Investigations
Day 2 - Participant Manual

Structured Decision Making & Risk Assessment

Applying SDM & Applying Protective Capacity

Building Effective Interviewing Skills

Case Initiation – Engaging the Child Using SOP Tools

Building Understanding After Child Contact

Preparing for Caregiver Contact

Day 2:

Investigations Training Agenda

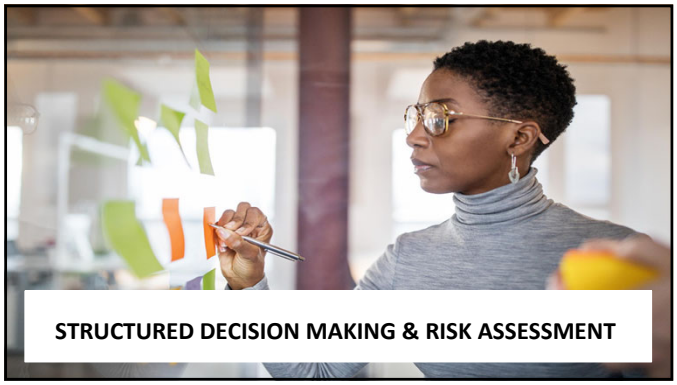
Monday	
9:00 –10:30	Welcome Structured Decision Making & Risk Assessment
10:30 -10:45	**Break**
10:45 – 12:00	Applying SDM & Assessing Protective Capacity
12:00 – 1:00	**Lunch Break**
1:00 –1:45	Building Effective Interview Skills
1:45 – 2:30	Case Initiation – Engaging the Child Using SOP Tools
2:30 – 2:45	**Break**
2:45 – 3:00	Building Understanding After Child Contact
3:00 – 4:00	Preparing for Caregiver Contact Wrap Up and Review

Investigations
Specialty Training

UA Little Rock MidSOUTH College of Business, Health, and Human Services, University of Arkansas at Little Rock

Day 2

1



2

Structured Decision Making & Risk Assessment

Today, you'll begin using that information to make investigative decisions that specialists make every day in the field.

3

Target Outcomes

- Understand safety through Safety Decision Making.
- Apply interview skills through guided simulation.
- Assess and identify protective capacity.

4

Reconnecting To The Flowers' Case

What Do We Know & What Does It Mean?

5

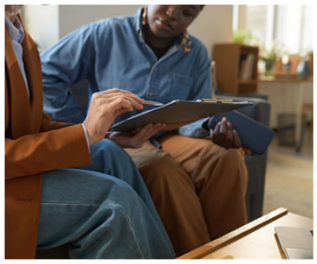
Why Safety Assessment Matters?

From Concerns to Safety Decisions

6

Understanding Threats to Safety VS Complicating Factors

What are we worried about right now?



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Guided Interview Practice

Reporter Contact (Hannah Lewis)

Activity

8

Applying What We Learned From The Reporter

Connecting Information to Safety Threats

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Wrap-Up & Key Takeaways

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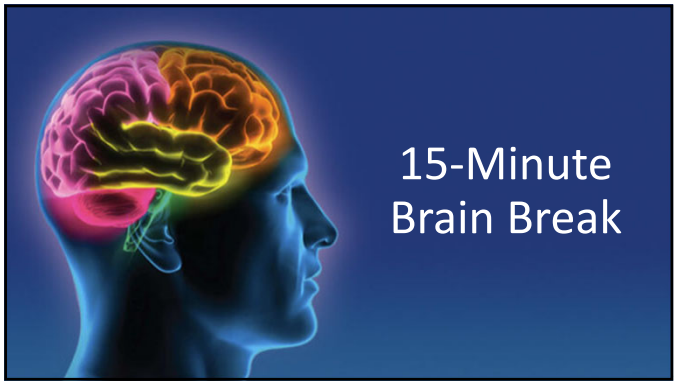

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APPLYING SDM & ASSESSING PROTECTIVE CAPACITY

What do you think protective capacity means?

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Target Outcomes

- Understand how to apply SDM thinking to their case.
- Begin connecting caregiver behavior, child impact, and safety concerns.
- Learn how to identify protective capacities.

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Using the SDM Model at Each Decision Point

Where are we in the process?

15

Introduction to Protective Capacities

Does the Caregiver have the ability and willingness to ensure the child's safety?

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C + B + I

Connecting Caregiver Behavior to Child Impact

17

Identifying Information Needed to Assess Protective Capacity

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Wrap-Up & Key Takeaways

Understanding of how to **apply SDM thinking**, recognize **protective capacity**, and identify **information gaps** that guide next steps in an investigation.

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BUILDING EFFECTIVE INTERVIEWING SKILLS

Why do you think how you ask a question matters?

