V. CHILD SEXUAL ABUSE PROTOCOL

1. **DEFINITION:** Sexual abuse means any act against a child that is described as a sex offense in § 761(h) of Title 11.[81]

2. **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

- **Exploitation:** occurs when [any individual] behaves unethically toward a child, using the parent's/caregiver's position of power to solicit sexual acts in an attempt to obtain some type of sexual gratification. This category includes situations in which [any individual] prostitutes a child or knowingly permits a child to be "used" by another party, regardless of whether [any individual] receives sexual gratification or other compensation (money, drugs) or no compensation at all;[82]

- **Medical Child Abuse**: Medical child abuse (also known as Munchausen syndrome by proxy, caregiver-fabricated illness in a child or factitious disorder by proxy) is a rare form of abuse involving the persistent fabrication, falsification or induction of physical or mental illness in a child by an adult, leading to unnecessary and potentially harmful medical investigations and/or treatment. The precise epidemiology and estimates of occurrence of this form of abuse are unknown as it frequently goes undetected, under-detected or misdiagnosed.

- **Pornography:** means production or possession of visual material (e.g., pictures, films, video) by [any individual] depicting a child engaged in a sexual act or a simulation of such an act. The visual material involves sexualized content, as opposed to "naked baby" pictures;[83]

- **Sexual Abuse:** means any sexual contact, sexual intercourse, or sexual penetration, as those terms are defined in the Delaware Criminal Code, between [any individual] and a child;[84]

- **Torture** (10 Del. C. § 901(1)b.3.); and,

- **Verbal Innuendo:** means inappropriate sexualized statements to a child by [any individual] intended to entice or alarm.[85]

2. CRIMINAL OFFENSES

- § 764 Indecent exposure in the second degree; unclassified misdemeanor;

---

[81] *See* 10 Del. C. § 901(21)
[82] *See* 10.1.8. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.
[83] *See* 10.1.16. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.
[84] *See* 10.1.18. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.
[85] *See* 9.1.12. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.

- § 765 Indecent exposure in the first degree; class A misdemeanor;
- § 766 Incest; class A misdemeanor;
- § 767 Unlawful sexual contact in the third degree; class A misdemeanor;
- § 768 Unlawful sexual contact in the second degree; class F felony;
- § 769 Unlawful sexual contact in the first degree; class D felony;
- § 770 Rape in the fourth degree; class C felony;
- § 771 Rape in the third degree; class B felony;
- § 772 Rape in the second degree; class B felony;
- § 773 Rape in the first degree; class A felony;
- § 774 Sexual extortion; class E felony;
- § 776 Continuous sexual abuse of a child; class B felony;
- § 777A Sex offender unlawful sexual conduct against a child;
- § 778 Sexual abuse of a child by a person in a position of trust, authority or supervision in the first degree; penalties;
- § 778A Sexual abuse of a child by a person in a position of trust, authority or supervision in the second degree; penalties;
- § 787 Trafficking of an individual, forced labor and sexual servitude; class D felony; class C felony; class B felony; class A felony;
- § 1100A Dealing in children; class E felony;
- § 1106 Unlawfully dealing with a child; class B misdemeanor;
- § 1108 Sexual exploitation of a child; class B felony;
- § 1109 Dealing in child pornography; class B felony;
- § 1111 Possession of child pornography; class F felony;
- § 1112A Sexual solicitation of a child; class C felony;
- § 1112B Promoting sexual solicitation of a child; class C felony; class B felony;
- § 1259 Sexual relations in detention facility; class G felony;

- § 1335 Violation of privacy; class A misdemeanor; class G felony; and
- § 1341 Lewdness; class B misdemeanor.

3. 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 child sexual abuse.

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[86]

16 Del. C. § 903 of the Delaware Code 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 must 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 must be made by telephone or otherwise. Reports and the contents thereof including a written report, if requested, must be made in accordance with the rules and regulations of the Department. An individual with knowledge of child abuse or neglect or knowledge that leads to a good faith suspicion of child abuse or neglect may not rely on another individual who has less direct knowledge to call the aforementioned report line."

