Critical Incident
Rapid Response Team

Ashton Riley Campbell Jenkins
Shana-Lynn Marie Cavanaugh

Florida Department of Children and Families
09/03/15
Critical Incident Rapid Response Team

Ashton Riley Campbell Jenkins
Shana-Lynn Marie Cavanaugh
Northeast Region
Circuit 7
2015-203047
Volusia County, Florida

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Executive Summary

On July 30, 2015, the Department of Children and Families received a report regarding the drowning deaths of two children, 16-month-old Ashton Riley Campbell Jenkins and 25-month-old Shana-Lynn Marie Cavanaugh, both of Volusia County. Shana-Lynn is the daughter of 33-year-old Martha Jenkins. Ashton is the only child of Ms. Jenkins’ 17-year-old daughter, whose name is not provided. The incident occurred when the toddlers got out of the home undetected while Martha Jenkins and her mother, Waltraud Jenkins, were sleeping.

Martha Jenkins went to bed late on the night of July 29, 2015, and awoke at approximately 11:00 a.m. July 30. When she realized that the children were no longer in bed, she looked for them and found the children in the swimming pool. It is unknown how the children gained access to the pool area; the sliding glass door leading outside was described as “heavy” and difficult for a small child to open. Household members reported that the sliding glass door was often left open to allow the pets to go in and out of the home. Upon seeing the children in the water, Ms. Jenkins called 911, and paramedics responded to the home and transported both children to local hospitals, where they were pronounced dead. In addition to Shana-Lynn, Ms. Jenkins has an older child (5-year-old, whose name is not provided) residing in the home; was unharmed.

Martha Jenkins submitted to a drug screen and tested positive for marijuana and methadone. Ms. Jenkins sporadically goes to a methadone clinic.

was not in the home when the incident occurred as she had been residing in an apartment that is being provided by an adoption agency. is pregnant and is planning to offer the child for adoption. She also complied with a drug screen and tested negative for all substances.

Because there were verified prior reports on both Martha Jenkins and within 12 months of the children’s deaths, on August 4, 2015, a Critical Incident Rapid Response Team (CIRRT) was deployed to review the Department’s past involvement with the family and to assess for potential systemic needs within the local system of care. The response team completed a review of the case records and conducted interviews with staff from child protective investigations, Community Partnership for Children (community-based care lead agency in the Northeast Region), Neighbor to Family’s Family In-home Resource and Support Team (FIRST), the Child Protection Team and Children’s Legal Services. The team identified opportunities for practice improvements to further strengthen the local system of care. The following is a summary of those findings:

Practice Assessment

A. Both protective investigations and case management services focused more on Martha Jenkins’ chronic health problems and minimized the severity of her substance abuse and its harmful impact on the children.
B. The Community Based Care Agency and their contracted service provider (FIRST) focused on meeting contract requirements as opposed to engaging the family to facilitate change.

C. **FIRST** case was included with Martha Jenkins’ **FIRST** case. The focus continued to be on Martha, and parental capacities and service needs were not adequately addressed.

D. There was a perception that the Region's leadership did not support removals except as a last resort. This perception affected the decisions made by frontline staff.

E. The dynamics of family violence were not fully assessed.

F. The application of the Child Welfare Practice Model was not aligned with the core concepts of the model. Additionally, the records lacked documentation, and there was a lack of reconciliation of conflicting information.

### Organizational Assessment

A. Recent changes in management have begun to break down the existing barriers and build more productive working relationships.

