Central Region
Quality Assurance Review

Circuits 5, 9, 10, 18 & 19
Child Protective Investigations
Quarter 3 Report Fiscal Year 2011-2012
**Date of Review:** March 2011 for Quarter 3.

**Region’s Overall performance achieved:** 89%

**Sample Period:** Investigative reports closed December 2011 - January 2012.

**Methodology**

Region QA staff randomly selected one closed investigation between December 2011 and January 31, 2012, from each of the Department’s 66 CPI units located in the Central Region using the Florida Safe Families Network (FSFN) “Child Investigation and Special Condition Status Report District-Daily”. The sample excluded “Special Conditions”, Institutional Investigations and investigations closed as “No Jurisdiction” or “Duplicate”. Three 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 CPI Supervisor and when possible the CPI, the Program Administrator and OMC II. Any concerns or disputes were resolved during the debriefings.

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

The distribution of the final sample of 66 reports, based upon one report per CPI unit, was as follows: Circuit 5- 14 reports (21%), Circuit 9- 23 reports (35%), Circuit 10- 12 reports (18%), Circuit 18- 10 reports (15%) and Circuit 19- 7 reports (11%). (Chart 1 below)
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

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

**Chart 2**

<table>
<thead>
<tr>
<th>Central Region Practice Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>%</strong></td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>THOROUGH ASSESSMENTS</td>
</tr>
<tr>
<td>OBSERVING &amp; INTERVIEWING</td>
</tr>
<tr>
<td>MALTREATMENT FINDINGS, FAMILY NEEDS &amp; SERVICES</td>
</tr>
<tr>
<td>PLANNING SAFE CASE CLOSURE</td>
</tr>
</tbody>
</table>

**Circuit 5**

**Conducting Thorough Assessments**

Completing thorough assessments throughout the investigative process to include developing realistic safety plans when needed achieved a rating of 89%.
1.0 Timely completion of required background checks and appropriately using the information to assess immediate safety and short/long term risks to each child and the need for services achieved a rating of 87%.

- Four reports reviewed did not adequately complete person searches.
- In three cases, local law enforcement checks were not completed.
- Untimely background checks and rechecks were indicated in three investigations.
- Out of State criminal or child welfare history was not requested in two reports reviewed (Georgia and New Jersey).
- One investigation did not document the completion of any background checks on the uncle and aunt.
- Calls for service were not completed in one report.

7.0 Completing the safety assessment process with sufficient thoroughness to identify risk and develop a safety plan if needed achieved a rating of 84%.

- In four cases the initial child safety assessment was completed without the chronological notes entered into FSFN.
- Four cases did not fully indicate or describe the family’s circumstances in the initial and updated assessments.
- Safety Plans were developed in three out of five cases when warranted and were entered into FSFN in two of the applicable cases.
- In one case, an updated safety assessment was not completed at case closure.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 86%.

- Examples of collateral contacts that would have been appropriate to contact included neighbors, extended family members, hospice counselor, law enforcement deputy, and school personnel.

10.0 Considering pertinent information obtained from the collateral contacts when assessing the overall safety of the child and/or the need for services achieved a rating of 94%.

- In three cases reviewed, pertinent information obtained from collateral contacts did not appear to be considered when assessing the overall safety of the child and/or the need for services.
- The concerns stated to the investigator by the grandparents were not considered when assessing the overall safety of the child and/or the need for services 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 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 receipt was not applicable as all child victims were seen immediately or within 24 hours of the report receipt.

4.0 Conducting interviews with the alleged child victim(s) and “other” child (ren) named in the report and/or residing in the home that addressed all maltreatments achieved a rating of 91%.
   • Two of the twelve applicable cases reviewed did not interview the victims independently or away from the parents or alleged perpetrator.
   • One cases reviewed did not document the attempt to interview the four year old child in the home.
   • The investigator documented the victim falling asleep in the arms of the father at case commencement. There was no return attempt to have the child victim interviewed the following day.

5.0 Conducting interviews with the mother, father, other caregiver, alleged perpetrator (if other than the mother or father), and other adult household members achieved a rating of 97%.
   • In one case the father and mother were not fully interviewed as to the alleged maltreatments.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 84%
   • Five reports had no interactions and physical descriptions of the children were not specific.
   • The development of two children age one and four was not documented in one case reviewed.
   • In one case, the interactions of the father and the newborn 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 96%.

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 85%.
   • The mother was not referred for parenting when recommended due to verified CPT findings of physical injury.
   • In one case the CPT referral was not completed timely in which the CPT would not be able to provide any services (report received October 18, 2011, referral attempted November 14, 2011).

17.0 Information and evidence gathered warranted the consideration of additional Maltreatments were not applicable during this review.
18.0 Supporting maltreatment findings through appropriate documentation and information gathering achieved a rating of 98%.
   • One report was closed with Verified Family Violence Threatens Child but the Summary/Implications indicted it was to close as Not Substantiated. The children
were witnesses the incident that became physical. Law enforcement was involved but no arrests were made.

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

20.0 Identifying appropriate services based on the child/family needs achieved a rating of 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 was not applicable.

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

Planning for Safe Investigation Case Closure
Gathering and sharing information between and among all parties including supervisors, case managers, substitute caregivers, etc., and appropriately acting upon information as necessary achieved a rating of 91%.

