Northeast Region
Quality Assurance Review

Circuits 3, 4, 7, and 8
Child Protective Investigations

1st Semi-Annual Report for Fiscal Year 2011-2012
**Dates of Review Period:** September 1, 2011 through December 31, 2011

**Sample Period for 1st Quarter:** July 25, 2011 – September 6, 2011

**Sample Period for 2nd Quarter:** September 20, 2011 – November 14, 2011

**Methodology**

1st Quarter: Due to the Department’s delay in finalizing the review process, region quality assurance staff randomly selected six investigations per circuit, using the Florida Safe Families Network (FSFN) “Child Investigations Closed within the Last 30 Days” report provided by headquarters.

**Circuit 3:** Six investigations closed between September 1, 2011 and September 6, 2011.

**Circuit 4:** Six investigations closed between July 28, 2011 and August 3, 2011.
Note: One of the six investigations was randomly selected to pilot the Quality Service Review process.

**Circuit 7:** Six investigations closed between July 25, 2011 and August 21, 2011.

**Circuit 8:** Six investigations closed between September 1, 2011 and September 6, 2011.

**Note:** The reviews for circuits 3 and 8 were conducted simultaneously.

2nd Quarter: Region quality assurance staff randomly selected one closed investigation from the FSFN “Child Investigations Closed within the Last 30 Days” report per unit.

**Circuit 3:** Four investigations closed between September 22, 2011 and October 2, 2011

**Circuit 4:** Seventeen investigations closed between November 9, 2011 and November 14, 2011.

**Circuit 7:** Twelve investigations closed between September 26, 2011 and September 29, 2011.

**Circuit 8:** Eight investigations closed between September 20, 2011 and October 2, 2011.

**Note:** The reviews for circuits 3 and 8 were conducted simultaneously.

The NE Region is comprised of four judicial circuits, and the Department is solely responsible for conducting the child protective investigations. A reduced sample of six investigations per circuit was reviewed for the first quarter, due to the delay in finalizing the CPI quality assurance review process. The distribution of the sample for the second quarter is shown below in Chart 1, and is consistent with the new requirement to randomly select one closed investigation per CPI unit.
The investigation records (both hard copy and electronic files) were reviewed side-by-side by a region Operations Review Specialist and the assigned Child Protective Investigator Supervisor, using the Quality of Practice Standards for Child Protective Investigations (revised August 2011). The revisions included the elimination of six review standards due to the availability of performance data through a FSFN query, and the inclusion of five additional review standards or sub-standards to expand the qualitative focus on practice.

<table>
<thead>
<tr>
<th>Eliminated Review Standards</th>
<th>New Review Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.0 Seeing “Other” children Timely</td>
<td>25.0 Indian Child Welfare Act Inquiry in Non-Removal Investigations</td>
</tr>
<tr>
<td>8.0 Second Party Review</td>
<td>32.4 Home Study Documentation in FSFN</td>
</tr>
<tr>
<td>11.0 Professional Assessments of Others</td>
<td>33.0 Placement of Sibling Groups</td>
</tr>
<tr>
<td>4.3 Appropriate Attempts to Engage Child Victim(s) and “Other” Children in the Investigative Process</td>
<td>27.4 Follow-up Communication and Consensus with the 2nd Party Reviewer Prior to Determining 2nd Party Review Recommendations Were No Longer Necessary</td>
</tr>
<tr>
<td>5.5 Appropriate Attempts to Engage the Parents and “Other” Adults in the Investigative Process</td>
<td>28.1 The Plan for Closing the Investigation was Thoughtful, Individualized and Matched to the Child and Family’s Present Situation, Preferences, and Long-Term View for Child Safety.</td>
</tr>
<tr>
<td>17.0 Added Maltreatments</td>
<td></td>
</tr>
</tbody>
</table>
Review standards 13.2 Timely CPT Referral, 14.0 CPT Discussion, and 16.0 Supervisory Review of CPT Exceptions were replaced or incorporated into Review Standard 13.0: The CPI Worked in Partnership with the CPT to Identify Child Maltreatment, Current and Long Term Concerns, and Child and Family Service Needs.

