 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 84%.

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%.
   • 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 81%.
   • Seven 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 87%.
   • In four of the 12 applicable cases, the supervisor did not ensure all guidance was completed or documented it was no longer necessary prior to closure.
• In three of the four 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 78%.

• In one of the two applicable cases, the case manager was not notified of case closure and the transfer of responsibilities. However, there was ongoing and appropriate communication with the case manager while the investigation was open.

Circuit 18

Conducting Thorough Assessments
Completing thorough assessments throughout the investigative process to include developing realistic safety plans when needed achieved a rating of 87%.

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 84%.

• Four cases did not complete timely rechecks of household members that were not identified as subjects at the time the report was received.
• Three cases did not complete an out of state welfare check when required.
• One case did not document the completion of local law enforcement checks of all subjects of the report.
• In one cases, prior reports were not identified and assessed for all subjects of the report.
• Call outs were not completed in one case.
• In one case, the mother’s friend was the identified alleged perpetrator for the incident alleged of physical injury. There is no documentation he was added to the investigation or checks were completed for him.

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 child safety assessments did not adequately assess prior abuse report history.
• In two cases, the overall initial safety assessment was not thorough to identify specific risks based on the information known and gathered prior to submission.
• Four of the applicable seven safety plans developed were not entered into FSFN.
• In one case, the CPI completed contact with the grandmother and documented the completion of a safety plan stating the grandmother would ensure the mother only had supervised visitation with the children. This safety plan is not
appropriate as the CPI requested the grandmother to restrict access of the children without a court order.

- In one case, the safety plan did not indicate what services the services provider will assist the family with.
- In one case, a safety plan was inadequately developed stating “I will be a good mother to [child’s name]. I will never over use my medication and I will seek the mental health help I need to make progress”.
- The safety plan did not include long term actions to include identified service needs in one case reviewed.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 88%.

- In one cases, school staff or extended family members were not contacted as a collateral source.
- In one case, no collateral contacts were completed.

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 75%.

- In one of the four applicable cases, the CPI completed contact with the grandmother and documented the completion of a safety plan stating the grandmother would ensure the mother only had supervised visitation with the children. This safety plan restricted the mother’s access to the children without a court order. The investigation was not presented to CLS although a determination was made to restrict the mother's access to the child.

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 78%.

- Local criminal records checks for the grandmother 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 90%.

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 100%.

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 87%.

- In two cases, a thorough interview did not occur with the child victims addressing the maltreatments.
• In one case, the 11 year old child was identified. The documentation does not support and interview was completed with the 11 year old child.

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%.

• The CPI did not interview the mother regarding the specific maltreatments of mental injury and failure to protect in one case.
• One case did not document the mother or father was interviewed regarding the reported allegations.
• In one case, there was no attempt to contact, notify, or interview the biological father although his location was known.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 89%.

• Interactions were not documented in two of the 10 cases.
• Observations were minimally described as “clean and free of marks and bruises” in two cases.

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

Making appropriate maltreatment findings, identifying, making appropriate referrals and engaging needed services for children and families achieved a rating of 93%.

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

17.0 The consideration of additional maltreatments achieved a rating of 52%.

• In one applicable case, the allegation of Substance Misuse by the mother as disclosed by the father was not thoroughly explored or added to the investigation. The allegations was not explored with the mother, children or collateral's to ascertain if there were any ongoing concerns with substance abuse.
• In one case, additional information was gathered which indicated the maltreatment of Inadequate Supervision had occurred. The supervisor identified in the initial review the need to add the maltreatment to the investigation. The CPI added Mental Injury and Failure to Protect. The documentation does not support all subjects of the investigation were interviewed regarding mental injury and Failure to Protect specific maltreatments. The maltreatments were added; however, the documentation does not support a field narrative was entered.

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

• In one case, the finding for Family Violence Threatens Child was incorrectly indicated as not substantiated. A finding of no indicators was warranted based on the evidence gathered indicating domestic violence occurred 11 years ago (prior to the birth of the children) with the charges being dropped. The father denied domestic violence occurring. There were no calls to service to support domestic violence occurring. The children disclosed witnessing only verbal arguments.

