Statement of Consideration (SOC)

PPTL 26-15 SOP G1.5 Supervision and Consultation. The following comments were received in response to SOP drafts sent for field review. Thanks to those who reviewed and commented. Comments about typographical and grammatical errors are excluded; these errors have been corrected as appropriate.

SOP G1.5

1. **Comment:** There is a long list of what will be covered in Inv and In-home consults, that list doesn't list those in OOHC consults. Am I understanding correctly that the longer list need to be covered but we are to only document the parts for example #12 in "in home services case consultations" ?

   Response: Language has been revised to 'consider' versus cover. A list of items to CONSIDER during OOHC consults has been added. FSOS training on how to do a case consultation vs supervision is being developed and will be forthcoming.

2. **Comment:** Not clear on what differentiates a "ongoing case consultation" bottom of pg 10 and "in home services case" pg 6. In practice I believe these are the same types of cases and have these two spots seems confusing because in practice a case is only one of two options in-home or out of home

   Response: This was an editing error and has been corrected.

3. **Comment:** #4 under investigative consults makes the ability to enter group consult contacts irrelevant since we now have to include barriers for specific cases.

   Response: Language regarding the inclusion of barriers, etc., in the service recordings has been removed and has been revised to clarify that documentation of consults should include only the date the consult is held and the parties involved. Group contacts are still available.

4. **Comment:** Everyone tends to function better with a Template Form. Will a template form be provided to field and linked to the policy for each function of Consultation so that it standardizes the requirements of the Consult under this new SOP? What in SOP prevents the Regions from implementing their own Processes that exceed what SOP requires? If nothing in SOP prevents this, each Region will function differently and that will not provide consistency across the state. Given this is a radical

change in the written consultation process, the change of practice will be difficult for some to accept and implement, including Regional Management.

Response: No template will be provided. A list of considerations for a consult has been added. Service regions and FSOS can set standards that they feel meet the needs of their respective teams. FSOS training on how to do a case consultation vs supervision is being developed and will be forthcoming.

5. **Comment:** Under INV Case consult-1. C.-NF is left out. What is the recommended consult on this type of case. Also, would these types of consults be on form or in contact? Also, the consult on 4 and under cases are taken out. What are the recommended consult times on this? Does this now fall under the normal INV consult timeframes?

   Response: All consultation forms are being removed. A safety assessment is needed in a near-fatality case, as there is still a living child in the home. Case consultations follow the investigative cadence guidelines listed for the related safety assessment. Cases with age four (4) and under assessed as safe with a plan or unsafe require a consult. This is a minimum cadence of consults and an FSOS or SSW can hold consults at any time as needed.

6. **Comment:** May provide consultation on any relative/fictive kin providers during the safety check and review, The standard appears to place accountability on the FSOS for consultation activities connected to a process they do not supervise or control. Supervisors may be evaluated on compliance with activities that occur within another team's workflow This expectation does not align with current practice and could result in inconsistent implementation across regions. Including this language under Provide Case Consultation standards may create the impression that Recruitment and Certification staff have a required role in the process. and document these consultations in service recordings- which TWIST case should it be documented in. This sentence reads referring to two different types of cases. May provide consultation The word "may" is basically saying that a consult does not have to take place throughout the entire approval process. There are no guidelines of when a consult is necessary and should occur, i.e., substance abuse, criminal charges, etc.

   Response: Language has been revised to remove 'or relative /fictive kin providers during the safety check and review'.

7. **Comment:** Consultation- 12 months and then a year thereafter until permanency. ASFA/ FED guidelines dictate 15 months to either move forward with ASFA or TPR. We need a 15 month and/ or consult every 6 months until permanency. I am an SSS

   Response: ASFA guidelines are related to court dates and timely permanency goals, they do not dictate consultation timelines. SOP 7.12 will be updated to reflect the change, as all consultation-related information will now be located in SOP G1.5.

8. **Comment:** I think that this is one of the best policy updates that have come down in recent years! This will severely (in a good way) cut down on a mundane task that most workers find unhelpful doing each month. Monthly consults on Investigations with a "Safe" SDM Safety Assessment finding not being required is a very common sense way to free up much needed time for frontline staff to focus on the cases with higher risk and/or present safety threats. The changes on consultations for ongoing cases are also very good and much needed! ONE NOTE: I would further clarify the Out of Home Case (OOHC) Case Consultation (FSOS #1) as to whether this should be a formal consultation completed by the FSOS or more of an informal staffing. Clarification is also needed as to whether or not these consults should be documented in the Service Recording.

   Response: There is a cadence of formal FSOS consults on OOHC cases and a separate cadence for regional OOHC consults. The FSOS participating in the regional OOHC consult could take the place of the formal FSOS consult if it falls on the same timeline. All consultations should be documented in TWIST. The date the consult is held and the parties involved should be included.

9. **Comment:** Alternative Response Case Consultation is not included or outlined. The case consultation for an alternative response case would be more family-driven and solution focused since there is no 'fact finding' to be done in order to support a finding at the close of the case. AR case consultation would ideally look different as we are asking supervisors to mirror with staff on how to interact with families without being so "check box" focused. AR case consultative questions might look like: 1. Who are the household members? 2. What led to agency involvement? 3. Who is this family/what are their strengths/values? 4. What is this family concerned about? 5. What is the SSW concerned about? 6. How have these concerns been handled in the past? 7. Are there safety threats that

has the SSW concerned and how has the family responded? 8. How does the family identify with their risk factors/high risk behaviors (ie: are they open to change, denying a problem, etc?) And how has the SSW addressed this? 9. What informal or formal supports has the family identified/what informal or formal supports has the SSW identified? 10. What needs to happen for this family to be successful and end agency involvement? The consultation above would fit 'safe with a plan', an 'unsafe' designation on the safety assessment would likely end up in the AR case being switched to an INV, so the INV consult would be appropriate then.

Response: Similar things can be discussed during AR consults. However, if a child is determined 'safe' during the safety assessment, a consult is not required unless the FSOS or SSW requests it. The list of topics to be **considered** may provide ideas to guide the conversation.

10. **Comment:** I like all of the suggested changes as far as eliminating required regional consults. I think that regional consults have always been duplicative and have only served the purpose of satisfying federal regulations. I would like to see OOHC consults on a regional level be reduced to the 3 month mark and the 12 month mark and every 12 months thereafter with an emphasis on preperms at the 9 month mark instead. That will aid in timeliness to permanency and eliminate duplicative consults. At the very least, I would like to see SOP state that a preperm will be held at the 9 month mark and that the regional specialist/representative can be invited to that preperm. I do not agree that any text should be put into TWIST. FSOS should not be required to write what barriers exist to closure, (12D) or under ongoing case consultation (1. Conducts a formal consultation with SSW, quarterly, on each case and, as part of the formal consultation, discusses and documents in service recordings the following items:: A. Strengths of the case; B. Areas for improvement; and C. Required tasks or actions and timeframes for each party.) This opens the worker and the supervisor up to a lot of other persons' supervision of their work. Through requests for records/attorney access/Ombudsman access, etc, this is too much of a personnel-related action to be listed in service recordings and would therefore be available to people who should not have knowledge of that supervision. Lastly, I would like to suggest that we add a required supervision within the month of a transfer, whether to another team, another county or another region.