Review Standard 35.0 Emergency Intake Form was expanded to include not only completion of the required form, but also documentation the CPI shared the medical information with the substitute caregiver.

Analysis of Review Findings
The changes noted above in the review standards were made with the goal of providing additional focus on the assessment of quality and family centered practices, through grouping the review standards into four critical areas of practice to assess whether the investigation record documented the Child Protective Investigator:

- conducted a thorough assessment;
- observed and interviewed children, parents and others;
- determined the appropriate maltreatment findings, and the family’s needs and services; and
- planned for a safe investigation case closure.

Chart 2 below documents the NE Region Circuit performance for the first and second quarters of this fiscal year on these four critical areas of practice.
**Assessment:** This area of practice considers whether all required background checks were completed and completed timely; safety assessment was completed with sufficient thoroughness; relevant collateral contacts were completed to determine the validity of the alleged maltreatment(s); pertinent information obtained from collateral contacts was considered when assessing the overall safety of the child and the service needs; whether the case was staffed with Children’s Legal Services (CLS) when warranted to determine the most appropriate avenue for serving the child and family; and in cases involving a removal whether the CPI completed an inquiry regarding possible Native American or Alaskan Indian heritage; and whether required background checks and the inspection of the substitute caregiver’s home were completed prior to the child’s placement.

Note: Review findings have consistently documented concerns about the failure to complete all required background checks for subjects of the report and members of the household. Additionally, concerns have been noted about the timely request of background checks, once additional individuals were identified as subjects of the report or members of the household. The failure to complete or the failure to complete timely negatively impacts the thoroughness of the investigation.

**Circuit 3:** Circuit 3’s performance documented a number of strengths in the first and second quarter reviews including ensuring the thoroughness of safety assessment process; completing collateral contacts that were relevant to supporting or refuting the alleged maltreatments; and appropriately using the information obtained through the investigation to assess the child’s overall safety and need for services. The circuit’s performance was negatively impacted by the failure to timely request all required background checks.

**Circuit 4:** In the first quarter, strengths were noted in ensuring the safety process was completed with sufficient thoroughness to identify risks and develop a safety plan when needed; ensuring information obtained from relevant collateral contacts was used appropriately to assess immediate safety and ongoing risks, and when an investigation involved a removal, ensuring the case was presented to CLS when warranted; and ensuring the home study and required background checks were completed prior to a child’s placement with a substitute caregiver. In the second quarter, performance regarding the safety planning process dropped significantly. Opportunities for improvement remained consistent in both quarters with deficiencies noted in completing background checks when required, and within established timeframes; and ensuring the collateral contacts completed were relevant to the presenting concerns.
Circuit 7: In the first and second quarter, Circuit 7’s one consistent area of strength was in ensuring the information obtained from relevant collateral contacts was appropriately used to assess the overall safety, and service needs of the child and family. Ensuring an investigation was presented to CLS when warranted was a strength in the first quarter and a deficit in the second quarter. Opportunities for improvement were documented in both quarters in the areas of ensuring required background checks were completed and completed timely; the safety assessment was completed with sufficient thoroughness to identify risks and develop a plan; and completed collateral contacts were relevant to the presenting concerns.

Circuit 8: A number of strengths were noted for Circuit 8 in the area of assessment. Circuit 8 documented full compliance in both quarters in ensuring the safety assessment process was completed with sufficient thoroughness to identify immediate safety and ongoing risks; ensuring the information obtained from relevant collateral contacts was appropriately used to assess overall safety and the need for services; information was presented to CLS when warranted to determine the appropriate avenue for intervening and serving the child and family, and ensuring compliance with the Indian Child Welfare Act when a removal occurred. Opportunities for improvement remain in ensuring all required background checks are completed and completed timely.

Observing and Interviewing: This area of practice considers whether diligent attempts to see the child were made when the child victim was not seen immediately or within 24 hours; the investigation included interviews with the alleged child victim(s) and other children; the CPI made appropriate efforts to engage the child victim and other children (new standard), and the parents and other adults (new standard) in the investigative process; and substantive and individualized observations of the children, as well as their interactions with other household members were documented.