B. Both protective investigations and case management had manageable caseloads at the time of their involvement.

C. There were gaps in training of the new Child Welfare Practice Model.

### Service Intervention/Array

A. The services in the area are plentiful; however, there is difficulty at times accessing these services.

B. There are often waitlists for Neighbor to Family therapists, substance abuse treatment and medication services.

C. In-home, non-judicial services tend to be well-being focused instead of safety focused. There is a need for formal safety management and formal safety services. When families are noncompliant with these providers, the cases typically are not staffed with Children’s Legal Services to request possible court action.
Introduction

On July 30, 2015, the Department of Children and Families (DCF) received a report regarding the drowning deaths of two children, 16-month-old Ashton Riley Campbell Jenkins and 25-month-old Shana-Lynn Marie Cavanaugh, both of Volusia County. This report will reflect two Critical Incident Rapid Response Team (CIRRT) investigations. Shana-Lynn is the daughter of 33-year-old Martha Jenkins. Ashton is the only child of Ms. Jenkins’ 17-year-old daughter, [redacted]. The incident occurred when the toddlers got out of the home undetected while Martha Jenkins and her mother, Waltraud Jenkins, were sleeping. During prior investigations, child protective investigators had discussed pool safety with the family on multiple occasions, including the hazardous condition of the pool.

Martha Jenkins went to bed late on the night of July 29, 2015 and awoke at approximately 11:00 a.m. July 30. When she realized that the children were no longer in bed, she looked for them and found the children in the swimming pool. It is unknown how the children gained access to the pool area; the sliding glass door leading outside was described as “heavy” and difficult for a small child to open. Household members reported that the sliding glass door was often left open to allow the pets to go in and out of the home. Upon seeing the children in the water, Ms. Jenkins called 911, and paramedics responded to the home and transported both children to local hospitals, where they were pronounced dead. On July 30, 2015, Martha Jenkins submitted to a drug screen and tested positive for marijuana and methadone. According to Ms. Jenkins, she sporadically goes to a methadone clinic.

In addition to Shana-Lynn, Martha Jenkins has an older child (5-year-old [redacted]) residing in the home; [redacted] was unharmed. As a result of the investigation, [redacted] was not in the home when the incident occurred as she had been residing in an apartment that is being provided by an adoption agency. [redacted] is pregnant and is planning to offer the child for adoption. She also complied with a drug screen and tested negative for all substances.

In December 2014, a child protective investigator verified Martha Jenkins as the caregiver responsible for physical injury of Shana-Lynn. Ms. Jenkins was referred to Neighbor to Family’s Family In-home Resource and Support Team (FIRST). Shana-Lynn received a chemical burn to her chest as a result of getting into bleach. Martha Jenkins refused to submit to a drug screen.

Another investigation was conducted in January 2015, involving [redacted] and Ashton Jenkins. The investigation was closed with verified findings of environmental hazards and substance misuse. The focus of the investigation was on Martha Jenkins’ substance abuse in the home. [redacted] also tested positive for marijuana and benzodiazepines at that time.

On August 4, 2015, a Critical Incident Rapid Response Team was deployed to review the Department’s past involvement with the family and to assess for potential systemic needs within the local system of care. The response team completed a review of the case records and
conducted interviews with staff from child protective investigations, Community Partnership for Children, FIRST, the Child Protection Team and Children’s Legal Services. The review team consisted of representatives from DCF’s Office of Child Welfare, Children’s Legal Services and Central Region staff, Sarasota YMCA (community-based care lead agency in the SunCoast Region), Central Florida Behavioral Health Network (a substance abuse service provider in the Central Region), Wayne Densch Center Inc. (a domestic violence service provider in the Central Region), and a Child Protection Team Medical Director.

