IV. CHILD DEATH PROTOCOL

A. DEFINITION: Death shall mean the loss of life of a child under the age of 18.

B. JOINT INVESTIGATIONS: Joint investigations may include all or any combination of MDT members from the signatory agencies. Specific offenses that require a joint investigation are listed below.

1. CIVIL OFFENSES
   - Death in which abuse or neglect is suspected;
   - Cause of death is under criminal investigation (unexpected/unexplained);
   - Intoxicated/impaired caregiver bed-sharing with an infant (12 months or younger);
   - Poisoning: means [any individual] intentionally or recklessly over-medicates or causes a child to ingest alcohol, drugs (legal/illegal) not prescribed for that child, or other toxic substances, resulting in significant [death];\(^{54}\)
   - Death occurred in a child care facility; and,
   - Torture (10 Del. C. § 901(1)b.3).

2. CRIMINAL OFFENSES
   - § 630 Vehicular homicide in the second degree; class D felony; minimum sentence; juvenile offenders;
   - § 630A Vehicular homicide in the first degree; class C felony; minimum sentence; juvenile offenders;
   - § 631 Criminally negligent homicide; class E felony;
   - § 632 Manslaughter; class B felony;
   - § 633 Murder by abuse or neglect in the second degree; class B felony;
   - § 634 Murder by abuse or neglect in the first degree; class A felony;
   - § 635 Murder in the second degree; class A felony;
   - § 636 Murder in the first degree; class A felony; and

\(^{54}\) See 10.1.15. DFS CPR Regulations
§ 1102 Endangering the welfare of a child; class E felony.

C. MULTIDISCIPLINARY RESPONSE

1. CROSS-REPORTING

For the aforementioned civil and criminal offenses, the MDT agencies agree to cross-report and share information regarding the report of a child death.

REPORTS TO DIVISION OF FAMILY SERVICES (DFS)

All suspected child abuse and neglect of any child, from birth to age 18, in the State of Delaware must be reported to the Division of Family Services Child Abuse Report Line (Report Line) at 1-800-292-9582.

DELAWARE CODE

Mandatory Reporting Law

16 Del. C. § 903 states: “Any person, agency, organization or entity who knows or in good faith suspects child abuse or neglect shall make a report in accordance with § 904 of this title…”

In addition, 16 Del. C. § 904 states: “Any report of child abuse or neglect required to be made under this chapter shall be made by contacting the Child Abuse and Neglect Report Line for the Department of Services for Children, Youth and Their Families. An immediate oral report shall be made by telephone or otherwise. Reports and the contents thereof including a written report, if requested, shall be made in accordance with the rules and regulations of the Division, or in accordance with the rules and regulations adopted by the Division. No individual with knowledge of child abuse or neglect or knowledge that leads to a good faith suspicion of child abuse or neglect shall rely on another individual who has less direct knowledge to call the aforementioned Report Line.”

Penalty for Violation

16 Del. C. § 914 states: “Whoever violates § 903 of this title shall be liable for a civil penalty not to exceed $10,000 for the first violation, and not to exceed $50,000 for any subsequent violation.”

Any person who has direct knowledge of suspected abuse must make an immediate report to the Report Line. Direct knowledge is obtained through disclosure (child discloses to you), discovery (you witness an act of abuse), or reason to suspect (you have observed behavioral and/or physical signs of child abuse). This report may include situations where multiple disciplines are involved, such as:

See 16 Del. C. § 903 and 904
See 16 Del. C. § 914
• Emergency medical services and law enforcement are dispatched to a child found unresponsive as a result of bed-sharing with a caregiver. A call must be made to the Report Line from both professionals.
• A child is transported to the hospital emergency department by a parent for accidental ingestion of medications. Both emergency department staff and the responding patrol officer must make the call to the Report Line.

The relationship between the child and perpetrator does not influence whether a report must be made to DFS. All reports, including domestic or intra-familial, institutional, and non-domestic or extra-familial, cases must also be reported to DFS.

Additionally, a separate report must be made to the Report Line for the following reasons:

• Additional suspects have been identified;
• Additional child victims have been identified; or,
• Secondary allegations have been disclosed (i.e. initial report was for a child death and upon medical assessment of other children in the home, injuries were identified to another child).

If a secondary allegation is disclosed to the CAC during the forensic interview process, then the MDT members present shall make a joint report to the DFS Report Line prior to conclusion of the post interview meeting. However, if circumstances prevent the joint report from being made, the MDT shall select a member to make the report on behalf of the team. The designee will make the report immediately and inform the Report Line worker that he/she is making the call on behalf of the applicable MDT agencies.

If known, the following should be provided to the DFS Report Line:

• Demographic information;
• Known information about the following:
  o Child, parents, siblings and alleged perpetrator;
  o The alleged child victim’s physical health, mental health, educational status;
  o Medical attention that may be needed for injuries;
  o The way the caregiver and alleged perpetrator’s behavior is impacting the care of the child; and,
  o Any circumstances that may jeopardize the child’s or DFS worker’s safety.
• Facts regarding the alleged abuse and any previous involvement with the family.
• What you are worried about, what is working well, and what needs to happen next to keep the child safe.
Reports received by DFS will either be screened in for investigation as an intra-familial case and/or institutional abuse (IA) case or will be screened out, documented, and maintained in the DFS reporting system.

Reports screened in for investigation by DFS are assigned a priority response time as follows:

- Priority 1 (P1) – Within 24 hours
- Priority 2 (P2) – Within 3 days
- Priority 3 (P3) – Within 10 days

In most cases, DFS will assign a P1 response if the case involves a child death.

