An Assessment of the Quality of Child Abuse and Neglect Investigative Practices in the District of Columbia

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May 24, 2010

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AN ASSESSMENT OF THE QUALITY OF CHILD ABUSE AND NEGLECT INVESTIGATIVE PRACTICES IN THE DISTRICT OF COLUMBIA

I. INTRODUCTION AND PURPOSE

The District of Columbia's Child and Family Services Agency (CFSA) is responsible for assessing reports alleging abuse and/or neglect of children within the boundaries of the District of Columbia. CFSA maintains a 24-hour Hotline for screening these reports and assigning those that meet the District's definition of child abuse or neglect to a social worker for further investigation. For some reports, District law requires that CFSA contact the District's Metropolitan Police Department's Youth Division (MPD) in order to trigger assignment of a police officer.[1] This may lead to a joint response from an investigative social worker and police officer.

In general, the tasks of child protection intake and investigation are to: interview the source of allegations;[2] determine whether the allegations meet the criteria for assignment to child protection investigative social worker; assess reports in a timely and comprehensive manner; make sound decisions regarding the safety of and reducing risk of harm to children; and, if needed, put in place safety plans and/or services to support families and extended families in safely caring for their children.

The Center for the Study of Social Policy (CSSP) is the federal court-appointed Monitor for the *LaShawn A. v. Fenty* (*LaShawn*) lawsuit, which has established requirements related to the performance of the District's child welfare system. CSSP performs a range of monitoring activities to assess and report on the District's performance in meeting the outcomes and implementation benchmarks set by the *LaShawn* Modified Final Order and its Amended Implementation Plan (AIP).[3]

In February 2006, the Monitor, in partnership with CFSA, released a report detailing the review of intake and investigations practices.[4] The review applied a structured protocol to a statistically valid, random sample of 134 electronic case records (FACES) of investigations closed by CFSA

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[1] *See*, DC ST § 4-1301.51 requiring mandatory investigation of child abuse and neglect cases by a multidisciplinary team in every instance of sexual abuse. *See also*, CFSA Investigations Policy VII Procedures D, E, and Z (September 30, 2003) found at: http://www.cfsa.dc.gov/cfsa/frames.asp?doc=/cfsa/lib/cfsa/policymanualpdffiles/policies/program%20-%20investigation%20%28final%29.pdf.

[2] At times, CFSA receives reports by facsimile.

[3] *LaShawn A. v. Fenty* Amended Implementation Plan, February 2007. Found at: http://www.cssp.org/uploadFiles/DC_LaShawn_A_v_Fenty_Amended_Implementation_Plan.pdf.

[4] *An Assessment of The Quality of Child Protective Services Investigations in the District of Columbia*, Washington, DC: Center for the Study of Social Policy, February 7, 2006. Found at: http://www.cssp.org/uploadFiles/An_Asmt_of_Quality_of_Child_Prot_Svcs_Invest_in_DC_Feb_10_2006.pdf.

during June 2005. An in-depth analysis of 15 cases of families, three whose records were included in the sample of 134 and an additional 12 cases sampled from the universe of investigations that month, was also completed.[5]

In 2007, in an effort to gain a snapshot of intake and investigation practice, the Monitor and CFSA collaborated to review 40 investigations records.[6] In order to contextualize the information gained from the record review and further understand systemic strengths and challenges in screening reports and conducting investigations, the Monitor conducted focus groups with a range of stakeholders. The findings of both the 2006 and 2007 reviews pointed to significant practice and system performance issues.[7]

This current report is based on a review of FACES records of investigations completed and one case with a disposition of incomplete from September 21 to October 16, 2009. The review was conducted by the Monitor, with assistance from CFSA. The goals of the review were to examine the current status of intake and investigations practices and the extent to which those practices have improved over time.

The specific areas of the *LaShawn* AIP addressed in the review and report include[8]:

- Investigations of alleged child abuse and neglect shall be initiated within 48 hours.[9] Initiation of an investigation includes seeing the child and talking with the child outside the presence of the caretaker. When children are not immediately located, documented good faith efforts to see the child within the first 48 hours shall include visiting the child's home, school and day care in an attempt to locate the child as well as contacting the reporter, if known, to elicit additional information about the child's location; contacts with the police shall be made for all allegations that involve moderate and high risk cases.

- Investigations of alleged abuse and neglect shall be completed within 30 days (of the receipt of a report of child maltreatment).

- CFSA shall routinely conduct investigations of alleged child abuse and neglect. Evidence of acceptable investigations shall include:

    - Use of CFSA's screening tool in prioritizing response times for initiating investigations and use of risk assessment protocol in making decisions resulting from an investigation,

    - A full and systematic analysis of a family's situation and the factors placing a child at risk,

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[5] The in-depth analysis included both a case record review and a QSR of these 15 cases.

[6] *An Assessment of the Quality of Child Abuse and Neglect Investigative Practice in the District of Columbia,* Washington, DC: Center for the Study of Social Policy, November 2007. Found at: http://www.cssp.org/uploadFiles/FINAL%20CPS%20Review%20Report%2011%2013%202007.pdf.

[7] In January 2008, CFSA experienced a surge in calls to the hotline resulting in a surge in investigations. The Agency asserts that it was unable to effectively address the issues raised in the 2007 report due to these increases.

[8] *LaShawn A. v. Fenty* Amended Implementation Plan, February 2007. Found at: http://www.cssp.org/uploadFiles/DC_LaShawn_A_v_Fenty_Amended_Implementation_Plan.pdf.

[9] District of Columbia law requires that an investigation be initiated within 24 hours. *See,* DC ST § 4-1301.04.

- Appropriate interviews with needed collateral contacts and with all children in the household outside the presence of the caretaker, parents or caregivers or shall include documentation by the worker of good faith efforts to see the child and that the worker has been unable to locate the child, and
- Medical and mental health evaluations of the children or parents when the worker determines that such evaluations are needed to complete the investigation.[10]

- CFSA shall investigate relative resources in all cases requiring removal of children from their homes; and
- Families who have been the subject of a report of abuse and/or neglect that is determined to be low or moderate risk and needing additional supports shall be referred to an appropriate Collaborative or community agency for services and supports.[11]

In addition, to fully assess overall quality, the Monitor measures CFSA's implementation of its policy on investigations including:

- Collaboration with the Metropolitan Police Department (MPD) and the Child Advocacy Center (CAC) in investigations of severe physical and sexual abuse;
- The use of Family Team Meetings (FTMs) for families of children who are at risk of removal from their home or whose children removed their homes within three business days of the child's removal;
- The process for transferring responsibility from an investigations social worker to one who continues to work with the family while a child remains at home.

Areas of Improvement

The Monitor found that important improvements have been made in investigations practice since the 2006 and 2007 reviews. One of the more notable improvements is clearer and more detailed documentation of investigative activities in FACES records. Additional improvements include:

- Social workers conducted safety assessments within the first day of the investigation more often than found in previous reviews.
- Alleged perpetrators were interviewed or attempts were made to interview them in almost all investigations.

[10] CFSA policy requires that the investigator connect with the Office of Clinical Practice (OCP) for support in completing needed medical and mental health evaluations. *See,* CFSA Investigations Policy VII Procedure A.4.vii (September 2003) found at: http://www.cfsa.dc.gov/cfsa/frames.asp?doc=/cfsa/lib/cfsa/policymanualpdffiles/policies/program%20-%20investigation%20%28final%29.pdf. CFSA does not have the authority to require an evaluation during investigation without parental consent or a court order. A clinical consultant from OCP is available to accompany workers to visits, as needed.

[11] In order for a case to be opened with the Collaboratives, families must consent.

- In almost all investigations, social workers made or attempted contact with the source of the report to the Hotline.
- Prior concerns about investigators not completing risk assessments and the retention of risk assessment data appear to have been resolved.
- All children received health screens prior to placement.

These are notable improvements and the Agency should be recognized for its on-going efforts to enhance the practices of investigative workers. Several quality improvement activities are now in place in the Intake and Investigations Administration including a supervisor's review after 18 days of all investigations and a multidisciplinary Grand Rounds, which selectively review investigations in progress to examine practice and quality. Each of these strategies is providing additional direction and support to workers and has likely contributed to noted improvements.

Areas of Challenge

Despite improvements that are cited in this report, there remain areas of practice that do not meet performance standards. Most importantly, the overall quality of investigations practice remains uneven and reviewers assessed that less than half (44%) of the investigations were of overall quality. In order to rate an investigation "of quality," the reviewer had to agree that all core contacts or "good faith efforts" were made; all allegations and safety concerns and risks were assessed and addressed; and good decision-making based on evidence documented. Using the same standard, in the February 2006 monitoring report, reviewers found 34 percent of the investigations reviewed to be of sufficient quality. While the current practice is improved over the practice described in 2006, far too many (more than half) of the investigations reviewed were not of overall quality. Additional challenges cited in this report include:

- Even when "good faith efforts" to see the children were taken into account, less than two-thirds (58%) of the records show that all alleged victim children were seen within 48 hours of a report to the Hotline.[12]
- Investigators did not consistently consult with persons who are most familiar with children and their families to inform investigation decisions.
- Investigators did not routinely connect families to services and supports as part of the investigation.
- The number of investigations not completed within mandated timeframes remains too high.

More detailed information on what's working well and areas for improvement can be found below in Section III: Overview of Findings.

[12] District of Columbia law and CFSA policy require that investigations be initiated within 24 hours. The *LaShawn* AIP standard for initiation is 48 hours.

II. METHODOLOGY

The findings in this report are based on a review of a statistically valid sample of CFSA electronic records of investigations which were completed from September 21 through October 16, 2009. Key aspects of intake and investigations practices were assessed as part of this review. Case record reviewers included CSSP staff and consultants and a CFSA Programs staff person.

Sample

This review is of a statistically valid random sample of 190 records of investigations completed between September 21 and October 16, 2009.[13] The sample is derived from the universe of 359 investigations of alleged abuse or neglect of a child by a parent or family member.[14] The number of investigation records reviewed yields findings with a margin of error of +/- 5%.

Instrument and Data Collection

Reviewers completed a structured survey instrument, based both on CFSA investigations records review instruments the Monitor has used in the past and the record review instrument CFSA uses as part of their Grand Rounds process.[15] The survey instrument was designed for review of FACES to assess the status of CFSA's investigations practice. SurveyMonkey, a web-based survey tool, was used for data entry and collection. CFSA reviewed drafts of and the final instruments, to include a piloting testing the web-based tool. Data collection took place in November and December 2009 at CFSA's Child Information Systems Administration (CISA) office. A copy of the data collection instrument is included in this report as Appendix A.

Reviewer Training

Each reviewer participated in a half day training facilitated by CSSP staff. The training included: the purpose of review; processes of the review; understanding the data collection instrument; learning to navigate FACES in a manner to sort for responses to questions; and reviewing two "test" case records. The results of the review of the test case records were discussed in-depth to ensure consistency in decision-making and responses.

Quality Assurance

To ensure inter-rater reliability and rater accuracy in completing the instrument, a 10 percent sample of instruments completed by each reviewer was checked by a CSSP staff person. Each instance of disagreement resulted in a discussion to determine facts used in determining a response. Reviewers also had the opportunity to consult with each other, as they worked in close proximity. CFSA management was also available and used for consultation during the record reviews.

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[13] This time frame allowed for investigations to be completed and documented in FACES within required timeframes prior to the commencement of the review.

[14] Excludes institutional abuse investigations, i.e. investigations of alleged abuse and/or neglect of a child by a licensed foster parent, staff of a daycare, school, or residential setting,

[15] Grand Rounds is an activity CFSA's Quality Assurance unit conducts in coordination with the Child Protective Services unit to discuss individual investigations and explore CPS practice strengths and challenges. At Grand Rounds, supervisors present individual investigations and a structured instrument is used to assess case practice.

Data Analysis

The data collection instruments were coded into a format which allowed for statistical analysis using the Statistical Package for the Social Sciences program. Written statements from reviewers in reference to specific questions in the instrument, as well as from the general comments section of the instrument were also captured and analyzed to gain a greater understanding of the qualitative data gathered for each record reviewed.

Limitations of Case Record Review

This review relied exclusively on documentation in FACES. It is possible that additional efforts in conducting investigations were not documented in some records and therefore not credited in the findings. Additionally, case record reviews have limitations in assessing the comprehensiveness and quality of service delivery. Some questions require a more in-depth assessment to more fully understand circumstances.

III. OVERVIEW OF FINDINGS

The District's child protection system ensures the *safety* of the majority children who were subjects of a report alleging neglect and/or abuse. There are specific areas needing improvement to ensure key child protection practices. The following summarizes the areas that were assessed as working well and other areas that remain in need of improvement.

What's Working Well

- **The Hotline routinely assigned the appropriate time period for an investigative social worker to respond to reports of maltreatment.**[16] CFSA allows for an immediate response to the hotline call or for a response within 24 hours of the receipt of the report, based on the allegation and other factors entered on an electronic form. Reviewers agreed with the response time assigned for 96 percent of investigations.

- **Investigative social workers interviewed other children in the household as well as the alleged perpetrator and the reporting source.**[17] In 69 of the 78 (88%) applicable instances, social workers interviewed each of the other children in the household.[18] There was documentation in 53 of those investigations that all children were seen outside of the presence of their parent or caretaker. The social worker interviewed all alleged perpetrators in 172 (92% of investigations in which an alleged perpetrator was identified) investigations. In an additional six (3%) investigations, the social worker made attempts to contact the alleged perpetrator(s). In 134 (81%) of the 166 investigations where the reporting source was known, investigators interviewed the source. Attempts were made to contact the source in an additional 26 (16%) instances. This is an improvement from the 2006 report when investigators contacted the reporting source in 76 percent of investigations and made attempts to contact them in an additional 13 percent of investigations.

- **Investigative social workers requested and collected basic information related to children's school attendance, vaccination and physician visits record.** Reviewers found that investigators routinely collected immunization and medical appointment history as well as attendance history for the child(ren) alleged to be victims of child abuse and/or neglect. This has become standard practice.

- **Children received health screens prior to placement.** All (100%) of the 22 children in the 13 investigations in which children were removed from their homes following an

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[16] In 2008, the National Resource Center for Child Protective Services completed a review of hotline practice and decision-making. *See*, "District of Columbia Child and Family Service Agency Intake Hotline Practice and Decision Making Final Report" (National Resource Center for Child Protective Services, undated).

[17] Based on information gathered by the Intake unit prior to the assignment of an investigative social worker, a child alleged to be a victim of harm, is designated in FACES as such. Any other children in the household, to whom the allegations do not apply at that stage of CFSA involvement, are deemed "other children in the household." That label is to be updated prior to closure of the investigation, as applicable.

[18] Includes a social worker's observation of and sound interactions with younger children; generally those under age four.

investigation received a health screening prior to placement. This performance meets the LaShawn AIP interim benchmark.

- **There is increased documentation of supervisory social worker involvement in investigation processes, although still at low levels.** In comparison to previous reviews of investigative practice, where the Monitor found little to no documented evidence of meaningful supervisory social worker consultation during the investigation, this review found documentation of supervisors providing consultation to social workers in 73 of the 190 (38%) of the investigation records. The Monitor is impressed that the quality of case record documentation is improving. Good documentation greatly benefits the work of subsequent social workers and supervisors to understand the course of a family's involvement with agencies and ultimately benefits the families and children themselves. Of note, however, is that even when supervisors offered sound directives, these directives were often not followed and supervisors nevertheless approved the closure of the investigation.

Areas for Improvement

- **Child protective services investigations are not regularly initiated within required timeframes.** Reviewers found that 110 of 190 investigations (58%) were initiated in required LaShawn AIP timeframes, defined as seeing the alleged victim children outside the presence of their parents/caretakers, within 48 hours.[19] This level of performance takes "good faith efforts" into account as there were no investigations in which all five required good faith efforts included in CFSA's policy were made.[20] In the majority of investigations, in addition to making the first unsuccessful visit to a home, the only other step taken was leaving a letter for the parent/caretaker requesting contact. In very few records there were notes of visiting the family's home at other times or attempting to see children at their school on the same day of the unsuccessful visit to the home. The Monitor's 2006 review found that that 56 percent of investigations were initiated within 48 hours. Performance has not significantly improved since the 2006 review.

- **Investigators did not consistently consult with persons who are most familiar with children and their families to inform investigations.** In many cases there were persons involved with a family who both parents/caretakers and children spoke of, such as relatives, teachers or day care providers, other service providers and current or recent CFSA or contracted agency social worker(s). These persons may likely have provided

[19] District of Columbia law requires that an investigation be initiated within 24 hours. *See,* DC ST § 4-1301.04.
[20] This review measured performance on "good faith efforts" against CFSA policy. *See*, CFSA Investigations Policy VII Procedure C.12 (September 30, 2003) found at: http://www.cfsa.dc.gov/cfsa/frames.asp?doc=/cfsa/lib/cfsa/policymanualpdffiles/policies/program%20-%20investigation%20%28final%29.pdf. In addition to the policy, CFSA promulgated an Administrative Issuance on March 7, 2008 (Immediate Requirements for All CPS Investigations). The Administrative Issuance includes a more expansive list of good faith efforts required to safely close a case when a child or family cannot be located.

information about a family's strengths, supports, or challenges but were rarely consulted as part of the investigation.

- **The District's Child Advocacy Center (CAC) continues to be underutilized as a resource in investigations.** The District's Memorandum of Understanding with the CAC requires that all children who are alleged victims of serious physical or sexual abuse should be forensically interviewed at the CAC. Children were taken to the CAC for an interview in only five (17%) of the 30 investigations in which children needed to be interviewed at the CAC. According to CFSA, despite the requirements of the MOU, this low incidence is attributable to the fact that scheduling CAC interviews is at the discretion of the Metropolitan Police Department (MPD) Youth Division (YD) detectives rather than a shared responsibility.

- **Investigators do not routinely gather information directly from medical and school personnel to address the allegations and/or assess whether or not the child(ren)'s medical, educational, safety, risk and well-being needs are being met.** The Agency has developed mechanisms for obtaining children's basic health, immunization and school attendance reports. However, social workers do not routinely reach out to medical and educational personnel to gather specific information related to the status of the child and family.[21] Knowing that a child has been immunized, had a scheduled visit with a physician, and attends school regularly is vitally important, but usually will not provide enough information to the social worker about health and educational issues that may factor into an assessment of child and family needs. A thorough assessment usually requires dialogue with these providers.

- **Investigators do not routinely connect families to services and supports during the investigation.** Agency involvement with a family is designed, at its core, to ensure children's safety and promote the family's ability to adequately and safely care for children. The function of child protective services, therefore, is to both determine whether a child has been abused and neglected and to immediately begin supporting an environment that promotes child safety. Connecting families to needed supports during the investigation is a necessary step toward keeping the family intact.[22]

  This review found a disconnect between what families need and the services and supports they are provided or successfully linked/referred to during the course of initial CPS contact. Reviewers found that in only one-third of investigations in which community-based service delivery was needed, were families referred to a Healthy Families/Thriving Community Collaborative or other agency for follow-up.

[21] CFSA states that it is only practice to interview medical and educational personnel when related to the allegations. The Monitor asserts that good practice is to interview these collateral contacts in every investigation as they are the providers who know the child and family the best.

[22] CFSA reports they do not connect families with services until a risk assessment has been completed. This practice, which the Monitor thinks is counterproductive and should be changed, may account for the low performance.

