STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
C/O OFFICE OF THE CHILD ADVOCATE
900 KING STREET, SUITE 210
WILMINGTON, DELAWARE 19801
TELEPHONE: (302) 255-1730
FAX: (302) 577-6831

GINGER L. WARD
CHAIR

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

May 23, 2018

The Honorable John Carney
Office of the Governor
820 N. French Street, 12th Floor
Wilmington, DE 19801

RE: Reviews of Child Deaths and Near Deaths due to Abuse or Neglect

Dear Governor Carney:

As one of its many statutory duties, the Child Protection Accountability Commission ("CPAC") is responsible for the review of child deaths and near deaths due to abuse or neglect. As required by law, CPAC approved findings from 16 cases at its May 23, 2018 meeting.[1]

Four of the cases (two deaths and two near deaths) had been previously reviewed and were awaiting the completion of prosecution. All four cases were successfully prosecuted, and the two death cases resulted in significant jail time. One additional strength was identified regarding the appropriate sentence length for a child death.

The 12 remaining cases were from deaths or near deaths that occurred between July 2017 and October 2017. These timely reviews enable CPAC to address current system issues as well as celebrate accomplishments. The children in these 12 cases range in age from two weeks to 7 years old with 3 deaths and 9 near deaths. The children were abused via poisoning (drug ingestion), abusive head trauma, fractures,

[1] 16 Del. C. § 932.

drowning and/or unsafe sleep conditions. These twelve cases resulted in 67 strengths and 84 current findings across system areas.

During this time period, significant findings were made regarding the MDT response to these cases. Thirty-six findings showed breakdowns with interviews, crime scene analysis, response to victim's siblings, lack of expertise with a smaller jurisdiction, and the handling of drug ingestion/poisoning cases. Much work has been done in this area with significant progress being noted. CPAC is hopeful this is an anomaly as there were also 32 strengths in the MDT category demonstrating collaborative efforts between law enforcement, DFS, DOJ and the medical community. The work CPAC has done in trainings and development of a new MOU to support this response must continue. CPAC and the Child Death Review Commission recently met and developed a new Joint Action Plan which is also attached to this letter. Reviving the CPAC Child Abuse and Neglect Best Practices workgroup to address ongoing issues will occur.

With respect to the medical interventions on these cases pre and post incident, 10 strengths and 9 findings were identified. The use of timely, evidence-based home visiting services for infants continues to be an issue with 4 findings again this quarter. The Joint Action Plan has focused on this breakdown.

Progress with DFS regarding the use of safety agreements, unresolved risk and risk assessment is seen this quarter. This is heartening given the unmanageable caseloads of frontline workers. Once caseloads are subtracted, 25 findings remained primarily focused on breakdowns in safety agreements – particularly when a child is hospitalized. CPAC and DFS continue to partner to improve these agreements. 20 strengths were also noted.

The most significant issue is the caseloads of DFS frontline workers. CPAC is most grateful for your leadership to tackle the complex issues that face DFS in the recruitment and retention of frontline child welfare workers. In 11 of the 12 cases contained in this letter, the DFS worker was significantly over the statutory caseload standard. The current caseloads harken back to circumstances 20 years ago prior to the passage of the Child Protection Act of 1997. CPAC will continue to advocate to the General Assembly this session for the 30 additional frontline positions proposed in the Governor's recommended budget. CPAC recognizes that the funding of these positions is but the first step in a complicated recruitment and retention plan.

CPAC encourages the State to consider opportunities to make these positions attractive with funding, hazard pay, technologic support (Smartphones and Surface Pros) as well as consider creative solutions such as a Children's Corp similar to the Teach for America model. Right now, some investigators are at 40 to 50 cases per worker even with a statutory standard of 11. This is a recipe for disaster and also significantly contributes to the turnover rate. It is critical that we all collectively ensure that once we tackle this crisis, we demand regular compliance with 29 Del. C. § 9015. CPAC remains a steadfast partner and the Joint Action Plan emphasizes the work of its Caseloads/Workload Committee to that end.

Thus far in 2018, Delaware has experienced 4 child abuse or neglect deaths and 5 near deaths. In 2017, 13 children died and another 30 almost died from abuse or neglect in Delaware. The children reflected in this letter are all from 2017. Drug ingestions remain a concern. CPAC only brings you the most horrific of the cases; however, for every one of these, there are countless more cases where DFS case workers are under the same pressures and children remain at risk of serious harm. Young children with sentinel injuries are often the victims of serious abuse just months later.

For your information we have included the strengths, findings and the details behind all of the cases presented in this letter together with the 2018 Joint Action Plan. CPAC stands ready as a partner as well as to answer any further questions you may have.