**REPORTS TO LAW ENFORCEMENT (LE)**

LE will receive notification of all civil offenses identified in the Child Death Protocol prior to DFS. As a result, a cross-report from DFS is unlikely.

Medical providers shall make an immediate report to the appropriate law enforcement jurisdiction to initiate a criminal investigation in child death cases.

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**DELWARE CODE**\(^{57}\)

24 Del. C. § 1762(a) states: “Every person certified to practice medicine who attends to or treats a stab wound; poisoning by other than accidental means; or a bullet wound, gunshot wound, powder burn, or other injury or condition arising from or caused by the discharge of a gun, pistol, or other firearm, or when such injury or condition is treated in a hospital, sanitarium, or other institution, the person, manager, superintendent, or other individual in charge shall report the injury or condition as soon as possible to the appropriate police authority where the attending or treating person was located at the time of treatment or where the hospital, sanitarium, or institution is located.”

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**REPORTS TO DEPARTMENT OF JUSTICE (DOJ)**

LE shall call DOJ’s Special Victims Unit upon receipt of a child death.

DFS is required to report offenses identified in the Child Death Protocol to the appropriate division at the Department of Justice. Additionally, DFS is required to report all persons, agencies, organizations and entities to DOJ for investigation if they fail to make mandatory reports of child abuse or neglect under 16 Del. C. § 903.

If the matter is referred to the Children’s Advocacy Center for a forensic interview, the CAC will notify the DOJ, DFS, and LE of the scheduled interview as soon as possible.

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\(^{57}\) See 24 Del. C. § 1762(a)
DELAWARE CODE\textsuperscript{58}

16 Del. C. § 906(e)(3) states: “The Division staff shall also contact the Delaware Department of Justice… upon receipt of any report under this section and shall provide such agency with a detailed description of the report received.”

REPORTS TO THE OFFICE OF THE INVESTIGATION COORDINATOR (IC)

The Office of the Investigation Coordinator receives reports of child deaths through data exchanges with DFS and the Delaware Criminal Justice Information System (DELJIS). Additionally, all MDT members shall provide case specific information as requested by the IC. For the purposes of conflict resolution, the Office of the Investigation Coordinator may be contacted to initiate or facilitate communication with other members of the MDT.

DELAWARE CODE\textsuperscript{59}

16 Del. C. § 906(c)(1)a. and b. state: “The Investigation Coordinator, or the Investigation Coordinator's staff, shall…have electronic access and the authority to track within the Department's internal information system and Delaware’s criminal justice information system each reported case of alleged child abuse or neglect. Monitor each case involving the death of, serious physical injury to, or allegations of sexual abuse of a child from inception to final criminal and civil disposition, and provide information as requested on the status of each case to the Division, the Department, the Delaware Department of Justice, the Children's Advocacy Center, and the Office of Child Advocate.”

16 Del. C. § 905(f) states: “Upon receipt of a report of child abuse or neglect, the Division shall immediately notify the Investigation Coordinator of the report, in sufficient detail to permit the Investigation Coordinator to undertake the Investigation Coordinator's duties, as specified in § 906 of this title.”

16 Del. C. § 906(d)(2) and (f)(3) state: The law enforcement agency and Delaware Department of Justice investigating a report of child abuse shall “provide information as necessary to the Investigation Coordinator to permit case tracking, monitoring and reporting by the Investigation Coordinator.”

REPORTS TO DIVISION OF FORENSIC SCIENCE (ME)

LE and medical providers shall immediately report all deaths of children to the Division of Forensic Science.

\textsuperscript{58} See 16 Del. C. § 906(e)(3)
\textsuperscript{59} See 16 Del. C. § 906(c)(1)a. and b., 905(f), and 906(d)(2) and (f)(3)
CHILD DEATH PROTOCOL

DELAWARE CODE

29 Del. C. § 4706(a) states: It shall be the duty of the person having knowledge of such death or of the person issuing a permit for cremation under § 3162 of Title 16 immediately to notify the Chief Medical Examiner, an Assistant Medical Examiner or a Deputy Medical Examiner, as the case may be, who in turn shall notify the Attorney General of the known facts concerning the time, place, manner and circumstances of such death.

REPORTS TO PROFESSIONAL REGULATORY BODIES

In keeping with the following statutory requirements, certain MDT members shall make reports to professional regulatory organizations and other agencies upon receipt of reports alleging abuse or neglect by professionals licensed in Delaware.

DELAWARE CODE

16 Del. C. § 906(c)(1)c. states the Investigation Coordinator or the Investigation Coordinator’s designee shall: “Within 5 business days of the receipt of a report concerning allegations of child abuse or neglect by a person known to be licensed or certified by a Delaware agency or professional regulatory organization, forward a report of such allegations to the appropriate Delaware agency or professional regulatory organization.”

16 Del. C. § 906(e)(6) and (f)(4) state the Division and DOJ shall: “Ensure that all cases involving allegations of child abuse or neglect by a person known to be licensed or certified by a Delaware agency or professional regulatory organization, have been reported to the appropriate Delaware agency or professional regulatory organization and the Investigation Coordinator in accordance with the provisions of this section.”