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 85%.

• In one of the three applicable cases reviewed, contact with the case manager did not occur until case closure.

24.0 Completing a thorough investigation and taking appropriate steps to ensure child safety achieved a rating of 89%.

• In three cases of the applicable 14 cases, there was an over 30 day gap in investigative activity.

• Two cases did not add household members to the report when it was discovered they were residing in the home.

• In one case, the initial CSA did not thoroughly reflect all of the investigative activity that occurred at that point in the investigation. Additionally, the CSA was not updated and resubmitted as directed

• A safety plan was not developed when needed in one case.

• A home study was not completed when the child was sheltered with the father in one case reviewed.

26.0 Providing appropriate supervisory guidance and direction; and ensuring the completion of a thorough investigation achieved a rating of 92%.

• In two cases, there was no update supervisor review following case transfer to update the guidance and directives previously provided until the case was submitted for closure.

• The supervisor disposition review was not completed in one case as an updated.
• Directives provided by the supervisor in the initial and updated child safety assessment were minimal based on the totality of the case in one case reviewed.
• In one case, two updated child safety assessments were not reviewed until 10 days after submission and twenty days after being submitted by the investigator.

27.0 Following through on the supervisory guidance and direction or documenting it was no longer necessary achieved a rating of 87%.
• In six of 14 cases, the CPI followed through on all CPIS and second party review directives.

28.0 Notifying the receiving case management agency of case closure to clearly communicate case transfer responsibilities achieved a rating of 67%.
• In one of three applicable cases, notification to the receiving case management agency of investigation closure was not documented.

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 was not applicable.

Circuit 9

Conducting Thorough Assessments
Completing thorough assessments throughout the investigative process to include developing realistic safety plans when needed achieved a rating of 85%.

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 85%.
• Eleven cases did not complete required criminal checks timely.
• Three cases lacked documentation of local law enforcement checks.
• In two cases, the FDLE checks were not completed on all household members.
• All prior reports were not located in the case file in one case reviewed.
• One case documented the request for rechecks but the results of the rechecks were not located or found in the case file.

7.0 Completing the safety assessment process with sufficient thoroughness to identify risks and develop a safety plan if needed achieved a rating of 86%.
• In six of the applicable 14 cases in which a safety plan was developed, the safety plan was not entered into FSFN.
• Four of the safety plans developed were simply statements regarding a task the parent shall complete. For example, “I will not expose the children to any drugs or violence”. The safety plans did not include long term actions to keep the child safe from harm.
• Criminal histories had not been obtained to be reviewed and assessed in the initial safety assessment in three cases.
• Missing or incomplete notes were indicated upon the completion of the initial safety assessment in three cases reviewed.
• In one of the investigations reviewed, no signed safety plan was found in the case file; however, the safety plan was developed and entered into FSFN.
In one case reviewed, a safety plan was not developed when needed with the father due to allegations of physical injury by the step-mother. The development of a safety plan was also directed in the supervisor review.

An updated safety assessment was completed and submitted in one case reviewed after the child victim had been interviewed.

In one case pertinent information had been excluded out of either the initial or updated assessment, unknown subjects were not updated, or incorrect information had been entered in the assessment.

One safety assessment simply stated “CPI to update CSA” in every section of the child safety assessment narrative.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 71%.

- There were no collateral contacts completed in three cases reviewed.
- Collateral contacts that should have made included neighbors, mental health providers, extended family members, and daycare/school personnel.

10.0 Considering pertinent information obtained from the collateral contacts when assessing the overall safety of the child and/or the need for services achieved a rating of 98%.

- One case did not utilize relevant information obtained from a Department of Juvenile Justice worker stating the child victim’s jaw was swollen at intake. This information was not discussed beyond this contact. In the same case the family’s nanny stated the mother works long hours and does not have time for the children, but this was not addressed with the mother.
- One case documented contact with a neighbor but the information obtained from the neighbor was only in regards to locating the family.

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 86%.

2.0 Diligent attempts to see the child victim immediately or within 24 hours of report receipt achieved a rating of 85%.

- The child victims were seen immediately or within 24 hours in 20 applicable cases out of 23 cases reviewed.
- The child was not seen and interviewed timely upon receipt of an additional (O2) report in one case.
4.0 Conducting interviews with the alleged child victim(s) and “other” child (ren) named in the report and/or residing in the home that addressed all maltreatments achieved a rating of 94%.
   - A ten day delay in interviewing the child victim occurred in one cases reviewed.
   - A one month delay in interviewing the child victim occurred in one case reviewed.
   - One case did not address all maltreatment allegations with the child victim and did not discuss specifics regarding an alleged incident.
   - There was no attempt to interview a four year old child in one case.

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 92%.
   - One case documented, the “CPI met with the mother” and “CPI met with the paramour” with no further documentation of interviews. Furthermore, the household members were not interviewed as to the allegations of the report.
   - One case did not sufficiently address the maltreatments with the alleged perpetrator.
   - Maltreatments were not addressed with the adult sibling residing in the home in one case.
   - One case did not sufficiently address the maltreatments with the father.
   - Two cases did not sufficiently address the maltreatments with the mother or the step mother.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 72%.
   - In 20 of the 23 applicable cases, familial interactions were either not documented or insufficiently documented. Examples of insufficient documentation of interactions included “NM interacted well with VCs”, “bonded and positive”, and "well bonded to both parents".
   - One case alleging physical injury only vaguely described the child’s appearance as “Child observed free of injury” The observations of the child were not considered relative to the seriousness of the alleged maltreatment.
   - There were no observations of a one year old in the home in one case.