Response: Language has been added to the OOHC consult section to suggest that the pre-permanency conference may be documented as the regional OOHC consult when the child has been in OOHC for nine (9) months. Language regarding the inclusion of barriers, etc., in the service recordings has been removed and has been revised to clarify that documentation of consults should include only the date the consult is held and the parties involved. The transfer of a case should be considered a key decision-making point in a case; therefore, a consultation should be held.

11. **Comment:** lI would like more guidance on the high-risk consults including 4 and under and Near Fatality reports. It is concerning if consults are not recommended due to ensuring safety for vulnerable children/cases. For consults on past dues and extensions, currently there are weekly consults recommended. What would now be the recommended consultations on these if FSOS's are not doing initials? SRC's. Would like to have clear guidance on how to doc the consult.

    Response: Any case with a safety assessment of unsafe or safe with a plan should trigger a consult. Consults may be held at the discretion of the FSOS to meet case-progression or staff-supervision needs. The FSOS or SSW can request a consult at any time and may include regional staff as needed. Documentation should include the date of the consultation and the parties involved and should be included in the TWIST service recordings. Please refer to SOP C2.11 Completing the Assessment and Documentation Tool (ADT) for information regarding extensions.

12. **Comment:** In the in-home consultation piece where it talks about what will be covered with the regional consult if the case has been open 15 months or more, one of the questions is what are the risks that led to the case being opened. I think we should really be shifting focus that cases should be opening due to safety concerns or family choice and we shouldn't be open cases based on 'risk' because every family has that. If a child is assessed as safe and the family declines offered services, we should be closing the case.

    Response: Language has been revised to indicate that the list is topics to be considered.

13. **Comment:** In reviewing the case consultation questions there is a lot of focus on risk language. I feel that the field is confused enough without

our double meaning of risk. The risk assessment assesses for the risk of future CHFS involvement, the 'high risk' behaviors we are talking about are behaviors that could jeopardize child safety. Is there a better word here? Language is so important and we are already confusing the field/community partners on what risk means. Could we use one of the following in place of "risk": 1. What safety-compromising patterns were identified? 2. What services are in place for each adult to address patterns of behavior that compromise safety? 3. What progress has been made by the mother, father, or other caregivers to reduce safety-compromising behavior patterns and the safety threats identified in the case plan.

Response: The risk tool includes high-risk behaviors that result in a high-risk case score. It is important to discuss high-risk behaviors as well as safety threats during a consultation.

14. **Comment:** Do we need to include the following items under In-Home Case Consultation: 7. Refers to SOP C2.8 Investigation Protocol if a new report is received and accepted during an ongoing case; That would fit in the In-Home Services SOP but doesn't feel like it really fits around case consultation. Also #8 and #9 are part of the in home consult but not the investigative consult steps which would be where most of the removals happen: 8. Provides consultation to the SSW when safety threats are identified, which may prohibit the child(ren) from remaining in the home, and requests consultation with the regional office if it appears the children cannot remain safely in the home; 9. Participates, along with the SSW and regional office designee in the consultation regarding removal. In the absence of the FSOS, the chief or acting supervisor may facilitate the request and participate in the consultation. Is it necessary to have this consult be a requirement? There are a lot of FSOS (I would wager most) who can make a removal decision without a regional consult to get 'permission to remove'. If there are supervisors who are abusing this power, that could be handled individually instead of mandating the entire state to complete these consults when an FSOS should be able to make a determination in consultation with their staff on whether or not to file a petition to remove a child. We want to encourage and empower our staff to critically think and hone decision-making skills.

    Response: Information has been added to refer to SOP C2.8 if a new report is received during an ongoing case. All information related to consultations will be consolidated from various SOP chapters into G1.50. The current policy on safety and risk consulting remains unchanged.

15. **Comment:** What is the difference between an In Home case, an OOHC case, and an "ongoing case"? Wouldn't all ongoing cases either be in home or out of home care?

    Response: This was an editing error and has been corrected.

16. **Comment:** 1. As a supervisor- I have concerns with not consulting every case monthly throughout the entirety of a case (even if marked safe)- a supervisor goes off what an SSW/SSC reports to them monthly and they are not able to remain fully up to date on a case if there are not regular consults. This can affect a supervisor's ability to respond to questions for attorneys/CAPTAs/Regional office/Etc. 2. What was the point of creating a mass entry consult button for FSOSs to enter monthly consults if you are going to require additional documentation for each individual case on each contact note? This contradicts the need for the button making it harder and more time consuming for FSOSs to enter monthly contact notes in each individual case. 3. If you are requiring regional office staff to be included within monthly consults with the FSOS and SSW/SSC- is this in addition to the already required consults with OOHC specialists for their consults at 3/6/9/12 months etc.? 4. Under OOHC Case consultation- it references a 90 calendar day FTM and 6 month FTM-- are the timeframes for case plans changing to every 3 months instead of every 6 months? FTMs are held within the first 10 days of removal and then every 6 months to address the case plan unless the parties request an FTM earlier. 5. Will there be updated training for FSOSs to go through regarding all changes prior to them being implimented?

    Response: The guidance in this SOP is the minimum cadence for consultations. Supervisors have the discretion to schedule/hold consults in a sequence that best meets the needs of a particular case or the specific supervision needs of staff. The FSOS or SSW can request a consult at any time. Regional staff **may** be included in a consult at any time at the request of the FSOS or SSW. OOHC consult on the referenced cadence is the only consult that requires the inclusion of FSOS, SSW, and a specialist. Language has been revised to clarify that documentation of consults should include only the date the consult is held and the parties involved. The ninety (90) day FTM policy is not new. All case plans are FTMs; however, not all FTMS are case plans. Training is being developed and is forthcoming, but will not be completed before implementation.

17. **Comment:** Submitting on behalf of (an SSS) as she's unable to get the link to open. It clearly states that consults should be entered into service

recordings to include: 1. following details: for Regional Consults A. The date the consultation was held; B. Type of consultation held; C. The parties involved in the consultation; D. Barriers to reunification; and E. Identify if the case is appropriate for concurrent planning. FSOS Supervision: A. Strengths of the case; B. Areas for improvement; and C. Required tasks or actions and timeframes for each party. Provide Case: A. Current status of home; B. Children currently placed in the home; C. Current exceptions; D. Review any prior action plans developed during the annual re-evaluation of foster/adoptive home review . We have always been advised to only put the date, who attended and what kind of consult was held.