24 Del. C. § 1731A(a) states any person may report to the Board information that the reporting person reasonably believes indicates that a person certified and registered to practice medicine in this State is or may be guilty of unprofessional conduct or may be unable to practice medicine with reasonable skill or safety to patients by reason of mental illness or mental incompetence; physical illness, including deterioration through the aging process or loss of motor skill; or excessive use or abuse of drugs, including alcohol. The following have an affirmative duty to report, and must report, such information to the Board in writing within 30 days of becoming aware of the information:

(1) All persons certified to practice medicine under this chapter;

(2) All certified, registered, or licensed healthcare providers;

(3) The Medical Society of Delaware;

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See 29 Del. C. § 4706(a)

See 16 Del. C. § 906(c)(1)c., 906(c)(6), 906(f)(4), and 24 Del. C. § 1731A(a)
(4) All healthcare institutions in the State;

(5) All state agencies other than law-enforcement agencies;

(6) All law-enforcement agencies in the State, except that such agencies are required to report only new or pending investigations of alleged criminal conduct specified in § 1731(b)(2) of this title, and are further required to report within 30 days of the close of a criminal investigation or the arrest of a person licensed under this chapter.

2. INVESTIGATION

For the purpose of conducting an effective joint investigation, communication and coordination should occur among the MDT members as soon as possible and continue throughout the life of the case.

Upon receipt of a report, DOJ, DFS, LE, and ME will communicate and coordinate a response; however, LE will take the lead in the Joint Investigation. LE agencies needing additional resources may consult with larger jurisdictions.

For all allegations within this Protocol, the MDT will determine from the list below the appropriate investigative actions that have been identified as best practices for responding to child abuse cases.

<table>
<thead>
<tr>
<th>Investigative Actions</th>
<th>Responsible Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact the DOJ Special Victims Unit immediately.</td>
<td>LE</td>
</tr>
<tr>
<td>Cross-report and coordinate an immediate response between MDT members.</td>
<td>MDT</td>
</tr>
<tr>
<td>Establish the location(s) where the incident occurred.</td>
<td>LE</td>
</tr>
<tr>
<td>Identify persons involved and coordinate interviews with child, siblings, caregivers, alleged perpetrator(s), and other witnesses.</td>
<td>DFS and LE</td>
</tr>
<tr>
<td>Exchange information regarding complaint, criminal and DFS history.</td>
<td>MDT</td>
</tr>
<tr>
<td>Consider consultation with police jurisdictions with more resources.</td>
<td>LE</td>
</tr>
<tr>
<td>Schedule forensic interview at CAC for any child witnesses to include siblings and other children in the home.</td>
<td>MDT</td>
</tr>
</tbody>
</table>
**Investigative Actions** | **Responsible Agency**
---|---
Discuss DFS’s required notification to the alleged perpetrator of the allegations. Limit the details of the allegations and the maltreatment type.\(^{62}\) | DFS and LE
Assess safety and need for out-of-home interventions of all children. | DFS
Consider Temporary Emergency Protective Custody of child and other children in home. | Medical, LE and DFS
Observe and photo/video document the crime scene(s); collect evidence. | LE
Complete Sudden Unexplained Infant Death Investigation (SUIDI) form. | LE and ME
Conduct doll/scene re-enactment and video document. | LE
Obtain consent or search warrant for blood draw if impairment is suspected for alleged perpetrator(s). | LE
Determine if elements of Child Torture are present (review the checklist on Common Elements of Child Torture). | MDT
Follow Guidelines for Child Abuse Medical Response for siblings and other children in the home. | LE, DFS and Medical
Take photographs of child and child’s injuries. | Medical, LE and ME
Conduct video documentation, with explanation by the medical provider, of any life supporting mechanisms provided to the child. | Medical and LE
Notify the Investigation Coordinator’s Office of the child death. | DFS, LE and DOJ
Utilize victim advocates to connect children and families with appropriate mental health, substance abuse, social services and additional resources. | MDT
Complete pre-arrest intake with DOJ. | LE and DOJ
Participate in MDT meetings (i.e. case review). | MDT

\(^{62}\) The federal Child Abuse Prevention and Treatment Act requires DFS to notify the alleged perpetrator of the complaints or allegations made against him or her at the initial time of contact regardless of how that contact is made (42 U.S.C. 5101 et seq).
INTERVIEWS

LE will conduct interviews with caregivers, alleged perpetrator(s), and other witnesses and will provide prior notice to DFS to allow for observation. Additionally, all interviews shall be audio recorded, and when practicable, video recorded by LE. DFS must receive clearance from LE before conducting follow up interviews for the purpose of gathering information relevant to the civil investigation. In the event that a LE response is delayed, DFS may obtain basic information from the family to assess the child’s safety until LE arrives to conduct the interviews.

Child witnesses to include siblings and other children in the home, ages 3 to 12, should be interviewed at the CAC in cases that fall within the Child Death Protocol. This does not preclude interviews of children under 3, who are verbal, or youth between the ages of 13 and 18. Multiple interviews by multiple interviewers can be detrimental to children and can create issues for successful civil and criminal case dispositions. Use of the CAC to conduct interviews is considered best practice to minimize trauma and re-victimization of child victims and/or child witnesses.

In any investigation of criminal conduct occurring at, or related to, a facility or organization where multiple children may have been exposed to, or victimized by, a perpetrator of the conduct being investigated, the MDT must consider the potential that other children have been victimized. Thus, the MDT should schedule and conduct interviews at the CAC of all children between the age of 3 and 12 who may have been exposed to, a victim of, or a witness to the conduct being investigated. Facilities or organizations where multiple children may be exposed to criminal conduct include, but are not limited to, child care centers, schools, and youth athletic organizations. This policy is intended to both define the scope of such investigations and to provide support to children who, by mere circumstance, are, or have been, in the presence of the subject of an investigation.