- **Family Team Meetings (FTMs) are not routinely held when children are at risk of removal or when children have been removed from their home as a result of an investigation.** There were five investigations in which a child was at risk of removal from his/her home. A Family Team Meeting was held in only one of those instances. Additionally, there were 13 investigations that involved a removal of a child from his/her home. A Family Team Meeting was held for eight of these 13 investigations. Participation in a Family Team Meeting is optional for families but there was no documentation of FTMs being offered and families opting out.

- **The number of investigations not completed within mandated timeframes remains too high.** CFSA has made significant improvements in keeping the backlog of investigations under 40 on a weekly basis, yet 63 (33%) investigations in this review went over the 30 day timeframe. Of the 63 investigations, 41 investigations were closed within 35 days for a total of 88% completed within 35 days.[23] Of the remaining 22 investigations, twenty two investigations were pending for a range of 36 to 60 days and one investigation took over 159 days to complete. Reviewers found documentation to reflect the reason investigations took longer in only 10 of the investigations that were not completed within 30 days.[24]

- **The overall quality of child protective services investigations continues to be uneven.** In the 2006 report, using the same standard of quality as in the current review, about one-third (34%) of investigations were assessed by reviewers to meet quality standards.[25] For this evaluation, reviewers judged less than half (44%) of the investigations to be of good quality. These more recent results reflect continuing concerns about investigations practices.

- **There is insufficient collaboration or consultation between CFSA staff when an in-house transfer is made.** The review found documentation of transfer staffings in less than half (48%) of the cases which were transferred to an ongoing CFSA social worker as a result of the investigation.[26] Investigative and ongoing workers must regularly communicate and share information in order to most successfully initiate work with a

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[23] District of Columbia law requires that a full investigation be completed no more than 30 days after the receipt of the first notice of the suspected abuse or neglect and allows that within 5 business days after the completion of the investigation, the Agency shall complete a final report of its findings. *See,* DC ST § 4-1301.06.

[24] For the 10 investigations in which reasons identified documentation for not closing an investigation within 30 days, reasons included the victim child or family had not yet been interviewed, the investigator was awaiting collateral information from a psychiatrist, the investigator was assisting the family with services prior to transfer. *See,* footnote 10 for information on the Administrative Issuance promulgated on March 7, 2008 (Immediate Requirements for All CPS Investigations), which includes a more expansive list of good faith efforts required to safely close a case when a child or family cannot be located.

[25] In order to rate an investigation "of quality," the reviewer had to agree that all core contacts or good faith efforts were made; all allegations and safety concerns and risks were assessed and addressed; good decision-making based on evidence documented.

[26] Reviewers looked for documentation of transfer staffing in both the investigations record and the ongoing case record. CFSA promulgated an Administrative Issuance on April 17, 2009 (Case Transfers from Child Protective Services).). The Administrative Issuance includes requirements on documentation with regard to case transfer.

family to stabilize the family and protect children and/or to promote successful reunification.

IV. FINDINGS

1. Assessment of Hotline Activities

The Child and Family Services Agency (CFSA) is responsible for receiving and appropriately responding to allegations of child abuse and neglect in the District of Columbia. CFSA policy and the *LaShawn* AIP require CFSA to maintain a 24-hour system for receiving and responding to reports of child abuse and neglect.

This case record review assessed whether CFSA's Hotline staff assigned the appropriate response time (priority level) to the report.

Response Time Assignment

For each report accepted by the CFSA Hotline for investigation, staff complete an electronic form based on information known about the child and family at the time. Results are used by Hotline staff to determine a time by which a social worker must see a child, either immediately or within 24 hours. Reviewers found that the assigned response time was reasonable for the majority (182/96%) of investigations. Reviewers disagreed with the priority assignment for eight (4%) investigations. The primary scenarios for disagreement were of children left without adult supervision.

2. Initiating an Investigation of Child Abuse or Neglect

District of Columbia law and CFSA policy requires CFSA to initiate an investigation within 24 hours of a report of abuse or neglect and more quickly depending on the specific allegation and safety concerns. The *LaShawn* AIP requires that investigations be initiated within 48 hours. An investigation is deemed to be initiated if the investigator has seen and spoken with the child(ren) alleged to have abused/neglected outside the presence of the child's parent(s) or caretaker(s) the investigator has made documented, good faith efforts to see the child, but has been unable to locate the him/her.

According to CFSA policy, in order to have completed good faith efforts to see a child, an investigator must do all of the following within 24 hours:

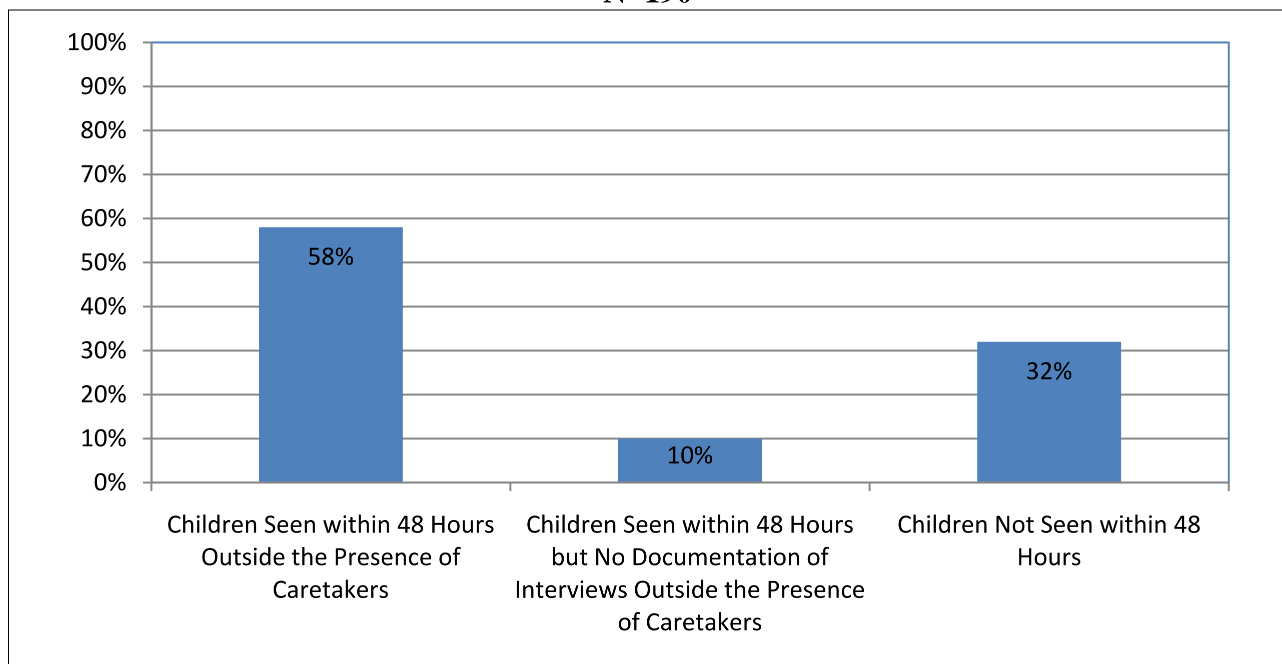
- Leave a notification letter at the home, indicating that a report has been received and requesting contact (for neglect referrals only);
- Conduct a school visit to interview the child, if the child is school age (to the neighborhood school or the school listed in the referral);
- Interview neighbors, the resident manager or landlord to confirm the address or determine the whereabouts of the family;
- Conduct at least two additional home visits at various times; and
- Send a certified letter within 24 hours of the home visits if the family failed to respond (only for neglect reports)[27]

[27] *See*, CFSA Investigations Policy VII Procedure C.12 (September 30, 2003) found at: http://www.cfsa.dc.gov/cfsa/frames.asp?doc=/cfsa/lib/cfsa/policymanualpdffiles/policies/program%20-

Case record reviewers reported the time within which investigations were initiated. If the investigator did not initiate an investigation within 24 hours of the report to the Hotline, reviewers looked for documentation of the required good faith efforts within that timeframe to see children outside of the presence of their parent/caretaker.

In 110 (58%) of the 190 investigations records reviewed, the alleged victim children were seen within 48 hours of the receipt of the report and were seen outside the presence of the caretakers thereby meeting the *LaShawn* AIP interim benchmark for initiating an investigation within 48 hours. There were an additional 20 (10%) investigations in which the children were seen within 48 hours but there is no documentation of whether or not the child was seen outside of the presence of their parent(s) or caretaker. In the remaining 60 (32%) investigations, the children were not seen within 48 hours. Results of the Monitor's 2006 record review indicated that 56% of investigations were initiated within 48 hours of the receipt of the report.

Figure 1: Initiating Investigations within 48 Hours
N=190



Source: CSSP Case Record Review, Winter 2009

In the 60 investigations in which the children were not seen in 48 hours, none included all five good faith efforts required by CFSA policy. For 49 investigations in which the social worker made at least one good faith effort, the most frequent effort was leaving a letter at the family's home indicating that a report had been received and requesting family contact. Other efforts such as visiting the child's school to establish contact, interviewing neighbors or returning to the home at various times were rarely documented.

%20investigation%20%28final%29.pdf. In addition to the policy, CFSA promulgated an Administrative Issuance on March 7, 2008 (Immediate Requirements for All CPS Investigations). The Administrative Issuance includes a more expansive list of good faith efforts required to safely close a case when a child or family cannot be located. This review measured performance against the activities required by the CFSA policy.

3. Assessment of Safety

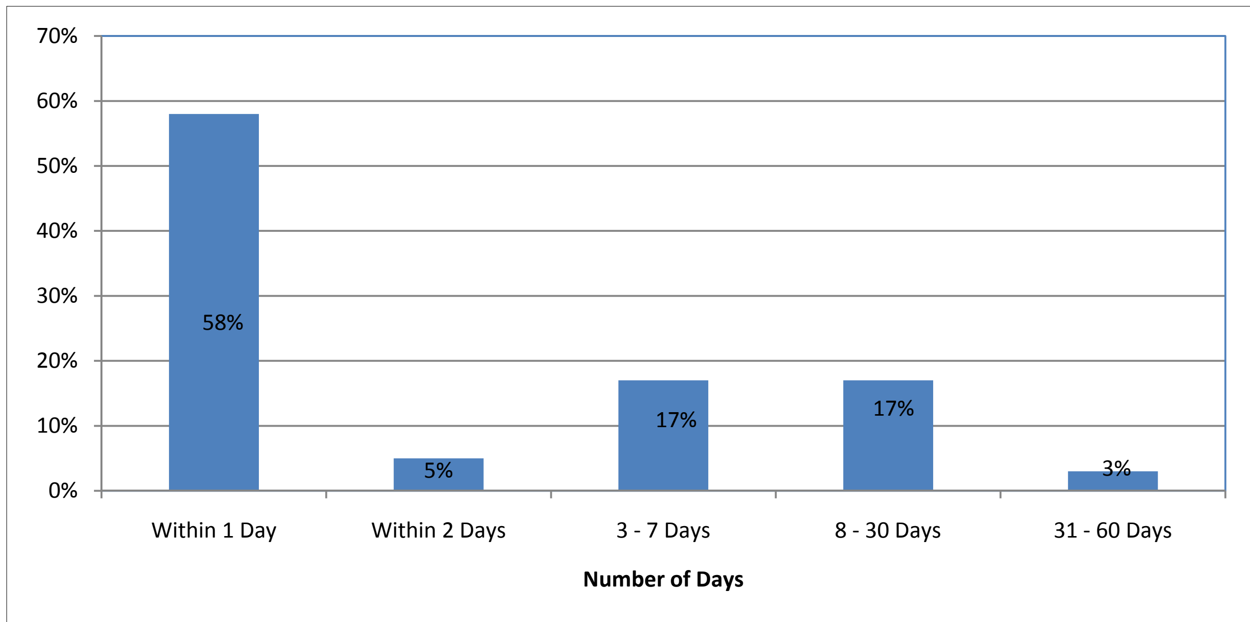
Investigative social workers are required to assess the immediate protection and safety needs of children. According to CFSA policy, the safety assessment tool in FACES is to be completed within 24 hours of face-to-face contact with the alleged victim child(ren) and is to be used to develop interventions to prevent the removal of the child(ren) from their home.

Reviewers assessed the time to completion of the safety assessment, whether the social worker gathered sufficient information to make a safety decision, and if so, determined, based on the documentation, whether or not they agreed with the safety decision. Additionally, reviewers also reported the date of the supervisor's approval of the safety assessment.

Completion of Safety Assessment Tool

The majority (119/63%) of safety assessment tools were completed in FACES within 48 hours of the date of the report to the Hotline.[28] In the remaining 70 (37%) investigations, safety assessments were completed, but after 48 hours of the receipt of the report.[29]

Figure 2: Time to Completion of Safety Assessment from Date of Report to Hotline N = 189[30]



Source: CSSP Case Record Review, Winter 2009

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[28] There was one investigation in the sample for which a safety assessment was not completed in FACES.

[29] According to CFSA policy, the investigator has 24 hours to complete a safety assessment after the child(ren) has been seen. Because District law requires children to be seen within 24 hours, this review used a 48 hour standard for assessing performance with completion of the safety assessment.

[30] There was one investigation in the sample for which a safety assessment was not completed in FACES. According to CFSA policy, the investigator has 24 hours to complete a safety assessment after the child(ren) has been seen. Because District law requires children to be seen within 24 hours, this review used a 48 hour standard for assessing performance with completion of the safety assessment.

Information Used for Safety Assessment

The investigator completes the safety assessment in FACES by indicating whether there is either credible information or no credible information for each of 20 signs of present danger. Additionally, for 14 signs of protective capacities of the caretaker, the social worker must also indicate whether each is a strength, need or unknown. The social worker then selects one of five possible safety decisions for each child in the household.

The CPS social work supervisor is required to review each of the factors in the safety assessment for accuracy and appropriateness and inform the social worker of any needed changes and the rationale for the changes.

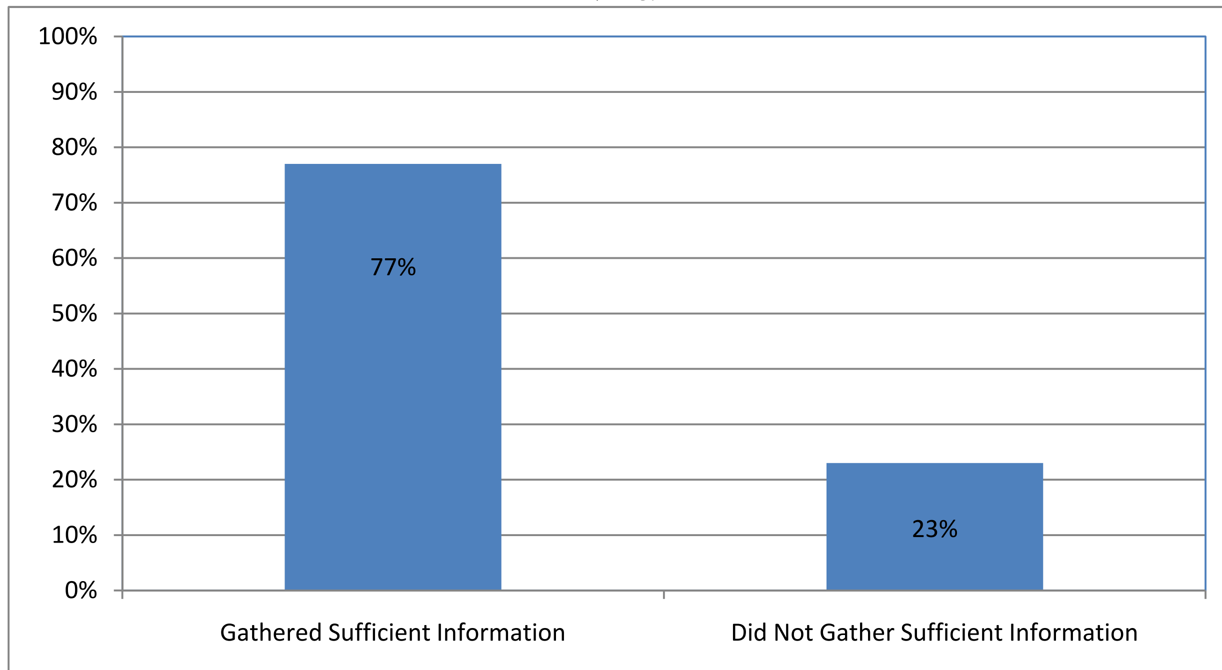
Reviewers were asked to assess whether sufficient information was gathered to make a safety determination. Of the 189 safety assessments completed, reviewers determined the investigator gathered sufficient information to make a safety determination in 146 (77%) investigations.[31] For the 43 investigations for which reviewers did not determine sufficient information was gathered, reviewers were asked to comment on why they determined insufficient information was gathered.

The following are examples of reviewer comments when the reviewer determined insufficient information was gathered:

- *The worker did not make contact with all the children until after the safety assessment was completed.*
- *When the safety assessment was completed the social worker had only made a telephone contact with the mother; there were no face-to-face interviews or home assessment conducted therefore insufficient information was gathered*
- *The safety decision did not document critical sources of information and appears to be based only on interviews with the 20 year old mother (alleged perpetrator) and maternal grandmother (alleged caregiver of both the mother and victim child); the reporter (mother's probation officer) was not contacted until 24 days after the safety decision was made.*
- *The investigator had not spoken to two of the children and notes this in the safety assessment. Without speaking to them, it's impossible to assess their safety.*

[31] There was one investigation in the sample for which a safety assessment was not completed in FACES.

Figure 3: Reviewer Assessment on whether Sufficient Information was Gathered for Safety Assessment
N=189



Source: CSSP Case Record Review, Winter 2009

Reviewers were also asked to judge whether, based on the documentation, they agreed with the safety assessment. Reviewers indicated agreeing with the safety decision in 135 (92%) of 146 investigations. For the remaining 11 investigations, reviewers were asked to comment on why they disagreed with the safety decision.

The predominate reason cited when reviewers disagreed with the safety decision related to children or caretakers not being seen before the completion of the assessment. The following are examples of reviewer comments when the reviewer disagreed with the safety decision:

- *The investigator did not initially see 3 of the 4 children until 7 days after the safety assessment was completed. In this reviewer's opinion, it's impossible to assess the safety of the children without having seen them. While the investigator indicates that she was unable to see the other 3 children prior to completing the safety assessment, there is no indication that she updates the safety assessment after seeing them.*
- *When the safety decision was complete, 3 of the siblings (ages 12, 8 and 7) had not been interviewed; therefore, safety and risk could not be adequately assessed.*
- *The safety assessment indicates that there is one or more sign of present danger. This referral is about a family with an infant on a breathing tube. The nurse who provides 12 hours per day care noticed that the infant had bed bug bites. By the time CPS investigates, the family has requested a new apartment and gotten rid of all of the mattresses. Additionally the family is living at a motel until they can be placed into a new*

apartment. It is unclear to this reviewer what the signs of present danger are and the worker does not present them in the narrative.