This report presents the CIRRT’s findings, including the child welfare history, the family composition, a summary of the local child welfare service providers, as well as an analysis of the system of care.
Case Participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Age at Time of Incident</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashton Riley Campbell Jenkins</td>
<td>16 months (DOB: 01/14)</td>
<td>Decedent</td>
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<tr>
<td>Shana-Lynn Marie Cavanaugh</td>
<td>2 years (DOB: 10/13)</td>
<td>Decedent</td>
</tr>
<tr>
<td></td>
<td>5 years (DOB: 10/17)</td>
<td>Sibling</td>
</tr>
<tr>
<td></td>
<td>17 years (DOB: 08/19)</td>
<td>Mother of Ashton</td>
</tr>
<tr>
<td>Martha Nicole Jenkins</td>
<td>33 years (DOB: 03/29)</td>
<td>Mother of Shana-Lynn, Ashton, and</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Waltraud Jenkins</td>
<td>61 years (DOB: 09/09)</td>
<td>Maternal Grandmother</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10 years (DOB: 05/13)</td>
<td>Half-sibling not in home</td>
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<tr>
<td></td>
<td>5 years (DOB: 05/10)</td>
<td>Cousin</td>
</tr>
<tr>
<td>Lorraine Renee Davis</td>
<td>41 years (DOB: 02/11)</td>
<td>Maternal Aunt</td>
</tr>
</tbody>
</table>

Cavanaugh/Jenkins Genogram:

- Waltraud Jenkins (Maternal Grandmother)
  - Martha Jenkins (Mother)
    - Shana-Lynn Marie Cavanaugh (deceased)
      - (5)
    - (11)
  - Lorraine Davis (Maternal Aunt)
    - (17)
  - Ashton Riley Campbell Jenkins (deceased)
Child Welfare Summary

Martha Jenkins has had an extensive history with the child welfare system dating back to 1999. At that time, the reported concerns were due to inadequate supervision with regards to then-2-year-old who was found wandering a block away from the family’s home. For two years afterward, there were no reports received on the family at the Florida Abuse Hotline; however, between November 2001 and December 2014, there were a total of 12 reports received, nearly all involving allegations of Ms. Jenkins’ substance abuse.

In November 2001, displayed extensive knowledge on how to smoke marijuana. During the investigation, Martha Jenkins gave Power of Attorney to her sister, Lorraine Davis, and went to reside with Ms. Davis in Georgia. Ms. Jenkins agreed to complete a substance abuse evaluation but later was uncooperative.

In July 2009, Martha Jenkins was admitted to treatment sought by her mother, Waltraud Jenkins, because Martha was pregnant and abusing prescription drugs. In January 2010, Martha Jenkins was after she was found unconscious on the bathroom floor and subsequently tested positive for opiates, benzodiazepines, cocaine and cannabis. Again, Waltraud Jenkins successfully sought treatment for her daughter, as Martha was again pregnant at the time of this incident and was observed with marks on her arms indicating drug use. There were two more investigations in 2010 alleging substance abuse. Martha Jenkins continued to be and was receiving services in Volusia County.

Despite the efforts of the aforementioned treatment programs, reports of Martha Jenkins’ substance use continued to be received at the hotline. During an investigation in September 2011, Ms. Jenkins reported that she was receiving treatment from a methadone clinic; however, she also tested positive for benzodiazepines when she was screened. Although she was referred for another substance abuse evaluation, there is no information to support whether she complied.

In June 2013, Ms. Jenkins again tested positive for benzodiazepines, amphetamines and methadone, when she gave birth to Shana-Lynn. Martha Jenkins and blamed her positive drug screen, except the methadone, on the medication she received while giving birth. By the time this report was received, household substance abuse issues were further compounded given that then-14-year-old was now involved with a treatment program.

In December 2013, Martha Jenkins was arrested after she and her mother, Waltraud, were involved in a physical altercation. Ms. Jenkins hit her mother in the face multiple times, resulting in a bloody nose. Pre-trial intervention services were engaged through criminal court, and Ms. Jenkins subsequently returned home. Another report was received in March 2014, again alleging
that there were ongoing substance abuse issues. This time, however, the allegations were not focused solely on Martha Jenkins, but were inclusive of the maternal grandparents as well, with specific concerns noted about the possibility of a methamphetamine lab on the property. Two unannounced visits yielded no evidence of drug paraphernalia or any indication of impairment with regards to any of the household members.