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 89%.
- The child was removed on December 7, 2012. The Child Health Check-Up was completed on December 11, 2012 which is outside of the 72 hour timeframe.
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 achieved a rating of 78%.
- In one case, the abuse report was received on December 31, 2012, however, the case manager was notified of the case on January 4, 2013. A staffing was held with regard to the child and the proposed actions to be taken as the child was being sheltered. A joint team decision was made to place the child in Tennessee with a relative.
24.0 Completing a thorough investigation and taking appropriate steps to ensure child safety achieved a rating of 78%.
- In five cases, background checks or call outs were not completed on all subjects of the abuse report, were not completed timely or were not adequately assessed.
- Four cases reviewed had inadequate safety plans.
- Collateral contacts were not adequately completed in two cases reviewed.
- One case did not have case file documentation indicating the child victim was interviewed.
26.0 Providing appropriate supervisory guidance and direction; and ensuring the completion of a thorough investigation achieved a rating of 89%.
- Appropriate supervisor guidance was provided in six of the ten cases reviewed.
27.0 Following through on the supervisory guidance and direction or documenting it was no longer necessary achieved a rating of 93%.
- In three cases the initial supervisor directives were not followed.
- In all six applicable cases, second party directives were followed.
28.0 Notifying the receiving case management agency of case closure to clearly communicate case transfer responsibilities achieved a rating of 100%.
Additional Review Elements

Central Region QA has incorporated the following additional review elements during CPI reviews. There were no changes made to the additional review element questions for the Quarter 3 review.

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

<table>
<thead>
<tr>
<th>Standard</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. TANF is accurately completed in FSFN for the investigation (all household members).</td>
<td>67%</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>76%</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>63%</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>74%</td>
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<tr>
<td>5. There was no “gap” in time (30 days or more) during the completion of investigative tasks by the investigator.</td>
<td>86%</td>
</tr>
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<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>98%</td>
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</table>

- In 21 of the 67 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, and one of the children not being included in the TANF form.
- 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 reviewed. This is an action item in each of the circuit’s individual Corrective Action Plan.
- In five of the eight applicable judicial cases, the ICWA form was uploaded into the FSFN filing cabinet prior to closure of the investigation. (Central Region requirement)

Two additional questions were added for review in Circuit 9 at the request of the Circuit 9 Operations Manager.

<table>
<thead>
<tr>
<th>Question</th>
<th>Percent</th>
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<tbody>
<tr>
<td>1. The investigator completed the water safety survey with the family.</td>
<td>13%</td>
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<tr>
<td>2. The investigator completed a safe sleep survey, if a child in the home was under two years old.</td>
<td>0%</td>
</tr>
</tbody>
</table>
• In three of 23 applicable cases, the water survey was completed with the family.
• None of the five applicable cases documented the completion of a safe sleep survey, if a child in the home was under two years old.

Requests for Action
There were two Requests for Action (RFA) completed during the review.

RFA #1
On November 5, 2012 the Department of Children and Families received a report alleging “The grandmother hits [the child] across her buttock with a clothing hanger; when she whips her.”

On November 22, 2012 the Department of Children and Families in Volusia County received a report alleging “On November 22nd, 2012, while visiting with their mother on Thanksgiving Day, the grandmother left the children alone to visit with their mother. While the grandmother was gone, mom took an overdose of Hydrocodone pills and placed a belt around her neck and attempted to strangle herself. In the past the children were placed in the care of their grandmother because of mom's suicidal behaviors. It is not known if mom is allowed unsupervised visits with her children. Mom stated that if she couldn't have her children then no one was going to have them. Mom locked herself and the children inside the home and refused to allow anyone to enter the home. Mom also threatened to kill her children. The children were not physically injured as a result of this incident but were crying hysterically. This is not the first time that mom has attempted suicide in the presence of the children. Mom was Baker Acted to Halifax Hospital.”