22

Target Outcomes

- Understand the importance of how questions are asked during interviews.
- Develop skills for forming clear, purposeful, and information-gathering questions.
- Understand that the way questions are asked directly impacts the quality and accuracy of the information received.

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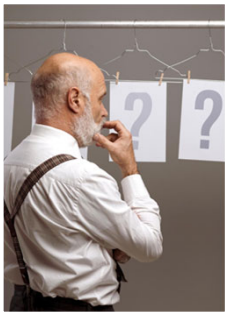

What Makes A Strong Question?

Getting Better Information Through How You Ask

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Improving Questions

Improving weak questions by transforming them into clear, open-ended, and information-gathering questions.

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Applying Strong Questions To The Flowers' Case

What Would You Ask Next?

26

Wrap-Up & Transition

Preparing for Interviews Through Strong Questioning

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BUILDING EFFECTIVE INTERVIEWING SKILLS

What is the purpose of making first contact with the child?

29

Target Outcomes

- Understand how to initiate an investigation through first contact with the child.
- Begin applying developmentally appropriate engagement strategies supported by SOP tools.

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Initiating The Case

What is Means to Initiate an Investigation

31

New Staff Training
Investigations
Guided Observation Preparation

Jasmine Guided Observation

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Introducing The Jasmine Guided Observation

Preparing For First Contact With The Child

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Preparing for Charlotte's Interview

What did we observe and learn?

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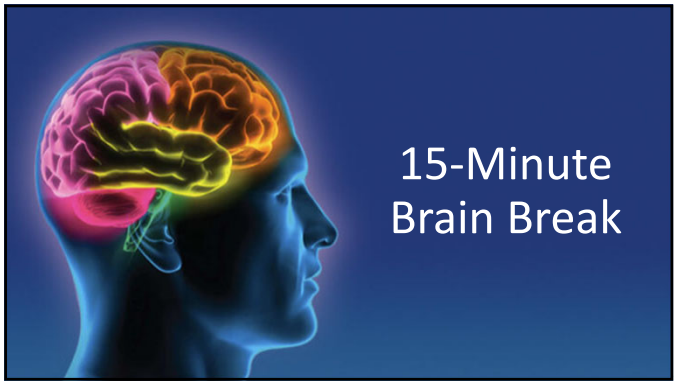

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BUILDING EFFECTIVE INTERVIEWING SKILLS

What is the next step after gathering information from the child?

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Target Outcomes

- Understand how organizing and making sense of information gathered from the child.
- Connect it to understanding caregiving patterns and emerging safety concerns.

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Organizing What We Know So Far

Organize information gathered so far into clear categories to support understanding of caregiving, environment, and emerging safety concerns.

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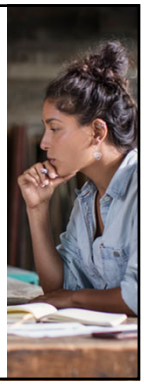
Recognizing What Matters

Identify the most important pieces of information.



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What Do We Still Need To Know?

Identifying the gaps.

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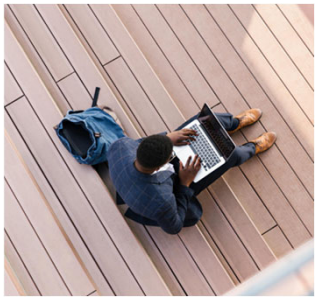

What Does this Mean For Next Steps?

Connect identified information and gaps to purposeful next steps in the investigation.

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Wrap-Up & Transition

From Information to Continued Investigation

43

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BUILDING EFFECTIVE INTERVIEWING SKILLS

Who are the next individuals you would need to speak with in this case?

45

Target Outcomes

- Understand how to approach caregiver contact and continue gathering information in a purposeful and structured way.
- Apply how to ask questions that build on what you already know.

46

Using Trauma – Informed Approach With Caregivers

47

What Does This Look Like In Conversation?

What does a respectful, non-judgmental approach sound like?

48

Using Trauma – Informed Approach With Charlotte

49

Common Pitfalls & How To Avoid Them

50

Wrap-Up & Day 3 Bridge

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Target Outcomes Evaluation

Referral Acceptance Snapshot

FLOWERS FAMILY

Training Case

From referral acceptance through investigative decision-making

REFERRAL ACCEPTANCE SNAPSHOT

Referral Number	Training case - not provided
Referral Date	08/15/2026 at 3:00 a.m.
Family Name	Flowers / Hill
County of Referral	Jefferson County

REPORTER INFORMATION

Reporter Name	Hannah Lewis, RN
Relationship to Referral	Emergency department nurse who cared for Jasmine and made the report
Reporter Location	Jefferson Regional Hospital
Reporter Phone Number	Not provided in the training materials

REFERRAL DISPOSITION

Priority	Priority 2
Maltreatment Types	Failure to provide necessary medical treatment / Medical Neglect; Inadequate Supervision by placing a child in a dangerous situation
Investigation Type	In-home investigation
Initiation Due	Within 72 hours of assignment (by 08/18/2026 at 3:00 a.m.)