The last report involving Martha Jenkins was received in December 2014 and again alleged concerns of ongoing substance abuse as well as supervision issues, after Shana-Lynn sustained chemical burns when she gained access to bleach and poured it on herself. At the time of the investigation, Ms. Jenkins tested positive for methadone and marijuana and expressed a desire to get help for her ongoing substance abuse issues. As a result, the family was referred for services through Neighbor to Family’s Family In-home Resource and Support Team (FIRST), the local community-based care provider program.

Only DCF involvement as a caretaker occurred in January 2015 after a report was received due to concerns of ongoing substance use as well as environmental hazards. Initially, [redacted] and her child, Ashton, were going from place to place and did not have stable housing. However, they subsequently returned to live with Martha Jenkins, who was now believed to be using heroin and reportedly had materials for building a methamphetamine lab in her home. [redacted] tested positive for marijuana and benzodiazepines and expressed a desire to receive services so that she would not lose custody of her child. As a result, the investigation was closed, citing that case management was already in the home (stemming from the December investigation) and that the provider would also be working with [redacted] and her child.

Case management remained engaged with the family; however, their primary client remained Martha Jenkins. Because Ms. Jenkins and [redacted] had a tenuous relationship, most of the provider’s time was spent working on conflict resolution as opposed to substance abuse issues. Eventually, Ms. Jenkins decided that she no longer wanted to cooperate with the provider or participate in services, and the service case was subsequently closed in early May 2015.
System of Care Review

This review is designed to provide an assessment of the child welfare system’s interactions with the Cavanaugh/Jenkins 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 Cavanaugh/Jenkins family were consistent with the Department’s policies and protocols.

FINDING A: Both protective investigations and case management services focused more on Martha Jenkins’ chronic health problems and minimized the severity of her substance abuse and its harmful impact on the children.

Martha Jenkins has been diagnosed with [redacted]. Ms. Jenkins has suffered many health complications dating back to 2010, and in June 2011, she signed a Power of Attorney for her sister to care for her children because she believed she had only days to live. In reviewing the case notes from both investigative and case management staff, the focus was on Ms. Jenkins’ physical health. This was also apparent during the interviews with case management and investigative staff. One interviewee even stated, “She didn’t need substance abuse treatment, she had [redacted]” Case management reported that her health problems prevented her from growth.

Martha Jenkins has an extensive substance abuse history and had been referred to substance abuse treatment multiple times with limited compliance with evaluations, drug screens and follow-up recommendations. Shortly after initiation of FIRST case management, Ms. Jenkins tested positive for methadone, marijuana, benzodiazepines, methamphetamines, and buprenorphine (Suboxone). When she was referred to the lab, and went the next day and tested positive for only methadone and marijuana, the initial test was determined to be a false positive.

Martha Jenkins was often uncooperative with the investigators, case managers and treatment. This was overlooked in multiple investigations and in-home, non-judicial cases regarding the Cavanaugh/Jenkins family.

FINDING B: The Community Based Care Agency and their contracted service provider (FIRST) focused meeting contract requirements as opposed to engaging the family to facilitate change.

During interviews with case management staff, the phrase “what is required in the contract” came up frequently. This was often referenced in terms of required contact with families. In a review of the case management notes, documentation is more about compliance than engaging the family or guiding the family toward self-realization that there is a problem and their behavior needs to change. Most of the home visits were announced, and the documentation reflects that the children were clean, well-groomed, and free of any marks and bruises. The safety plan is not ever addressed, and the persons responsible to manage the safety plan (Waltraud and Lorraine) are not spoken to about the safety plan progress.
The caregivers’ Stages of Change based on their addictions were documented; however, steps made by case management staff on how they were assisting the caregiver on progressing through the Stage of Change was not addressed.

FINDING C: The FIRST case was included with Martha Jenkins’ FIRST case. The focus continued to be on Martha and her parental capacities and service needs were not adequately addressed.