If additional information is needed prior to scheduling the forensic interview with child witnesses, the First Responder Minimal Facts Interview Protocol should be utilized (See Appendix A). If both LE and DFS are present, then a lead interviewer should be identified prior to conducting the interview. This Protocol will still allow DFS to assess child safety through its in-house protocols while preserving the criminal investigation.

FIRST RESPONDER

Minimal Facts Interview Protocol

1. Establish rapport
2. Ask limited questions to determine the following:
   - What happened?
   - Who is/are the alleged perpetrator(s)?
   - Where did it happen?
   - When did it happen?
   - Ask about witnesses/other victims
3. Provide respectful end
**FORENSIC INTERVIEW AT THE CAC**

After making a cross-report, LE, DFS, and/or DOJ may contact the CAC in the jurisdiction where the alleged crime occurred to request a forensic interview. LE and DFS will communicate prior to contacting the CAC to determine who will make the request and the appropriate timeframe for scheduling the interview.

Forensic interviews will be scheduled on a non-urgent basis (within 5 business days) or urgent basis (within 2 business days) subject to the availability of MDT member agencies, children, and their caregivers. Please note that the CAC will accommodate after-hours interviews on an emergency basis as needed. The CAC will acquire interpreter services as needed for the child and/or family. All interviews will be video and audio recorded.

The forensic interviewer will conduct the interview utilizing a nationally recognized forensic interview protocol and forensic interview aids, as appropriate. Members of the MDT may be present for the interview based on availability. MDT members should refrain from engaging in pre-interview contact with the caregiver and child at the CAC to avoid impacting the forensic interview process.

The forensic interviewer will facilitate the CAC process. This process includes pre-interview meetings, the forensic interview, and post-interview meetings. MDT members should be prepared to discuss the following: complaint and criminal history concerning all individuals involved in the case; DFS history; prior forensic interviews at the CAC; current allegations; and strategies for the interview to include introduction of evidence to the child.

During the post-interview team meeting, the MDT may discuss interview outcomes; prosecutorial merit; next investigative steps; and medical, mental health, victim advocacy and safety needs of the child and family. Additionally, the MDT may determine that a multi-session or subsequent interview is required based on the case circumstances and the needs of child.

**If a secondary allegation is disclosed to the CAC** during the forensic interview process, then the MDT members present shall make a joint report to the DFS Report Line prior to conclusion of the post interview meeting. However, if circumstances prevent the joint report from being made, the MDT shall select a member to make the report on behalf of the team. The designee will make the report immediately and inform the Report Line worker that he/she is making the call on behalf of the applicable MDT agencies.

When the MDT meets with the caregiver post-interview, DOJ will take the lead in sharing information related to the interview and possible criminal prosecution.

Following the post-interview meeting, the CAC Family Resource Advocate will facilitate a discussion with the caregiver about social and mental health services and other resources available for the child and/or family. Referrals will be made by the CAC as appropriate.
During the course of an investigation, a MDT meeting may be required to discuss new information obtained by any of the team members. The meeting shall be convened by the IC upon request of any team member. Otherwise, these discussions will take place at regularly scheduled MDT Case Review meetings.

If additional information is needed from the child by a MDT member, then the other team members should be contacted and a follow up forensic interview should be scheduled.

**PRESERVATION OF EVIDENCE**

LE will establish, examine and document the location(s) of incident as soon as practicable. The crime scene(s) and other corroborative evidence (e.g. diapers) should be collected and photographed or video recorded.

LE will complete the Sudden Unexplained Infant Death Investigation (SUIDI) form (See Appendix G). Prior notice will be given to ME to allow for observation.

LE will conduct a doll and scene re-enactment with the alleged perpetrator to provide a visual demonstration of the mechanism of injury and/or death. Prior notice will be given to ME to allow for observation. This re-enactment will be video documented and conducted at the scene when possible. DFS and DOJ may observe the re-enactment.

Interviews by LE should be audio recorded and when practicable, video recorded. Forensic interviews with the child and siblings will be video and audio recorded at the CAC. Interviews with caregivers, alleged perpetrator(s), other witnesses, and those children not interviewed at the CAC will be audio recorded and when practicable, video recorded by LE. Any recordings created during the interview process at the CAC will be turned over to LE and LE will thereafter become the agency owning this evidence.

Photographs must be taken to document the number and size of the injuries to the child; scale of injury should be documented in photograph. These photographs will be taken as part of the medical examination process if the child has been transported to a medical facility. This does not preclude LE and ME from taking photographs as needed for investigative purposes. Please note that smartphones should be used to take photographs only in exigent circumstances.

If life supporting mechanisms were utilized, then LE will video document these efforts to include the explanation by the medical provider. In addition, any evidence collected by medical providers not given to LE will be turned over to the ME.

In nearly all child death cases, the body will be transported to the hospital. In cases where the death is suspicious and the child is pronounced at the hospital, parents and caregivers will not be permitted to touch the body. However, parents and caregivers may be permitted to touch the body with supervision by LE, in consultation with ME, in cases where there is a sudden unexpected infant death (i.e., sudden
infant death syndrome (SIDS), unknown cause, and accidental suffocation in bed).63 For cases in which the child is pronounced and remains on scene, LE will preserve the body and maintain the scene, not allowing anyone to touch the body until the ME assumes responsibility.

For circumstances where impairment of the alleged perpetrator(s) is suspected, consent to draw blood will be attempted by LE. Otherwise, a search warrant will be obtained.

**POST-MORTEM EXAMINATION**

The ME will conduct a post-mortem examination of the child in all unexpected and unexplained death cases. LE and DOJ will be contacted prior to the post-mortem examination to allow for observation. A post-mortem computed tomography (CT) scan at designated hospitals may occur prior to the post-mortem examination.