- *At the point of the safety assessment, the 16 year old child is living in the home of his girlfriend and her family. The investigator does not go out to the girlfriend's home to determine if it's safe, nor does she talk to the parents to see if it's ok that the child remain in their home and that he will be provided for.*

4. Collateral Investigation Contacts[32]

CFSA's Investigations policy requires that various collateral contacts occur during each investigation. In order to assess CFSA's practice with interviewing collateral contacts, reviewers focused on the following requirements:

- contact with the reporting source to obtain additional information and determine if the child is in imminent danger of serious harm;
- face-to-face contact with all persons in the report and household including parents, caregivers, and children (children are to be interviewed outside the presence of their parent or caretaker);[33]
- contact with daycare personnel, pre-school or school staff, including the child's teacher, school nurse, or social worker;
- contact with the medical provider to obtain medical information regarding current and historical information for the child (which may require an authorization);
- contact with relatives or neighbors when evidence indicates that they may have information pertinent to the investigation;
- contact with any community social service provider known to be providing services to the family within the past 12 months

Other Children in the Household

A CFSA Hotline worker may determine that there are other children residing in a family but for many reasons, these other children may not be alleged victims. That information should be updated in the case record by the investigative social worker as needed. There were other children in the household besides the alleged victim children in 67 of the investigation records reviewed in the 2006 report. All children were seen in 57 (85%) of those investigations.[34] For this review, there were other children in the household besides the alleged victim children in 78 investigations. All children were seen in 69 (88%) investigations.

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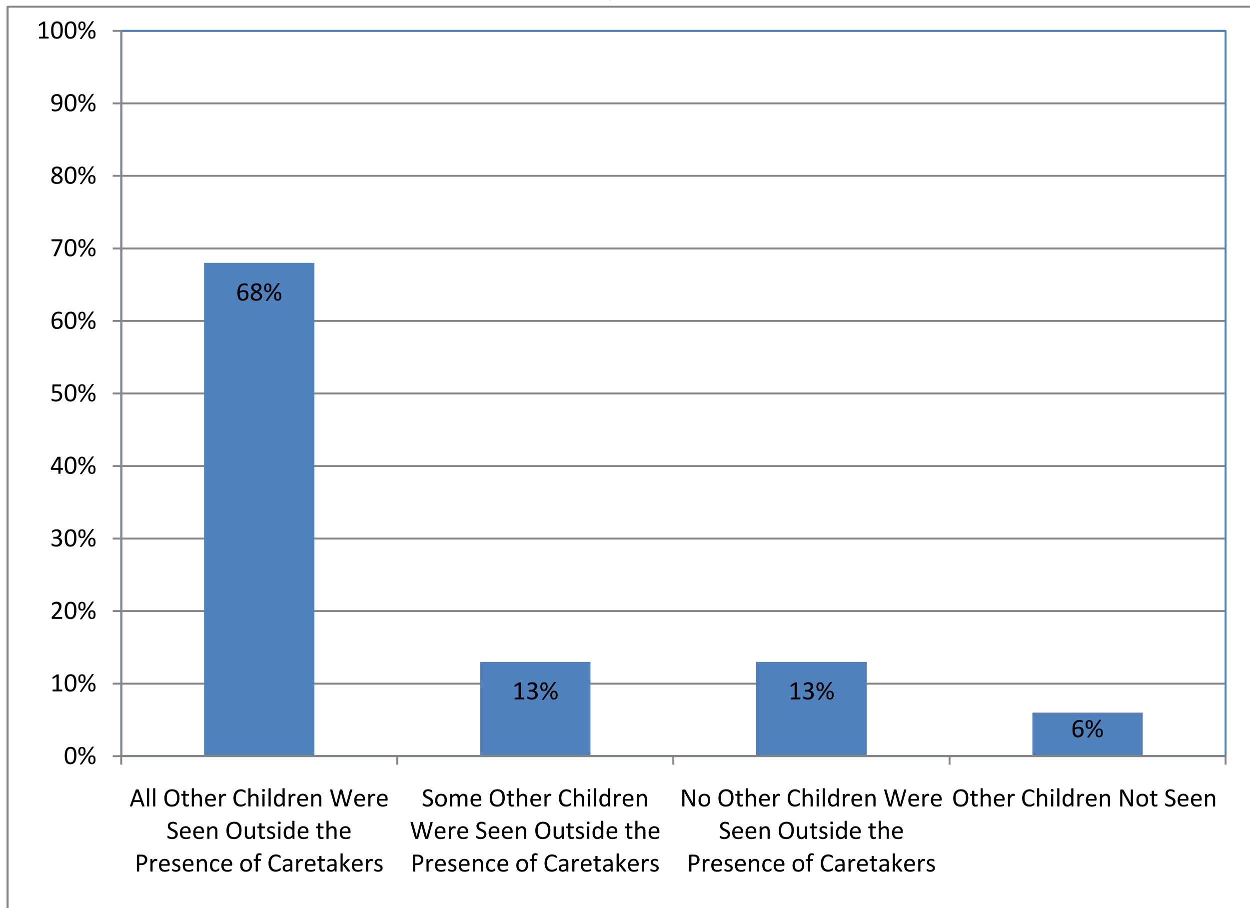
[32] CFSA has defined five core contacts that are included in the full range of collateral contacts. The standards for the five core contacts are: 1.) initial 24-hour face-to-face contact is held with alleged victim; 2.) face-to-face interview is conducted with alleged maltreater; 3.) contact with the reporting source; 4.) contact with the medical and educational providers; and 5.) all household members must be interviewed.

[33] Although policy requires individual, face-to-face interviews with each caretaker and household member within 24 hours of the receipt of the report, this review only assessed whether the alleged victim(s) and other children in the household were interviewed face-to-face within 48 hours, as required by *LaShawn*.

[34] *An Assessment of the Quality of Child Protective Services Investigations in the District of Columbia*, Washington, DC: Center for the Study of Social Policy, February 7, 2006. Found at: http://www.cssp.org/uploadFiles/An_Asmt_of_Quality_of_Child_Prot_Svcs_Invest_in_DC_Feb_10_2006.pdf.

In this review, there were 78 investigations with other children in the household who were not alleged victim children. In 53 (68%) of the 78 investigations, the social worker noted a face-to-face interview outside the presence of the caretakers, parents or caregivers with all other children in the household. In 10 (13%) investigations, reviewers noted this activity for only some of the other children in the household and in 10 (13%) investigations, none of the other children in the household were interviewed outside the presence of the caretakers, parents or caregivers. In the remaining five (6%) investigations, the other children in the household were not seen at all.

Figure 4: Face-to-Face Interviews with Other Children in the Household[35]
N=78



Source: CSSP Case Record Review, Winter 2009

[35] Outside the Presence of the Caretaker

Alleged Perpetrators

In 188 (99%) of the 190 investigations reviewed, an alleged perpetrator was identified. In 172 (92%) of the 188 applicable investigations, the investigator conducted a face-to-face interview with all of the alleged perpetrators. In half (8 of 16) of the remaining investigations, some of the alleged perpetrators were interviewed and in the other eight, none of the alleged perpetrators were interviewed. For these 16 investigations in which only some of the alleged perpetrators or none of the alleged perpetrators were interviewed, reviewers found documentation of efforts to contact them in six (3%) investigations. There were no efforts to contact the alleged perpetrator in 10 (5%) investigations.

Other Adults in the Home

The investigator had face-to-face contact with all other adults in the home in 46 (64%) of the 72 investigations in which there were other adults in the family's home. There was face-to-face contact with some other adults in 7 (10%) of the investigations. In 19 (26%) investigations there were no interviews with other adults in the family's home.

For the 26 investigations in which some or none of the other adults in the home were interviewed, the investigator made efforts to contact the other adults in 4 (15%) investigations. There were no efforts found in 22 (85%) of the 26 investigations.

Reporting Source

There were 166 investigations in which a reporting source was identified. The investigator spoke with the reporting source in a majority (81%) of the investigations and attempted to reach the source of the report in an additional 16% of investigation.

Collaterals

The social worker should contact persons involved with the family who may be able to inform the investigation and/or speak to the child or parent's functioning. Table 1 shows the number of applicable collaterals across investigations as well as contacts made or attempted contacts by the social worker. As shown by the data, the extent of collateral contacts varies considerably.

Table 1: Interviews with Collaterals Applicable in an Investigation[36]

Collateral	Contact Made	Contact Attempted	No Contact or Attempt
Law Enforcement	68%	22%	10%
Family Friend	58%		42%
Relatives	43%	5%	52%
Other (e.g. probation officer, additional relatives, medical professionals, school personnel other than teachers)[37]	41%	2%	57%
Neighbor	26%	3%	71%
Teacher or Child Care Provider	25%	2%	73%
Mental Health Professional	25%	5%	70%
Substance Abuse Treatment Provider	9%	N/A	91%

Source: CSSP Case Record Review, Winter 2009

5. Involvement of the Metropolitan Police Department (MPD) and the Child Advocacy Center (CAC) in Relevant Investigations

According to CFSA's policy and a Memorandum of Understanding (MOU) with MPD's Youth Division (MPD YD), CFSA and MPD YD are to conduct a joint investigation for all sexual abuse cases and cases of serious physical abuse.

CFSA policy also requires that for sexual abuse or serious physical abuse investigations, a forensic interview is to be requested at the CAC.[38] Contact with the CAC is initiated by MPD YD, giving CFSA little direct control over which investigations are referred for a forensic interview.

The reviewers assessed whether there was documentation that officers from the District's Metropolitan Police Department – Youth Division (MPD-YD) were involved in investigation of

[36] Depending on the nature of the investigation, different collateral contacts would be required; therefore not all collateral contact categories would be required in every investigation. The percentages in this table are for the investigations in which the particular contact was applicable.

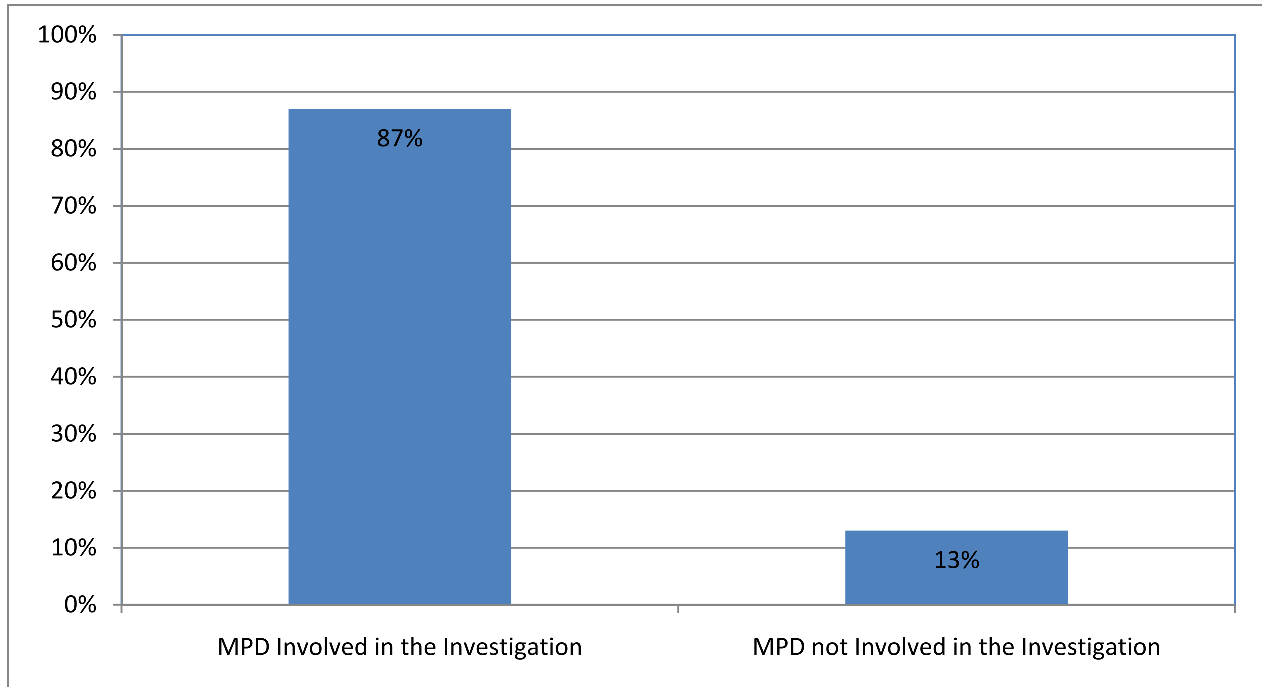
[37] There were 88 investigations for which at least one other person was identified as a collateral that the investigator either contacted, attempted to contact or did not contact. Thirty-two of the 88 investigations had an additional person identified as a collateral contact. For those 32 investigations, the additional collateral was contacted in 41% of investigations. In 3% of those 32 investigations, the investigator attempted to contact the additional collateral and in 56% the collateral was not contacted.

[38] *See*, CFSA Investigations Policy VII Procedure D (September 30, 2003) found at: http://www.cfsa.dc.gov/cfsa/frames.asp?doc=/cfsa/lib/cfsa/policymanualpdffiles/policies/program%20-%20investigation%20%28final%29.pdf.

allegations of serious physical or sexual abuse and whether children were interviewed at the Child Advocacy Center (CAC) when needed.

Thirty of the 190 investigations reviewed included allegations of serious physical or sexual abuse of a child. There was evidence of MPD-YD involvement in 26 (87%) of the 30 applicable investigations.[39]

Figure 5: MPD Involvement in Investigations of Serious Physical or Sexual Abuse N=30

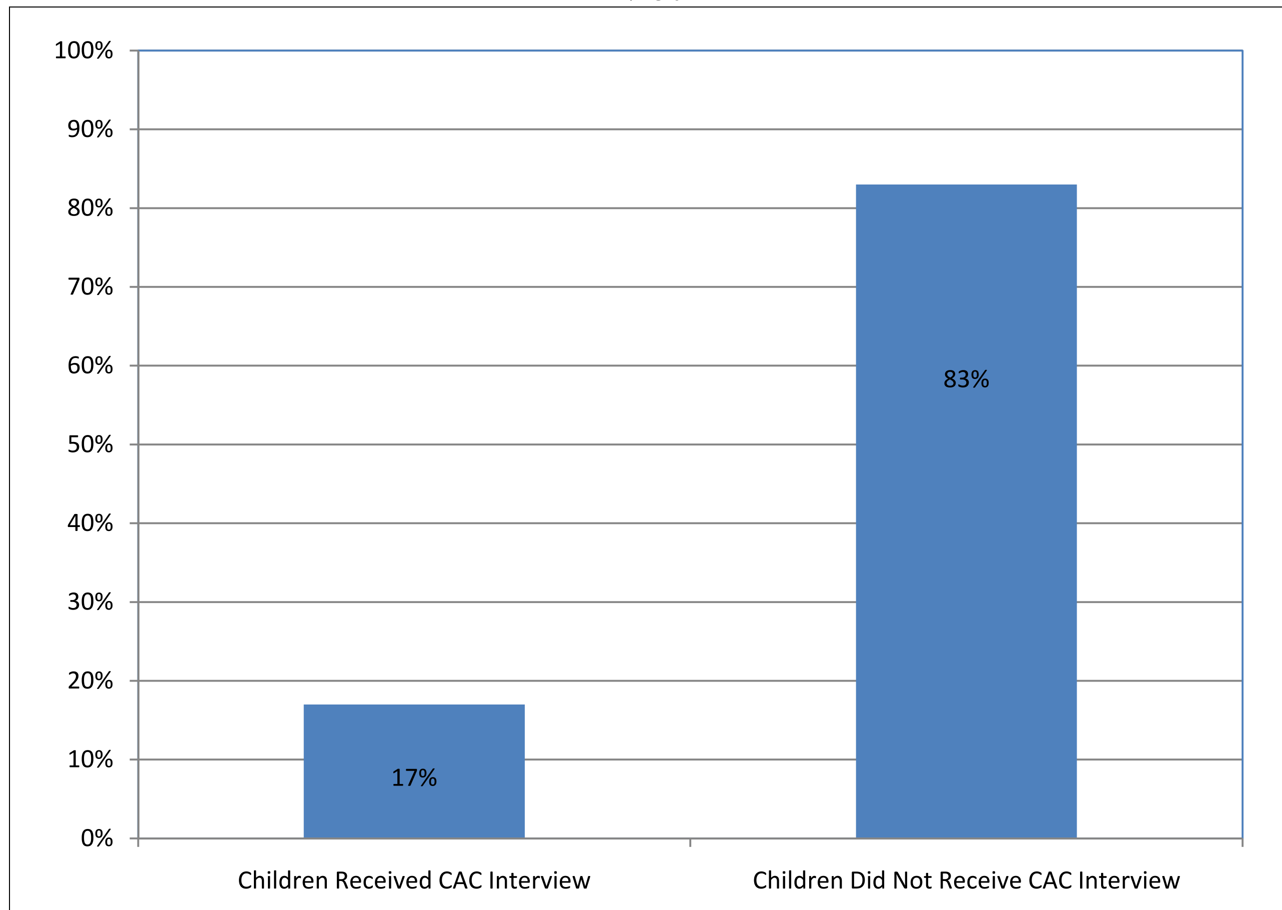


Source: CSSP Case Record Review, Winter 2009

Of these 30 investigations, five (17%) included a CAC interview for all of the children needing to be interviewed based on CFSA policy. In the remaining 25 (83%) investigations, none of the children were taken to the CAC interview.

[39] This review did not collect information as to why MPD was not involved with the four remaining investigations.

Figure 6: Child Advocacy Center Involvement in Investigations of Serious Physical or Sexual Abuse
N=30



Source: CSSP Case Record Review, Winter 2009

6. Information Gathering from Medical and Educational Professionals

Gathering Medical and Educational Information

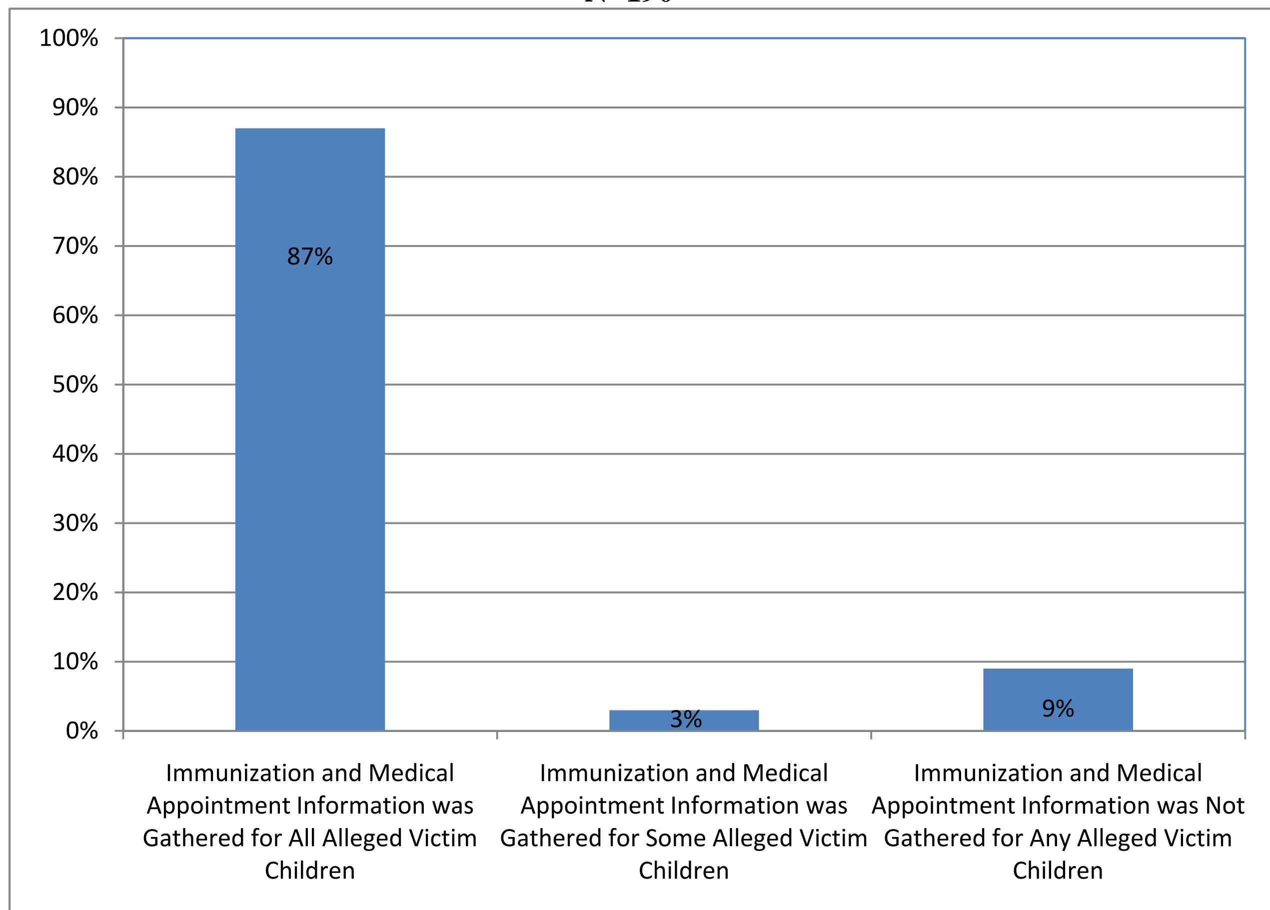
Reviewers assessed the medical and educational information gathered during investigations. In addition to looking for whether there was information about the alleged victim child(ren)'s immunization history, for those investigations involving allegations of medical neglect, reviewers assessed whether the investigator or a CFSA nurse gathered information from the medical provider to address the allegations or to determine whether the child(ren)'s medical needs were being met and to asses safety, risk and well-being. Reviewers did the same for the alleged (victim) child(ren)'s education, looking for attendance information and whether social workers asked school/daycare providers for information to assess safety, risk and well-being.

