Central Region
Quality Assurance Review

Circuits 5, 9, 10, 18 & 19
Child Protective Investigations
Quarter 2 Report Fiscal Year 2011-2012
Date of Review: December 2011 for Quarter 2

Region’s Overall performance achieved: 92%

Sample Period: Investigative reports closed December 1, 2011 - December 31, 2011.

Methodology

Region QA staff randomly selected one closed investigation between December 1, 2011 and December 31, 2011, 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)
Investigations were reviewed using the Quality of Practice Standards (QPS) for Child Protective Investigations (revised August 2011) to focus on qualitative standards. Although qualitatively driven, some important compliance standards are included. An example would be measuring if statutory requirements were met in referring the child to the Child Protection Team (CPT) when required. The main qualitative standard (#24) requires the reviewer to determine if the investigation was thorough.

**Analysis of Review Findings**

In preparing for the QPS reviews, child welfare staff from Central Office and the Regional QA Managers refined the previous QPS standards and methodology to focus more heavily on assessing quality and family centered practices. As a result, review elements were grouped into four specific practice trend areas:

- 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.

Refer to Attachment 1 for the Central Region Matrix by Standard and overall
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 86%.
   - Five reports reviewed did not adequately complete person searches.
   - In three cases, local law enforcement checks were not completed.
   - Delays in rechecks were indicated in one investigation.
   - One investigation did not document the completion of any background checks on the grandfather.
   - Prior abuse reports of the mother’s paramour were not adequately assessed in one investigation

7.0 Completing the safety assessment process with sufficient thoroughness to identify risk and develop a safety plan if needed achieved a rating of 89%.
   - In four cases the initial child safety assessment either update the Signs of Present Danger section, incorrectly answered a second party review qualifying question, or did not consider prior reports or all household members when completing the initial or updated safety assessment.
   - CPIs developed Safety Plans in three out of six cases when warranted and were entered into FSFN in all three 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 83%.
   - Collateral contacts that would have been appropriate to contact included neighbors, health care providers, landlords, probation officers, extended family members, non-custodial parents, 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 95%.
   - In two cases reviewed, pertinent information obtained from school personnel did not appear to be considered 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 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, there were no diligent attempts to see the child victim for 9 days after report receipt. There was only one applicable case in this domain as the child victims were either seen immediately or within twenty-four hours in the remaining cases.

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%.
   - Two of the eleven applicable cases reviewed did not fully interview all victims or children identified in the report.

5.0 Conducting interviews with the mother, father, other caregiver, alleged perpetrator (if other than the mother or father), and other adult household members achieved a rating of 89%.
   - Four cases did not document interviews were conducted with the step-grandfather, grandfather, grandmother and mother.
   - In one case the father, who was a household member, was only interviewed by telephone and not face to face.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 87%
   - Six of the case files reviewed had no or limited observations of the children identified in the report.
   - In one report, four of the five children were only seen at school, therefore, no interactions with the children’s parents or caregivers could be observed and documented.
   - One report had no interactions and physical descriptions of the child were not specific.

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 100%.

17.0 Information and evidence gathered warranted the consideration of additional Maltreatments achieved a rating of 100%.

18.0 Supporting maltreatment findings through appropriate documentation and information gathering achieved a rating of 100%.

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 94%.
   • One report did not document rationale as to why a Family Preservation staffing was not completed to determine if In-Home Services were needed. The father refused the investigators offer for a counseling referral stating he would obtain his own therapist.
   • In one case, the case file did not document the completion of a CHORE referral to assist the family with home repairs, which the CPI identified as an immediate need for the family. Parenting was also identified as a service need which was not referred on behalf of the mother.

22.0 Ensuring service engagement achieved a rating of 78%.
   • Of the four applicable cases, verification of engagement of a daycare referral was not completed in three cases and verification of engagement of a counseling referral was not completed in one case.

