

## VI. CHILD NEGLECT PROTOCOL

**A. DEFINITION:** Neglect or neglected child means that a person: is responsible for the care, custody, and/or control of the child; and has the ability and financial means to provide for the care of the child; and

1. Fails to provide necessary care with regard to: food, clothing, shelter, education, health, medical or other care necessary for the child's emotional, physical, or mental health, or safety and general well-being; or
2. Chronically and severely abuses alcohol or a controlled substance, is not active in treatment for such abuse, and the abuse threatens the child's ability to receive care necessary for that child's safety and general well-being; or
3. Fails to provide necessary supervision appropriate for a child when the child is unable to care for that child's own basic needs or safety, after considering such factors as the child's age, mental ability, physical condition, the length of the caregiver's absence, and the context of the child's environment.<sup>90</sup>

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

### 1. CIVIL OFFENSES

- **Abandonment (Age 10 and Under):** means [any individual] fails to assume or refuses to assume responsibility or to provide basic care for a child on a daily basis;
- **Caregiver/Parent Death:** means a child's primary caregiver/parent died as a result of a murder/suicide due to domestic violence and the child is dependent;
- **Caregiver/Parent Under the Influence:** means incidents reported by law enforcement when a caregiver's/parent's substance abuse impairs his/her ability to supervise, protect or care for the child and the child is dependent or no responsible caregiver is available;
- **Child Left Alone (Age 11 and Under):** means a child has been left alone for an extended period of time or beyond the child's capability to maintain immediate, basic care and safety for self and/or other children under age 11 left in their care and control;
- **Child Witness/Exposure to Domestic Violence in the Household:** means at least one caregiver/parent is a victim or perpetrator of violence that is chronic and/or severe and a child has witnessed in the last 12 months one or more family violence incidents that are consistent with felony-level charges (e.g., resulted in an injury that required or should have resulted in

---

<sup>90</sup> See 10 Del. C. § 901(18)

hospitalization or medical attention; involved the use of a weapon or dangerous instrument). Includes situations in which a child has been exposed in the last 12 months to chronic episodes of domestic violence that are consistent with misdemeanor-level charges (e.g., pushing, hitting, kicking, throwing objects, threats involving bodily harm to a caregiver or child) and these episodes are known to the police;<sup>91</sup>

- **Exploitation:** means the parent/caregiver teaches, encourages, or instructs a child to engage in illegal behaviors (e.g., shoplifting, burglary, drug dealing);
- **Hazardous Conditions in Household:** means a child is exposed to deplorable, unsanitary and dangerous living conditions (e.g. exposed electrical wiring, broken windows or stairs, and access to weapons, chemicals or harmful drugs) and these conditions impact the child’s health and safety;
- **Inappropriate Confinement:** means the alleged perpetrator has confined the child in a bedroom, basement, or any other space for a period of time that is inappropriate for the child’s age and/or vulnerability;<sup>92</sup>
- **Lack of Supervision (Age 6 and Younger):** means the caregiver/parent of a child fails to provide immediate care to ensure the well-being and safety of the child, who is unable to care for him/herself or respond appropriately to an emergency. These are incidents in which the caregiver/parent is physically present, but is not attending to the child due to behaviors such as substance abuse;<sup>93</sup>
- **Life-Threatening Medical Neglect:** means a caregiver’s/parent’s failure to obtain medical care for a child has resulted in hospitalization and medical diagnosis indicates the medical issue(s) were caused by or could have been prevented by the caregiver/parent;
- **Lock Out:** means the caregiver/parent locked a child aged ten or younger out of the house or locks a child over age ten out of the house on a recurring basis;<sup>94</sup>
- **Runaway:** in-state or out-of-state runaways whose caregiver/parent refuses to resume responsibility for the child’s care;
- **Severe Physical Neglect:** means failure by the caregiver/parent of a child to provide for the basic needs (e.g., food, clothing, shelter) of the child, for no apparent financial reason, and this failure could result in bodily harm or death. This category includes inaction by a parent/caregiver or a failure to protect the child that results in severe harm to the child.<sup>95</sup>

---

<sup>91</sup> See <http://kids.delaware.gov/policies/dfs/sdm-DelawareIntakeManual-2015March.pdf>

<sup>92</sup> See <http://kids.delaware.gov/policies/dfs/sdm-DelawareIntakeManual-2015March.pdf>

<sup>93</sup> See 9.1.6 DFS CPR Regulations. [http://kids.delaware.gov/fs/fs\\_cpr.shtml](http://kids.delaware.gov/fs/fs_cpr.shtml).