16 Del. C. § 904 also states: "When 2 or more persons who are required to report under § 903 of this title have joint knowledge of a known or suspected instance of child abuse or neglect, the telephone report may be made by 1 person with joint knowledge who was selected by mutual agreement of those persons involved. The report must include all persons with joint knowledge of the known or suspected instance of child abuse or neglect at the time the report is made. Any person who has knowledge that the individual who was originally designated to report has failed to do so shall immediately make the report required under § 903 of this title."

[86] *See* 16 Del. C. § 903 and 904

Penalty for Violation[87]

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."

State Response to Reports of Abuse or Neglect[88]

16 Del. C. § 906(e)(3) states: "In implementing the Department's role in the child protection system, the Department shall…conduct an investigation on a multidisciplinary case that involves intra-familial or institutional child abuse or neglect, human trafficking of a child, or death of a child 3 years of age or less that appears to be sudden, unexpected, and unexplained. The Department may investigate any other report."

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:

- During a forensic interview for allegations of sexual abuse, a child makes a disclosure of physical abuse. All MDT members must make the call to the Report Line.
- A child is brought to the hospital emergency department by the parent after being referred by the medical provider. Both the medical provider and emergency department staff 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. This includes reports of sexual abuse involving children in state operated or contracted residential facilities. In addition to making a call to the DFS Report Line, the facility staff must also contact the alleged victim's parents or legal guardians, the DFS caseworker for children in DSCYF custody, and the child's attorney or other legal representation. The federal Prison Rape Elimination Act (PREA) requires that staff and contractors in these facilities provide children with a means to privately report sexual abuse and sexual harassment by another child or a staff member/contractor. Children may make anonymous reports to the DFS Report Line.

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,

[87] *See* 16 Del. C. § 914
[88] *See* 16 Del. C. § 906(e)(3)

- Secondary allegations have been disclosed (i.e., initial report alleged sexual abuse and child later disclosed physical abuse).

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 Hotline caseworker 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:
    - Child, parents, siblings and alleged perpetrator;
    - The child victim's physical health, mental health, educational status;
    - Medical attention that may be needed for injuries;
    - The way the caregiver and alleged perpetrator's behavior is impacting the care of the child; and,
    - Any circumstances that may jeopardize the child's or DFS caseworker'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 intra-familial, institutional abuse (IA) or extra-familial for victims of trafficking, 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

REPORTS TO LAW ENFORCEMENT (LE)

DFS must make an immediate report to the appropriate law enforcement jurisdiction for all civil offenses identified in the Sexual Abuse Protocol, including cases that screen out (e.g., extra-familial cases). DFS will also document its contact with the appropriate law enforcement agency in the DFS reporting system.

DELAWARE CODE[89]

16 Del. C. § 903 states: "…In addition to and not in lieu of reporting to the Department, any such person may also give oral or written notification of said knowledge or suspicion to any police officer who is in the presence of such person for the purpose of rendering assistance to the child in question or investigating the cause of the child's injuries or condition."

16 Del. C. § 905(d) states: "Upon receipt of a report on any multidisciplinary case, the Department shall notify the appropriate law-enforcement agency and shall provide a detailed description of the report received. Notwithstanding any provision of the Delaware Code to the contrary, to the extent the law-enforcement agency with primary jurisdiction over the case is unable to assist, the primary law-enforcement agency may request another law-enforcement agency with jurisdiction to exercise such jurisdiction. Upon request, the other law-enforcement agency may exercise such jurisdiction."

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."

In addition to making a report to the DFS Report Line, Division of Youth Rehabilitative Services (DYRS) staff and its contractors must also make an immediate report to the appropriate law enforcement jurisdiction for allegations of sexual abuse involving children in state operated or contracted residential facilities (includes child on child and staff on child). The facility will also document that such referrals have been made.