Response: Language has been revised to indicate that the list is topics to be **considered**. Language has been revised to clarify that documentation of consults should include only the date the consult is held and the parties involved.

18. **Comment:** The consultation recommendations being entered in TWIST is a good idea. I definitely agree. Thank You for getting rid of the High Risk. This was the ultimate way to really micromanage a specific set of cases. We can set a specific SOP for these investigations for the SSW and FSOS to follow without having to require very time-consuming consultations that most in field do not see as needed. I would love to see the SRC be required within 5 days or 10 days after removal. Give the local office an opportunity to make the decisions and then consult after the emergency exists. I think the SRC is needed, just not before removal. If the local FSOS is struggling with removal decisions, this is a great opportunity to supervise and provide guidance for growth. We currently have reduced the ability to critically think and FSOS's are not growing in this area. We have turned them into robots where they call for a SRC before they have even thought through the case situation because of the SRC requirement. Give them the option for a SRC prior to removal, support them as needed, let them work through an emergency, and then guide them through a SRC. I like the ideas around change with this concept. The FSOS is ultimately approving the case decisions in TWIST regardless of case function so this gives them some flexibility. The FSOS always has the ability to request support from regional and central office. Please consider that we should not be requiring demographic information or any information already in TWIST on any consult form. This is duplicative and cumbersome. We can review TWIST for all that information. Please let the consult form be the conversation and recommendation without all

that duplicative work that someone has already been paid to enter in TWIST. Consults are often not productive because of the dread of completing the form with information that already exists in TWIST. I do have questions around the monitoring with data and personnel related issues for a FSOS that is not maybe following the SOP at all or is not performing consultation tasks at the minimum standard. How will an Associate monitor or evaluate this standard? Overall, I appreciate the opportunity for change in this area.

Response: All consultation forms have been deleted. DSR will review the performance planning standards.

19. **Comment:** 1. Title of chapter needs to be FSOS consults if it is only going to address FSOS consults. OR move all policies related to consults to this chapter for ease of finding and so that policy is clear, concise, and not conflicting. When staff search for information in SOP, they need to be able to find all things related to "Consultation" in one place. 2. Due to random cadence of consults based on case circumstances, there is not a way for FSOSs to be monitored for their progress/tracking of FSOS consults, which is a performance plan measurement. Will performance plans be altered or what is the solution for tracking consults? 3. Not consulting cases marked as safe in the SDM conflicts with SSWIs performance plan and job specifications that require staff perform under the direct consultation/supervision of a supervisor due to the staff member's lack of experience. Will job specifications change? If not, will FSOS be able to pend back safety assessments if they disagree with the workers' assessment? 4. Policy dictates that when entering contacts FSOS is not to list tasks staff are to complete following consults, but in the open discussion in the statewide meeting, it was mentioned that FSOS need to list what actions workers are going to take to remove barriers. This is conflicting guidance. 5. While policy is the minimum requirement for consults, this creates a very low bar for oversight in cases. Majority of staff in our region have under 5 years' experience, which requires more frequent consults/supervision/guidance. 6. According to this policy draft, all regional consults are being eliminated. If high risk consults/specialized consults are not required, will management reports still be run to track these cases? Our regional staff plan to continue to monitor these cases and provide guidance and support to frontline staff during these investigations. These reports will be very important to this endeavor. 7. "Consultation can occur at any time...should be completed at key decision-making points." What are key decision-making points? 8. There are consults labeled In Home Services,

Out of Home Care, and Ongoing case Consultations. What distinguishes the ongoing case consult from the other two, and is that one required in addition to the other two consults? 9. While some supervision is different and separate from consultation, there are times when they do overlap. FSOS training instructs FSOS to utilize their consults as time to provide coaching, mentoring, and guidance on engagement with clients and service provision. This policy contradicts training and guidance provided by the Cabinet. 10. HB 778 requires access to consults/forms/informs to outside entities. How will this new process protect staff from outside scrutiny or blame if/when something goes wrong in a case?

Response: The chapter title has been changed to G1.5 Consultation. All information related to consultations is being moved from other sections of the SOP manual to this chapter. DSR will review the performance planning standards. Language has been revised to clarify that documentation of consults should include only the date the consult is held and the parties involved. Consults may be held at the discretion of the FSOS to meet case-progression or staff-supervision needs. The FSOS or SSW can request a consult at any time and may include regional staff as needed. Key decision-making points are any time there is a significant change in the case. Some examples of key decision-making points have been identified under the various case types. The ongoing case information in the original draft was an editing error and has been corrected. Updated FSOS training is being developed and is forthcoming. Many of these edits are due to information from the findings report. All consultation forms have been eliminated.

20. **Comment:** Recommended Revisions to OOHC Consultation Timeframes Current consultation requirements include: A. After a child has been in Out-of-Home Care (OOHC) for three (3) months, with documentation completed on the Initial Three-Month OOHC Case Consultation Template; B. When a child has been in OOHC for nine (9) months; C. When a child has been in OOHC for twelve (12) months; and D. Every twelve (12) months thereafter, according to the child's entry date into OOHC, until the child achieves permanency. Recommended Additions: Six-Month OOHC Consultation An OOHC Case Specialist consultation should be completed at the six (6) month mark, prior to case plan renegotiation, to assess parental progress, evaluate barriers to reunification, review service effectiveness, and ensure permanency planning efforts remain timely and appropriate. Fifteen-Month OOHC Consultation An OOHC Case Specialist consultation should be completed at the fifteen (15) month

mark to determine whether the requirements of the Adoption and Safe Families Act (ASFA) have been met and whether a recommendation for filing a petition to terminate parental rights or pursuing another permanency goal is warranted. Ongoing Six-Month Consultations Following the twelve (12) month consultation, OOHC Case Specialist consultations should occur every six (6) months thereafter until permanency is achieved. More frequent consultations would provide ongoing assessment of case progress, identify barriers to permanency, and support timely decision-making. Discretionary Consultations An OOHC Case Specialist consultation may be requested at any time when the Social Worker (SW) and Family Services Office Supervisor (FSOS) determine that additional consultation with regional staff is necessary to address case complexities, barriers to permanency, safety concerns, or other significant case developments. These recommendations would prompt continuous oversight and helping drive timely permanency outcomes for children in OOHC. Recommendation Regarding Documentation of Required Tasks and Actions in Service Recordings Current language states: "Conducts a formal consultation with the SSW, quarterly, on each case and, as part of the formal consultation, discusses and documents in service recordings the following items: A. Strengths of the case; B. Areas for improvement; and C. Required tasks or actions and timeframes for each party." Recommended Revision: I recommend removing the requirement to document specific required tasks, actions, and timeframes for each party within service recordings. While consultations should include discussions regarding case strengths, areas for improvement, and next steps, documenting assigned tasks and deadlines in service recordings may create unnecessary liability for workers and supervisors. Instead, I feel that service recordings should document that consultation occurred, summarize key themes, and note that action items were discussed. Specific assignments, accountability measures, and timelines should be maintained through internal tracking mechanisms that support case management while minimizing potential liability and reducing the risk of documentation being interpreted as unmet mandates.