In addition to notes on school attendance, reviewers looked for information gathered from school personnel to address the allegations and/or assess whether child(ren)'s educational, safety, risk and well-being needs were being met.

➢ *Medical Information*

In 166 (87%) of the 190 investigations reviewed, reviewers found evidence that the investigator gathered appointment and/or immunization history for all alleged victim children. In an additional six (3%) investigations, appointment and/or immunization history was gathered for only some alleged victims. Appointment and/or immunization history was not gathered for the alleged victim in 18 (9%) investigations. See Figure 6 below.

Figure 7: Gathering Immunization and Medical Appointment Information during an Investigation
N=190

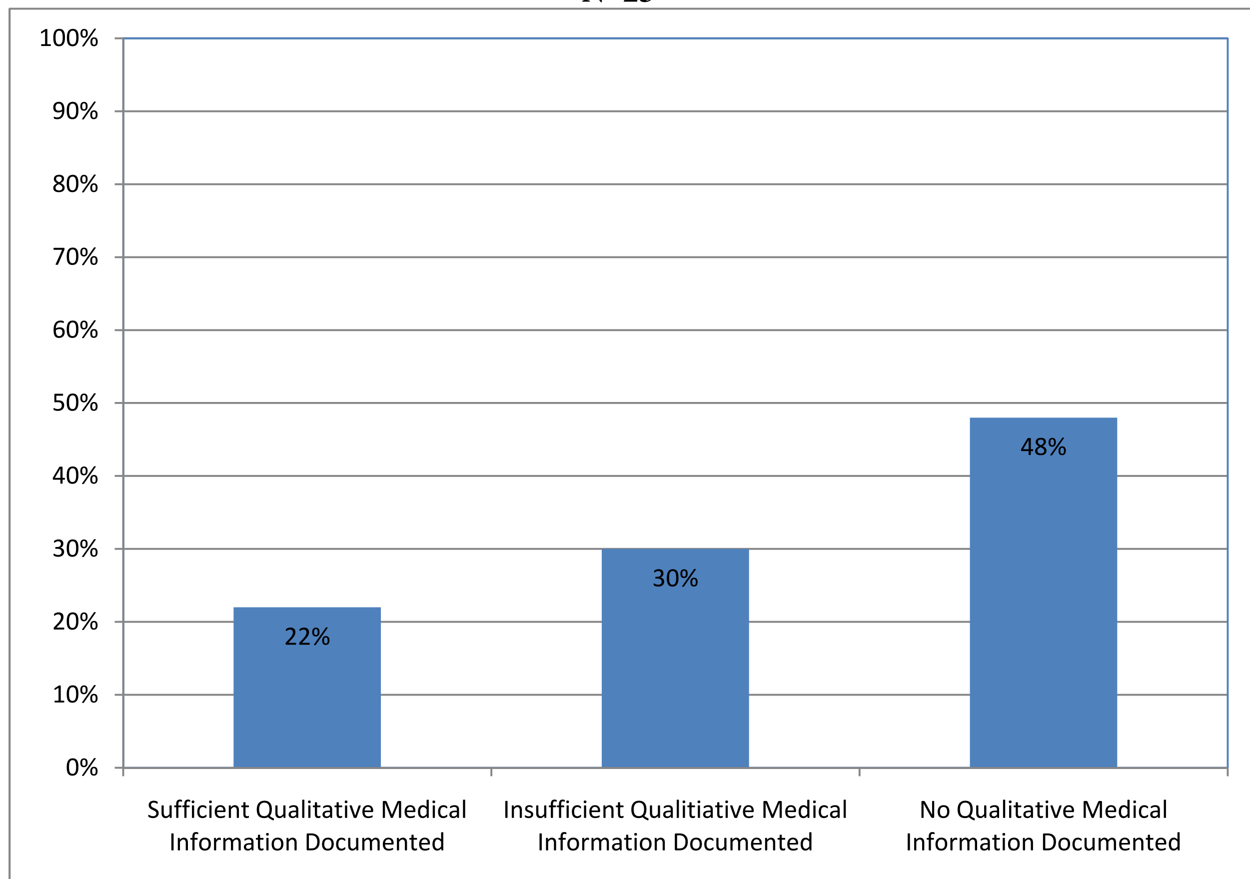


Source: CSSP Case Record Review, Winter 2009

Of the 190 investigations reviewed, there were 23 which involved allegations of medical neglect. Reviewers found that in five of those 23 (22%) investigations, the social worker and/or CFSA nurse documented gathering information on whether the child or family needed help in meeting the child's medical needs. In seven (30%) investigations, reviewers found that contact with the

medical provider was made, but that the documented information was insufficient to assess whether or not the child's needs were being met.

Figure 8: Gathering Qualitative Medical Information during an Investigation of Medical Neglect
N=23[40]



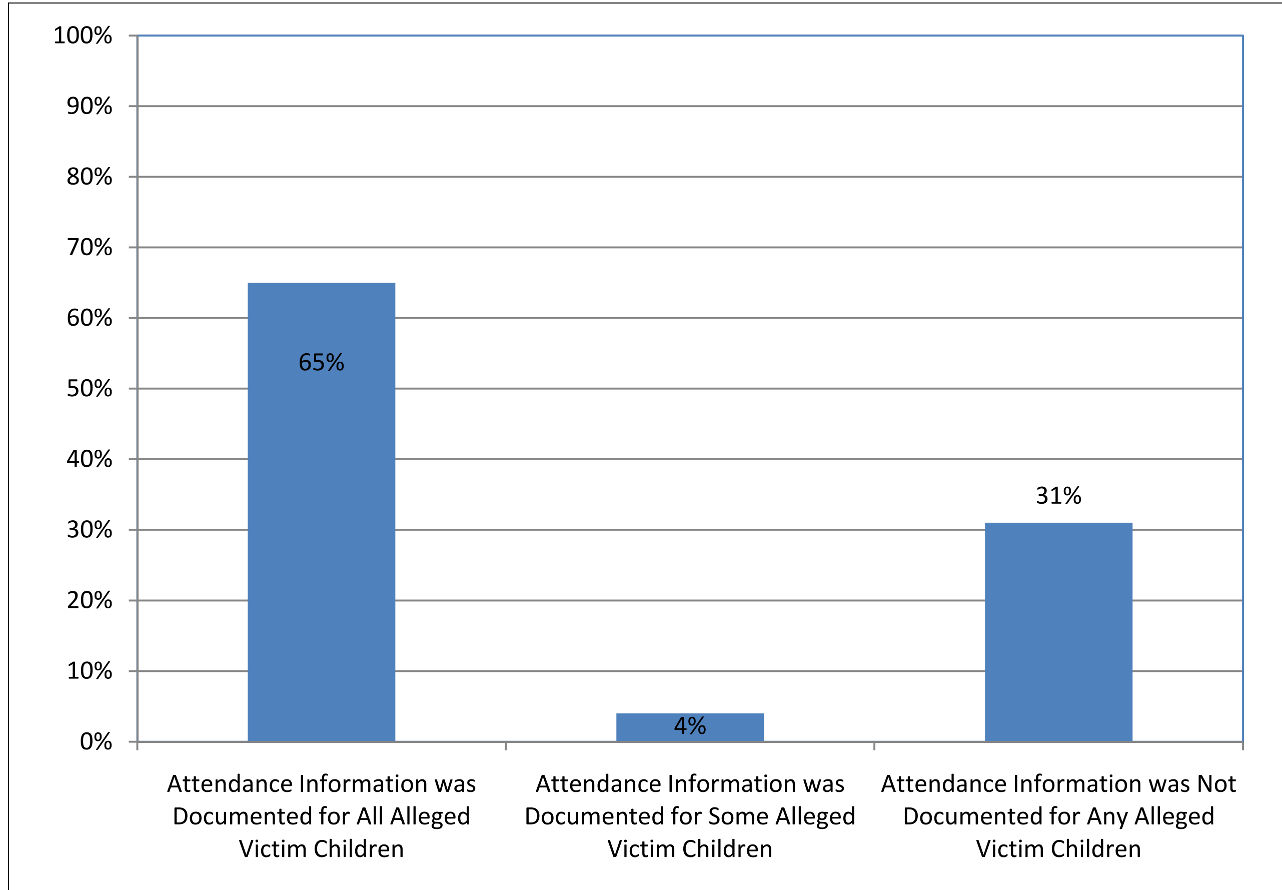
Source: CSSP Case Record Review, Winter 2009

➢ *Educational Information*

Of the 190 investigations reviewed, there were 155 which included (alleged victim) children who were school age or enrolled in daycare. For 101 (65%) of those 155 investigations, the social worker gathered basic attendance information for all victim children. In an additional six (4%) investigations, the social worker gathered attendance information for only some victim children. In 48 (31%) investigations, the social worker gathered no information regarding school/daycare attendance.

[40] This question was only answered for cases of medical neglect.

Figure 9: Gathering Attendance Information from School/Daycare Personnel
N=155

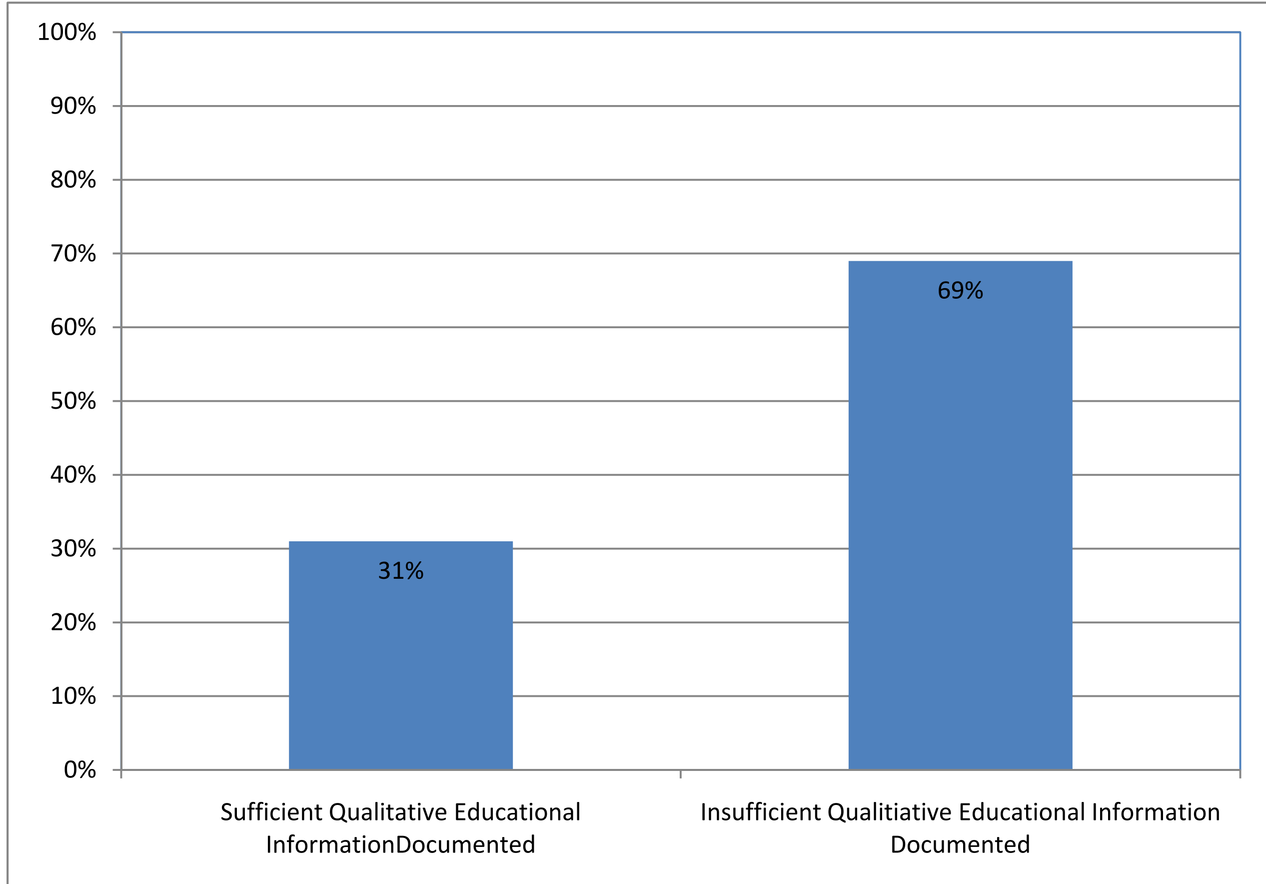


Source: CSSP Case Record Review, Winter 2009

As noted above, for the 155 applicable investigations, there were 107 (69%) in which the social worker gathered school or daycare attendance information for some or all (victim) children. For these 107 investigations, reviewers were then asked to assess whether or not the social worker went beyond attendance data to elicit information about the allegations and/or assess the child's education status, safety and risk issues as well as overall well-being.

Reviewers found that in 33 (31%) of the 107 investigations, investigators gathered sufficient information from school personnel or day care providers to inform an assessment. In an additional 74 (69%) investigations, reviewers found social workers made contact with educational personnel, but that insufficient information was gathered or that the information documented was not sufficient to assess particular status questions and needs.

Figure 10: Gathering Qualitative Information from School/Daycare Personnel N=107



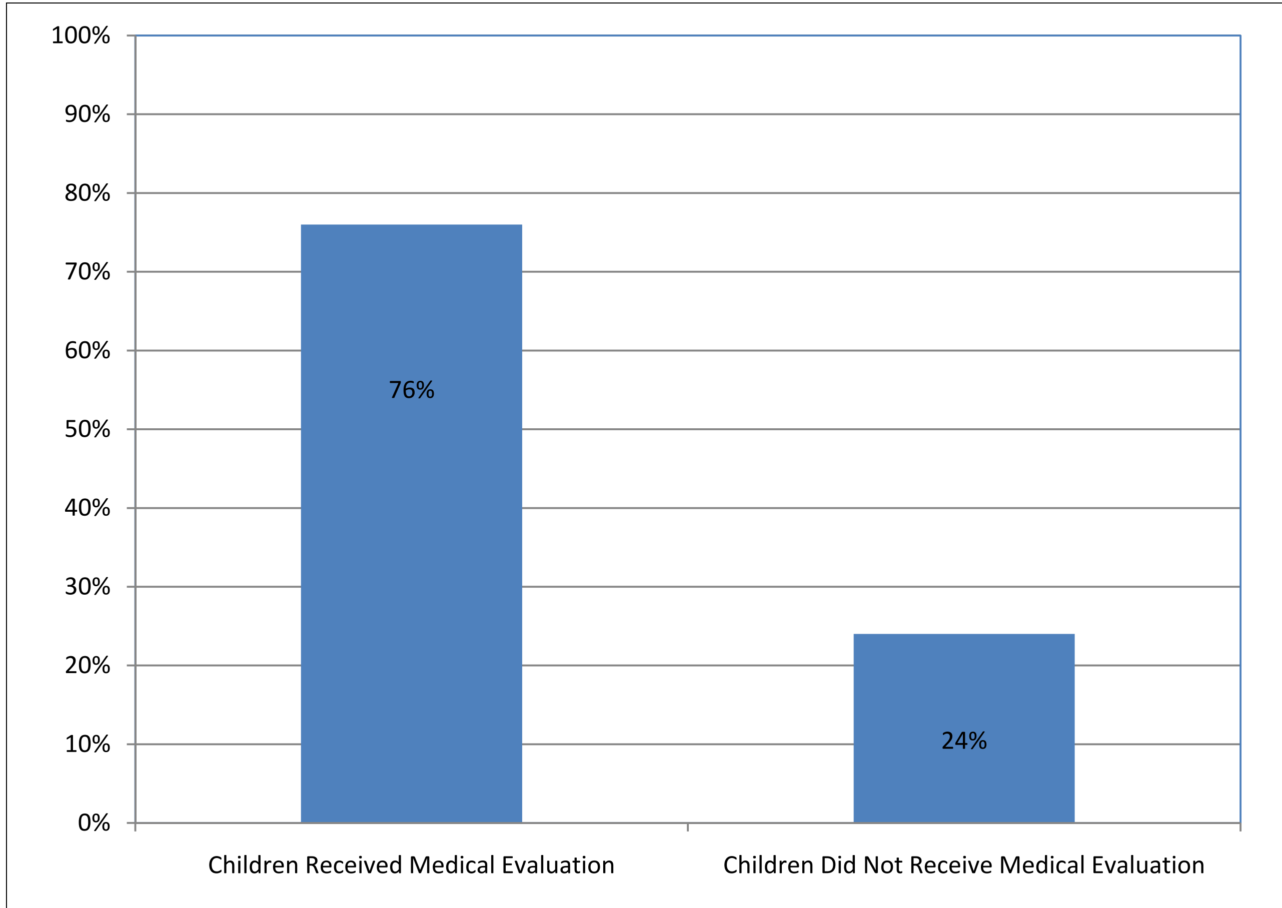
Source: CSSP Case Record Review, Winter 2009

➢ *Medical and Mental Health Evaluations*

CFSA policy and the *LaShawn* AIP require appropriate medical and mental health evaluations of children as part of the investigation of abuse or neglect in cases where it is determined that such evaluations are necessary.

Of the 190 investigations, reviewers determined that a medical evaluation was necessary in 29 investigations. In 22 (76%) of those investigations, all of the children identified as needing a medical evaluation received one. There were seven (24%) investigations in which none of the children received the needed medical evaluation.