Respectfully,

Tania M. Culley, Esquire
Executive Director
Child Protection Accountability Commission

Enclosures
cc: CPAC Commissioners
General Assembly

Child Abuse and Neglect Panel

Findings Summary

May 23, 2018

INITIALS

	*Current	**Prior	Grand Total
Legal	**2**		**2**
DFS Contact with DOJ	2		2
MDT Response	**36**		**36**
Crime Scene	5		5
Doll Re-enactment	3		3
General - Civil Investigation	1		1
General - Criminal Investigation	4		4
Interviews - Adult	8		8
Interviews - Child	7		7
Medical Exam	7		7
Reporting	1		1
Medical	**9**	**3**	**12**
Home Visiting Programs	4		4
Medical Exam/ Standard of Care - ED	3		3
Medical Exam/Standard of Care - Birth	1	2	3
Reporting	1	1	2
Risk Assessment/ Caseloads	**19**	**5**	**24**
Caseloads	12		12
Collaterals		1	1
Risk Assessment - Abridged	1		1
Risk Assessment - Closed Despite Risk Level	1	2	3
Risk Assessment - Screen Out	2		2
Risk Assessment - Tools	3	1	4
Risk Assessment - Unsubstantiated		1	1
Safety/ Use of History/ Supervisory Oversight	**13**		**13**
Completed Incorrectly/ Late	9		9
Inappropriate Parent/ Relative Component	1		1
No Safety Assessment of Non-Victims	1		1
Oversight of Agreement	2		2
Unresolved Risk	**5**		**5**
Child - Medical	1		1
Contacts	2		2
Interviews - Child	2		2
Grand Total	**84**	**8**	**92**

**Current - within 1 year of incident*

***Prior - 1 year or more prior to incident*

Office of the Child Advocate
900 King Street, Ste 350
Wilmington, DE 19801

Child Abuse and Neglect Panel

Findings Detail and Rationale

5-23-18

INITIALS

System Area	Finding	PUBLIC Rationale	Sum of #
Legal			2
	DFS Contact with DOJ		2
		The DFS supervisor did not consult with the Civil DAG to determine whether the case worker could pursue interviews and a home visit with the family. The law enforcement agency was adamant that these activities not occur.	1
		The father was non-compliant in the prior investigation, and the caseworker did not consider consulting with the Civil DAG. He refused to sign consents for the caseworker to complete collateral contacts, asked the caseworker to leave the home and did not permit the mother to speak.	1
MDT Response			36
	Crime Scene		5
		No scene investigation was completed by the law enforcement agency.	4
		While illicit drugs were noted at the crime scene, the law enforcement agency did not document that medications prescribed to the mother were found or counted. Co-ingestion with a prescribed medication was suspected for this case.	1
	Doll Re-enactment		3
		No doll re-enactment was completed by the law enforcement agency.	2
		No official doll re-enactment was completed by the law enforcement agency.	1
	General - Civil Investigation		1
		At the direction of the law enforcement agency, DFS did not conduct a home assessment prior to the infant's discharge from the hospital.	1
	General - Criminal Investigation		4
		The law enforcement agency did not complete a blood draw on the mother after the child tested positive for illicit drugs.	1
		The law enforcement agency did not immediately secure the parents cell phones for evidence and the cell phones were unable to be download once obtained.	1
		The local law enforcement agency's limited resources and training impacted the DFS investigation.	1
		The law enforcement agency did not immediately reassign the case when the assigned detective was transferred.	1
	Interviews - Adult		8
		DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	1
		LE interviews did not address the concerns of child physical abuse identified during the medical exam.	1
		During the death investigation, DFS and LE did not seek assistance from an interpreter to conduct interviews with the witnesses. Other adults were utilized to translate the conversations.	1
		A joint investigation did not occur. DFS conducted interviews with parents prior to the police response.	1
		The DFS case worker conducted telephone interviews with the father during the prior investigations.	1
		The law enforcement agency did not immediately conduct suspect/witness interviews.	1
		The MDT did not conduct a suspect/witness interview with the mother's paramour.	1