Response: The listed cadence for each case type is the minimum standard. Consults may be held at the discretion of the FSOS to meet case-progression or staff-supervision needs. They can occur at any time during the life of a case, at the request of the FSOS or SSW. Language has been revised to indicate that the list is topics to be **considered** during the discussion. Language has been revised to clarify that

documentation of consults should include only the date the consult is held and the parties involved.

21. **Comment:** Is completion of the safety assessment required prior to a regional consultation for placement out of the home? How will regions monitor progress on cases where the goal is RTP 12+ months but there are no longer ASFAs required per SOP? Will regional specialists be consulted when an FSOS determines a regional consult is needed and will a new form replace the DPP 20; does documenting the barriers in case consult contacts include listing the tasks that need to be completed to ensure safety? Where will tasks be documented if not in the service recordings?

    Response: Ideally**,** safety assessments are completed prior to any consult, but if staff are in the field, it should not be a barrier to a safety and risk consult. All consultation information throughout the SOP manual is being moved to SOP G1.5. An FSOS can request a regional consultation at any time. All consultation forms are being eliminated. Documentation of a consult in service recordings should only include the date of the consult and the parties involved. Supervisors are free to maintain supervision information using whatever informal technique they find most useful.

22. **Comment:** 1. Conducts a formal consultation with SSW, quarterly, on each case and, as part of the formal consultation, discusses and documents in service recordings I do not believe that we should be putting action steps for consults in TWIST.

    Response: No action steps should be documented in TWIST. Language has been revised to clarify that documentation of consults should include only the date the consult is held and the parties involved.

23. **Comment:** While I understand and appreciate the need to restructure processes, I respectfully oppose several proposed changes that I believe could have significant unintended consequences for child safety, decision-making quality, and support provided to field staff. The DPP-20 consultation process is a critical safeguard that ensures prevention services, safety interventions, and alternatives to removal have been fully considered before a child enters out-of-home care. It promotes thoughtful decision-making, consistency, accountability, and provides valuable support to workers and supervisors managing complex safety determinations. Eliminating the DPP-20 process and reducing regional

oversight may result in increased removals, decreased use of prevention services, greater variation in decision-making across regions, and reduced support for frontline staff. These outcomes could contribute to more children entering foster care and increased system costs. Research consistently identifies quality supervision and consultation as key predictors of child welfare worker retention, job satisfaction, and effective decision-making. Studies have found that supervision quality is one of the strongest factors influencing workforce stability, worker satisfaction, and confidence in practice. Workers who receive strong supervisory support report higher job satisfaction, while supervisors who receive regular consultation report lower stress, greater organizational support, and improved ability to guide staff. Beyond quality assurance, regional consultations and removal reviews serve as important mechanisms for mentorship, collaboration, consistency, and support in high-risk cases. At a time when child welfare agencies continue to face recruitment and retention challenges, reducing opportunities for consultation may inadvertently remove one of the strongest supports available to workers and supervisors. Kentucky has made significant investments in prevention services and efforts to safely reduce unnecessary foster care placements. Maintaining regional consultation requirements for physical abuse investigations involving children four years of age and younger, along with preserving the DPP-20 consultation process, supports those goals by promoting critical review, consistent decision-making, and consideration of safe alternatives to removal. These processes provide essential safeguards for vulnerable children, strengthen policy-driven practice, and support positive outcomes for children, families, and the workforce.

Response: The safety risk consultation process is not being eliminated; only the form is being removed. The listed cadence for each case type is the **minimum** standard. Consults may be held at the discretion of the FSOS to meet case-progression or staff-supervision needs. They can occur at any time during the life of a case, at the request of the FSOS or SSW. An FSOS can request a regional consultation at any time.

24. **Comment:** With the new policy that means FSOS will no longer be able to enter group contacts if we go by the draft SOP of documentation due to each barrier identified on the cases are different on investigations, in home, ongoing, and OOHC case consultations. To streamline consults ultimately is effective however, this format will create additional

workload onto the FSOS and will ultimately make documenting consults long, tedious and create more work.

Response: Language has been revised to clarify that documentation of consults should include only the date the consult is held and the parties involved. Group contacts will remain available.

25. **Comment: FSOS** I have spent some time reviewing this policy draft and find the timeframes for staffing very confusing 10 days, 14 days, Monthly, at the 6 month mark, whenever big changes happen, whenever a new report is made, (both accepted inv AND DNC inv).These timeframes do not lend themselves to being able to complete thorough consults as the consults will have to be more sporadic in order to meet the timeframes verses planned protective time to focus on staffing. Since the staffing are directed by the type of case that it is, and most workers work many different types of cases, it will be hard to schedule which cases will need to be talked about around their regular duties.

    In addition, as a supervisor, how am I going to figure out when to staff these cases. Instead of setting protective time to staff all someone's cases , I am going to have to keep a calendar of what type of case it is, when it moved to a different function, If ANYONE calls in a referral to drop what I am doing to get a good staffing on a case. It is going to be hard to also remain up to date on the cases…..which for others that may not be as hard ….but I often get called by the court or attorneys needing information.

    I like the specifications about how to document what we talk about as I thought that the contacts we enter are just too general BUT if we are entering these huge contact we will not be able to enter our contacts with the group contacts toggle button that Twist just gave us to be able to use to cut down on time entering contact. So this defeats the purpose as each contact for consults will have to be specific.

    Response: The listed cadence for each case type is the **minimum** standard. Consults may be held at the discretion of the FSOS to meet case-progression or staff-supervision needs. They can occur at any time during the life of a case, at the request of the FSOS or SSW. An FSOS can request a regional consultation at any time. Supervisors are free to schedule discussions and maintain supervision information in whatever technique they find most useful. Language has been revised to clarify

that TWIST documentation of consults should include only the date the consult is held and the parties involved. Group contacts will remain available.

26. **Comment: FSOS-** The changes to ongoing case consultations are convoluted and will be too hard to keep up with. The information listed to be reviewed during consults is good. Ongoing case consults between FSOS and worker need to occur monthly. As an FSOS, this is how I keep up with the cases for which I have supervision responsibility. Monthly consults is critical for the FSOS to know what is going on in their cases.

    Response: The listed cadence for each case type is the **minimum** standard. Consults may be held at the discretion of the FSOS to meet case-progression or staff-supervision needs. They can occur at any time during the life of a case, at the request of the FSOS or SSW. Language has been edited to clarify that the list includes items to be **considered** during the discussion. Supervisors are free to schedule discussions and maintain supervision information in whatever technique they find most useful.

