Critical Incident Rapid Response Team

Jahrasha Golson

Florida Department of Children and Families
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Northeast
Circuit 4
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Executive Summary

On February 19, 2024, the Department was notified of the death of 6-year-old Jahrasha Golson after she was found unresponsive with her father, Tyrone Golson (60 years of age). The father reportedly gave Jahrasha Benadryl for seasonal allergies the previous night. During the night, he found Jahrasha unresponsive. Law enforcement and emergency services responded to the home, and the father was brought into law enforcement's custody for additional questioning. An autopsy was completed. The manner of death was homicide and the cause of death was multiple blunt trauma and diphenhydramine toxicity.

The fatality incident occurred during an open investigation received on January 3, 2024, after [redacted], was observed to have what appeared to be a busted lip and alleged the father would beat the children, the father used substances, and the home was filthy.

Due to the children being involved in a verified investigation within 12 months of the fatality incident, DCF Secretary Shevaun Harris deployed a Critical Incident Rapid Response Team to Duval County. This report presents the team's findings, a summary of the family's child welfare history, the family's composition, and an analysis of child welfare service providers. The team reviewed the family's prior interventions in the child welfare system to assess for any potential systemic issues within the local system of care.

The review team consisted of representatives from DCF's Office of Children and Family Wellbeing (OCFW) in the Central Region, Office of Quality and Innovation (OQI), Substance Abuse and Mental Health (SAMH) Program Office in the SunCoast Region, Children's Legal Services (CLS) in the Northwest Region, and the Associate Statewide Child Protection Team (CPT) Medical Director.

The team reviewed case records involving all key case participants and conducted interviews with child welfare professionals involved in the recent interventions. The following agencies provided records and information during the review: DCF Child Protective Investigations (CPI) staff and leadership, Family Support Services of North Florida (FSSNF), and their contracted service provider, Jewish Family and Community Services (JFCS) of Jacksonville, which operates the Strengthening Ties and Empowering Parents (STEPS) program.

Summary of findings:

<u>Practice Assessment</u>

- There were multiple inadequate assessments, guidance, and follow through with agencies involved that impacted the decision-making and case trajectory in the verified prior report and the open investigation. Available information was not used in a meaningful way to drive decision making, assess child safety, and determine service needs. In addition, the totality of the child welfare history that was available was not considered in the safety decisions or in the risk assessments that were conducted in the case.

- Neither the Department nor CPT staff utilized their own internal escalation processes/protocols to ensure that identified issues or concerns were addressed. This resulted in missed opportunities for accurate decision making, which further impacted case trajectory.

Organizational Assessment

- While the investigative staff involved in the prior verified report were well experienced in the child welfare field, the limited level of experience of investigative staff in their current roles impacted safety decision making during the open investigation.

Service Array

- There are a variety of services available to assist families in Duval County. In this case, investigations staff did refer the father to services through the STEPS program; however, given the level of intervention needed, it was not an appropriate referral as the father had previously refused to engage with providers.

Case Participants

Name	Age at Time of Incident	Relationship
Jahrasha Golson	6	Decedent
[redacted]	[redacted]	Sibling
Tyrone Golson	60	Father
[redacted]	-	Mother (deceased) to [redacted]
Elizabeth Luckett	43	Mother to Jahrasha

Child Welfare Summary

The family has a history with the Department between 2015 and 2024 with a pattern of physical abuse perpetrated by the father. The family was previously engaged with judicial case management services in 2015 because of [redacted]. A 2023 report was verified for physical abuse of both children with the father as the caregiver responsible.

[redacted]

[redacted]

[redacted].