	The law enforcement agency did not obtain initial statements from suspects/witnesses at the hospital.	1
Interviews - Child		7
	DFS and LE did not conduct interviews with the father's children residing outside of the home and other witnesses, who interacted with the victim within 24 to 48 hours of the near death incident.	1
	Forensic interviews did not occur with the children who were present during the near death incident.	1
	Forensic interview did not occur with the young child who was present during the near death incident.	1
	There was a delay by a children's advocacy center in scheduling the forensic interviews with the young children, who resided in the home where the incident occurred.	1
	There was a delay by the MDT in referring the young children, who resided in the home where the incident occurred, to a children's advocacy center for a forensic interview.	1
	The law enforcement agency did not attend the forensic interview of the victim.	1
	Forensic interview did not occur with the young sibling who was present in the home during the near death incident.	1
Medical Exam		7
	The young sibling was not medically evaluated.	1
	DFS and LE did not follow up with the CARE Team to discuss the child abuse medical expert's concerns for child physical abuse. The child presented with multiple contusions on various planes of her body and no plausible mechanism was provided by the family.	1
	The law enforcement agency did not consult the child abuse medical expert.	1
	The siblings were not medically evaluated.	1
	The young siblings were not medically evaluated.	1
	There is not sufficient education and training related to the identification of Factitious Disorder (Imposed on Another).	1
	The young child who was present during the near death incident was not medically evaluated.	1
Reporting		1
	The DFS caseworker delayed reporting the child's suspected drug overdose to the law enforcement agency.	1
Medical		12
Home Visiting Programs		4
	Home Visiting Services were not in place at the time of the near death incident or post incident.	2
	Home Visiting Services were not in place at the time of the near death incident.	1
	The family was not referred to a Home Visiting Service post incident.	1
Medical Exam/ Standard of Care - ED		3
	A forensic nuse evaluation was not considered by the hospital emergency department after the infant presented with a tibia fracture.	1
	A forensic nurse evaluation was not considered by the hospital emergency department after the infant presented with bruising and fractures.	1
	The hospital emergency department refused to order scans for the young sibling despite non-accidental trauma to the victim and a recent history of physical abuse of the sibling.	1

	Medical Exam/Standard of Care - Birth		3
		Abusive Head Trauma/Shaken Baby Syndrome and infant safe sleep education were not documented within the medical records.	1
		A drug screen was not completed by the birth hospital for the mother or infant despite several red flags for prenatal substance exposure. Mother was prescribed Suboxone and had a history of prescription opioid dependence, and the infant was symptomatic.	1
		The birth hospital discharged mother with a prescription pain medication despite her history of prescription opioid dependence.	1
	Reporting		2
		The initial treating hospital did not report the incident to the appropriate law enforcement jurisdiction.	1
		A report was not made to the DFS Report Line when the victim was born and the mother was displaying parental risk factors while in the hospital.	1
Risk Assessment/ Caseloads			24
	Caseloads		12
		The caseload for the detectives assigned to investigate major crimes for this law enforcement jurisdiction was high and may have had an impact on the criminal investigation.	1
		The caseworker was over the investigation caseload statutory standards the entire time the case was open, and the caseload appears to have had a negative impact on the DFS response in the case.	1
		The caseworker was over the treatment caseload statutory standards while the case was open. However, it is unclear whether the caseload has had a negative impact on the DFS response in the case.	1
		The caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	1
		The caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it is unclear whether the caseload has had a negative impact on the DFS response in the case.	1
		The DFS case workers were over the investigation and treatment caseload statutory standards while the cases were open, and the caseload appears to have had a negative impact on the treatment case.	1
		The DFS case workers were over the investigation and treatment (initial worker only) caseload statutory standards while the cases were open. However, it does not appear that the caseloads negatively impacted the DFS response to those cases.	1
		The caseworker was over the investigation caseload statutory standards the entire time the case was open, and the caseload appears to have had a negative impact on the response in the case.	1
		The DFS caseworker was over the investigation caseload statutory standards for a portion of time while the case was open. However, it is unclear whether the caseload has had a negative impact on the DFS response in the case.	1
		The DFS caseworkers were over the investigation and permanency caseload statutory standards while the cases were open.However, it does not appear that the caseloads negatively impacted the DFS response to those cases.	1
		The DFS caseworkers were over the investigation caseload statutory standards during the current and prior investigations. However, it is unclear whether the caseloads had a negative impact on the DFS response in those case.	2