27. **Comment: Investigative Case Consultation**

The FSOS: (I would like to add Chiefs as well since you are paying us to fill in for the FSOS)

C. All pathways not utilizing the safety assessment require one (1) consultation within fourteen (14) calendar days of acceptance and as needed thereafter. The following are some examples:

1. **Fatalities (without a surviving child);**
2. **Foster homes with no allegations involving birth children;**
3. **Specialized investigations;**
4. **Dependency cases (I think there should be some 'wiggle room' here, usually, Dependency Cases are from Court and the Court is clear on what they want.)**
5. **Status cases; (Please make an exception for pre-adjudicated Status Cases, as I am the 'unofficial**

Court Juvenile Liaison' in my county and the Court is Ordering us to be involved for 'Status' and 'Public Charges' and Ordering us to Open and Provide services, but CI, is not coding the intake accordingly. Also, the Court is very clear on what they want, so, I don't think a consult is required within 14days, if, we get a Court Order, it's not up for debate on what to do, if it was it would be called a 'Court Option' or 'Court Suggestions', but, 'Court Orders are Court Orders'.)

6. **Human trafficking (non-caretaker); and**
7. **Female genital mutilation (non-caretaker).**

2. **The FSOS:**

M. ~~Is the court case active and what court orders are in place~~ **Status of the court case and any court orders in place; (and consult with the GAL & County Attorney or Commonwealth Attorney as needed to get input/recommendation(s))**

10. For emergency and on-call situations, the FSOS and regional office may consult without the SSW.

A. If available, a master's degree-level practitioner is recommended as a participant in the consultation. If not available, the SRAA/SRCA or designee is appropriate. ~~Regional office maintains a copy of the signed **DPP-20**;~~. **(I would like an exception to be added, for Licensed Social Workers (LSW) or Licensed Clinical Social Worker (LCSW) (in 'good standing' meaning, active license) which can substitute for a master's degree)**

Out of Home Care (OOHC) ~~Regional~~ Case Consultation

The FSOS:

1. **Consults with SSW:**
   - **A. Within ten (10) calendar days of the temporary removal hearing and prior to the ten (10) day case plan;**
   - **B. Prior to the ninety (90) calendar day FTM;**
   - **C. Prior to the six (6) month case plan FTM;**
   - **D. At the point of any significant change in the case;**

E. **Upon any new allegations of maltreatment received, including reports that do not meet criteria;**
F. **Prior to the annual permanency review;**
G. **Prior to the beginning of a trial home visit; (Courts have strong feelings about this topic; I would like to add, 'Consult with the GAL and/or County Attorney to get input, as needed or required')**
H. **Prior to reunification/reunification assessment;**
I. **Prior to case closure; and**
J. **As requested by SSW.**

Response: The decision to add a chief would be a service-region decision. Dependency and status cases lead to a large number of youth entering OOHC. It is important that these cases are staffed at the local level as well as with the Office of Legal Services, specifically when DCBS did not seek custody. Although it's important to update the GAL on the child's placement, the Cabinet is the decision-maker regarding placement. People with an LSW or LCSW would already have a master's degree.

28. **Comment: SSS-**I am a Protection Specialist with XXXX Regional Office. My current responsibilities addressed in this SOP revision include consultation on high-risk cases involving physical abuse of children ages four and under, foster home investigations, daycare investigations, school investigations, human trafficking investigations, and fatality/near-fatality investigations.

    I am writing regarding the proposed change in the draft SOP that extends the required initial consultation from 72 hours to 14 days. I have concerns about the potential impact of this change on case quality and staff development.

    Frontline staff and FSOS personnel are not always fully versed in SOP requirements and often benefit from early guidance from a Protection Specialist. However, staff may not consistently seek consultation unless it is specifically mandated by policy. The current 72-hour consultation provides an important opportunity for Protection Specialists to review investigative actions taken to date, discuss planned next steps, identify potential gaps, and provide guidance on case direction.

    These consultations serve not only as a quality assurance measure but also as a valuable coaching and mentoring opportunity for newer staff. Early involvement helps ensure critical information is identified and

addressed promptly, reducing the risk of oversight during the initial stages of an investigation.

My concern is that delaying consultation until the 14-day mark may result in missed opportunities to identify issues early in the case process. Additionally, the proposed language appears to indicate that FSOS staff would consult with the frontline SSW unless regional staff are specifically invited by the FSOS and frontline SSW. This may further limit access to specialized expertise during a critical period of the investigation.

I appreciate the opportunity to provide feedback and respectfully request consideration of the benefits of maintaining the current 72-hour consultation requirement and adding regional staff to consultations.

Response: Prior policy required a once-per-calendar-month consult on all investigations, including specialized. The new policy requires them within fourtenn (14) calendar days.

29. **Comment: SSS-** I currently serve as a Protection Specialist within XXX. My primary responsibilities include providing HR consultation on specialized investigations, including physical abuse reports involving children under age four, school investigations, DCBS and PCC foster home investigations, human trafficking investigations, daycare investigations, and F-NF investigations.

    Under current SOP, staff are required to complete consultation within 72 hours of receiving a specialized investigation report. The proposed SOP revisions would extend this requirement to within 14 days of receipt. I respectfully ask that the importance of maintaining the current 72-hour consultation requirement be carefully considered.

    Specialized investigations are often complex and involve specific procedural requirements that must be completed promptly to ensure child safety and compliance with policy. Consultation within the first 72 hours is critical to ensuring that investigations begin appropriately, required actions are completed timely, and staff receive the guidance and support necessary to effectively manage these cases.

    The first 72 hours of a specialized investigation are often the most crucial. Early consultation provides an opportunity for regional staff to review completed tasks, discuss investigative planning, identify any missed procedural requirements, and offer support and education to frontline workers. These consultations not only promote quality casework

but also strengthen collaboration between regional office staff and frontline personnel.

Frontline workers are routinely managing multiple competing priorities. When staff are overwhelmed, inexperienced, or unfamiliar with specialized investigations, important procedural requirements can be inadvertently overlooked. Examples may include notifying OIG, sending required notification letters to schools, or identifying and notifying ongoing workers when an out-of-home care child is placed in a foster home that becomes the subject of an investigation. While these may appear to be minor procedural steps, they are essential components of a thorough and compliant investigation. Conducting consultation within 72 hours helps ensure these critical requirements are completed in a timely manner.

Eliminating the 72-hour consultation requirement may reduce the quality and consistency of specialized investigations, limit opportunities for Protection Specialists to mentor and support staff, and increase the risk that important procedural requirements are missed. Ultimately, maintaining timely consultation supports better outcomes for children and families, promotes policy compliance, and provides valuable support to frontline staff during some of the agency's most complex investigations.

Thank you for your consideration of the impact this proposed change may have on the quality of investigations, the families we serve, and the staff responsible for carrying out this important work.

