State of Delaware

Child Protection Accountability Commission (CPAC)

Children's Justice Act

Annual Progress Report and Grant Application

May 31, 2019

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I. Annual Progress Report and Grant Application

A. Task Force Membership and Function

Name and Title	Task Force Designation	Description
Colonel Nathaniel McQueen, Jr., Superintendent, Delaware State Police	Law Enforcement Community	Colonel McQueen represents the Delaware State Police (DSP) on the Task Force. He joined the DSP ranks in 1988 and has served in many leadership roles during his career. He regularly sends Cpl. Adrienne Owen as his proxy. She is a 24-year veteran of DSP, and for the last seven years, Adrienne has served as the DSP Domestic Violence Policy and Training Coordinator
Major Robert McLucas Captain Joseph Bloch, New Castle County Police Department		Major Robert McLucas represented the New Castle County Police Department on the Task Force, and Captain Bloch replaced him on the Task Force as of August 2018. Captain Bloch joined the County Police in 1997 and has been assigned to the Patrol Division, Criminal Investigation Unit, and Professional Development Unit.
The Honorable Michael K. Newell, Chief Judge, Family Court	Criminal Court Judge	The Chief Judge of the Family Court has statewide administrative responsibilities, and the Family Court has extensive jurisdiction over domestic matters, including juvenile delinquency, child neglect, child abuse, adult misdemeanor crimes against juveniles, orders of protection from abuse, intra-family misdemeanor crimes, etc.
The Honorable Joelle Hitch, Judge, Family Court	Civil Court Judge	Judge Hitch hears a broad range of cases including child neglect, dependency, child abuse, custody and visitation of children, adoptions, terminations of parental rights, etc.
James Kriner, Esquire, Deputy Attorney General, Department of Justice	Prosecuting Attorney(s)	Mr. Kriner heads the Special Victims Unit, which is a specialized unit within the Department of Justice that handles all felony level, criminal child abuse cases involving the death or serious physical injury of a child, as well as all sexual abuse cases.
Abigail Layton, Esquire, Deputy Attorney General, Department of Justice		Ms. Layton is the Director of the Family Division and oversees three units: Child Support, Child Protection, and Juvenile Delinquency and Truancy.
Kathryn Lunger, Esquire, Assistant Public Defender, Office of Defense Services	Defense Attorney	Ms. Lunger is an Assistant Public Defender at the Delaware Office of Defense Services, which is responsible for representing indigent people at every stage of the criminal process in both adult and juvenile courts.

Name and Title	Task Force Designation	Description
Tania M. Culley, Esquire, Child Advocate, Office of the Child Advocate	Child Advocate (Attorney for Children)	As the Child Advocate, Ms. Culley is responsible for coordinating the programs which provide legal representation for children, including the Court Appointed Special Advocate (CASA) Program and serving as the Executive Director of CPAC.
Ellen Levin, CASA	Court Appointed Special Advocate Representative	Ms. Levin is a volunteer for the Court Appointed Special Advocate Program. She also serves as the Chair of the Child Abuse and Neglect Panel.
Allan De Jong, M.D., Medical Director, Nemours/Alfred I. duPont Hospital for Children	Health Professional	Dr. De Jong is a pediatrician and the Co-Director of the Children at Risk Evaluation (CARE) Program at the Nemours/Alfred I. duPont Hospital for Children.
Robert Dunleavy, LCSW Director, Division of Prevention and Behavioral Health Services	Mental Health Professional	Mr. Dunleavy is the Director of the Division of Prevention and Behavioral Health Services, which provides a statewide range of voluntary mental health and substance abuse treatment and prevention services for children and youth.
Josette Manning, Esq., Cabinet Secretary, Department of Services for Children, Youth and Their Families **Trenee Parker, Director, Division of Family Services**	Child Protective Service Agency	As the Cabinet Secretary of the Department of Services for Children, Youth and Their Families, Ms. Manning is responsible for a staff of 1,200 professionals tasked with coordinating services for children and youth who have experienced abuse and neglect, are in foster care or awaiting adoption, are in need of behavioral health services, or have been court ordered to juvenile detention services. Ms. Parker is the Director of the Division of Family Services, which investigates child abuse, neglect and dependency, offers treatment services, foster care, adoption, independent living and child care licensing services.
Meg Garey, Member of the Interagency Committee on Adoption	Parent and/or Representative of Parent Groups	Ms. Garey is a member of the Interagency Committee on Adoption and the Executive Director of A Better Chance for Our Children, a non-profit agency that provides services and resources to families and children involved in foster care and adoption.
Nicole Magnusson	Adult former victims of child abuse and or neglect	Ms. Magnusson is a Financial Advisor at Ameriprise Financial Services. She is a former foster youth in Delaware and was appointed to CPAC after the statutory changes were approved on July 15, 2014.

Name and Title	Task Force Designation	Description
Wendy Strauss, Executive Director, Governor's Advisory Council for Exceptional Citizens	Individual experienced in working with children with disabilities	As the Executive Director, Ms. Strauss has liaison responsibilities specifically with the Department of Education (DOE) and generally within Delaware's human services delivery system. At a federal level, the Council serves as the State Advisory Panel for the Individuals with Disabilities Education Act (IDEA) and its amendments. As such, the Council advises the DOE of unmet needs within the state in the education of children with disabilities. Ms. Strauss participates in one of the Committees under the Task Force.
John Hulse, Education Associate, 21st CCLC and Title I Programs, Department of Education	Individual experienced in working with homeless children and youths (as defined in section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a)).	Mr. Hulse is an Education Associate and he serves as the State Coordinator for Homeless Children and Youth. He also serves as the 21st Century Community Learning Centers (CCLC) State Program Officer. He participates in one of the Committees under the Task Force.

i. Purpose and Statutory Requirements

The Child Protection Accountability Commission's (CPAC) purpose is to monitor Delaware's child protection system to ensure the health, safety, and well-being of Delaware's abused, neglected, and dependent children (16 Del. C. § 931(b)). CPAC is comprised of key child welfare system leaders, who meet regularly with members of the public and others, to identify system shortcomings and the ongoing need for system reform.

In Delaware, CPAC serves as the federally mandated Citizen Review Panel and CJA State Task Force, and as such, fulfills specific statutory requirements for each. To accomplish its duties under CJA, CPAC maintains a multidisciplinary Task Force on children's justice as specified in Section 107(c)(1) of CAPTA. Delaware's Task Force membership is also designated under Section 931(a) of Title 16 of the Delaware Code, and it includes members from other disciplines.

The 24 Task Force members are as follows (16 Del. C. § 931(a)): (1) The Secretary of the Department of Services for Children, Youth and Their Families; (2) The Director of the Division of Family Services; (3) Two representatives from the Attorney General's Office, appointed by the Attorney General; (4) Two members of the Family Court, appointed by the Chief Judge of the Family Court; (5) One member of the House of Representatives, appointed by the Speaker of the House; (6) One member of the Senate, appointed by the President Pro Tempore of the Senate; (7) The Secretary of the Department of Education;

(8) The Director of the Division of Prevention and Behavioral Health Services; (9) The Chair of the Domestic Violence Coordinating Council; (10) The Superintendent of the Delaware State Police; (11) The Chair of the Child Death Review Commission; (12) The Investigation Coordinator, as defined in § 902 of this title; (13) One youth or young adult who has experienced foster care in Delaware, appointed by the Secretary of the Department; (14) One Representative from the Office of Defense Services, appointed by the Chief Defender; and (15) Eight at-large members appointed by the Governor with 1 person from the medical community, 1 person from the Interagency Committee on Adoption who works with youth engaged in the foster care system, 1 person from a law-enforcement agency other than the State Police and 5 persons from the child protection community.

ii. Structure and Staff

The Office of the Child Advocate (OCA) is a non-judicial state agency charged with safeguarding the welfare of Delaware's children. OCA was created in 1999 in response to numerous child deaths in Delaware resulting from child abuse. These cases pointed to deficiencies in the child protection system that could only be remedied through the collaborative efforts of Delaware's many child welfare agencies. The General Assembly determined that an office to oversee these efforts, staff CPAC, and provide legal representation on behalf of Delaware's dependent, neglected, and abused children was necessary. Pursuant to 29 Del. C. § 9005A, OCA is mandated to coordinate a program of legal representation for children which includes the Court Appointed Special Advocate Program (CASA); to periodically review all relevant child welfare policies and procedures with a view toward improving the lives of children; recommend changes in procedures for investigating and overseeing the welfare of children; to assist the Office of the Investigation Coordinator in accomplishing its goals; to assist CPAC in investigating and reviewing deaths and near deaths of abused and neglected children; to develop and provide training to child welfare system professionals; and to staff CPAC.

In addition to managing OCA, the Child Advocate serves as the Executive Director of CPAC and is responsible for overseeing the OCA staff who perform the duties of the Task Force. The OCA staff are as follows:

- Contract Training Specialist, who develops and provides a variety of trainings to the multidisciplinary team (MDT) and other professionals;
- Contract Data Analyst, who gathers, analyzes and produces reports on the various measurable aspects of the child welfare system;
- Child Abuse and Neglect Review Specialist, who prepares reviews of deaths and near deaths of abused and neglected children;

- Child Abuse Investigation Coordinator together with Investigation Coordinator Case Review Specialists, who monitor each reported case involving the death of, serious physical injury to, or allegations of sexual abuse of a child from inception to final criminal and civil disposition; and,
- Chief Policy Advisor/CJA Coordinator, who shepherds staff and committees to ensure accomplishment of tasks and compliance with the charge assigned by CPAC.

The Task Force accomplishes its goals through the work of its 8 committees: Abuse Intervention, Caseloads/Workloads, Child Abuse and Neglect Steering, Data Utilization, Education, Legislative, Substance-Exposed Infants/Medically Fragile Children, and Training. In April 2013, CPAC charged the Abuse Intervention Committee with providing oversight for the CJA grant activities and reporting the progress of its activities to CPAC. The Committee is chaired by Task Force Member, Abigail Layton, Esquire, and its charge is as follows: to provide measurable oversight of the Children's Justice Act grant activities by planning and administering the Three-Year Assessment; monitoring the progress of recommendations identified in the Three-Year Assessment Report; and recommending to CPAC future system priorities related to the investigative, administrative and judicial handling of cases of child abuse and neglect.

While the Abuse Intervention Committee provides oversight of the grant, the remaining committees help shape how Delaware responds to cases of child abuse and neglect. The Caseloads/Workloads Committee is responsible for evaluating the caseloads and workloads of the Division of Family Services (DFS) treatment workers and providing recommendations for change to CPAC, as appropriate. The Child Abuse and Neglect Steering Committee supervises the confidential investigation and retrospective review of deaths and near deaths of abused or neglected children pursuant to 16 Del. C. §§ 932-935. The next committee, Data Utilization, assesses the voluminous data presented to CPAC on a quarterly basis to inform system improvement and CPAC initiatives.

The third committee, Education, is charged with the following: implementing the Memorandum of Understanding between the Department of Services for Children, Youth and Their Families (DSCYF) and the Department of Education (DOE), its school districts, and its charter schools, which focuses on child abuse reporting and school enrollment for youth in foster care; streamlining training and education on issues related to child welfare; and looking at educational outcomes for children in foster care and exploring ways to improve those outcomes. Another committee under the Task Force, the Legislative Committee, is responsible for reviewing proposed legislation related to child protection and making recommendations to the full Task Force for action.

The Task Force partnered with the Child Death Review Commission for its Joint Committee on Substance-Exposed Infants/Medically Fragile Children, and the Committee is charged as follows: To a) establish a definition of medically fragile child, inclusive of drug-exposed/addicted infants; b) draft a statute to mirror the definition as needed and consider adding language to the neglect statute; c) recommend universal drug screenings for infants in all birthing facilities in the state; d) review and revise the DFS Hospital High Risk Medical Discharge Protocol to include all drug-exposed and medically fragile children. It shall include: responding to drug-exposed infants and implementing the Plan of Safe Care per CAPTA; and, involving the MDT in ongoing communication and collaboration for medically fragile children; referring medically fragile children to evidence-based home visiting programs prior to discharge; and, reviewing and including the Neonatal Abstinence Syndrome Guidelines for Management developed by Delaware Healthy Mother & Infant Consortium's Standards of Care Committee.

The last committee under the Task Force, the Training Committee, is charged with ensuring the training needs of the child protection system are being met through ongoing, comprehensive, multidisciplinary training opportunities on child abuse or neglect. The Training Committee is mainly responsible for carrying out the activities identified under the CJA grant.

iii. Meeting Frequency and Minutes

The Task Force meets on a quarterly basis to oversee the work of its 8 committees. Between quarterly Task Force meetings, CPAC's various committees and workgroups engage in substantive work at the direction of the Task Force. Minutes are taken for all meetings and posted in compliance with the Freedom of Information Act (See Appendix A: CPAC Quarterly Meeting Minutes).

iv. Work Plan

The Task Force meets every 1.5 years with the Child Death Review Commission (CDRC) to review the statistics, strengths and findings, and other necessary information related to the investigation and review of deaths and near deaths of abused or neglected children. As a result of this meeting, the Joint Commissions (CPAC and CDRC) establish an Action Plan with its prioritized recommendations for system improvement. Then twice a year, at its quarterly meetings, the Task Force monitors the Action Plan and provides an update on the status of its recommendations. CPAC also uses this forum as its three-year assessment.

v. Administration of the Grant

The OCA Chief Policy Advisor/CJA Coordinator is responsible for administering the CJA grant on behalf of CPAC. Specifically, the Chief Policy Advisor/CJA Coordinator is responsible for the following activities: drafting the Annual Progress Report, Grant Application and Three-Year Assessment; submitting an annual grant application and quarterly fiscal and progress reports to the Criminal Justice Council; and administering and overseeing the activities under the grant.

vi. Fiscal Management of the Grant

Since October 1, 2012, the Criminal Justice Council (CJC), with assistance from the Administrative Office of the Courts, has supported OCA with the fiscal management of the grant. The CJC is also responsible for the financial reporting on behalf of CPAC. In addition, CJC staff meets quarterly with the Chief Policy Advisor/CJA Coordinator to provide oversight for program and fiscal activities under the grant.

B. Prior Year Performance Report (May 2018-May 2019)

i. Description of Activities Using CJA Funds

a. Activity: Contract with a Training Specialist

Description: The Task Force contracted with a Training Specialist to provide administrative support to CPAC for all child abuse intervention training activities related to the CJA grant, including the mandatory reporting training programs and any ongoing comprehensive training to multidisciplinary team members and other professionals. During this period, the responsibilities of the Training Specialist included: identifying training needs of the Task Force; annually updating and revising the mandatory reporting training programs; organizing the train- the-trainer session; developing advanced training programs both in-person and web-based; evaluating the effectiveness of all training programs; organizing and facilitating in-person training programs with local and national subject matter experts; maintaining the number of professionals trained; utilizing available software to develop web-based training programs; providing technical support to users on OCA's online training system; managing the online training system and surveys; collaborating with educators and the medical community to make the mandatory reporting trainings available on their professional development systems; and staffing the CPAC Training Committees and its workgroups. In August 2018, Jessica Begley resigned as the Training Coordinator, and Kathleen McCormick was hired as the new Training Specialist in September 2018. This new position focuses more on preparing and developing training programs and analyzing training needs. There is less of a need for the Training Specialist to present the in-person training programs. This position was contracted by OCA, on behalf of CPAC, and no benefits were provided. CJA funds were utilized to pay for the contractual services provided by the Training Specialist, and a Surface Pro and accessories were purchased for the new contractor.

Task Force Recommendation(s): 1. Support of training and education initiatives related to the investigation and prosecution of child abuse and neglect cases using a multidisciplinary team approach; 2. Recommend education for medical providers around the standard of care for providing medical exams to siblings and other children in the home; and, 3. 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.