Samples of blood and hair follicles will be collected by ME and tested for drugs and/or toxins. Items unable to be stored by the ME will be turned over to LE for storage, and testing at the discretion of DOJ. Disposal of evidence (e.g. diapers) should be cleared with DOJ to ensure resolution of a criminal proceeding is complete.

**COMMON ELEMENTS OF CHILD TORTURE**

Child torture may not immediately be identified until the abuse and/or neglect results in serious physical injury or death often after multiple interventions for less serious offenses. Therefore, MDT members should consider the elements of child torture in every case and communicate any identified elements to other members of the team.

Cases can be quickly assessed by using the checklist below, and child torture should be considered when several elements are identified, either currently or historically within a case. For instance, child torture should be suspected if a 4-year-old child has current unexplained fracture, linear bruising was observed on the buttocks two months prior, and parent is withholding food, threatening the child, and isolating the child from family.

Please also refer to Appendix “B” for the complete version of the checklist.

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63 See http://www.cdc.gov/sids/
## Section One: Deprivation of Basic Necessities (at least 1 element)

<table>
<thead>
<tr>
<th>Current or History of Allegations for Neglect</th>
<th>Withholding Food</th>
<th>Withholding Water</th>
<th>Withholding Clothing</th>
<th>Subjecting to Extremes of Heat or Cold</th>
<th>Limiting Access to Others</th>
<th>Limiting Access to Routine Medical Care</th>
<th>Forcing Child to Stay Outside for Extended Periods or Sleep Outside</th>
<th>Limiting Access to Toilet</th>
<th>Limiting Access to Personal Hygiene/Bathing</th>
<th>Inability to Move Free of Confinement</th>
<th>Withholding Access to Schooling/Withdrawing to Home School</th>
<th>Sleep Deprivation</th>
<th>Low Body Mass Index</th>
<th>Other:</th>
</tr>
</thead>
</table>

## Section Two: Physical Abuse (at least 2 physical assaults or 1 severe assault)

<table>
<thead>
<tr>
<th>Current or History of Allegations for Physical Abuse</th>
<th>Bruising Shaped like Hands, Fingers, or Objects, or Black Eyes</th>
<th>Fractures that are Unexplained and Unusual</th>
<th>Ligature, Binding, and Compression Marks due to Restraints</th>
<th>Contact or Scald Burns to the Skin or Genitalia</th>
<th>Flexion of a Limb or Part of Limb beyond its Normal Range</th>
<th>Human Bite Marks</th>
<th>Force-Feeding</th>
<th>Asphyxiation</th>
<th>Other:</th>
</tr>
</thead>
</table>

## Section Three: Psychological Maltreatment (2 or more elements, can be a single incident)

<table>
<thead>
<tr>
<th>Current or History of Allegations for Psychological Maltreatment</th>
<th>Rejection by Caregiver</th>
<th>Terrorizing</th>
<th>Isolating</th>
<th>Threats of Harm or Death to Child, Sibling(s) or Pets</th>
<th>Exploiting/Corrupting</th>
<th>Unresponsive to Child’s Emotional Needs</th>
<th>Shaming/Humiliation</th>
<th>Other:</th>
</tr>
</thead>
</table>

## Section Four: Supplemental Items

<table>
<thead>
<tr>
<th>Current or History of Allegations for Sexual Abuse</th>
<th>Penile, Digital or Object Penetration of the Anus</th>
<th>Assault to the Genitals</th>
<th>Forcing Sexual Intercourse</th>
<th>Forcing to Remain Naked or Dance</th>
<th>Forcing to Witness or Participate in Sexual Violence against another person</th>
<th>Other:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Forcing Excessive Exercise for Punishment</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>History of Prior Referrals and /or Investigations by the Division of Family Services (DFS)</th>
<th>One Child is Targeted</th>
<th>Sibling(s) Abused</th>
<th>Siblings Join in Blaming Victim and May Lack Empathy</th>
<th>Family System is Blended and Both Caregivers Participate in the Alleged Abuse and/or Neglect</th>
<th>One Caregiver Fails to Protect</th>
</tr>
</thead>
</table>

68
No Disclosure is Made by Targeted Child or Siblings
Caregivers Provide Reasonable Explanations in Response to Allegations
Caregivers Allege Mental Health Issues for Targeted Child (e.g. self-injury) and Report Repeated Attempts to Seek Help

TEMPORARY EMERGENCY PROTECTIVE CUSTODY

In accordance with Delaware Code, Physicians, DFS investigators, or LE may take Temporary Emergency Protective Custody of a child in imminent danger of serious physical harm or a threat to life as a result of abuse or neglect for up to 4 hours. DFS may only take Temporary Emergency Protective Custody of a child in a school, day care facility, and child care facility.

Physicians and LE must immediately notify DFS upon invoking this authority. This shall end once DFS responds.

A reasonable attempt shall also be made to advise the parents, guardians or others legally responsible for the child’s care, being mindful not to compromise the investigation.

DELAWARE CODE

16 Del. C. § 907(a) and (e) state: “A police officer or a physician who reasonably suspects that a child is in imminent danger of suffering serious physical harm or a threat to life as a result of abuse or neglect and who reasonably suspects the harm or threat to life may occur before the Family Court can issue a temporary protective custody order may take or retain temporary emergency protective custody of the child without the consent of the child's parents, guardian or others legally responsible for the child's care… A Division investigator conducting an investigation pursuant to § 906 of this title shall have the same authority as that granted to a police officer or physician… provided that the child in question is located at a school, day care facility or child care facility at the time that the authority is initially exercised.”