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

Making appropriate maltreatment findings, identifying, making appropriate referrals and engaging needed services for children and families achieved a rating of 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 92%.
   - Eleven applicable cases warranted CPT referrals. In one case, pharmacy records for a twelve month period would need to be accessed and reviewed by CPT in order to make a determination of medical neglect. There is no documentation that this information was obtained.
   - In one case, CPT was contacted on the fourth day of the investigation, with the child scheduled to be seen on the tenth day, as the mother was late for the first appointment. Based upon the interview, CPT recommended the child participate in counseling, the victim's brother to be interviewed for potential sexual abuse,
the older brother to receive counseling for his behaviors and the mother to attend parenting and counseling. Some of the items were considered and put into place prior to the investigative closure.

17.0 The consideration of additional maltreatments achieved a rating of 58%.
- In the four applicable cases, the allegations of inadequate supervision, substance misuse, and medical neglect were not fully explored and/or added to the abuse report.
- In one case, threatened harm was added to the maltreatments of an institutional daycare investigation. The daycare employee was observed pulling on the ear of the child victim. While physical injury was closed with no indicators, Threatened Harm was added to the report and closed with verified findings. See Request for Assistance section below.

18.0 Supporting maltreatment findings through appropriate documentation and information gathering achieved a rating of 97%.
- Three cases reviewed indicated documentation did not support the maltreatment findings. These case maltreatments were identified as sexual abuse, threatened harm, and medical neglect.

20.0 Identifying appropriate services based on the child/family needs achieved ratings of 98%.
- In one of the nine applicable cases, the younger child was not interviewed as to the allegations, and identification of services did not occur.
- A service for one child's ADHD was not identified in one case.

21.0 Making appropriate service referrals based on the child/family needs achieved ratings of 92%.
- In one case no other family members appeared to be involved in service provision except the child victim, including the recommended parenting for the mother.
- The concern regarding the child possibly having ADHD was known; however, a referral was not completed in one case.

22.0 Ensuring service engagement achieved a rating of 97%.
- In one case, the child’s registration or attendance at Early Head Start was not confirmed.
- In one case, the mother stated the kids are involved with 4C, but there was no documentation that this was confirmed prior to closure.

29.0 Making concerted efforts to provide appropriate services that would allow the child to remain safely in his/her own home was 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%.

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 85%.
24.0 Completing a thorough investigation and taking appropriate steps to ensure child safety achieved a rating of 84%.
- Review elements impacting the thoroughness of the investigation included: additional maltreatments not assessed, background checks not completed or completed timely, child interactions, gaps in casework activity and delay in chronological note entries, collateral contacts, lack of follow through with CPT recommendations, and an incomplete CPT assessments as pharmacy records for a twelve month period would need to be accessed and reviewed in order to make a better opinion, but this step was not taken.

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

27.0 Following through on the supervisory guidance and direction or documenting it was no longer necessary achieved a rating of 81%.
- In six cases, CPI followed through on all supervisory directives, and in 14 cases, the CPI followed through on the majority of directives.
- In three of five cases, the second party review directives were not completed. In these three cases, the supervisor did not ensure follow-up communication and consensus with the second party reviewer prior to determining the second party recommendations were no longer necessary.

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

35.0 Obtaining medical information, including prescribed medication, and/or other needs of the child as known by the parent, guardian or legal custodian and sharing the necessary information with the substitute caregiver achieved a rating of 78%.
- In the one applicable removal case, there was a question as to what cream the mother was using on the child, but nothing was noted specifically as being queried from the mother as to other needs, etc.

Circuit 10

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

1.0 Timely completion of required background checks and appropriately using the information to assess immediate safety and short/long term risks to each child and the need for services achieved a rating of 78%.
- In five cases background checks (re-checks) were not requested timely.
- In four cases all prior abuse reports were not assessed.
- A search for priors was not completed timely in one case reviewed.
- In two investigations, background checks were not completed on paramours that were subjects of the report or household members.
• Person searches were not completed on all Household members in one report.
• One case did not document the completion of an out of state check to New York.
• One case lacked completion of a Florida Department of Law Enforcement and local law enforcement checks for all subjects of the abuse 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 81%.
• In six cases, the child safety assessment was incomplete, as pertinent information necessary to complete the safety assessment was not obtained through interviews with subjects of the report.
• Five cases did not adequately account for all prior reports or required criminal checks.
• An appropriate safety plan was developed in two of four applicable cases. In one case a safety plan was warranted to address medical neglect. A safety plan appeared warranted in another case involving domestic violence, the grandmother was established as a safeguard but a safety plan was not developed with a parent. The safety plan was created in FSFN in the two cases where safety plans were developed.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 71%.
• In five cases, adequate efforts to contact the reporter were not made.
• Relevant collateral contacts that should have been made included neighbors, non custodial parents, school staff, and sources identified by the reporter and extended family members.

