EXHIBIT F2

EVIDENT CHANGE
Inform Systems. Transform Lives.

# ARKANSAS INVESTIGATIONS CQI REPORT

## April–June 2026

**Submitted: June 2026**

**Updated: August 2026**

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## ABOUT EVIDENT CHANGE

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# EXECUTIVE SUMMARY

A continuous quality improvement (CQI) process was developed for the Arkansas Division of Children and Family Services (DCFS) to examine how investigations are initiated; how safety, risk, and needs are assessed; how information is gathered throughout an investigation; and how decisions are made about services for families at investigation closure.

The CQI process leveraged multiple data sources to reflect a more nuanced understanding of investigation practice. The data analyzed for this process included administrative data; a review of investigation narrative, decisions, and assessments; and interviews with staff.

This report summarizes the first quarter of reviews and will be updated each quarter based on a new sample of investigations.

## KEY FINDINGS

- **Timely initiation:** Most investigations are initiated within priority guidelines, with compliance slightly lower for Priority 2 response (71%) compared with Priority 1 response (80%).
- **Safety assessment:** No safety decision was documented in 27% of investigations; 61% of narrative reviews indicated untimely entry into the Data Collection System.
- **Risk assessment:** Most (88%) investigations had a risk assessment completed, and 78% followed the recommendation from the safety and risk matrix.
- **Time to closure:** Only 60% of investigations closed within 45 days of initiation.

## PRACTICE IMPLICATIONS

- **Initial interviews are thorough:** Based on narrative review, 90% of alleged victims were interviewed one on one at first face-to-face contact, as were 88% of caregivers.
- **Limited documentation of Safety-Organized Practice (SOP):** Only slightly more than half (52%) of reviewed investigation narratives included a mention of SOP.
- **Supervisory support:** Most (64%) reviewed investigations had documented supervisory support.

Detailed data are provided in the report that follows.

## REVIEW PERIOD BY THE NUMBERS

This section provides a high-level overview of data reviewed and outcomes from the review period of April to July 2026. These data will be tracked over time across periods under review.

### DATA SOURCES

**5,130**
Investigations from **administrative** data

**50**
Investigation **narratives**

**34**
**Interviews**

### DATA OUTCOMES BY PROCESS STEP

| | |
|---|---|
| **Investigation Initiation:** ***Strong*** | Investigations are being initiated within priority guidelines, and most alleged victims and caregivers are interviewed about allegations at the first face-to-face contact (F2F).<br>**80% Priority 1, 71% Priority 2** — Initiated timely<br>**90%** — Alleged victims interviewed at first F2F |
| **SDM® Safety Assessment and Information Gathering:** ***Mixed*** | Most investigations had at least one Structured Decision Making® (SDM) safety assessment completed, most at investigation start. Documentation of SOP was limited. Team Decision Making® (TDM™) meetings were used appropriately.<br>**60%** — Safety assessments completed within five days of investigation initiation<br>**27%** — Investigations with no safety assessment<br>**60%** — Investigations assessed as safe with immediate safety plan and with a corresponding TDM meeting |
| **SDM Risk Assessment and Investigation Closure:** ***Mixed*** | Risk assessments were completed for most investigations, and the safety and risk matrix was generally followed. Not following the matrix was driven mostly by instances of households assessed as safe with higher risk levels. Many investigations stay open past the expected 45 days.<br>**88%** — Had a documented risk assessment<br>**78%** — Followed recommendation from safety and risk matrix<br>**60%** — Investigations that closed within 45 days |

# INTRODUCTION

In January 2026, Evident Change began developing a continuous quality improvement (CQI) process for investigations at the Arkansas Division of Children and Family Services (DCFS). This followed an earlier investigation review initiative requested by DCFS targeting a subsample of families with a history of recurring alleged child maltreatment. Findings from this earlier review were reported in December 2025, and in January 2026, Evident Change partnered with DCFS staff and supervisors to refine the review tool and processes used to support an ongoing quarterly review of investigation practice across the state.

Between January and March 2026, Evident Change conducted a series of conversations with DCFS to (1) understand relevant policies and expected practice for screening referrals; and (2) determine priorities for CQI at investigation. This report summarizes the CQI process that was developed and findings from the first review period that followed, in April–June 2026.

## INVESTIGATIVE PROCESS AND CQI PRIORITIES

Concerns of potential abuse and neglect that rise to the minimum statutory requirement for in-person response may receive an investigation. Investigations require gathering of evidence to formally determine if child abuse or neglect has occurred.

Evident Change reviewed existing investigation review findings with DCFS to determine which information was most relevant and useful to support ongoing investigation of alleged child maltreatment. In partnership with DCFS staff and supervisors, Evident Change leveraged these discussions to identify CQI priorities that were integrated into a refined investigation review tool, detailed below. Each step of the investigation process has related CQI priorities and corresponding data metrics to help identify where practice occurs with fidelity and where gaps exist.

### INVESTIGATIVE PROCESS FLOW

#### Investigation Initiation

Right now, screening reports for suspected abuse and neglect in Arkansas is conducted by the Arkansas State Police Crimes Against Children Division (CACD). Once a referral is accepted by the Child Abuse Hotline, it is assigned to DCFS or CACD for further investigation.

Screening at the Child Abuse Hotline determines which investigative agency is assigned to the referral and the response priority: either Priority 1 (requiring initiation within 24 hours) or Priority 2 (requiring initiation

within 72 hours). These determinations are supported by accurate completion of the Structured Decision Making® (SDM) Hotline Assessment and typically reflect the type of abuse alleged in a referral. Referrals also may be screened in as a differential response (DR) assigned to DCFS. CQI for DR is currently part of Arkansas's ongoing Quality Services Peer Review, or case review CQI. No DRs are included in the investigation CQI sample.

After assignment, DCFS or CACD staff are expected to review for any potential history of involvement and make efforts to contact the reporter of the alleged maltreatment. As of August 2023, anonymous reports of alleged child maltreatment are not accepted in Arkansas. Investigations are expected to follow the priority response timeline through timely initiation of first face-to-face contact with the alleged victim. Initiation is considered timely if at least three contact attempts have been made to see the alleged victim, at reasonably different and appropriate times. At this first contact with the alleged victim, best practice relies on a private interview or observation. Afterward, separate interviews with caregivers should occur, and allegations should be discussed.

**Safety Assessment and Information Gathering**

Upon first face-to-face contact with all alleged victim children and household caregivers during an investigation, safety is expected to be assessed to determine whether a child can safely remain in the home. The SDM® safety assessment is designed to identify any immediate safety concerns; that is, any aspects of a child's environment or experiences (such as contact with alleged offender) that could cause immediate harm if unaddressed.

The safety assessment produces three different safety decisions.

- Households are assessed as **safe** if there are no safety threats in the immediate environment that could cause children harm if left unaddressed.
- If safety threats are identified but they can be mitigated through a plan co-created by investigation staff and the family, the household is assessed as **safe with immediate safety plan**. Agency policy outlines specific requirements for appropriate plans in such instances, and these are intended to be short-term solutions to isolated concerns carried out with the help of a safety and support network (e.g., identifying a family member with whom an unhoused family can reside while permanent housing is sought).
- If safety threats are present and they cannot be mitigated through an immediate safety plan, the household is assessed as **unsafe**, and it requires removal of a child from the home and initiation of out-of-home services.

Additional safety assessments are expected to be conducted throughout an investigation to support decisions related to safety and to (1) document any changes to the household that could impact overall

safety outcomes; and (2) ensure safety before closing an investigation. These time points for formal safety assessment ensure that safety is factored into ongoing decisions about how to best serve families.