Response: Current policy requires a seventy-two (72) hour consult on physical abuse reports involving youth age four (4) and under. All other reports mentioned required a once-per-calendar-month consult. These reports will still receive a formal FSOS consult if the safety assessment identifies them as unsafe or safe with a plan. Additionally, regional staff, FSOS, and SSW can hold a consult at any time. This is the minimum required consultation cadence. Regional staff and FSOS have the discretion to hold consults on any case for any staff based on need.

30. **Comment: SRA-** I chose not to submit my feedback regarding the FDR for SOP G1.5 anonymously because, as an SRA, I feel strongly that these proposed changes warrant reconsideration.

Several years ago, DCBS engaged a contracted vendor to evaluate and streamline the consultation process. At that time, the discussion centered on improving existing consultation tools, embedding forms within TWIST, enhancing communication between DSR and DPP, and creating a more efficient and meaningful consultation process. Unfortunately, that work was never fully realized after the contract ended.

When this workgroup reconvened this year, I sent the same regional representative who had previously participated. She returned from the meeting deeply concerned about the potential impact these recommendations could have on practice, supervision, and ultimately outcomes for children and families.

From my perspective, these proposed revisions appear to be driven largely by concerns associated with HB 778 and the expanded access granted to the External Review Panel. While I understand those concerns, I believe we may be making sweeping statewide changes to a consultation structure that supports all cases in response to legislation that will affect only a relatively small subset of cases. In doing so, I fear we risk losing a process that has historically supported quality practice, accountability, and workforce development.

I also want to share that I feel somewhat disconnected from the reasoning behind these recommendations because they do not appear to reflect the realities currently facing our regions. We are supervising a relatively inexperienced workforce, carrying significant vacancies, and managing increasingly complex cases. Consultation requirements have historically served not only as a compliance tool, but as a mechanism to support decision-making, develop staff competency, promote consistency in practice, and move children toward permanency. Reducing those safeguards without a clear operational plan for accountability, tracking, and workforce development places additional burden on frontline staff and supervisors who are already stretched thin.

My concerns are outlined below.

Consultation Forms and Accountability

The introduction states that the purpose of consultation is to utilize supervisory expertise to guide casework and ensure tasks and objectives identified in assessments, case plans, and supervisory direction are completed. However, the proposed SOP eliminates consultation forms altogether.

Removing consultation templates creates significant concerns regarding:

- Tracking action steps and case progression;
- Supervisors' ability to monitor completion of assigned tasks;
- Documentation supporting coaching, corrective action, and employee accountability; and
- Consistency in supervisory practice statewide.

During the SRA meeting, we were advised that supervisors could maintain notes in notebooks. However, OLS has routinely advised regions that handwritten supervisory notes may also be subject to Open Records requests. If the concern is discoverability, replacing structured consultation documentation with informal handwritten notes does not appear to address that concern.

Rather than eliminating consultation forms entirely, I would encourage us to improve them and provide supervisors with training on effective supervision, coaching, and consultation practices. In my career, I have never received formal training on how to conduct quality supervision, despite now serving as an SRA. This seems like an opportunity to strengthen practice rather than reduce expectations.

Timelines and Workforce Considerations

Many of the objective consultation timelines currently in SOP have been removed and replaced with broader language such as "significant changes occur."

This raises several questions:

- How will supervisors consistently track consultation requirements?
- How will these requirements be measured for evaluation purposes?
- Will evaluation standards also be revised?
- How will consistency be maintained across regions?

Additionally, we currently have a very young workforce in many areas of the state. Many workers still require assistance identifying safety threats, distinguishing poverty from neglect, and developing critical thinking skills. Experienced workers may request consultation when needed, but newer staff often do not yet recognize when additional guidance is necessary.

Reducing required consultation frequency may unintentionally decrease opportunities for mentorship, skill development, and oversight precisely when our workforce needs it most.

Investigative Consultations

While utilizing safety assessment outcomes to determine consultation frequency sounds reasonable conceptually, implementation presents significant challenges.

Supervisors already manage substantial workloads. Requiring them to monitor safety assessment outcomes in order to determine consultation schedules creates an additional administrative burden.

I am also struggling to understand the rationale for reducing consultation requirements on specialized investigations. These cases are often among our most complex and highest liability investigations, yet the proposed SOP requires only one consultation within fourteen days.

Similarly, eliminating or reducing regional consultations shifts more decision-making responsibility and liability solely to frontline supervisors and staff. Regional consultations have historically served not only as quality assurance mechanisms, but also as opportunities to develop supervisory skills and promote consistency in practice.

In-Home and OOHC Services

Reducing required consultations for in-home cases to every six months and eliminating monthly OOHC consultations raises concerns regarding:

- Timely movement toward permanency;
- Length of time children remain in care;
- Consistency in case planning;
- Identification of barriers; and
- Ongoing supervisory support.

These changes assume a level of experience and independent practice that many staff simply have not yet developed.

Recommendations

Rather than eliminating consultation templates and significantly reducing consultation requirements, I respectfully suggest we consider:

- Revising and improving existing consultation tools;
- Providing statewide training on effective supervision and consultation practices;
- Maintaining objective consultation triggers for high-risk and complex cases; and
- Clarifying documentation expectations and the impact on employee evaluations.
-

I fully support efforts to improve efficiency and address concerns related to records disclosure. However, I believe these proposed revisions may have unintended consequences that negatively impact child safety, timely permanency, workforce development, and accountability. Given those potential implications, I respectfully urge reconsideration of these changes before they are finalized.

Thank you for considering this feedback and for the work being done to improve practice statewide.

Response: It is agreed that consultation has historically served many important functions within DCBS, including supporting decision-making, promoting accountability, developing staff competency, providing mentorship, and ensuring workers and supervisors do not feel isolated in making difficult decisions. In fact, these themes emerged consistently throughout the statewide consultation reform assessment conducted in partnership with Deloitte. Staff across all regions identified consultation as valuable because it provides additional perspectives, shared accountability, professional development opportunities, and support for workers managing complex cases and high caseloads.

At the same time, the assessment identified several consistent challenges with the current consultation structure, which informed the workgroup's recommendations. These findings were not driven by HB 778 or concerns related to external review. Rather, they reflected feedback gathered through the review of over forty-eight (48) forms and protocols, shadowing of consultation practices across multiple regions, analysis of two hundred twenty-four (224) staff surveys, seven (7) statewide focus groups, and research on consultation practices in other states.

One of the strongest findings from the assessment was that consultation and supervision have become increasingly blurred, resulting in a process that often serves multiple purposes simultaneously, including compliance monitoring, case review, staff development, approval authority, and consultation. The assessment found that many activities currently labeled as "consultation" operate in practice as supervision or administrative oversight.