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

34.0 Ensuring that children receive a Child Health Check-Up within 72 hours of removal achieved a rating of 100%.

37.0 Visiting children in shelter care on a weekly basis until the case transfer and acceptance by the CBC provider achieved a rating of 78%.
   • In the one applicable case, three children were placed with a maternal grandmother and a face to face contact was not completed. The case transfer staffing did not occur until 7 days later.

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 achieved a rating of 100%.

24.0 Completing a thorough investigation and taking appropriate steps to ensure child safety achieved a rating of 87%.
   • In six cases of the applicable 14 cases, there was an over 30 day gap in investigative activity.
   • The new home of the family was not observed after the family relocated in three cases reviewed.
   • One case did not have a CPT referral completed and one case did not have a timely completion of a CPT referral.
   • Late entry of chronological notes was indicated in one case.
   • There was a two month delay between the identification of the service need and the completion of the CHORE referral in one case.
   • The father was not interviewed in one case reviewed.
• One case resulted in the generation of an abuse report at investigation day 60 as a result of learning law enforcement had been called to the home on three occasions while the report was open due to a verbal altercation, domestic violence, and suicide threat.

26.0 Providing appropriate supervisory guidance and direction; and ensuring the completion of a thorough investigation achieved a rating of 92%.
• In four cases a 30 day review was not documented as being completed.
• The supervisor review was not completed at case closure in one case as an updated assessment was not submitted to the supervisor.

27.0 Following through on the supervisory guidance and direction or documenting it was no longer necessary achieved a rating of 89%.
• In seven 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 93%.
• 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 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 92%.
• Timely completion of required background checks and appropriately using the information to assess immediate safety and short/long term risks to each child and the need for services achieved a rating of 88%.
• Four cases did not complete required criminal checks timely.
• Three cases lacked documentation of local law enforcement checks.
• In three cases, the CPI did not complete a criminal history check for the mother, grandmother, or sitter.
• Two of the cases did not document the completion of out of state child protective services checks for family or household members that previously resided out of state. One case did not request re-checks on a household member after demographic information was obtained until case closure.
• One case did not complete criminal checks and call outs until after the case was closed.

7.0 Completing the safety assessment process with sufficient thoroughness to identify risks and develop a safety plan if needed achieved a rating of 85%.
• In eight of the applicable 11 cases in which a safety plan was developed, the safety plan was not entered into FSFN.
Seven of the cases reviewed indicated pertinent information had been excluded out of either the initial or updated assessment, unknowns were not updated, or incorrect information had been entered in the assessment.

Four of the safety plans developed were simply statements regarding a task the parent shall complete. For example, “the mother will obtain an injunction”. The safety plans did not include long term actions to keep the child safe from harm.

In two of the investigations reviewed, no parent signature was found on the written safety plan.

One safety assessment did not correctly identify the elements to qualify the safety assessment for second party review.

One safety assessment did not appropriately rate the level of risk as high when the family had not been located prior to the completion of the initial assessment.

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 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 99%.

Of the two cases reviewed in which a removal occurred, one case did not complete local law enforcement checks on the maternal aunt with whom the child was placed.
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%.

- Two of the cases reviewed did not sufficiently address the maltreatments with the mothers.
- Maltreatments were not addressed with the grandparents residing in the home in one of the cases.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 81%.

- In 13 cases, familial interactions were either not or sufficiently documented.
- One case only vaguely described the child as observed with “no marks or bruises”.

**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 80%.

- Five applicable cases warranted CPT referrals. In one case, a CPT referral was not completed when two children in the home were observed with injuries to the face.

17.0 The consideration of additional maltreatments achieved a rating of 33%.

- In the four applicable cases, the allegations of domestic violence, sexual abuse and substance misuse (two of the four cases) were not fully explored and/or added to the abuse report.

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 environmental hazards in two case and substance misuse in one case.

20.0 Identifying appropriate services based on the child/family needs achieved ratings of 98%.

21.0 Making appropriate service referrals based on the child/family needs achieved ratings of 95%.

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.

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 50%.