INCIDENT DESCRIPTION

What happened? When did it happen? Who was involved? Does the person still have access to the child?

Jasmine Hill, age seven months and nonverbal, was seen in the emergency department at Jefferson Regional Hospital at approximately 10:00 p.m. on 08/14/2026. Jasmine also has a blister or lesion on the back of her index finger on her left hand and several bruises on her forehead (one is purple and the other is older and yellowing). All the injuries varied between a couple days while others appeared to be a five to seven days old. The lesions appeared to be infected, and Jasmine's finger, legs and hand are swollen. Medical personnel observed fever, an elevated white blood cell count, and concern that the infection had gone untreated.

According to the grandmother, Georgia Weems, “Jasmine's parents got into a fight at the family gathering tonight” while the family was outside in the yard so the grandmother took Jasmine and her sister to her house. When the grandmother was giving Jasmine a bath, she became concerned about the raised blisters that were hot to the touch and decided to take him to the hospital. When questioned about the bruises, the grandmother stated that this is not the first time that she has noticed bruises on Jasmine. When her mother questioned her about past bruises, Charlotte couldn't provide an explanation. This led Georgia to think that mom is not watching Jasmine, so she doesn't know how she gets the injuries. Jasmine is not yet fully mobile but is currently rolling over. The mother, Charlotte Flowers, showed up at the hospital while Jasmine was being examined.

Charlotte arrived at the hospital while Jasmine was being examined. Jasmine was treated and discharged on antibiotics. Charlotte was dismissive and stated she did not think the antibiotics were necessary. Charlotte stated that she and the children would stay at Georgia Weems' home. The treating physician was concerned about inadequate supervision and the delay in seeking medical treatment. Following discharge, Jasmine, Frankie, and Charlotte were reported to be staying at Georgia's residence.

CHILDREN'S CURRENT CONDITIONS / INJURIES

Jasmine has swollen, pus-filled blisters that are sensitive to touch. The infected areas appear several days old. Medical personnel expressed concern that the infection had gone untreated. Jasmine is small for her age. She was prescribed medication after discharge; later case information indicates that the medication has not been given consistently.

WHEN WAS THE CHILD LAST SEEN AND BY WHOM?

Dr. Rhonda Dickson saw and treated Jasmine in the emergency department on 08/14/2026. Jasmine was seen two months ago for swelling from recent ant bites on 6/1/26, and it was noted that Charlotte was informed that Jasmine may have an allergy to ant bites.

KNOWN RISK FACTORS / CONCERNS

The referral identifies domestic violence between Charlotte and Brad, delayed medical care, supervision concerns, unexplained prior bruising, and uncertainty regarding how Jasmine sustained the injuries.

FAMILY INFORMATION

Jasmine Hill

Role: Alleged victim
DOB: 01/14/2026
Age / Development: Seven months old; nonverbal
Sex: Female
Relationship: Daughter of Charlotte Flowers and Brad Hill; younger sister of Frankie Flowers; granddaughter of Georgia Weems
Primary Address: 284 S. Hwy. 63, Altheimer, AR 72004
Current Location: Georgia Weems' residence following hospital discharge
Prior Department History: No prior role identified in the provided materials

Frankie Flowers

Role: Sibling / child in the household
DOB: 12/04/2018
Sex: Female
Relationship: Daughter of Charlotte Flowers from a prior relationship; older sister of Jasmine; granddaughter of Georgia Weems
Primary Address: 284 S. Hwy. 63, Altheimer, AR 72004
Current Location: Georgia Weems' residence
Additional Information: Verbal; carries significant caretaking responsibility for Jasmine. Her father is not involved and his whereabouts are unknown.
Prior Department History: Prior inadequate supervision report approximately eight months earlier; Frankie was found outside unsupervised. The report was unsubstantiated.

Charlotte Flowers

Role: Primary caregiver / alleged offender
DOB: 04/02/2002
Sex: Female
Phone: 870-541-7100, ext. 0749
Relationship: Mother of Jasmine and Frankie; daughter of Georgia Weems; live-in partner of Brad Hill
Primary Address: 284 S. Hwy. 63, Altheimer, AR 72004
Current Location: Georgia Weems' residence

Brad Hill

Role: Adult household member; Jasmine's father; not named as an alleged offender on the referral
DOB: 06/21/1992
Sex: Male
Phone: 501-666-1585
Relationship: Father of Jasmine; Charlotte's live-in boyfriend; no relation to Frankie or Georgia
Address: 284 S. Hwy. 63, Altheimer, AR 72004

Georgia Weems

Role: Maternal grandmother
DOB: 03/21/1982
Sex: Female
Phone: 870-536-2010
Relationship: Mother of Charlotte; grandmother of Jasmine and Frankie
Address: 1616 Pennsylvania Ave., Pine Bluff, AR 72004

REPORTER AND COLLATERAL SOURCES

- Hannah Lewis, RN - emergency department nurse who cared for Jasmine and made the report.
- Dr. Rhonda Dickson - emergency department physician who treated Jasmine; introduced as a collateral on Day 3.
- Dr. Farley - Charlotte's psychiatrist; introduced as a collateral on Day 3.
- Law enforcement - approximately seven calls to Charlotte and Brad's residence over the past two years; introduced on Day 3.