Regarding documentation, the workgroup recognizes the importance of accountability and tracking. However, the statewide assessment consistently identified consultation forms as one of the most significant barriers to effective practice. Staff across all levels reported that consultation forms are often duplicative, time-consuming, inconsistent across regions, and result in a "checkbox" approach that detracts from meaningful discussion and coaching. The assessment documented extensive regional variation in forms

and protocols, with many regions developing their own versions because existing forms were not meeting operational needs.

Importantly, the proposed revisions do not eliminate supervisory accountability or documentation requirements. Rather, they seek to distinguish between supervision and consultation and allow supervisors greater flexibility in how they document and monitor case progression. The assessment found that supervisors currently spend a substantial portion of consultation sessions completing forms rather than engaging in coaching, problem-solving, and critical-thinking discussions with staff.

We also recognize the concerns raised regarding workforce experience and vacancies. The assessment similarly identified that Kentucky's workforce is increasingly inexperienced and that supervision and mentorship remain critical functions. However, the findings suggested that these activities are best supported by effective supervisory practice rather than by universally mandated consultation requirements applied equally to all workers and cases, regardless of complexity or need. Multiple focus groups emphasized that blanket consultation requirements may not be the most effective approach to workforce development and that supervisors should have greater flexibility to tailor support based on workers' competencies and case complexity.

Similarly, the recommendations regarding consultation frequency were informed by findings that staff experience many consultation requirements as repetitive and duplicative, particularly when there have been no significant changes in the case. Approximately 70% of supervisors surveyed agreed that consultation processes are duplicative with other required processes, and the most frequently identified opportunity for improvement across surveys and focus groups was reducing unnecessary or repetitive consultations.

The proposed changes are not intended to reduce support for staff, diminish accountability, or eliminate opportunities for consultation when needed. Rather, they seek to align consultation requirements with the purpose of consultation itself: bringing additional expertise, perspectives, and support to complex decisions while allowing supervisors to exercise professional judgment regarding the level of oversight and coaching required for individual workers and cases.

Finally, it’s agreed that continued investment in supervisory training and workforce development is essential. The assessment itself identified professional development, mentorship, and support as among the greatest

strengths of the consultation process, and preserving these functions remains a core objective of the proposed revisions.

31. **Comment: FSOS-** I have concerns with documenting the barriers in the FSOS consults with the SSW. Noted below. We have always been told that was not necessary. Then why now? These should be documented in ongoing field work contacts. I do not think it is necessary to put on the consults.

    - **Barriers identified to resolving safety threats and assisting the family towards independence and case closure.**

    Clarification on this section for OOHC needs to be done. Do we document all this information in our Consultation contact? We have never documented the information in our consult contact. So again, I worry about putting this information in the consultation contact.

    1. Conducts a formal consultation with SSW, quarterly, on each case and, as part of the formal consultation, **discusses and documents in service recordings** the following items:
        A. Strengths of the case;
        B. Areas for improvement; and
        C. Required tasks or actions and timeframes for each party.
        D.

We need clear expectations. I like the idea of not having a form, but let's make sure we understand what needs to be done. Those of us who have been here for a while and have always been told that we put NO CASE-specific information in the consults, this is a tad confusing and feels like micromanagement.

Response: Language has been revised to clarify that documentation of consults should include only the date the consult is held and the parties involved. Language has also been edited to clarify that the list includes items to be **considered** during the discussion.

32. **Comment: FSOS** Specifically, I want to address the section for Out of Home Care Consults.
    - On page 9, this section starts with the heading, "**Out of Home Care (OOHC) Regional Case Consultation" and below that is guidance for the FSOS.**
    - **It states the FSOS should conduct consults with the SSW at specific times. For example, 10 days after the temporary removal hearing, prior to 90 calendar days of the FTM, etc.**

- **However, if you scroll past these guidelines there is another heading, "Ongoing Case Consultation".**
- **Under this heading, the FSOS is instructed to conduct consults with the SSW quarterly but does not mention the specific times listed in the previous heading of "Out of Home Care Regional Case Consultation."**

So, I find this to be a little confusing. Perhaps the first heading I mentioned is for the regional out of home care specialists. If that is the case, simply changing "FSOS" to Out of Home Care Specialist" would fix that issue. Because, as it stands, the FSOS would have to complete quarterly consults, but also have to work out the timing of all the cases to then be within the timelines mentioned in the first section. I hope I am making sense. I am a visual person, so I have copied and pasted the sections below. I have highlighted my concerns and possible changes.

Out of Home Care (OOHC) Regional Case Consultation

The FSOS: - I think changing this to the Regional Out of Home Care Specialist makes more sense.

2. **Consults with SSW and FSOS: I would add this to include FSOS.**
   - **K. Within ten (10) calendar days of the temporary removal hearing and prior to the ten (10) day case plan;**
   - **L. Prior to the ninety (90) calendar day FTM;**
   - **M. Prior to the six (6) month case plan FTM;**
   - **N. At the point of any significant change in the case;**
   - **O. Upon any new allegations of maltreatment received, including reports that do not meet criteria;**
   - **P. Prior to the annual permanency review;**
   - **Q. Prior to the beginning of a trial home visit;**
   - **R. Prior to reunification/reunification assessment;**
   - **S. Prior to case closure; and**
   - **T. As requested by SSW.**
1. **Includes an OOHC specialist, in consultation with the SSW, for the following OOHC case:**
   - **A. After a child has been in OOHC for three (3) months. and documents information on the three (3) month initial OOHC case consultation template;**
   - **B. When a child has been in OOHC for nine (9) months,**
   - **C. When a child has been in OOHC for twelve (12) months; and**

D. Every twelve (12) months thereafter, according to the child's entry date into OOHC, until the child achieves permanency;

2. The results of the periodic case consultations are documented Document the results of the periodic case consultations on the Ongoing OOHC Case Consultation Template.
3. Ongoing OOHC consultations will be documented Documents OOHC consultations in service recordings and will include including the following details:
   A. The date the consultation was held;
   B. Type of consultation held;
   C. The parties involved in the consultation;
   D. Barriers to reunification; I would change "Reunification and replace with "Permanency Plan" as all cases do not have a goal of reunification but all cases have a permanency plan. and I would want to also include steps to overcome permanency barriers.
   E. Identify if the case is appropriate for concurrent planning.
4. Maintain Tthe completed case consultation template will be maintained by with the regional office designee (either electronically or in hard copy format).
5. Document For agency cases, the consultation is documented utilizing the Agency Case Consultation Template.

Ongoing Case Consultation

The FSOS: By making the changes above, the FSOS can conduct quarterly consults without having to be mindful of the specific timelines mentioned in the prior section.