Medical providers are encouraged to make an immediate report to the appropriate law enforcement jurisdiction to initiate a criminal investigation in sexual abuse cases. The law enforcement jurisdiction will determine whether or not a criminal investigative response is appropriate and take the necessary actions.

REPORTS TO DEPARTMENT OF JUSTICE (DOJ)

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.

LE shall call DOJ's Special Victims Unit upon receipt of allegations of sexual abuse to a child.

[89] *See* 16 Del. C. § 903 and 905(d) and 24 Del. C. § 1762(a)

REPORTS TO THE OFFICE OF THE INVESTIGATION COORDINATOR (IC)

The Office of the Investigation Coordinator receives reports of sexual abuse through data exchanges with DFS and the Delaware Criminal Justice Information System (DELJIS). The IC may schedule an MDT meeting within 48-72 hours of receipt of the report to discuss necessary investigative actions and safety measures. MDT members may also be asked to provide case specific information as requested by the IC throughout the course of the investigation. 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[90]

16 Del. C. § 906(c)(1) states: "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 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, a children's advocacy center, and the Office of Child Advocate."

16 Del. C. § 905(g) states: "Upon receipt of a report of death, serious physical injury or sexual abuse, or any other report requested by the Investigation Coordinator, the Department shall 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 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.

[90] *See* 16 Del. C. § 906(c)(1)a. and b., 905(f), and 906(d)(2) and (f)(3)

DELAWARE CODE[91]

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 Department 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 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;

(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.

[91] *See* 16 Del. C. § 906(c)(1)c., 906(e)(6), 906(f)(4), and 24 Del. C. § 1731A

DELAWARE CODE

State Response to Reports of Abuse or Neglect[92]

16 Del. C. § 906 states LE, DFS, DOJ and IC shall: "Participate as a member of the multidisciplinary team, and keep the team regularly apprised of the status and findings of its investigation."

16 Del. C. § 906(e)(3) states: "In implementing the Department's role in the child protection system, the Department shall…conduct an investigation on a multidisciplinary case that involves intrafamilial or institutional child abuse or neglect, human trafficking of a child, or death of a child 3 years of age or less that appears to be sudden, unexpected, and unexplained. The Department may investigate any other report."

16 Del. C. § 906(d)(6) and (e)(22) state LE and the Department shall: "Coordinate with the multidisciplinary team to secure forensic interviews and medical examinations, where applicable, and to conduct interviews while considering the criminal investigation together with the Department's statutory duties to promptly assess child safety. Absent good cause, children ages 3 through 12, and all suspected child victims of human trafficking, shall be interviewed in a children's advocacy center."

16 Del. C. § 906(d)(4) states LE shall: "Notify the multidisciplinary team as to whether it will be exercising jurisdiction in the case, or will be requesting another law-enforcement agency with jurisdiction to exercise such jurisdiction. Upon request, the other law-enforcement agency may exercise such jurisdiction."

Upon receipt of a report, DOJ, DFS, and LE 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.

While assessing the nature of the allegation, MDT members should consider whether indicators of juvenile trafficking are present. If indicators are present, MDT members will refer to the Juvenile Trafficking Protocol.

Sexual behaviors that are significantly different from same age peers and the age ranges at which children are able to consent to sexual contact will be considered throughout the investigation. Please refer to Appendix H for additional information.

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.

Investigative Actions	Responsible Agency
Cross-report to appropriate MDT members.	CAC, DFS, DOJ, IC, LE and Medical
Establish the location(s) where the incident occurred.	DFS and LE