In the current investigation, the mother went to her residence with the children and the aunt, an altercation occurred and the mother locked the aunt out of the residence. A verbal altercation occurred between the mother and aunt. Law enforcement responded to the home and the mother was Baker Acted. The children denied a physical altercation occurred between the mother and the aunt when interviewed. A child in the home observed the mother to place a belt around her neck.

On November 28, 2012 the CPI met with the grandmother and completed a safety plan indicating she would not allow unsupervised contact between the children and the mother. The safety plan did not include the mother, service needs for the mother to include substance abuse services, mental health services, and a long term goal/plan for the care of the children.

There were no collateral contacts completed (to include law enforcement) throughout the investigation.

The investigation did not contain call outs to the mother’s residence.

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) Determine the need to complete a CLS Staffing due to the safety plan implemented that restricts the mother’s contact with the children.
3) Obtain and review/assess the mother’s mental health/Baker Act records.
4) Contact the mother and notify her of the Brevard Investigation and complete a thorough interview. Discuss with the mother the long term plans for her children’s care.
5) Offer the mother appropriate and specific services to address mental health and substance abuse.
6) Complete collateral contact with the reporter, school officials, and neighbors for concerns.
7) Obtain call outs to the mother’s address.
8) Refer investigative information to Food Stamp Fraud Division as the mother continues to claim food stamps for the children although they are not in her care. Refer the grandparents to apply for food stamps and cash assistance.

A response to the RFA was received on February 25, 2013.

It was determined the mother was arrested in 2011 and the children went to reside with the grandmother prior to the Department’s involvement. The grandmother does not have custody. The mother’s criminal attorney advised the grandmother he would obtain a power of attorney from the mother so the grandmother would have custody without Department intervention.

The mother’s mental health records were obtained and reviewed.

Additional attempts to locate and interview the mother were unsuccessful. Services were not able to be offered to the mother. Additional collaterals were completed as required. Call outs to the home of the mother were requested and obtained.

An online notification was completed to the ACCESS Integrity site regarding the mother’s possible Food Stamps fraud.

RFA #2

On December 12, 2012, the Department of Children and Families received a report alleging “Mom has a history of using meth intravenously and smoking it. She was placed on probation for child neglect after she left [child’s name] home alone while she went out to get drugs. Mom continues to use drugs. Last night, 12/12/12, mom was arrested after she was caught with a controlled substance. The children were at home with the grandmother. The grandmother is known to use Marijuana. No known harm to the children as a result.”

There are two reported priors in Florida. The first one was in 2010 when the child victim
was born positive for methamphetamines. The case was closed verified for substance misuse. The mother admitted to recent drug use during the pregnancy. The mother completed a substance abuse evaluation at Tri-County and was recommended for treatment. The second report was received in May 2012 when the child victim was found walking on a major road and the 1 year old was in a crib in an unsecured home. The mother was nowhere to be found. Law enforcement was notified and the mother was arrested for child neglect. The mother admitted leaving the children alone to get milk. The mother did admit to using marijuana but not around her children. The mother did cooperate with the “FIT” program and the case was closed with some goals being met. The report also alleged family violence with the father (closed with not substantiated findings of family violence). The mother reported she was sheltered as a child because her mother went to prison for drugs. The grandmother also admitted to it in the 2010 prior. No records were located to support the mother’s statement.

During the current investigation, the children were located with the maternal grandmother while the mother was arrested for possession of drug equipment. The grandmother’s home was found to be hazardous with exposed insulation, holes on the floor and clutter everywhere. A safety plan was implemented for the children to leave the home until the conditions of the home improve and the home is re-inspected. The grandmother was also asked about the allegations that she consumes marijuana which she admitted that she does. The grandmother refused to drug screen. The grandmother reported she and her husband are planning on moving soon and they plan on taking the grandchildren with them. The four year old child was not interviewed. The home was re-inspected days later and the conditions did improve as observed in pictures secured in file. The father of one of the children picked up his child from the grandmother. The home of the father was observed. The father reported the child would sleep with him. The father requested a daycare referral but reported that he did not have a car to transport the child. The mother admitted to drug usage and reported she is currently in the JASA (drug program) and is trying to get things right in her life. The mother reported that she was raped when she was 13 but it was not documented and was not asked by whom. The mother explained the grandmother is upset the father has the child because he used to beat up the mother.