A report was received in May 2017, with allegations that Jahrasha sustained a clavicle fracture. Both Mr. Golson and Ms. Luckett were unable to explain how the injury occurred and were not following up with medical treatment. Additional concerns revealed the parents were using marijuana and tested positive for the substance during the investigation. Initially, both children were removed from the parents. CPT was contacted and determined there was no medical neglect and no physical abuse as the injury was sustained during Jahrasha' s delivery. As a result of CPT's findings, the shelter petition was voluntarily dismissed. The report was closed with no indicators of bone fracture or medical neglect and the family was referred to Strengthening Ties & Empowering Parents. However, the father did not engage in the program.

Two reports were received in 2021, both alleging physical abuse. The first report was received in May, alleging that the father bit [redacted] thumb to keep [redacted] from sucking on his thumb. [redacted]

was observed with a swollen left thumb, which he could barely move. There were inconsistent statements provided by [redacted] and the father as to how the injury occurred. The injury was treated at Nemour's Children's Hospital. Collateral contacts did not express concerns for the children or the father's parenting. The report was closed with not substantiated findings of physical injury, and the father was referred to STEPS. The second report was received in November, concerning that the father spanked [redacted] causing him to be in pain. In addition, [redacted] reported that the father punched him in the eye. Upon investigative onsite, the CPI documented that there were no injuries to [redacted] and the dark marks under his eyes appeared to be natural "bags" and darkness and were not swollen. Collateral contacts did not present any concerns regarding the father's care of the children. The report was closed with no indicators of physical injury. The family was referred to Chrysalis and STEPS; however, the father did not engage in the programs.

A report was received in May 2023 after [redacted] was observed with a bloodshot, red eye. [redacted] and the father reported that [redacted] poked himself in the eye causing the redness. The Jacksonville Sheriff's Office (JSO) was contacted due to the nature of the allegations and accompanied the CPI to interview the family. The law enforcement report noted that while the child did have an injury to his eye, the CPI did not determine there was immediate danger and indicated no further assistance from their agency at that time, and they would be following up with CPT. JSO took this as an informational report, and it was closed with no further action. [redacted] and Jahrasha were also evaluated by CPT. CPT observed [redacted] with bruising to his right eye with sub-conjunctival hemorrhaging and opined that the injury was not consistent with the statements provided. Additionally, [redacted] was observed with patterned linear marks on his face, neck, back and thighs indicative of physical abuse with an object. CPT observed Jahrasha was observed with linear patterns and loop shaped marks covering the entirety of her back, which she reported was from her father after she defecated in her pants. CPT opined that there were positive findings of physical abuse and recommended an out-of-home plan for the children. Although CPI staff implemented a safety plan, the father refused to sign the plan or cooperate. The safety provider reported that she has not observed any physical discipline towards the children, and prior to closure, [redacted] was interviewed and reported no concerns. The report was closed with verified findings of physical injury, and the family was referred to STEPS; however, the father did not engage in the program.

A sixth report was received January 3, 2024, after [redacted] was allegedly observed with a busted lip. Additional concerns were reported including the father using marijuana and cocaine, concerns for the condition of the home, and the father limiting the children's food. The family was unable to be located initially and when the father was contacted, he refused to cooperate with the CPI staff. As a result, [redacted] was not seen until seven days later at school when he was observed free of any injuries. [redacted] reported he did not have a busted lip and was not hit by his father but had a blister. He also reportedly disclosed that he could not tell some things because he would get into trouble. Additional attempts were made to engage the father and see Jahrasha; however, it was not until January 30, 2024, that the father allowed Jahrasha to be seen via Facetime, after which the father refused to allow CPI into the home or to see her in person. At the time of the fatality incident, the report was open.

System of Care Review

This review is designed to provide an assessment of the child welfare system's interactions with the Golson family and to identify issues that may have influenced the system's response and decision-making.

Practice Assessment

PURPOSE: This practice assessment examines whether the child welfare professionals' actions and decision making regarding the family were consistent with the Department's policies and protocols.

FINDING A: There were multiple inadequate assessments, guidance, and follow through with agencies involved that impacted the decision making and case trajectory in the verified prior report and the open investigation. Available information was not used in a meaningful way to drive decision making, assess child safety, and determine service needs. In addition, the totality of the child welfare history that was available was not considered in the safety decisions or in the risk assessments that were conducted in the case.