[92] *See* 16 Del. C. § 906

Investigative Actions	Responsible Agency
Identify persons involved and exchange information regarding complaint, criminal and DFS history.	DFS and LE
Determine preliminary actions and coordinate interviews of caregivers, alleged perpetrator(s), other witnesses and child if CAC is not to be utilized.	DFS, DOJ and LE
Schedule forensic interviews at CAC for any child victims or child witnesses to include siblings and other children in the home.	CAC, DFS, DOJ and LE
Determine if indicators of juvenile trafficking are present.	DFS and LE
Consider consultation with police jurisdictions with more resources.	LE
May participate in MDT meeting within 48 to 72 hours.	DFS, DOJ, IC, LE and Medical
Adhere to the federal Prison Rape Elimination Act – Juvenile Facility Standards.	DYRS/Contractors
Discuss DFS's required notification to the alleged perpetrator of the allegations. Limit the details of the allegations and the maltreatment type.[93]	LE and DFS
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.	DFS, LE and Medical
Observe and photo/video document the crime scene(s); collect evidence.	LE
Determine if elements of Child Torture are present (review the checklist on Common Elements of Child Torture).	CAC, DFS, DOJ, IC, LE and Medical
Follow Guidelines for Child Abuse Medical Response for child and other children in the home.	DFS, LE and Medical
Consider Sexual Assault Evidence Collection Kit.	Medical
Determine if indicators of medical child abuse are present (Review the Checklist on Common Indicators of Medical Child Abuse).	DFS, DOJ, LE and Medical

[93] 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).

Investigative Actions	Responsible Agency
Utilize victim advocates to connect children and families with appropriate mental health, substance abuse, social services and additional resources.	CAC, DFS, DOJ, LE and Medical
Complete pre-arrest intake with DOJ.	LE and DOJ
Participate in MDT Case Review meetings.	CAC, DFS, DOJ, IC, LE and Medical

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 an 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 victims and witnesses to include siblings and other children in the home or having access to the perpetrator, ages 3 to 12, should be interviewed at the CAC in cases that fall within the Sexual Abuse 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 the child, 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 the child's 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

DELAWARE CODE[94]

16 Del. C. § 906 states: "Absent good cause, children ages 3 through 12, and all suspected child victims of human trafficking, shall be interviewed in a children's advocacy center."

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. The MDT should schedule and conduct interviews at the CAC of all children between the age of 3 and 12 or who may have been exposed to, a victim of, or a witness to the conduct being investigated. In accordance with the MDT Protocol for Scheduling Forensic Interviews for Child Victims, 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.

[94] *See* 16 Del. C. § 906

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 Hotline caseworker 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, an 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 an MDT member, then the other team members should be contacted and a follow up forensic interview should be scheduled.

PRISON RAPE ELIMINATION ACT (PREA)

The federal Prison Rape Elimination Act (PREA) established national standards in 2012 to eliminate prison rape in juvenile and adult facilities. The juvenile standards include prevention planning, reporting requirements, specific investigatory actions, disciplinary sanctions for staff, and medical and mental health screenings for children. DYRS, through its state operated and contracted residential facilities, is responsible for following these standards in providing residential care for juveniles. The applicable standards are referenced throughout the Child Sexual Abuse Protocol.

Please also see Appendix I for the complete version of the National Standards to Prevent, Detect, and Respond to Prison Rape under PREA pertaining to Juvenile Facilities.

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 should be collected and photographed or video recorded. For sexual abuse allegations involving children in state operated or contracted residential facilities, PREA requires that DYRS staff and its contractors separate the alleged victim and alleged perpetrator, and preserve and protect any crime scene until LE can assume responsibility. This includes asking the alleged victim not to take any action that could destroy physical evidence.

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. Forensic interviews with the child and siblings will be video and audio recorded at the CAC. 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.

Based upon information from all sources, to include the child, parents/caregivers, LE and DFS, the Sexual Assault Nurse Examiner/Forensic Nurse Examiner or medical provider will determine if a sexual assault evidence collection kit should be completed. If it is determined that a sexual assault evidence collection kit is necessary, the Sexual Assault Nurse Examiner/Forensic Nurse Examiner or medical provider will complete same. Any photographs necessary to document physical injuries will be completed as part of the medical examination. Items collected by medical providers as part of the forensic evaluation (including the sexual assault evidence kits) will be turned over to LE.