- One case file did not document completion of the Child Health Check-Up within 72 hours or prior to case closure.
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 87%. Review elements impacting the thoroughness of the investigation included: additional maltreatments not added, background checks not completed or completed timely, child interactions, gaps in casework activity, collateral contacts and concerns for child visitation.
26.0 Providing appropriate supervisory guidance and direction; and ensuring the completion of a thorough investigation achieved a rating of 84%.
   • In 15 of 21 applicable reports, ongoing supervisory guidance and direction did not thoroughly identify all needed follow up tasks to be completed prior to case closure or were not given.
27.0 Following through on the supervisory guidance and direction or documenting it was no longer necessary achieved a rating of 86%.
   • In 10 cases, CPI followed through on all supervisory directives, and in eight cases, the CPI followed through on the majority of directives.
   • In three of 14 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 39%.
   • Case management was not notified of closure in the two applicable cases.
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 0%.
   • In the one applicable removal case, sharing medical information with the caregiver was not documented and the Emergency Intake form was not completed.

Circuit 10

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 85%.
   • Four cases lacked completion of local law enforcement checks for all subjects of the abuse report.
In three investigations, background checks were not completed on a father, grandfather or grandparents that were subjects of the report or frequent caregivers.

In one case background checks (re-checks) were not requested timely.

In one case all prior abuse reports were not assessed.

One case did not document the completion of calls for service to the family’s home.

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

In six cases, the updated child safety assessment was incomplete, as pertinent information necessary to complete the safety assessment was not obtained.

An appropriate safety plan was developed in seven of eight applicable cases. In one case a safety plan was warranted to address domestic violence. The safety plan was not created in FSFN in two cases.

Completing relevant collateral contacts during the course of the investigation achieved a rating of 89%.

In two cases, adequate efforts to contact the reporter were not made.

Relevant collateral contacts not documented included neighbors, non custodial parents and extended family members.

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%.

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%.

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

Completing background checks and physically inspecting the home prior to placing the child with relatives/non-relatives achieved a rating of 100%.

Observing and Interviewing Children, Parents, Others
Completing thorough interviews with children and other participants, making substantive observations of behaviors and documenting interactions between children and family members achieved a rating of 95%.

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.

Conducting interviews with the alleged child victim(s) and “other” child (ren) named in the report and/or residing in the home that addressed all maltreatments achieved a rating of 98%.

In one of 11 applicable cases, the oldest child in the home was not interviewed as to being left home alone or missing meals.

Conducting interviews with the mother, father, other caregiver, alleged perpetrator (if other than the mother or father), and other adult household members achieved a rating of 94%.
In three of 12 cases, there was no documentation that an interview was completed with a grandmother residing in the home. The mother in one case was not interviewed as to additional concerns raised during the investigation, and in one case the mother was not engaged in the interview process until a month after the report was received.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 93%.

- In three cases, familial interactions were not documented (in one of these cases the child victim was only observed at school). Interactions and observations of one child victim were not documented 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 91%.

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

17.0 The consideration of additional maltreatments achieved a rating of 78%.

- One case warranted further investigative activity regarding additional maltreatments as the grandparents reported the child to be touching herself and others. Also, the child was observed with a bite mark which was not explored further with the mother.

18.0 Supporting maltreatment findings through appropriate documentation and information gathering achieved a rating of 98%.

- In one case, substantial information was not obtained during the investigation to support a finding of Family Violence Threatens Child.

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%.

**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 78%.

23.0 Initiating timely communication with case management services applied to two cases and achieved a rating of 89%.

- Communication with the case management services provider occurred over a month after the case receipt. However, telephone contact was attempted the day the report was received.
24.0 Completing a thorough investigation and taking appropriate steps to ensure child safety achieved a rating of 78%.
- In seven 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.
- Three cases reviewed indicated there was no safety plan developed, if needed and/or the safety plan was not entered into FSFN.
- In one case the child was not interviewed as to the maltreatments.
- 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 98%.
- In one case, the ongoing supervisory review did not include additional new information obtained during the investigation.