Note: This review standard requires the CPI to document the child's physical appearance, developmental progress, behavioral indicators and interactions with others in the household. Investigations typically describe the child's physical appearance, but lack an individualized account of the child’s developmental progress, behavioral indicators and interactions with other household members. If the report alleged the child was fearful of one or more of the caregivers, the observations at a minimum must describe the child’s level of comfort in interacting with the caregiver(s). If the report alleged the infant was not receiving the care and stimulation needed to thrive, the observations of the child and caregiver, and the developmental milestones met would be critical to fully addressing the concerns alleged in the report. CPI staff appear to lack a working knowledge of the stages of child development, which is critical to individualizing observations and meeting this standard. CPI Supervisors should focus
on this area when conducting individual supervisory sessions, and attend to this requirement when conducting periodic reviews of the case record.

**Circuit 3:** Significant improvement was noted in Circuit 3’s review findings from the second quarter versus the first quarter, with full compliance noted in documenting diligent attempts to see the child victim at least daily if the child was not seen immediately when required or within 24 hours. Opportunity for improvement remains in documenting individualized and substantive observations and interactions of the children with family members relevant to the alleged concerns.

**Circuit 4:** Improvement was noted in Circuit 4 documenting diligent attempts to see child victims when the child victim was not seen immediately when required or within 24 hours; ensuring interviews with the alleged child victims and other children addressed all of the alleged maltreatments; documenting efforts to engage the child victims and other children in the investigative process, and in ensuring all alleged maltreatments are addressed with the mother, father, alleged perpetrator and caregiver, if other than the mother and father. An opportunity for improvement remains in documenting substantive and individualized observations of the children and interactions with household members.

**Circuit 7:** A decrease in performance was noted in all requirements addressed in the area of Observing and Interviewing. Performance dropped from full compliance to 80% in the areas of conducting interviews addressing all maltreatments with the alleged child victims and other children, and in documenting efforts to engage the child victims and other children in the investigative process. Additionally, deficits were noted in documenting diligent attempts to see child victims at least daily when not seen immediately when required or within 24 hours; ensuring interviews with child victims, other children, parents, perpetrators and caregivers addressed all of the alleged maltreatments; and in documenting substantive observations and interactions of the children and family members during the investigative process.

**Circuit 8:** The circuit maintained full compliance with the requirement to document attempts to engage the child victim and other children in the investigative process. Areas in need of improvement included ensuring interviews were conducted and addressed all alleged maltreatments with the alleged child victims and other children, and with the parents, caregivers and alleged perpetrators, and documenting substantive and individualized observations and interactions of the children with household members.
Maltreatment, Family Needs and Services: This area of practice considers whether the CPI worked in partnership with the Child Protection Team (CPT) to identify child maltreatment and any current or long term concerns and service needs; whether all maltreatment findings were supported by the information gathered through the investigation; the case was staffed for early service intervention if removal was considered and services would allow the child to safely remain in the home; and appropriate services and/or ongoing supervision were identified consistent with the child and family's needs, appropriate referrals were made, and service engagement was confirmed. If removal occurred, the reviewers are required to look for the CPI’s documented concerted efforts to provide services when appropriate; and if removal was necessary the CPI’s documented efforts to give placement priority to relatives or non-relatives able to provide care.

The Northeast Region consistently documents exceptional performance in ensuring maltreatment findings are adequately supported, and in ensuring the family’s engagement with immediate services and/or ongoing supervision before approving an investigation for closure.

Circuit 3: Circuit 3 has consistently documented strengths in the areas of maltreatment findings, and the identification and provision of needed services to the children and families served. Full compliance was achieved in all but one of the applicable standards in the first quarter, and all of the applicable standards assigned to this critical area of practice in the second quarter.

Circuit 4: Circuit 4 has also consistently documented strengths in the areas of maltreatment findings, and the identification and provision of needed services to the children and families served. Full compliance was achieved in all but one of the applicable standards (documenting weekly contact with children in shelter status) in the first quarter, and in all of the applicable standards assigned to this critical area of practice in the second quarter.