In addition to formal time points for safety assessments, investigative staff are expected to informally assess safety during any contact with families. Informal assessments can include follow-up visits to the family home to assess the environment or additional conversations with family members to assess other safety concerns. Information gathering—through interviews, collateral contacts, and observations related to overall needs and family functioning—is a key part of the process that ensures investigation staff can regularly assess for safety and identify changes in environment that could impact safety. It is expected that, at minimum, investigation staff conduct a private interview or observations with alleged victims, caregivers (and alleged offenders if not caregivers), and siblings under 18 who reside in the home. Beyond this, investigation workers may connect with collateral contacts who have other windows into understanding the family's functioning. Examples may include school personnel, therapists/counselors, and safety and support network members.

These efforts are strengthened through use of Safety-Organized Practice (SOP), a component of practice included in the Arkansas DCFS At One Table practice model implemented in 2022. The purpose of SOP throughout investigations is to conduct a rigorous and balanced assessment of what is working well for the family as well as any worries for safety and well-being. SOP is intended to ensure gathering of quality information to make clearer and more accurate safety decisions through strengthened family engagement. With this understanding, SOP can be used to help the family begin to build their safety and support network so they can keep their family intact while working to overcome identified challenges. Use of these practices requires that at least one safe adult other than the people who could have caused the child harm be involved in an immediate safety plan used with the family.

Documentation of interactions between DCFS staff and families throughout the investigation is critical to ensure a thorough understanding of how decisions were made and how information about family safety, needs, experiences, and progress factored into overall service delivery. Quality documentation includes evidence of what is working well with a family, what the agency or family are worried about, and what needs to happen next—all foundational questions within SOP. These ongoing informal assessments may not always be captured by completing the SDM safety assessment but should be documented in the agency's electronic case management system as part of the investigative process. Evident Change reviews both sources as part of the investigation review process.

**Risk Assessment and Investigation Closure**

The investigation process is intended to determine whether abuse or neglect is occurring in the home and what, if any, additional services may be needed to ensure positive outcomes for children and families. Investigations are expected to close within 45 days of acceptance, unless otherwise approved for extension

by a supervisor when more time is needed to gather information or work with a family. In general, investigations are not intended to serve as a longstanding intervention.

Prior to determining if an investigation can be closed, investigation staff use what is learned from the information gathering throughout the investigation to make a finding regarding the initial allegation or other identified concerns of abuse or neglect and take one of the following actions: open a case, connect to an existing case if the family is currently involved with DCFS, or close the investigation without ongoing services. Closure decisions and subsequent service needs, if relevant, are typically informed by this overall finding, along with outcomes of the safety and risk assessments. Each assessment is designed to help answer a distinct question related to family experiences and the investigation process. Whereas the safety assessment is based on observations and information gathering with the family, The risk assessment is an actuarial assessment that classifies families by their likelihood of reinvolvement with the child welfare system. Several factors contribute to the risk score on the risk assessment, including current involvement with the agency, history of involvement with child welfare, and various family characteristics associated with child welfare involvement, such as substance abuse. Risk is about the long term: Instead of focusing on imminent danger of serious harm, the risk assessment considers the odds there will be involvement with child welfare in the future.

A practice matrix related to safety and risk outcomes is used to make a recommendation for action regardless of investigation findings (Figure 1). Investigations are recommended for closure without further action when families have a "safe" outcome on the safety assessment and low or moderate risk on the risk assessment. Families with unresolved safety threats are recommended for ongoing services. Families may also be offered prevention services if there are no safety threats but risk is high or very high.

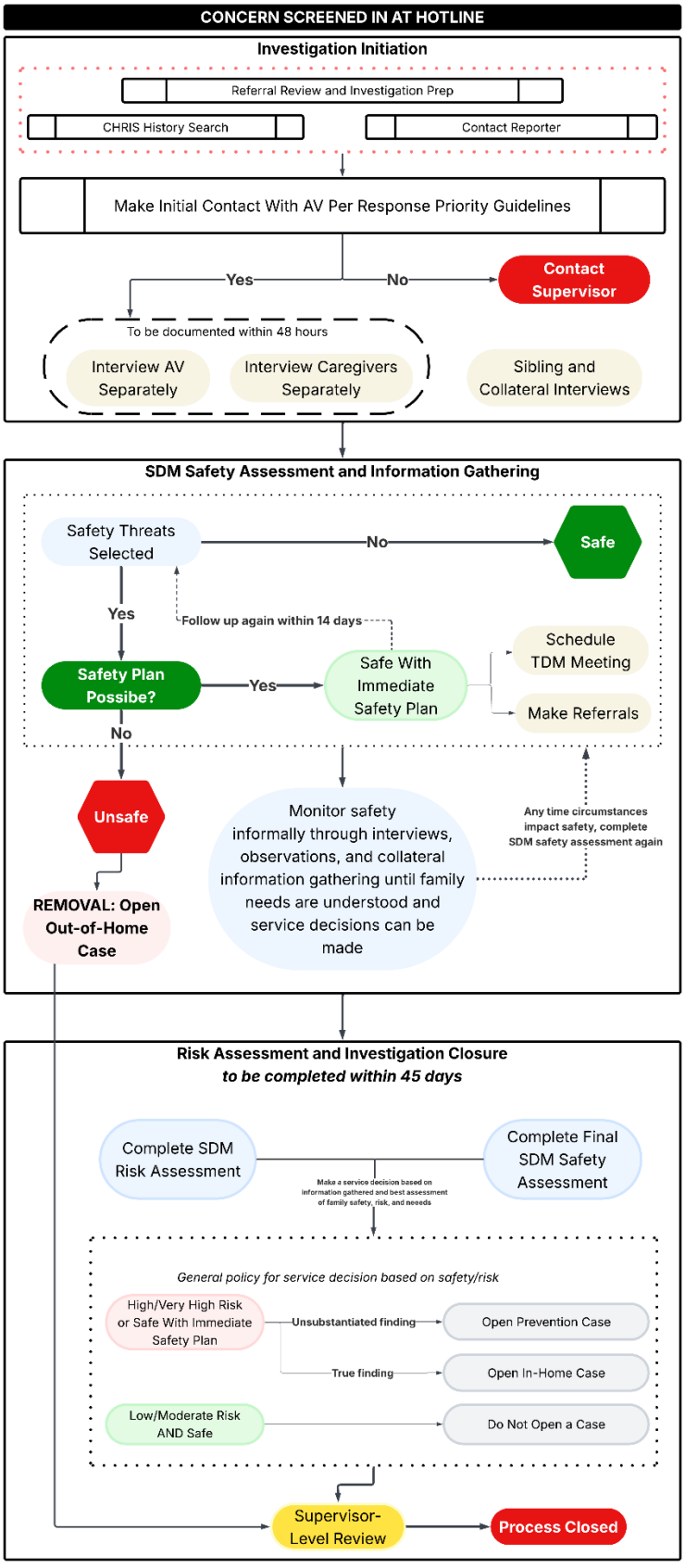
**Figure 1**
**Safety and Risk Matrix**

| | Safe | Safe With Immediate Plan | Unsafe |
|---|---|---|---|
| **Low/Moderate Risk** | Do not open case | Open a case (prevention case for unsubstantiated; in-home case for true) | Open out-of-home case |
| **High/Very High Risk** | Open a case | Open a case | Open out-of-home case |

Decisions about investigation closure are expected to be approved by supervisors after they review documented practices from the investigation period.