<u>Description of Evaluation Work</u>

Evaluation Methods: The Chief Policy Advisor/CJA Coordinator submitted quarterly program reports to the Criminal Justice Council, the agency responsible for the fiscal

management of the grant. The quarterly reports described the accomplishments and activities of the Training Specialist together with the other activities listed in the CJA program performance report. The Chief Policy Advisor/CJA Coordinator also met quarterly with staff from the Criminal Justice Council to discuss these activities and progress towards meeting the task force recommendations and the extent to which it contributes to the reform of state systems (See Appendix B: Example of Criminal Justice Council Program Report). Lastly, the Chief Policy Advisor/CJA Coordinator had monthly meetings with the Training Specialist and plans to evaluate the contract annually.

Output: The Training Coordinator/Specialist worked an average of 35 hours a week. Prior to her departure, Jessica Begley finalized a 30-minute web-based training called Minimal Facts: Guidelines for Mandated Reporters. The training gives professional reporters guidance on how to ask children questions that will assist them in making a clear and concise report to Delaware's Child Abuse and Neglect Report Line. The training was made available on OCA's online training system, and the Department of Education also made the training available on their professional development management system for all public school employees. In September 2018, Jessica Begley provided 10 to 15 hours of training to Kathleen McCormick to ensure a smooth transition of the Training Specialist duties. The training included an overview of OCA's online training system and the Articulate software, which OCA uses to develop its web-based training programs.

In December 2018, Kathleen McCormick finalized a 3 in 1 Mandatory Reporting Training – a combined web-based training program for medical professionals, educators and general professional audiences. The training allows users to select content that is specific to their discipline, and the Training Specialist only has to update one web-based training program instead of three. In addition, the education required for medical providers around the standard of care for providing medical exams to siblings and other children in the home was included in this training, and thus satisfies a recommendation from the Three-Year Assessment. The training was uploaded to OCA's online training system. At the same time, Ms. McCormick created several in-person trainings on the following topics: Child Neglect, Student on Student Sexual Assault, Parental Substance Abuse, and Protective vs. Risk Factors. These trainings are in the process of being reviewed and approved by OCA. In March 2019, Ms. McCormick updated the in-person Mandatory Reporting Trainings for medical professionals, educators, and general professional audiences. She was able to reduce the amount of text and add more visuals on the presentations to make them more appealing to in-person audiences. In response to feedback from the training evaluations, she developed a magnet and handout to help mandated reporters recall the Report Line number and minimal facts questions for talking to children about knowledge or suspicion of child abuse and neglect. Ms. McCormick

was also responsible for managing OCA's online training system and surveys through Survey Monkey. Between January and March 2019, she provided technical support to numerous physicians, who were participating in the web-based Mandatory Reporting Training for medical professionals. She also maintained the number of professionals trained, and reported those numbers to the CPAC Training Committee and its Mandatory Reporting Workgroup. Additionally, she helped organize and facilitate the Protecting Delaware's Children Conference, a multidisciplinary conference for child welfare professionals, on April 2, 2019. Her responsibilities included: communicating with several national speakers; updating the agenda and brochure; selecting the two awards for the award ceremony; organizing the packets for the workshops; managing the continuing educations credits; and preparing the conference evaluation. Lastly, she staffed the Training Committee on 11/30/18 and 2/8/19; the Mandatory Reporting Workgroup on 11/30/18, 1/18/19 and 4/17/19; and the Protecting Delaware's Children Conference Workgroup on 10/5/18, 1/8/19 and 3/5/19.

Outcome: Improved coordination of training programs on the investigative, administrative and judicial handling of cases of child abuse and neglect provided by or sponsored by the Task Force.

b. Activity: Provide Ongoing Comprehensive Training to Multidisciplinary Team Members and Others involved in the Judicial/Administrative Handling of Cases

Description: The Task Force provided regular training and demonstrative tools to investigators and prosecutors involved in the investigation and prosecution of child abuse and neglect cases. Training was provided on the Memorandum of Understanding (MOU) for the Multidisciplinary Response to Child Abuse and Neglect (MDT Best Practices MOU) and conducting doll re-enactments in child abuse and neglect death and near death cases. In addition, the Task Force hosted a one-day conference with the Court Improvement Program and other agencies on topics relevant to professionals involved in the investigative, administrative, and civil and criminal judicial handling of child abuse and neglect cases. The trainings were targeted to law enforcement, prosecutors, Judges, attorneys, case workers from the Division of Family Services, therapists, educators, community providers and medical professionals who regularly respond to allegations of child abuse and neglect in Delaware. CJA funds were used for the rental of facilities, speakers' fees, costs of meals and refreshments, local transportation, and other items incidental to the one-day conference. An annual fee was also paid to the company that hosts the MDT Best Practices MOU mobile application, and a Google developer fee was paid.

Task Force Recommendation(s): 1. Support of training and education initiatives related to the investigation and prosecution of child abuse and neglect cases using a multidisciplinary team approach; 2. 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, law enforcement 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; and, Provide a list of direct contact numbers for all forensic nurse examiner teams and identified medical coordinators of care to the MDT; 3. 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; and, 4. Recommend education for medical providers around the standard of care for providing medical exams to siblings and other children in the home.

***These recommendations for training continue to be aligned with the State of Delaware Child and Family Services Plan (CFSP) - 2019 Annual Progress and Services Report (APSR) Objectives: Continue to enhance the knowledge and skill of child welfare staff involved in investigation and treatment of child maltreatment.*[1]

Description of Evaluation Work

Evaluation Methods: To evaluate the effectiveness of the multidisciplinary response to child abuse and neglect cases, the Task Force relied on the reviews of child abuse and neglect deaths and near deaths by the CPAC Child Abuse and Neglect Panel[2] and cases

[1] State of Delaware CFSP 2019 APSR is available at: https://kids.delaware.gov/pdfs_archive/fs/fs-cfsp-apsr-2019.pdf

[2] The Child Abuse and Neglect Panel is authorized by the Task Force to conduct the confidential investigations and retrospective reviews of deaths or near deaths of abused or neglected children.

monitored by the Office of the Investigation Coordinator.[3] During this reporting period, the Child Abuse and Neglect Panel identified 92 findings and 141 strengths from its reviews, which related to the MDT Response (See Appendix C: Child Abuse and Neglect Panel Findings and Strengths – MDT Response). The findings that were seen most often involved crime scene investigations by law enforcement agencies, joint interviews between DFS and law enforcement for adults, interviews of children at the Children's Advocacy Center, and medical exams for children. There were also several strengths seen for interviews of children at the Children's Advocacy Center and medical exams for children. Since the last reporting period, there was a 28% increase in the findings and 33% increase in the strengths. At every quarterly meeting, the Task Force reviews the work of the Panel and findings and strengths related to the MDT response, and a letter is submitted to the Governor, General Assembly and public describing how it plans to address the issues identified (Appendix D: Child Abuse and Neglect Panel Letters to Governor). Lastly, the findings help identify the current training needs for the MDT.

Additionally, the Office of the Investigation Coordinator monitored 1,328 cases (17 deaths, 58 serious physical injury cases, and 1,253 suspected sexual abuse cases) in SFY18 by initiating and facilitating communication between the MDT and addressing any issues with non-compliance of the MDT Best Practices MOU. The IC also provides the county based MDT members with an email notification upon receipt of child victims of serious physical injury and death to ensure a coordinated, immediate MDT response. Any system issues are immediately brought to the attention of the individual agencies, and for cases also referred to the Child Abuse and Neglect Panel, the Office of the Investigation Coordinator presents those findings to the Panel. A Surface Pro and accessories were purchased for a Case Review Specialist at the Office of the Investigation Coordinator to help with the evaluation of the multidisciplinary response to child abuse and neglect cases.

In addition, surveys were used as the evaluation method for the one-day conference (See Appendix E: 2019 Protecting Delaware's Children Conference Evaluation).

Output: On August 2, 2018, Cpl. Adrienne Owen from the Delaware State Police facilitated a half-day training for law enforcement agencies on how to conduct doll re-enactments. There were 37 representatives in attendance from 12 law enforcement jurisdictions.

[3] The Office of the Investigation Coordinator is responsible for monitoring each reported case involving the death of, serious physical injury to, or allegations of sexual abuse of a child from inception to final criminal and civil disposition.

Colleen Woodall from the Division of Family Services also provided training to DFS staff on the MDT Best Practices MOU. A total of 9 sessions were held between August 22, 2018 and October 9, 2018, with a total of 233 attendees.

In addition, Cpl. Adrienne Owen and Rosalie Morales from the Office of the Child Advocate provided training on the MDT Best Practices MOU to the Civil and Criminal Deputy Attorneys General at the Department of Justice on October 19, 2018. The trainings were attended by approximately 35 representatives.

CPAC partnered the Court Improvement Program and other agencies to host Protecting Delaware's Children: A Multidisciplinary Conference for Child Welfare Professionals on April 2, 2019 at the Dover Downs Hotel and Casino in Dover, Delaware. Over 400 professionals attended from the following disciplines: Children's Advocacy Center (14), community service providers (59), Department of Justice (31), Department of Services for Children, Youth and Their Families (113), education (11), Family Court (45), law enforcement (68), medical (21), and child advocates/Court Appointed Special Advocates (78). The conference featured 14 workshops from national and local experts who addressed multidisciplinary collaboration and various aspects of child abuse. The following workshops were offered related to CJA: Investigating Child Homicide Cases (Part 1 & 2); Blindsided: 7 Sneaky Challenges Facing Survivors of Childhood Sexual Abuse; Infants with Prenatal Substance Exposure and their Families: Multidisciplinary Collaboration for the Development of Plans of Safe Care for Safety and Services for the Family; First, Do No Harm: Understanding Medical Child Abuse; Social Media—Privacy and Safety Considerations; and Why Don't They Just Leave? (identifying victims of trafficking). The conference brochure is available on the CPAC/OCA website for additional information: https://courts.delaware.gov/childadvocate/index.aspx.

The MDT Best Practices MOU mobile application had 565 active users during this period and 2,998 opens. There are more than twice as many users for the same period last year.

Outcome: Improved understanding of best practices associated with the investigation and prosecution of cases of child abuse and neglect, child death and child sexual abuse.

c. Activity: Develop a Web-based Refresher Training on SDM Safety Assessment and Safety Planning

Description: The Division of Family Services provided full day workshops to staff in each of its 3 counties on the Structured Decision Making (SDM) System Refresher: Safety Assessment and Child Safety Agreements. The training was targeted for DFS

investigators and supervisors. Participants received an overview of the foundations of the SDM system along with the importance of using SDM definitions. In addition, participants had an opportunity to learn and practice the use of the safety assessment and creating rigorous behaviorally based child safety agreements. CJA funds were used to hire a professional videographer to record one of the full day sessions and to develop a web-based training for new staff and others, who did not have the opportunity to attend one of the in-person training sessions. This activity satisfies the below recommendation from the Three-Year Assessment.

Task Force Recommendation(s): 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.

Description of Evaluation Work

Evaluation Methods: To evaluate the effectiveness of the safety training, the Task Force relied on the reviews of child abuse and neglect deaths and near deaths by the CPAC Child Abuse and Neglect Panel and cases monitored by the Office of the Investigation Coordinator. During this reporting period, the Child Abuse and Neglect Panel identified 21 findings and 14 strengths from its reviews, which related to safety assessment and child safety agreements for incidents that occurred after the training was provided to staff (See Appendix F: Child Abuse and Neglect Panel Findings and Strengths – Safety Assessment). At every quarterly meeting, the Task Force reviews the work of the Panel and findings and strengths related to assessing child safety, and a letter is submitted to the Governor, General Assembly and public describing how it plans to address the issues identified. The DFS representative on the Child Abuse and Neglect Panel also shares these findings and strengths with DFS staff and administrators.

Additionally, as previously mentioned, the Office of the Investigation Coordinator monitored 1,328 cases (17 deaths, 58 serious physical injury cases, and 1,253 suspected sexual abuse cases) in SFY18 by initiating and facilitating communication between the MDT and addressing any issues with non-compliance of the MDT Best Practices MOU. The IC also provides the county based MDT members with an email notification upon receipt of child victims of serious physical injury and death to ensure a coordinated, immediate MDT response. Issues around safety assessment and the need for out-of-home interventions are discussed in this notification. Any system issues are immediately brought to the attention of the individual agencies, and for cases also referred to the Child Abuse and Neglect Panel, the Office of the Investigation Coordinator presents those findings to the Panel.

Output: Heather Meitner from the National Council on Crime and Delinquency's Children's Research Center provided three full day trainings on 5/30/18 (Sussex County), 5/31/18 (Kent County), and 6/1/18 (New Castle County) to approximately 100 DFS investigators, supervisors and other staff (See Appendix G: SDM System Refresher).

Outcome: Improve safety assessment and planning in the civil response to cases of child abuse and neglect cases.

d. Activity: Provide MDT Scholarships to representatives involved in the investigation, prosecution and judicial handling of cases of child abuse and neglect

Description: Partial scholarships were provided to representatives from the multidisciplinary team, who were directly responsible for the investigation and prosecution of child abuse and neglect cases or the review of such cases, to give them the opportunity to attend national conferences, to learn advanced techniques, and to enhance their relationship with other members of the MDT. Priority was given to representatives from the Division of Family Services, Office of the Investigation Coordinator, statewide law enforcement agencies, criminal/civil Deputy Attorneys General from the Department of Justice, Children's Advocacy Center forensic interviewers, and related child welfare partners such as hospital based Sexual Assault Nurse Examiners. CJA funds were used to pay for travel and per diem expenses.

Task Force Recommendation(s): 1. Support of training and education initiatives related to the investigation and prosecution of child abuse and neglect cases using a multidisciplinary team approach.

Description of Evaluation Work

Evaluation Methods: As previously mentioned, the Task Force relied on the reviews of child abuse and neglect deaths and near deaths by the CPAC Child Abuse and Neglect Panel and cases monitored by the Office of the Investigation Coordinator to evaluate the effectiveness of the multidisciplinary response to child abuse and neglect cases.

Output: Six representatives attended the 30th Annual Crimes Against Children Conference from August 13-16, 2018. The representatives were from the Delaware State Police, Department of Justice, Division of Family Services, Children's Advocacy Center, and Office of the Child Advocate. Four representatives attended the Sixteenth International Conference on Shaken Baby Syndrome/Abusive Head Trauma from September 16-18, 2018. The representatives were from the Delaware State Police, New

Castle County Police Department, and Office of the Investigation Coordinator. Nine representatives attended the 35th International Symposium on Child Abuse from March 19-21, 2019. The representatives were from the Delaware State Police, Department of Justice, Division of Family Services, New Castle County Police Department, Office of the Investigation Coordinator and the Office of the Child Advocate. Representatives from Delaware also presented on the MDT Best Practices MOU at the 30th Annual Crimes Against Children Conference and the 35th International Symposium on Child Abuse to support other states in implementing best practice guidelines. A presentation was also given on Infants with Prenatal Substance Exposure and their Families at the Symposium by the DFS Director and Child Abuse Investigation Coordinator.

Outcome: Improved understanding of best practices associated with the investigation and prosecution of cases of child abuse and neglect, child death and child sexual abuse; and, improved reviews of child abuse and neglect deaths and near deaths.

e. Activity: Train Professionals on the Recognition and Reporting of Child Abuse and Neglect through in-person and web-based training

Description: The Task Force is responsible for overseeing the statewide training on the recognition and reporting of child abuse and neglect. CPAC accomplishes this through its existing mandatory reporting training programs for educators, medical professionals, and general community and professional audiences. The training programs are revised and updated annually by the Training Specialist with oversight by the Mandatory Reporting Workgroup, and the web-based trainings are available on OCA's online training system and other agency's learning management systems, as appropriate. CJA funds were used to pay annual fees for the Articulate: E-learning software and Survey Monkey, and monthly fees for OCA's online training system.