Figure 11: Needed Medical Evaluations during an Investigation
N=29[41]

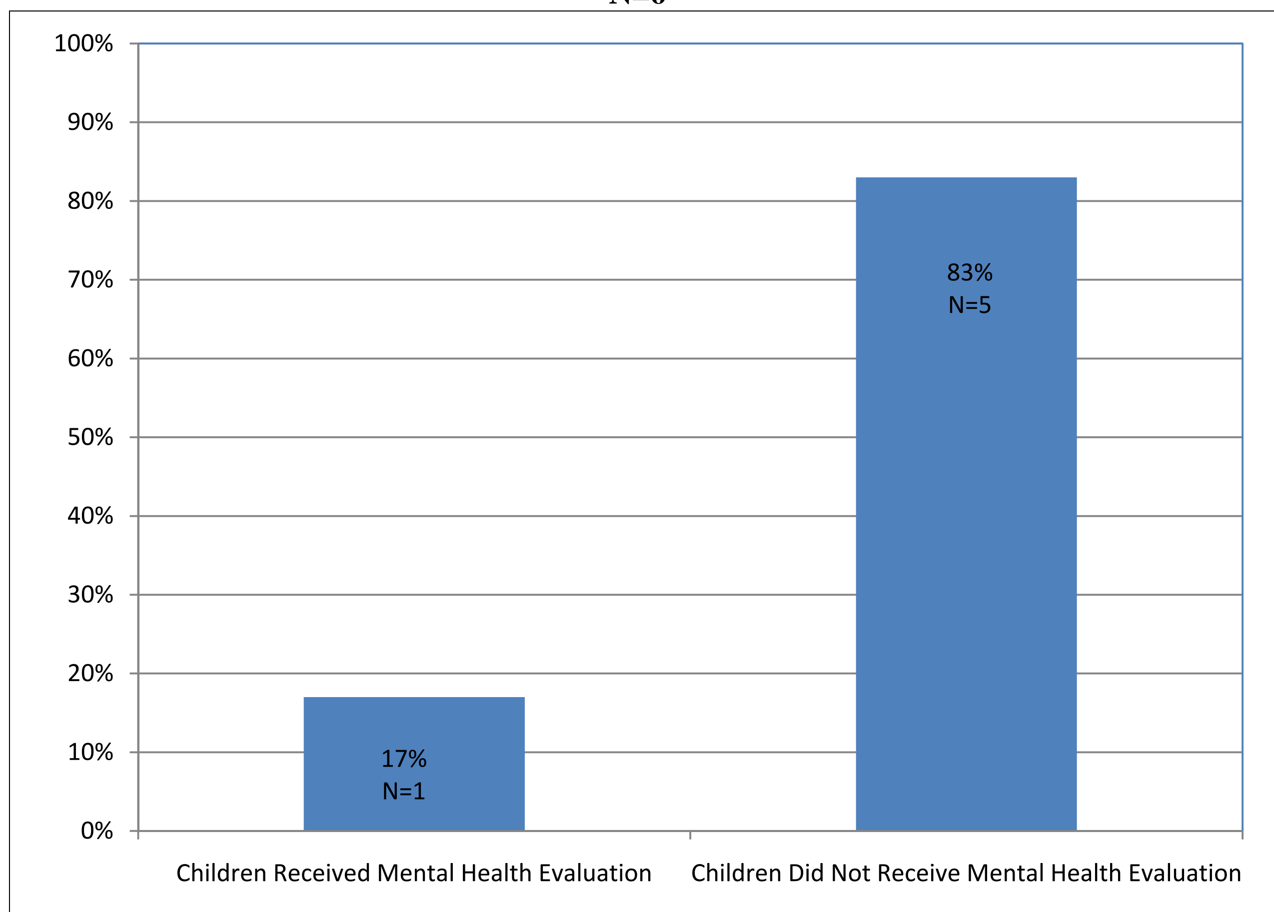


Source: CSSP Case Record Review, Winter 2009

Of the 190 investigations, there were six in which reviewers determined that a mental health evaluation should have been secured. In only one of the six investigations did all of the children requiring a mental health evaluation receive a mental health evaluation.

[41] There were only 29 investigations for which reviewers determined medical evaluations were needed.

Figure 12: Mental Health Evaluations during an Investigation
N=6[42]



Source: CSSP Case Record Review, Winter 2009

7. Assessment of Risk

Gathering Information to Inform Risk Assessment

Investigative social workers are expected to gather a range of information to understand and address risk of harm to children. While social workers and their supervisors use their professional judgment when conducting investigations, for the most part, decision-making regarding risk of harm is determined by CFSA's Structured Decision Making® Initial Risk tool. The tool requires information such as whether the family has been previously reported to CFSA, substance abuse and domestic violence history of caretakers, their response to the investigation, and demographic data, such as the age of the primary caretaker and the number and ages of children in the home. This information is relied upon to determine risk of harm to children and to make decisions on whether or not the case will be transferred to an ongoing CFSA social worker.

[42] There were only six investigations for which reviewers determined mental health evaluations were needed.

Circumstances deemed to place the family in the moderate, high or intensive risk categories as transferred for supervision and case management.[43]

Reviewers were asked whether the social worker gathered sufficient information to complete the risk assessment. Reviewers determined that the social worker gathered sufficient information to, at minimum, complete the risk assessment form for 166 (87%) of 186 investigations.[44]

Reviewers were asked to comment when they believed that the documented information was insufficient to complete the risk assessment. In many instances, the reviewer commented that the social worker had not spoken to key individuals prior to completion of the risk assessment. The following are examples of reviewer comments:

- *Other interviews needed to be conducted.*
- *It appears that the risk assessment was completed prior to the worker interviewing anyone associated with this case, including the mother/perpetrator and victim child. The record does not document the worker actually interviewing the reporter and the neighbor who was involved in this situation. It also does not document efforts to interview contact with other collateral contacts.*
- *Sufficient information on current and past medical history is not documented on the victim and siblings. Additionally school information was only obtained from STARS related to absence on the 12 year old sibling. There was no contact with teachers or other school personnel related to academic progress and other relevant concerns. There was also no contact with the youngest siblings' day care provider.*

Reviewers also found that the social worker's responses on the risk assessment form were reflective of the documented information for 114 of 190 (60%) investigations. In an additional 49 (26%) investigations, reviewers determined that the risk assessment responses were only partially reflective of the information gathered during the investigation. In three (2%) investigations reviewers concluded the risk assessment responses were not reflective of the information gathered during the investigation.

Reviewers were also asked to comment on why they believed the responses on the risk assessment form were only partially reflective of the information documented in the investigation. Comments involved not accurately reflecting families' prior history with the agency or not accounting for a secondary caretaker in the home. The following are examples of reviewer comments:

- *The risk assessment says that the family has not previously received services, this is not true. The family had an open case with CFSA.*
- *The worker stated no secondary caretaker but there are fathers that are involved in their children's lives and a godmother who was caring for one of the alleged victim children.*

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[43] Social Work supervisors may elevate but not reduce risk of harm level determined by the responses to SDM® questions.
[44] Of the 190 investigations reviewed, there were four investigations for which a risk assessment was not completed.

- *The family is currently transient, yet in the risk assessment the box is checked indicating that the family has housing which is physically safe.*
- *The risk assessment has checked that the primary caretaker has no past or current mental health problems. The mother admits to being diagnosed and receiving treatment for depression.*

Overall Risk Assessment Ratings

There were 186 investigations for which a risk assessment form was completed and a final overall risk rating assigned. Based on a family's circumstances a rating of low, moderate, high, or intensive risk of harm is assigned. Table 2 below details the breakdown of the overall risk determined by the social worker's responses on the form.

Table 2: Overall Final Risk Rating
N=186[45]

Rating	Number and Percent of Investigations
Low	29 (16%)
Moderate	84 (45%)
High	64 (34%)
Intensive	9 (5%)
Total	186 (100%)

Source: CSSP Case Record Review, Winter 2009

8. Connection to CFSA On-Going Services and the Collaboratives or Other Community-Based Service Providers

CFSA uses a Structured Decision Making® (SDM) Initial Risk Assessment form developed in consultation with the Children's Research Center.[46] It is the practice and policy of CFSA, consistent with recommendations from the Children's Research Center, to make decisions on next steps with the family based on the SDM risk rating as opposed to whether or not allegations are substantiated.

For each of the risk rating levels (low, moderate, high, intensive) unless CFSA petitions the family court based on a substantiated allegation and gains an order for the parent/caretaker to participate in on-going CFSA or community-based services, participation is voluntary. The

[45] Of the 190 investigations reviewed, there were four investigations for which a risk assessment was not completed.
[46] The Children's Research Center (CRC) was established to help federal, state, and local child welfare agencies reduce child abuse and neglect by developing case management systems and conducting research that improves service delivery to children and families. The CRC works with state and county agencies to implement Structured Decision Making® (SDM) systems to provide workers with simple, objective, and reliable tools with which to make the best possible decisions for individual cases, and to provide managers with information for improved planning, evaluation, and resource allocation. For more information, see: http://www.nccd-crc.org/crc/crc/c_index_main.html.

family must consent to services. CFSA policy and the LaShawn AIP require that families who have been the subject of a report of abuse and/or neglect that is determined to be low or moderate risk and needing additional supports shall be referred to an appropriate Collaborative or community agency for services and supports. Additionally, by CFSA policy, families with high or intensive risk ratings are transferred to ongoing services at CFSA.[47]

Referrals to the Collaboratives for Low or Moderate Risk Cases

The interim benchmark of the LaShawn AIP requires that 70 percent of families who have been the subject of a report of abuse and/or neglect that is determined to be low or moderate risk and needing additional supports be referred to an appropriate Collaborative or community agency for services and supports.[48]

Risk assessments were included in 186 of the records reviewed. There were 113 investigations applicable to this measure, with a risk rating of low or moderate. Of these 113 investigations, reviewers found 56 investigations did not require a referral for intervention. In 19 (33%) of the remaining 57 investigations, the investigator made a referral to the appropriate Collaborative. For 38 (67%) of the applicable investigations the investigator did not make the required referral. This level of performance does not meet the interim benchmark. Opportunities may be missed to improve family functioning and to serve in preventive capacity, perhaps preventing another instance of involvement with CFSA.

Referral for On-Going Services for High or Intensive Risk Cases

Some families whose circumstances are deemed to be of high or intensive risk of future abuse or neglect may already be receiving CFSA services, either through an in-home or foster care case. In those instances, an investigative social worker should be consulting with their peer during the investigation and ensuring that the investigation record is linked electronically with the already open case. As previously stated, for other families, unless CFSA finds it necessary to gain a court order for in-home services or remove a child to ensure child safety, the parent's or caretaker's consent to receiving services is required.

Of the 186 investigations for which a risk assessment was complete, there were nine with a risk rating of intensive. In all nine investigations, either a child(ren) was removed from home, the family was already involved with CFSA or a private child placement agency, or the family was referred to and consented to being involved with a CFSA in-home services unit.

Of the 186 investigations for which a risk assessment was completed, there were 64 with a risk rating of "high." In 43 of the 64 investigations, the family's case was linked to an already open case or the family was referred and consented to being involved with a CFSA in-home services unit. For the remaining 21 investigations, the Monitor performed a secondary analysis and agreed with the decision not to refer the family for on-going services for 19 investigations. In those instances, families either declined services, requested a referral to a Collaborative, or there

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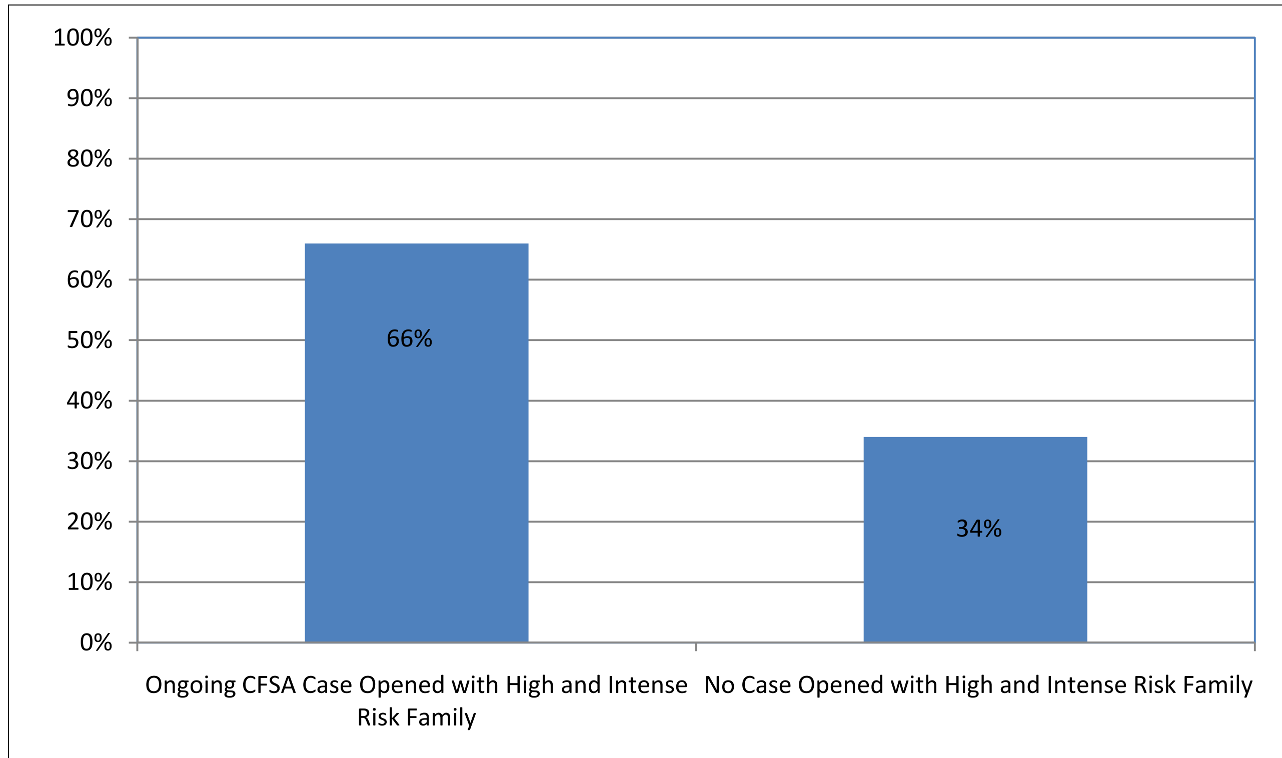
[47] If an investigation is "unfounded" or "inconclusive" with a high or intensive risk rating, the family must consent to opening an ongoing case with CFSA. *See*, the Administrative Issuance promulgated on June 8, 2009 (Service Referrals for High and Intensive Risk Families with Unfounded or Inconclusive Allegations).

[48] CFSA uses the SDM initial risk assessment tool to make these determinations.

was no need for intervention. For two of the investigations, documentation indicates the records will be "linked" in FACES, but the link in FACES did not occur.[49]

Figure 13: Referral for On-Going Services for High or Intensive Risk Cases
N=73



Source: CSSP Case Record Review, Winter 2009

Immediate Service Needs During an Investigation and Referrals for Services

Reviewers assessed whether the families presented immediate service needs during the investigation and whether the investigator referred the family for services or whether the family was already involved with the needed service provider(s). In addition to identifying service needs that were explicitly documented by the investigator, reviewers also independently judged what immediate service needs the family presented based on the case record documentation. Table 3 describes the referral patterns, whether the family was already receiving the needed service prior to or as a result of the investigation and the identified service needs for which families were not already receiving services or were not referred to services by the investigator. Overall, data

[49] In one of the cases, it was not appropriate to link to an ongoing case since the case involved a child in placement whose guardianship arrangement was close to finalization. The parties in the household who were referred for investigation, had no involvement in that open case. The Monitor has no further information on this family or the children. Their involvement with CFSA ended with the closing of the investigation. In the other investigation, the social worker not only had no contact with the social worker already involved with the family, but, again, the records are not linked. Upon review of that already open case, the Monitor has no concerns about the children and family to date.

indicate a lack of consistency in families being referred or connected to services during the course of investigations.

Table 3: Referrals, Service Connections and Service Needs during a CPS Investigation

	Number of Investigations In Which Family Was Already Receiving Service	Number of Investigations In Which Family Was Referred For Service	Number of Investigations In Which Service Need Was Identified, But Family Was Not Referred or Receiving
Mental Health Services (parent)	19	9	11
Substance Abuse Services (parent)	5	22	14
Medical Treatment (parent)	6	2	5
Parenting Skill Education	3	5	55
Substance Abuse (child)	1	2	4
Domestic Violence Intervention	1	11	11
Other (e.g. day care assistance, food stamps, furniture voucher)	18[50]	20[51]	31[52]

Source: CSSP Case Record Review, Winter 2009

[50] There were 69 investigations for which an additional service need was identified. In five of the 69 investigations, a second service need was identified for which the family was already receiving services.
[51] There were 69 investigations for which an additional service need was identified. In ten of the 69 investigations, a second service need was identified for which the family was referred.
[52] There were 69 investigations for which an additional service need was identified. In ten of the 69 investigations, a second service need identified was identified and a referral was not made or the family was not already receiving services.

9. Investigation Findings and Support for Determination

CFSA policy requires that at the conclusion of an investigation, the investigator must determine whether or not the maltreatment occurred for each allegation and victim. By CFSA policy, there are three assessment findings and one must be chosen for each allegation and victim: substantiated, unfounded, or inconclusive.[53] Of the 190 investigations, 126 (66%) were unfounded, 48 (25%) were substantiated, 15 (8%) were inconclusive and 1 (1%) was incomplete.