10.0 Considering pertinent information obtained from the collateral contacts when assessing the overall safety of the child and/or the need for services achieved a rating of 96%.
• A law enforcement report was not obtained when a domestic violence incident was reported in one case reviewed.
• A medical release of information was not obtained to obtain the medical records for the child's November doctor's visit as to the child's alleged bruising. The CPI was instructed by the nurse to send the release so the doctor's notes could be obtained and 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 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%.
• All required background checks were completed, however, in the one applicable removal case a “recheck” from a recently closed prior was utilized as criminal checks.
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 There were no applicable cases requiring diligent attempts to see the child victim immediately or within 24 hours of report as all investigations reviewed had child victims seen either immediately or within 24 hours.

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 88%.
   • In four of nine applicable cases, all the children in the home were not interviewed as to all of the maltreatments.
   • One applicable case did not interview the child victim as to the caregivers alcohol use.
   • In one case, there is not an entry in FSFN chronological notes of the interview with the child victim at the initial home visit with the child on date of the report was received. Documentation doesn't reflect a conversation between the child and the CPI until December 1, 2011 when the child was spoken to at school as to new injuries.

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 83%.
   • The mother’s paramour was not interviewed in two cases.
   • Other household members were not interviewed as to the report maltreatments in two investigations.
   • In two of 12 cases, there was no documentation that an interview was completed with the father. The father was interviewed by phone in one case reviewed. The mother in one case was not interviewed face-to-face, as when an attempt to interview was completed she was in New York at a funeral.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 85%.
   • In eight cases, familial interactions were not documented or minimally described (in two of these cases the child victims were only observed at the hospital and school).

Determining Maltreatment Findings, Family Needs and Services
Making appropriate maltreatment findings, identifying, making appropriate referrals and engaging needed services for children and families achieved a rating of 88%.

13.0 Working in partnership with the CPT to identify child maltreatment, current and long-term concerns and needed services achieved a rating of 71%.
   • In two of the five applicable cases, there were delays in completing the referral to CPT. One case had a 10 day delay and the other a 28 day delay.
• A referral to CPT was not completed in one investigation which involved completing the CPT referral in another county so that the child could be seen by a CPT in the county in which the child was currently located.

17.0 The consideration of additional maltreatments achieved a rating of 59%.
• In one of the three applicable cases, domestic violence between the parents was not explored to determine the effects to the child and if the maltreatment of Family Violence Threatens Child should have been added to the report.
• The investigator did not fully explore the possibility of adding Environmental Hazards due to concerns with the child’s hygiene and the condition of the home.

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 91%.
• One case did not identify Batterer’s Intervention Program and Anger Management for the father involving a case in which domestic violence existed.

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 56%.
• In the one applicable removal case, the Child Health Check-Up was not completed for both of the children within 72 hours of removal. The Child Health Check-Up was only completed for one child after 72 hours of removal. The other child aged out of care prior to completion.

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

23.0 Initiating timely communication with case management services applied to two cases and achieved a rating of 78%.
• Communication with the case management services provider occurred during the life of the investigation; however, contact was not completed within one day the report was received.

24.0 Completing a thorough investigation and taking appropriate steps to ensure child safety achieved a rating of 72%.
• In ten cases, required background checks were either not completed, not completed timely or were not appropriately assessed.
• Six cases reviewed indicated incomplete contact with collateral sources.
• In four cases the subjects of the report were not interviewed as to the maltreatments.
• Three cases had considerable gaps of case inactivity.
• One case reviewed indicated there was no safety plan developed.
• One case reviewed indicated the home was not observed.

26.0 Providing appropriate supervisory guidance and direction; and ensuring the completion of a thorough investigation achieved a rating of 93%.

• In four cases, the ongoing supervisory guidance did not ensure the completion of a thorough investigation.

27.0 Following through on the supervisory guidance and direction or documenting it was no longer necessary achieved a rating of 80%.

• In ten of the 12 applicable cases, the supervisor did not ensure all guidance was completed or documented it was no longer necessary. In five 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 91%.

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

• Five of the applicable ten cases did not assess the implications based on prior reports and criminal history in FSFN. The background history and implications section of FSFN only states “please see FSFN”.

• Untimely background checks and rechecks were not completed in five applicable cases.

• Two cases did not document the completion of local law enforcement checks of all subjects of the report.

• One case did not document the completion of an out-of-state child welfare check.

• One of the applicable ten cases did not assess the results of the NCIC checks.

• In one case, all household members did not have any background checks completed.

7.0 Completing the safety assessment process with sufficient thoroughness to identify risks and develop a safety plan if needed achieved a rating of 89%.

• In two cases, the safety plan was not created in FSFN.

• In one case, the updated child safety assessment indicated services were engaged and the children’s school attendance improved; however, there was no supporting documentation in the chronological notes to indicate how this information was obtained.

• The safety plan in one of the applicable ten cases stated “Will not leave children home alone or unsupervised. Aware of limitations when discipling chx” The safety plan did not document the immediate and long term safety actions. The
safety plan did not indicate any services to support the parents and children (daycare or parenting).

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 89%.
   • In four of the applicable ten cases reviewed, collateral contacts were not completed with relatives (two cases), neighbors (two cases), daycare, school staff, counseling treatment provider, and parent’s prescribing physician.