<sup>94</sup> See <http://kids.delaware.gov/policies/dfs/sdm-DelawareIntakeManual-2015March.pdf>

<sup>95</sup> See 9.1.11 DFS CPR Regulations. [http://kids.delaware.gov/fs/fs\\_cpr.shtml](http://kids.delaware.gov/fs/fs_cpr.shtml).

## 2. CRIMINAL OFFENSES

- § 603 Reckless endangering in the second degree; class A misdemeanor;
- § 604 Reckless endangering in the first degree; class E felony;
- § 621 Terroristic threatening;
- § 625 Unlawfully administering drugs; class A misdemeanor;
- § 626 Unlawfully administering controlled substance or counterfeit substance or narcotic drugs; class G felony;
- § 781 Unlawful imprisonment in the second degree; class A misdemeanor;
- § 782 Unlawful imprisonment in the first degree; class G felony;
- § 785 Interference with custody; class G felony; class A misdemeanor;
- § 1100A Dealing in children; class E felony;
- § 1101 Abandonment of child; class E felony; class F felony;
- § 1102 Endangering the welfare of a child; class G felony or class A misdemeanor; and
- § 1106 Unlawfully dealing with a child; class B misdemeanor.

**\*Includes reports of child exposure to chronic domestic violence incidents in the household.**

## 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 neglect.

### **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<sup>96</sup>

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<sup>97</sup>

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 neglect 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 neglect), or reason to suspect (you have observed behavioral and/or physical signs of child neglect). This report may include situations where multiple disciplines are involved, such as:

- Child transported to emergency room for treatment of an accidental drug overdose. LE and hospital staff must both make a call to the Report Line.
- Child makes a disclosure to a school employee and the School Resource Officer that the parent left the children home alone for several days. Both professionals must make the call.

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,

---

<sup>96</sup> See 16 Del. C. § 903 and 904

<sup>97</sup> See 16 Del. C. § 914

- Secondary allegations have been disclosed (i.e. initial report alleged neglect and child later disclosed sexual abuse or additional perpetrators have been identified).

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:
  - Child, parents, siblings and alleged perpetrator;
  - The alleged 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 worker's safety.
- Facts regarding the alleged neglect 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

### **REPORTS TO LAW ENFORCEMENT (LE)**

DFS must make an immediate report to the appropriate law enforcement jurisdiction for all civil offenses identified in the Child Neglect 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<sup>98</sup>**

16 Del. C. § 903 of the Delaware Code states: “...In addition to and not in lieu of reporting to the Division of Family Services, 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. § 906(e)(3) states: “The Division staff shall also contact...the appropriate law-enforcement agency upon receipt of any report under this section and shall provide such agency with a detailed description of the report received.”

Other MDT agencies are encouraged to make an immediate report to the appropriate law enforcement jurisdiction to initiate a criminal investigation when appropriate. 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 civil offenses identified in the Child Neglect 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.

Before clearing a case without an arrest, LE consultation with DOJ is recommended.

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.

**DELAWARE CODE<sup>99</sup>**

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)**

No reports are required to the Office of the Investigation Coordinator for the civil offenses identified in the Child Neglect Protocol, unless indicators of child torture are present. 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.

---

<sup>98</sup> See 16 Del. C. § 903 and 906(e)(3)

<sup>99</sup> See 16 Del. C. § 906(e)(3)

**DELAWARE CODE<sup>100</sup>**

16 Del. C. § 906(c)(1)a. of the Delaware Code 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 and Delaware’s criminal justice information system each reported case of alleged child abuse or neglect.”

**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<sup>101</sup>**

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;
- (4) All healthcare institutions in the State;

<sup>100</sup> See 16 Del. C. § 906(c)(1)a.