PRIOR DEPARTMENT HISTORY

Approximately eight months before the current referral, the Department received a report alleging inadequate supervision after Frankie, then identified in the case materials as age seven, was found outside unsupervised. A neighbor made the report. The allegation was unsubstantiated.

PRIORITY / INITIATION

Child	Hill, Jasmine
Priority	Priority 2
Start Date	08/15/2026
Initiation Due	08/18/2026 at 3:00 a.m. (72 hours)
Expected Initiation Location	Georgia Weems' residence, where Jasmine was reported to be staying after discharge

SOLUTION-FOCUSED QUESTIONS

EXCEPTION

While it is likely that this conversation was prompted by a problem, the following questions will help to focus on an individual's strengths and abilities. In most situations, it is the best set of questions for starting interviews—just like family conference meetings start with strengths/exceptions/safety. The first question below is for a "near-miss" situation, and the last is more suited to conversations about values and accomplishments.

- When was a time that ____ could have happened, but it didn't?
- When was a time that things were going well for you?
- What are some things you've done that you are most proud of?

PREFERRED FUTURE

These questions will surface what an individual would like to see for themselves or their family. You could ask the miracle question for this information in order to get details about what would be different in the person's life.

- How would you like things to be?
- What would it look like if this problem went away?
- Who would be around helping you keep things on track, and what would they be doing?
- What do you see happening next?

COPING

These questions will bring up another set of strengths and resources, but they will be more closely related to the problem and how someone deals with it OR who else helps them in this situation.

- How have you dealt with this situation?
- How do you keep things from getting worse?
- Who supports you when things get tough?

SCALING

With these questions, we are trying to show that the situation is not as black and white as an individual might think or to help them notice the difference between their desire/importance score and their ability score.

On a scale of 1–10, with 10 being [*desirable condition, outcome, confidence, ability, or importance*], where would rate yourself?

How did you get to that number?

What makes it a __ and not a 1?

What is a small thing that could happen to make it go up by just one number?

POSITION

This is an attempt to get people out of their own perspective and to consider the concerns and perspectives of others.

If _____ were here, what would they say they [*are worried about, think is working well, think about the situation, would like to see happen next*]?

If _____ were here, [*insert any of the four previous types of questions*]?

APPRECIATIVE INQUIRY

Appreciative inquiry (AI) involves asking questions that strengthen individual or system capacity to achieve the highest potential by surfacing and making visible:

- People's past and present capacities;
- Achievements, assets, unexplored potentials;
- Innovations, strengths, high-point moments;
- Lived values, traditions, stories;
- Expressions of wisdom; and
- Visions of valued and possible futures.[1]

WHY DO THIS IN CHILD WELFARE ORGANIZATIONS?

Child welfare organizations have great potential for practice to be regularly surrounded by fear, blame, and defensiveness.[2] In this context, the idea of making your work visible, sharing it with others, and even learning from your own and others' practices can be hard to imagine. AI is one vehicle for trying to help make this possible. Specifically, AI can help a child welfare organization do the following.

DEVELOP LOCAL PRACTICE WISDOM

AI provides a method for countering people's tendency to isolate or silo their work by encouraging everyone to ask questions about the details of everyday practice *when it is at its best*. Sharing everyday successes has the following benefits.

- This allows everyone in the organization to share stories of high-point moments, new practice innovations they have made or discovered, successful interventions they have used, and general all-around good practice.
- When these stories are described and circulated, the "know-how" about what really works in the organization grows and people become more willing and interested in sharing and learning from their work.

[1] Personal communication, W. Madsen and P. Decter, Family Centered Services Project, 2010.

[2] Turnell, A. (in press). Building a culture of appreciative inquiry around child protection practice. Draft chapter in Turnell, A. (in press). *Building safety in child protection practice: Working with a strengths and solution focus in an environment of risk*. London: Palgrave-Macmillan. Contact the author at aturnell@iinet.net.au for more information.

SUPPORT THE IMPLEMENTATION OF NEW SAFETY- AND SOLUTION-BASED PRACTICES

While safety- and solution-focused approaches were developed independently of AI, they have a great deal in common, including the following.