Child Protective Investigation #2023-147399

On May 5, 2023, an investigation was received with concerns for [redacted] having a "bloodshot" eye. Upon onsite of the investigation on May 05, 2023, the CPI accurately determined that [redacted] injuries were inconsistent with the explanation provided. The child had a bloodshot eye, and the child reported he had done it to himself. The father explained that he had been spanking the child and that the child had "poked" himself in the eye during the disciplinary act. The CPI notified the CPT the same day to ensure the child was seen timely. After the child was seen at CPT and after consultation with CPT, the CPI implemented a safety plan. The CPI appropriately identified present danger. An in-home safety plan was created, with the father remaining in the home and a safety monitor coming into the home. After refusing to sign the safety plan, the father verbally agreed to the safety monitor being in the home. The safety plan actions were not sufficient or appropriate given the extensive history with the family.

Although there was a timely initial supervisory and second-tier consultation, there was insufficient guidance provided. This led to an incomplete assessment of the family, which impacted the decision making and trajectory of the case. The applicable CFOP 170-5 titled "Child Protective Investigations," chapters 4, 6, 17, and 26 are especially pertinent to field staff as they prepare for field activities and for supervisors providing adequate supervision. The following are areas where additional supervisory guidance was warranted:

- Initial Consultation
    - While the CPIS stated that "present danger had been found," the CPIS did not provide a rationale for the in-home safety plan that was implemented given the extensive prior history with the family and physical injury cases. CFOP 170-7 Chapter 1, titled "Develop and Manage Safety Plans" states, in part, that "To the fullest extent possible, the parent(s)/legal guardian(s) will be engaged in developing the safety plan" and goes on to discuss that the parents demonstrate an understanding of why a safety plan is needed. Safety plans are to be signed by both parents, the safety providers, supervisors and assigned worker, and in this case, were not. There was also no discussion documented regarding how the safety monitor was vetted and if the safety monitor was aligned with the father or the children, or if the safety monitor was aware of why a safety plan was needed. Further, the father had only given verbal agreement to the safety plan but would

not sign the safety plan as he had indicated he was not willing to work with the Department. This should have triggered additional discussion with the CPI, as well as the program administrator (PA), to discuss the level of intrusiveness needed on the safety plan.
    - Regarding the Present Danger Assessment (PDA), all danger threats that were active at the time were not identified. The danger threat of "violent/impulsive behavior" should have also been selected with appropriate safety actions to mitigate that danger threat reflected on the safety plan.
    - There was no discussion documented for the CPI to follow up on CPT recommendations, and there was no documentation that guidance was provided to contact the parent and discuss the CPT recommendations.
    - There was no documented guidance regarding discussing with the CPI that chronological notes needed to be updated.
    - As part of supervisory guidance, referrals that might be needed by a family should also be discussed to determine their efficacy. In this case, the father had already been referred to the same service (STEPS) on multiple investigations, with no success or engagement with the provider. This should have prompted a discussion with the CPI regarding the father's willingness to engage with services and the impact on the safety decision in the case.
- Second Tier Consultation
    - The Northeast Region has a process for second-tier consultations that allows the PA to delegate the required activities for present danger safety plans to be completed by the Family Safety Specialist (FSS) staff. The second-tier consultation completed by the FSS was not thorough, nor did it provide definitive feedback. The documentation appears to be more suggestions and not tasks that must be completed, i.e., "FSS suggest documenting how the safety monitor was vetted, how the safety plan will be monitored, implement safety management, and refer the family to services." Interviews reflected that the FSS does not feel empowered to make task requirements as those staff do not report to her and she is not their supervisor. There is no defined process to convey cases of concern to the PA from the reviews that the FSS completes.
    - The FSS stated that the PDA was sufficient; however, as with the initial consultation, there was the missed danger threat on the PDA that should have also been assessed by the CPI.
- Follow-up Consultation
    - Weekly supervisory consultations are required when a present danger safety plan is in place, however, none were documented in this case.
    - As part of the follow-up consultations, there is no documentation to support the change in case direction as closing safe versus unsafe.
- Closure consultation
    - When the Streamline Family Functioning Assessment (FFA) process is utilized; a supervisor closure consultation must be completed to ensure that all required investigative tasks have been completed, confirmation of typed chronological notes containing sufficient information to support the safety determination are in the case record, and agreement with the final safety decision.
        i. In this case, the Chrono notes do not contain the domain functioning information that is needed to support the safety decision.
        ii. In the initial consultation, as well as the second-tier consultation, safety management was mentioned as being needed. There is no explanation provided as to why safety management was not completed when it is an available service to assist with investigations.