TRANSPORTATION

If the alleged perpetrator is the caregiver or is unknown, an alternative means of transportation should be provided to the child for medical examinations, forensic interviews at the CAC, and out-of-home interventions. Under these circumstances, DFS or LE may transport the child to the hospital or seek medical transport for the child, and both agencies are entitled to immunity from any liability in accordance with § 4001 of Title 10.

64 See 16 Del. C. § 907(a) and (e)
DFS may also transport a child under the following conditions: DFS invokes Temporary Emergency Protective Custody from a school, day care facility or child care facility; DFS obtained a signed consent from the parent; or DFS is currently awarded Temporary Custody by the Family Court.

**MEDICAL EXAMINATION**

A medical examination will be considered for any other children residing in the home of a deceased child. Medical examinations may be conducted to identify, document, diagnose, prevent, and treat medical conditions and/or trauma (resulting from abuse and unrelated to abuse), as well as to assess issues related to patient safety and well-being.

To determine the appropriate medical response for the other children living in the home, the MDT shall follow the **Delaware Multidisciplinary Team Guidelines for Child Abuse Medical Response** (Medical Response Guidelines). Please refer to Appendix “C” for the complete version of the Medical Response Guidelines.

In cases where other children living in the home are suspected to be injured, the Medical Response Guidelines must be followed using the below Medical Response Matrix for Serious Physical Injury cases. Please note that Step 2 of the Medical Response Matrix and any medical response which involves calling the designated medical services provider will not be implemented until the resources become available.

<table>
<thead>
<tr>
<th>Abuse Fact Pattern</th>
<th>Medical Response</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child is 0-6 months of age for any injury.</td>
<td>Step 1. IMMEDIATE EMS TRANSPORT to nearest hospital.</td>
<td>Step 1. IMMEDIATE</td>
</tr>
<tr>
<td></td>
<td>Step 2. Call designated medical services provider.</td>
<td>Step 2. 24 HR</td>
</tr>
<tr>
<td>Severe or extensive injuries at any age, including but not limited to: head trauma, burns, fractures, chest or abdominal injuries.</td>
<td>Step 1. IMMEDIATE EMS TRANSPORT to nearest hospital.</td>
<td>Step 1. IMMEDIATE</td>
</tr>
<tr>
<td></td>
<td>Step 2. Call designated medical services provider.</td>
<td>Step 2. 24 HR</td>
</tr>
<tr>
<td>Child appears to be intoxicated, drugged, or otherwise non-responsive or abnormally responsive.</td>
<td>Step 1. IMMEDIATE EMS TRANSPORT to nearest hospital.</td>
<td>Step 1. IMMEDIATE</td>
</tr>
<tr>
<td></td>
<td>Step 2. Call designated medical services provider.</td>
<td>Step 2. 24 HR</td>
</tr>
</tbody>
</table>
Prior to responding to the designated hospitals to seek a medical examination for a child, DFS or LE may call the Forensic Nurse Examiner Program to request a forensic exam and to provide case specific details.

Please remember that DFS has the authority to seek a medical examination for a child victim without the consent of the child’s parents or caregiver. For siblings and other children in the home, the American Academy of Pediatrics recommends a timely medical examination for siblings and other children in the home when one child is identified as a victim of abuse.

**DELaware CODE**

16 Del. C. § 906(e)(7) of the Delaware Code states: “The Division shall have authority to secure a medical examination of a child, without the consent of those responsible for the care, custody and control of the child, if the child has been reported to be a victim of abuse or neglect…”

The medical examination should include written record and photographic documentation of injuries. If no medical assessment is conducted, then LE will be responsible for taking the photographs to document the number and size of the injuries. For the purposes of its investigation, DFS may need to take photographs, but every effort should be made by the agencies not to duplicate these efforts. Smartphones should be used to take photographs only in exigent circumstances.

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65 See 16 Del. C. § 906(e)(7)
In these cases, the medical providers are charged with determining, based upon a reasonable degree of medical certainty, whether the child’s injury is accidental, inflicted or caused by a medical condition. Both the medical examination and information gathered by LE and DFS are used to make this determination. These preliminary medical findings will be provided immediately to LE and DFS upon completion of the examination. Subsequent findings and medical records should be obtained prior to completion of an investigation.

Potential questions that should be asked of the medical provider are listed below. Avoid asking a physician whether it is “possible” that a caregiver’s explanation caused the injury, because the answer will always be yes. Instead, use the words “probable, likely or consistent with” when speaking with medical providers and note that medical providers only speak in terms of probability and not absolutes.

### COLLECTING THE MEDICAL EVIDENCE

**Questions for the Medical Provider**

- What is the nature and extent of the child’s injury or illness?
- What is the mechanism of injury? What type and amount of force are required to produce the injury?
- Does the history the caregiver provided explain (in whole or in part) the child’s injury?
- Have other diagnoses been explored and ruled out, whether by information gathering, examination, or medical tests?
- Could the injury be consistent with an accident?
- Can the timing of the injury be estimated? To what degree of certainty?
- Have all injuries been assessed in light of any exculpatory statements?
- What treatments were necessary to treat the injury or illness?
- What are the child’s potential risks from the abusive event?
- What are the long-term medical consequences and residual effects of the abuse?

MDT members should consider the possibility of injuries that were not reported by the child or not readily visible (i.e. internal injuries or age progression of injuries). Be mindful that minor injuries, when paired with a history of alleged abuse or neglect, may be indicative of chronic physical abuse or torture.