	Collaterals	1
	The prior investigation was opened for several months, and the case worker missed opportunities to gather information from medical collaterals and to follow up on missed medical appointments.	1
	Risk Assessment - Abridged	1
	The prior investigation was abridged by DFS without face to face contact with the family, and DFS did not consider contacting DOJ to discuss lack of cooperation.	1
	Risk Assessment - Closed Despite Risk Level	3
	The SDM Risk Assessment identified the risk as high at the conclusion of two prior investigations. Ongoing service was recommended in each; however, the case dispositions were overridden to close the investigations. Risk factors included significant DFS history and mental health issues for the victim.	1
	The SDM Risk Assessment identified the risk as high in the near death investigation. Ongoing service was recommended; however, the case disposition was overridden to close the investigation. Primary caregiver mental health and alcohol or drug use were not identified in the risk, and mother did not comply with parenting classes.	1
	The SDM Risk Assessment identified the risk as high at the conclusion of two prior investigations. Ongoing service was recommended in each; however, the case dispositions were overridden to close the investigations.	1
	Risk Assessment - Screen Out	2
	Despite a prior report involving domestic violence, the DFS Report Line screened out a recent hotline report, which alleged domestic violence in the presence of the children.	1
	The DFS Report Line screened out a prior hotline report, which alleged that an infant was born substance exposed. The prior screened out reports were not considered, and risk factors included domestic violence, homelessness and childhood history of maltreatment.	1
	Risk Assessment - Tools	4
	For the near death investigation, the SDM Risk Assessment was not completed correctly. Primary caregiver mental health was not considered. As a result, the risk was scored as moderate and the case was closed.	1
	In the prior nvestigation, the mother's mental health and out of state child protection agency history were not considered in the SDM Risk Assessment. As a result, the case was not considered for ongoing treatment services.	1
	In the prior investigation, a National Crime Information Center check was not completed for the parents and history with the out of state child protective services agency was not checked for the father despite learning that the parents resided out of state in the last several months.	1
	In the prior investigation, the SDM Risk Assessment was not completed correctly. The mother's substance abuse was not taken into consideration, and the father's out of state child protective services history, in known, was not considered.	1
	Risk Assessment - Unsubstantiated	1
	There was no finding of neglect in the prior investigation despite the victim being found wandering outside alone. There was at least one prior report with similar allegations.	1
Safety/ Use of History/ Supervisory Oversight		13
	Completed Incorrectly/ Late	9
	For the near death incident, the caseworker identified the victim as safe with agreement in the SDM safety assessment. However, the agreement did not consider the hospitalized victim.	1

	For the near death incident, the caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization. As a result, the mother was not required to have supervised or monitored contact with child.	1
	In the prior investigation, DFS did not conduct a home assessment prior to the infant's discharge from the hospital, and the hotline report alleged concerns with the conditions of the home.	1
	For the near death incident, the caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization. A safety agreement was completed for the siblings, but it did not consider the hospitalized victim.	1
	In the near death investigation, the case worker incorrectly identified the child as safe in the SDM safety assessment due to her hospitalization and no safety agreement was initially completed for the hospitalized victim.	1
	In the near death investigation, the case worker incorrectly identified the child as safe in the SDM safety assessment due to his hospitalization and no safety agreement was initially completed for the hospitalized victim.	1
	DFS entered into a safety agreement with the young sibling's father and another relative, but a home assessment was not initially conducted and the relative was not contacted in person.	1
	For the near death incident, the caseworker identified the victim as safe with agreement in the SDM safety assessment. However, a safety agreement was not completed for the hospitalized victim.	1
	Despite safety threats being identified for the mother in the prior investigation, DFS did not involve her in the safety agreement or specify an appropriate safety intervention for the substance exposed infant. In addition, there was no oversight of the plan.	1
	Inappropriate Parent/ Relative Component	1
	For the near death incident, DFS initially completed a safety agreement with the mother and another participant, allowing the young siblings to remain in the mother's care without restrictions. However, the mother was not ruled out as a suspect.	1
	No Safety Assessment of Non-Victims	1
	It was not clearly communicated to the placement resource for the sibling that DFS was awarded custody and a home assessment was not completed prior to placement.	1
	Oversight of Agreement	2
	Prior to terminating the safety agreement, DFS did not conduct a home visit to confirm the mother's medications were secure.	1
	Prior to terminating the safety agreement, DFS did not conduct a home visit with the mother to confirm she had stable housing.	1
Unresolved Risk		5
	Child - Medical	1
	Prior to case closure, the victim was observed to have a black eye by the DFS caseworker and no medical follow up occurred.	1
	Contacts	2
	There was no contact with the children for several months during the prior treatment case.	1

	In the prior investigation, there was a lack of follow up by the caseworker after the infant was discharged from the hospital. The initial contact with the victim and the mother did not occur until approximately 45 days after the interview with the father.	1
Interviews - Child		2
	In the prior investigation, the out of state child protective services agency denied the courtesy request, and DFS did not attempt the initial contact with the mother or infant at the out of state hospital.	1
	The half sibling was not interviewed or observed by the caseworker in the prior investigation.	1
Grand Total		**92**

Child Abuse and Neglect Panel

Strengths Summary

5-23-18

INITIALS		
	***Current**	**Grand Total**
Education	**1**	**1**
Basic Needs	1	1
Legal	**4**	**4**
Court Hearings/ Process	3	3
DFS Contact with DOJ	1	1
MDT Response	**32**	**32**
Documentation	2	2
General - Civil Investigation	11	11
General - Criminal Investigation	6	6
General - Criminal/Civil Investigation	7	7
Interviews - Child	4	4
Medical Exam	1	1
Prosecution/Pleas/Sentence	1	1
Medical	**10**	**10**
Documentation	1	1
Medical Exam/Standard of Care - CARE	3	3
Medical Exam/Standard of Care - ED	5	5
Medical Exam/Standard of Care - Reporting	1	1
Risk Assessment/ Caseloads	**14**	**14**
Collaterals	6	6
Hotline Accepted	2	2
Risk Assessment - Alternative Response	1	1
Risk Assessment - Substantiated	1	1
Risk Assessment - Tools	4	4
Safety/ Use of History/ Supervisory Oversight	**6**	**6**
Completed Correctly/On Time	4	4
Custody/Guardianship Petitions	2	2
Grand Total	**67**	**67**