Task Force Recommendation(s): 1. Support of training and education initiatives related to the investigation and prosecution of child abuse and neglect cases using a multidisciplinary team approach; and, 2. Recommend education for medical providers around the standard of care for providing medical exams to siblings and other children in the home.

Description of Evaluation Work

Evaluation Methods: Surveys were used as the evaluation method for the mandatory reporting trainings (See Appendix H: Mandatory Reporting Training Evaluations). The survey responses not only help with identifying the training needs but other necessary resources or tools for mandated reporters.

Output: As previously mentioned, in December 2018, the Training Specialist finalized a 3 in 1 Mandatory Reporting Training – a combined web-based training program for medical professionals, educators and general professional audiences. In addition, the education required for medical providers around the standard of care for providing medical exams to siblings and other children in the home was included in this training. The training was uploaded to OCA's online training system. In March 2019, the Training Specialist updated the in-person Mandatory Reporting Trainings for medical professionals, educators, and general professional audiences. She was able to reduce the amount of text and add more visuals on the presentations to make them more appealing to in-person audiences. In response to feedback from the training evaluations, she developed a magnet and handout to help mandated reporters recall the Report Line number and minimal facts questions for talking to children about knowledge or suspicion of child abuse/neglect.

Staff from the Division of Family Services and Office of the Child Advocate conducted in-person training sessions for 120 educators and 186 participants from general professional audiences. For the web-based training on OCA's online training system, 396 participants completed the training for general community and professional audiences, 379 completed the training for educators, and 5,833 completed the training for medical professionals. Another 9,674 educators completed the web-based training through the Department of Education's Blackboard course management system.

Outcome: Improved recognition and response to suspicions of child abuse and neglect by educators, medical providers and general community and professional audiences.

f. Activity: Make web-based training available to the child welfare community through OCA's Online Training System

Description: OCA's online training system was utilized to provide web-based training to professionals statewide. The training programs include: Child Abuse and Neglect 101; Children's Advocacy Center of Delaware 101; Court Appointed Special Advocates Legal Boot Camp; Delaware's Child Protection Registry; Extended Jurisdiction; Youth Engagement in Court; the Family Court Called: You've Been Appointed; 3 in 1 Mandatory Reporting Training; and Minimal Facts: Guidelines for Mandated Reporters. CJA funds were used to pay the monthly fees to TraCorp, the company that hosts OCA's online training system, and the annual fees for the Articulate: E-learning software and Survey Monkey.

Task Force Recommendation(s): 1. Support of training and education initiatives related to the investigation and prosecution of child abuse and neglect cases using a multidisciplinary team approach; and, 2. Recommend education for medical providers around the standard of care for providing medical exams to siblings and other children in the home.

Description of Evaluation Work

Evaluation Methods: All web-based training programs are evaluated utilizing Survey Monkey.

Output: OCA's online training system has provided web-based training and resources to over 16,400 users since its inception in 2012. All web-based training can be accessed through OCA's online training system at http://ocade.server.tracorp.com/. Additional advanced training programs have been developed, but are still being reviewed by workgroups under the Task Force. Upon approval, these training programs will be made available on OCA's online training system utilizing the Articulate: E-learning software. In FFY20, OCA plans to transition from TraCorp, the current company that hosts OCA's online training system, to the Delaware Learning Center. The Delaware Learning Center is the State of Delaware's learning management system, which is utilized by various state agencies to train its employees and contractors. They are willing to work with OCA to make it available to outside users such as medical professionals, educators and general professional audiences.

Outcome: Improved access to child welfare trainings developed by the Task Force.

g. Activity: Attend the CJA Grantee Meeting/National Citizen Review Panel Conference

Description: The CJA Coordinator and Task Force Chairperson attend the annual CJA Grantee Meeting and the National Citizen Review Panel Conference due to CPAC's roles as the CJA Task Force and Citizen Review Panel. CJA funds were used to pay for travel and per diem expenses.

Need: To fulfill the CAPTA requirements as the CJA Task Force and Citizen Review Panel, attendance at these meetings is necessary.

Description of Evaluation Work

Output: The Chief Policy Advisor/CJA Coordinator and the Division of Family Services representative on the Child Abuse and Neglect Panel attended the National Citizen

Review Panel Conference from June 5-7, 2018. A workshop was presented on the MDT Best Practices MOU. In addition, the Chief Policy Advisor/CJA Coordinator and Executive Director of CPAC attended the CJA Grantee Meeting on April 23-24, 2019.

Outcome: Distinct path forward in the dual role as the CRP and CJA Task Force; and improved understanding of the obligations under each and where the obligations intersect.

ii. Description of Activities Aligned with the Children and Family Services Plan (CFSP) and Annual Progress and Services Report (APSR)

a. State of Delaware CFSP - 2019 APSR Priorities:

1. *Continue to implement, train and promote Safety Organized Practice (SOP), Structured Decision Making® (SDM®), differential responses to reports of abuse and neglect, Team Decision Making (TDM), family search and engagement and timely permanency strategies.*

   The Task Force originally recommended that the Division of Family Services adopt SDM in 2012, and the suite of tools was adopted shortly thereafter. Since then, the Task Force has continued to monitor the implementation and use of the SDM Safety and Risk Assessment tools, child safety agreements and TDM meetings. In fact, the Task Force identified the following recommendations related to Safety and Risk Assessment in its 2018 Three-Year Assessment: 1. Provide ongoing training on the SDM Risk Assessment tool to reinforce the policy and ensure consistent application; and 2. 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.

   During the reporting period, the Task Force monitored implementation and use of the SDM Safety and Risk Assessment tools through the reviews of child abuse and neglect deaths and near deaths by the CPAC Child Abuse and Neglect Panel and cases monitored by the Office of the Investigation Coordinator. During this reporting period, the Child Abuse and Neglect Panel had 122 findings and 67 strengths related to the safety and risk assessment (See Appendix I: Child Abuse and Neglect Panel Findings and Strengths – Safety and Risk Assessment). Half of the findings (62) and 35 strengths were directly related to the SDM Safety and Risk Assessment tools. At every quarterly meeting, the Task Force reviews the work of the Panel and findings and strengths related to assessing child safety, and a letter is submitted to the Governor, General Assembly and public describing how it plans to address the issues

identified. The DFS representative on the Child Abuse and Neglect Panel also shares these findings and strengths with DFS staff and administrators.

Additionally, as previously mentioned, the Office of the Investigation Coordinator monitored 1,328 cases (17 deaths, 58 serious physical injury cases, and 1,253 suspected sexual abuse cases) in SFY18 by initiating and facilitating communication between the MDT and addressing any issues with non-compliance of the MDT Best Practices MOU. The IC also provides the county based MDT members with an email notification upon receipt of child victims of serious physical injury and death to ensure a coordinated, immediate MDT response. Issues around safety assessment and the need for out-of-home interventions are discussed in this notification. Any issues related to safety or risk assessment were brought to the immediate attention of the Division of Family Services administration. For cases also referred to the Child Abuse and Neglect Panel, the Office of the Investigation Coordinator presents those findings to the Panel.

2. *Implement policy and provisions for plans of safe care for substance-exposed infants.*

In May 2015, CPAC and CDRC voted to create a specialized Joint Committee on Substance-Exposed Infants and Medically Fragile Children. This Joint Committee was formed to address a number of systemic findings from the reviews of child abuse and neglect deaths and near deaths. During the reporting period, the Committee continued to receive In-Depth Technical Assistance for Substance Exposed Infants (SEI-IDTA) through the National Center on Substance Abuse and Child Welfare (NCSACW). As part of the SEI-IDTA, representatives from the Committee participated in a Policy Academy along with 10 other states and developed a state action plan. The Committee successfully completed its Action Plan goals during the SFY18 and accomplished the following: implemented universal screening of pregnant women in all birthing facilities; established a system of care and educational resources for medical providers, birth hospitals, treatment providers and social service agencies; implemented a universal statewide protocol for the preparation and monitoring of Plans of Safe Care for infants with prenatal substance exposure and their affected families; and, maintained an awareness of the effects of stigma in discouraging women from treatment or prenatal care. The SEI-IDTA will be ending in SFY19.

In October 2017, the Committee supported the implementation by the Division of Family Services of the Plan of Safe Care Pilot Program in two birthing hospitals in Sussex County. The Pilot Program was expanded in January 2018 to include Kent

County hospitals. In early SFY19, the New Castle County hospitals implemented the protocol. Now, all 6 birthing hospitals have implemented the Plan of Safe Care protocol as of August 2018. Thanks to the leadership at the Division of Services, under the direction of Director Trenee Parker, Delaware is the first state to have statewide implementation in all birthing hospitals. In CY18, there were 612 notifications to DFS. There were approximately 152 more notifications in 2018 than in 2017.

Presently, the Committee is monitoring the implementation of a federal Regional Partnership Grant award to increase the well-being of and to improve the permanency outcomes for children affected by substance abuse. It is a prenatal intervention model that will target pregnant women who are engaged in medication assisted treatment to provide wraparound, multidisciplinary services, including a home visiting nurse, peer recovery coach and parenting classes. Children and Families First is the lead agency for the grant, and the model of care is Delaware's H.O.P.E. Model – "Healthy Outcomes with Parent Engagement." The Committee also remains a steadfast partner with Director Parker and her DFS team, whose commitment of personnel, time and resources to improve services and resources for these infants and their families cannot be understated.

3. *Continue collaboration with community partners in implementing and monitoring goals and activities of the CFSP and CFSR-PIP through quarterly CPAC meetings, CPAC committee meetings and the CFSP annual stakeholder meeting. Family Court, private foster care providers and health care representatives are involved in CFSR-PIP activity implementation and monitoring.*

   As a continuous quality improvement activity, the Division of Family Services held an annual stakeholder meeting on March 27, 2019 to present program accomplishments and priorities, review performance measures, and gather stakeholder input to inform the coming year's strategic planning. One hundred nine stakeholders were invited. Sixty stakeholders attended representing community service agencies, advocates, Family Court, Administration for Children and Families Region III, foster parents, caseworkers and the Chief of the Nanticoke Indian Association. Representatives from the DFS sister divisions, Division of Prevention and Behavioral Health Services (DPBHS) and the Division of Management Support Services (DMSS), were in attendance. The DFS Director, Deputy Director, regional administrators and program managers were also present. The agenda included a review of the agency's mission and vision, guiding principles, contextual data,

population statistics and performance measures. The group provided input on child welfare strengths and areas of concern.

The worries expressed by the stakeholders were as follows:

- Caseload and workload is too high.
- Collaboration with families, youth, team members and other service providers can be improved.
- There is a gap of efforts and services to prevent foster care entry.
- Visitation for foster children is too infrequent, lacks good quality and normalcy.
- Partners and the general public have misperceptions of DFS functions/roles; cross-training with partners would help as would community education.
- There are inconsistent services driven by changes in service team members.

The strengths noted by the stakeholders were as follows:

- Child Abuse and Neglect Panel case reviews indicate safety agreements being implemented and reviewed timely.
- Absence of Maltreatment measure has improved.
- Low foster care re-entry rate.
- Children are not maltreated in foster care.
- Team Decision Making (TDM) meetings continue.
- Relative and non-relative supports have increased.
- Safety plans, TDMs add another protective adult in the home.
- Across systems, we are seeing a bigger picture of child welfare outcomes.
- Community awareness of child abuse is rising as evidenced by rising Report Line calls.
- Delaware has a strong commitment to youth not only in the Department but in the community as well.
- Delaware has strong performance for well-being measures.
- Improving family engagement.
- Strong public-private partnerships committed to good outcomes for children and families.

Comments and suggested edits to the 2020-2024 CFSP were accepted until April 23, 2019. DFS completed the CFSR PIP 2-year implementation period on March 31, 2019. Additional time was reserved for reporting case review measurements. Representatives from the Court Improvement Program and private foster care providers were key partners in completing PIP activities. The Chief Policy Advisor/CJA Coordinator also participated on the Safety PIP.

In addition, agency and community partners were asked to submit an annual report for the APSR detailing their agency's accomplishments and priorities. The Chief Policy Advisor/CJA Coordinator submitted a report on behalf of CPAC/OCA and all if its program areas, including the Court Appointed Special Advocates Program, the Child Abuse and Neglect Panel, and the Office of the Investigation Coordinator. DFS distributes the APSR to stakeholders annually, and the reports are made available at the following link: http://kids.delaware.gov/fs/fs_cfs_review_plan.shtml.

C. Prior Year Line Item Budget Expenditures (May 2018-May 2019)

While CJA funds must be obligated and liquidated no later than two years after the end of the fiscal year in which the funds are awarded, Delaware has always obligated and liquidated the funds during the second year of the grant award. For instance, the FFY16 grant award was received in September 2016. However, CPAC did not begin obligating those funds until October 1, 2017; the remaining funds were obligated and liquidated by September 30, 2018. As a result of this practice, both FFY16 and FFY17 funds were used during the reporting period. As such, partial budgets will be listed below.

FFY16 (Grant Award $88,978) **May 16, 2018 - September 30, 2018**		**FFY17 (Grant Award $88,956)** **October 1, 2018 – May 15, 2019**		
Funding Activity	**Total**	**Funding Activity**	**Total**	**Grand Total**
Training Specialist	$16,335.00	Training Specialist	$16,815.16	$33,150.16
Equipment	$2,211.61	Equipment	$1,344.53	$3,556.14
Comprehensive Training to MDT	$0.00	Comprehensive Training to MDT	$27,201.96	$27,201.96
SDM Refresher	$1,012.50	SDM Refresher	$0.00	$1,012.50
MDT Scholarships	$8,905.53	MDT Scholarships	$3,823.10	$12,728.63
Web-based Training	$2,985.73	Web-based Training	$1,935.00	$4,920.73
CJA Grantee Meeting/National Citizen Review Panel Conference	$1,378.29	CJA Grantee Meeting/National Citizen Review Panel Conference	$1,791.00	$3,169.29
Total FFY16 Funds	**$32,828.66**	**Total FFY17 Funds**	**$52,910.75**	**$85,739.41**

D. Application for Proposed Activities (September 2019-September 2020)

i. Description of Proposed Activities Using CJA Funds

a. Activity: Contract with a Training Specialist

Description: The Task Force will contract with a Training Specialist to provide administrative support to CPAC for all child abuse intervention training activities related to the CJA grant, including the mandatory reporting training programs and any ongoing comprehensive training to multidisciplinary team members and other professionals. The position will be contracted by OCA, on behalf of CPAC, and no benefits will be provided.

Goal(s): Education on child abuse intervention is coordinated and accessible to child welfare professionals and others statewide.

Objective(s): 1. Identify the training needs of the Task Force; 2. Annually update and revise the mandatory reporting training programs; 3. Organize in-person mandatory reporting training to educators and general professional audiences; 4. Organize train-the-trainer sessions; 5. Develop advanced training programs both in-person and web-based; 6. Evaluate the effectiveness of all training programs; 7. Organize in-person training programs with local and national subject matter experts; 8. Maintain the number of professionals trained; 9. Utilize available software to develop web-based training programs; 10. Provide technical support to users on OCA's online training system; 11. Manage the online training system and surveys; and 12. Staff the CPAC Training Committee.

Reform of State Systems: This activity contributes to the investigative, administrative, and judicial handling of cases of child abuse and neglect.

Task Force Recommendation(s): 1. Support of training and education initiatives related to the investigation and prosecution of child abuse and neglect cases using a multidisciplinary team approach; 2. Recommend education for medical providers around the standard of care for providing medical exams to siblings and other children in the home; and, 3. 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.