This investigation process is detailed in Figure 2.

## Figure 2
## Investigation Process Flow



### CQI PRIORITY AREAS AT A GLANCE

For each part of the investigation process, CQI priorities were identified in collaboration with DCFS investigation staff and supervisors (Table 1). These priorities were intended to directly assess whether practice was occurring as expected and where there were opportunities to improve practice. Specific, available data points were identified for each priority to ensure that the CQI process could help answer each question.

**TABLE 1**

**CQI PRIORITIES**

| PROCESS COMPONENT | PRIORITIES |
|---|---|
| Investigation initiation | • Are correct calls being screened in?<br>• Are child welfare involvement history checks and reporter contact occurring?<br>• Are investigations initiated within priority guidelines?<br>• Are initial interviews occurring as required? |
| Safety assessment and information gathering | • Is the safety assessment completed accurately at investigation initiation?<br>• Is the safety assessment completed when circumstances impacting safety change and/or at the end of an investigation?<br>• Is SOP used to gather information sufficiently and assess safety informally on an ongoing basis?<br>• Are families connected with necessary resources based on what is learned about safety and needs?<br>• Do Team Decision Making® (TDM™) meetings occur when necessary? |
| Risk assessment and investigation closure | • Is risk assessed accurately prior to investigation closure?<br>• Do service recommendations appropriately follow the safety and risk matrix?<br>• Are investigations closed promptly?<br>• Are supervisors supporting investigation closure decisions? |

Together, these CQI priorities are expected to provide a comprehensive assessment of investigation practice.

## CQI PROCESS AND METHODOLOGY

### METHODOLOGY

The current review period began in April 2026 and sampled from six months prior, capturing investigations that closed between October and November of 2025. To get the most comprehensive assessment of investigation practices, Evident Change uses a triangulation methodology that relies on multiple forms of

data collection to track CQI priorities both quantitatively and qualitatively. The types of methodology used for each of the CQI priorities are detailed in Appendix A.

### Administrative Data Analysis

Evident Change conducted administrative data analysis on all investigations that closed in October and November of 2025. The focus of the analysis was to understand trends in initiation of investigation, safety and risk assessment completion, closure and service decisions, and any available outcomes for families after investigation closure.

A total of 6,351 referrals were screened-in during this review period; 5,130 (81%) of these received investigation services either by DCFS or CACD while the remainder appear to have been screened in but received a DR priority where no investigation was opened (1,221; 19%). DR assignments were excluded from the current investigation CQI, and unless otherwise noted in the report, the sample reported on will reflect the 5,130 referrals that were screened in and investigated (Table 2).

**TABLE 2**

**ADMINISTRATIVE DATA SAMPLE TRENDS**
**(n=5,130)**

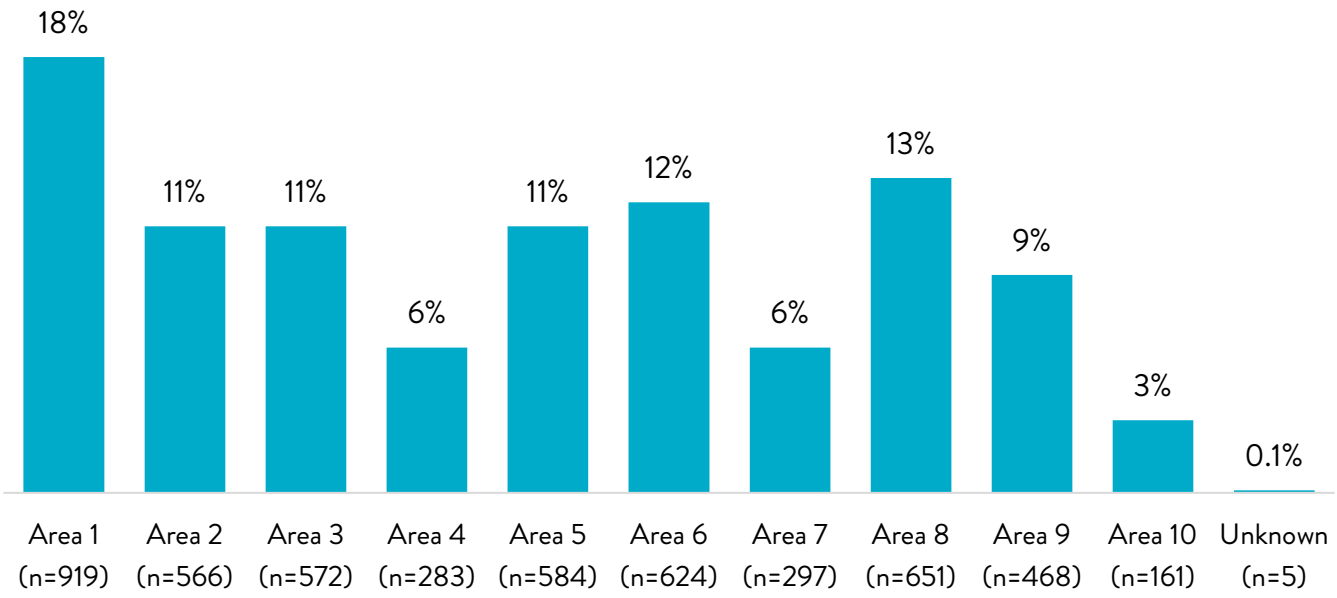
| | |
|---|---|
| **Assigned Agency** | |
| DCFS | 79% |
| CACD | 21% |
| **Allegation Count*** | |
| None | 19% |
| 1 | 68% |
| 2 | 12% |
| 3 | 1% |
| 4 | <1% |
| **Number of Alleged Victims** | |
| 0 (screened out) | <1% |
| 1 | 77% |
| 2 | 13% |
| 3 | 5% |
| 4 | 3% |
| 5+ | 2 |

| TABLE 2<br><br>ADMINISTRATIVE DATA SAMPLE TRENDS<br>(n=5,130) | |
|---|---|
| **Youngest Alleged Victim Age** | |
| Under 1 | 10% |
| 1–4 years | 21% |
| 5+ | 69% |

*These data reflect the initial full sample of 6,351 that includes referrals with no allegations and likely were assigned to DR.

Distribution by area for initiated investigations is shown in Figure 3.

**Figure 3**
**Investigations by Area**
**(n=5,130)**




## Investigation Review

Evident Change staff reviewed a random subsample of 50 investigations, evenly distributed across areas, that were closed from October to November 2025 to determine whether the documented process and interactions with families aligned with policy and practice expectations.

Evident Change staff used an investigation review tool that was tailored for this CQI effort and co-created alongside DCFS staff and supervisors. The review, in part, assessed whether the SDM safety and risk assessments were completed accurately (e.g., the selections made on the tool aligned with the information

gathered and documented) and timely, as well as other key elements of practice, such as whether SOP tools were used in working with the family, proper interviews with involved family members were conducted, and decisions about services aligned with safety and risk determinations.

### Interviews

To better understand the practice efforts by DCFS staff during investigations included in the review, Evident Change staff made efforts to contact the individual staff who worked on reviewed investigations for an interview. Knowing that not all practice is documented within the agency's electronic case management system consistently, these interviews provide an opportunity for Evident Change staff to gain the most comprehensive understanding of what occurred in practice. During interviews, staff can fill in gaps or provide more context to information that was missing or unclear by a review of investigation narrative.