FINALS		
	***Current**	**Grand Total**
Legal	**1**	**1**
Prosecution/Pleas/Sentence	1	1
Grand Total	**1**	**1**

TOTAL STRENGTHS **68**

*Current - within 1 year of incident

**Prior - 1 year or more prior to incident

Child Abuse and Neglect Panel

Strengths Detail and Rationale

5-23-18

INITIALS

System Area	Strength	Rationale	Count of #
Education			1
	Basic Needs		1
		School administration proactively reached out to the family upon the child's absences and implemented homebound instruction for the child.	1
Legal			4
	Court Hearings/ Process		3
		The Court made a finding of abuse and neglect against both parents.	1
		The Court made a finding of medical child abuse in the case.	1
		DFS moved quickly to change the permanency plan and to request to be excused from making reasonable efforts in this case due to the child's serious unexplained injuries.	1
	DFS Contact with DOJ		1
		Upon receipt of the May 2017 referral regarding allegations of statutory rape, DFS consulted with the Department of Justice prior to accepting the case for investigation.	1
MDT Response			32
	Documentation		2
		The DFS caseworker thoroughly documented the case events in the near death investigation.	2
	General - Civil Investigation		11
		The DFS caseworker consulted with the child abuse medical expert.	1
		During the 2016 investigation, the DFS caseworker educated Mother on infant safe sleep practices.	1
		A team decision making meeting was held during the near death investigation, and included the medical team as part of the meeting.	1
		Upon discovery of the safety agreement violations, the DFS caseworker immediately sought custody of the children.	1
		There was a good MDT response to the near death investigation between DFS and the medical team.	1
		The DFS treatment caseworker had quality contact with the family.	1
		The DFS caseworker made referrals to Child Development Watch for the child, and to the substance abuse providers for the parents.	1
		During the prior investigation, the DFS caseworker provided infant safe sleep education to the father when no crib was identified within the home.	2
		There was good collaboration between DFS, DOJ and the medical team during the investigation, as well as with follow up medical care for the child.	1

	There was excellent communication between DFS, DOJ, law enforcement, and the medical team.	1
General - Criminal Investigation		6
	The law enforcement agency requested a legal blood draw of the child for evidentiary purposes.	1
	Great MDT response to the death investigation between the law enforcement agency and the medical examiner's investigators. After completing the scene investigation, the law enforcement agency held the scene to allow the medical examiner's investigator to obtain scene photos.	1
	There was great collaboration between the law enforcement agency and the forensic investigators.	2
	The forensic investigator assigned to the case requested assistance from an investigator with more experience in child death cases.	2
General - Criminal/Civil Investigation		7
	Great collaborative MDT response, to include forensic interview being conducted within 24 hours, an immediate scene investigation by the law enforcement agency, and implementation of a safety plan by the DFS caseworker.	1
	Excellent communication was maintained between the DFS caseworker and the law enforcement agency.	1
	The criminal and DFS history was shared with the MDT, and good communication was maintained between the DFS caseworkers, the law enforcement agency, the DAG, and the medical team.	1
	The MDT response included regular communication, consult with the child abuse medical expert, and a meeting with DOJ.	1
	There was excellent MDT collaboration and response to the death investigation.	2
	Great collaborative response to the near death investigation by DFS, DOJ, and the law enforcement agency, to include the DFS case worker being present for the suspect/witness interviews and doll re-enactment.	1
Interviews - Child		4
	An urgent forensic interview was scheduled and held at the CAC.	1
	A forensic interview was scheduled and held at the CAC for the siblings residing in the home where the incident occurred.	2
	Forensic interviews were conducted with the child, and the two minor children residing in the home where the incident occurred.	1
Medical Exam		1
	The DFS caseworker ensured the child's siblings and other children in the home were medically evaluated.	1