Description of Evaluation Methods: The Chief Policy Advisor/CJA Coordinator will submit quarterly program reports to the Criminal Justice Council, the agency responsible for the fiscal management of the grant. The quarterly reports will describe the

accomplishments and activities of the Training Specialist together with the other activities listed in the CJA grant application. The Chief Policy Advisor/CJA Coordinator will also meet with staff from the Criminal Justice Council to discuss these activities and progress towards meeting the task force recommendations and the extent to which it contributes to the reform of state systems. Lastly, the Chief Policy Advisor/CJA Coordinator will meet monthly with the Training Specialist and evaluate the contract annually.

b. Activity: Provide Ongoing Comprehensive Training to Multidisciplinary Team Members and Others involved in the Judicial/Administrative Handling of Cases

Description: The Task Force will provide regular training and demonstrative tools to investigators and prosecutors involved in the investigation and prosecution of child abuse and neglect cases. The training will be targeted to the Division of Family Services, Office of the Investigation Coordinator, statewide law enforcement agencies, criminal/civil Deputy Attorneys General from Department of Justice, Children's Advocacy Center forensic interviewers and clinicians, and related child welfare partners such as hospital based Sexual Assault Nurse Examiners. Training will also be made available to professionals involved in the judicial and administrative handling of child abuse cases.

Goal(s): Specialized training will be provided to professionals involved in the investigative, administrative, and civil and criminal judicial handling of child abuse cases.

Objective(s): 1. Provide ongoing training on the MDT Best Practices MOU, including the coordination of medical services and safety planning during a child's hospital admission and the revisions to the MDT Case Review Protocol; 2. Facilitate ongoing county-based trainings for law enforcement agencies on conducting doll re-enactments in child abuse and neglect death and near death cases; 3. Promote use of the mobile application on MDT Best Practices MOU; 4. Facilitate and sponsor the ChildFirst™ Forensic Interviewing Training for professionals involved in the investigative handling of child abuse cases; and, 5. Sponsor a one-day advanced workshop on topics relevant to professionals involved in the investigative, administrative, and civil and criminal judicial handling of child abuse and neglect cases.

Reform of State Systems: This activity contributes to the investigative, administrative, and judicial handling of cases of child abuse and neglect as well as the reform of State protocols and procedures.

Task Force Recommendation(s): 1. Support of training and education initiatives related to the investigation and prosecution of child abuse and neglect cases using a

multidisciplinary team approach; 2. 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, law enforcement 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; and, Provide a list of direct contact numbers for all forensic nurse examiner teams and identified medical coordinators of care to the MDT; 3. 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; and, 4. Recommend education for medical providers around the standard of care for providing medical exams to siblings and other children in the home.

Description of Evaluation Methods: The Task Force will use the reviews of child abuse and neglect deaths and near deaths by the CPAC Child Abuse and Neglect Panel and cases monitored by the Office of the Investigation Coordinator to evaluate the effectiveness of the multidisciplinary response to child abuse cases and neglect cases. In addition, Survey Monkey will be used to evaluate the training programs.

c. Activity: Provide MDT Scholarships to representatives involved in the investigation, prosecution and judicial handling of cases of child abuse and neglect

Description: Partial scholarships will be provided to representatives from the multidisciplinary team, who are directly responsible for the investigation and prosecution of child abuse and neglect cases or the review of such cases, to give them the opportunity to attend national conferences, to learn advanced techniques, and to enhance their relationship with other members of the MDT. Priority will be given to representatives

from the Division of Family Services, Office of the Investigation Coordinator, statewide law enforcement agencies, criminal/civil Deputy Attorneys General from the DOJ, Children's Advocacy Center forensic interviewers, and related child welfare partners such as hospital based Sexual Assault Nurse Examiners. The national conferences may include: San Diego International Conference on Child and Family Maltreatment; the International Conference on Shaken Baby Syndrome/Abusive Head Trauma; the International Symposium on Child Abuse; and the Annual Crimes Against Children Conference.

Goal(s): Specialized training will be provided to investigators and prosecutors responsible for the most difficult child abuse and neglect cases.

Objective(s): Offer partial scholarships to representatives from the MDT to attend national conferences.

Reform of State Systems: This activity contributes to the investigative, administrative, and judicial handling of cases of child abuse and neglect.

Task Force Recommendation(s): Support of training and education initiatives related to the investigation and prosecution of child abuse and neglect cases using a multidisciplinary team approach.

Evaluation Methods: The Task Force will use the reviews of child abuse and neglect deaths and near deaths by the CPAC Child Abuse and Neglect Panel and cases monitored by the Office of the Investigation Coordinator to evaluate the effectiveness of the MOU.

d. Activity: Train Professionals on the Recognition and Reporting of Child Abuse and Neglect through in-person and web-based training

Description: The Task Force is responsible for overseeing the statewide training on the recognition and reporting of child abuse and neglect. CPAC accomplishes this through its existing mandatory reporting training programs for educators, medical professionals, and general community and professional audiences. The training programs are revised and updated annually by CPAC staff, and the web-based trainings are available on OCA's online training system.

Goal(s): Enhanced recognition and reporting of child abuse and neglect.

Objective(s): Provide in-person and web-based mandatory reporting training to educators, medical professionals and general professional audiences.

Reform of State Systems: This activity contributes to the investigative, administrative, and judicial handling of cases of child abuse and neglect.

Task Force Recommendation(s): 1. Support of training and education initiatives related to the investigation and prosecution of child abuse and neglect cases using a multidisciplinary team approach; and, 2. Recommend education for medical providers around the standard of care for providing medical exams to siblings and other children in the home.

Evaluation Methods: Surveys will be used as the evaluation method for the mandatory reporting trainings.

e. Activity: Make web-based training available to the child welfare community through OCA's Online Training System

Description: OCA's online training system will be utilized to provide web-based training to professionals statewide. The current training programs include: Child Abuse and Neglect 101; Children's Advocacy Center of Delaware 101; Court Appointed Special Advocates Legal Boot Camp; Delaware's Child Protection Registry; Extended Jurisdiction; Youth Engagement in Court; the Family Court Called: You've Been Appointed; 3 in 1 Mandatory Reporting Training; and Minimal Facts: Guidelines for Mandated Reporters.

Goal(s): 1. Education on child abuse intervention is coordinated and accessible to child welfare professionals and others statewide; and, 2. Enhanced recognition and reporting of child abuse and neglect.

Objective(s): 1. Partner with the Delaware Learning Center to host web-based trainings on OCA's online training system; 2. Utilize Articulate: E-learning software and/or a professional videography services to develop additional web-based training programs; 3. Research topics on child abuse intervention or utilize subject matters experts to develop the advanced training courses; and, 4. Maintain training evaluations through Survey Monkey.

Reform of State Systems: This activity contributes to the investigative, administrative, and judicial handling of cases of child abuse and neglect.

Task Force Recommendation(s): 1. Support of training and education initiatives related to the investigation and prosecution of child abuse and neglect cases using a multidisciplinary team approach; and, 2. Recommend education for medical providers

around the standard of care for providing medical exams to siblings and other children in the home.

Evaluation Methods: All web-based training programs will be evaluated utilizing Survey Monkey. The online training system will be evaluated based on the amount of technical assistance needed from the Training Specialist and the comments about technical issues listed in the survey results.

f. Attend the CJA Grantee Meeting/National Citizen Review Panel Conference

Description: The CJA Coordinator and Task Force Chairperson will attend the annual CJA Grantee Meeting and the National Citizen Review Panel Conference due to CPAC's roles as the CJA Task Force and Citizen Review Panel.

E. **Proposed Line Item Budget** (September 2019-September 2020)

FFY18 (Grant Award $88,957.00)	
Funding Activity	**Total**
Training Specialist	$54,600.00
Comprehensive Training to MDT	$15,000.00
MDT Scholarships	$14,000.00
Web-based Training	$1,000.00
CJA Grantee Meeting/National Citizen Review Panel Conference	$4,357.00
Total FFY18 Funds	**$88,957.00**

F. Governor's Letter

STATE OF DELAWARE
OFFICE OF THE GOVERNOR
TATNALL BUILDING, SECOND FLOOR
MARTIN LUTHER KING, JR. BOULEVARD SOUTH
DOVER, DELAWARE 19901

JOHN CARNEY
GOVERNOR

PHONE (302) 744-4101
FAX (302) 739-2775

May 31, 2019

Jerry Milner, Acting Commissioner
Administration on Children, Youth and Families (ACYF)
Mary E. Switzer Building
330 C Street, SW
Washington, D.C. 20201

Dear Acting Commissioner Milner:

Delaware is pleased to submit an application for funding under the Children's Justice Act. Please be assured of the following:

- Delaware received the FY 2018 child abuse and neglect Basic State Grant and continues to comply with the requirements stipulated in Section 106(b) of the Act;
- Delaware has maintained a State multidisciplinary task force on children's justice;
- Delaware has adopted or continues to progress in adopting recommendations of the State Task Force or a comparable alternative to such recommendations;
- Delaware will make such reports to the Secretary as may reasonably be required, including an annual report on how assistance received under this program was expended throughout the State, with particular attention to the areas described in paragraphs (1) through (3) of Section 107(a);
- Delaware will maintain and provide access to records relating to activities under CJA; and
- Delaware will participate in at least one Federally initiated CJA meeting each year that the grant is in effect and are authorized to use grant funds to cover travel and per diem expenses for two CJA representatives (CJA Coordinator and Task Force Chairperson) to attend the meeting.

We are looking forward to continuing the projects supported by these funds.

Sincerely,

John C. Carney
Governor

G. Certification Regarding Lobbying

CHILDREN & FAMILIES

CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, ``Disclosure Form to Report Lobbying,'' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, ``Disclosure Form to Report Lobbying,'' in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature 

Title Child Advocate

Organization Office of the Child Advocate

III. Appendices

State of Delaware Child Protection Accountability Commission Quarterly Meeting Minutes

WEDNESDAY, MAY 23, 2018
9:00 AM – 12:00 PM – New Castle County Courthouse
500 King Street, 12th Floor, Wilmington, Delaware

Those in Attendance:

Members of the Commission:	Statutory Role:
Trenee Parker	Director, Division of Family Services 16 Del. C. § 931(a)(2)
James Kriner, Esq.	Two Representatives from the Attorney General's Office 16 Del. C. § 931(a)(3)
Abigail Layton, Esq.	Two Representatives from the Attorney General's Office 16 Del. C. § 931(a)(3)
The Honorable Michael Newell	Family Court 16 Del. C. § 931(a)(4)
The Honorable Joelle Hitch	Family Court 16 Del. C. § 931(a)(4)
Susan Haberstroh	Secretary of the Department of Education 16 Del. C. § 931(a)(8)
Robert Dunleavy	Director, Div. of Prevention of Behavioral Health Services 16 Del. C. § 931(a)(9)
Maureen Monagle	Chair of the Domestic Violence Coordinating Council 16 Del. C. § 931(a)(10)
Cpl. Adrienne Owen	Designee for Superintendent of the Delaware State Police 16 Del. C. § 931(a)(11)
Dr. Garrett Colmorgen	Chair of the Child Death Review Commission 16 Del. C. § 931(a)(12)
Jennifer Donahue, Esq.	The Investigation Coordinator 16 Del. C. § 931(a)(13)
Nicole Magnusson	Young Adult 16 Del. C. § 931(a)(14)
Kathryn Lunger, Esq.	One Representative from the Public Defender's Office 16 Del. C. § 931(a)(15)
Dr. Allan De Jong	At-large Member - Medical Community 16 Del. C. § 931(a)(16)
Major Robert McLucas	At-large Member - Law Enforcement 16 Del. C. § 931(a)(16)
Randall Williams	At-large Member - Child Protection Community 16 Del. C. § 931(a)(16)
Janice Mink	At-large Member - Child Protection Community 16 Del. C. § 931(a)(16)

Staff:
Kelly Ensslin, Esq.
Rosalie Morales
Stepfanie Scollo

Members of the Public:

Addie Assay, Esq.	Mariann Kenville-Moore	Anne Pedrick	Eleanor Torres, Esq.
Bridget Brainard	Sgt. Jamie Leonard	Jennifer Perry	Kendal Trickey
Islanda Finamore, Esq.	Sue Murray	Marissa Reed	Lauren Vella
Meg Garey	Rachael Neff	Leigh Rosetti	Brittany Willard

I. CHAIRPERSON'S WELCOME AND INTRODUCTIONS

Janice Mink opened the meeting and welcomed the attendees.

II. APPROVAL OF MINUTES

The minutes from February 14, 2018 were approved with one noted revision. A motion was made by Dr.

Colmorgen to approve the minutes, and the Honorable Michael Newell seconded the motion. All others were in favor. The motion carried.

III. EXECUTIVE DIRECTOR'S REPORT

Kelly Ensslin, Esq. provided the Executive Director's report on Tania Culley's behalf. Currently, OCA is fully staffed, but two positions, a casual/seasonal Family Crisis Therapist and Training Coordinator, will become vacant in August. The volume in the Office of the Investigation Coordinator has been unmanageable, and resources internally are being shifted to assist with the monitoring of cases of child abuse and neglect. Additionally, Ms. Ensslin discussed the caseloads for the Deputy Child Advocates and Contract Child Attorneys, and shared that 4 contract attorneys retained their contracts for the next fiscal year. Court observations of Contract Child Attorneys were conducted in February. Ms. Ensslin also mentioned the CASA Recognition event that occurred in January and the new training for CASA Volunteers that was recently implemented.

Ms. Ensslin stated that Ms. Ward will be stepping down as CPAC Chair due to her business commitments, and Ms. Culley will be communicating with the Governor's Office after guidance from the CPAC Executive Committee.

IV. REVIEW AND APPROVAL OF JOINT ACTION PLAN

Rosalie Morales distributed the revised Joint Action Plan to the Commission and summarized the 4 prioritized recommendations. Ms. Morales also proposed that a prioritized recommendation be added regarding the statutory caseload mandates as required by 29 Del. C. § 9015. In addition to the prioritized recommendations, the Joint Action Plan includes the 7 additional recommendations identified by the Commission as well as the 10 ongoing recommendations from the 2016-2017 Joint Action Plan.

Since one of the prioritized recommendations relates to developing protocols that may impact the Delaware Multidisciplinary Team (MDT) Guidelines for Child Abuse Medical Response, Mr. Williams asked that the Training Committee's Child Abuse and Neglect Best Practices Workgroup consider the guidelines instead of creating something new.

A motion was made by Dr. Colmorgen to approve the 2018-2019 Joint Action Plan, and Mr. Williams seconded the motion. All others were in favor. The motion carried.

Ms. Morales added, every three years, CPAC is required to conduct a comprehensive review and evaluation of the investigative, administrative and judicial handling of cases of child abuse and neglect and to make training and policy recommendations to receive funding annually from the federal Children's Justice Act (CJA). The Joint Retreat and resulting Joint Action Plan satisfies this requirement under the grant. Therefore, Ms. Morales will be providing information about the Joint Retreat and Action Plan in Delaware's 2018 CJA Annual Progress Report and Grant Application and Three-Year Assessment Report, which is due on May 31, 2018.

V. INVESTIGATION COORDINATOR REPORT/SEI REPORT

Jennifer Donahue. Esq. shared an update on the policy initiatives involving infants with prenatal substance exposure and their families. Ms. Donahue talked about a recent site visit from the National Center on

Substance Abuse and Child Welfare and the expansion of the hospital pilot program to St. Francis and Christiana Care. The HOPE Model and passage of Aiden's Law was also discussed. Lastly, Ms. Donahue acknowledged her partnership with Trenee Parker in accomplishing these initiatives.

Additionally, Ms. Donahue reported on the quarter three data received by the Office of the Investigation Coordinator (IC). She noted that data was not received from the Division of Family Services (DFS) for the past 3 months due to implementation of their new data management system. Ms. Donahue presented on the death, serious physical injury and sexual abuse cases opened between January and March 2018 and provided an analysis of the open cases that were charged in the quarter.