27.0 Following through on the supervisory guidance and direction or documenting it was no longer necessary achieved a rating of 91%.
- In five of the 12 applicable cases, the supervisor did not ensure all guidance was completed or documentation it was no longer necessary. On all cases reviewed, second party guidance and recommendations were completed.

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 95%.

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 seven cases, NCIC checks were not assessed.
- In three cases, there was no documented person searches were completed.
- In three cases, FCIC checks were not completed on all household members.
- Timely completion of call for service and/or local law enforcement checks were not completed in three cases reviewed.
- One case did not document the completion of local law enforcement checks of all 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 98%.
- In one case, the initial and updated child safety assessment was not completed thoroughly as the home of the grandparents and the home of the mother (the child later resided with were not seen and assessed) was not seen by the investigator. Also, the mother was not interviewed after the child was sent to reside with her.
9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 100%.
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 93%.

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 95%.
   • In one of the nine applicable cases, the child victim was not interviewed as to the physical injury maltreatment but was only interviewed as to the allegations of a companion Child on Child Special Condition report.
5.0 Conducting interviews with the mother, father, other caregiver, alleged perpetrator (if other than the mother or father), and other adult household members achieved a rating of 91%.
   • In two cases reviewed, alleged maltreatments where not discussed with the father and mother. The investigator did not make sufficient attempts to engage the parents in one of these cases reviewed.
   • One case documented the interview with the grandparents, who were household members, occurred over the telephone.
   • The uncle (household member) was not interviewed in one case.
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 98%.

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 78%.
• In the one applicable case reviewed, there was no supporting field narrative added to the maltreatment that was appropriately added to the investigation.

18.0 Supporting maltreatment findings through appropriate documentation and information gathering achieved a rating of 100%.

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

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

22.0 Ensuring service engagement achieved a rating of 100%.

29.0 Making concerted efforts to provide appropriate services that would allow the child to remain safely in his/her own home achieved a rating of 100%.

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

34.0 Ensuring that children receive a Child Health Check-Up within 72 hours of removal achieved a rating of 100%.

37.0 Visiting children in shelter care on a weekly basis until the case transfer and acceptance by the CBC provider achieved a rating of 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 94%.

23.0 Initiating timely communication with case management services achieved a rating of 100%.

24.0 Completing a thorough investigation and taking appropriate steps to ensure child safety achieved a rating of 96%.

• 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 100%.

27.0 Following through on the supervisory guidance and direction or documenting it was no longer necessary achieved a rating of 96%.

• In two cases initial directives were not followed through on.

28.0 Notifying the receiving case management agency of case closure to clearly communicate case transfer responsibilities achieved a rating of 50%.

• In one of the two applicable cases the case management agency was not notified of the investigations closure.

Circuit 19

Conducting Thorough Assessments
Completing thorough assessments throughout the investigative process to include developing realistic safety plans when needed achieved a rating of 97%.

1.0 Timely completion of required background checks and appropriately using the information to assess immediate safety and short/long term risks to each child and the need for services achieved a rating of 90%.
   - Two cases did not document the completion of out of state child welfare checks.
   - In one case, the NCIC/FCIC checks for the adult sibling was not documented as 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 97%.
   - In one case the initial and updated assessment was not completed with sufficient thoroughness. The development of a safety plan was not required in any of the cases.

9.0 Completing relevant collateral contacts during the course of the investigation achieved a rating of 100%.

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 97%.

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 100%.

6.0 Documenting observations and interactions of the children with family members achieved a rating of 90%.
   - In two of the seven applicable cases, interactions were not sufficiently 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 95%.

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 75%.
   • In one of the four applicable cases, threatened harm and failure to protect maltreatments were not added to a child subject of the report in which there was a threat of being sexually abused and the mother was not being protective.
19.0 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 substance misuse.
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 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%.