	Prosecution/ Pleas/Sentence	1
	DOJ convened a team meeting with DFS and LE to plan and discuss the ongoing investigation.	1
Medical		10
	Documentation	1
	The documentation in the medical record by the PCP was thorough.	1
	Medical Exam/ Standard of Care - CARE	3
	The child received comprehensive medical testing not exclusive to the drug ingestion, which included a forensic evaluation, and social work and CARE Team consults.	1
	The CARE Team included blunt force trauma in its differential diagnosis and ensured that a referral was made to the DFS Child Abuse and Neglect Report Line.	1
	Genetic testing was completed in an effort to explore a plausible explanation for the child's medical condition.	1
	Medical Exam/ Standard of Care - ED	5
	The hospital emergency department contacted the law enforcement agency to report the drug ingestion.	1
	In addition to the victim, the children in the home at the time of the near death incident received drug screens.	1
	The children's hospital staff consulted with the CARE Team as a result of the child's altered mental status. This led to suspicion of factitious disorder as the CARE Team identified inconsistencies between the mother's story and the child's medical record.	1
	A vicarious trauma response was established by the emergency department with therapists on site for any professionals involved with the case.	2
	Medical Exam/Standard of Care - Reporting	1
	Mother's OB/Gyn and the birth hospital made referrals to the DFS Report Line due to the age difference between the teen mother and father.	1
Risk Assessment/ Caseloads		14
	Collaterals	6
	Collateral contacts were completed by the DFS caseworker prior to modification of the safety agreement.	1
	Collateral contacts were completed by the DFS caseworker with multiple medical facilities both within and out of state.	1
	The DFS caseworker consulted with the out of state child protection agency regarding the prior sexual abuse allegation by the mother.	1
	The DFS caseworker consulted with the out of state child protection agency regarding any history with the Mother.	1

		The DFS caseworker consulted three out of state child protection agencies and completed National Crime Information Center checks.	2
	Hotline Accepted		2
		DFS accepted the prior hotline report for investigation despite the case being out of state and the mother testing positive for marijuana with no other risk factors.	2
	Risk Assessment - Alternative Response		1
		The two 2016 screened-out hotline reports alleging statutory rape were referred to law enforcement and the Department of Justice.	1
	Risk Assessment - Substantiated		1
		At the conclusion of the DFS investigation, both parents were substantiated for abuse and neglect due to the extent of the child's injuries.	1
	Risk Assessment - Tools		4
		A framework was completed during the investigation case prior to transferring the case to treatment.	1
		The DFS caseworker referred Mother for a psychological evaluation.	1
		A Framework was completed during the investigation case.	1
		The permanency caseworker maintained regular, quality contact with the child, and attended follow-up medical appointments.	1
Safety/ Use of History/ Supervisory Oversight			6
	Completed Correctly/On Time		4
		DFS completed a safety agreement restricting the contact between the parents and any other children.	1
		There was consistent review and modification, when necessary, of the safety agreement by the DFS caseworker.	3
	Custody/Guardianship Petitions		2
		The DFS caseworkers immediately responded to the hospital (after-hours) and petitioned for emergency custody (day-shift).	2
Grand Total			**67**

FINALS

System Area	Strength	Rationale	Count of #
Legal			1
	Prosecution/ Pleas/Sentence		1
		The perpetrator received a strong sentence for the criminal charge.	1
Grand Total			**1**

TOTAL STRENGTHS **68**

Child Protection Accountability Commission & Child Death Review Commission

2018-2019 Action Plan

Summary of Action Plan: The recommendations from the 2018 Joint Retreat stem from the review of 41 child abuse and neglect death and near death cases approved by CPAC for incidents that occurred between May 2016 and July 2017. The result was 267 findings and 194 strengths. 5 prioritized recommendations for system improvement are below, along with 7 additional recommendations identified by the Joint Commissions and 10 ongoing recommendations from the 2016-2017 Action Plan. All the recommendations below will be explored by CPAC and its partner agencies.

Prioritized Recommendations from 2018 Joint Retreat (4):	**Status**
1. Revive the CPAC CAN Best Practices Workgroup to integrate the following into MOU training, or in the development of protocols to address coordination of medical services and the MDT as follows: a. Develop a protocol or plan to coordinate hospital discharge between DFS, LE and the identified medical coordinator of care for children of any age who present to the hospital and where child abuse or neglect is suspected. b. Develop a protocol or plan for meetings between MDT and medical providers on immediate safety plan during child's hospital admission. c. Develop a protocol or plan to seek medical examinations at the children's hospital for victims, siblings and other children in the home, 6 months or younger, when child abuse or neglect is suspected; or contact the designated medical services provider within 24 hours if the examination occurred elsewhere. d. Develop a protocol or plan to assign a detective to review complaints of child abuse or neglect involving children, 6 months or younger, prior to closing the case. e. Consider other recommendations that were not prioritized as follows: ▪ Assist the MDT in receiving all medical records, including preliminary and subsequent medical findings and photographic documentation of injuries, through use of the identified medical coordinator of care in the hospital. ▪ Allow in-house forensic nurse examiners to be accessible to the MDT 24 hours a day in the children's hospital and other hospitals in Delaware. ▪ Provide a list of direct contact numbers for all forensic nurse examiner teams and identified medical coordinators of care to the MDT. **Agency Responsible**: CPAC/CAN Best Practices Workgroup; **Timeframe**: 12 – 18 months	**CPAC/CDRC Approval Date:** 5/23/18; 5/11/18
2. Create an automatic medical referral for evidence-based home visiting services in the standard nursing admission orders for every Delaware birthing hospital when the mother comes into labor and delivery and the newborn is at risk. This referral should have a pre-checked box with the ability to opt out if delineated risk factors are not present. **Agency Responsible**: CDRC/Delaware Perinatal Cooperative; **Timeframe**: 12 – 18 months	**CPAC/CDRC Approval Date:** 5/23/18; 5/11/18