VI. CPAC DATA DASHBOARD

Brittany Willard gave a presentation on the quarterly child welfare trends identified by the CPAC Data Utilization Committee. This included a discussion of the DFS caseloads, the DFS hotline reports, cases opened by the Child Abuse and Neglect (CAN) Panel, incidents received by the Children's Advocacy Center, children in DSCYF custody (entries and at the end of the quarter), Family Court hearing guidelines, and youth with a permanency plan of APPLA.

VII. CHILD ABUSE AND NEGLECT DEATH/NEAR DEATH REVIEWS

A. CAN CASELOADS REPORT/ADMINISTRATIVE UPDATE

Ms. Morales reported that there are 64 CAN cases open with 16 cases before the Commission today for approval. This month 4 initials will be reviewed by the CAN Panel, and another 12 cases will be reviewed between June and August. There are also 14 cases that are pending prosecution, and 11 cases that will be scheduled for a final review between now and August.

B. CAN FINDINGS/DETAILS/LETTER TO GOVERNOR

Janice Mink reported on the 16 cases reviewed by the CAN Panel in the last quarter. Twelve cases (3 deaths and 9 near deaths) were reviewed by the Panel for the first time and resulted in 67 strengths and 84 current findings across system areas. Ms. Mink also discussed the Governor's letter and how the strengths and findings were distributed along with the solutions CPAC has identified to address the system issues. Dr. Colmorgen motioned to approve the letter to the Governor and the Honorable Michael Newell seconded his motion. All other members voted in favor.

VIII. COMMISSIONER REPORTS

A. DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES

Secretary Josette Manning acknowledged the work of her staff in managing the DFS caseloads. In addition, Secretary Manning discussed the implementation of FOCUS, the Department's new data management system. Lastly, Secretary Manning recognized Trenee Parker and Sue Murray for the Division's accomplishments related to the hospital pilot program.

I. DIVISION OF FAMILY SERVICES

Trenee Parker shared that DFS staff now have smartphones. Additionally, Ms. Parker discussed the administrative support that has been provided to the regions to address the increased workloads for staff. Ms. Parker also reported on the recent activities with the Children's Research Center, and expansion of Family Assessment Intervention Response (FAIR) for teens and contracts for infants with prenatal substance exposure and families at risk of neglect due to domestic violence. Lastly, Ms. Parker discussed the revisions to the new worker training protocols.

II. PREVENTTION AND BEHAVIORAL HEALTH SERVICES

Bob Dunleavy discussed how the Division of Prevention and Behavioral Health Services (PBH) is prioritizing mental health support for DFS involved children. He shared that PBH is changing its crisis service provider in New Castle and Kent Counties; Delaware Guidance Services will be the provider as of June 1st. Mr. Dunleavy also talked about updates to the Youth Response Unit, which is a partnership between PBH and the Wilmington Police Department.

B. CHILD DEATH REVIEW COMMISSION

Dr. Garrett Colmorgen reported that the Child Death Review Commission's (CDRC) 2017 Annual Report was released last week. In addition, an update was provided on the Sudden Death in the Young Grant and the site visit by staff from the Centers for Disease Control and Prevention. Dr. Colmorgen also shared that CDRC and OCA staff participated in the National Child Death Review Meeting in early May.

C. FAMILY COURT

The Honorable Michael Newell shared an update on Kent County caseloads for judicial officers, quality hearing surveys, and the visit host pilot guidelines. In addition, Chief Judge Newell discussed how Family Court would like to conduct surveys of older youth to learn more about youth engagement. Lastly, Chief Judge Newell mentioned the Foster Care Conference held on May 17th and the Permanency Training scheduled for July 10th.

D. LAW ENFORCEMENT

Sgt. Leonard reported that the New Castle County Police Department (NCCCPD) completed its training of staff on the new Memorandum of Understanding for the MDT Response. In addition, NCCPD identified other cases in which there was a miscommunication about the medical findings, so they will be coming up with a plan to ensure the communication is better between all team members.

E. MEDICAL COMMUNITY

Dr. Allan De Jong gave an update on the Victims of Crime Act (VOCA) grant received by Nemours/Alfred I. duPont Hospital, including the recruitment of medical providers and implementation of the Guidelines for Child Abuse Medical Response. Dr. De Jong also discussed Dr. Stephanie Deutsch's participation in the MDT Case Review process.

IX. CPAC COMMITTEE REPORTS

A. TRAINING COMMITTEE'S MDT CASE REVIEW WORKGROUP

Jim Kriner, Esq. reported that the workgroup completed its revisions to the MDT Case Review Protocol. The revised protocol was included in the packet to CPAC, and the workgroup is seeking the Commission's approval of the protocol to pilot it in July. A motion was made by Mr. Williams to approve the protocol and seconded by Dr. Colmorgen. All other members voted in favor.

B. CASELOADS/WORKLOADS COMMITTEE

Sue Murray provided an update on the Caseload/Workload Study. She reported that DFS piloted the survey tool with a limited number of treatment workers and modifications were suggested. Following a meeting to discuss the modifications, the tool will be launched with all treatment staff. Rachael Neff added that the Child Welfare League of America reported that there is no universally adopted methodology to conduct this study, and that DFS and the Court are partnering with Delaware State University to help with the analysis.

X. NEW BUSINESS

A. Training on Teen Dating Violence

Maureen Monagle discussed an incident that occurred at a charter school and suggested that the board of directors recommended inappropriate consequences for the alleged offender. As a result, the board of directors should also be required to receive 2 hours of training on teen dating violence and sexual assault.

XI. PUBLIC COMMENT AND ADJOURNMENT

Mariann Kenville-Moore discussed Senate Bills 209 and 210. She asked the Commission to take a look at the bills and to provide comment. Secretary Manning made a motion to call a Legislative Committee meeting to discuss the bills. The motion was seconded by Abigail Layton, Esq. The Honorable Michael Newell and the Honorable Joelle Hitch abstained. All others voted in favor.

The meeting was adjourned at 11:40 a.m.

State of Delaware Child Protection Accountability Commission
Quarterly Meeting Minutes

WEDNESDAY, AUGUST 8, 2018
9:00 AM – 12:00 PM – New Castle County Courthouse
500 King Street, 12th Floor, Wilmington, Delaware

Those in Attendance:

Members of the Commission:	**Statutory Role:**
Ginger Ward, Chair	Child Protection Community 16 Del. C. § 931(a)(15)
James Kriner, Esq.	Two Representatives from the Attorney General's Office 16 Del. C. § 931(a)(3)
Rep. Valerie Longhurst	One member of the House of Representatives 16 Del. C. § 931(a)(5)
Robert Dunleavy	Director, Div. of Prevention of Behavioral Health Services 16 Del. C. § 931(a)(8)
Maureen Monagle	Chair of the Domestic Violence Coordinating Council 16 Del. C. § 931(a)(9)
Dr. Garrett Colmorgen	Chair of the Child Death Review Commission 16 Del. C. § 931(a)(11)
Jennifer Donahue, Esq.	The Investigation Coordinator 16 Del. C. § 931(a)(12)
Nicole Magnusson	Young Adult 16 Del. C. § 931(a)(13)
Kathryn Lunger, Esq.	One Representative from the Public Defender's Office 16 Del. C. § 931(a)(14)
Dr. Allan De Jong	At-large Member - Medical Community 16 Del. C. § 931(a)(15)
Randall Williams	At-large Member - Child Protection Community 16 Del. C. § 931(a)(15)
Janice Mink	At-large Member - Child Protection Community 16 Del. C. § 931(a)(15)
Ellen Levin	At-large Member - Child Protection Community 16 Del. C. § 931(a)(15)

Staff:
Tania Culley, Esq.
Rosalie Morales
Stepfanie Scollo

Members of the Public:

Addie Assay, Esq.	Caroline Jones	Sue Murray	Molly Shaw, Esq.
Deborah Colligan	Cindy Knapp	Anne Pedrick	Lori Sitler
Lise Esper	Sgt. Jamie Leonard	Jennifer Perry	Lauren Vella
Islanda Finamore, Esq.	Alyssa Moore	Meredith Seitz	Brittany Willard

I. CHAIRPERSON'S WELCOME AND INTRODUCTIONS

Ginger Ward opened the meeting and welcomed the attendees. Ms. Ward also announced her resignation as chair, and this would be her last CPAC meeting.

II. APPROVAL OF MINUTES

The minutes from May 23, 2018 were approved. A motion was made by Dr. Colmorgen to approve the minutes, and Jim Kriner, Esq. seconded the motion. There was one abstention. All others were in favor, and the motion carried.

III. APPROVAL OF FINAL REPORT & PROTOCOL FOR DE-ESCALATION OF LIFE SUPPORT

Molly Shaw, Esq. presented the Final Report and Protocol for De-escalation of Life Support for Children in the Custody of the Department of Services for Children, Youth and Their Families (DSCYF) on behalf of the CPAC Training Committee's De-Escalation of Life Support Workgroup. The Workgroup recruited members from the medical profession, the judiciary, DFS and the legal community. Many of the workgroup members were involved in the *DSCYF v. Hunt* case and provided insight to the case. The Workgroup created a protocol detailing the best practices to be considered at every stage of a case in hopes that it provides an outline that will improve outcomes of future cases. A motion was made by Jennifer Donahue, Esq. to approve the Final Report and Protocol for De-Escalation of Life Support, and Janice Mink seconded the motion. All other were in favor. The motion carried.

IV. APPROVAL OF CHILD SAFETY PROGRAMS

Tania Culley, Esq. shared a history on SB 102 and explained that the CPAC Education Committee was charged with identifying the personal body safety educational programming for children, grades pre-kindergarten to 6, on behalf of CPAC and DSCYF. Rosalie Morales discussed the 4 personal body safety programs for students and the letter that will be distributed to parents explaining the programming. Ms. Morales also reported the Beau Biden Foundation and Prevent Child Abuse Delaware are applying for funding through the Longwood Foundation to deliver the programming to students and school employees, and they have requested a letter of support from CPAC. Lastly, Ms. Morales requested approval to add additional educational programming for school employees. Minimal Facts: Guidelines for Mandated Reporters, a 30-minute online module, will be added to the list of approved programs.

These items required approval from CPAC. Randy Williams motioned to approve the list of approved programs, and Dr. Colmorgen second. All others were in favor. The motion carried.

Dr. Colmorgen motioned to approved the letter to parents, and Janice Mink seconded. All others were in favor. The motion carried.

Dr. Colmorgen motioned to approve the letter of support, and Janice Mink seconded. All others were in favor. The motion carried.

Dr. Colmorgen motioned to approve the educational programming for school employees, and Janice Mink seconded. All others were in favor. The motion carried.

V. LEGISLATIVE COMMITTEE UPDATE

Tania Culley, Esq. reported the CPAC Legislative Committee met on June 8th and July 30th to discuss the impact of SB209 and SB210 on crimes against children, and to formulate next steps for CPAC. At the meetings, a representative from the Department of Justice (DOJ) discussed the differences between the current versus revised code, and its impact on crimes against children. The Committee formulated a draft letter summarizing the impact, and requesting changes to the proposed criminal code for consideration by the Commission. Janice Mink motioned for approval of letter, and Dr. Colmorgen seconded the motion. Jim Kriner, Esq. and Kathryn Lunger, Esq. abstained, and 11 other members voted in favor of the motion.

The motion carried. The letter will be sent on behalf of the Commission to the Administrative Office of the Courts to be submitted to the Criminal Justice Improvement Committee.

VI. EXECUTIVE COMMITTEE UPDATE

Prior to the Executive Committee update, Janice Mink announced her resignation from CPAC. After 19 years as a Commissioner, Ms. Mink will be retiring from CPAC, the Child Abuse and Neglect (CAN) Steering Committee, and the CAN Panel at the end of the calendar year. Therefore, her last Commission meeting will be on November 14, 2018.

Mr. Williams shared that the CPAC Executive Committee met twice to address funding for the Office of the Investigation Coordinator (IC) and the relocation of the Child Death Review Commission (CDRC) to OCA. OCA has already restructured its staff to provide additional support to IC; however, the IC needs additional resources to perform its statutory mandate along with the added responsibility of Multidisciplinary Team (MDT) Case Review. The Commission was also asked to approve a letter to the Administrative Office of the Courts, which requests four full-time state positions and the relocation of CDRC. Dr. Colmorgen motioned for approval of the letter, and Mr. Williams seconded the motion. All others voted in favor. The motion carried.

Mr. Williams also discussed the five CPAC vacancies. After some general discussion, the Commission suggested follow up activities, including recommendation letters for the proposed at-large members.

VII. CHILD ABUSE AND NEGLECT DEATH/NEAR DEATH REVIEWS

A. CAN CASELOADS REPORT/ADMINISTRATIVE UPDATE

Ms. Culley reported that there are 68 CAN cases open with 21 cases before the Commission today for approval. This month 3 initials and 5 finals will be reviewed by the CAN Panel, and another 19 cases are being prepared for an initial review. There are also 11 cases that are pending prosecution, and 9 cases that will be scheduled for a final review. Thus far, in 2018, there have been 17 near deaths and 8 deaths.

B. CAN FINDINGS/DETAILS/LETTER TO GOVERNOR

Janice Mink reported on the 21 cases reviewed by the CAN Panel in the last quarter. Twelve cases (2 deaths and 10 near deaths) were reviewed by the Panel for the first time and resulted in 79 strengths and 89 current findings across system areas. Ms. Mink also discussed the Governor's letter and how the strengths and findings were distributed along with the solutions CPAC has identified to address the system issues. Dr. Colmorgen motioned to approve the CAN packet, and Mr. Williams seconded his motion. All other members voted in favor. The motion carried.

VIII. EXECUTIVE DIRECTOR'S REPORT

Ms. Culley provided the Executive Director's report. She discussed the change in staffing in the OCA office. Currently, OCA is in the process of hiring a Family Crisis Therapist (FCT) position and CPAC Training Specialist. Gwen Stubbolo will be retiring in October, and OCA submitted a request to fill her position as CASA Program Director. Ms. Culley shared additional detail about the restructuring of staff to provide

support to IC, as well as the restructuring of the Managing Attorney and casual/seasonal Deputy Child Advocate positions. Three new Contract Child Attorneys were hired.

Next, Ms. Culley provided an update on recognition activities for volunteer attorneys and Court Appointed Special Advocate (CASA) volunteers. Awards are being issued to the volunteer attorneys; 114 attorneys have volunteered for ten years and 27 for fifteen years. CASA Volunteer plaques of recognition are up to date and are on display in the OCA conference room.

OCA recently implemented its new CASA training, and great feedback was received. The CASA Program is currently working on a recruitment plan and hopes to apply for a National CASA grant to develop a growth plan. Ms. Culley shared that OCA is designing a new data management system. Brittany Willard and her team continue to perform quality assurance measures against the excel spreadsheets to make sure the new system is working. IC will be the next program to be inputted into the data management system, followed by CAN.

Ms. Culley discussed CPAC's funding priorities, which are as follows: funding for IC positions, Ivyane D.F. Davis Memorial Scholarship, Division of Family Services (DFS) caseloads, Prevent Child Abuse Delaware funding for personal body safety educational programming for children, and the DOJ Special Victims Unit. The Chair and Executive Director will continue to send a letter annually to the Governor and then the Joint Finance Committee (JFC) with input from the Executive Committee.

Lastly, Ms. Culley discussed the legislative agenda, which includes changes around the exchange of MDT records and information, criminal child abuse changes, and revisions to the termination and transfer of parental rights statute and the definitions of abuse and neglect.