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 achieved a rating of 100%.
24.0 Completing a thorough investigation and taking appropriate steps to ensure child safety achieved a rating of 90%.
   • Three cases reviewed did not complete all background checks to include out of state child welfare checks.
26.0 Providing appropriate supervisory guidance and direction; and ensuring the completion of a thorough investigation achieved a rating of 87%.
   • Four of the seven applicable cases did not provide appropriate guidance.
27.0 Following through on the supervisory guidance and direction or documenting it was no longer necessary achieved a rating of 87%.
   • Four of seven applicable cases did not ensure follow through with supervisory and second party 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. These additional review elements for the region are summarized below in Table 1.

Table 1

<table>
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<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>47%</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>83%</td>
</tr>
<tr>
<td>3. There was no &quot;gap&quot; in time (30 days or more) during the investigation of investigative tasks completed by the investigator.</td>
<td>67%</td>
</tr>
<tr>
<td>4. The investigator provided notification to the family regarding their Rights &amp; Responsibilities / HIPPA.</td>
<td>98%</td>
</tr>
<tr>
<td>5. &quot;During the course of the investigation, a family arrangement was NOT made in an attempt to resolve a safety concern.&quot;</td>
<td>100%</td>
</tr>
<tr>
<td>6. 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>7. The supervisor did not conduct the initial and/or the final supervisory review(s) using only the electronic file in FSFN.</td>
<td>92%</td>
</tr>
<tr>
<td>8. Remval only: If placement occurred with a relative or non-relative, there is documentation in the case file that the completed home study (positive or negative) was filed with the court.</td>
<td>100%</td>
</tr>
</tbody>
</table>

- 25 of the 66 reports reviewed had TANF was incorrectly completed in FSFN.
- Twenty-two reports had a gap in time (30 days or more) during the investigation of investigative activity.

Requests for Action

There was no Request for Action (RFA) during the review.

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.
- 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.

- 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-30.002(1)(g) 1 and 4, F.A.C.

- Obtaining medical information, including prescribed medications, and/or other needs of the child as known by the parent, guardian or legal custodian and shared the information with the substitute caregiver when a child has been removed. 39.402(11), F.S. and 65C-29.003(6)(a) 1.d., F.A.C.

- Completion of weekly child visits with the child while until the case was transferred to and accepted by the CBC provider who subsequently agreed to conduct the required visits. 394.455, F.S.; 65C-35.007 and 65C-28.016, F.A.C. CFOP 175-98.
## Attachment 1

<table>
<thead>
<tr>
<th>Question</th>
<th>9</th>
<th>7</th>
<th>5</th>
<th>0</th>
<th>NA</th>
<th># Cases</th>
<th>% achieved 2nd Qtr FY 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></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>66</td>
<td>86%</td>
</tr>
<tr>
<td>2 Diligent attempts to see the child victim were made at least daily if the child victim was not seen immediately or within 24 hours of report receipt from the Florida Abuse Hotline. If the initial attempt to contact the child victim was unsuccessful, regular attempts (daily and at varying locations and times of the day) are required until all child victims are seen.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>66</td>
<td>96%</td>
</tr>
<tr>
<td>3 BLANK</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 An interview was conducted and addressed all maltreatments with the alleged child victim(s) and other child(ren) named in the report and/or residing in the home.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>66</td>
<td>97%</td>
</tr>
<tr>
<td>4.1 Interviews with child victim(s) were conducted and addressed all maltreatments.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></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></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>66</td>
<td>98%</td>
</tr>
<tr>
<td>4.3 The CPI made appropriate attempts to engage with child victim(s) and “other children” in the investigative process.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>66</td>
<td>100%</td>
</tr>
<tr>
<td>5 Interviews that addressed all maltreatments were conducted with the mother, father, other caregiver, alleged perpetrator (if other than the mother or father), and other adult household members.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>66</td>
<td>94%</td>
</tr>
<tr>
<td>5.1 Interview with mother;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>66</td>
<td>96%</td>
</tr>
<tr>
<td>5.2 Interview with father</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>66</td>
<td>96%</td>
</tr>
<tr>
<td>5.3 Interview with alleged perpetrator (if other than the mother or father) and;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>66</td>
<td>96%</td>
</tr>
<tr>
<td>5.4 Interviews with other adult household members</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>66</td>
<td>96%</td>
</tr>
<tr>
<td>5.5 The CPI made appropriate attempts to engage with the parents and other adults during the investigative process.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>66</td>
<td>97%</td>
</tr>
</tbody>
</table>
### 6 Substantive observations and interactions of the children with family members were completed and documented during the course of the investigation.