Prioritized Recommendations from 2018 Joint Retreat (4):	**Status**
3. Advocate to DHSS and the General Assembly for Medicaid reimbursement for all evidence-based home visiting providers in Delaware. **Agency Responsible**: CDRC/Division of Public Health; **Timeframe**: 12 – 18 months	**CPAC/CDRC Approval Date:** 5/23/18; 5/11/18
4. Advocate for increased funding to the DOJ Special Victims Unit, which has statewide jurisdiction of all felony level, criminal child abuse cases including those involving serious physical injury, death or sexual abuse of a child to ensure the same level of victim service and MDT collaboration in all counties. **Agency Responsible**: CPAC; **Timeframe**: Annually	**CPAC/CDRC Approval Date:** 5/23/18; 5/11/18
5. Advocate for compliance with statutory caseload mandates as required by 29 Del. C. § 9015 and continue to work on promising practices and strategies for recruitment and retention of the child welfare workforce. a. Reconvene the CPAC Caseload/Workloads Committee to review treatment caseloads and state standards. Agency Responsible: CPAC Caseloads/Workloads Committee b. Consider adjusting DFS caseloads based on complexity of the cases to better utilize staff strengths and balance workload. Agency Responsible: Division of Family Services c. Explore the use of differential response for domestic violence, substance exposed infants, and chronic neglect cases accepted by DFS. Agency Responsible: Division of Family Services d. Include caseloads in its prioritized list of CPAC funding requests to be submitted to the Governor and General Assembly each fiscal year. Agency Responsible: CPAC Chair/Executive Director	**CPAC/CDRC Approval Date:** 5/23/18; TBD

Additional Recommendations from 2018 Joint Retreat (7):	**Status**
1. Advocate for change in LogistiCare criteria for transporting victims, siblings and other children in the home to the hospital. **Action by OCA**: OCA will contact LogistiCare; **Timeframe**: 12 – 18 months	**CPAC/CDRC Approval Date:** 5/23/18; 5/11/18
2. Ensure CAN Panel findings are being addressed with local law enforcement agencies through either the MDT Case Review process, Police Chiefs' Council or the Office of the Investigation Coordinator. **Action by OCA**: Ask CPAC Steering Committee and Office of the Investigation Coordinator (IC) to consider; **Timeframe**: 6 months	**CPAC/CDRC Approval Date:** 5/23/18; 5/11/18
3. Recommend education for medical providers around the standard of care for providing medical exams to siblings and other children in the home. **Action by OCA**: Ask CPAC Training Committee to consider; **Timeframe**: 6 months	**CPAC/CDRC Approval Date:** 5/23/18; 5/11/18
4. Offer regular training to law enforcement agencies on how to conduct doll re-enactments, which are part of both infant death and near death scene investigations. **Action by OCA**: OCA will include in CAN Trainings and annual conferences as well as offer trainings to individual jurisdictions as requested; **Timeframe**: Annually	**CPAC/CDRC Approval Date:** 5/23/18; 5/11/18
5. Send a survey to providers to identify the type of electronic medical record and include the code to allow providers to automatically download the encrypted evidence-based home visiting referral form for all pregnant women. **Action by OCA**: Ask IC to consider incorporating into Infants with Prenatal Substance Exposure (IPSE) work; **Timeframe**: 12 – 18 months	**CPAC/CDRC Approval Date:** 5/23/18; 5/11/18
6. Include the evidence-based home visiting referral form in the treatment plan developed by medication-assisted treatment providers. **Action by OCA**: : Ask IC to consider incorporating into IPSE work; **Timeframe**: 12 – 18 months	**CPAC/CDRC Approval Date:** 5/23/18; 5/11/18
7. Provide training to DFS workers on the available evidence-based home visiting programs and consider referrals as part of the child safety agreement for children, 6 months and younger. **Action by OCA**: Ask DFS to consider in annual training of workers or ask IC to consider as part of IPSE training to DFS; **Timeframe**: 12 – 18 months	**CPAC/CDRC Approval Date:** 5/23/18; 5/11/18