- There is no documentation that the CPIS provided guidance regarding the insufficient information collection throughout the case, as well as statements made by the children that were not reconciled. [redacted] disclosed his sister had marks from beatings, and Jahrasha had stated the father "tore my skin off." These statements warranted additional reconciliation during the assessment of the family dynamics and domain information collection.
- During the closure review process, the risk assessment should also be reviewed. The CPIS missed that the risk assessment was scored incorrectly. Risk assessments are scored numerically, with those numbers correlating to low, medium, high, and very high risk. Service providers utilize the risk assessment score to determine the level of services offered to the families. This score impacted the services that were subsequently referred. (See the service array for details.)

Child Protective Investigation #2024-002577 (open at time of the fatality)

On January 3, 2024, an investigation was received with concerns for the child, [redacted], having a "busted lip." The father refused access to the CPI at the time of investigative on-site and during the time the investigation was open. [redacted] was seen and interviewed at school, seven days after the case was received, and Jahrasha was not seen face to face at any time during the investigation, with only a virtual contact made on January 30, 2024. There was a lack of urgency to locate the children on this case as well as failure to follow CFOPs, Florida statute, and administrative code. The following are areas where additional supervisory guidance was warranted:

- Pre-commencement Consultation
  - Although interviews reflected that there was a pre-commencement consultation as required with provisionally certified staff, there was no guidance provided regarding the prior history. Due to the family's extensive history with the Department, discussing prior history is vital when planning initial contact with the family. CFOP 170-5, chapter 6-5 titled "Pre-commencement Planning and Teaming" describes in detail the areas to be discussed as well as guidance that is to be provided to staff during the pre-commencement consultation. This consultation is also required to be documented in the Florida Safe Families Network (FSFN), but it was not in this case.
- Initial consultation
  - There was no face-to-face contact with Jahrasha, and the supervisor did not escalate the issue with the PA or seek a legal staffing due to the father's statements of fleeing departmental contact. The CPI and CPIS viewed the child through "Facetime" on the worker's iPhone; however, this is not conducive to evaluating the child for any type of marks or bruises on the body nor is this an accepted practice for following CFOP and statutory requirements. While there were no allegations of physical injury to Jahrasha, given the totality of the family's history, a body check would have been appropriate. The home environment could also not be fully evaluated to ensure that the children's basic needs were being met, as well as addressing the allegations and assessing for safety without face-to-face contact.
  - Present danger was not identified; however, there was an active danger threat with the father saying "good luck in finding me," which would indicate a possibility of fleeing with the children to avoid agency involvement. Interviews indicate that the supervisor was not familiar with the Motion to Produce or Take Into Custody Order (TICO) process. These are legal proceedings which result in a court order

for the Department to have access to children to assess their safety during investigations. Had the case been escalated to the PA, the PA could have provided sufficient guidance to the supervisor.