IX. JOINT LEGISLATIVE OVERSIGHT & SUNSET COMMITTEE FINAL REPORT

Ms. Culley discussed the Final Report of the Joint Legislative Oversight and Sunset Committee, which was distributed to CPAC via email. In addition to recommending that CPAC continue to exist, three recommendations were also put forward by the Committee. The first involved the Committee providing a letter to JFC in support of CPAC's funding priorities. The second recommendation was in support of the Committee co-sponsoring House Bill 140, Aiden's Law. Lastly, the Committee recommended a transition plan for the Executive Director since Ms. Culley plans to retire in 2021. Ms. Culley suggested the Executive Committee begin meeting at least twice a year.

X. INVESTIGATION COORDINATOR REPORT/SEI REPORT

Jennifer Donahue, Esq. shared that Aiden's Law was signed on June 7, 2018. On August 1st, Delaware was the first state in the country to have full implementation of Plans of Safe Care, and all hospitals in the state are participating in the hospital pilot programs. Ms. Donahue shared that the In-depth Technical Assistance from the National Center on Substance Abuse and Child Welfare will be ending soon; however, the experts plan to stay on as consultants. Additionally, the HOPE Model was implemented in September. The Joint Committee on Substance-Exposed Infants/Medically Fragile Children will continue to meet quarterly to oversee the HOPE Model and plans of safe care. The group is working on a plan of safe care implementation guide and possibly a mobile application.

Additionally, Ms. Donahue reported on the data received by the Office of the Investigation Coordinator (IC). Ms. Donahue presented on the death, serious physical injury and sexual abuse cases opened between April and June 2018 and provided an analysis of the open cases that were charged in the quarter. Ms. Donahue also discussed how the IC Referrals are used as reminders about the best practices in the Memorandum of Understanding for the MDT Response to Child Abuse and Neglect. The IC is also scheduling short presentations with MDT members to make sure other agencies are familiar with the office.

XI. CPAC DATA DASHBOARD

Brittany Willard gave a presentation on the quarterly child welfare trends identified by the CPAC Data Utilization Committee. This included a discussion of the DFS caseloads, the DFS hotline reports, interviews conducted by the Children's Advocacy Center, children in DSCYF custody (entries and at the end of the quarter), and number of youth on extended jurisdiction.

XII. COMMISSIONER REPORTS

A. DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES

I. DIVISION OF FAMILY SERVICES

Sue Murray discussed the administrative support that has been provided to the regions to address the increased workloads for staff. All case workers now have smart phones, and DFS is getting an estimate for Surface Pros. Ms. Murray also provided an update on the pilot for infants with prenatal substance exposure. The pilot is being expanded to New Castle County, and four workers have been identified. In addition, DFS plans to develop a statewide unit for these infants along with the serious injury and sexual abuse cases. The Caseloads/Workloads Study was also discussed. All treatment staff completed the month-long survey phase. The response rate was 60%. The next step is to analyze the data with assistance from Delaware State University and Brittany Willard.

II. PREVENTTION AND BEHAVIORAL HEALTH SERVICES

Bob Dunleavy provided an update on the change in crisis service provider to Delaware Guidance Services statewide. The complaints have decreased. Mr. Dunleavy also talked about the Youth Response Unit, which is now under Victims Services at the Wilmington Police Department. Prevention and Behavioral Health Services (PBH) has also been updating its technology for staff. PBH recently updated its telephone system for the intake unit, which includes a direct transfer to crisis services and DFS.

B. CHILDREN'S ADOVCACY CENTER

Mr. Williams shared that Governor Carney visited the Children's Advocacy Center (CAC) at the children's hospital on July 27, 2018 and raised a few questions about training parents on the Stewards of Children Program and using the schools to engage them. Mr. Williams will reach out to Patty Dailey Lewis at the Beau Biden Foundation to discuss this further. Additionally, Mr. Williams spoke about the

Victims of Crime Act (VOCA) grant that Nemours/Alfred I. duPont Hospital received to hire medical professionals to fully implement the CPAC Guidelines for the Child Abuse Medical Response. The positions have been posted, and there have been some preliminary interviews. The CAC filed an appeal for its re-accreditation with the National Children's Alliance. Mr. Williams plans to come back to CPAC for support with its 2020 budget requests. Lastly, the Children's Advocacy Center is sponsoring a training for the MDT on vicarious trauma and resilience. The group had its first multi-session training with Dr. Downing a few weeks ago.

C. DEPARTMENT OF JUSTICE

Jim Kriner, Esq. shared that the Special Victims Unit (SVU) received a Deputy position, which will be housed in Kent County. As a result, the SVU in New Castle and Kent Counties is handling all child abuse and sexual assault cases. CPAC will continue to include the SVU in it funding priorities as additional resources are still needed.

D. INTERAGENCY COMMITTEE ON ADOPTION

Cindy Knapp reported that they are planning an event for National Adoption Day on November 17th. The Interagency Committee on Adoption continues to work with law enforcement on providing training for working with children and youth who have been adopted.

E. PUBLIC DEFENDER'S OFFICE

Kathryn Lunger, Esq. mentioned that legislation recently passed expanding the Juvenile Civil Citation Program to provide law enforcement officers with the discretion to refer any first-time juvenile offender engaged in any misdemeanor-level behavior.

XIII. NEW BUSINESS

No new business.

XIV. PUBLIC COMMENT AND ADJOURNMENT

No public comment.

The meeting was adjourned at 11:27 a.m.

State of Delaware Child Protection Accountability Commission
Quarterly Meeting Minutes

WEDNESDAY, NOVEMBER 14, 2018
9:00 AM – 12:00 PM – New Castle County Courthouse
500 King Street, 12th Floor, Wilmington, Delaware

Those in Attendance:

Members of the Commission:	Statutory Role:
Mary Dugan, Esq., Chair	Child Protection Community 16 Del. C. § 931(a)(15)
The Hon. Josette Manning	Secretary of Services for Children, Youth & Their Families 16 Del. C. § 931(a)(1)
Trenee Parker	Director, Division of Family Services 16 Del. C. § 931(a)(2)
James Kriner, Esq.	Two Representatives from the Attorney General's Office 16 Del. C. § 931(a)(3)
Abigail Layton, Esq.	Two Representatives from the Attorney General's Office 16 Del. C. § 931(a)(3)
The Honorable Michael Newell	Family Court 16 Del. C. § 931(a)(4)
The Honorable Joelle Hitch	Family Court 16 Del. C. § 931(a)(4)
Rep. Valerie Longhurst	One member of the House of Representatives 16 Del. C. § 931(a)(5)
Susan Haberstroh	Designee for Secretary of the Department of Education 16 Del. C. § 931(a)(7)
Robert Dunleavy	Director, Div. of Prevention of Behavioral Health Services 16 Del. C. § 931(a)(8)
Maureen Monagle	Chair of the Domestic Violence Coordinating Council 16 Del. C. § 931(a)(9)
Cpl. Adrienne Owen	Designee for Superintendent of the Delaware State Police 16 Del. C. § 931(a)(10)
Dr. Garrett Colmorgen	Chair of the Child Death Review Commission 16 Del. C. § 931(a)(11)
Jennifer Donahue, Esq.	Investigation Coordinator 16 Del. C. § 931(a)(12)
Kathryn Lunger, Esq.	One Representative from the Public Defender's Office 16 Del. C. § 931(a)(14)
Ellen Levin	At-large Member - Child Protection Community 16 Del. C. § 931(a)(15)
Janice Mink	At-large Member - Child Protection Community 16 Del. C. § 931(a)(15)
Randall Williams	At-large Member - Child Protection Community 16 Del. C. § 931(a)(15)
Meg Garey	At-large Member – Interagency Committee on Adoption 16 Del. C. § 931(a)(15)
Cpt. Joseph Bloch	At-large Member – Law Enforcement Agency 16 Del. C. § 931(a)(15)
Dr. Allan De Jong	At-large Member - Medical Community 16 Del. C. § 931(a)(15)

Staff:
Tania Culley, Esq.
Rosalie Morales
Stepfanie Scollo

Members of the Public:

Deborah Colligan	Kathleen McCormick	Erin Ridout	Eleanor Torres, Esq.
Kelly Ensslin, Esq.	Sue Murray	JoAnn Santangelo	Lauren Vella
Islanda Finamore, Esq.	Rachael Neff	Meredith Seitz	Brittany Willard
Sgt. Jamie Leonard	Anne Pedrick	Lori Sitler	

State of Delaware Child Protection Accountability Commission
Quarterly Meeting Minutes

I. WELCOME/INTRODUCTIONS

Mary Dugan, Esq. was welcomed as the new Chair of the Child Protection Accountability Commission (CPAC). Dr. Elizabeth Higley, Captain Joseph Bloch, and Meg Garey were recognized as recently appointed Commissioners.

II. APPROVAL OF MINUTES

The minutes from August 8, 2018 were approved. A motion was made by Dr. Colmorgen to approve the minutes, and Dr. De Jong seconded the motion. There were four abstentions. All others were in favor, and the motion carried.

III. FY18 CPAC ANNUAL REPORT

Rosalie Morales presented the CPAC Annual Report to the Commission and highlighted CPAC's FY18 accomplishments. Secretary Josette Manning recommended a revision to the section of the report that describes the work of the Joint Committee on Substance-Exposed Infants/Medically Fragile Children. Ms. Morales will add language to acknowledge the leadership of Trenee Parker and her staff in implementing the Plan of Safe Care Protocol in all birthing hospitals. Randall Williams motioned to approve the report with the noted revision, and Dr. De Jong seconded. All voted in favor. The motion carried.

IV. EXECUTIVE COMMITTEE REPORT

Mr. Williams provided a report on the CPAC Executive Committee. First, the Committee asked the Commission to finalize the appointment of Ellen Levin as the Chair of the Child Abuse and Neglect (CAN) Panel and as a public member on the Executive Committee. At the meeting, Ms. Dugan, as the Chair of CPAC, signed a letter confirming Ms. Levin's appointments to these positions.

Next, Mr. Williams discussed the Judicial Branch's budget request to relocate all non-judicial agencies out of the judiciary. Mr. Williams shared that the Executive Committee is taking steps to address this issue and will keep the Commission informed. CPAC's budgetary requests were also reviewed. A draft letter was included in the packet to CPAC requesting four positions for the Office of the Investigation Coordinator (IC) and the relocation of the Child Death Review Commission (CDRC) to the Office of the Child Advocate (OCA). Mr. Williams asked the Commission to approve the letter to Mike Jackson, Director of the Office of Management and Budget (OMB). Janice Mink motioned for approval of the letter with the provision that the Executive Committee could modify it after a discussion with Mr. Jackson, and Mr. Williams seconded the motion. There were two abstentions. All others voted in favor. The motion carried.

Mr. Williams reported that the Committee is waiting on a response from the Administrative Office of the Courts (AOC) on the changes requested to the proposed Criminal Code. At its last quarterly meeting, CPAC approved and submitted a letter to AOC delineating these changes. Lastly, the Executive Committee plans to meet more frequently to support OCA/CPAC, and as a result, the bylaws will need to be amended to expand that support more formally.

V. EXECUTIVE DIRECTOR'S REPORT

Ms. Culley provided the Executive Director's report. She discussed the change in staffing in the OCA office. Melissa Palokas was hired as the Court Appointed Special Advocate (CASA) State Director. OCA was also given approval to fill the Sussex County Coordinator position vacated by Ms. Palokas. In addition, Bonnie McDaniel was hired as a casual/seasonal Family Crisis Therapist, and Kathleen McCormick was hired as the contractual CPAC Training Specialist. Kelly Ensslin, Esq. is now managing all volunteer attorneys, two contractual Child Attorneys, and helping run the CASA Program. As a result, a request for reclassification was recently submitted for Ms. Ensslin. If approved, Ms. Ensslin will oversee the entire CASA Program.

Ms. Culley discussed the flex training for new CASA volunteers. The training allows volunteers to complete part of the 30-hour new volunteer training online. A National CASA Grant was also awarded to OCA to bring in a consultant to help with volunteer recruitment. OCA's goal is for every child in the Department of Services for Children, Youth and Their Families (DSCYF) custody to be assigned a Child Attorney and CASA. OCA is also working with the Family Court and Department of Justice to develop a CASA Peer Mentor Program.

Lastly, Ms. Culley shared an update on OCA's new data management system, which was funded by the Family Court's Court Improvement Program (CIP). Ms. Culley added that CIP funds recently supported another ten users for OCA's data management system and funded the CPAC Data Manager and another staff member to attend a national conference to participate in advanced training on the system. Ms. Culley thanked Family Court for its unwavering support of OCA through funding of this data management system and for funding the CPAC Data Manager.

VI. TRIBUTE

The Commission acknowledged Janice Mink's retirement from CPAC. First, Secretary Manning presented Ms. Mink with a proclamation from Governor John Carney. In addition, Representative Valerie Longhurst presented Ms. Mink with tributes from the House and Senate. Next, Ms. Culley gave Ms. Mink a service award from the Commission for her 19 years of service as a CPAC Commissioner. Additionally, several CPAC Commissioners offered remarks about Ms. Mink's impact on the child welfare community, including the creation of OCA and her advocacy on the CAN Panel. Ms. Mink asked the Commission implement a panel to monitor and review child sexual abuse cases.

VII. CHILD ABUSE AND NEGLECT DEATH/NEAR DEATH REVIEWS

A. CAN CASELOADS REPORT/ADMINISTRATIVE UPDATE

Rosalie Morales reported that there are 75 CAN cases open with 19 cases before the Commission today for approval. There were 57 cases open this time last year, so the Panel saw a 32% increase. In October, the Panel reviewed three initials and two finals. Three initials and seven finals are scheduled for review tomorrow. Beginning in December, the Panel will go back to reviewing four cases a month, and in January, two panel meetings will be scheduled to stay in compliance with the statutory requirement to review these cases within six months. Between January and October, there were 13 deaths and 29 near deaths.

B. CAN FINDINGS/DETAILS/LETTER TO GOVERNOR

Janice Mink reported on the 19 cases reviewed by the CAN Panel in the last quarter. Nine cases (4 deaths and 5 near deaths) were reviewed by the Panel for the first time and resulted in 57 current strengths and 66 findings across system areas. Ms. Mink also discussed the Governor's letter and how the strengths and findings were distributed along with the solutions CPAC has identified to address the system issues. Dr. Colmorgen motioned to approve the CAN packet, and Jennifer Donahue, Esq. seconded his motion. All other members voted in favor. The motion carried.

VIII. REVIEW OF CPAC ACTION PLAN

Ms. Culley reviewed the 2018-2019 Action Plan and asked the Commissioners to provide an update on the progress towards the recommendations. Updates were provided by various Commissioners on the five prioritized and seven additional recommendations from the 2018 Joint Retreat. The Commission voted to remove one of the additional recommendations regarding a change in LogistiCare criteria. The 2018-2019 Action Plan with the 11/14/18 status updates is available on the OCA website: https://courts.delaware.gov/forms/download.aspx?id=108428.

IX. INVESTIGATION COORDINATOR REPORT

Ms. Donahue gave a presentation on the quarterly data received by the Office of the Investigation Coordinator (IC). Ms. Donahue presented on the death, serious physical injury and sexual abuse cases opened between July and September 2018. Ms. Donahue described victim and offender profiles together with the types of cases associated with these maltreatment types. Child on child sexual abuse and juvenile trafficking cases were presented separately due to the unique characteristics in those cases. Ms. Donahue also discussed the backlog and need for additional resources.

X. CPAC DATA DASHBOARD

Brittany Willard gave a presentation on the quarterly child welfare trends identified by the CPAC Data Utilization Committee. This included a discussion of the DFS caseloads, the DFS hotline reports, cases received by DOJ, Children's Advocacy Center case types, children entering DSCYF custody, and permanency outcomes.