Of the 50 investigation reviews, 34 (68%) of staff responded and met virtually with Evident Change reviewers. Up to three attempts were made to reach all staff within the review period. One staff noted during interviews that the process of talking through the investigation with a reviewer helped them reconsider how they might approach similar situations in the future, suggesting that participation itself may be beneficial.

## SAMPLE AT A GLANCE

Table 3 highlights the sample characteristics for each form of review in this report.

**TABLE 3**

**SAMPLE CHARACTERISTICS BY METHODOLOGY***

| CHARACTERISTIC | ADMINISTRATIVE DATA | INVESTIGATION REVIEW |
|---|---|---|
| **Sample Size** | | |
| N | 5,130 | 50 |
| **Initial Allegation**† | | |
| Abuse | 39% | 44% |
| Neglect/abandonment | 41% | 60% |
| Sexual abuse/exploitation | 15% | 6% |
| **Priority Assignment** | | |
| Priority 1 | 25% | 32% |
| Priority 2 | 75% | 68% |

| TABLE 3<br><br>SAMPLE CHARACTERISTICS BY METHODOLOGY* | | |
|---|---|---|
| **CHARACTERISTIC** | **ADMINISTRATIVE DATA** | **INVESTIGATION REVIEW** |
| **Length of Services‡** | | |
| Closed within 45 days | 60% | 84% |
| Closed 46+ days | 40% | 16% |

*Interviews were conducted on the investigation review sample.

†Multiple allegations may be selected, so percentages may not add up to 100%.

‡Reflects 5,030 investigations with an available closure date. A total of 100 records did not have a closure date due to either a missing data entry or an investigation lingering as open (2%).

# FINDINGS BY INVESTIGATION PROCESS COMPONENT

## INVESTIGATION INITIATION

### REFERRALS RECEIVED AND SCREENING CONCERNS

Screening decision quality (including hotline assessment fidelity and override use) is assessed in the companion Hotline CQI report; the findings below are limited to what arrived for investigation and the screening concerns identified during investigation review. Of the 6,351 screened-in referrals, 1,221 (19%) had no investigation documentation because they were deemed as DR and no investigation was opened. However, almost all of these DRs had both a safety and risk assessment completed.

One fifth (20%) of screened-in investigations were substantiated from the current sample. Because substantiation requires a higher evidentiary threshold than the screen-in decision, this figure is not a measure of screening accuracy and should not be read as the share of referrals screened incorrectly; it is reported as a baseline to track across review periods.

Of reviewed investigations, one was noted by reviewers to have been inappropriately screened in due to a lack of ability and information to locate the family. No assessments or services were provided as a result. Across the 50 reviewed investigations, this was the only screening concern reviewers identified, indicating that screen-in decisions in the reviewed sample were largely appropriate.

## REPORTER CONTACT AND REVIEW OF HISTORY

Reviewing history and reporter contact at investigation onset can help prepare staff with relevant information ahead of making initial contact with a family.

Based on reviews, almost all (96%) investigations in the sample included documentation of contact with the reporter. Reviewing family history with the agency was the most frequently and consistently cited (50%) activity investigators described during interviews as part of their preparation to contact a family.

According to administrative data, most families in the current sample did not have any prior reports accepted for investigations or prior true findings. Trends in history with DCFS for the current sample are detailed in Table 4.

| TABLE 4<br><br>PRIOR HISTORY SAMPLE TRENDS<br>(n=5,130) | |
|---|---|
| **Prior Reports Accepted for Investigation in Past Five Years** | |
| None | 61% |
| 1–3 | 29% |
| 4–9 | 9% |
| 10+ | 1% |
| **Prior True Finding** | |
| None | 86% |
| At least 1 | 14% |

## TIMELINESS OF INVESTIGATION INITIATION

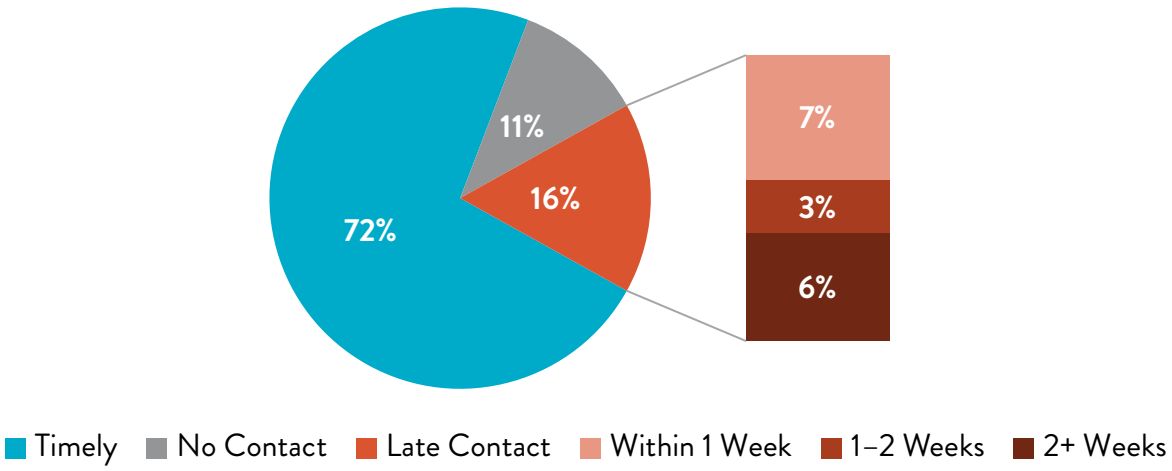
DCFS is expected to make face-to-face contact with alleged victims in an investigation within the assigned priority timeframe: within 24 hours (Priority 1) or 72 hours (Priority 2). The average time to contact from initiation was 1.5 days, falling within both levels of priority (not shown). Timeliness of first contact was met for most investigations regardless of priority level, as shown in Table 5.

| TABLE 5<br><br>TIMELY CONTACT BY PRIORITY LEVEL<br>(n=4,041)* | |
|---|---|
| Priority 1 | 80% |
| Priority 2 | 71% |

*Excludes 1,088 CACD investigations for which initial contact dates were not available from current data extract.

Most (72%) of the investigations had timely initial contact; the remainder experienced either late contact (16%) or no contact (11%, generally, due to an unable-to-locate or administrative closure disposition). When late, contact typically occurred within a week or more than two weeks after assignment. These breakdowns of timeliness are shown in Figure 4.