The documentation does not support collateral contacts were completed throughout the investigation.

No services were identified or offered to the father or the maternal grandmother. There was no verification that the mother was completing service with JASA while incarcerated. Services necessary for the mother include substance abuse, parenting, counseling, and mental health services.

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) Determine the need to complete a Children’s Legal Services (CLS) Staffing pending outcome of the current situation.

3) Interview the 4 year old child.

4) Obtain and review/assess the mother's compliance with the JASA program and compliance with FIT program task given at closure. Determine the mother’s current incarceration status.

5) Determine the current situation of [child's name]. Is she still residing with the maternal grandmother? Is the grandmother willing to complete a drug test, evaluation and follow recommendations, if she is still in caregiver role? What is the current condition of the home?

6) Complete background checks on the maternal grandfather,(as he resides with the maternal grandmother).

7) Obtain additional information surrounding the maternal grandmother’s prior judicial case and was it in Florida as the FDLE does not reflect any arrest. Request out of state checks, if applicable.

8) Find out who raped the mother and if that person is in direct contact with the children. Offer the mother appropriate and specific services to address mental health, sexual assault and substance abuse.

9) Reassess the father’s home. Complete background checks and interviews on all household participants. Make a community service referral for a toddler bed. Offer the father services to address domestic violence.

10) Complete collateral contact with the neighbors and relatives for concerns.

11) Obtain call outs to the father’s address and analyze disturbances.

A response to the RFA was received on February 29, 2013.

The investigator returned to the home of the maternal grandmother to attempt to re-interview the child residing with the maternal grandmother. She would not permit the investigator to interview the child as the case is closed. The grandmother was observed packing up the home as she reported to be relocating. She stated she smokes marijuana at night to help her sleep and does not smoke around the child. She refused any services or to complete a drug screen. The maternal grandmother stated the mother was removed from her care as a child. She stated she completed her case plan and the mother was returned to her custody. No records could be located in FSFN. Local criminal checks were completed on the maternal grandfather.

The mother was determined to be enrolled in substance abuse treatment while incarcerated. The mother indicated her father’s best friend raped her when she was 13 years old. The mother would not identify this person by name. The mother declined services and stated she had “dealt” with the incident.

The father’s home was visited on two occasions with no hazards noted. The father stated the child will sleep in his bed and he will sleep on the couch. The father stated he is now employed and will purchase a bed for the child. There were no call outs to the father’s home.
Neighbor collaterals declined to speak with the investigator.

A CLS staffing was determined to not be needed.

**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 observations and interactions of the children with family members were completed and documented during the course of the investigation. 39.301(10) (b), F.S.; and 65C-29.003(3) (c), 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 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.
- Ensure when the CPI placed the child with relatives/non-relatives the investigation file contained evidence of required background checks prior to the child’s placement. 39.521(2) (r) 3 & 39.401(3), F.S., and 65C-30.009(2) (c) 1, 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.
- Ensure 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) per region policy.
• Ensure if the investigator documented taking pictures of the home, children, etc., the pictures were located in the case file per region identified best practice.