Martha Jenkins was referred to FIRST as a result of a December 2014 investigation, and was added to that existing FIRST referral after a January 2015 investigation. had begun to exhibit some of the same patterns of behavior that her mother, Martha, did. Both Martha and were pregnant at 14- to 15-years-old, and they both have a history of substance abuse and illness. At the time of the January investigation, had a 10-month-old child, and she was pregnant. At commencement of that investigation, tested positive for benzodiazepines and marijuana and was drifting from house to house.

While it is unknown what Martha’s childhood was like, there is a very clear understanding of what childhood was like. By only treating as a child on the case and not also as a parent, a significant opportunity to intervene in a more meaningful way on behalf of two children ( and Ashton) was missed.

FINDING D: There was a perception that the Region’s leadership did not support removals except as a last resort. This perception affected the decisions made by frontline staff.

The Department’s practice and statutes dictate that child welfare professionals attempt the least intrusive means of intervention whenever safely possible. During interviews with frontline staff and management, it was evident that they believed there was a push from leadership to reduce the number of removals. Reducing unnecessary removals is appropriate. In order to safely reduce removals, the non-judicial services put in place must vigorously manage safety threats and escalate cases when the non-judicial services are no longer managing the danger threats in the home.

Investigators have sought court action regarding Martha Jenkins by staffing with Children’s Legal Services (CLS) on four occasions. On at least two other documented occasions, it was decided, by investigative staff, that legal consultation was not warranted. In July 2009, the investigation was staffed with CLS, and it was determined that there was not legal sufficiency to take court action. In January 2010, February 2010, and January 2011, investigative staff again sought court action and CLS agreed; however, court action was not taken on any of the three occasions. In 2010, safety planning with Waltraud was the action determined to be least intrusive. In 2011, the investigation was referred to FIRST for in-home, non-judicial services.

In June 2013, when Martha Jenkins tested positive for methadone, benzodiazepines and amphetamines at the birth of Shana-Lynn, the case was staffed with the Operations Manager and it was determined that it was safe for Shana-Lynn to go home with Martha Jenkins. CLS was not consulted at that time, and Martha Jenkins was referred to FIS but declined services.
Martha Jenkins was served by the FIRST program twice and was noncompliant both times. Neither time was the case staffed with Children’s Legal Services. In fact, in the most recent case, when FIRST contacted investigations staff, due to noncompliance, FIRST was advised by investigative staff that there were not sufficient grounds to take legal action. Children’s Legal Services was not contacted for a legal opinion.

**FINDING E:** The dynamics of family violence were not fully assessed.

There are multiple verbal and child abuse investigation reports as well as arrests in this family system that would indicate a need to examine domestic violence dynamics further. Shaun Cavanaugh, Shana-Lynn and [redacted] father, who was often in and out of the home, has an extensive history of violence. He has multiple arrests for domestic battery and battery on a law enforcement officer. There were also multiple verbal reports that he was violent toward Martha. Martha Jenkins also has an arrest history for violence, including an aggravated battery charge against a pregnant woman and an arrest for battery against her mother.

When investigations alleging family violence were received, the focus tended to be on whether or not there was a recent incident. Investigators used law enforcement call-outs to the home and neighbor testimony to determine there had been no recent incidence of violence. The family dynamics in the household were never fully addressed.

**FINDING F:** The application of the Child Welfare Practice Model was not aligned with the core concepts of the model. Additionally, the records lacked documentation and there was a lack of reconciliation of conflicting information.

Overall, the Present Danger Assessments, Family Functioning Assessments, and Safety Plans were not supported by the information that was documented. In the December 2014 investigation, present danger was identified due to Martha Jenkins refusing to submit to a drug screen, and it was believed that the circular wounds on her face could be related to methamphetamine use. The present danger threat that was identified was “other.” The present danger safety plan was initiated five days after present danger was identified. The safety actions on the present danger safety plan included household members (Waltraud and Lorraine) observing the children in the home for injuries and ensuring they had proper supervision. The following safety action was also listed on the present danger safety plan: “All parties will keep the sliding glass doors closed to prevent the children from accessing the pool area unsupervised to prevent drowning accidents.”