10.0 Considering pertinent information obtained from the collateral contacts when assessing the overall safety of the child and/or the need for services achieved a rating of 93%.
   • Two applicable cases did not utilize pertinent information from a relative and treatment provider when assessing the overall safety of the child and/or the need for services.

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 100%.

Observing and Interviewing Children, Parents, Others
Completing thorough interviews with children and other participants, making substantive observations of behaviors and documenting interactions between children and family members achieved a rating of 96%.

2.0 Diligent attempts to see the child victim immediately or within 24 hours of report receipt achieved a rating of 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 100%.

5.0 Conducting interviews with the mother, father, other caregiver, alleged perpetrator (if other than the mother or father), and other adult household members achieved a rating of 96%.
   • In one case reviewed the alleged maltreatments where not sufficiently discussed with the mother regarding her prescribed pain medication and sufficient attempts to engage the mother did not occur.
   • One case did not document an interview with the mother’s paramour with whom she previously had a domestic violence incident.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 93%.
   • Interactions were not documented in three of the 10 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 94%.
   - In the one applicable case reviewed, there was no supporting field narrative added to the maltreatments that were appropriately added to the investigation.

18.0 Supporting maltreatment findings through appropriate documentation and information gathering achieved a rating of 98%.
   - In one case, the reviewer disagreed with the Not Substantiated findings of Substance Misuse (the findings for Substance Misuse were Not Substantiated by a faint line on the mother's drug screen. According to the Drug Check directions that come with the drug screen and the directions on the drug test itself indicate a faint line is not positive, it is negative. Also, any adverse effects to the children were not documented) and Inadequate Supervision (the mother had left the child with a neighbor/friend while she was at the home of her paramour next door or with her friend in Merritt Island. The caregiver had agreed to let the child stay at the home and had made adequate arrangements with the mother. The caregiver had the mother’s contact information and was able to call her in case of an emergency. The mother had not intended for the child to be with the caregiver for a significant period of time and had been in contact with the caregiver on a daily basis to check on the child. The child was not without adult supervision at any time).

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 94%.
   - One case reviewed had a 59 day gap in case activity that resulted in a delay in completing service referrals for identified needs.

22.0 Ensuring service engagement achieved a rating of 62%.
   - There was no documentation of service engagement in four of the applicable seven cases reviewed.

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 50%.
   - One of the two applicable removal cases did not have documentation that the Child Health Check-Up was completed within 72 hours but it was completed 72 hours after the removal occurred.

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 78%.
   - In the one applicable case reviewed the child was not seen for ten days until the case transfer to the CBC provider.
Planning for Safe Investigation Case Closure
Gathering and sharing information between and among all parties including supervisors, case managers, substitute caregivers, etc., and appropriately acting upon information as necessary achieved a rating of 96%.

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 91%.
   • In two applicable cases, interviews with all subjects were not completed face-to-face or did not address all maltreatments identified in the abuse report.

26.0 Providing appropriate supervisory guidance and direction; and ensuring the completion of a thorough investigation achieved a rating of 98%.
   • There was a 53 day gap in investigative activities in one case reviewed. A supervisor review did occur at day 30 in this case.

27.0 Following through on the supervisory guidance and direction or documenting it was no longer necessary achieved a rating of 93%.
   • In two of the ten applicable cases initial supervisor directives were not followed.
   • In one of the ten applicable cases, initial supervisor directives and second party directives were not followed.

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

Circuit 19

Conducting Thorough Assessments
Completing thorough assessments throughout the investigative process to include developing realistic safety plans when needed achieved a rating of 94%.

1.0 Timely completion of required background checks and appropriately using the information to assess immediate safety and short/long term risks to each child and the need for services achieved a rating of 87%.
   • Two cases did not document the completion of local checks for all subjects. In both cases, the local checks were requested; however, the local check results were not located in the case file.
   • In one case, an additional household member was identified as residing in the home. There was no documentation background checks were completed for this subject. In the same case, the father indicated he and the victim frequently stay at the home of his paramour. The subjects of this household were not identified.

7.0 Completing the safety assessment process with sufficient thoroughness to identify risk and develop a safety plan, if needed achieved a rating of 97%.
   • In one case the initial and updated assessment did not consider the risks to the victim while staying at the home of the father’s paramour.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 87%.
• Three reports did not document relevant collateral contacts with the following: children’s school staff (in two cases), parent not subject of the report, maternal relative, and law enforcement.

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

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

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

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 94%.

2.0 Diligent attempts to see the child victim immediately or within 24 hours of report 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 93%.
• In one of the six applicable cases, the investigator did not interview the victim regarding additional maltreatment information received while the investigation was open.
• One report did not attempt to engage any of the “other children” in the investigative process.

5.0 Conducting interviews with the mother, father, other caregiver, alleged perpetrator (if other than the mother or father), and other adult household members achieved a rating of 87%.
• In four of the applicable seven cases the father was not interviewed in two cases, paternal grandparents were not thoroughly interviewed as to a substance abuse and family violence maltreatment, and a family violence maltreatment was not addressed with the mother.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 100%.

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

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

17.0 The consideration of additional maltreatments achieved a rating of 59%.
• In one of the two applicable cases, family violence was appropriately added to the report; however, the maltreatment was not thoroughly explored as part of the investigation. In the second investigation, family violence was alleged to have occurred but the Family Violence Maltreatment was not added to the investigation.