<sup>101</sup> See 16 Del. C. § 906(c)(1)c., 906(e)(6), 906(f)(4), and 24 Del. C. § 1731A(a)

- (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, DFS/LE will communicate and coordinate a response; however, LE will take the lead in the Joint Investigation when a criminal investigative response is warranted. Should DFS receive the report first, they must notify LE prior to making contact with any child, caregiver, or alleged perpetrator associated with the investigation in order to maintain the integrity of the case. Should LE receive the complaint first, they must call DFS immediately in order to apprise DFS of the case status and to obtain DFS history with the family. Please note that not all cases in the Child Neglect Protocol will require a joint response. In such instances, LE or DFS will conduct its own investigation as per agency policy. 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.

Investigative Actions	Responsible Agency
Cross-report and coordinate a response between MDT members.	MDT
Establish the location(s) where the incident occurred.	LE
Identify persons involved and coordinate interviews with child, siblings, caregivers, alleged perpetrator(s), and other witnesses.	DFS and LE
Exchange information regarding complaint, criminal and DFS history.	MDT
Consider consultation with police jurisdictions with more resources.	LE
Schedule forensic interview at CAC for any child victims or child witnesses to include siblings and other children in the home.	MDT

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. <sup>102</sup>	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.	Medical, LE and DFS
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).	MDT
Follow Guidelines for Child Abuse Medical Response for child and other children in the home.	DFS, LE and Medical
Take photographs of child and child's injuries.	Medical, LE and DFS
Consult with DOJ (particularly for active DFS cases, for cases with DFS history and for cases with complaint and criminal history).	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

## **INTERVIEWS**

In cases where a joint response is required, LE, in collaboration with DFS, will discuss who will conduct interviews with the child, siblings, caregivers, alleged perpetrator(s), and other witnesses. Additionally, all interviews shall be audio recorded, and when practicable, video recorded by LE. When a joint response is not practicable, DFS or LE will be notified of interviews in a timely manner and will be given an opportunity to observe and/or participate.

---

<sup>102</sup> 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).

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. Information to consider when discussing who will conduct the interview with the alleged child victim will include:

- Preliminary investigative information obtained from the referent and/or sources other than the child;
- Child’s cognitive, developmental, and emotional abilities;
- Safety issues, including environment and access to perpetrator; and,
- Special considerations, translation services and interpreters.

If LE and DFS decide to make a referral to the CAC, then LE and DFS should decline to interview the child about the allegations.

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 LE and DFS are considering using the CAC, but additional information is needed from 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**

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 should be photographed or video recorded.

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 may be taken to document any injuries to the child or the condition and current state of the child; scale of injury should be documented in photograph. These photographs may be taken as part of the medical examination process if the child has been transported to a medical facility. This does not preclude LE or DFS from taking photographs as needed for investigative purposes. If no medical examination is required, observation and photographs of the child will be coordinated between LE and DFS to prevent further trauma to the child. Please note that smartphones should be used to take photographs only in exigent circumstances.

### **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 child appears to be severely underweight, is shamed by the parent for developmental delays, and there was a previous report of bite marks. **Please follow the Serious Physical Injury Protocol once child torture is suspected.**

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

**Section One: Deprivation of Basic Necessities (at least 1 element)** **Current or History of Allegations for Neglect**

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

**Section Two: Physical Abuse (at least 2 physical assaults or 1 severe assault)** **Current or History of Allegations for Physical Abuse**

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

**Section Three: Psychological Maltreatment (2 or more elements, can be a single incident)** **Current or History of Allegations for Psychological Maltreatment**

- |  |  |
|--|--|
| <input type="checkbox"/> Rejection by Caregiver                                | <input type="checkbox"/> Exploiting/Corrupting                   |
| <input type="checkbox"/> Terrorizing   | <input type="checkbox"/> Unresponsive to Child's Emotional Needs |
| <input type="checkbox"/> Isolating   | <input type="checkbox"/> Shaming/Humiliation                     |
| <input type="checkbox"/> Threats of Harm or Death to Child, Sibling(s) or Pets | <input type="checkbox"/> Other:                                  |

**Section Four: Supplemental Items** **Current or History of Allegations for Sexual Abuse**

- |  |  |
|--|--|
| <input type="checkbox"/> Penile, Digital or Object Penetration of the Anus | <input type="checkbox"/> Forcing to Remain Naked or Dance  |
| <input type="checkbox"/> Assault to the Genitals                           | <input type="checkbox"/> Forcing to Witness or Participate in Sexual Violence against another person |
| <input type="checkbox"/> Forcing Sexual Intercourse                        | <input type="checkbox"/> 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, 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<sup>103</sup>**

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.