- Both approaches focus on *what works* as a platform for learning and repeating the behavior.
- Both focus on the best of what could be, instead of lamenting what should be.
- Both use inquiry and a questioning approach to help people find and articulate their own unique solutions to problems.
- When child welfare organizations begin to try to adopt safety- and solution-focused approaches, workers will look to agency leaders, managers, and supervisors to see if they practice what they preach.
- Using AI can help embed new approaches throughout that organization, giving workers a chance both to practice some new skills and to see the depth of the commitment in the leadership of the organization to different ways of thinking and practice.

GROUNDING ORGANIZATIONAL CULTURE IN REFLECTION, APPRECIATION, AND ONGOING LEARNING

Finally, use of regular AIs, even in small ways, can begin to shift an organizational culture as well.

- Staff begin to see their own knowledge and skills recognized publicly.
- They develop greater enthusiasm for sharing what they know with others.
- They gain a greater sense that everyone in the organization appreciates one another and the collective work being done.
- Learning can become exciting and contagious.

HOW DO YOU DO AI?

Like the solution-focused approach, AI uses questions as a driving practice, so learning this approach first involves getting comfortable asking detailed questions about everyday practice when it is at its best, most effective, and most useful. This is something that can be done in very large settings (like a training) or in smaller ones (such as a case consultation, individual or group supervision, or even a staff meeting). What is essential is that the inquiry and dialogue be based in genuine curiosity and in the belief that everyone knows something about effective practice. Once these stories and moments about best practice are elicited, they should be documented in some way and shared with others.

POSSIBLE QUESTIONS FOR AN APPRECIATIVE INQUIRY INTERVIEW

USING THE EARS MODEL: ELICITING, AMPLIFYING, REFLECTING, START OVER

Philip Decter, MSW

Adapted from Andrew Turnell[3]

Eliciting Questions (pick one):

- ☐ Can you describe a recent piece of work about which you feel particularly good?
- ☐ Can you tell me about a family you worked with where you were stuck, yet you still made some progress?
- ☐ Can you tell me about a situation at work that you cared about that had the potential to become a train wreck, yet you still managed to salvage a small component about which you felt okay?

Amplifying Questions (pick four to eight, at least one from each area):

- ☐ Where did this happen?
- ☐ When did this happen?
- ☐ Who else was involved?
- ☐ How did you make this happen?
- ☐ What else did you do? What else? And what else?

- ☐ How did you get the idea to do it that way?
- ☐ Was that difficult for you to do?
- ☐ What was the hardest part of doing this piece of work for you?
- ☐ Even though that part was hard, how did you keep it going?
- ☐ What did the person you worked with do to build this success?
- ☐ What would the other person say you did to contribute to achieving this outcome?

[3]Turnell, A. (in press). Building a culture of appreciative inquiry around child protection practice. Draft chapter in Turnell, A. (in press). *Building safety in child protection practice: Working with a strengths and solution focus in an environment of risk*. London: Palgrave-Macmillan. Contact the author at aturnell@iinet.net.au for more information.

- ☐ How did you know that what you were doing was helping?
- ☐ What differences did you see in the person you were working with that told you what you were doing was working?

- ☐ What aspect do you feel proudest about in this situation?
- ☐ If we had a video of you doing that (the thing that makes you proud), what would we see on the video?
- ☐ What are the practices that go into doing that?
- ☐ What steps went into those practices?

Reflection Questions (pick at least two):

- ☐ From this piece of work, what would you like to bring into other similar situations?
- ☐ If you were to consult with other colleagues working in a similar situation, what suggestions from this experience would you offer to them?
- ☐ When you think about this piece of work, what was the most important thing you learned?
- ☐ What would you like to do with what you have learned? How would you like to bring those insights more into your work?
- ☐ As you think about what you would like to do with what you have learned, what does that say about what you value and what is important to you in your work?
- ☐ What does that say about your hopes and dreams for yourself in doing this work?
- ☐ What does that say about what you are committed to and what you stand for in this work?

Wrap-Up:

- ☐ What have you learned or relearned about yourself or your work from this conversation?
- ☐ What difference, if any, does it make to hear yourself say these things out loud today?