In situations where the child or investigation has revealed information indicating the need for bodily evidence collection prior to being medically examined, investigating MDT members will share this information with the medical provider to ensure such evidence may be collected.

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 an 8-year-old child presents with a sexually transmitted infection, cigarette burns were observed two months prior, and parent is withholding food, threatening the child, and isolating the child from family.

The document is also located in the Appendices as Appendix B.

Section One: Deprivation of Basic Necessities (at least 1 element)

☐ **Current or History of Allegations for Neglect**

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

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

☐ **Current or History of Allegations for Physical Abuse**

☐ Bruising Shaped like Hands, Fingers, or Objects, or Black Eyes ☐ Fractures that are Unexplained and Unusual ☐ Ligature, Binding, and Compression Marks due to Restraints ☐ Contact or Scald Burns to the Skin or Genitalia	☐ Flexion of a Limb or Part of Limb beyond its Normal Range ☐ Human Bite Marks ☐ Force-Feeding ☐ Asphyxiation ☐ Other:

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

☐ **Current or History of Allegations for Psychological Maltreatment**

☐ Rejection by Caregiver ☐ Terrorizing ☐ Isolating ☐ Threats of Harm or Death to Child, Sibling(s) or Pets	☐ Exploiting/Corrupting ☐ Unresponsive to Child's Emotional Needs ☐ Shaming/Humiliation ☐ Other:

Section Four: Supplemental Items

☐ **Current or History of Allegations for Sexual Abuse**

☐ Penile, Digital or Object Penetration of the Anus ☐ Assault to the Genitals ☐ Forcing Sexual Intercourse	☐ Forcing to Remain Naked or Dance ☐ Forcing to Witness or Participate in Sexual Violence against another person ☐ Other

☐ **Forcing Excessive Exercise for Punishment**

☐ **History of Prior Referrals and /or Investigations by the Division of Family Services (DFS)**

☐ **One Child is Targeted**

☐ **Sibling(s) Abused**

☐ **Siblings Join in Blaming Victim and May Lack Empathy**

☐ **Family System is Blended and Both Caregivers Participate in the Alleged Abuse and/or Neglect**

☐ **One Caregiver Fails to Protect**

☐ **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, nurse practitioners, 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[95]

16 Del. C. § 907(a) and (e) state: "A police officer, nurse practitioner 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 Department 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. For instance, a non-offending relative, who has been ruled out as a suspect and cleared through background checks, should be considered first before transport by DFS or LE. However, DFS or LE may seek medical transport for the child or may provide transportation to the medical exam. Both agencies are entitled to immunity from any liability in accordance with § 4001 of Title 10.

[95] *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

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. A medical examination will be conducted for any child, who is the alleged victim of a sexual abuse report and considered for other children residing in the home or children to whom the alleged perpetrator had access. The Delaware Multidisciplinary Team Guidelines for Child Abuse Medical Response should be consulted to determine the appropriate medical response. The medical coordinator of care from the CARE Program at the children's hospital should be contacted within 24 hours for consultation and a follow-up plan, regardless of whether or not a medical examination was sought.

To determine the appropriate medical response for the child and other children in the home or children to whom the alleged perpetrator had access, the MDT should 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.

The Medical Response Matrix for Child Sexual Abuse cases is listed below. If any child experiencing sexual abuse is additionally suggesting a significant mental health issue, such as suicidal ideation or gesture, or severe depression, then an immediate medical response is needed to determine the appropriate mental health services, regardless of when the last reported contact occurred.