18.0 Supporting maltreatment findings through appropriate documentation and information gathering achieved a rating of 97%.

• In one case, there was not enough information documented to support a not substantiated finding of medical neglect. A CPT exception was completed when referred by the investigator, as the child’s primary care physician indicated no concerns for neglect.

19.0 Requesting an Early Services Intervention (ESI) Staffing, to determine if Community Based Care (CBC) should provide family preservation services to allow the child to remain safely in the home was not applicable.

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 78%.

• In the one applicable removal case, the Child Health Check-Up was not completed within 72 hours of removal but was completed after. Documentation of the completion of the Child Health Check-Up was located in the case file.

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 91%.

23.0 Initiating timely communication with case management services was not applicable.

24.0 Completing a thorough investigation and taking appropriate steps to ensure child safety achieved a rating of 84%.

• Three cases reviewed did not complete all background checks. Two cases reviewed did not document an interview with the father.

26.0 Providing appropriate supervisory guidance and direction; and ensuring the completion of a thorough investigation achieved a rating of 87%.

• Five of the seven applicable cases did not provide appropriate initial or ongoing guidance based upon information documented in the case file.

27.0 Following through on the supervisory guidance and direction or documenting it was no longer necessary achieved a rating of 84%.

• Three of seven applicable cases did not ensure follow through with supervisory and second party review guidance.
28.0 Notifying the receiving case management agency of case closure to clearly communicate case transfer responsibilities achieved a rating of 100%.

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

Additional Review Elements

Central Region QA has incorporated the following additional review elements during CPI reviews. For the Quarter 3 review, two questions from previous reviews were eliminated from the review tool. These two questions were:

“The investigator provided notification to the family regarding their Rights & Responsibilities/HIPPA”.

"During the course of the investigation, a family arrangement was NOT made in an attempt to resolve a safety concern".

One additional review element was added to the review tool and assessed during the Quarter 3 review. This question states:

“If the reporter narrative indicated a subject of the abuse report was hearing impaired or it was determined by the investigator a subject of the abuse report was hearing impaired, the investigator arranged for certified interpreter, TTY communications device or amplified hearing device, or there is documentation the subject of the report declined services and the appropriate forms were completed”.

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>45%</td>
</tr>
<tr>
<td>2. If the investigator documented taking pictures of the home, children, etc. the pictures were located in the case file.</td>
<td>82%</td>
</tr>
<tr>
<td>3. There was no “gap” in time (30 days or more) during the investigation of investigative tasks completed by the investigator.</td>
<td>62%</td>
</tr>
<tr>
<td>4. If the reporter narrative indicated a subject of the abuse report was hearing impaired or it was determined by the investigator a subject of the abuse report was hearing impaired, the investigator arranged for certified interpreter, TTY communications device or amplified hearing device, or there is documentation the subject of the report declined services and the appropriate forms were completed.</td>
<td>0%</td>
</tr>
<tr>
<td>5. The CPI did not leave a business card at commencement, or contacted the family via telephone, prior to making an unannounced visit and contact with the child victim/family.</td>
<td>98%</td>
</tr>
<tr>
<td>6. The supervisor did not conduct the initial and/or the final supervisory review(s) using only the electronic file in FSFN.</td>
<td>89%</td>
</tr>
</tbody>
</table>
7. Removal only: If placement occurred with a relative or non-relative, there is documentation in the case file that the completed home study (positive or negative) was filed with the court. 33%

- In 36 of the 66 reports reviewed TANF was incorrectly completed in FSFN.
- Twenty-five reports had a gap in time (30 days or more) during the investigation of investigative activity.
- In one abuse report, the reporter narrative indicated the father of the children may be hearing impaired. There was no further documentation that this was addressed with the father or that appropriate services were provided.

Requests for Action

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

- In one institutional case, the reviewer disagreed with the Verified findings of Threatened Harm that was added to the abuse report as to the daycare owner. The investigation revealed the daycare owner had “tugged” on the child victim’s ear. Though her actions were not appropriate she did not cause any observable inflicted injury or damage to the child victim’s ear. The daycare was cited by the Department and fined $500. The allegations and evidence determined by the investigation do not support the Verified maltreatment of Threatened Harm. The RFA was discussed and reviewed by the reviewer and Program Administrator. A determination was made to change the Verified maltreatment to Not Substantiated. A data request change was submitted and the maltreatment finding was changed to Not Substantiated in FSFN.
- In the second investigation in which an RFA was generated, the judge in the dependency case court ordered a home study be completed on the home of the father as the placement with him was pending the completion of a home study. It was determined no home study had been completed at the home of the father. A home study was completed by the case manager, provided to the reviewer, and the RFA was resolved.

Summary and Recommendations

The Central Region should focus improvement strategies on the following recommendations that present opportunities for qualitative improvement across the Central Region. 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:

- 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.
- Completing relevant collateral contacts during the course of the investigation 39.301(11) (b) 2, F.S.; 65C-29.003(9), F.A.C.; 65C-30.001(28), F.A.C.
Ensuring the observations and interactions of the children with family members are completed and documented during the course of the investigation. 39.301(10) (b), F.S.; 65C-29.003(3) (c), F.A.C.