### 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 3rd Qtr FY 2012-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Required background checks were completed timely and the information was appropriately used to assess immediate safety and short/long term risks to each child and the need for services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>63</td>
<td>85%</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>3</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>63</td>
<td>87%</td>
</tr>
<tr>
<td>3 BLANK</td>
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<td></td>
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</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>36</td>
<td>12</td>
<td>4</td>
<td>2</td>
<td>9</td>
<td>63</td>
<td>88%</td>
</tr>
<tr>
<td>4.1 Interviews with child victim(s) were conducted and addressed all maltreatments.</td>
<td>37</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>14</td>
<td>63</td>
<td>92%</td>
</tr>
<tr>
<td>4.2 Interviews with “other” child(ren) were conducted and addressed all maltreatments.</td>
<td>15</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>42</td>
<td>63</td>
<td>86%</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>45</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>10</td>
<td>63</td>
<td>93%</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>42</td>
<td>20</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>63</td>
<td>92%</td>
</tr>
<tr>
<td>5.1 Interview with mother;</td>
<td>45</td>
<td>11</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>63</td>
<td>94%</td>
</tr>
<tr>
<td>5.2 Interview with father</td>
<td>33</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>21</td>
<td>63</td>
<td>89%</td>
</tr>
<tr>
<td>5.3 Interview with alleged perpetrator (if other than the mother or father) and;</td>
<td>9</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>53</td>
<td>63</td>
<td>98%</td>
</tr>
<tr>
<td>5.4 Interviews with other adult household members</td>
<td>24</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>30</td>
<td>63</td>
<td>89%</td>
</tr>
<tr>
<td>5.5 The CPI made appropriate attempts to engage with the parents and other adults during</td>
<td>50</td>
<td>10</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>63</td>
<td>94%</td>
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the investigative process.

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<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>21</td>
<td>34</td>
<td>8</td>
<td>0</td>
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<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>24</td>
<td>36</td>
<td>3</td>
<td>0</td>
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<tbody>
<tr>
<td>7.1</td>
<td>The initial safety assessment was completed with sufficient thoroughness to identify risks.</td>
<td>33</td>
<td>24</td>
<td>6</td>
<td>0</td>
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<tbody>
<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>37</td>
<td>23</td>
<td>2</td>
<td>0</td>
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<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>16</td>
<td>11</td>
<td>5</td>
<td>4</td>
</tr>
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<tbody>
<tr>
<td>7.4</td>
<td>The safety plan was documented in FSFN.</td>
<td>26</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Relevant collateral contacts were completed during the course of the investigation.</td>
<td>41</td>
<td>17</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<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</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

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<p>| | | | | | |</p>
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<thead>
<tr>
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</thead>
<tbody>
<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>9</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12.1</td>
<td>A Children's Legal Services staffing was held when warranted.</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<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>8</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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<th></th>
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</tr>
</thead>
<tbody>
<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>18</td>
<td>4</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>13.1</td>
<td>A referral was made to the CPT when</td>
<td>20</td>
<td>2</td>
<td>0</td>
<td>1</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.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>54</td>
<td>63</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.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>50</td>
<td>63</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>54</td>
<td>7</td>
<td>0</td>
<td>2</td>
<td>63</td>
<td>94%</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.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>61</td>
<td>63</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.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>46</td>
<td>63</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>47</td>
<td>63</td>
</tr>
</tbody>
</table>

20.2 Mother

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>14</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>48</td>
<td>63</td>
</tr>
</tbody>
</table>

20.3 Father

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>55</td>
<td>63</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)

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>61</td>
<td>63</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).