Table 4: Investigation Determination
N=190

Determination	Number and Percent of Investigations
Substantiated	48 (25%)
Unfounded	126 (66%)
Inconclusive	15 (8%)
Incomplete	1 (1%)
Total	190 (100%)

Source: CSSP Case Record Review, Winter 2009

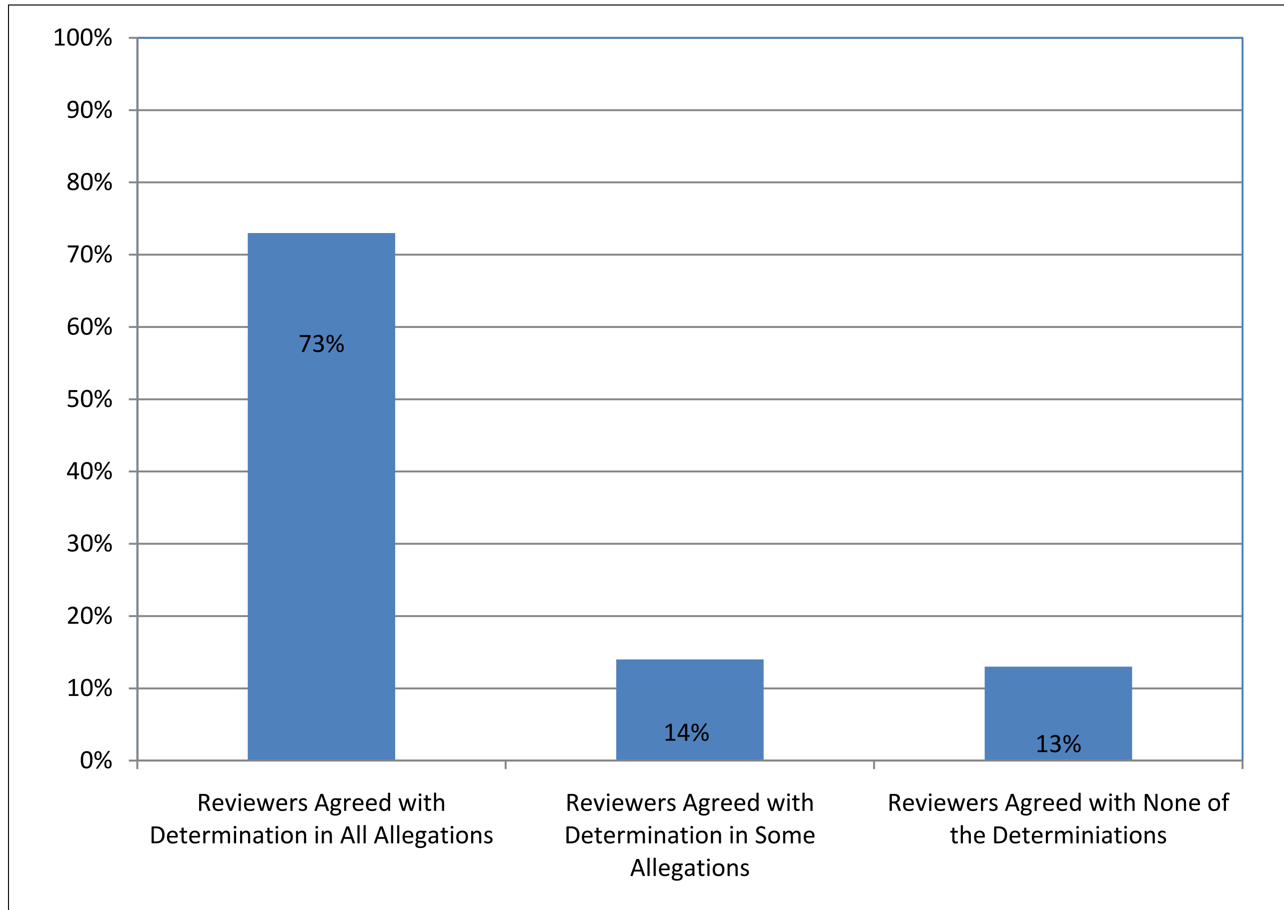
Support for the Determination

Reviewers were asked to assess whether or not the information documented in the case record supported the determination for all allegations made in the investigation. For the majority (73%) of the 190 investigations, reviewers agreed with the determination for all allegations. There were 26 (14%) investigations for which the reviewers agreed with the determination for some allegations, but not all. In 24 (13%) investigations, the reviewer disagreed with the determination for all allegations.

It is important to note that reviewer agreement with the investigation determination is not synonymous with reviewer assessment that the investigation was of overall quality. Reviewer agreement with determination is based on whether the investigator made the best decision with the information available to him or her at the time of investigation closure. The reviewer assessment of quality relates to whether all core contacts or good faith efforts were made, all allegations and safety concerns and risks were assessed and addressed, and there was good decision-making based on evidence documented.

[53] *See*, CFSA Investigations Policy VII Procedure W (September 30, 2003) found at: http://www.cfsa.dc.gov/cfsa/frames.asp?doc=/cfsa/lib/cfsa/policymanualpdffiles/policies/program%20-%20investigation%20%28final%29.pdf.

Figure 14: Reviewer Agreement with Investigation Determination
N=190



Source: CSSP Case Record Review, Winter 2009

Overall, reviewers disagreed with the determination for all allegations or some allegations mostly when the allegation was unfounded. Of the 50 investigations for which the reviewers disagreed with all or some allegations, 35 were unfounded investigations which reviewers thought should have been founded. For the remaining 15 investigations, the reviewers disagreed with the determination of six substantiated investigations and nine inconclusive investigations.

The following are examples when the reviewer did not agree with the investigation determination:

- Unfounded Investigation: *The mother admits to hitting the child with a belt and bruising her especially when she is frustrated. It is unclear to the reviewer why this allegation is unfounded for physical abuse. The investigator justifies an unfounded determination by saying the mother did not intend to bruise the child, but that is not support for not substantiating the allegation.*

- Unfounded Investigation: *According to the fireman, a neighbor's call about smelling smoke was received at 11:47am and the children's mother returned to her home around 1pm. The children's mother reports leaving the almost 4 year old child napping in the home and taking the 3 year old child with her when she ran an errand. She reports that she had never done this before. The children had the day off from daycare. It is unclear to this reviewer why this report is unfounded.*

- Unfounded Investigation: *The allegation is that the child has a burn on his foot. The mother says that it's not a burn, but rather a blister from new shoes. The investigator never follows up with a doctor to determine whether or not this is a realistic explanation for the unexplained injury. There is a history of unexplained injuries for this* [particular child in the family].

- Inconclusive Investigation: *The investigator documents "Based on the evidence this social worker received from his investigation it has been determined that the children are not abused or neglected. The alleged maltreator, was arrested for simple assault (kissing a minor). It is therefore recommended that the disposition for the allegation of sexual abuse (other) be inconclusive and a case not be opened." It is unclear how if the stepfather* [was] *arrested for simple assault* [for kissing a minor] *why it is inconclusive that he sexually abused the child.*

- Inconclusive Investigation: *This is an allegation involving a 5 year old found wandering in the street alone at night. The allegation is against a caretaker not the parents* (given the facts)*, the worker should have been able to decide whether the allegation* (of maltreatment by the parents) *is substantiated or unfounded.*[54]

- Substantiated Investigation: [These allegations involved a 2-parent family with allegations that the children had] *missed a substantial number of days from school.* [The report] was *substantiated for the children's mother and not their father. Their father reported that his work shift begins at 2:30pm.*

10. <u>Timely Completion of Investigations</u>

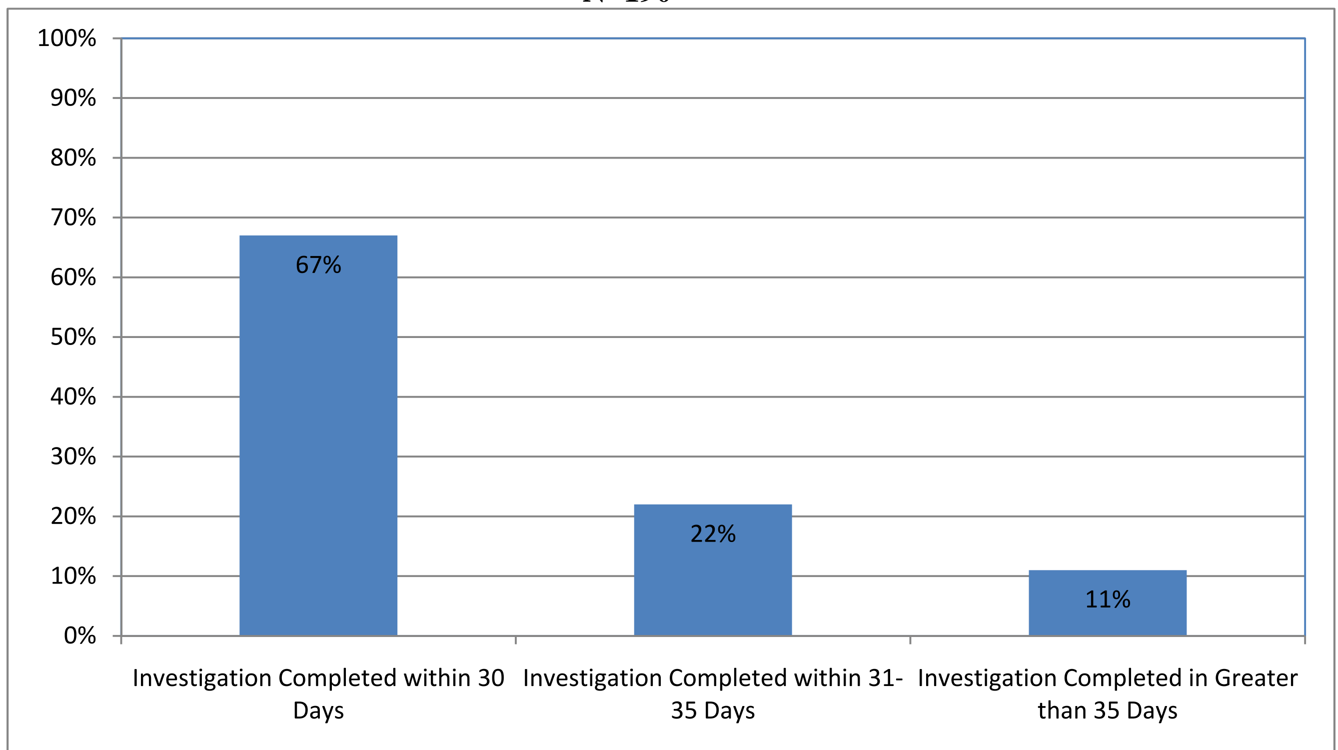
CFSA policy and the <u>*LaShawn*</u> AIP require CFSA to complete each investigation within 30 days from receipt of the report at the hotline.[55] CFSA/FACES requires supervisory approval for the completion of an investigation. The <u>*LaShawn*</u> AIP set an interim benchmark that ninety percent of investigations be completed within 30 days recognizing that some investigations will require more time. Of the 190 investigations reviewed, 127 (67%) were completed within 30 days. Of the remaining 63 investigations, 41 investigations were completed within 35 days. Twenty-two

[54] This finding is particularly problematic due to the ramifications to the alleged perpetrator of an inconclusive determination. With an inconclusive determination, the alleged perpetrator's name is put on the child abuse registry and the alleged perpetrator must wait a period of time to request that his/her name be expunged.

[55] District of Columbia law requires that a full investigation be completed no more than 30 days after the receipt of the first notice of the suspected abuse or neglect and allows that within 5 business days after the completion of the investigation, the Agency shall complete a final report of its findings. *See,* DC ST § 4-1301.06.

investigations were pending for a range of 36 to 60 days. One case took 159 days to complete. Reviewers found documentation to reflect the reason investigations took longer than 30 days in only 10 of the investigations that were not completed within 30 days.[56]

Figure 15: Timely Completion of Investigations
N=190



Source: CSSP Case Record Review, Winter 2009

11. Activities Associated with Transfer to CFSA On-Going Services

CFSA's policy requires investigations resulting in a need for on-going services be transferred from the Investigation Unit to an on-going worker within five days of the removal of a child(ren) from their home or disposition of the investigation.[57] A transfer staffing or meeting involving representatives from the investigations program (such as the supervisor and investigator); ongoing program (such as a supervisor and social worker); CFSA corporation counsel when appropriate; the placement unit when appropriate; and a program manager for high-risk cases is

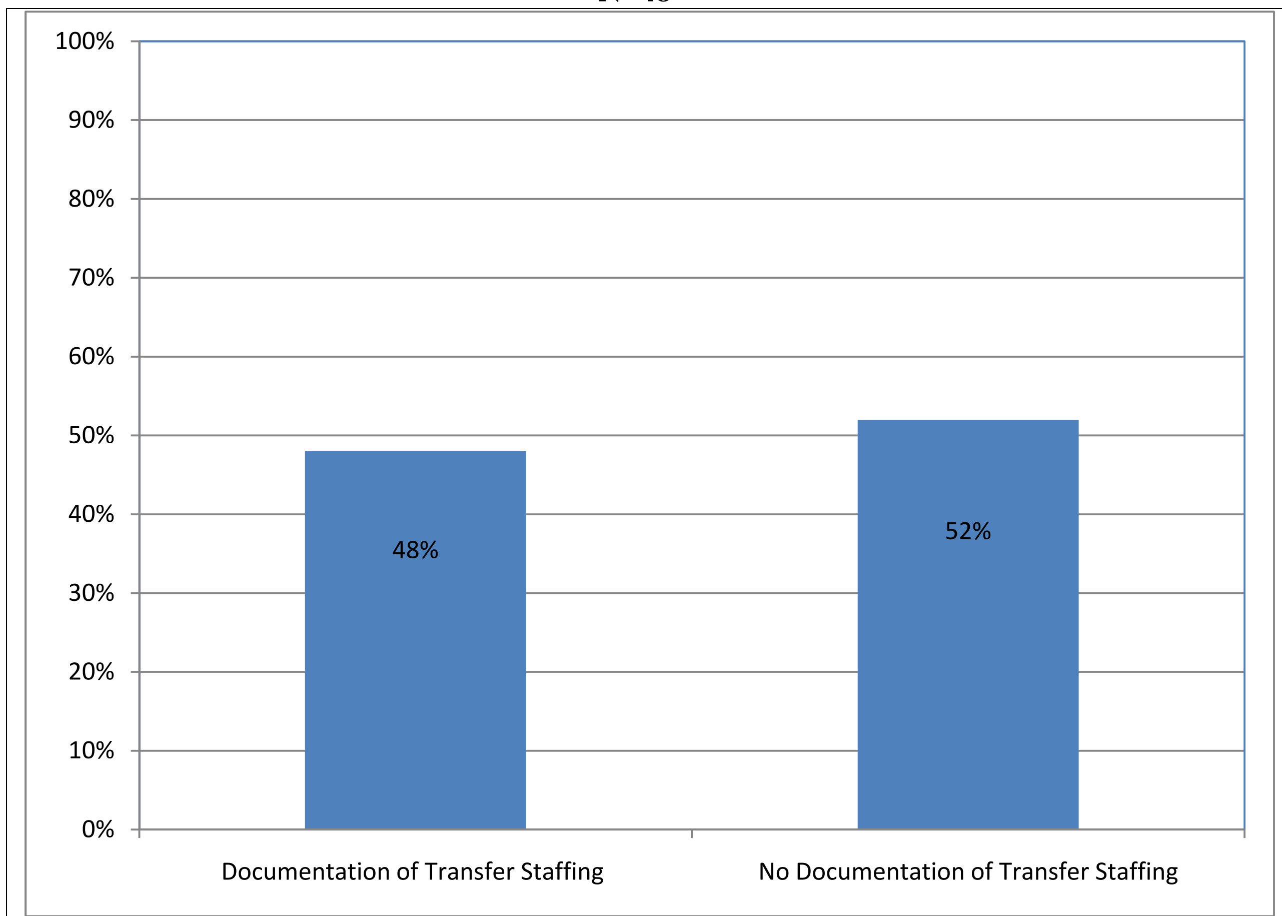
[56] For the 10 investigations in which reasons identified documentation for not closing an investigation within 30 days, reasons included the victim child or family had not yet been interviewed, the investigator was awaiting collateral information from a psychiatrist, the investigator was assisting the family with services prior to transfer.
[57] Reviewers looked for documentation of transfer staffing in both the investigations record and the ongoing case record. They did not evaluate whether or not the staffing occurred within five days of the removal of the child(ren). CFSA promulgated an Administrative Issuance on April 17, 2009 (Case Transfers from Child Protective Services).). The Administrative Issuance includes requirements on documentation with regard to case transfer.

to occur within five days of the request to transfer the case.[58] The staffing is conducted to ensure continuity of services, as well to share relevant information.

For the 48 investigations that were transferred to a CFSA on-going unit or linked to an already open case, reviewers found documentation of a transfer staffing in less than half (48%) of investigations.[59]

Reviewers also documented who was in attendance at the transfer staffing. Participants in transfer staffings were most likely to be the CPS investigator, the ongoing social worker and their respective supervisors.

Figure 16: Completion of Transfer Staffing
N=48[60]



Source: CSSP Case Record Review, Winter 2009

[58] *See*, CFSA Investigations Policy VII Procedure Y (September 30, 2003) found at: http://www.cfsa.dc.gov/cfsa/frames.asp?doc=/cfsa/lib/cfsa/policymanualpdffiles/policies/program%20-%20investigation%20%28final%29.pdf.

[59] Reviewers did not measure the five day requirement, they only assessed whether or not the staffing occurred.

[60] The investigation was transferred to a CFSA on-going unit or linked to an already open case in 49 investigations.

12. Activities with Children Removed from Their Homes

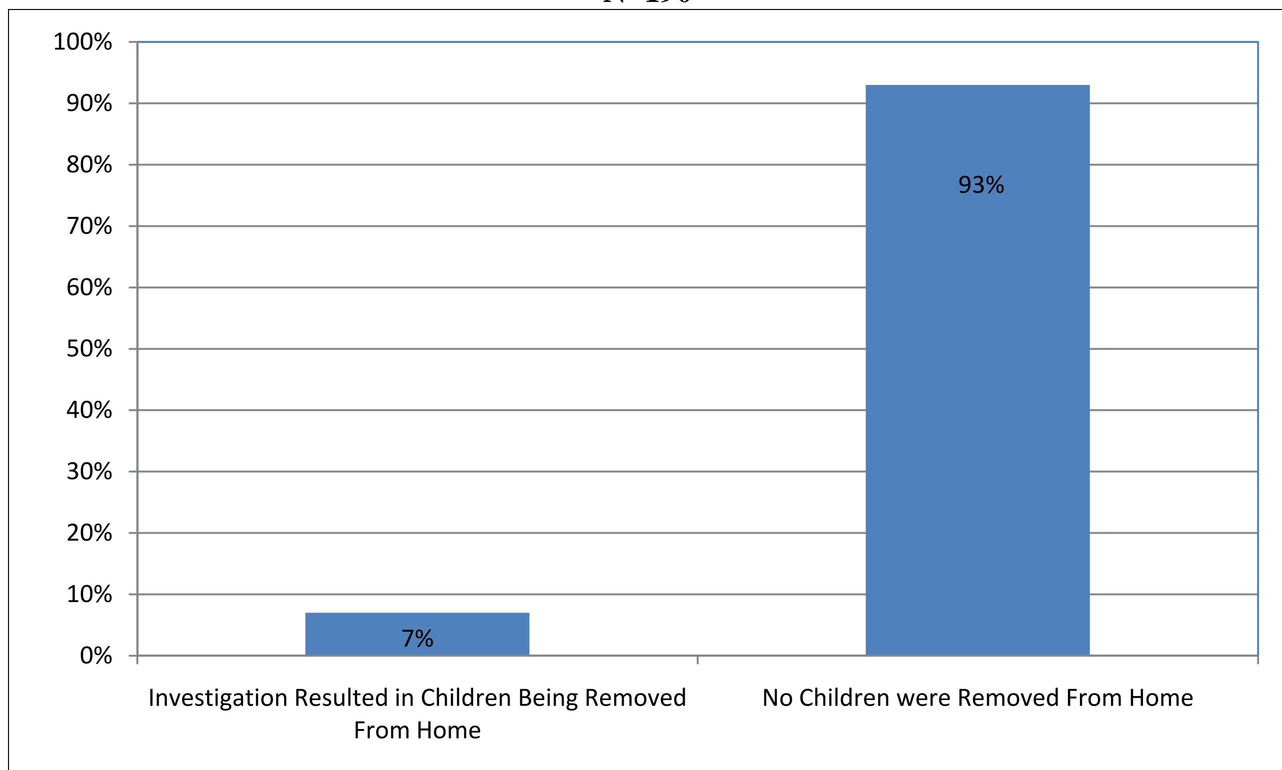
For those investigations resulting in a child being placed into foster care, the reviewers assessed: whether efforts were made to prevent placements on a case by case basis; whether Family Team Meetings were held; whether relatives were explored as placement resources; and whether a health screening was conducted.

Removal of Children from their Homes

According to CFSA policy, when a child is in immediate or imminent danger, the investigators are to consider a broad range of safety-oriented responses, including those that protect a child without taking custody of the child. The policy indicates if the investigator has reasonable grounds to believe the child is in immediate danger from his/her surroundings or is suffering from illness or injury or is otherwise endangered, and the removal of the child from his/her surroundings is necessary, the investigator, in consultation with the supervisor and program manager, is to conduct a removal.