- Incorrect danger threats were identified on the PDA. During initial consultations, discussion of danger threats is part of the learning that takes place for field staff to ensure all active danger threats are identified. While the initial consult accurately indicates that the PDA was not sufficient, this needed additional follow-up by the CPIS to ensure that the CPI had assessed present danger correctly. The CPIS indicated a follow-up consultation was needed and had even provided a due date to review the revised PDA. However, the follow-up consultation was not completed nor was the PDA updated until after Jahrasha's death.
- There was no guidance to consult with the behavioral health consultant (BHC) regarding the substance misuse allegations. Interviews reflect that the BHC is very responsive and will go in the field with CPI staff to attempt engagement with the parent. The BHC also can provide information to CPI staff regarding the safety implications for illicit drug use.
- While interviews indicate that there are multiple unseen children/victims lists that are generated and distributed to supervisors and CPIs daily, there were no formal staffings with the PA to discuss the attempts to locate the children on the open case. There is no documentation to support that diligent efforts were discussed or explained with the provisionally certified CPI.
- The prior history was not assessed correctly by the CPIS. In the initial consultation, the CPIS stated that "that there was no pattern of behaviors;" however, a review of FSFN does show a pattern of injury to the children.
- The initial consult did not discuss the lack of reporter contact. The CPI did not contact the reporter until the 4th week of the case; however, report contact is required to be attempted before commencement of the investigation per CFOP 170-5, chapter 6-4 titled "Required Reporter Contact". The reporter often has valuable information and insight that can assist the CPI when launching their investigation.

  > "The investigator must attempt to contact the reporter prior to commencing the investigation in order to verify information contained in the allegation narrative and to explore additional information the reporter might have on the maltreatment incident or on the child/family in general…".

- The guidance by the supervisor regarding CPT contact is not documented. This was a mandated referral that was not referred until February 5, 2024. In certain situations, field staff are required to contact CPT to inquire if CPT will be conducting a physical exam, completing forensic interviews, or assessing medical records to determine if abuse or neglect are present. An injury to the face is one of the scenarios when CPI staff must contact CPT to discuss information collection and observations of the child and discuss next steps. In situations when injuries are noted on a child, it is imperative to consult with CPT as soon as possible to have an accurate assessment of the injuries. Interviews reflect that CPT staff had remembered the children from prior investigations and had attempted contact by email with the CPI and CPIS regarding the urgent nature of the CPT referral; however, the CPI and CPIS did not respond to CPT's concerns.

While each case had unique challenges, there were commonalties of the quality of supervision on both investigations.

- There were missed opportunities to staff the cases with Children's Legal Services (CLS).
  - Legal consultation when the father was refusing to sign a safety plan on the verified prior.
  - Legal consultation when the father refused to allow access to Jahrasha and made statements indicating potential fleeing on the open case.
- The lack of information on family dynamics and functioning hampered safety assessments. Additionally, there were no guidelines on what further information was required. Relevant collaterals for the family would have been school records, including school health clinic or disciplinary, primary care physician, as well as contact with Jahrasha's mother. Collaterals from the school would have also been beneficial. The teacher, principal, and social worker would have been resources to discuss the issues with [redacted] and his previous injuries and potential behavior that was escalating according to the father. Further, the school collaterals could have provided information/observations as to the dynamics of the father and [redacted] as well as potentially informing the CPI of the homeschooling decisions for Jahrasha. The father mentioned taking the children for medical treatment. A medical collateral could provide information regarding the reasons for treatment as well as any observations of the children and the parent. As the father was difficult to engage, the supervisor of each case should have provided guidance to contact as many professional contacts as possible to glean information about the family. While Jahrasha's mother appears to not be in a regular caregiving role, it is a requirement to attempt to contact the other parent when an investigation is received, and there is no mention in either investigation of attempting to contact the mother.
- Photos of the children were not found in either case record. Photographs were needed to confirm the condition of the children.
- CPT reports, findings, and recommendations were not followed. Although a safety plan was initiated because of the CPT exam findings in May 2023, the other recommendations were not addressed by investigations staff. In the open case, requests from CPT were not acknowledged by field staff. Supervisors play an integral role in ensuring that the information obtained from CPT is considered when making safety decisions during investigations.
- Subject matter experts were not contacted or consulted. There was an indicator of possible mental health concerns for the father on a prior case and substance misuse allegations on the open case. Interviews reflect positive relationships with the BHC and that the BHC will go in the field to assist CPIs with assessments. This resource could ensure that the family dynamics were thoroughly assessed and that appropriate services were in place.