**Figure 4**
**Timeliness of Contact with Alleged Victim**
**(n=3,946)***



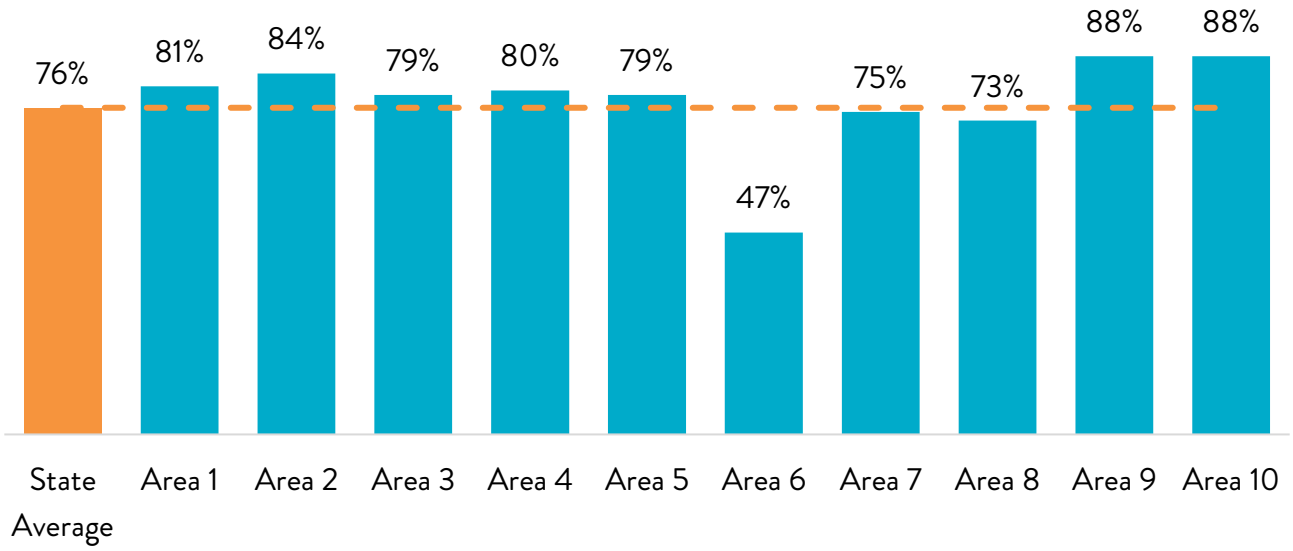

*Analysis of timeliness excluded 1,088 CACD cases as well as 95 DCFS cases in which the recorded first contact date preceded the referral date, limiting calculation of timeliness.

Of investigations receiving late contact, 43% occurred within a week, but 38% occurred more than two weeks after assignment (not shown). The smallest proportion of families with late contact were seen within the one- to two-week timeframe after assignment.

Due diligence is required of DCFS when attempts are made to contact families; this means at least three documented attempts to locate and/or contact the family. Of the entire sample, 76% of children were either seen timely or due diligence was documented. Due diligence is much rarer when a child is not located quickly, reinforcing the importance of early contact. Of the children not seen within the priority window, only about 23% had the required three-plus timely attempts recorded. Roughly 700 children were neither seen on time nor had any timely attempt logged.

Timely initiation varied slightly by area. Area 6 stood out as the clear outlier on initiation timeliness, with only 47% of investigations initiated on time compared with 73–88% in every other area. Figure 5 shows these data by area.

**Figure 5**
**Timely Initiation by Area**
**(n=5,129)**




## INTERVIEWS AT INVESTIGATION INITIATION

Of reviewed investigations, most (86%) alleged victims were seen face to face within the initiation timeframe, aligning with available administrative data on first contact. Investigation review allowed for a more nuanced, qualitative look at how interviews were carried out during this initial contact.

Based on reviews, most investigations included age-appropriate interviews relating to allegations, safety, and other relevant factors with alleged victim/child and siblings/other children (when applicable) at first face-to-face contact. Contact with the alleged victim child was not documented in 4% of the sample. Most (82%) caregivers were interviewed regarding allegations at first face-to-face contact. The remaining caregivers were interviewed at some other time—sometimes within a few days of initiation, still timely even though outside of first contact. Table 6 shows data related to these interviews.

**TABLE 6**

**INTERVIEWS AT FIRST FACE-TO-FACE CONTACT**
**(N = 50)**

| Interviewee | % Yes/Somewhat |
|---|---|
| Alleged child/victim | 90% |
| Siblings/other children (as applicable)* | 88% |
| Caregivers in the home being investigated | 82% |
| Caregivers residing outside the home* | 47% |

*n=32

# SAFETY ASSESSMENT AND INFORMATION GATHERING

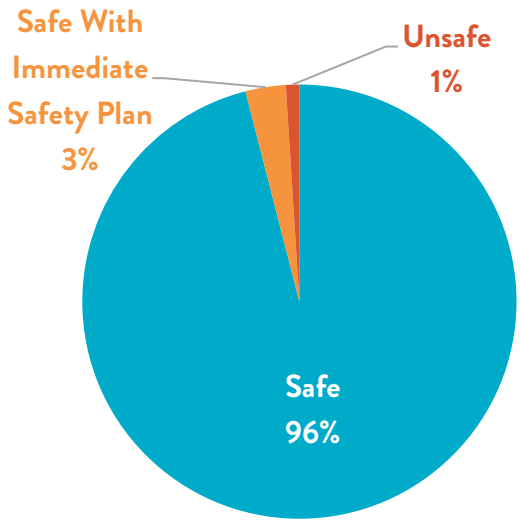
## SAFETY ASSESSMENT

Most (73%) investigations had at least one safety assessment completed, with most (60%) initial safety assessments from administrative data showing completion within five days of investigation initiation. Table 7 shows completion data of safety assessments; these include DRs due to availability of safety assessment data and comparable expectations for assessment completion.

| TABLE 7<br><br>SAFETY ASSESSMENT DATA<br>(N = 6,351) | |
|---|---|
| **Completion Level** | |
| At least one assessment completed | 73% |
| Incomplete assessment | <0.5% |
| Missing/blank; no safety decision documented | 27% |
| **Timeliness to Initial SDM Safety Assessment** | |
| Within five days of initiation | 60% |
| More than five days after initiation | 40% |

Figure 6 shows the breakdown of safety decisions for all completed safety assessments in the current administrative data sample, with almost all (96%) assessed as safe without any identified safety threats.

**Figure 6**
**Safety Assessment Outcome – Overall**
**(n=4,633)**



Reviews reflected this breakdown, with 90% of reviewed investigations having a safe outcome. However, almost half (46%) of reviewed investigations had errors in safety completion documented by reviewers. The most common error (in 61% of incorrectly completed safety assessments) was untimely entry into the Data Collection System (DCS), and most investigations with errors in formal safety assessments had a single type of error rather than multiple types (e.g., untimely completion and incorrect selections). Table 8 shows types of errors and frequency of errors in safety assessment completion documented in investigations reviewed.

| TABLE 8<br><br>SDM SAFETY ASSESSMENT COMPLETION | |
|---|---|
| **SDM Safety Assessment Accuracy (N=50)** | |
| Completed accurately | 54% |
| Completed inaccurately | 46% |
| **Error Frequency (n=23)** | |
| Completed with one type of error | 74% |
| Completed with multiple types of errors | 26% |
| **Frequency of Error Type (n=23)*** | |
| Incorrect household assessed | 17% |
| Untimely completion | 48% |
| Untimely entry into DCS | 61% |

*Multiple error types may be selected, so percentages do not total 100%.

Reviewers also assessed whether narrative identified potential safety threats and whether these were appropriately reflected in completed safety assessments. Of 13 applicable investigations, nine (69%) had accurate alignment between narrative and selections on the safety assessment. Two (15%) had inaccurate selections, and for two (15%), reviewers were unable to determine household safety with available narrative. Both investigations with misalignment between narrative and safety assessment selections had safety threats documented in the narrative, but they were not selected on the safety assessments. In both of these instances, a correct selection on the safety assessment would have recommended that an immediate safety plan be put in place that otherwise was not implemented.

## USE OF SOP PRACTICES

Investigation review data indicated minimal documentation of SOP. Slightly more than half (52%) of investigations reviewed had no SOP practices documented. From the remaining investigations, solution-focused questions were the most frequently documented (67%). Table 9 shows frequency of different tools among the 48% of investigations with documented SOP.

| TABLE 9<br><br>SOP TOOLS DOCUMENTED<br>(n=24) | |
|---|---|
| Three Questions, Three-Column Map | 33% |
| Three Houses | 0% |
| Solution-focused questions (e.g., scaling, exception, relationship) | 67% |

Most (76%) investigations reviewed had relevant collaterals interviewed during investigation. Investigative staff contacted school personnel, medical staff, and others with relevant information. Medical professionals were regularly involved in collateral contact to determine if alleged victims were receiving ongoing care and if caregiver explanations of injuries aligned with the child's injuries. Staff also used SOP tools to engage an alleged victim to understand what was going well, identify safety and support network members, and understand triggers related to the child's behaviors.