<p>| | | | | | |</p>
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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>35</td>
<td>24</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>66</td>
</tr>
</tbody>
</table>

### 7 The safety assessment process was completed with sufficient thoroughness to identify risks and develop a safety plan if needed.

<p>| | | | | | |</p>
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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>39</td>
<td>22</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>66</td>
</tr>
</tbody>
</table>

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

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<thead>
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</thead>
<tbody>
<tr>
<td>54</td>
<td>7</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>66</td>
</tr>
</tbody>
</table>

#### 7.2 The updated safety assessment(s) was completed with sufficient thoroughness to identify risks and accurately reflected information obtained during the course of the investigation.

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<tr>
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</thead>
<tbody>
<tr>
<td>47</td>
<td>15</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>66</td>
</tr>
</tbody>
</table>

#### 7.3 The safety plan, when needed, was sufficient and appropriately identified the immediate and long term actions required to keep the child safe from harm.

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<tr>
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</thead>
<tbody>
<tr>
<td>21</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>32</td>
<td>66</td>
</tr>
</tbody>
</table>

#### 7.4 The safety plan was documented in FSFN.

<p>| | | | | | |</p>
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<tr>
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<tbody>
<tr>
<td>18</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>38</td>
<td>66</td>
</tr>
</tbody>
</table>

### 8 BLANK

### 9 Relevant collateral contacts were completed during the course of the investigation.

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</thead>
<tbody>
<tr>
<td>46</td>
<td>17</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>66</td>
</tr>
</tbody>
</table>

### 10 Pertinent information was obtained from the collateral contacts and was appropriately considered when assessing the overall safety of the child and/or need for services.

<p>| | | | | | |</p>
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<tr>
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</thead>
<tbody>
<tr>
<td>60</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>66</td>
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</tbody>
</table>

### 11 BLANK

### 12 The CPI presented the case to CLS for a staffing when warranted and when the investigation was legally sufficient, a petition was filed or a valid reason for not filing a petition was documented.

<p>| | | | | | |</p>
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<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>57</td>
<td>66</td>
</tr>
</tbody>
</table>

#### 12.1 A Children’s Legal Services staffing was held when warranted.

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>57</td>
<td>66</td>
</tr>
</tbody>
</table>

#### 12.2 A dependency petition was filed or a valid reason for not pursuing a dependency action was documented, when the CLS staffing documented legal sufficiency.

<p>| | | | | | |</p>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>57</td>
<td>66</td>
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</tbody>
</table>

### 13 The CPI worked in partnership with the Child Protection Team (CPT) to identify child maltreatment, current and long term concerns and child and family service needs.

<p>| | | | | | |</p>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>48</td>
<td>66</td>
</tr>
</tbody>
</table>

#### 13.1 A referral was made to the CPT when required.

<p>| | | | | | |</p>
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<thead>
<tr>
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<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>48</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.

|   | 7 | 0 | 0 | 1 | 58 | 66 | 88% |

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.

|   | 5 | 2 | 2 | 3 | 54 | 66 | 64% |

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

|   | 61 | 5 | 0 | 0 | 0 | 66 | 98% |

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.

|   | 3 | 0 | 0 | 0 | 63 | 66 | 100% |

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.

|   | 34 | 1 | 0 | 0 | 31 | 66 | 99% |

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

|   | 30 | 1 | 0 | 0 | 35 | 66 | 99% |

20.2 Mother

|   | 33 | 1 | 0 | 0 | 32 | 66 | 99% |

20.3 Father

|   | 23 | 0 | 0 | 0 | 43 | 66 | 100% |

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

|   | 7 | 1 | 0 | 0 | 58 | 66 | 97% |

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).