Circuit 7: Circuit 7 achieved full compliance for all but two applicable standards (immediate services and/or ongoing supervision needs were identified for the child, mother, father and caregiver; and documenting service engagement with immediate services and/or ongoing supervision needs) in the first quarter, and full compliance with all applicable standards in the second quarter.

Circuit 8: Circuit 8 achieved full compliance for all applicable standards in the first quarter, and for all but one applicable standard (ensuring a child health check-up was completed within 72 hours of removal) in the second quarter.
Planning for Safe Case Closure: This area of practice considers whether timely communication and coordination occurred when there was an active service case at the time the investigation report was received; the investigation was thorough and appropriate steps were taken to ensure the child’s safety; appropriate supervisory guidance was provided, and tracked to completion; timely notification occurred with the case management agency when the investigation was approved for closure (new standard); the plan for closure was thoughtful, individualized, and matched to the child family’s present situation (new standard); and medical information was provided to the caregiver when a removal occurred.

Note: The practice area documented the most opportunities for improvement remains in Planning for Safe Case Closure. The region’s and circuits’ performance was in part negatively impacted by the two new qualitative standards focused on communication and coordination with the case management agency.

Circuit 3: Improvement in performance was noted in the second quarter in all but one standard (plan for closure was thoughtful, individualized and matched to the child and family’s present situation). However, opportunities for improvement remain in ensuring the investigation was thorough, and appropriate steps were taken to ensure child safety; and ensuring follow through on supervisory guidance and direction. The thoroughness of investigations was impacted by the failure to complete all required background checks, and/or the failure to timely request the required background checks noted in Assessment above. Both quarters documented full compliance in documenting appropriate supervisory guidance and direction.

Circuit 4: The most challenging area of practice for Circuit 4 remains in Planning Safe Case Closure. Significant deficits were noted in ensuring the thoroughness of investigations, which is negatively impacted by the failure to complete or timely request required background checks on subjects of the report and members of the household. Additionally, deficits were noted in ensuring follow through on supervisory guidance and direction; ensuring the case management agency was timely notified when an investigation was approved for closure; and ensuring the plan for case closure was thoughtful and individualized and matched to the child and family’s situation.

Circuit 7: The most challenging area of practice for Circuit 7 remains in Planning a Safe Case Closure. The second quarter documented a significant drop in performance for all applicable standards. Concerns were noted about the thoroughness of the investigation, negatively impacted by the failure to consistently and timely request required background checks on subjects of the report and members of the household; documenting and ensuring follow through on appropriate supervisory guidance and
direction; and ensuring the plan for case closure was thoughtful, individualized, and matched to the child and family’s situation.

**Circuit 8:** Low scores were also documented on the majority of applicable standards for Circuit 8 in both the first and second quarter reviews. Deficits were consistently noted in ensuring the thoroughness of the investigation, negatively impacted by the failure to consistently and timely request required background checks; ensuring follow through on supervisory guidance and direction; ensuring the case management agency was timely notified when the investigation was approved for closure; and in obtaining and sharing medical information with the substitute caregiver when removal was required. A consistent strength was noted both quarters in ensuring the plan for safe case closure was thoughtful and individualized to the child and family’s situation, and an area documenting a need for improvement was noted in ensuring appropriate supervisory guidance and direction were documented.

**Summary and Recommendations:**

The Northeast Region should focus improvement strategies on the areas outlined below to both improve outcomes for the children and families served, and the quality of practice.

1. CPI Supervisors ensure all barriers to obtaining required background checks are addressed and resolved or surfaced to the Operations Manager.
2. CPI Supervisors incorporate a review of substantive and individualized observations when conducting individualized supervisory reviews, and when reviewing the investigation record for progress and/or closure.
3. CPI Supervisors ensure CPIs are provided a guide to assist them in assessing child development while in the field.
4. CPI Supervisors review the new standards and guidelines incorporated into the statewide quality assurance process. See chart on page 3 of this report.
5. CPI Supervisors ensure the final review for closure includes a review of the supervisory direction provided and the follow through to ensure all actions are completed or a note is entered documenting why the direction is not longer needed.