Prior to discharge, if concerns exist regarding the safety of other child living in the home of a deceased child, then the medical providers may consider requesting a meeting in accordance with Hospital High Risk Medical Discharge Protocol (See Appendix D). The Protocol ensures that children (birth to age 18) with special medical needs, who are active with DFS or have been reported to DFS by Delaware hospitals, are discharged in a planned and safe manner.

In addition to the medical examination for allegations of abuse or neglect, the American Academy of Pediatrics (AAP) recommends that children in foster care receive an initial health screening within 72

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hours of placement to identify any immediate medical, mental health and dental needs, and a comprehensive health evaluation within 30 days of placement to review all available medical history, to identify medical conditions and to develop an individualized treatment plan for the child. Additionally, the AAP recommends that the child receive a screening each time the placement changes. 67 The Foster Care Health Program at the Nemours Alfred I. duPont Hospital for Children is the state’s specialty clinic, and DFS is responsible for making these referrals as appropriate.

SAFETY ASSESSMENT

DFS is responsible for assessing the safety of the other children in the home and/or visiting the home during the course of the investigation. If safety threats are present, DFS will consider whether an out-of-home intervention is warranted by safety agreement or custody. For children placed in out-of-home interventions through a safety agreement, DFS will conduct background checks on all individuals in that home and complete home assessments.

LE will notify DFS if removal of a child appears necessary. LE should communicate concerns and information regarding the child’s safety that may impact DFS interventions. DFS, not LE, is responsible for making placement decisions when safety threats are present and the child(ren) cannot remain at the current residence. As noted above, for situations in which a child is in imminent danger, then it would be appropriate for LE to take Temporary Emergency Protective Custody.

BEHAVIORAL HEALTH AND SOCIAL SERVICES

The child and family should be connected to any needed behavioral health and social services in order to reduce trauma, promote healing and improve outcomes. Child abuse and neglect can be experienced as traumatic events and can have a lifelong impact on the child and the family if appropriate resources and supportive services are not provided. The social and mental health needs of all should be considered in every case and discussed as part of the MDT meetings throughout the life of the case.

The Division of Prevention and Behavioral Health Services (DPBHS) provides a wide range of individualized, trauma-informed, and community-based behavioral health services to children and families statewide. Every child residing in Delaware can be referred to prevention/early intervention and crisis services which are provided through DPBHS. To refer or receive information about these services call the DPBHS Access Unit at 1-800-722-7710 or the Crisis Service at 1-800-969-4357.

DPBHS provides the outpatient treatment and supportive services to youth who are uninsured or insured by Medicaid through an array of specialized evidence-based practices to promote the best outcomes for children and families. In the event a child needs treatment outside of his/her community (including homes and school), the DPBHS treatment continuum may include day treatment, partial hospitalization program, residential rehabilitative treatment and inpatient hospitalization services.

Children presenting with indicators of trauma who are uninsured or insured by Medicaid should be referred to the Access Unit at DPBHS. Staff in the Access Unit will collect behavioral health and substance abuse information. If the child is in need of services beyond prevention, early intervention or outpatient, staff will complete a service intensity tool (e.g. Child and Adolescent Service Intensity Instrument (CASII) and American Society of Addiction Medicine (ASAM)) and make appropriate referrals for services. For children in need of treatment with private insurance, the families should be referred to their insurance company for information about benefits and providers.

For children entering foster care, the DFS Office of Evidence-Based Practice (OEBP) will conduct a screening to assist in identifying the needed mental health services for children and their families. In addition, if a child in foster care exhibits trauma or symptoms of trauma, the caseworker will alert the OEBP for further Trauma Screening.

MDT members may connect children and their families to these and other services with the assistance of the victim advocates identified below.

**VICTIM ADVOCATES**

Victim advocates are responsible for assessing the needs of the child and family and connecting them to culturally appropriate resources and services. Victim advocates are available in each of the MDT agencies as follows:

- DSCYF/Division of Family Services – Domestic Violence Liaisons & Substance Abuse Liaisons
- Law Enforcement – Victim Service Specialists
- Department of Justice – Social Workers
- Children’s Advocacy Center – Family Resource Advocates
- Hospitals – Social Workers

To ensure there are no gaps in services, victim advocates should communicate with each other and coordinate with mental health and social service providers throughout the course of the investigation and beyond. The roles and responsibilities of the victim advocates will vary among the agencies, so not all advocates will provide the same array services. However, the following constellation of services may be provided as needed: emergency crisis assessment and intervention, risk assessment and safety intervention for caregivers and families, information on Victims Information Notification Everyday (VINE), assistance with filing for emergency financial assistance and education regarding victim’s rights, case status updates, court accompaniment, and information and referrals for appropriate social service agencies (e.g. housing, protective orders, domestic violence intervention, food, transportation, public assistance, and landlord/employer intervention).

Please see Appendix “E” for agency contacts and additional service information.
ARREST

LE should call DOJ’s Special Victims Unit upon receipt of a child death. Communication with DOJ should be ongoing throughout the criminal investigation and prior to charging, whenever possible to ensure the best outcome for the criminal case.

When an alleged perpetrator is arrested, a no contact order with the other children in the home shall be recommended, as a specific condition of bail and/or other conditions that may be necessary to protect the child(ren) and any other members of the community. Input from DFS should be considered and offered to the issuing judicial officer. LE and/or DFS may contact DOJ to request a modification to the contact conditions of bail.Regardless of contact conditions of bail, DFS will consider an in-home intervention or an out-of-home intervention once safety threats are identified, including safety agreements, custody and placement needs.