A Family Functioning Assessment (FFA) was complete on this household more than 50 days after the commencement of this investigation. The following four danger threats were identified: The child’s living conditions are hazardous and the child has already been seriously injured or will likely be seriously injured; other; parent/caregiver is not meeting the child’s basic needs for food, clothing, and or supervision, and the child is/has already been seriously harmed or will likely be seriously harmed; and parent/caregiver views child and/or acts toward the child in extremely negative ways, and such behavior has or will result in serious harm to the child. The information collection documented in the FFA did not support the identified danger threats. Martha was determined to have significant diminished caregiver protective capacities, and [redacted] protective capacities were all determined to be adequate. Ashton was determined to be safe due to the

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danger threats in the home being effectively managed by Shana-Lynn determined to be unsafe. Shana-Lynn was examined at the Child Protection Team, which determined that her injuries were a result of neglect. Child Protection Team staff noted that it appeared that Martha was under the influence during her interview, and she refused a drug screen at that time. It was determined that an in-home safety plan could be put in place. The family was referred to Neighbor to Family’s FIRST program. In May 2015, FIRST closed its in-home, non-judicial services case. The family declined services, and it was determined that there were no safety concerns in the home at that time.

In January 2015, an investigation was received in regards to Martha and Ashton. It was alleged that Martha was using heroin while the children were present in the home. It was also alleged that there were materials for building a methamphetamine lab in the home and that the condition of the home was hazardous. At commencement of the investigation, Martha and Ashton were not living in Waltraud’s home; they were going from place to place and did not have stable housing. She tested positive for benzodiazepines and marijuana. There was no present danger to Ashton identified. During the course of the investigation, Martha moved back into Waltraud’s home. The FFA did not identify any impending danger threats, and Ashton was determined to be safe in the care of

The most significant gaps in reconciliation were the present and impending danger safety plans. Waltraud and Lorraine were household members but were not included in the Family Functioning Assessment, and their protective capacities were not assessed, yet they were the only two people utilized on the safety plans to provide protection of the children. Lorraine and Waltraud were never assessed to determine if they were willing to take actions to protect the children. In fact, they both made statements to the contrary. Lorraine was overheard by the investigator arguing with Martha. Lorraine told Martha that she was not going to be responsible for anyone else’s children but her own. Waltraud told the investigator that she wanted to buy a mobile home and move out of the house because she could not take the chaos any longer. Despite these statements, Waltraud and Lorraine remained the sole individuals tasked with providing protection. Once the safety plans were initiated, there was no further documentation, by either investigations or case management, that the safety plan had been discussed with Lorraine and/or Waltraud.
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: Recent changes in management have begun to break down the existing barriers and build more productive working relationships.

Within the last year, there have been changes to the management of both investigative and Children’s Legal Services staff. Both were tasked with breaking down some of the barriers that had existed in the circuit. Training involved all stakeholders, roles were defined and relationship-building began to occur. Additionally, the establishment of a new Child Protection Team in the circuit has also built up the relationship between the Child Protection Team and DCF, and it has increased the engagement of the Child Protection Team in collaborating on investigations.

FINDING B: Both protective investigations and case management had manageable caseloads at the time of their involvement.

For the three most recent investigations, investigators averaged receiving 11 new intakes a month. With the exception of the most recent investigator (who had three years’ experience as a child protective investigator), all other investigators and supervisors had more than 15 years of experience in Child Protective Investigations.

The FIRST program also had experienced staff, and turnover was low. At the time, most caseloads averaged between 8-10 cases.

FINDING C: There were gaps in training of the new Child Welfare Practice Model.