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>47</td>
<td>63</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Score 1</th>
<th>Score 0</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>14</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>48</td>
<td>63</td>
</tr>
<tr>
<td>21.2 Mother</td>
<td>14</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>48</td>
<td>63</td>
</tr>
<tr>
<td>-------------------</td>
<td>----</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>21.3 Father</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>56</td>
<td>63</td>
</tr>
<tr>
<td>21.4 Other Caregiver or Caretaker Responsible (if someone other than the mother or father and has access or ongoing contact with the child)</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>61</td>
<td>63</td>
</tr>
<tr>
<td>22 If documentation reflects the need for immediate services and/or ongoing supervision, the investigation record contained evidence the services were engaged.</td>
<td>13</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>48</td>
<td>63</td>
</tr>
<tr>
<td>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.</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>63</td>
</tr>
<tr>
<td>24 The investigation was thorough and appropriate steps were taken to ensure child safety.</td>
<td>14</td>
<td>45</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>63</td>
</tr>
<tr>
<td>25 BLANK</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26 Appropriate supervisory guidance and direction were provided and ensured a thorough investigation was completed.</td>
<td>26</td>
<td>33</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>63</td>
</tr>
<tr>
<td>26.1 Initial supervisory guidance</td>
<td>40</td>
<td>20</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>63</td>
</tr>
<tr>
<td>26.2 On-going supervisory guidance</td>
<td>11</td>
<td>21</td>
<td>6</td>
<td>6</td>
<td>19</td>
<td>63</td>
</tr>
<tr>
<td>27 Follow through occurred on the supervisory guidance and direction provided, or there was documentation it was no longer necessary.</td>
<td>40</td>
<td>22</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>63</td>
</tr>
<tr>
<td>27.1 The CPI followed through on the supervisory guidance and direction.</td>
<td>43</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>63</td>
</tr>
<tr>
<td>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.</td>
<td>36</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>63</td>
</tr>
<tr>
<td>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.</td>
<td>18</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>41</td>
<td>63</td>
</tr>
<tr>
<td>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.</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>58</td>
<td>63</td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
<td>Part</td>
<td>Total</td>
<td>Passed</td>
<td>Percentage</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>------</td>
<td>-------</td>
<td>--------</td>
<td>------------</td>
</tr>
<tr>
<td>28 When the investigation was being closed, the case file documents the</td>
<td>6</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>52</td>
<td>63</td>
</tr>
<tr>
<td>CPI or CPI Supervisor ensured the receiving case management agency was</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>notified of the closure, and the transfer of responsibilities from CPI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>to case management was clearly communicated.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28.1 The plan for closing the investigation case was thoughtful,</td>
<td>50</td>
<td>9</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>63</td>
</tr>
<tr>
<td>individualized and matched to the child and family's present situation,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>preferences, and long-term view for child safety.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29 Prior to the removal, the CPI made concerted efforts to provide</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>56</td>
<td>63</td>
</tr>
<tr>
<td>appropriate services that would allow the child to remain safely in</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>his/her own home.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Upon removing the child from his/her home, the CPI made the</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>55</td>
<td>63</td>
</tr>
<tr>
<td>appropriate inquiries to determine if the child was of American</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indian or Native Alaskan descent so that the appropriate tribe could</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>be contacted regarding the need for an alternative placement.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 Once the decision was made to remove the child, placement priority</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>55</td>
<td>63</td>
</tr>
<tr>
<td>was given to responsible relatives/non-relatives rather than licensed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32 When the CPI placed the child with relatives or non-relatives, the</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>56</td>
<td>63</td>
</tr>
<tr>
<td>case file contained evidence required background checks and a physical</td>
<td></td>
<td></td>
<td></td>
<td></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>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.1 The required background checks were completed during the home</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>56</td>
<td>63</td>
</tr>
<tr>
<td>study process prior to the child's placement.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.2 A physical inspection of the home was completed during the home</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>56</td>
<td>63</td>
</tr>
<tr>
<td>study process prior to the child's placement.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.3 An evaluation of the prospective caregiver's capacity to protect</td>
<td>5</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>56</td>
<td>63</td>
</tr>
<tr>
<td>was completed during the home study process prior to the child's</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>placement.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>33 BLANK</td>
<td></td>
<td></td>
<td></td>
<td></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>4</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>55</td>
<td>63</td>
</tr>
<tr>
<td>relative or non-relative caregiver, a Child Health Check-Up was</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>completed within 72 hours of removal.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
### 34.1 The Child Health Check-Up was completed within 72 hours of the child's removal and a copy is in the case file.

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>55</td>
<td>63</td>
</tr>
<tr>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>50%</td>
</tr>
</tbody>
</table>

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

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>59</td>
<td>63</td>
</tr>
<tr>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

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

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

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### 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.

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### Overall Response

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### Conducting Thorough Assessments

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### Observing & Interviewing Children, Parents, Others

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### Determining Maltreatment Findings, Family Needs & Services

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### Planning for Safe Case Closure

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