Before clearing a case without an arrest, LE consultation with DOJ shall occur. LE will notify DFS upon case closure.

CRIMINAL PROCEEDINGS

DOJ may review the following information (both current and historical):

- All police reports and any other information obtained during the investigation concerning all individuals involved in the case;
- All non-redacted DFS records;
- All medical records pertaining to the child;
- All CAC records; and,
- Inventory and/or copies of any evidence.

The Deputy Attorney General (DAG) will evaluate the case to determine prosecutorial merits and will collaborate with LE to identify additional investigative actions as appropriate.

When two or more Divisions (typically Family & Criminal) within DOJ are involved with a particular case, the DAGs will coordinate with each other to ensure the most appropriate legal outcomes are achieved. The Civil and Criminal DAGs shall communicate regularly regarding the case status. The DAG prosecuting the criminal matter will take the lead in this process.

Before resolution of a criminal proceeding, DOJ should confer with DFS, on active cases, regarding issues impacting child safety, such as vacating the No Contact Order and potential impact to a civil substantiation proceeding prior to completion of the civil investigation. This discussion should also include recommended services and/or evaluations for the perpetrator and child. Upon a criminal conviction where the civil case was unfounded and closed, the Criminal DAG will notify the Civil DAG.
CIVIL DISPOSITION

DFS makes a determination as to whether abuse or neglect has occurred within 45 calendar days. Upon completion of the civil investigation, DFS will make a finding once it has established that a preponderance of the evidence exists; the civil finding is not dependent upon the status or outcome of the criminal case.

DFS is required to give written notice to the alleged perpetrator of its finding. Recognizing that this notice to the alleged perpetrator may impact an active criminal investigation, DFS shall contact LE/DOJ prior to case closure in order to maintain the integrity of the case.

DELAWARE CODE

16 Del. C. § 924(a)(2)b. states: “[The Division shall] advise the person that the Division intends to substantiate the allegations and enter the person on the Child Protection Registry for the incident of abuse or neglect at a designated Child Protection Level.”

In addition to the DFS investigation, there may be a civil proceeding in the Family Court, such as if DFS petitions for temporary custody of a child or if the alleged perpetrator appeals a finding by DFS and a Substantiation Hearing is scheduled.

MDT members may be subpoenaed to testify in civil proceedings and/or provide case documentation or evidence subject to any relevant statutory provisions and Court rulings as to the confidentiality and admissibility of said evidence.

3. MDT CASE REVIEW

MDT Case Review is the formal process in which the team convenes regularly scheduled meetings in each county to monitor and discuss the case progress, which may include the following:

- Review interview outcomes;
- Discuss, plan and monitor the progress of the investigation;
- Review any medical examinations;
- Discuss child protection and other safety issues;
- Provide input for prosecution and sentencing decisions;
- Discuss emotional support and treatment needs of the child and family members as well as strategies for meeting those needs;
- Assess the families’ reactions and response to the child’s disclosure and involvement in the criminal justice and/or child protection systems;

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[68 See 16 Del. C., § 924(a)(2)b.]
• Review criminal and civil case updates, ongoing involvement of the child and family and disposition;
• Make provisions for court education and court support;
• Discuss ongoing cultural and special needs issues relevant to the case; and,
• Ensure that all children and families are afforded the legal rights and comprehensive services to which they are entitled.

MDT Case Review may include representatives from the following disciplines: CAC, DFS, DOJ, IC, LE, medical, mental health, and victim advocates.

Please see Appendix “F” for an example of a MDT Case Review Protocol utilized in Delaware.

4. CONFIDENTIALITY, INFORMATION SHARING & DOCUMENTATION

The Child Abuse Prevention and Treatment Act (CAPTA) requires that states preserve the confidentiality of all reports and records pertaining to cases that fall within this MOU to protect the privacy rights of the child and family.\(^69\) However, exceptions are permitted in certain limited circumstances, and the Delaware Code provides guidance on who may access the information.

**DELAWARE CODE\(^70\)**

16 Del. C. § 906(e) states: “The Division shall only release information to persons who have a legitimate public safety need for such information or a need based on the health and safety of a child subject to abuse, neglect or the risk of maltreatment, and such information shall be used only for the purpose for which the information is released.”

MDT members are **authorized and encouraged** to communicate information with one another pertaining to families and children in a legal, ethical, professional, and timely manner throughout the course of an investigation in accordance with agency policies and existing agreements (e.g. MOUs). As noted above, applicable state and federal confidentiality laws apply.

To obtain records, the requesting MDT agency must contact the MDT agency from which the records originated. **Information may be shared between MDT agencies; however, records shall only be disseminated by the agency owning those records.** Mental health and substance abuse records are afforded a stricter level of protection under state and federal statutes requiring consent of the parent or pursuant to a subpoena issued by DOJ.

If a criminal or civil proceeding is pending, DOJ may also issue a subpoena for records or for court testimony.

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\(^70\) See 16 Del. C. § 906(e)
Documentation should be specific to case facts and should not include information related to the opinions of the MDT members (i.e., the initial concerns of the investigator as to the strength, strategy, or course of the criminal investigation).

5. CONFLICT RESOLUTION

The MDT shall make every effort to resolve disputes through discussion and negotiation at the lowest levels of the agencies. If the dispute cannot be resolved at this level, then the MDT members involved in the dispute shall contact their individual supervisors for assistance. Once the chain of command is exhausted or at the request of one of the supervisors, a team meeting may be scheduled. Additionally, the Investigation Coordinator’s Office may be contacted to initiate or facilitate communication with other members of the MDT.