There were many inconsistencies in the recollection of frontline staff on how much training they had received in the new practice model. What was consistent was that there had been a year or more of a gap between staff initially being trained on the model and practicing. Some staff reported that they had received multiple refresher trainings before implementations, while others reported that the training offered was only for supervisors and they had not received any further training.
**Service Intervention/Array**

PURPOSE: This section assesses the inventory of services within the Volusia County child welfare system of care where the Cavanaugh/Jenkins family’s case originated.

**FINDING A:** The services in the area are plentiful; however, there is difficulty, at times, accessing these services.

Child welfare agencies in Volusia County have many options of services for the referral of families. However, accessibility of these services at times is difficult. For example, it was often reported by staff that Stewart Marchman was the only substance abuse provider in the circuit, and most of its services were offered only from 8:00 AM to 5:00 PM Monday through Friday. Additionally, the local domestic violence service provider offers only intimate partner violence services. There are no services available that address family violence.

**FINDING B:** There are often waitlists for Neighbor to Family therapists, substance abuse treatment and medication services.

Investigative and case management staff reported that families were often put on waitlists for substance abuse services and for therapists. Case management staff reported that because there were often waitlists for families to obtain needed services, this would require them to work harder with families.

**FINDING C:** In-home, non-judicial services tend to be well-being focused instead of safety focused. There is a need for formal safety management and formal safety services. When families are noncompliant with these providers, the cases typically are not staffed with Children’s Legal Services to request possible court action.

In-home, non-judicial cases for unsafe children are still often viewed as “voluntary” and are closed when the family is noncompliant. During ongoing case management, there was no documentation that the safety plan was discussed with any of the household members. The majority of home visits were announced and tended to be well-being driven. For example, the case notes reference that the case manager went to the home for a “well-being check.” Section 39.001(b)1, Florida Statutes, states, “The health and safety of children served shall be of paramount concern.” This fundamental principle is neglected when both the investigator’s and case manager’s primary focus is not on management of the safety plan. Documentation that a child is free of marks or bruises is not an assessment of child safety; it is solely a declaration that the individual observed the child without any visible physical trauma.

In the Cavanaugh/Jenkins case, at every interaction with this family, there should have been an assessment of Martha’s protective capacities and the potential dangers that her behavior posed to her children as well as the other children in the home. It was believed, throughout the past 16 years of this family’s involvement with the Department of Children and Families, that Waltraud was protective, and as long as the children were in her house, they would be safe. This assumption was made without ever fully assessing Waltraud’s level of protectiveness or her willingness to be protective of the children.
At every contact with this family, there needed to be a discussion about the pool and the doors leading to the pool, as this was a safety action listed on the safety plan. Further questions needed to be asked, such as: Were the doors ever left open? At one point, the investigator was going to assist in having the pool drained. There was not any further documentation regarding this.

Lastly, when families are not compliant with in-home, non-judicial cases, these cases need to be staffed with Children’s Legal Services. There was a local belief by both investigations and case management staff and management that the case management organization cannot directly go to CLS but must first go to the investigative staff. Lead agency staff confirmed that staff from the FIRST program are not allowed to staff cases with CLS without going through investigation staff first. Children’s Legal Services was very clear that this is not the policy and that either investigative or case management staff may request a staffing. It is required that investigative staff must be involved if it is determined that removal of children is necessary, but this should not preclude case management staff from consulting with Children’s Legal Services.
Immediate Operational Response

At the time of the review, DCF leadership, Community Partnership for Children, and Neighbor to Family had already identified some systemic barriers and had taken steps to remedy them. Neighbor to Family was working on a process to close the communication gaps between DCF, Children’s Legal Services, Community Partnership for Children, and Neighbor to Family. Neighbor to Family also developed a Safety Services Team to help identify the need for safety services and the safety actions that would be needed. A family advocate will also go out with child protection investigators to help engage the family and to assess the family’s willingness to engage in non-judicial services. Neighbor to Family has also begun to review its screening tools used in closed cases.