Although present danger was identified in the prior investigation, the children were subsequently determined to be safe; however, there was minimal documentation and insufficient information collected to support that safety decision. The inadequate assessment of the family's prior history with the Department, the totality of the injuries, and the children's statements contributed to the trajectory of both cases. There was no acknowledgement of the father's previous lack of cooperation and his unwillingness to engage with the Department and the potential impact on child safety. Therefore, the insufficient supervisory guidance significantly impacted the decision making on both investigations.

FINDING B: Neither the Department nor CPT staff utilized their respective internal escalation processes/protocols to ensure that any identified issues or concerns were addressed. This

resulted in missed opportunities for accurate decision making which further impacted case trajectory.

Child Protective Investigations

The Department has a well-known internal escalation process to ensure concerns are communicated and appropriate guidance is provided. The supervisors are aware of the process to staff cases of concern with both the FSS and the PA, as well as staffing removals with the operations manager. Interviews revealed that while staff were aware of the escalation process, they did not seem to understand the nature of the cases to prompt their utilization of the escalation process. In both cases – the open and the verified prior – there were no formal staffings with the PA to seek additional guidance and direction. With specific regard to the verified prior, the FSS did not escalate the case to the PA for additional oversight to ensure the proper safety decision was made concerning present danger.

Child Protection Team

Through interviews, it was noted that CPT staff also have an escalation process. The PA indicated that CPT will frequently contact her if they cannot get in contact with the CPI or the CPIS. Typically, CPT staff will reach out to the CPIS and, if the situation is not resolved, CPT will email the CPI, the CPIS, and the PA. In addition, the case coordinator will escalate the cases through CPT leadership as well if they are unsuccessful with contacting investigative staff.

While there is also a robust Multi-Disciplinary Team (MDT) staffing process to discuss cases of concern, there were no MDTs requested on either the verified prior or the open case despite CPT having noted multiple issues. In the verified prior case, CPT had safety concerns and very specific recommendations regarding contact between the father and children (specifically, no unsupervised contact), as well as other recommendations that would benefit the children.) While CPT did discuss their findings with the CPI, with a safety plan being implemented, none of the other recommendations were followed (such as no unsupervised contact between the father and the children).

In the open case, CPI staff contacted CPT on February 5, 2024, and the nurse practitioner requested via email that the CPI go back in the field to see the children and asked that the CPIS also go with the CPI. The nurse practitioner recognized the names of the children due to the previous reports and was concerned about their well-being. The nurse practitioner was not able to connect with the CPI or the CPIS regarding the concerns. The nurse practitioner did not attempt to contact the PA to convey the concerns, nor was CPT leadership involved to escalate the concerns.

Organizational Assessment

PURPOSE: This section examines the level of staffing, experience, caseload, training, and performance as potential factors in the management of this case.

FINDING A: While the investigative staff involved in the prior verified report were well-experienced in the child welfare field, the limited level of experience of investigative staff in their current roles impacted safety decision making during the open investigation.

Historically, Duval County has struggled to maintain a stable workforce. Recently that has not been the case and the operations manager credits “changing the culture” as the reason that the service center at the time of the CIRRT review only has three (3) vacancies out of 35 total positions: two (2) CPI positions and one (1) CPIS position. He also states having regular pre-

service training classes has helped with ensuring that staffing levels are maintained. The operations manager recognizes that there is also a need for ongoing training to ensure that staff are not only supported, but also have frequent reminders of important topics for the field. He has utilized the Regional Program Office, as well as Office of Quality and Innovation personnel, to provide training boosters to field staff regarding various topics. He also requires weekly meetings with the supervisors to relay information as well as a way of building rapport and providing support.