XI. COMMITTEE REPORTS

A. LEGISLATIVE

Ms. Culley plans to schedule the next Committee meeting in early 2019. In addition to the proposed Criminal Code, other draft legislation will need to be reviewed by the Committee. There are proposed changes to the child abuse crimes, to termination of parental rights statute, as well as a draft bill for confidentiality of multidisciplinary team (MDT) records and the forensic interview.

B. TRAINING

Ms. Morales provided an update on the workgroups under the Training Committee. The Mandatory Reporting workgroup, with the help of the CPAC Training Specialist, finalized a web-based mandatory reporting training for all professionals called the 3 in 1 training. Professionals are able to select the content that is appropriate for their discipline. Now, staff only need to update the web-based presentation every two years, unless there are statutory updates. This web-based presentation was done in preparation for license renewal for physicians. CPAC again partnered with the Medical Society of Delaware to get it accredited, and it will be available on OCA's learning management system on January 1, 2019.

Two other workgroups, MDT Case Review and CAN Best Practices, are reconvening over the next quarter. MDT Case Review will be evaluating the implementation of the new case review protocol, and CAN Best Practices will be addressing the Joint Action Plan recommendations. In addition, the ChildFirst/MDT Workgroup is gathering information and ultimately making a recommendation to CPAC about whether the state should continue using the CornerHouse® Forensic Interview Protocol or make the transition to the ChildFirst® Protocol. Lastly, the Protecting Delaware Children Conference is scheduled for April 2, 2019. A save the date went out in September.

C. SUBSTANCE EXPOSED INFANTS/MEDICALLY FRAGILE

Jennifer Donahue, Esq. shared that the Committee will now meet quarterly starting next month to oversee the plan of safe care implementation and Delaware Hope Model. The Delaware Hope Model began accepting cases on October 1, 2018. Trenee Parker and Colleen Woodall have trained DFS and providers on the Plan of Safe Care Protocol. Hospital meetings are occurring quarterly with all six birthing hospitals. Ms. Donahue continues to maintain the database on infants with prenatal substance exposure, and she will provide a presentation on the CY18 data at the next CPAC meeting. Finally, Ms. Parker and Ms. Donahue will be presenting on Delaware's work at the 35th International Symposium on Child Abuse in March 2019.

D. CASELOADS/WORKLOADS

Rachael Neff provided an update on the Committee's time study and workload analysis. Through a partnership with Delaware State University's (DSU), two rounds of focus groups occurred with DFS treatment caseworkers. This was followed by a time study, which occurred over a 4-week period in July. The CPAC Data Manager along with interns were responsible for entering the information gathered through the time study. Since then, DSU has been conducting the data analysis, and the Committee has been going back and forth with them about what additional information is needed. The Committee is interested in learning where workers are spending their time and where they are not, and then looking at the data from a best practice lens to determine if it fits with what quality case management should look like. The goal of the Committee is to recommend a caseload standard for treatment caseworkers in its final report. Sue Murray added that DFS is also looking at how caseloads are calculated. Currently, only fully functioning staff are reported in the CPAC Dashboard.

XII. COMMISSIONER REPORTS

A. DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES

Meredith Seitz reported that DSCYF gave a budget presentation to OMB last week, and several budget requests were made. The requests include hazardous duty pay for some classifications of Department employees and reinstatement of the Davis Memorial Scholarship funds. DSCYF is also developing a long term staffing plan for next five years.

I. DIVISION OF FAMILY SERVICES

Trenee Parker shared that DFS is working with OMB to develop a plan to meet staffing needs. During year one, 34 additional positions will be requested for investigations. DFS also plans to expand its use of contractual services for its family assessment intervention response (FAIR). DFS has already expanded FAIR to include domestic violence, lower risk infants with prenatal substance exposure, and families with allegations of physical neglect. DFS is also working on a fully functioning quality services unit. Three additional staff are needed to conduct quality assurance reviews in the required timeframes, and one person has already transitioned from FOCUS development to the unit. DFS also plans to increase the board rate for Level 1 and 2 foster parents since there has been no rate increase in 18 years. Lastly, to address the caseload issues, DFS created a Region 5. It will be an expanded statewide services unit with oversight by Shelley Yingling and two Assistant Regional Administrators. The Region will oversee the Report Hotline, which added a 12pm to 8pm shift, sex abuse and serious physical injury cases, foster care, and coaching. An additional unit will be added to investigate sex abuse and serious physical injury cases in Kent and Sussex.

II. PREVENTTION AND BEHAVIORAL HEALTH SERVICES

Bob Dunleavy reported that the Division of Prevention and Behavioral Health Services (PBHS) applied for four federal grants and was awarded all of them. One grant will expand school mental health supports in three school districts across the state. A second grant will expand services to the developmental disabilities population, and another hopes to expand services for young adults up to age 24. PBHS is also partnering with the Division of Substance Abuse and Mental Health for youth who have experienced their first psychotic break so it does not continue. PBHS is also working on transitions team for 17 year-olds, so they can successfully transition from PBHS to the adult system.

B. CHILD DEATH REVIEW COMMISSION

Dr. Colmorgen shared that the Sudden Death in the Young (SDY) Grant from the Centers for Disease Control (CDC) was awarded for an additional five years. The Child Death Review Commission (CDRC) was given $10,000 more than the last grant cycle. In addition, Delaware is one of three states that was asked to present at the CDC reverse site visit on the successes and barriers of the SDY Grant. CDRC was also asked to participate in a roundtable discussion on Maternal Mortality Review with Senator Carper and other agencies on August 7, 2018. There has been a lot of national attention regarding maternal mortality review (MMR), and Delaware is currently on the forefront with the MMR

Panel. During the year, CDRC partnered with the Office of Vital Statistics to link all deaths of women (child bearing age) with birth certificates to see if there were missing maternal deaths. As suspected, the deaths increased by more than 50%. Additionally, the Bayhealth Medical Center became a Cribs for Kids partner, and both of its hospitals were trained over the summer. DFS caseworkers, who handle infants with prenatal drug exposure, were also trained on infant safe sleeping and Abusive Head trauma on October 26, 2018.

C. DEPARTMENT OF EDUCATION

Susan Haberstroh provided an update on the nonacademic training workgroup. School districts and charter schools have been notified about the four options available for educational programming on personal body safety, child sexual abuse and other forms of abuse. In addition, the workgroup is developing additional modules for educators and staff to help them meet their training hours. The Memorandum of Understanding between the Department of Education, local education agencies and DSCYF has been signed. The Data Workgroup is working on finalizing uniform definitions for the data reporting. Once finalized, the education section of the CPAC Dashboard will be restructured to include more data points.

D. FAMILY COURT

Judge Hitch introduced JoAnn Santangelo, the new CIP Coordinator. In addition, Judge Hitch shared that the procedures for filing a petition for termination of parental rights and adoption have been updated, so the procedures are the same for both types of petitions. The CIP Steering Committee has also been discussing the impact of the federal Family First Prevention Services Act.

E. MEDICAL

Dr. Allan De Jong gave an update on the Victims of Crime Act (VOCA) Grant received by Nemours/Alfred I. duPont Hospital, including the recruitment of medical providers and implementation of the Guidelines for Child Abuse Medical Response. Nemours hired a Nurse Practitioner as of December for New Castle County. She will be responsible for non-acute evaluations of victims of alleged physical and sexual abuse. However, she will not be able to see patients independently until she is fully trained. Nemours is still working on solutions for the southern two counties.

XIII. NEW BUSINESS

Meg Garey added that November is National Adoption Month. Delaware will celebrate National Adoption Day on November 17, 2018, and five families will be finalizing their adoptions.

XIV. PUBLIC COMMENT AND ADJOURNMENT

No public comment.

The meeting was adjourned at 11:54 a.m.

State of Delaware Child Protection Accountability Commission
Quarterly Meeting Minutes

TUESDAY, MARCH 26, 2019
9:00 AM – 11:30 AM – New Castle County Courthouse
500 King Street, 12th Floor, Wilmington, Delaware

Those in Attendance:

Members of the Commission:	Statutory Role:
Mary Dugan, Esq., Chair	Child Protection Community 16 Del. C. § 931(a)(15)
The Hon. Josette Manning	Secretary of Services for Children, Youth & Their Families 16 Del. C. § 931(a)(1)
Trenee Parker	Director, Division of Family Services 16 Del. C. § 931(a)(2)
James Kriner, Esq.	Two Representatives from the Attorney General's Office 16 Del. C. § 931(a)(3)
Abigail Layton, Esq.	Two Representatives from the Attorney General's Office 16 Del. C. § 931(a)(3)
The Honorable Michael Newell	Family Court 16 Del. C. § 931(a)(4)
The Honorable Joelle Hitch	Family Court 16 Del. C. § 931(a)(4)
Susan Haberstroh	Designee for Secretary of the Department of Education 16 Del. C. § 931(a)(7)
Robert Dunleavy	Director, Div. of Prevention of Behavioral Health Services 16 Del. C. § 931(a)(8)
Maureen Monagle	Chair of the Domestic Violence Coordinating Council 16 Del. C. § 931(a)(9)
Nicole Magnusson	Young Adult 16 Del. C. § 931(a)(13)
Elizabeth Higley	At-large Member - Child Protection Community 16 Del. C. § 931(a)(15)
Ellen Levin	At-large Member - Child Protection Community 16 Del. C. § 931(a)(15)
Randall Williams	At-large Member - Child Protection Community 16 Del. C. § 931(a)(15)
Dr. Allan De Jong	At-large Member - Medical Community 16 Del. C. § 931(a)(15)

Staff:
Tania Culley, Esq.
Rosalie Morales
Stepfanie Scollo

Members of the Public:

Deborah Colligan	Sue Murray	Anne Pedrick	Lori Sitler
Kelly Ensslin, Esq.	Rachael Neff	Jennifer Perry	Eleanor Torres, Esq.
Islanda Finamore, Esq.	Leslie Newman	JoAnn Santangelo	Brittany Willard
Sgt. Jamie Leonard	Melissa Palokas	Meredith Seitz	

I. WELCOME/INTRODUCTIONS

Mary Dugan, Esq. opened the meeting and welcomed the attendees. Dr. Elizabeth Higley and Senator Bryan Townsend were recognized as recently appointed Commissioners.

II. APPROVAL OF MINUTES

The minutes from November 14, 2018 were approved. A motion was made by The Honorable Josette Manning to approve the minutes, and The Honorable Michael Newell seconded the motion. All were in

favor, and the motion carried.

III. EXECUTIVE COMMITTEE REPORT

Ms. Dugan provided the Child Protection Accountability Commission (CPAC) Executive Committee's Report. The Committee had a telephonic meeting in February, and the following items were addressed: continued monitoring of the proposed criminal code, Victims of Crime Act (VOCA) grant application, and CPAC and the Office of the Child Advocate (OCA) budget requests.

IV. EXECUTIVE DIRECTOR'S REPORT

Ms. Culley provided the Executive Director's report. She first introduced Melissa Palokas, who was hired as the Court Appointed Special Advocate (CASA) State Director. Two new CASA Program Coordinators were hired, Amy Hughes in Sussex County and LaTysse McKinzie-Mack in New Castle County. The CASA Program was recently short staffed in New Castle County due to one employee out on medical leave and another out on maternity leave. New Castle County is now accepting cases again.

Ms. Culley discussed the representation of clients in the custody of the Department of Services for Children, Youth and Their Families (DSCYF). The Deputy Child Advocates are representing 110 clients right now with 75% of them being in Kent and Sussex Counties. The Contract Child Attorneys are representing 305 clients; 22 of those clients are currently on Extended Jurisdiction. In addition, there are 260 Volunteer Attorneys; 203 of those attorneys are assigned to 310 kids. Another 37 attorneys are available to take a case, and 20 attorneys are on hold until further notice by them. There are 220 CASA Volunteers who are assigned to 305 clients; 23 volunteers are available and most are in Sussex County. There were 14 newly trained CASA Volunteers – 5 in Kent, 5 in New Castle and 4 in Sussex. In 2018, OCA had 80 clients and 66 petitions in Kent, 244 clients and 213 petitions in New Castle, and 72 clients and 56 petitions in Sussex. In total, 396 children came into DSCYF custody and 475 children exited in 2018.

Next, Ms. Culley provided an update on the CASA media campaign that took place from January 15 to February 15, 2019. The WJBR campaign, which was funded by the VOCA, brought in a lot of volunteer interest in New Castle and Kent Counties. The CASA Program also begun a new flex training this year. The flex training has been successful and is improving diversity by allowing training to be conducted in a face-to-face setting as well as online. A CASA retreat is scheduled for June 13th, and it will involve stakeholders to develop a brand and mission for the program. Ms. Culley discussed the advanced trainings for volunteers, and the 2019 training calendar with various topics.

Lastly, Ms. Culley discussed OCA's data management system. As of December 2017, OCA implemented a cloud-based system called Apricot to track its program areas in one central location. The Court Improvement Program (CIP) funded the initial setup and all the costs for the first two years of operations. OCA expressed its gratitude to Family Court for its ongoing support. Two of OCA's program areas, legal services and Office of the Investigation Coordinator, are currently utilizing the data management system. The remaining programs that will be moved over in the future are as follows: intakes, the Child Abuse and Neglect (CAN) Panel, infants with prenatal substance exposure, and the Child Death Review Commission (CDRC) when/if they merge with OCA. The second contract year is up in December, and OCA will be requesting funding through CIP again this year.

V. APPROVAL OF JOINT FINANCE COMMITTEE LETTER

Ms. Culley asked for the Commission's approval to submit two letters to the Joint Finance Committee (JFC) Co-Chair's, Representative Quinton Johnson and Senator Harris McDowell, on behalf of CPAC. The first letter is the CPAC FY20 Budget Request for the Office of the Investigation Coordinator (IC). The positions requested are for four full-time state positions, an IC Deputy and three Multidisciplinary Team (MDT) Coordination Specialists. IC is currently supported by the Investigation Coordinator, and one MDT Coordination Specialist in Sussex County. Ms. Culley shared that these additional resources are needed to actively monitor MDT cases and to transition the MDT Case Review process from the Children's Advocacy Center to the IC. In addition, CPAC, through OCA, has applied for and received VOCA funding for two of these positions plus equipment for 20 months as a temporary partial funding measure that will need to be sustained by the State. Ms. Culley asked for a motion to give the Chair and Executive Director the authority to act on the CPAC FY20 budget requests. A motion was made by Ellen Levin, and Nicole Magnusson seconded the motion. All were in favor, and the motion carried.

Additionally, Ms. Culley discussed the second letter to JFC which delineates all of CPAC's funding priorities: 1. OCA/Office of the Investigation Coordinator; 2. Division of Family Services Caseloads; 3. Children's Advocacy Center; 4. Ivyane Davis Scholarship Fund; 5. Department of Justice; 6. OCA/CASA Program; 7. OCA/Child Death Review Commission; 8. Family Court; and 9. Prevent Child Abuse Delaware. Ms. Culley requested a motion to give the Chair and Executive Director the authority to act on the CPAC Funding Priorities. A motion was made by The Honorable Josette Manning, and Jim Kriner, Esq. seconded the motion. All were in favor, and the motion carried.

VI. CHILD ABUSE AND NEGLECT DEATH/NEAR DEATH REVIEWS

A. CAN CASELOADS REPORT/ADMINISTRATIVE UPDATE

Rosalie Morales reported that the CAN Panel has 72 cases open with 20 cases before the Commission today for approval. In January, the Panel had two meetings and reviewed 9 initials and one final. In February, the Panel reviewed 3 initials and one final. Another four initials and 4 finals are scheduled for review by the Panel this week. By adding the meeting in January, the CAN Panel has been able to stay in compliance with the statutory requirement to review these cases within six months. Lastly, in 2018, there were 34 near deaths and 14 deaths, which was a slight increase from 2017.