Ensuring when information and evidence gathered through interviews and observations indicated an additional alleged maltreatment might have occurred the CPI ensures this new information was investigated, included in the assessment process and documented. A field narrative should also be added to support the addition of any maltreatments discovered during the course of the investigation in accordance with the FSFN policy.

Completion of ongoing supervisory guidance and direction to include documentation of 30 day supervisory disposition reviews to avoid/ detect gaps in the investigative process and ensure timely completion of supervisory directives. 39.301(4), F.S.; 65C-29.003(6) (b), F.A.C.; CFOP 175-17 & 42; Central Region CPI Initiatives and Strategies- Quality, Practice, Performance.

Completion of a Child Health Check-Up within 72 hours when a child is removed and placed in a licensed home or with a relative or non-relative caregiver. 39.407, F.S.; 65C-29.008(1); 65C-30.001(17); 65C-30.001(17); 65C-30.002(1) (g) 1 and 4, F.A.C.

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

Training to investigations staff regarding the accurate completion and approval of TANF forms in FSFN. CFOP 175-39.
### 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 2011-2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Required background checks were completed timely and the information was appropriately used to assess immediate safety and short/long term risks to each child and the need for services.</td>
<td>26</td>
<td>34</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>66</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>4</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>61</td>
<td>66</td>
<td>93%</td>
</tr>
<tr>
<td>3 BLANK</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>44</td>
<td>12</td>
<td>3</td>
<td>0</td>
<td>7</td>
<td>66</td>
<td>93%</td>
</tr>
<tr>
<td>4.1 Interviews with child victim(s) were conducted and addressed all maltreatments.</td>
<td>45</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>66</td>
<td>96%</td>
</tr>
<tr>
<td>4.2 Interviews with “other” child(ren) were conducted and addressed all maltreatments.</td>
<td>16</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>42</td>
<td>66</td>
<td>82%</td>
</tr>
<tr>
<td>4.3 The CPI made appropriate attempts to engage with child victim(s) and &quot;other children&quot; in the investigative process.</td>
<td>47</td>
<td>9</td>
<td>0</td>
<td>1</td>
<td>9</td>
<td>66</td>
<td>95%</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>46</td>
<td>15</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>66</td>
<td>92%</td>
</tr>
<tr>
<td>5.1 Interview with mother;</td>
<td>50</td>
<td>5</td>
<td>2</td>
<td>0</td>
<td>9</td>
<td>66</td>
<td>97%</td>
</tr>
<tr>
<td>5.2 Interview with father</td>
<td>33</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>25</td>
<td>66</td>
<td>89%</td>
</tr>
<tr>
<td>5.3 Interview with alleged perpetrator (if other than the mother or father) and;</td>
<td>10</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>50</td>
<td>66</td>
<td>74%</td>
</tr>
<tr>
<td>5.4 Interviews with other adult household members</td>
<td>24</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>33</td>
<td>66</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>50</td>
<td>14</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>66</td>
<td>94%</td>
</tr>
<tr>
<td>Substantive Observations and Interactions of the Children with Family Members</td>
<td>Value</td>
<td>26</td>
<td>29</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>66</td>
</tr>
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</tr>
<tr>
<td>The Safety Assessment Process was Completed with Sufficient Thoroughness to Identify Risks and Develop a Safety Plan if Needed</td>
<td>Value</td>
<td>26</td>
<td>38</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>66</td>
</tr>
<tr>
<td>The Initial Safety Assessment was Completed with Sufficient Thoroughness to Identify Risks</td>
<td>Value</td>
<td>43</td>
<td>13</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>66</td>
</tr>
<tr>
<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>Value</td>
<td>49</td>
<td>16</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>66</td>
</tr>
<tr>
<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>Value</td>
<td>20</td>
<td>3</td>
<td>4</td>
<td>6</td>
<td>33</td>
<td>66</td>
</tr>
<tr>
<td>The Safety Plan was Documented in FSFN</td>
<td>Value</td>
<td>19</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td>38</td>
<td>66</td>
</tr>
<tr>
<td>Relevant Collateral Contacts were Completed During the Course of the Investigation</td>
<td>Value</td>
<td>26</td>
<td>26</td>
<td>10</td>
<td>4</td>
<td>0</td>
<td>66</td>
</tr>
<tr>
<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>Value</td>
<td>52</td>
<td>9</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>66</td>
</tr>
<tr>
<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>Value</td>
<td>22</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>36</td>
<td>66</td>
</tr>
<tr>
<td>A referral was made to the CPT when required</td>
<td>Value</td>
<td>28</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>36</td>
<td>66</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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<tbody>
<tr>
<td>10</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>49</td>
<td>66</td>
<td>85%</td>
</tr>
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17 When the information and evidence gathered through interviews and observations indicated an additional alleged maltreatment might have occurred, the CPI ensured this new information was processed appropriately.