The CPIS assigned to the verified prior report from May 2023 had over 19 years of child welfare experience and the CPI had over two and a half years of child welfare experience. Regarding the open case received in January 2024, the CPI was provisionally certified with less than one year of child welfare experience and had been assigned cases for approximately six months before the January report was assigned. While the CPIS had a total of 3.5 years of child welfare experience as a CPI, they had less than a year of supervisory experience. CPIs who are provisionally certified often need a closer level of supervision as they learn the details of conducting child abuse investigations. Provisional staff often need additional support when encountering parents who have a difficult temperament to help them engage those parents in the investigative process.

The CPIS in the open investigation was managing a unit that was comprised of 66% provisionally certified staff. In addition, because there is no formalized on-boarding process for new supervisors, such as learning how to balance caseloads, data requirements, and personnel management, they were learning the details of supervision at the same time. It is important to note that the department is in the development stage for a training program to address new supervisory skill building.

In this case, the father was not willing to allow access to his child or the home. Provisional staff may not have been aware of legal options on how to proceed, as well as additional resources needed and/or available to aid in the engagement process, such as taking additional experienced staff in the field to re-engage the parent and additional supports. Provisional staff may also not have felt empowered to complete full body checks or to request assistance from others, such as a school nurse, in completing this task.

While high caseload levels can commonly be a factor in effective investigations, caseloads do not appear to have been a factor in terms of affecting the casework. The average cases received per CPI for the unit who investigated the verified prior was 12 for the previous three months. The average cases received per CPI for the unit who investigated the open case was 11.6 for the previous three months.

Service Intervention/Array

PURPOSE: This section assesses the inventory of services within the child welfare system of care.

FINDING A: There are a variety of services available to assist families in Duval County. In this case, investigations staff did refer the father to services through the STEPS program, however, given the level of intervention needed, it was not an appropriate referral as the father had previously refused to engage with providers.

FSSNF is the lead agency in Duval County. They have a plethora of services that are available to assist the community as well as the child welfare system. One of their contracted case management organizations is Jewish Family and Community Services (JFCS) of Jacksonville. JFCS manages the STEPS program to help stabilize families and provides referrals to other

community services that the family might need. Depending on the risk level, families receive between one and three home visits a month, for an average of three months. For high-risk families, there are more frequent home visits. Case management can also be offered along with developmental assessments for the children, parenting, and other programs that the family thinks would benefit them. For low to moderate risk families, the mode of contact is usually by phone and is more community linkage-based referrals rather than direct service provision.

As mentioned in Practice Assessment Finding A, the risk assessment was scored incorrectly, resulting in a moderate risk score. This is important as STEPS utilizes the risk score in determining the intensity of engagement attempts and the close-the-loop staffing. As the case was scored moderate risk, three phone calls were attempted, a letter was sent to the parent, and Department was notified by email of the referral being closed. With a high-risk score, more attempts are made, a letter is mailed to the parents, and an email is sent to the Department to notify of the parents not responding or declining. The purpose of the email is to trigger the Department to set up the close-the-loop staffing. Interviews indicate that an official close-the-loop staffing rarely occurs, but the email is often acknowledged by field staff.

The Golson family had been referred to STEPS on multiple occasions over the past few years. In each instance, the father refused to engage and would not acknowledge the attempted contact with the provider. This lack of engagement with the service should have triggered the supervisor and CPI on the case to discuss the effectiveness of the referral and what would be a more appropriate service and the level of intrusiveness required.

Immediate Operational Response

In response to the review findings, the Department has implemented the following immediate actions in the Northeast Region (NER):

Practice Assessment Finding A:

There were multiple inadequate assessments, guidance, and follow through with agencies involved that impacted the decision-making and case trajectory in the verified prior report and the open investigation. Available information was not used in a meaningful way to drive decision making, assess child safety, and determine service needs. In addition, the totality of the child welfare history that was available was not considered in the safety decisions or in the risk assessments that were conducted in the case.