## FAMILY CONNECTION TO RESOURCES

Half (50%) of investigations from the investigation review had documented identification of safety and support networks for families. Most often, this focused on additional family members who may serve as supports for the family (92%). Table 10 shows frequency of different support network members discussed with families.

| TABLE 10<br><br>SAFETY AND SUPPORT NETWORK MEMBER IDENTIFICATION*<br>(n=25) | |
|---|---|
| Additional family members | 92% |
| Resource providers | 28% |
| Community members | 16% |
| Fictive kin | 4% |

* Selections are not mutually exclusive, so totals do not add up to 100%.

In most (80%) investigations reviewed, ongoing family needs were assessed and documented prior to closure. Instances where reviewers identified gaps included opportunities to connect families to specific services related to observed behavior patterns or needs; these gaps are limited by investigation review to assess only based on what is documented. For example, in one interview an Evident Change reviewer learned that prevention services were offered to a father (he declined) after he and his daughter expressed a desire to work on improving their relationship. This was not documented in the agency's electronic case

management system but was shared with the reviewer during the interview with the worker. Table 11 shows breakdown of family needs assessment prior to investigation closure.

| TABLE 11<br><br>ASSESSMENT OF FAMILY NEEDS PRIOR TO INVESTIGATION CLOSURE<br>(N = 50) | |
|---|---|
| Yes, and no unmet needs documented | 56% |
| Yes; unmet needs were documented along with support to address needs | 24% |
| No | 14% |
| Unable to determine | 3% |

## TDM MEETINGS

TDM meetings are meant to bring together family members, their supports, and DCFS to discuss and make a placement decision that ensures the safety of the child. A TDM meeting generally occurs anytime an immediate safety plan is implemented or a child is removed from the family home. Of the investigations with a "safe with immediate safety plan" outcome on the safety assessment (n=30), 60% had a TDM meeting documented based on administrative data. However, several other TDM meetings were documented across all safety decisions, indicating TDM meetings may be used in a variety of situations not directly linked to an immediate safety plan. Investigation review identified only two instances where an immediate safety plan was needed; in both, a timely TDM meeting was documented within three days. Table 12 shows the breakdown of documented TDM meetings by safety decision from administrative data.

| TABLE 12<br><br>TDM MEETINGS AND COMPLETED SDM SAFETY ASSESSMENT DECISIONS<br>(n=4,633) | |
|---|---|
| **Safety Decision** | **Percentage With TDM Meeting** |
| Safe (n=4,452) | 1% |
| Safe with immediate safety plan (n=30) | 60% |
| Unsafe (n=151) | 50% |

Note: 14 incomplete SDM safety assessments were excluded from these data.

# RISK ASSESSMENT AND INVESTIGATION CLOSURE

## RISK ASSESSMENT PRIOR TO CLOSURE

According to administrative data, most (88%) investigations had a documented risk assessment. For investigations with a recorded closure date and a risk assessment, all (100%) assessments were completed prior to the closure date. Of the 12% of investigations with no risk level recorded, most had closure, indicating that there is a compliance gap with risk not being assessed on these investigations prior to closure. Table 13 shows the breakdown in risk assessment levels.

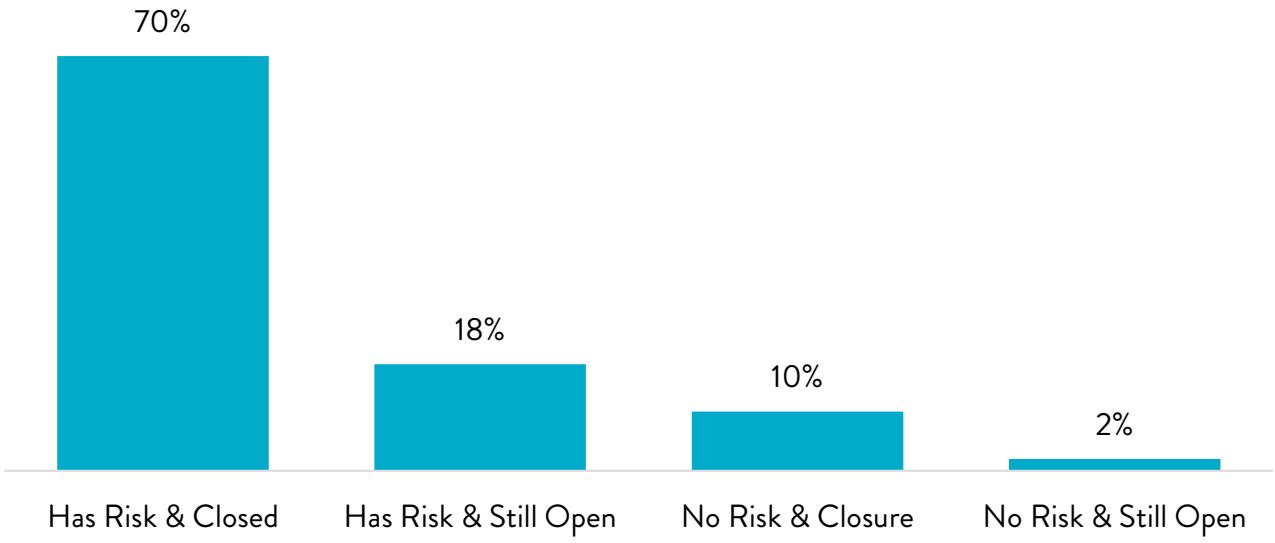
**TABLE 13**

**RISK ASSESSMENT DISTRIBUTION**
**(N = 6,351)**

| Risk Level | % |
|---|---|
| Low | 19% |
| Moderate | 50% |
| High | 17% |
| Very High | 2% |
| Not Recorded | 12% |

The breakdown in risk level and case closure is shown in Figure 7, indicating a potential gap in 10% of investigations with a closure date but no risk assessment.

**Figure 7**
**Risk and Case Closure**
**(n=6,294)**



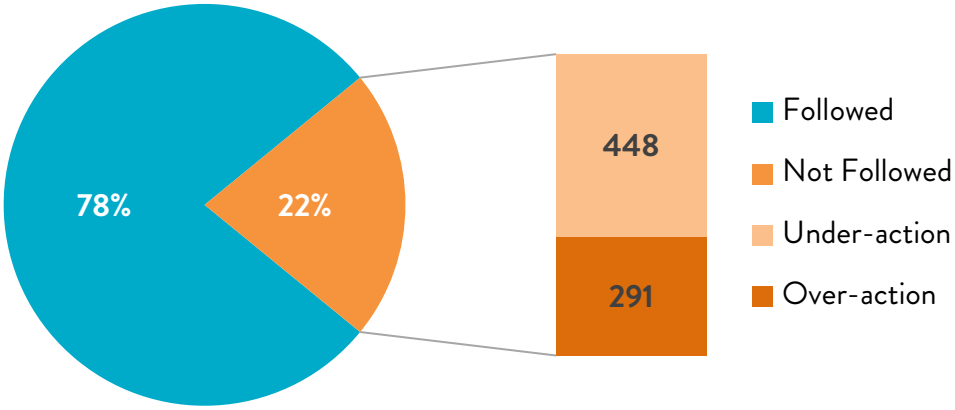
According to administrative data, the risk assessment rarely requires an override use (<1%), with most overrides documented raising the risk level from high to very high, more often with a discretionary override than based on policy.