Of the 190 investigations reviewed, 13 (7%) resulted in a total of 22 children being removed from their home. Two (15%) of the 13 investigations involved the removal of sibling groups and in both of those investigations, the siblings were placed together. Comparatively, in the 2006 review, the families in 14 (10%) of 134 investigations experienced the removal of 27 children.

Figure 17: Children Removed from Home
N=190



Source: CSSP Case Record Review, Winter 2009

Efforts to Avoid Removal and Keep Children Safely at Home

Reviewers assessed that in six of the 13 investigations where a child(ren) was removed from the custody of their parent/caretaker, the immediate removal was warranted. In the remaining seven investigations, reviewers found that efforts were made to prevent removal of all children in five cases and efforts were not made to prevent removal of all children in two cases.[61]

Family Team Meetings

According to CFSA policy, Family Team Meetings (FTM) are to be held every time a child is removed from the home.[62] These meetings are structured planning and decision-making meetings using skilled and trained facilitators to engage families, family supports and professional partners in creating plans for children's safety, reducing risks and in laying the groundwork for permanency. Nationally, best practice suggests that Family Team Meetings should be held prior to children being removed from their homes so that families and service providers can work together to avoid removal whenever possible, to ensure a sound decisions about removal is made by the family's team and to investigate relative resources as potential caregivers if the team determines removal is necessary.

For the 13 investigations that involved a removal of a child from his/her home, there were six investigations where a Family Team Meeting was held after the child was removed. No FTMs were held prior to removal for those removed. In addition to the 13 investigations which involved a removal of a child from his/her home, there were five investigations in which the record documented that a child was at risk of removal from his/her home. A Family Team Meeting was held for one of the five investigations in which a child was at risk of removal.

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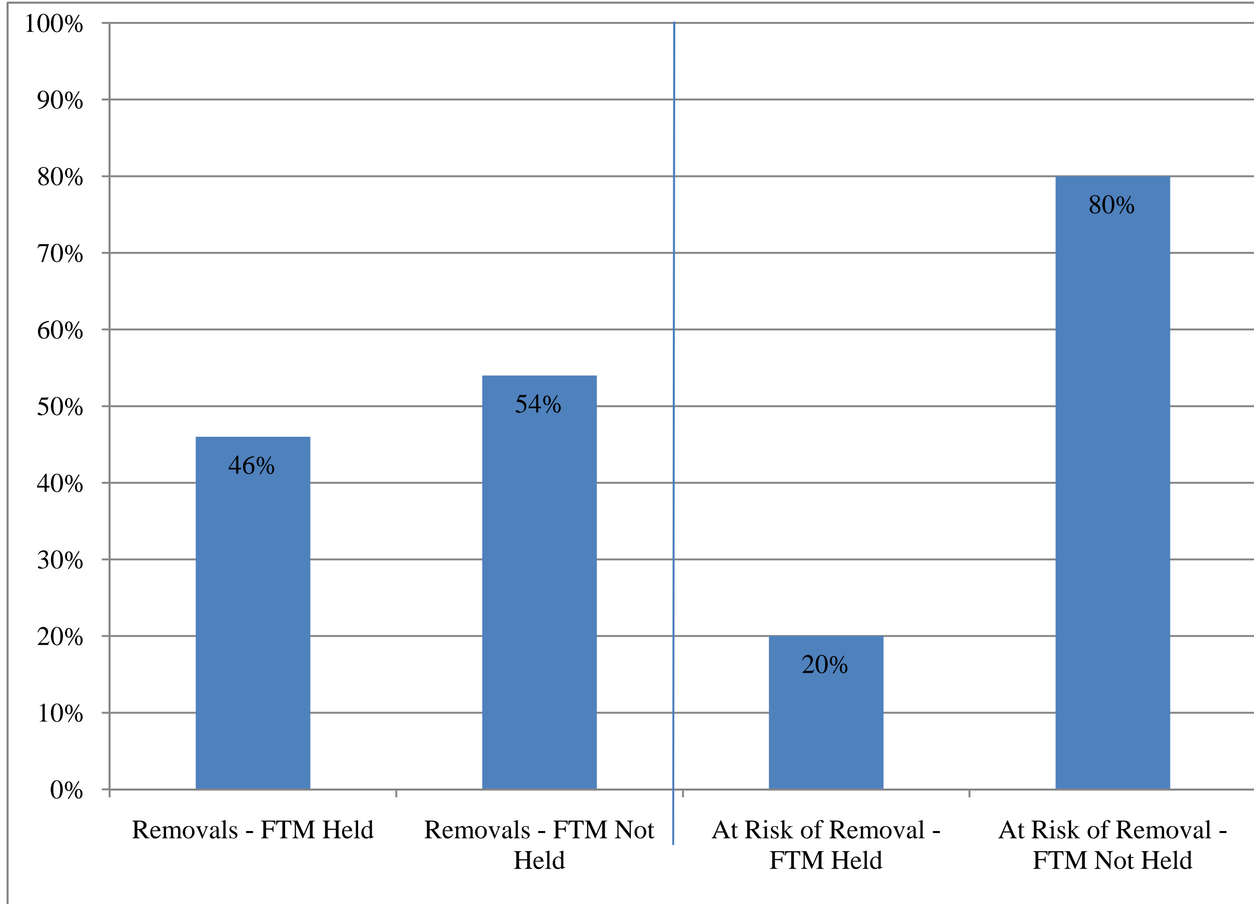
[61] Efforts that Reviewers looked for included, but were not limited to: efforts to create a safety plan which would have allowed all or some of the children to remain at home; efforts to arrange for the child to reside with a relative; efforts to implement services which would provide for a level of supervision to have the some or all of the children remain home; and efforts to seek court-ordered supervision while some or all of the children remained at home.

[62] An FTM may be waived in certain cases involving domestic violence allegations, pending criminal matters, or if the family declines a meeting.

Figure 18: Family Team Meetings
N=13



Source: CSSP Case Record Review, Winter 2009

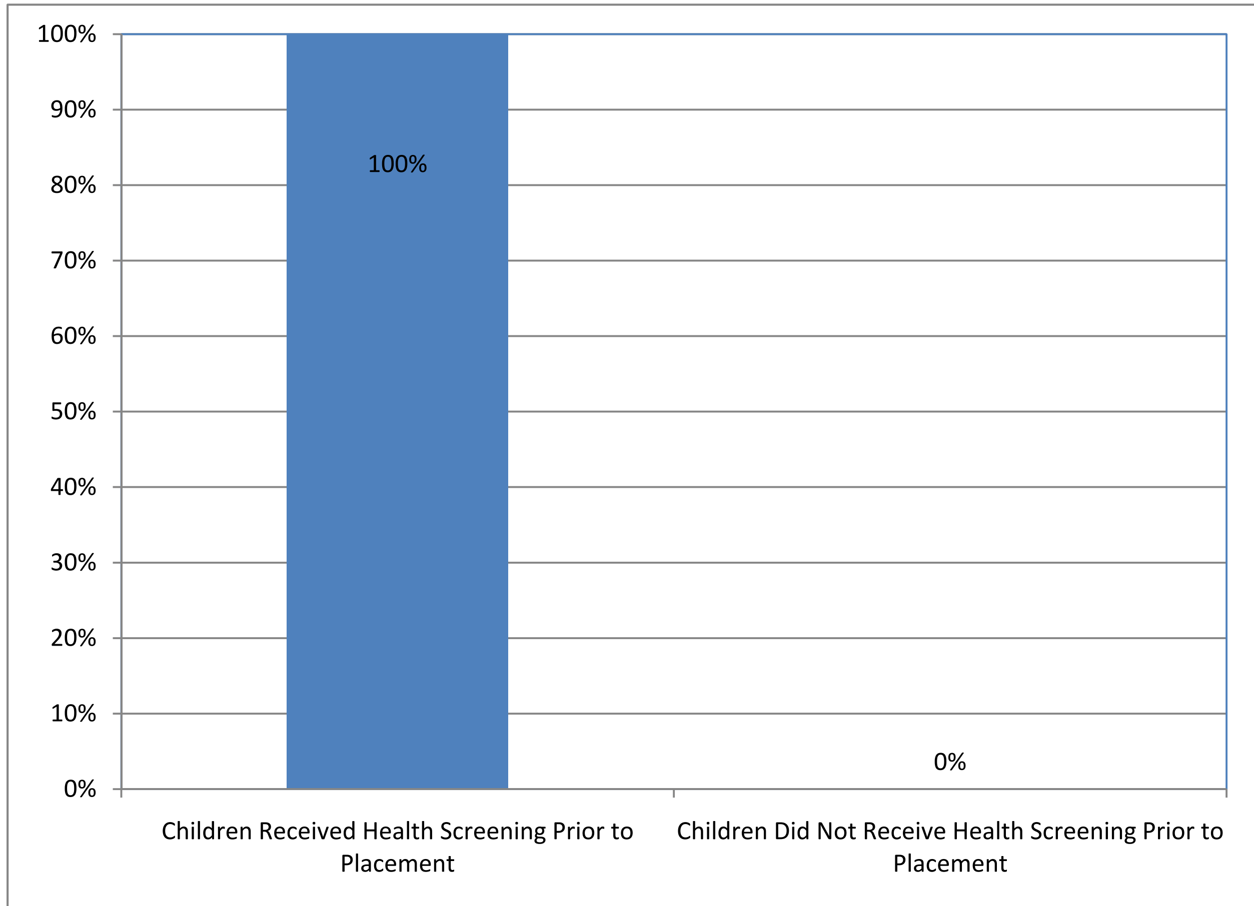
Investigating Relative Resources as Placement Options

In accordance with CFSA policy and the *LaShawn* AIP, CFSA must investigate relative resources in all cases requiring removal of children from their homes. For the 13 investigations which involved a removal of a child(ren), reviewers found in both the investigation documentation and the FTM documentation that relatives were explored or identified as placement resources in slightly more than half (7) investigations.

Health Screening Prior to Placement

CFSA policy and the *LaShawn* AIP require a child to have a health screening prior to placement into foster care. CFSA is required to ensure that 90% of children in foster care have a health screening prior to placement. In the 13 investigations which involved the removal of 22 children from their home, all (100%) children received a health screening prior to placement.

Figure 19: Health Screen Prior to Placement
N=22



Source: CSSP Case Record Review, Winter 2009

13. Supervisory Involvement

According to CFSA policy, the investigative supervisors are responsible for a variety of tasks, including documenting all supervisory activities, contacts and decisions in FACES within 24 hours of event occurrence; providing assistance in decisions related to the removal of children from the home; approving safety and risk assessments; and providing weekly one-on-one individual conferences with staff.

The reviewers found evidence in FACES of supervisory/managerial consultation, directives or decisions in 73 (38%) investigations. Evidence of supervisory involvement included documentation by both the investigator and the supervisor of case consultation, supervisory instructions documented in FACES of follow-up activities, and consultation at the time of investigation assignment of activities required based on allegations. Some of the communications from supervisors were reminders to complete expected steps in the investigation. In some instances, sound directives or recommendations did not result in follow-up responses/actions from the social worker, yet the supervisor approved the investigation for closure.

14. Overall Quality of Investigations

Reviewers assessed whether each investigation documented in FACES was thorough, comprehensive and of "good quality." The *LaShawn* AIP interim benchmark requires that 80% of investigations be acceptable in terms of the quality standard.

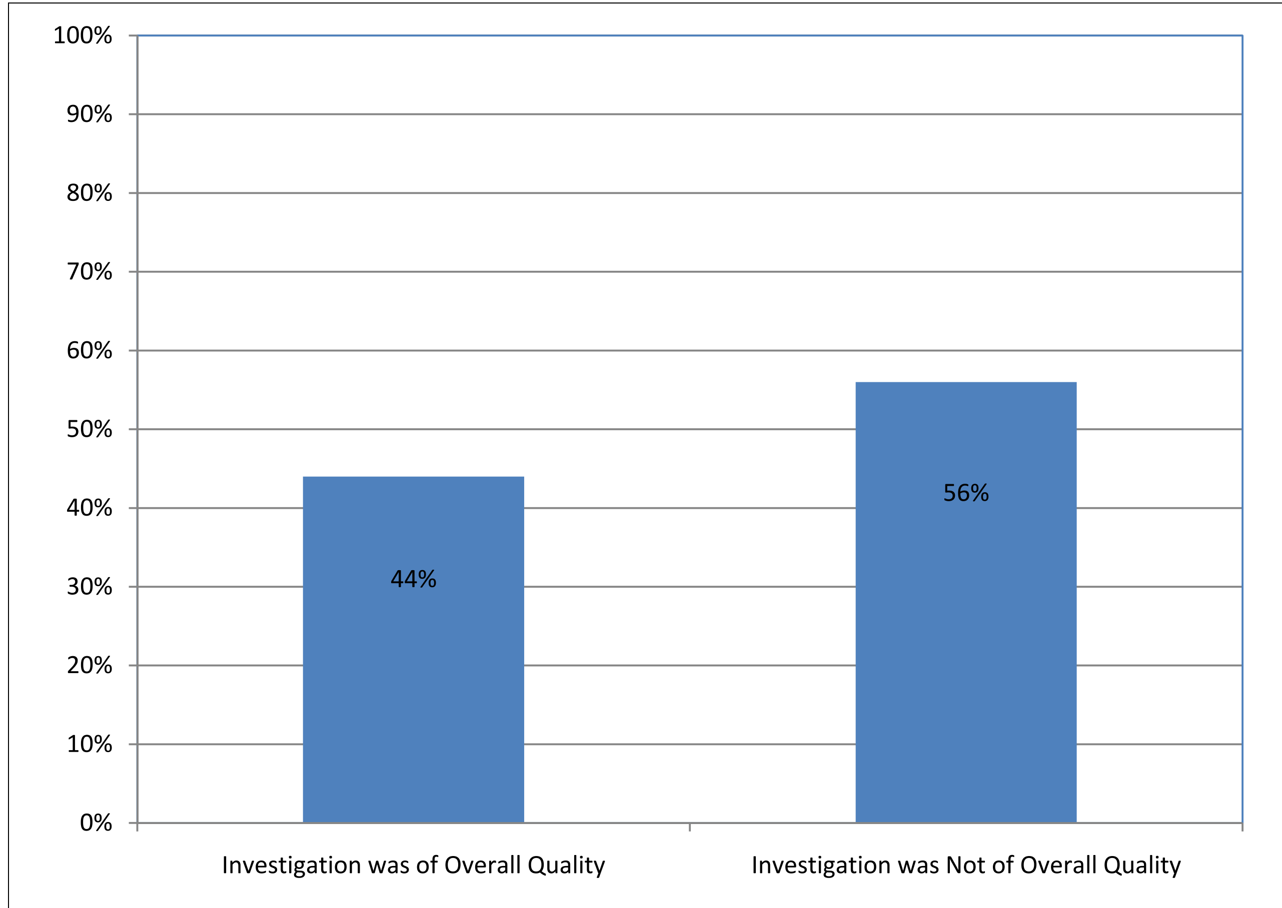
The *LaShawn* AIP indicates that evidence of acceptable investigations includes:

- use of CFSA's screening tool in prioritizing response times for initiating investigations and use of risk assessment protocol in making decisions resulting from an investigation
- a full and systematic analysis of a family's situation and the factors placing a child at risk
- appropriate interviews with needed collateral contacts and with all children in the household outside the presence of the caretaker, parents or caregivers, or shall include documentation, by the worker, of good-faith efforts to see the child and that the worker has been unable to locate the child
- medical and mental health evaluations of the children or parents when the worker determines that such evaluations are needed to complete the investigation

Overall Quality of Investigations

The reviewers deemed 83 (44%) of the 190 investigations to be thorough, comprehensive and of quality; 107 (56%) were not. The reviewers subjectively assessed the thoroughness of information gathered from applicable sources and the appropriateness of decision-making related to safety, risk and overall investigation findings. Reviewers were required to justify their responses by providing at least one reason for deciding an investigation was or was not of acceptable quality.

Figure 20: Reviewer Assessment of Overall Quality
N=190



Source: CSSP Case Record Review, Winter 2009

Reasons Investigations were Deemed to be of High Quality

- Investigators conducted thorough interviews with all family members and collateral contacts
    - *"Documentation of activities was clear and comprehensive."*
    - *"Families were linked to needed services."*
    - *"Allegations and safety concerns including those not included in the original report were addressed."*

Reasons Investigations were Deemed Not to be of High Quality

- Social Workers Did Not Interview Critical Individuals To Inform The Investigation

In most (92 or 86%) of 107 investigations that reviewers deemed not be of high quality, critical core and collateral contacts were not made. In nearly one-third of those instances (29 of 92), the key missing contact was school personnel. In others medical and mental health professionals as well as relatives, staff of CFSA ongoing or foster care services and social workers with private agencies were not contacted. Examples of reviewer comments include:

- *“Documentation indicates that core collateral contacts were not made (reporter, neighbor, physician, school personnel”;*
- *“Contact with school personnel and physicians of the victim children were not made.”;*
- *“The investigator spoke with the mother and child (and) made no further contacts.”;*
- *“Many critical contacts were not made (mother’s probation officer, substance abuse treatment [provider] and victim children’s physician).”;*
- *“Several core contacts were missed including the mental health provider who interviewed the child during the investigation and the child’s physician.”*
- *“The investigator should have talked to and documented conversation with the ongoing worker who is in the home often to determine whether or not the allegations were true and whether or not there were safety concerns or risk to the children.”; and*
- *“The child's teacher was not contacted although the reporter expressed concern related to the child's emotional state in the classroom.”*
- *“School staff, who may have been more familiar with the children and factors were not contacted.”*

Other themes from reviewers’ comments in selecting this response relate to delays in meeting with children as well as inadequate assessment of substance use and mental health issues.

- *“5 year-old seen 2 weeks after report with no documentation of attempts to see.”*
- *“It took the investigator almost one month to see the fourth victim child.”*
- *“There were 2 home visit attempts, the day after the reports and a week after the report.”’*

V. RECOMMENDATIONS FOR IMPROVEMENT

Below are the Monitor's recommendations for continuing improvements to the Child Protective Services Division. It is important to note that many, if not all, of these recommendations have been made repeatedly in previous monitoring reports. While the current review documented both CFSA's continuing improvement efforts and improved results in some areas, it is also clear that there is additional work that remains to be done to insure consistent high quality child protective services practice in the District of Columbia.

- **CFSA needs to identify the remaining barriers to ensuring that investigations are initiated timely.** The *LaShawn* AIP interim performance benchmark for timely initiation of investigations allows more time that District law (48 vs. 24 hours); yet performance on the less arduous benchmark is still unacceptably low. Policy allows for "good faith efforts" that require a series of activities that must be taken when a worker cannot locate and/or interview a victim child(ren). This review found limited documentation of good faith efforts, suggesting that either staff don't understand the policy or that there are unknown barriers to adhering to it. The Monitor recommends that CFSA fully assess with social workers and supervisors why the performance on timely initiation and good faith efforts to initiate remain low. To the extent that the assessment reflects a need for additional investigative staff, despite their low caseloads, this need should be identified and rectified. To the extent that access to cars or other logistical barriers contribute to this performance, they need to be addressed.

- **CFSA, MPD and the CAC need to review existing protocols, determine the reasons why they are not consistently adhered to and take steps to ensure that children who are sexually abused and suffer serious physical abuse are seen at the CAC as needed.** District officials need to determine whether the limited use of the CAC is because referral protocols are not clear or are not followed or because referral protocols need to be reassessed to allow greater access to the CAC. CFSA, MPD and the CAC need to determine if the low number of referrals reflects a lack of capacity at the CAC and the need for additional resources or whether there are other barriers. Regardless, all barriers to proper use of the CAC need to be resolved.