In Progress/Deferred Recommendations from 2017-2018 Action Plan (15):	Status
1. Develop a MDT protocol for removal of life support cases. **Agency Responsible**: DOJ/OCA/Family Court; **Timeframe**: 6-12 months	**In Progress** Draft protocol complete. Should have final report to CPAC in 8/18.
2. Finalize and implement the DOJ comprehensive case management system. The system must be capable of producing current information regarding the status of any individual case, and must be capable of producing reports on case outcomes. The system must also allow the DOJ to track the caseloads of its Deputies and staff, so that informed resource allocation decisions can be made, and must ensure cross-referencing of all cases within the DOJ which share similar interested parties. **Agency Responsible:** DOJ; **Timeframe:** Immediately **Repeat recommendation from the May 2013 Final Report of the Joint Committee on the Investigation and Prosecution of Child Abuse*	**In Progress** DOJ SVU in NCC continues to pilot the case management system.
3. Recommend to the Delaware Police Chiefs' Council that all police departments supply their departments with cameras to document child abuse. **Agency Responsible:** CPAC Training Committee; **Timeframe:** April 2017	**In Progress** Considered at the 2018 Retreat
4. Consider and draft the following legislation: a. *Add Child Abuse First and Second degrees to the list of violent felonies and enhance the sentencing penalties*; b. *Create a negligent mens rea for child abuse and create a statute to address those who enable child abuse*; c. Modification of the crime of Murder by Abuse or Neglect; d. *Resolve inconsistencies in Title 11 due to the differing definitions of physical injury and serious physical injury*; e. Consideration of enhanced sentencing penalties for the crime of Rape involving a child to include a life sentence; **Agency Responsible:** CPAC Legislative Committee; **Timeframe:** February 2017 **Some are repeat recommendations from the May 2013 Final Report of the Joint Committee on the Inv. & Prosecution of Child Abuse*	**In Progress** DOJ sent legislation to OCA/IC. IC continues to work through informally with partners. Should be ready for 2019. Considered at the 2018 Retreat.

In Progress/Deferred Recommendations from 2017-2018 Action Plan (15):	Status
5. Provide ongoing training on the SDM Risk Assessment tool to reinforce the policy and ensure consistent application. **Agency Responsible:** DFS; **Timeframe:** Immediately and ongoing	**In Progress** DFS has worked with CRC to provide refresher safety and risk assessment training. The training is scheduled for 5/30- 6/1. Considered at the 2018 Retreat.
6. Revise the DFS non-relative/relative home safety assessment form, build it into the DFS case management system as part of the SDM Caregiver Safety Assessment when a home assessment is indicated, and provide training. **Agency Responsible:** DFS; **Timeframe:** 18 months	**In Progress** The form and workflow prompts for the home safety assessment are complete. Training is still pending as FOCUS training is being enhanced.
7. Provide supervisory training to DFS supervisors that is specific to child welfare and case management utilizing a national evidence-based curriculum. **Agency Responsible:** DFS; **Timeframe:** 18 months	**In Progress** DFS did have supervisory training in 10/17. We have also continued to provide quarterly training at existing meetings for supervisors and managers on various supervisory and management topics. Comprehensive Child Welfare Supervisory training is underway. The workgroup has landed on an evidenced based curriculum and are working on an implementation plan to commence in August – September 2018. Considered at the 2018 Retreat.
8. Utilize the Division of Substance Abuse and Mental Health (DSAMH)/DSCYF partnership and Casey Family Programs to better assist high risk families involved in the child welfare system, with risk factors such as mental health, substance abuse and domestic violence, and to identify appropriate services for children and caregivers. **Agency Responsible:** DSCYF; **Timeframe:** 3-6 months	**In Progress** MHAC (Meetings with DSAMH and DPH) continue in each county and the work of the RPG continues as well.

In Progress/Deferred Recommendations from 2017-2018 Action Plan (15):	Status
9. Provide ongoing booster training on safety assessments and safety planning to DFS staff to enhance understanding of the safety threats, interventions, and violations of safety plans. **Agency Responsible:** DFS; **Timeframe:** 6-12 months and then annually	**In Progress** DFS has collaborated with CRC and will be providing training on safety and risk assessment training scheduled for 5/30- 6/1. Considered at the 2018 Retreat.
10. Establish a process between DFS and Family Court in cases where guardianship petitions are filed to ensure legal protections are in place for the child and the needs of the child are being addressed. **Agency Responsible:** DFS/Family Court; **Timeframe:** 6-12 months	**In Progress** Guardianship Checklist has been drafted and awaiting approval from DOJ and Court.