## SAFETY AND RISK MATRIX AND SERVICE RECOMMENDATIONS

A total of 3,387 investigations had a safety and risk outcome documented for the subsequent analysis of service recommendation and actions. Most of the investigations from the current administrative data sample were assessed to be safe with a risk level of low (20%) or moderate (56%).

A majority of recommendations from the safety and risk matrix were followed, as shown in Figure 8. When a recommendation was not followed, it was more often due to under-action (not opening services when the matrix would recommend otherwise) rather than over-action (opening when matrix does not recommend).

**Figure 8**
**Safety and Risk Matrix Followed**
**(n=3,387)**



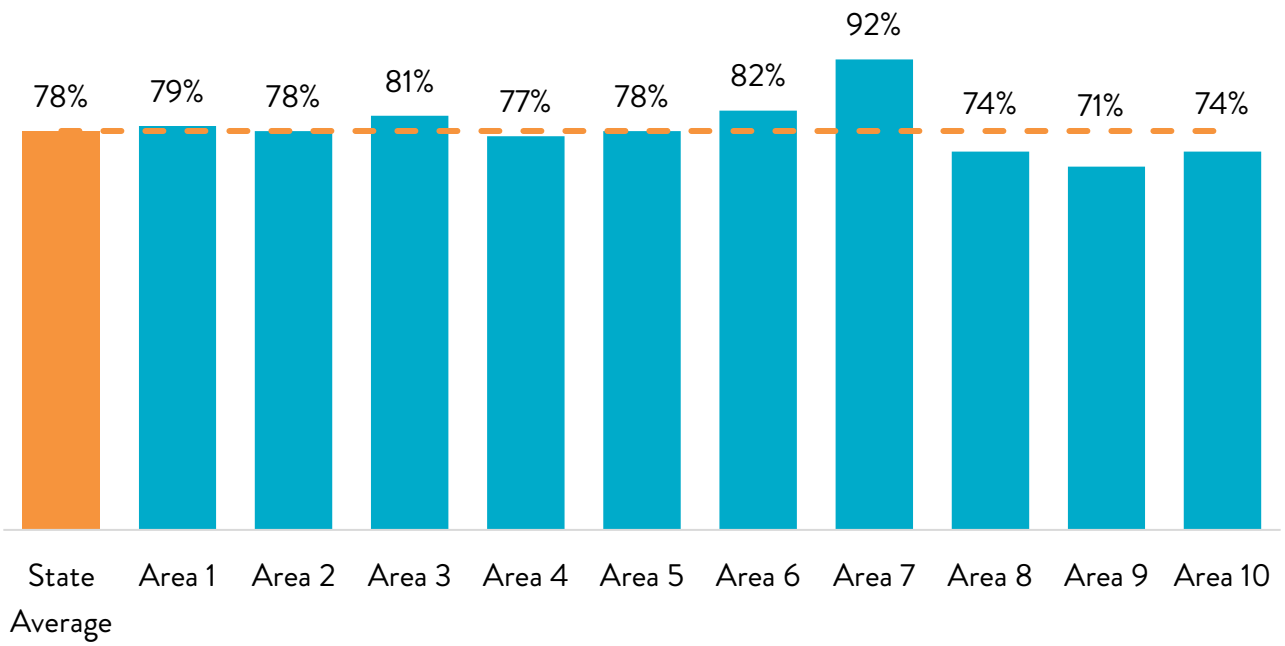

The extent to which recommended actions were followed varied by safety and risk combinations. Table 14 shows the rate at which recommendations were followed within each combination of safety decision and risk level. The lowest rates of compliance with the safety and risk matrix were for investigations with no safety threats (i.e., safety decision of safe), but the risk level was driving a recommendation to open for prevention services. These may also reflect instances where optional services were declined by families.

| TABLE 14<br>PERCENTAGE OF SAFETY AND RISK MATRIX RECOMMENDATIONS FOLLOWED<br>(n=3,387) | | | | |
|---|---|---|---|---|
| Safety Outcome | Risk Level | | | |
| | Low | Moderate | High | Very High |
| Safe | 94% | 87% | 38% | 54% |
| Safe with immediate safety plan | 50% | 78% | 67% | 100% |
| Unsafe | 100% | 79% | 87% | 71% |

Prior substantiation and child age emerged in the data as two key factors driving "unsafe" safety decisions or risk levels of high or very high for families, approximately 20% of families with available safety and risk outcomes (n=5,129). Forty-four percent of children with one prior true finding fell into this group, compared with 16% of children with no prior history (rising to 51% with three priors and 67% with four). For age, 35% of children under age 1 fell into this group, dropping to 13–19% for school-age and teen victims.

Recommendations were followed to different extents depending on the area, with the highest rate in Area 7 (92%) and the lowest in Area 9 (71%). These data are shown in Figure 9.

**Figure 9**
**Followed Matrix Recommendation by Area**
**(n=3,386)**

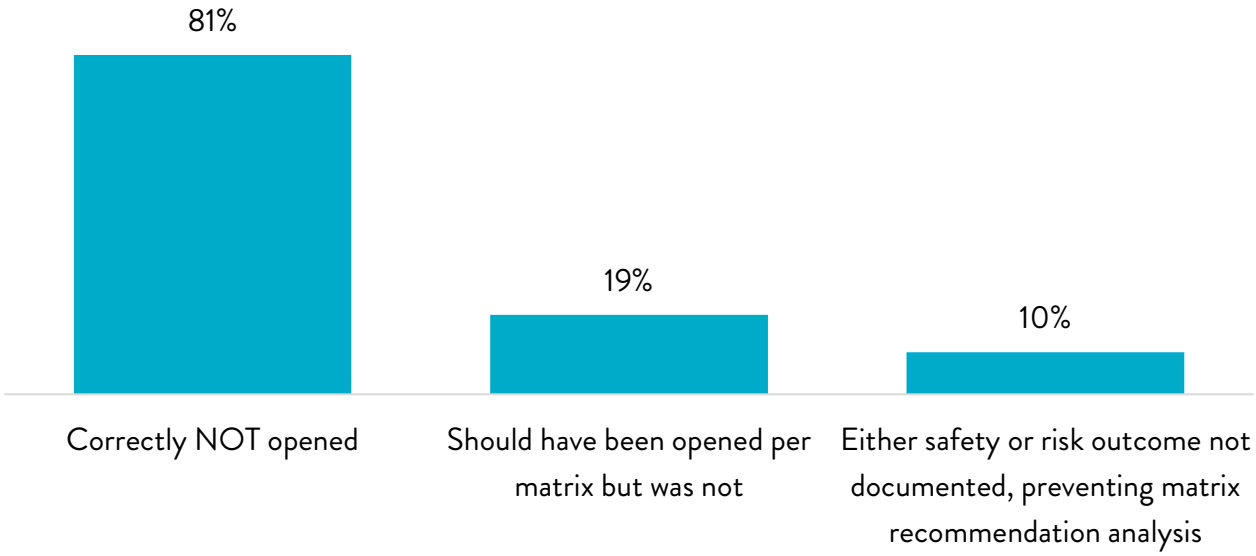



From reviewed investigations, most (80%) followed the safety and risk matrix or had well-documented rationale for not following the original recommendation (12%), such as a family requesting additional services

despite having safe home circumstances and low risk. In 8% of reviewed investigations, the recommendation was not followed, and it was unclear why or how this decision was made.