Operational Response

1. The NER implemented a regional policy that requires a staffing to occur between the CPI, CPIS, PA, and the Operations Manager (OM) on every investigation that has verified findings and will not be moving to formal case management services. The NER data analyst pulls a weekly report identifying cases closed verified without on-going case management services and adds the cases to a tracker that is sent to the Child Protection Director (CPD), OMs, and PAs. In addition to documenting in a FSFN consultation note, the tracker has a comment section for the OMs and PAs to acknowledge a staffing occurred and justification for the closure decision.
2. The NER has implemented red flag staffings. The NER data analyst pulls a report weekly on cases meeting the criteria for a red flag staffing. Red flag staffings include the CPI, CPIS, OPA, OM, and any pertinent stakeholder. Red flag staffings occur on every investigation that meets the following criteria:
    - Bone Fracture

- Burns
- Physical Injury with injuries above the neck on children 5 and under
- Failure to Thrive/Malnutrition/Dehydration
- Near Death/Drowning
- Internal Injuries
- Asphyxiation/Suffocation/Drowning
- Any case of concern noted by CPI, CPIS, PA, or OM.

The report is shared weekly with the PAs and OMs. Information in the report is added to a Red Flag tracker that is monitored by the designated FSS who coordinates the staffings.

3. Tier 2 consultations are completed on all Present Danger cases by the PA rather than another designated second party reviewer (specialist, etc.)
    a. All present danger cases are referred to safety management within 24 hours of determination. Safety plans are monitored every seven days and at critical junctures to include interviewing all children in the home.
    b. Present Danger cases require follow-up consultations by the supervisor at 14 days to discuss the safety plan and whether it should be continued. Follow-up consults are then required every seven days.
    c. The NER has implemented a process wherein a weekly report is pulled by the data analyst identifying cases with present danger plans. These cases are added to a tracker. The tracker and report are shared weekly with the PAs and OMs for review and comments. This includes a column for comments to document expected outcomes and timeframes. This is in addition to FSFN documentation. PAs will complete a follow-up consult at 21 days to ensure compliance. An additional column was added to document the last day the child(ren) were seen for follow up on safety plan monitoring.

Practice Assessment Finding B:

Neither the Department nor CPT staff utilized their own internal escalation processes/protocols, to ensure that any identified issues or concerns were addressed. This resulted in missed opportunities for accurate decision making which further impacted case trajectory.

Operational Response

All CPT reports will be reviewed by both the CPIS and PA with a consultation or note entered in Comprehensive Child Welfare Information Systems (CCWIS) / FSFN that identifies next steps. If there are any concerns, the PA or the CPIS will escalate their concerns to CPT as soon as identified.

1. All CPT reports will go to a single point of contact, the designated FSS, and entered into a tracker. The PAs will be notified by email by the FSS of any verified reports from CPT. PAs will follow up to ensure concerns are escalated and staffed as appropriate. The Northeast region operations managers will monitor the tracker and ensure follow-up tasks are complete.

Organizational Assessment Finding A:

While the investigative staff involved in the prior verified report were well-experienced in the child welfare field, the limited level of experience of investigative staff in their current roles impacted safety decision making during the open investigation.

Operational Response

1. On-going training on the safety practice has been schedule for the CPI staff by the Family Safety Program Office Training Team.
2. Case consultation training has been scheduled for CPIS staff and will be on-going with training provided by the Family Safety Program Office.
3. The Circuit 4 OM host weekly meetings with the CPIS and PA Team to train on the safety practice and to staff complex cases.
4. Notification are being sent prior to assignment of any cases meeting the Red Flag criteria. The PAs and OMs will identify the most appropriate CPI to be assigned.