Abuse Fact Pattern	Medical Response	Time Frame
Any type of contact between the child or abuser involving either the child's or abuser's body having occurred **within the past 120 hours (to encompass evidentiary and medical needs).***	**Step 1. URGENT RESPONSE directly to Sexual Assault Nurse Examiner/ Forensic Nurse Examiner Program.** **Step 2. Call CARE Program for consultation and follow-up plan.**	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Any child describing sexual assault or abuse with significant genital or anal pain, genital or anal bleeding, sores in the genital or anal areas, and any pre-pubertal girl with a discharge **regardless of when the last reported contact occurred.***	**Step 1. URGENT RESPONSE directly to Sexual Assault Nurse Examiner/ Forensic Nurse Examiner Program.** **Step 2. Call CARE Program for consultation and follow-up plan.**	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Contact of abuser's mouth with child's body (e.g., genitals, breasts or anus) as reported by child or witnessed by another individual. Unknown timeframe or delayed report.*	Call CARE Program for consultation and follow-up plan, regardless of whether or not an immediate medical response is sought.	24 HR
Contact of abuser's genitals with child's body (e.g. genitals, breasts, anus or mouth) as reported by child or witnessed by another individual. Unknown timeframe or delayed report.*	Call CARE Program for consultation and follow-up plan, regardless of whether or not an immediate medical response is sought.	24 HR
Contact of abuser's hands, fingers or objects with child's genital or anus as reported by child or witnessed by another individual. Unknown timeframe or delayed report.*	Call CARE Program for consultation and follow-up plan, regardless of whether or not an immediate medical response is sought.	24 HR
Pre-teen sibling of a preteen child confirmed to have STD.*	Call CARE Program for consultation and follow-up plan, regardless of whether or not an immediate medical response is sought.	24 HR
Any child with genital and/or anal pain or discharge; lesions/bumps/ulcers; bleeding; or painful urination, regardless of type of contact reported by child.*	Call CARE Program for consultation and follow-up plan, regardless of whether or not an immediate medical response is sought.	24 HR
Any pre-teen child with an abnormal examination or an STD.*	Call CARE Program for consultation and follow-up plan, regardless of whether or not an immediate medical response is sought.	24 HR
For other serious concerns not included in the above criteria, an investigator or caregiver may request an examination.*	Call CARE Program for consultation and follow-up plan, regardless of whether or not an immediate medical response is sought.	24 HR

A forensic exam may also be requested by DFS or LE. 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.

PREA requires that children who experience sexual abuse in state operated or contracted residential facilities have access to forensic medical examinations. PREA also requires that DYRS staff and its contractors ensure children in state operated or contracted residential facilities have timely access to emergency medical treatment, including emergency contraception and sexually transmitted infections prophylaxis.

Please remember that DFS has the authority to seek a medical examination for a child victim, and any siblings or other children in the child's household 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[96]

16 Del. C. § 906(e)(7) of the Delaware Code states: "The Department shall have authority to secure a medical examination of a child, and any siblings or other children in the child's household 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… If such a medical examination is authorized under this section, the Department is authorized to transport the child to the medical examination. Medical examinations under this paragraph are covered under § 3557 of Title 18."

In situations where the child or investigation has revealed information indicating the need for bodily evidence collection prior to being medically examined, investigating MDT members will share this information with the medical provider to ensure such evidence may be collected.

The medical examination should include written record and photographic documentation of injuries. 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.

[96] *See* 16 Del. C. § 906(e)(7)

COLLECTING THE MEDICAL EVIDENCE[97]

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.

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 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.[98] The Foster Care Health Program at the Nemours Children's Health is the state's specialty clinic, and DFS is responsible for making these referrals as appropriate.

MEDICAL CHILD ABUSE

Medical Child Abuse, previously known as Munchausen syndrome by proxy, caregiver-fabricated illness in a child and factitious disorder by proxy, can be very difficult to diagnose. This form of abuse involves a child receiving unnecessary and harmful, or potentially harmful, medical care at the instigation of a caregiver. Commonly observed conditions and symptoms that caregivers create in instances of medical child abuse include failure to thrive, allergies, asthma, vomiting, diarrhea, seizures, and infections. While non-medical MDT members will not be diagnosing Medical Child Abuse, these MDT members

[97] Retrieved on February 6, 2017, from Office of Juvenile Justice and Delinquency Prevention's Portable Guide to Investigating Child Abuse: http://www.ojjdp.gov/pubs/243908.pdf

[98] Retrieved on February 6, 2017, from Fostering Health: Healthcare for Children and Adolescents in Foster Care: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/documents/fosteringhealthbook.pdf

should still be familiar with the indicators. This is to ensure that these cases, which are easily overlooked, may be identified earlier. Below are some indicators to help identify medical child abuse.