---

<sup>103</sup> 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 may be considered for any child, who is the alleged victim of a child neglect report, and other children residing in the home. 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 child and other children in the home, 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 Neglect cases is listed below. 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.

Neglect Fact Pattern	Medical Response	Time Frame
<b>Drug-endangered children.</b> <ul style="list-style-type: none"> <li>▪ Concerns for heavy parental drug use and/or drug manufacturing or distributing in the home.</li> <li>▪ Child was in the care of intoxicated caregivers (abuse of drugs or alcohol in the home).</li> </ul>	Step 1. <b>IMMEDIATE MEDICAL RESPONSE</b> at discretion of first responder.  Step 2. Call designated medical services provider.	Step 1. <b>IMMEDIATE</b>  Step 2. 24 HR
<b>Child was left unsupervised in environments that are potentially dangerous or lethal.</b>	Step 1. <b>IMMEDIATE MEDICAL RESPONSE</b> at discretion of first responder.  Step 2. Call designated medical services provider.	Step 1. <b>IMMEDIATE</b>  Step 2. 24 HR
<b>Persistent failure to comply with prescribed medical treatment; or suspected harmful overuse of medical services/treatment.</b>	Step 1. <b>IMMEDIATE MEDICAL RESPONSE</b> at discretion of first responder.  Step 2. Call designated medical services provider.	Step 1. <b>IMMEDIATE</b>  Step 2. 24 HR
<b>Child appears malnourished or starved and/or demonstrates deprivational behaviors.</b>	Step 1. <b>IMMEDIATE MEDICAL RESPONSE</b> at discretion of first responder.  Step 2. Call designated medical services provider.	Step 1. <b>IMMEDIATE</b>  Step 2. 24 HR

Any child suggesting a significant mental health issue such as suicidal ideation or gesture, or severe depression, <b><u>regardless of when the last reported contact occurred.</u></b>	<b>Step 1. URGENT RESPONSE OR EMS TRANSPORT to nearest hospital for:</b> A) Necessary medical services. B) Necessary mental health services.  <b>Step 2. Call designated medical services provider.</b> <i>Step 2 to be implemented at later date.</i>	<b>Step 1. IMMEDIATE</b>   Step 2. 24 HR
Caregiver or investigator expressed a request for examination or a serious concern not included in other criteria.	Call designated medical services provider.  <i>To be implemented at later date.</i>	5 Days
Siblings or juvenile housemates of child(ren) with injuries or conditions that are being evaluated for abuse or neglect.	Call designated medical services provider.  <i>To be implemented at later date.</i>	24 HR

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<sup>104</sup>

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 any injuries to the child or the condition and current state of the child. If no medical assessment is conducted, then LE will be responsible for taking the photographs. For the purposes of its investigation, DFS may also 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.

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

<sup>104</sup> See 16 Del. C. § 906(e)(7)

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 or condition. 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<sup>105</sup>**

### **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 regarding the child’s safety exist, 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 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,

---

<sup>105</sup> 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>

the AAP recommends that the child receive a screening each time the placement changes.<sup>106</sup> 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 alleged child victim and 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

---

<sup>106</sup> 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>

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**

Upon completion of the criminal investigation, if probable cause is established, then an arrest is recommended.

When an alleged perpetrator is arrested, a no contact order with the alleged 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.

LE consultation with DOJ is recommended regarding charging decisions for complex criminal investigations listed under this Protocol. 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<sup>107</sup>**

16 Del. C. 924(a)(2)b. of the Delaware Code 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;
- 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.

---

<sup>107</sup> See 16 Del. C. § 924(a)(2)b.

#### 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.<sup>108</sup> However, exceptions are permitted in certain limited circumstances, and the Delaware Code provides guidance on who may access the information.

##### **DELAWARE CODE<sup>109</sup>**

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.

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 agency management. 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.

<sup>108</sup> 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/>

<sup>109</sup> See 16 Del. C. § 906(e)