Beyond the safety and risk matrix analysis of reviewed investigations, Evident Change examined matrix accuracy for records where no investigation data exist but safety and risk assessments were conducted (DR; see Figure 10). Of the 1,018 DRs with both a safety decision and risk level recorded, 824 (81%) were correctly handled per the matrix: "Safe" safety decisions paired with low or moderate risk, indicating no investigation was needed. However, 194 DRs (19%) showed matrix indicators that should have prompted an investigation: 19 had unsafe or immediate safety plan determinations, and 175 carried high or very high-risk levels.

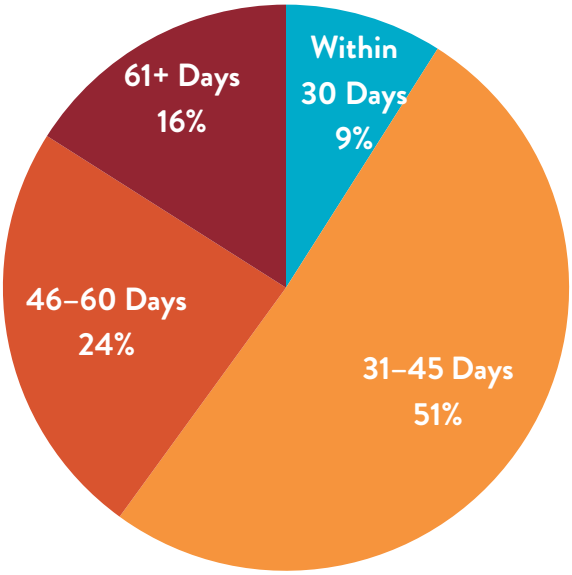
**Figure 10**
**Safety and Risk Matrix for Differential Response**
**(n=1,018)**




## TIMELINESS OF INVESTIGATION CLOSURE

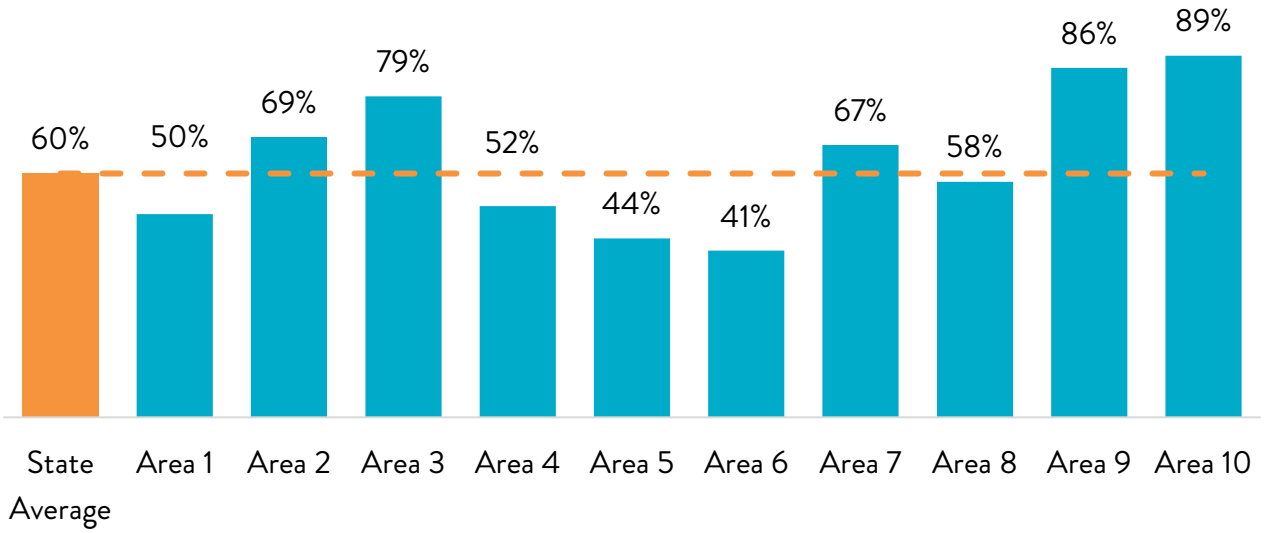
A total of 5,030 investigations from administrative data had a closure date available. From this period under review, 1.5% of investigations had no closure date recorded despite sampling occurring at about the six-month mark from expected investigation closure time. The lack of closure date could signify a documentation error in recording closure within CHRIS or investigations still lingering as open. Of the 100 investigations without a closure date, 99 were assigned to CACD; this represents 9% of all CACD cases within this sample, a rate without a closure date higher than that among DCFS-assigned cases (<0.5%). Slightly more than half (60%) of these closed within the expected 45-day investigation period. Figure 11 shows the time to closure for the current sample.

**Figure 11**
**Time to Closure**
**(n=5,029)**




Timeliness to closure showed meaningful differences by area. While Area 10 had the highest rate of timely closure (89%), Area 6 had the lowest rate (41%). These data are shown in Figure 12.

**Figure 12**
**Timeliness to Closure by Area (Closed Within 45 Days)**
**(n=5,029)**



### SUPERVISORY SUPPORT

Investigation review trends indicated that 64% of investigations in the sample had some documented supervisory support. Most investigations reviewed revealed supervisory support at the time of investigation closure but were limited in details related to ongoing support throughout the investigation.

In addition to supervisory support, two staff specifically noted the use of peer support during the investigation process. While supervisory support is an important piece of closure, investigative staff should regularly meet with their supervisor regarding initial and ongoing assessments of safety and risk. When supervisors are working investigations, they should also be expected to participate in supervisory consultation throughout the process.

# CONCLUSION

The current CQI review of investigation practice highlighted several strengths and practice opportunities at each part of the screening process. These are shown in Figure 13.

**Figure 13**
**Practice Strengths and Opportunities from April–June 2026 Review Period**

# APPENDIX

Below are the types of methodology used for each of the investigation CQI priorities.

| PROCESS COMPONENT | PRIORITIES | ADMIN DATA | INVESTIGATION REVIEW | INTERVIEW |
|---|---|---|---|---|
| Investigation initiation | Are correct calls being screened in? | ✓ | | |
| | Are child welfare involvement history checks and reporter contact occurring? | ✓ | ✓ | |
| | Are investigation initiated within priority guidelines? | ✓ | ✓ | ✓ |
| | Are initial interviews occurring as required? | | ✓ | ✓ |
| Safety assessment and information gathering | Is the safety assessment completed accurately at investigation initiation? | ✓ | ✓ | ✓ |
| | Is the safety assessment completed when circumstances impacting safety change and/or at the end of investigation? | ✓ | ✓ | ✓ |
| | Is SOP used to gather information sufficiently and assess safety informally on an ongoing basis? | | ✓ | ✓ |
| | Are families connected with necessary resources based on what is learned about safety and needs? | ✓ | ✓ | ✓ |
| | Do TDM meetings occur when necessary? | | ✓ | ✓ |
| Risk assessment and investigation closure | Is risk assessed accurately prior to investigation closure? | ✓ | ✓ | ✓ |
| | Do service recommendations appropriately follow the safety and risk matrix? | ✓ | ✓ | ✓ |
| | Are investigations closed promptly? | ✓ | ✓ | |
| | Are supervisors supporting investigation closure decisions? | ✓ | ✓ | ✓ |