The document is also located in the Appendices as Appendix D.

Section One: Indicators in a Caregiver
➢ Mother is the abuser in 85% of cases ➢ Appears to need or thrive on attention from physicians or other medical professionals ➢ Seems devoted to child and insists that only they can accommodate the child's needs ➢ Is either directly involved in a profession related to healthcare or is very knowledgeable medically and has a familiarity with medical terminology ➢ Seeks another medical opinion when told that the child is healthy ➢ Persistent about borderline abnormal results with no medical validity or refutes the validity of normal results ➢ Does not express relief when told that the child is improving or a diagnosis is ruled out ➢ Insists on invasive or painful procedures and hospitalizations ➢ Publicly solicits sympathy, donations, or benefits because of the child's illness
Section Two: Indicators in a Child
➢ Median age for victims is between 14 months and 2.7 years ➢ Boys and girls are victimized equally ➢ Unexplained fear of doctors or hospitals ➢ Believe the symptoms and diagnoses caregiver tells them ➢ Unhealthy attachment to caregiver ➢ Siblings that have died or also have unexplained illnesses
Section Three: Indicators in Medical Care
➢ Inconsistent histories or symptoms from different sources ➢ Use of multiple medical facilities ➢ Excessive or inappropriate history of procedures, medications, tests, hospitalizations, surgeries ➢ Pattern of missed appointments or discharge of the child against medical advice ➢ Diagnosis does not match the objective findings ➢ Signs and symptoms only appear in the presence of one caregiver ➢ Signs or symptoms are strange or unusual and do not fit any disease or match test results ➢ Failure of illness to respond to its normal treatments or unusual intolerance to those treatments ➢ Symptoms that improve under medical care but get worse at home

HOSPITAL DISCHARGE

For children admitted to the emergency department or inpatient, a meeting or teleconference will occur prior to discharge to discuss the initial report; the complaint, criminal and DFS history; the medical

examination and findings; information gathered by LE and DFS; emotional support and treatment needs of the child victim and family members; and child protection and other safety issues. The medical coordinator of care, designated by the hospital (e.g., CARE Program or discharge coordinator from the local hospital), will coordinate a meeting or teleconference with the involved MDT members. DFS, LE, the medical coordinator of care, and physician will participate and determine a plan for discharge that considers the child's safety and well-being. DOJ shall be notified and may participate. In addition, the medical coordinator of care will assist the MDT in receiving all medical records, including preliminary and subsequent medical findings and photographic documentation of injuries. Finally, the medical coordinator of care will provide this information to the IC upon request.

SAFETY ASSESSMENT

DFS, in consultation with the MDT, is responsible for assessing the safety of the child victim and other children in the home or children to whom the alleged perpetrator had access. 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 through the review of prior DFS history on all individuals in that home and through the completion of home assessments. Placement of the children with individuals who were either present in the home or may have had access to the children at the time of incident, shall be excluded. These assessments will also occur while the child is hospitalized, if applicable, and DFS will consider an immediate intervention in the hospital when safety threats are present.

Throughout the investigation, the MDT shall 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 and/or with the caregiver. Therefore, an immediate call to the Report Line is required when these situations exist.

As noted above, for situations in which a child is in imminent danger, then it would be appropriate for LE, the physician or nurse practitioner to take Temporary Emergency Protective Custody and make an immediate call the Report Line.