LINKING THE THREE QUESTIONS AND SOLUTION-FOCUSED QUESTIONS

WHAT ARE WE WORRIED ABOUT?	WHAT IS WORKING WELL?	WHAT NEEDS TO HAPPEN?
Questions of genuine curiosity Assumptions of good intentions Behavioral detail Impact on the child Voice of the child **Externalizing the problem** • *When did the violence first come into your life?* • *Who, what, where, when?* • *How often, how much?* • *First, last, most recent?* **Position questions** • *Is this how you want things to be? Why or why not?* **Relationship questions** • *Who else is worried?* **Networks** • *Who else knows?* **Scaling questions** • *Safety/danger, progress* • *What is keeping the number from being higher?* **Future unchanged** • *What will happen if things keep going the way they are going?*	Questions of genuine curiosity Assumptions that good intentions are not always enough Behavioral detail Impact on the child Voice of the child **Exception questions** • *Has there ever been a time when, before you got high, you were able to find a safe adult to watch your child?* • *Who, what, where, when?* • *How often? How much?* • *First, last, most recent?* **Coping** • *How have you made it this far?* • *How have you accomplished what you have?* **Position questions** • *Is it important to you that you have taken these steps?* • *Why?* **Relationship questions** • *Who would be most pleased that you have taken these steps?* **Network** • *Who helps?* **Scaling questions** • *Safety/danger, progress* • *What is keeping the number as high as it is?*	Questions of genuine curiosity Assumptions that best-made plans do not always work out as they should Behavioral detail Impact on the child Voice of the child **Preferred future questions** • *How would you like things to be instead?* • *If we meet up in a year and things are better, what will they look like?* **Position questions** • *What kind of difference would it make for you to take this step?* **Scaling questions** • *What does up by one look like? Up by two?* • *Willingness, confidence, capacity* **Relationship questions** • *What do other people hope will happen?* • *What can they do to help?* • *What kind of difference would it make to your children to take these steps?* **Monitoring questions** • *How will we know this is working?* • *Who will have to see what?*

SDM SAFETY ASSESSMENT

Arkansas State Police and Division of Children and Family Services

Family Name: _____ **Referral/Case ID:** _____

Date of Assessment: _____ **County:** _____

Worker Name: _____

Assessment Type: ○ Initial ○ Reassessment ○ Case closure

Household Assessed: _____

Caregiver(s) Assessed: _____

Names of Children Assessed:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

If more than six children are assessed, include additional names and numbers (e.g., 7. Joe Smith):

SECTION 1: FACTORS INFLUENCING CHILD VULNERABILITY

These are conditions resulting in child's inability to protect self; select all that apply to *any* child.

- ☐ Child is age 0–5.
- ☐ Child has a diagnosed or suspected medical or mental condition (includes medically fragile).
- ☐ Child has limited or no readily accessible support network.
- ☐ Child has diminished mental capacity.
- ☐ Child has diminished physical capacity.
- ☐ None apply.

SECTION 2: CURRENT SAFETY THREATS

The following is a list of safety threats, defined as behaviors or conditions that describe a child being in imminent danger of serious harm. Assess the above household for each safety threat. Select "Yes" for all that are present for the family at the time of the assessment and "No" for all that are absent, based on the information available at this time. Select "Yes" for each that applies to an individual behavior, but *do not* select "Yes" for more than one safety threat for the same behavior.

Yes **No**

○ ○ 1. Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation/differential response (DR) case, as indicated by (select all that apply):

☐ Serious injury or abuse to the child other than accidental.

☐ Caregiver fears harming the child.

☐ Caregiver has threatened to cause harm or retaliate against the child.

☐ Caregiver has made substantial or unreasonable use of physical force.

☐ Substance-exposed infant is in danger.

○ ○ 2. Child sexual abuse is suspected, AND circumstances suggest that the child's safety may be of immediate concern.

○ ○ 3. Caregiver is aware of the potential harm AND is unwilling OR unable to protect the child from actual or threatened serious harm by others. This may include physical abuse, emotional abuse, sexual abuse, sexual exploitation, trafficking, or neglect. *Domestic violence behaviors should be captured under safety threat 9*.

○ ○ 4. Caregiver's explanation or lack of explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern.

○ ○ 5. Caregiver does not meet the child's immediate needs for supervision, food, and/or clothing. Select all that apply.

☐ Supervision

☐ Food

☐ Clothing

○ ○ 6. Caregiver does not meet the child's immediate needs for medical or critical mental health care (suicidal/homicidal).

○ ○ 7. Physical living conditions are hazardous and immediately threatening to the child's health and/or safety.

Yes **No**

○ ○ 8. Caregiver's substance abuse seriously impairs their ability to supervise, protect, or care for the child.

○ ○ 9. Domestic violence exists, and offender behavior poses an imminent danger of serious physical and/or emotional harm to the child.

○ ○ 10. Caregiver frequently describes the child in predominantly negative terms or acts toward the child in negative ways; AND these actions make the child a danger to self or others, suicidal, act out aggressively, or severely withdrawn or anxious.

○ ○ 11. Caregiver's mental instability, developmental status, or cognitive deficiency seriously impairs their current ability to supervise, protect, or care for the child.

○ ○ 12. Family currently refuses access to or hides the child and/or seeks to hinder an investigation/DR case.

○ ○ 13. The child may be in immediate danger because of current circumstances AND because the caregiver severely maltreated a child in their care in the past (where the incident was resolved or unresolved) or because the caregiver has been unable to resolve a prior pattern of severe maltreatment.