|   | 21 | 2 | 1 | 0 | 42 | 66 | 96% |

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

|   | 20 | 1 | 1 | 0 | 44 | 66 | 97% |

21.2 Mother

|   | 21 | 2 | 1 | 0 | 42 | 66 | 96% |
### Central Region CPI QA Review December 2011

#### Quality Assurance

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Score</th>
<th>Yes</th>
<th>No</th>
<th>//</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>21.3 Father</td>
<td></td>
<td>14</td>
<td>2</td>
<td>0</td>
<td>50</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></td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>0</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></td>
<td>19</td>
<td>2</td>
<td>3</td>
<td>0</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></td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>24 The investigation was thorough and appropriate steps were taken to ensure child safety.</td>
<td></td>
<td>31</td>
<td>32</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>25 BLANK</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></td>
<td>40</td>
<td>24</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>26.1 Initial supervisory guidance</td>
<td></td>
<td>62</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>26.2 On-going supervisory guidance</td>
<td></td>
<td>30</td>
<td>13</td>
<td>7</td>
<td>6</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></td>
<td>36</td>
<td>28</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>27.1 The CPI followed through on the supervisory guidance and direction.</td>
<td></td>
<td>37</td>
<td>25</td>
<td>2</td>
<td>0</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></td>
<td>39</td>
<td>24</td>
<td>2</td>
<td>0</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></td>
<td>33</td>
<td>1</td>
<td>4</td>
<td>1</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></td>
<td>16</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>28 When the investigation was being closed, the case file documents the CPI or CPI Supervisor ensured the receiving case management agency was notified of the closure, and the transfer of responsibilities from CPI to case management was clearly communicated.</td>
<td>8  2  0  2  54  66  80%</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>28.1 The plan for closing the investigation case was thoughtful, individualized and matched to the child and family's present situation, preferences, and long-term view for child safety.</td>
<td>9  3  0  0  54  66  98%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29 Prior to the removal, the CPI made concerted efforts to provide appropriate services that would allow the child to remain safely in his/her own home.</td>
<td>3  0  0  0  63  66  100%</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 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>5  0  0  0  61  66  100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 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  0  0  0  59  66  100%</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 case file contained evidence required background checks and a physical inspection of the home were completed prior to the child’s placement.</td>
<td>6  1  0  0  59  66  97%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.1 The required background checks were completed during the home study process prior to the child’s placement.</td>
<td>6  1  0  0  59  66  97%</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 study process prior to the child’s placement.</td>
<td>7  0  0  0  59  66  100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.3 An evaluation of the prospective caregiver’s capacity to protect was completed during the home study process prior to the child’s placement.</td>
<td>7  0  0  0  59  66  100%</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>33 BLANK</td>
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<td></td>
</tr>
<tr>
<td>34 If the child was removed and placed in a licensed home or with a relative or non-relative caregiver, a Child Health Check-Up was completed within 72 hours of removal.</td>
<td>5  0  0  1  60  66  83%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td>Description</td>
<td>Score</td>
<td>Total</td>
<td>No.</td>
<td>Yes</td>
</tr>
<tr>
<td>------</td>
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<td>-----</td>
</tr>
<tr>
<td>34.1</td>
<td>The Child Health Check-Up was completed within 72 hours of the child's removal and a copy is in the case file.</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>34.2</td>
<td>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>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>35.1</td>
<td>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>2</td>
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<td>36.1</td>
<td>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>
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<td>37.1</td>
<td>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>
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<td>Overall</td>
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<td>Response</td>
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<td>Removal</td>
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<td>Conducting Thorough Assessments</td>
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<td>Observing &amp; Interviewing Children, Parents, Others</td>
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<td>Determining Maltreatment Findings, Family Needs &amp; Services</td>
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<td>Planning for Safe Case Closure</td>
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