MDT MEETINGS

During the course of an investigation, multiple MDT meetings may be scheduled. IC may schedule an MDT meeting within 48 to 72 hours of receipt of a sexual abuse report to discuss necessary investigative actions and safety measures. IC may also schedule an MDT meeting, at the request of any MDT member, to discuss new information learned during the course of the investigation which could impact the outcome of the case or the safety of the child. These meetings may include CAC, CARE Program, DFS, DOJ, LE and other involved medical providers (e.g., FNEs or emergency department physicians). DOJ will also be invited to attend these meetings. MDT members may also be asked to provide case specific information as requested by the IC throughout the course of the investigation. In situations in which the IC does not convene an initial MDT meeting, these discussions will take place at regularly scheduled MDT Case Reviews

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 (normal business hours) or the Crisis Service at 1-800-969-4357 (24/7). The crisis service of DPBPH is also known as Mobile Response and Stabilization Services (MRSS) and can provide immediate onsite assessment, information and referral services and is a free service regardless of insurance or financial status.

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 and make appropriate referrals for services. Those needing immediate emergency services should be referred to the DPBHS crisis service.

For children in need of treatment (beyond crisis services) and insured under commercial private insurance, the families should be referred to their insurance company for information about benefits and providers.

For children entering foster care, the DPBHS crisis service 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 DPBHS 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, both community-based and system-based, are responsible for assessing the needs of the child and family and connecting them to culturally appropriate resources and services. System-based advocates are located 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, system-based advocates should communicate with each other and with community-based to coordinate mental health and social services throughout the course of the investigation and beyond. The roles and responsibilities of the victim advocates will vary among the agencies and organizations, so not all advocates will provide the same array of 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, 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).

PREA requires that DYRS staff and its contractors provide children in state operated or contracted residential facilities timely access to crisis intervention services by an appropriate mental health practitioner. Ongoing treatment must also be provided, as appropriate. Additionally, the facility must ensure the child has access to victim advocates.

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

ARREST

LE should call DOJ's Special Victims Unit upon receipt of allegations of sexual abuse to a child. 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 child victim and/or other children in the home may 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.

For criminal investigations involving children in state operated or contracted residential facilities, PREA requires DYRS staff and its contractors to inform the alleged victim of any criminal charges or convictions related to the allegations, as well as the alleged perpetrator's employment or status in the facility if he or she is a staff member.

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[99]

16 Del. C. § 924(a)(2)b. states: "[The Department shall] advise the person that the Department 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.

At the conclusion of the DFS investigation, PREA requires DYRS staff and its contractors to report to the alleged victim, in a state operated or contracted residential facility, whether the allegations were determined to be substantiated or unsubstantiated. The notification will also be documented by staff.

3. MDT CASE REVIEW

- Case review is the formal process in which the MDT convenes to monitor and assess its independent and collective effectiveness in response to child abuse, child neglect and child death cases. The process facilitates best practices by encouraging mutual accountability and helping to assure that children's physical, mental and emotional needs are met sensitively, effectively and in a timely manner. Delaware's MDT follows the national standards, as outlined below:
- 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;
- 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.

[99] *See* 16 Del. C. § 924(a)(2)b.

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

Please see Appendix F for the 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.[100] However, exceptions are permitted in certain limited circumstances, and the Delaware Code provides guidance on who may access the information.

DELAWARE CODE[101]

16 Del. C. § 909(c) states: "The Department may 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 may be used only for the purpose for which the information is released."

16 Del. C. § 912(b) states: "A member of the multidisciplinary team may share all information and each record received, prepared, or maintained by or amongst members of the multidisciplinary team to carry out the responsibilities of the multidisciplinary team under law to protect children from abuse and neglect as authorized by the federal child Abuse Prevention and Treatment Act [42 U.S.C. § 5106a(b)(2)]. A multidisciplinary team record is confidential and may be disclosed to a person, including an entity, beyond the multidisciplinary team only as authorized by law or court rule."

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.

[100] Retrieved on February 6, 2017, from Child Welfare Information Gateway's Factsheet Disclosure of Confidential Child Abuse and Neglect Records: https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/confide/
[101] *See* 16 Del. C. § 906(e) and 912(b)

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.