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<tr>
<td>9</td>
<td>4</td>
<td>0</td>
<td>6</td>
<td>47</td>
<td>66</td>
<td>66%</td>
</tr>
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</table>

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

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<tbody>
<tr>
<td>60</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>66</td>
<td>98%</td>
</tr>
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</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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<tbody>
<tr>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>61</td>
<td>66</td>
<td>100%</td>
</tr>
</tbody>
</table>

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

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</thead>
<tbody>
<tr>
<td>32</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>30</td>
<td>66</td>
<td>97%</td>
</tr>
</tbody>
</table>

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

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<tbody>
<tr>
<td>27</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>36</td>
<td>66</td>
<td>95%</td>
</tr>
</tbody>
</table>

20.2 Mother

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>29</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>35</td>
<td>66</td>
<td>98%</td>
</tr>
</tbody>
</table>

20.3 Father

<p>| | | | | | | |</p>
<table>
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</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>47</td>
<td>66</td>
<td>95%</td>
</tr>
</tbody>
</table>

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

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<table>
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</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>66</td>
<td>100%</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).

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</thead>
<tbody>
<tr>
<td>23</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>40</td>
<td>66</td>
<td>96%</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>
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</thead>
<tbody>
<tr>
<td>20</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>43</td>
<td>66</td>
<td>96%</td>
</tr>
</tbody>
</table>

21.2 Mother

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>19</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>45</td>
<td>66</td>
<td>93%</td>
</tr>
<tr>
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</tr>
<tr>
<td>21.3 Father</td>
<td>14</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>51</td>
<td>66</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>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>62</td>
<td>66</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>19</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>42</td>
<td>66</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>1</td>
<td>0</td>
<td>62</td>
<td>66</td>
</tr>
<tr>
<td>24 The investigation was thorough and appropriate steps were taken to ensure child safety.</td>
<td>21</td>
<td>40</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>66</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>36</td>
<td>28</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>66</td>
</tr>
<tr>
<td>26.1 Initial supervisory guidance</td>
<td>60</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>66</td>
</tr>
<tr>
<td>26.2 On-going supervisory guidance</td>
<td>25</td>
<td>21</td>
<td>4</td>
<td>6</td>
<td>10</td>
<td>66</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>24</td>
<td>39</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>66</td>
</tr>
<tr>
<td>27.1 The CPI followed through on the supervisory guidance and direction.</td>
<td>25</td>
<td>38</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>66</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>25</td>
<td>38</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>66</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>13</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>44</td>
<td>66</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>7</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>50</td>
<td>66</td>
</tr>
<tr>
<td></td>
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<tr>
<td><strong>28</strong> When the investigation was being closed, the case file documents the CPI or CPI Supervisor ensured the receiving case management agency was notified of the closure, and the transfer of responsibilities from CPI to case management was clearly communicated.</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>54</td>
<td>66</td>
</tr>
<tr>
<td><strong>28.1</strong> The plan for closing the investigation case was thoughtful, individualized and matched to the child and family's present situation, preferences, and long-term view for child safety.</td>
<td>58</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>66</td>
</tr>
<tr>
<td><strong>29</strong> Prior to the removal, the CPI made concerted efforts to provide appropriate services that would allow the child to remain safely in his/her own home.</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>62</td>
<td>66</td>
</tr>
<tr>
<td><strong>30</strong> Upon removing the child from his/her home, the CPI made the appropriate inquiries to determine if the child was of American Indian or Native Alaskan descent so that the appropriate tribe could be contacted regarding the need for an alternative placement.</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>59</td>
<td>66</td>
</tr>
<tr>
<td><strong>31</strong> Once the decision was made to remove the child, placement priority was given to responsible relatives/non-relatives rather than licensed care.</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>59</td>
<td>66</td>
</tr>
<tr>
<td><strong>32</strong> When the CPI placed the child with relatives or non-relatives, the case file contained evidence required background checks and a physical inspection of the home were completed prior to the child's placement.</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>66</td>
</tr>
<tr>
<td><strong>32.1</strong> The required background checks were completed during the home study process prior to the child's placement.</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>66</td>
</tr>
<tr>
<td><strong>32.2</strong> A physical inspection of the home was completed during the home study process prior to the child's placement.</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>66</td>
</tr>
<tr>
<td><strong>32.3</strong> An evaluation of the prospective caregiver's capacity to protect was completed during the home study process prior to the child's placement.</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>66</td>
</tr>
<tr>
<td><strong>33</strong> BLANK</td>
<td></td>
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</tr>
<tr>
<td><strong>34</strong> If the child was removed and placed in a licensed home or with a relative or non-relative caregiver, a Child Health Check-Up was completed within 72 hours of removal.</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>60</td>
<td>66</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>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>60</td>
<td>66</td>
</tr>
<tr>
<td>---</td>
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</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>
<td>1</td>
<td>0</td>
<td>63</td>
<td>66</td>
</tr>
<tr>
<td>35 The CPI obtained medical information, including prescribed medicines, and/or other needs of the child as known by the parent, guardian or legal custodian and shared the necessary information with the substitute caregiver.</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>60</td>
<td>66</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>
<td>0</td>
<td>0</td>
<td>65</td>
<td>66</td>
</tr>
<tr>
<td>37 The CPI visited the child in shelter care on a weekly basis until the case was transferred to and accepted by the CBC provider who subsequently agreed to conduct the required visits.</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>64</td>
<td>66</td>
</tr>
</tbody>
</table>

Overall | 89% |
Response | 89% |
Removal | 91% |
**Conducting Thorough Assessments** | 87% |
**Observing & Interviewing Children, Parents, Others** | 89% |
**Determining Maltreatment Findings, Family Needs & Services** | 91% |
**Planning for Safe Case Closure** | 89% |