- **Specialized training for CPS investigative staff and supervisors must be a priority.** CFSA has indicated on several occasions their plans to develop the curricula and provide intensive specialized training for CPS staff. To the Monitor's knowledge, this training has not occurred except in very piecemeal and limited ways. In addition to specialized training designed to specifically meet the needs of investigators, CFSA should develop and provide training on the investigations practice guide, which is in development.

- **CFSA's use of the safety and risk assessment protocols need to be reassessed within the context of the agency's practice model and movement to develop a differential response system.** Effective use of the SDM protocols require that workers have the skills to engage low and moderate risk families to accept community-based services as needed and that there be clear protocols and sufficient resources so that families can be linked to and provided needed services. Further, the creators of the SDM risk assessment

tool recommend periodic calibration of the tool by jurisdictions using it as well as refresher training for staff after initial implementation. To the Monitor's knowledge, this calibration has not occurred. This must be done by CFSA in order to address reliability of their safety and risk assessment process.

- **Investigative staff must be trained and expected to have in-depth conversations with collaterals, specifically with medical and educational personnel and with the ongoing social worker on already open cases.** Collateral contacts provide much of the necessary information used to determine the outcome of an investigation. An informed decision about each allegation of child abuse or neglect requires interviewing all persons with information that might be of use and medical professionals, teachers and ongoing CFSA workers are frequently in the best position to provide information about families that is critical to an investigator's assessment.

- **For many families, more must be done to initiate safety and other services during the 30 day investigation period.** CFSA must advance ways of beginning to meet the needs of children and families more quickly and support social workers and supervisors of the Child Protective Services unit to refer and initiate services for children and families as part of the investigation. Additionally, a CFSA worker needs to follow-up on all service referrals, including those to the Collaboratives, to ensure that the referrals have been properly received and that families have established a link to a worker at the agency to which they have been referred.

- **CFSA must improve practice on investigating relative resources to implement the Fostering Connections to Success and Increasing Adoptions Act.**[63] The new federal law requires notice to relatives when children enter care. This review found that for the 13 investigations involving a removal of a child(ren), relatives were explored or identified as placement resources in slightly more than half (7) investigations. In order to implement the new federal law, CFSA must improve practice on investigating and notifying relatives when children enter care.

- **Documentation in FACES should reflect quality improvement efforts.** CFSA has implemented a number of quality assurance methods in the investigations unit such as a managerial review of investigations 18 days post-report, Grand Rounds facilitated by CFSA's Quality Improvement Administration, and increased supervisory involvement in oversight of investigations. Either social workers or their supervisors should be responsible for documenting that those reviews have occurred, what recommendations were made and that the necessary follow-up was completed. Supervisors should be expected to ensure that necessary follow-up actions have been taken prior to closing an investigations case.

[63] *See*, Fostering Connection to Success and Increasing Adoptions Act (H.R. 6893).

APPENDIX A:

DC Investigations Review Instrument 2009

DC Investigations Review Instrument 2009 Version 4, November

1. Introductory Information

* 1. Case Reviewer's Name

* 2. CSSP Sample Number:

* 3. Referral Name:

* 4. Referral Number:

5. Case ID (If Applicable):

* 6. Investigative Social Worker:

* 7. Date for Review:

	MM	DD	YYYY
Date	/	/	

* 8. Are you able to complete the review of this investigation?

- Yes
- No

2. Reason Review Could not be Completed

* 9. Please identify the reason the review cannot be completed:

- No information in FACES
- Investigation not closed from September 21-October 16, 2009

Other (please explain)

3. Hotline

* 10. What was the response time given to the report?

- Immediate-Priority 1
- Within 24 hours-Priority 2-Abuse Related
- Within 24 hours-Priority 2-Neglect Related

* 11. Based on the report and allegations is the response time reasonable?

- Yes
- No

If no, please explain

* 12. Indicate the general reason for the allegations/nature of concerns (check all that apply):

- Domestic violence
- Substance Abuse
- Educational neglect
- Fatality
- Medical neglect
- Neglect due to food, clothing, shelter
- Neglect due to lack of supervision or abandonment
- Physical abuse
- Positive toxicity
- Sexual Abuse

Other (please specify):

4. Contact with Alleged Maltreated/Abused Children and Others

* 13. Indicate the number of alleged child victims:

* 14. When were alleged victim children seen during the initiation of the investigation?

- ALL alleged victim children were seen WITHIN 24 HOURS of the receipt of the report
- ALL alleged victim children were seen WITHIN 48 HOURS of the receipt of the report
- ALL alleged victim children were NOT SEEN WITHIN 48 HOURS of the receipt of the report

If you selected "ALL alleged victim children were NOT SEEN WITHIN 48 HOURS of the receipt of the report", please enter the number of children not seen within 48 hours:

5. Contact with Alleged Maltreated/Abused Children and Others- Seen within 24 h...

* 15. For those alleged victim children seen within 24 or 48 hours, were the children seen outside of the presence of caretakers, parents or caregivers?

- Yes, ALL ALLEGED VICTIM children were SEEN OUTSIDE THE PRESENCE OF CARETAKERS, parents, or caregivers
- SOME ALLEGED VICTIM children were SEEN OUTSIDE THE PRESENCE OF CARETAKERS, parents, or caregivers
- NONE of the alleged victim children WERE SEEN OUTSIDE THE PRESENCE OF CARETAKERS, parents or caregivers

Please Enter Comments:

6. Contact with Alleged Maltreated/Abused Children and Others- Seen within 24 h...

* 16. List the number of children seen outside the presence of caretakers, parents, or caregivers:

7. Contact with Alleged Maltreated/Abused Children and Others

* 17. Indicate the good faith efforts to see victim children (check all that apply). If the family is not at home [at the time of Investigations Worker's arrival to the assessment location and/or home], the Investigations Worker shall complete the following within 24 hours.

- The Social Worker left a notification letter at the home, indicating that a report has been received and requesting contact (only for neglect reports)
- The Social Worker conducted a school visit to interview the child, if child is school age (to the neighborhood school or the school listed in the referral)
- The Social Worker interviewed neighbors, the resident manager, or landlord to confirm the address or determine the whereabouts of the family
- The Social Worker conducted at least 2 additional home visits at various times
- The Social Worker sent a certified letter within 24 hours of the home visit since the family failed to respond (only for neglect reports)
- None of the above
- N/A, all victim children seen within 24 hours

8.

* 18. Were the other children in the household (not the alleged victim children) seen outside the presence of the caretakers, parents, or caregivers?

- Yes, all other children in the household were seen outside the presence of caretakers, parents or caregivers
- Some other children in the household were seen outside the presence of caretakers, parents or caregivers
- None of the other children in the household were seen outside the presence of caretakers, parents, or caregivers
- N/A, there are no other children in the household
- N/A the other children were not seen

* 19. Did the Social Worker have face to face contact with the following individuals to address the allegations?

	Contact with	If contact was made with only some or none, were efforts made to contact?
Alleged perpetrators (N/A if perpetrator is unknown)		
Parent/Caretaker		
Other children in household		
Other adults in the household		

9. Contact with Alleged Maltreated/Abused Children and Others

* 20. List the date the safety assessment form was completed by the investigator?

Date MM / DD / YYYY

* 21. By the time the safety assessment was completed, were all alleged victim children and their siblings in the household interviewed?

- Yes (ALL Children)
- No

* 22. Did the assessment address the safety decision for all alleged victims and siblings in the household?

- Yes (ALL Children)
- No

* 23. In your opinion, did the Social Worker gather sufficient information to make safety decisions for all alleged victims and siblings in the household? (Regardless of time period within which decision was made.)

- Yes (ALL Children)
- No

Please enter comments:

10. Contact with Alleged Maltreated/Abused Children and Others-Gathered Suffici...

* 24. Do you agree with the safety decision?

- Yes
- No

If no, please explain:

11. Contact with Alleged Maltreated/Abused Children and Others

* 25. What is the date of Supervisory approval of the safety assessment?

	MM	DD	YYYY
Date	/	/	

12. Activites During Investigation

* 26. If allegations related to serious physical or all sexual abuse, was there documentation of police involvement?

- Yes
- No
- N/A, allegations not related to serious physical or sexual abuse

If yes, describe nature of police involvement – decision made, TOT, arrests, etc.

13. Activites During Investigation-Allegation related to serious physical/sexua...

* 27. If allegations related to serious physical abuse and/or all sexual abuse, were the children who needed to be interviewed as per the MOU criteria seen at the CAC?

jn Yes, all children

jn Some children

jn No (no children received CAC intervention as needed)

If no or some, please explain:

14. Contact with Collaterals

* 28. Did the Social Worker make contact with the following persons to inform the investigation? Include phone conversation, face-to-face interaction, and instances where hardcopy information was received and reviewed from the collateral party. Check a response for each collateral.

	Yes	Attempted (Including voicemail, sent fax/email)	No	Not Applicable/Not Needed
Family friend	jn	jn	jn	jn
Law enforcement professional	jn	jn	jn	jn
Mental health professional	jn	jn	jn	jn
Neighbor (when evidence indicates they may have information relevant to the investigation)	jn	jn	jn	jn
Relatives, beyond the other adults in the household (when evidence indicates they may have information relevant to the investigation)	jn	jn	jn	jn
Source of Report	jn	jn	jn	jn
Substance abuse treatment provider	jn	jn	jn	jn
Teacher or child care provider	jn	jn	jn	jn
Other	jn	jn	jn	jn
Other	jn	jn	jn	jn

Please specify 'Other'

15. Other Actvities During Investigation

* 29. Did the alleged victim child(ren) need a medical evaluation in order to make a determination on the allegation(s)?

- Yes
- No

If yes, please explain:

16. Other Actvities During Investigation

* 30. List the number of children that needed the medical evaluation:

17. Other Actvities During Investigation

* 31. For those children who needed the medical evaluation/exam, did the child(ren) receive the medical evaluation during the investigation?

- Yes, all children needing it per Q30
- Some children needing it per Q30
- Requested parent take child for medical evaluation, but parent refused
- None of the child(ren) who needed a medical exam received it

Other (please specify):

18. Other Actvities During Investigation

* 32. List the number of children that received the medical exam:

19. Other Actvities During Investigation

* 33. Did the investigator gather appointment and/or an immunization history for all alleged victim children? (Exclude the information gathered from a medical evaluation per question 30/medical evaluation to make determination of allegations)

- Yes for all alleged victims
- For some alleged victims
- No

20. Other Actvities During Investigation

* 34. If the allegation involved medical neglect, did the investigator or CFSA nurse gather medical information (beyond immunization status) to address the allegations and assess whether or not the child(ren)'s medical, safety, risk and well-being needs were being met?

- Yes (In order to answer yes to this question, the Social Worker and/or nurse must have documented the medical provider's assessment of the quality of the care the child is receiving from the parent caretaker and the child's current health needs.)
- Some, i.e. – contact with the medical provider was made but insufficient information was gathered
- No
- Not Applicable

If you selected 'Some' or 'No', please explain:

21.

* 35. Did the alleged victim child(ren) need a mental health evaluation in order to make a determination on the allegation(s)?

- Yes
- No

If yes, please explain:

22.

* 36. List the number of children that needed the mental health evaluation:

23.

* 37. For those children who needed the mental health evaluation/exam, did the child(ren) receive the mental health evaluation during the investigation?

- Yes, all children needing it per Q36
- Some children needing it per Q36
- Requested parent take child for mental health evaluation, but parent refused
- None of the child(ren) who needed a mental health exam received it
- Other (please specify):

24.

* 38. List the number of children that received a mental health evaluation:

25. Other Actvities During Investigation

* 39. Did the investigator gather information from educational (day care or school) personnel about the alleged victim children's educational status (such as, information about educational attendance, performance)?

- Yes for all alleged victims
- For some alleged victims
- No
- N/A-child not in daycare, early childhood education or regular school, or allegations did not address educational neglect or otherwise require educational information.

If no, please explain:

26. Other Actvities During Investigation

* 40. Did the information gathered from school personnel or day care/early childhood education providers provide enough information (beyond attendance records) to address the allegations and/or assess whether or not the child(ren)'s educational, safety, risk, and well-being needs are being met?

- Yes (In order to answer yes to this question, the Social Worker and/or nurse must have documented enough information to determine the school personnel or day care provider's assessment of educational, behavioral and emotional status of the child and the quality of care the child is receiving from parent or caretaker.)
- Some, i.e. – contact with the educational personnel was made but insufficient information was gathered
- No

If you selected 'Some' or 'No', please explain:

27. Other Actvities During Investigation

* 41. Did the Social Worker gather sufficient information from all contacts to address the allegations and assess whether or not the child(ren)'s safety, risk, and well-being needs are being met?

- Yes
- No

If no, please explain what information was missing or inadequately addressed:

28. Initial Risk Assessment

* 42. Did the Social Worker gather sufficient information to complete the risk assessment?

- Yes
- No
- N/A

If no, please explain:

29.

* 43. Were the risk assessment responses reflective of the information gathered during the investigation?

- Yes to all questions
- Partially, to some questions
- No

If you selected 'Partially' or 'No', please explain

30.

* 44. What was the (final) overall risk rating for the investigation?

- Intensive
- High
- Moderate
- Low

* 45. Is the (final) risk rating reflective of a supervisory override?

- Yes
- No

* 46. Do you agree with the (final) overall risk rating?

- Yes
- No

If no, please explain:

31. Services/Intervention

* 47. Indicate, in your opinion, which services were needed during the investigation; Indicate services to which referrals were made; and those which the child/family was already receiving.

	Family stated already receiving, no verification	Already receiving and SW verified	Referred	Needed	Not Applicable/Not Needed
Parent - Mental Health Services	jn	jn	jn	jn	jn
Parent - Substance Abuse Treatment/evaluation	jn	jn	jn	jn	jn
Parent – Medical Treatment	jn	jn	jn	jn	jn
Parenting skill education	jn	jn	jn	jn	jn
Child - Mental Health Services	jn	jn	jn	jn	jn
Child - Substance Abuse Treatment/evaluation	jn	jn	jn	jn	jn
Domestic Violence intervention	jn	jn	jn	jn	jn
Employment assistance	jn	jn	jn	jn	jn
Financial assistance (TANF)	jn	jn	jn	jn	jn
Housing assistance	jn	jn	jn	jn	jn
Other	jn	jn	jn	jn	jn
Other	jn	jn	jn	jn	jn

If other(s) (please specify):

* 48. Were any children at risk of removal or removed from their home?

jn Yes, child(ren) was at risk of removal

jn Yes, child(ren) removed

jn No, no child(ren) was at risk of removal or removed

32. Services/Intervention

* 49. Was a Family Team Meeting held for instances in which a child(ren) was at risk of removal?

- Yes
- No
- N/A (i.e. some sex abuse, child fatality, or domestic violence cases)

33. Services/Intervention

* 50. Was a Family Team Meeting held prior to removal?

- Yes
- No, FTM never held
- No, FTM held after removal

34.

* 51. How many days after removal was a Family Team Meeting held?

35. Practice Strengths/Challenges

* 52. Were there any systemic barriers affecting CPS' ability to complete the investigation? (Examples include CAC delays, schools denying access, resource issues, and judicial interference)?

- Yes
- No

If yes, please explain:

* 53. What was the overall determination made in this investigation?

- Unfounded
- Substantiated
- Inconclusive
- Incomplete

* 54. Does the information documented support the determination(s) for all allegations made in this investigation?

jm Yes – for all allegations

jm Partially – for some allegations, but not all

jm No, not for any allegations

If you responded 'Partially' or 'No', please explain:

* 55. In your opinion, overall, was the investigation thorough, comprehensive, and of good quality?

jm Yes-All core contacts or good faith efforts were made; all allegations and safety concerns and risks were assessed and addressed; good decision-making based on evidence documented

jm No-many core contacts were not made all allegations and safety concerns and risks were not assessed and addressed.

* 56. Please list three factors contributing to your response regarding the quality of the investigation:

Factor #1

Factor #2

Factor #3

* 57. What was the (final) overall risk rating for the investigation?

jm Intensive

jm High

jm Moderate

jm Low

jm N/A

36. Referral for Follow-up/Case Management

* 58. For families whose circumstances were determined to be of low or moderate risk, was the family referred to a Collaborative?

- Yes
- No
- N/A, a referral for intervention is not needed

If you responded 'No' or 'N/A', please explain:

37.

* 59. For families whose circumstances were determined to be of high or intensive risk was their case transferred to a CFSA on-going unit (or linked to an already open case, if applicable)?

- Yes
- No

If No, please explain (i.e., allegations are unfounded, family declined referral)

38.

* 60. For family situations rated high or intensive risk, is there documentation of a transfer staffing?

- Yes
- No
- N/A

Please enter date for transfer staffing (enter as MM/DD/YYYY):

39.

* 61. Indicate participants in transfer staffing (check all that apply):

- CPS Social Worker
- CPS Social Worker's supervisor
- Ongoing Social Worker
- Ongoing Social Worker's supervisor
- Program Monitor
- In-home and Reunification Program Manager
- Nurse
- Clinical Specialist (DV, substance abuse consultant)
- Collaborative Worker

Other (please specify):

40. Case Closure

* 62. Last date of an investigative activity (investigator made a contact, attempted a contact, or reviewed faxed information):

Date MM / DD / YYYY

* 63. Date investigation submitted for supervisory approval:

Date MM / DD / YYYY

* 64. Date of supervisory approval:

Date MM / DD / YYYY

* 65. If the investigation entered backlogged status, does the documentation reflect the reason(s)?

- Yes
- No
- N/A, investigation completed within 30 days of report

If yes, please explain:

41. Supervisory Conferences

* 66. Is there evidence of supervisory/managerial consultation/directives/decisions (not just the approval of forms) with the Social Worker during the investigation (include directives issued immediately before investigation closing)?

- Yes
- No

If yes, please provide examples:

42. High and Intensive Risk

* 67. Were any children removed from home?

- Yes
- No

43. Placement Cases

* 68. List the number of child(ren) removed from the home:

* 69. Were efforts made to avoid placement and maintain the child(ren) safely at home?

- Yes
- No, for all children
- N/A, Child is unsafe and must be removed from the home

If you responded "Yes' or 'No', please explain:

44. Placement Cases

* 70. List the number of children for whom efforts were made to avoid placement:

45. Placement Cases

* 71. If this child was part of a sibling group coming into placement, was he/she placed with siblings?

- Yes, all
- Yes, some
- Unable to determine
- No, this child was not placed with siblings
- N/A, this child is not part of sibling group coming into placement

If no, please explain:

* 72. Were relatives explored or identified as placement resources for any child(ren)?

- Yes
- No, for all children
- Unable to determine
- N/A, no relatives offered by parent/caretaker

46.

* 73. Please list the number of children for whom relatives were explored or identified:

* 74. Please indicate how relatives were explored or identified:

47.

* 75. Did the child(ren) receive a health screening prior to placement?

Note: children discharged from a medical facility/hospital are medically cleared.

- Yes, all
- Some
- No, for all children

If 'Some', please indicate the number of children who received a health screening prior to placement:

* 76. What was the type of placement identified for the children upon removal, check all that apply?

- Emergency foster home
- Emergency group home
- Hospital, psychiatric unit
- Hospital, medical unit
- Non-relative foster home
- Relative's or family friend's home
- Unable to determine

Other (please identify):

48. Comments

* 77. Please enter any comments regarding the case review:

- None
- Applicable, answer below

Please specify