2. Conducts a formal consultation with SSW, quarterly, on each case and, as part of the formal consultation, discusses and documents in service recordings the following items::
   A. Strengths of the case;
   B. Areas for improvement; and
   C. Required tasks or actions and timeframes for each party.
3. Ensures that safety threats have been resolved or addressed through a plan, prior to closure of the case. staff complete all identified tasks or actions as discussed. and it is documented on the appropriate consultation form;
4. Documents the following information on the individual supervisory consultation form when a task or action is unable to be completed by the next quarterly consultation;:
   A. Barriers to completing the task or action; and
   B. Anticipated date of completion of the task or action.

5. **Assesses the completion of the identified tasks or actions at the next quarterly consultation.**

Response: Edits have been made to clarify the FSOS role. Language has been revised to clarify that documentation of consults should include only the date the consult is held and the parties involved. Much of the above-cited information has been deleted in the updated procedure.

33. **Comment:** In my opinion investigative consultations should not be boxed in to a specific timeframe of how frequently they should be held throughout the life of the case. It would be important to align with assessing safety such as with the initial consultation after the initial contact with the family was made to assess safety however supervisors should be given the autonomy and SOP language should align more broadly to give supervisors that autonomy to decide when consultation should be completed based on any identified safety threats throughout the life of the case. The reality is if the case is safe with a plan or unsafe, the SW and FSOS are having regional consultations for removal and case work is guided by the recommendations from that consult. It is also my opinion that dependency or status cases should not be grouped in with all other cases not utilizing the safety assessment as those are not specialized cases (assigned to the specialized investigative team). There are also case types that are missing from that group however again, they would not be applicable to necessarily be grouped with specialized cases. Court related activities and out of state courtesies are not included in the group. If there needs to be a minimum amount of consults outlined in SOP it may still be better to document something to the affect of; consults will be completed as often as necessary throughout the life of the case to appropriately assess safety but at a minimum will be completed upon initially receiving the investigation and prior to assessing for case closure or could include language of at least monthly if this is more appropriate. Given that worker caseloads are between 60-100 cases each and supervisors are balancing completing consults monthly for each of those cases (150-200 total) it would not be feasible to complete consults every 14 calendar days and if that doesn't get done, get penalized for it. I also don't believe as supervisors it would be feasible to enter case consultations in twist for 150-200 cases monthly one by one documenting specific case barriers to each case individually. The group contact that was recently updated in TWIST has been EXTREMELY HELPFUL to actually being able to document the case consults I do complete monthly. Prior to that group contact, it was extremely difficult to enter due to competing job demands and not

having the time as it takes hours to enter by hand every case consultation in twist without the group contact, that is including a generic documentation statement for every case and not entering barriers to each specific case. Entering specific barriers for each case will take even longer and it does not seem necessary. It would be helpful to be able to still enter a generic statement including date of consult, parties involved, and that additional steps to completing the investigation and any identified barriers to resolve safety threats were discussed and be able to enter them in the group tab as you can pick and choose which cases you include in the group tab and this is the most handy thing for supervisors that was added to assist with reducing work load tasks.

Response: Not every case that is safe with a plan has the discussion for removal. The listed cadence for each case type is the **minimum** standard. Consults may be held at the discretion of the FSOS to meet case-progression or staff-supervision needs. They can occur at any time during the life of a case, at the request of the FSOS or SSW. An FSOS can request a regional consultation at any time. Supervisors are free to schedule discussions and maintain supervision information in whatever technique they find most useful. Language has been revised to clarify that documentation of consults should include only the date the consult is held and the parties involved. Group contacts will remain available

34. **Comment:** I wanted to share my concerns with the updates to the below policy. I am very worried for monthly consults not being required as there are often concerns/ risks or steps overlooked by frontline staff due to the amount of cases etc. I also worry about ASFAS not being required as those consults really assist me as a supervisor especially one being newer to the role. They are beneficial with keeping my ongoing OOHC cases on track for permanency. These changes really worry me for the ongoing safety for children as well as getting children into a permanency in a timely manner. The oversight in both areas is very much needed.

    Response: Consults may be held at the discretion of the FSOS to meet case-progression or staff-supervision needs. They can occur at any time during the life of a case, at the request of the FSOS or SSW. Language has been edited to clarify that the list includes items to be **considered** during the discussion. Supervisors are free to schedule discussions and maintain supervision information in whatever technique they find most useful.

35. **Comment:** I have reviewed the attached FDR and have the following comments:

    I am concerned that the High Risk 4 and under regional consults have been removed from the consultation SOP. Currently, when these consults are done there are multiple things staff have not done and need to be told to go do during these consults and then during follow ups there are tasks staff have still not completed and need to be reminded to go do.

    Task Examples:

    Request medical records, sometimes staff request them sometimes they do not.

    Review medical records, sometimes staff document they received the medical records but they don't document or summarize what was found. Sometimes they upload the records and sometimes they do not. (recently we requested medical records during an investigation which noted no concerns. Another investigation was received and we requested records again – the records had been altered by the Physician's office and now had concerns noted during the first investigation timeframes. If we had not received and reviewed the original records, we would not have known this). This is an issue with the Dr. office but also shows that in our initial investigation they didn't have concerns.

    Make a home visit – staff generally see the child at the Doctor's office, hospital, in the office and haven't been to the home thus meaning safety has clearly not been assessed. We have to tell them to make a home visit, take pictures, measure distances, etc..

    Refer to consult with UK Forensics – FSOS's don't generally do this, this is most often a suggestion made by the Protection Specialists during consults. Sometimes this is needed and assists with proving or disproving allegations. I fear referrals may not get made to UK when they should be.

    I am concerned about a rise in Fatalities and Near Fatalities from this as well.

    Investigative Case Consultation

    1. C. 1. Fatalities (without a surviving child)

I think consultation is needed on Near Fatalities too

4. C. So we document the barriers but not how to address or overcome the barriers? Ie: the tasks…? I think it would be beneficial to provide an example of a contact showing what should be entered so we can provide legitimate feedback.

In Home Services Case Consultations

#8 thru #11 these all reference the safety and risk consultation process which is in regard to removal but it's under the In Home Consultation section? Why would this not be under the investigative consult piece? Now there is no form to document the SRC on? This should have different documentation guidance than the other consult pieces and should not be in the flow of an In Home Consult.

Response: The actual task of having consultations is not being removed, only the form is going away. Consults may be held at the discretion of the FSOS to meet case-progression or staff-supervision needs. They can occur at any time during the life of a case, at the request of the FSOS or SSW. The listed cadence for each case type is the **minimum** standard. Language has been revised to indicate that the list is a set of topics to be **considered** during the discussion. There is no mandate to discuss each topic or to only include what is on the list during the discussion. Language has been revised to clarify that documentation of consults should include only the date the consult is held and the parties involved.

A safety assessment is needed in a near-fatality case, as there is still a living child in the home. Case consultations follow the investigative cadence guidelines listed for the related safety assessment. Cases with age four (4) and under that are assessed as safe with a plan or unsafe require a consult.