○ ○ 14. Other (specify): _____

SAFETY DECISION

If no safety threats are present, select this safety decision.

○ **Safe.** No safety threats were identified at this time. Based on currently available information, no children are likely to be in imminent danger of serious harm. Continue to the risk assessment and complete the investigation as required.

IF A SAFETY THREAT IS IDENTIFIED BY CACD AT ANY POINT IN THE INVESTIGATION, CACD CONTACTS DCFS AND STOPS COMPLETING THE SAFETY ASSESSMENT TOOL HERE. DCFS TAKES OVER TO COMPLETE SECTION 3.

SECTION 3: SAFETY-PLANNING CAPACITIES AND SAFETY INTERVENTIONS

Complete this section only if one or more safety threats are selected.

SAFETY-PLANNING CAPACITIES

Document caregiver capacities if present for any caregiver based on information gathered. (All three capacities must apply to move forward with an immediate safety plan.)

☐ a. Caregiver is capable of participating in an in-home immediate safety plan.

☐ b. Caregiver is willing to participate in an in-home immediate safety plan.

☐ c. Caregiver has the support of at least one adult who was not involved in the allegation, and the supporting adult is willing and able to participate in an in-home immediate safety plan.

☐ d. Other: _____

For each safety-planning capacity selected, provide details that demonstrate its presence.

SAFETY INTERVENTIONS

Consider each identified safety threat and the safety-planning capacity of the family and network to determine if it is possible to create an immediate safety plan to control for the safety threat. Remember that an immediate safety plan should describe in detail immediate action steps that the family and their network will take to help keep the child safe from the safety threat. If this is possible, select "Safe with immediate safety plan" and the specific interventions being used from the list below (select all that apply), document the immediate safety plan, and continue to the risk assessment. If it is not possible to create an immediate safety plan, proceed to Section 4 and select "Unsafe."

☐ a. Safety interventions provided by the worker

☐ b. Safety interventions involving caregiver, other household members, or network

- ☐ Alleged offender understands the worries about the safety of their child and offers to leave the home voluntarily if the child will remain with a legal custodian or guardian.
- ☐ Non-offending legal custodian or guardian has taken or will take legal action that requires the alleged offender to leave the home or restricts access to the child.
- ☐ Non-offending legal custodian or guardian will move to a safe environment with the child.
- ☐ Extended family members or network will participate as part of an immediate safety plan action step.
- ☐ Other safety intervention involving caregiver, other household members, or network.

  Describe: _____

☐ c. Safety interventions provided by agencies or service providers

- ☐ Community agencies or services are part of an immediate safety plan action step.
- ☐ Formal tribal and/or Indian Child Welfare Act (ICWA) intervention is part of an immediate safety plan action step.
- ☐ Other safety intervention provided by agencies or service providers.

Describe: _____

☐ d. Legal action planned or initiated; the child remains in the home.

Note: Legal action cannot be the only item on an immediate safety plan.

☐ e. No interventions are possible at this time.

SAFETY DECISION

○ **Safe with immediate safety plan.** One or more safety threats are present; however, the child can safely remain in the home with an immediate safety plan. In-home protective interventions have been initiated through an immediate safety plan, and the child will remain in the home as long as the safety interventions mitigate the safety threats. Select all in-home interventions used in the immediate safety plan. *Consult Team Decision Making (TDM) protocol to determine whether a TDM meeting is required.*

SECTION 4: PLACEMENT INTERVENTION

SAFETY DECISION

○ **Unsafe.** One or more safety threats are present. An immediate safety plan was considered but could not be created. As a result, placement is the only protective intervention possible for one or more children. Without placement, one or more children will likely be in imminent danger of serious harm. *Consult TDM protocol to determine whether a TDM meeting is required.*

Safety Assessment Discussion

Does this safety decision apply to all children in the household?

○ Yes

○ No. Provide the safety decision for each child: _____

Question Makeover Activity

Improving Interview Questions

Instructions: Below are examples of questions that may limit responses, assume information, or lead the person being interviewed.

Working with your group, rewrite each question to make it:

- Open-ended
- Solution-Focused
- Neutral
- Focused on gathering information

Use the space provided to write your improved questions.

Original Question	Rewritten Question
1. Did you take her to the doctor?	
2. She knew she was hurt, right?	
3. Did you leave her alone?	
4. Was the injury serious?	
5. She gets hurt a lot, doesn't she?	

6. You just ignored the injury, right?	
7. Was anyone watching her at the time?	
8. Did you know she needed medical care?	
9. You treated her and sent her home, correct?	
10. Did the grandmother overreact?	

Reflection Questions:

- Which question was the most difficult to rewrite? Why?
- What changes made your questions stronger?
- How will this impact your future interviews?

Key Reminder: Strong questions encourage explanation, avoid assumptions, and allow the person to share information in their own words.

UAMS Health

Safe Sleep

What is SUID?

Each year in the United States, thousands of babies die suddenly and unexpectedly. These deaths are called SUID, which stands for "Sudden Unexpected Infant Death." This can include death from known causes (such as suffocation, entrapment – when a baby gets caught between two objects, like a mattress and the wall – strangulation, and intentional harm). SIDS is a type of sudden unexpected infant death that doesn't have a known cause, even after a complete investigation.

Fast facts about SIDS:

- SIDS is the leading cause of death in babies 1 month to 1 year of age.
- Most SIDS deaths happen when babies are between 1 month and 4 months of age.

What can I do to help prevent SIDS in my baby?

There are three important things that can lower the risk of SIDS:

- Provide breast milk for your baby, if possible. Breastfeeding has many health benefits for both mother and baby, and has been associated with a lower incidence of SIDS.
- Do not smoke during pregnancy, and do not smoke or allow smoking around your baby. For help on how to quit smoking, call the Arkansas Tobacco Quitline at 1-800-QUIT-NOW (1-800-784-8669)
- Provide a safe sleep environment for your infant.

What should I know about safe sleep?

- Babies sleep safest on their backs. Babies who sleep on their backs are much less likely to die of SIDS than are babies who sleep on their stomachs or sides.
- Every sleep time counts. Babies should sleep on their backs for all sleep times – for naps and at night. Babies who are used to sleeping on their backs but who are then placed on their stomachs to sleep, like for a nap, are at very high risk of SIDS.

- Sleep surface matters. Babies who sleep on a soft surface, such as an adult bed, or under a soft covering, such as a soft blanket or quilt, are more likely to die of SIDS or suffocation.

How can I make sure my baby is safe when he or she sleeps?	
✓	Always place a baby on his or her back to sleep, for naps and at night. “Back to sleep” is the safest position for all babies, including preterm babies. Remember that every sleep time counts
✓	Use a firm sleep surface covered by a fitted sheet. Firm sleep surfaces include an infant mattress in a crib, bassinet, or portable play area. Do not use a car seat, carrier, swing, bouncy seat, rock and play, or other similar product as baby’s everyday sleep area. Never place baby to sleep on soft surfaces, such as on a couch or sofa, pillows, quilts, sheepskins, or blankets.
✓	Yes to room sharing. Keep baby’s sleep area in the same room where you sleep. Your baby should not sleep in an adult bed, on a couch, or in a chair.
✗	No to co-bedding. Baby should never sleep in the bed (or on a couch) with you or anyone else, including siblings. If you bring baby into your bed to feed, make sure to put him or her back in a separate sleep area when baby is finished.
✓	Keep soft objects, toys, crib bumpers, and loose bedding out of your baby’s sleep area. DO NOT use pillows, blankets, quilts, sheepskins, or crib bumpers anywhere in your baby’s sleep area. Evidence does not support using crib bumpers to prevent injury. In fact, crib bumpers can cause serious injuries and even death. Keeping them out of baby’s sleep area is the best way to avoid these dangers.
✗	Do not let your baby get too hot during sleep. You may dress your baby in one layer more of clothing than an adult would wear to be comfortable, but no more. Sleep sacks and wearable blankets are appropriate as well. Keep the room at a temperature that is comfortable for an adult.
✓	Give your baby a dry pacifier that is not attached to a string for naps and at night.
✓	Wait until the baby is breast feeding well (usually 2-4 weeks) before trying a pacifier, but don’t force your baby to use it. If the pacifier falls out of baby’s mouth during sleep, there is no need to put it back in.
✓	Follow health care provider guidance on your baby’s vaccines and regular health checkups.

	Avoid products that claim to reduce the risk of SIDS and other sleep-related causes of infant death. These wedges, positioners, and other products have not been tested for safety.
	Do not use home heart or breathing monitors to reduce the risk of SIDS (unless your baby's doctor has recommended this). If you have questions about using these monitors for other health conditions, talk with your baby's doctor.
	Give your baby plenty of tummy time when he or she is awake and when someone is watching. Giving your baby tummy time when you can watch him/her helps your baby's neck, shoulder, and arm muscles get stronger. It also helps to prevent flat spots on the back of your baby's head. Allow your baby plenty of playtime while on his/her tummy.

Make sure everyone who cares for your baby knows the ways to reduce the risk of SIDS and other sleep-related causes of infant death.

Babies sleep safest on their backs, and every sleep time counts! Help family members, babysitters, daycare workers—EVERYONE—reduce your baby's risk of SIDS and ensure a safe sleep area for your baby. Share these safe sleep messages with everyone who cares for your baby or for any baby younger than 1 year of age.

Source: *Created in part by MidSOUTH from https://uamshealth.com/safe-sleep/*