B. CAN FINDINGS/DETAILS/LETTER TO GOVERNOR

Ellen Levin reported on the 20 cases reviewed by the CAN Panel in the last quarter. Nine of the cases (3 deaths and 6 near deaths) were finals, so they had been previously reviewed by the Panel and were awaiting the completion of prosecution. Six of the cases were ultimately prosecuted. The 11 remaining cases were reviewed for the first time. There were 4 deaths and 7 near deaths, and these incidents occurred between May 2018 and July 2018. Other than one sibling group, the children range in age from two months old to two years old. These eleven cases resulted in 53 strengths and 33 current findings across system areas. 27 strengths were noted for the MDT while only 8 findings were made. Progress with DFS regarding the use of safety agreements, unresolved risk and risk assessment was seen this quarter. There were 16 strengths and only 21 findings made in these categories. Nicole Magnusson

motioned to approve the CAN packet, and The Honorable Michael Newell seconded the motion. All other members voted in favor. The motion carried.

VII. INVESTIGATION COORDINATOR REPORT

Ms. Morales and Jennifer Perry gave a presentation on the Calendar Year 2018 data received by the Office of the Investigation Coordinator. In CY18, 4,099 referrals were screened by the IC; 1,393 of those referrals were screened in. Of those screened in cases, there were 1,184 sexual abuse cases, 58 serious physical injury cases, 22 juvenile trafficking cases and 20 deaths. Trends and outcomes were also provided on the 531 cases closed by the IC. Throughout the presentation, it was clear that the IC continues to struggle with managing its caseload.

Additionally, there was further discussion about the amount of time the IC is spending to track each reported case involving sexual abuse and the length of time these cases remain open with the MDT. The IC will review and provide an update to CPAC.

VIII. CPAC DATA DASHBOARD

Brittany Willard gave a presentation on the quarterly child welfare trends identified by the CPAC Data Utilization Committee. This included a discussion of the DFS caseloads, the DFS hotline reports, Children's Advocacy Center case types, children entering DSCYF custody, permanency outcomes and education outcomes for children in DSCYF custody. There was further discussion about the chart on chronic absences (more than 15 days) for children in DSCYF custody. This data represents children who were marked as being absent at any point during the school year, and it includes any absences that occurred while the child was in his or her own home and since he or she entered DSCYF custody. As a result, the Commissioners were concerned that the chart may misrepresent the number of absences for children in DSCYF custody.

IX. COMMITTEE REPORTS

A. LEGISLATIVE

Ms. Culley discussed the proposed changes to the child abuse crimes. The first bill makes Child Abuse First Degree and Child Abuse Second Degree violent felonies consistent with the same crimes against adults. Jim Kriner, Esq. motioned to approve the bill, and Abigail Layton, Esq. seconded the motion. All other members voted in favor. The motion carried.

The second bill ensures that Child Abuse Second Degree is a Class D felony similar to Assault Second Degree. The bill also increases the victim's age from age 3 to less than 6 years of age when physical injury of a child is Child Abuse Second Degree to make it consistent with Assault Second Degree. The bill includes criminal negligence resulting in serious physical injury in Child Abuse Second Degree. Lastly, the bill reorganizes the Child Abuse statutes to make them more succinct. Abigail Layton, Esq. motioned to approve the bill, and Ellen Levin seconded the motion. All other members voted in favor. The motion carried.

Ms. Culley also provided an update on the proposed changes to the Criminal Code. Ms. Culley was confidentially provided a draft of the changes that addresses some of CPAC's concerns. The Commission discussed that the Executive Committee and Legislative Committee will need to take action if the proposed bill moves forward. In addition, Ms. Layton read a statement from Attorney General Kathy Jennings. At this time, no further direction from the Commission was needed.

B. EDUCATION

Susan Haberstroh reported that the Education Committee has been focused on two workgroups: the non-academic training and Title IX. The Non-Academic Training Workgroup is making sure that all schools have one of four curriculums in place for Erin's Law. All the schools have identified a contact person, who is responsible for curriculum development, but not all schools have identified a curriculum that they will be using. Eight charter schools and districts will be using Prevent Child Abuse Delaware's (PCAD) program. Ms. Culley added that approximately 70,000 public school children are required to have personal body safety training, and there are only four programs available. PCAD and the Beau Biden Foundation for the Protection of Children received a grant from the Longwood Foundation to provide personal body safety training and Stewards of Children. Even with the grant money and the funding PCAD receives from grant in aide, they can only train 30,000 students. Ms. Culley emphasized that requests should still be made to PCAD to demonstrate the need. Susan shared that the workgroup is also creating other non-academic training modules for school employees, such a refresher for child abuse reporting and detection and a module on sex trafficking.

The Title IX Workgroup is developing flow charts around the reporting obligations in Titles 14 (School Crimes) and 16 (Mandatory Reporting). The workgroup plans to have recommendations for the Education Committee in August, so that school employees have resources available for the school year.

C. SUBSTANCE EXPOSED INFANTS/MEDICALLY FRAGILE

Trenee Parker gave a presentation on the Calendar Year 2018 infants with prenatal substance exposure. In CY18, 612 notifications were made to the Division of Family Services (DFS). Ms. Parker discussed the trends and outcomes for these infants together with the three pathways. In addition, Ms. Parker presented the Committee's goals for 2019, which are to finalize and publish the Plan of Safe Care Implementation Guide, to provide oversight of Plan of Safe Care Program and Delaware HOPE Model, facilitate discussions on adopting universal drug test panels and continue data collection. Randy Williams motioned to approve the Plan of Safe Care Implementation Guide, and Ellen Levin seconded the motion. All other members voted in favor. The motion carried.

D. CASELOADS/WORKLOADS

Rachael Neff and Sue Murray gave a presentation on the progress of the Caseloads/Workloads Committee. The background of the original committee and the 2008 Final Report was discussed. The report recommended that the caseload standards for investigation and treatment be lowered. The investigation caseload standard for investigation was lowered to 11. However, the recommendation for a graduated reduction (18 to 14 to 12) for treatment did not occur due to the fiscal impact. Since that time, CPAC has continued to monitor the caseloads and recommended that the Committee reconvene at its 2016-2017 retreat. An update was also provided on the Committee's progress. The Committee

engaged in a partnership with Delaware State University to conduct a time study and focus group. Currently, the Committee is working to finalize its report and recommendations to CPAC. The report will be submitted to CPAC no later than August. Ms. Culley raised that the report will likely have a fiscal impact, which will need to be considered by CPAC and DSCYF for the FY21 budget year. Ms. Neff and Ms. Murray will also be presenting at the 2019 Protecting Delaware's Children's conference along with Dr. Vicky Kelly and Dr. Julie Collins from the Child Welfare League of America.

X. COMMISSIONER REPORTS

A. DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES

No report provided.

I. DIVISION OF FAMILY SERVICES

Trenee Parker shared that all new positions are filled. In addition, the 12-8 Hotline Unit and Kent/Sussex Serious Injury/Sexual Abuse Unit are both up and running. A supervisor has been hired for the Coaching Unit in Kent County. All of these units along with foster care are now under Region 5 to establish consistency in practice. DFS is also looking at new ways to serve the youth that are currently out of state. In addition, DFS is working with PBHS to provide more in-home services to support foster parents and youth.

The Division's FY20 budget request is for 37 additional staff, including 3 workers to support Continuous Quality Improvement (CQI) Unit. This unit is required to review 90 cases every 6 months. Lastly, DFS hired Sarah Azevedo as the new Intake and Investigation Program Manager and Sophia Cywinski as the Independent Living Program Manager.

II. PREVENTTION AND BEHAVIORAL HEALTH SERVICES

Bob Dunleavy reported that the Division of Prevention and Behavioral Health Services (PBHS) mentioned that the request for proposal is available for the System of Care grant on the DSCYF website.

XI. NEW BUSINESS

There was no new business.

XII. PUBLIC COMMENT AND ADJOURNMENT

No public comment.

The meeting was adjourned at 11:32 a.m.

PROGRAM REPORT

Grant ID: 2121
Applicant Agency: Office of the Child Advocate
Project Dates: 10/1/2018 to 9/30/2019
Report Period: 1/1/2019 to 3/31/2019
Submission Date 4/19/2019

Report Due Date: 4/30/2019
Report Status: Submitted
Approval Status: Pending
Final Report: No

Is the Project On Schedule? Yes

Explanation:

Activities Conducting During this Period: Services were provided by the CJA Training Specialist, Kathleen McCormick. During the last quarter, she updated the 2019 Onsite Mandatory Reporting Trainings for medical professionals, educators, and general professional audiences. She was able to reduce the amount of text and add more visuals on the presentations to make them more appealing to in-person audiences. In response to feedback from the training evaluations, she developed a magnet and handout to help mandated reporters recall the Report Line number and minimal facts questions for talking to children about knowledge or suspicion of child abuse/neglect. Ms. McCormick was also responsible for managing the online training system (TraCorp Learning Management System) and surveys through Survey Monkey. During the reporting period, she provided technical support to numerous physicians, who were participating in the online Mandatory Reporting Training for medical professionals. She also maintained the number of professionals trained, and reported those numbers to the Mandatory Reporting Workgroup. Additionally, she helped organize and facilitate the Protecting Delaware's Children Conference. Her responsibilities included: communicating with several national speakers; updating the agenda and brochure; selecting the two awards for the award ceremony; organizing the packets for the workshops; managing the continuing educations credits; and preparing the conference evaluation. She attended several trainings to prepare for the OCA's transition from the TraCorp Learning Management System to the Delaware Learning Center. Lastly, she staffed the Training Committee on 2/8/19, the Mandatory Reporting Workgroup on 1/18/19, and the Protecting Delaware's Children Conference Workgroup on 1/8/19 and 3/5/19.

The TraCorp Learning Management System continued to be used an online platform to train a variety of child welfare professionals. OCA paid the monthly fees ($377) to TraCorp. In the last quarter, (4,353) professionals completed the online mandatory reporting training for educators (44), general professional audiences (117) and medical professionals (4,192).

Transportation was purchased for Rosalie Morales and Tania Culley for the Children's Justice Act Grantee Meeting in April 2019 (Amtrak - $165) and Citizen Review Panel (CRP) Conference in June 2019 (Airfare - $1,066). Registration fees were also submitted for the CRP Conference.

A Surface Pro and warranty was purchased for Jennifer Falkowski, OCA Case Review Specialist. Ms. Falkowski supports OCA's Office of the Investigation Coordinator in the review and monitoring of child victims of serious physical injury, death, and sexual abuse.

Airfare was purchased for a speaker for the Protecting Delaware's Children Conference scheduled for April 2, 2019. Additionally, payment for meals and audio visual services was submitted to the Dover Downs Hotel and Casino for the conference.

Partial MDT scholarships were provided to several representatives to attend the 35th International Symposium on Child Abuse from March 19-21, 2019. The representatives were as follows: Alan Bluto, Delaware State Police; Gerald Windish, Delaware State Police; Jennifer Buzzuro, Delaware State Police; Gino Cevallos, New Castle County Police; Jean Gardner, Division of Family Services; Monica Morris, Division of Family Services; Kevin Smith, Department of Justice; Jennifer Donahue, OCA/Office of the Investigation Coordinator; and Rosalie Morales, OCA.

Performance Indicators:

1. Established by DCJC
2. Established by Subgrantee

Quarterly Report Project Narrative !

Project Narrative

The Quarterly Report project narrative should accurately reflect progress toward the attainment of goals and objectives. Thus, the goals of the project should be presented with the progress toward the goal stated underneath. The objectives of the application should also be listed in the Quarterly Report with the progress of each stated beneath this objective.

e.g.

Goal:

Progress:

Implementation Objective:

Progress:

The Quarterly Report should also state any problems that the project may have had during the last quarter. A miscellaneous section is provided in the Quarterly Report so that the project director can provide any additional information that the subgrantee believes to be pertinent (i.e. Accomplishments in addition to the stated goals and objectives).

1. Goal: Specify the goal statement for the project. The goal statement should clearly communicate the intended result of the project as of the end of the subgrant period. State what progress has been made toward the attainment of that goal.

Goal Statement: This project will improve: (1) the assessment and investigation of suspected child abuse and neglect cases, including cases of suspected child sexual abuse and exploitation, in a manner that limits additional trauma to the child and the child's family; (2) the assessment and investigation of cases of suspected child abuse-related fatalities and suspected child neglect-related fatalities; (3) the investigation and prosecution of cases of child abuse and neglect, including child sexual abuse and exploitation; and (4) the assessment and investigation of cases involving children with disabilities or serious health-related problems who are suspected victims of child abuse or neglect.

During the quarter, progress was made towards the assessment and investigation of suspected child abuse and neglect cases as a revised onsite Mandatory Reporting Trainings were published together with resources for mandated reporters such as educators and general professional audiences. Physicians also completed the required training as part of their license renewal process.

2. Identify the implementation objectives for the project. After each implementation objective, state the progress toward the attainment of the objective

The implementation objectives are as follows: The Task Force will provide regular training and demonstrative tools to investigators and prosecutors involved in the investigation and prosecution of child abuse and neglect cases. The training will be targeted to the Division of Family Services, Office of the Investigation Coordinator, statewide law enforcement agencies, criminal/civil Deputy Attorneys General from Department of Justice, Children's Advocacy Center forensic interviewers and clinicians, and related child welfare partners such as hospital based Sexual Assault Nurse Examiners. Training will also be made available to professionals involved in the judicial and administrative handling of child abuse cases and other professionals responsible for reporting child abuse and neglect.

Rosalie Morales provided Mandatory Reporting Training to Court Appointed Special Advocates (CASA) Volunteers, who serve as advocates for children in foster care. Three separate trainings were held during the reporting period. Ms. Morales also provided training to the Early Childhood Center at the Jewish Community Center, at a Community Behavioral Health Forum and to school based health centers.

3. Identify the performance objectives for the project. Performance objectives indicate major behavior (activities) necessary to conduct the project as planned. Indicate progress toward attainment of each performance objective.

The performance objectives are as follows:

1. Contract with a Training Coordinator - OCA has an existing contract with Kathleen McCormick.

2. Provide Ongoing Comprehensive Training to Multidisciplinary Team Members and Others involved in the Judicial/Administrative Handling of Cases - No progress has been made this quarter.

3. Provide MDT Scholarships to representatives involved in the investigation, prosecution and judicial handling of cases of child abuse and neglect – Nine scholarships were provided during the quarter, and representatives attended the 35th International Symposium on Child Abuse from March 19-21, 2019.

4. Train Professionals on the Recognition and Reporting of Child Abuse and Neglect through in-person and web-based training – The 2019 Onsite Mandatory Reporting Trainings for medical professionals, educators, and general professional audiences were revised during the reporting period. A magnet and handout were also developed. Onsite and online training was provided to over 4,000 participants.

5. Make web-based training available to the child welfare community through OCA's Online Training System – Several existing web-based trainings are available through OCA's Online Training System. No additional web-based trainings have been added during this quarter.

6. Attend the CJA Grantee Meeting/National Citizen Review Panel Conference – Transportation costs and registration fees were paid during this quarter.

7. Protecting Delaware's Children conference will be held – Payment was made to the Dover Downs Hotel and Casino for the conference, and airfare was purchased for speaker, Marcus Stallworth.

8. A copy of the CJA Annual Progress Report will be provided - No progress has been made this quarter. Report is due May 31, 2019.

4. Identify impact objectives for the project. Impact objectives measure the extent to which what happened was the result of the funded activity. Indicate progress toward attainment of each impact objective.

The impact objectives are as follows:

1. Education on child abuse intervention will be coordinated and accessible to child welfare professionals and others statewide - Web-based trainings have been approved by the Mandatory Reporting Workgroup. Now, the trainings will need to be developed through Articulate.

2. Specialized training will be provided to professionals involved in the investigative, administrative, and civil and criminal judicial handling of child abuse cases - No progress has been made this quarter.

3. Specialized training will be provided to investigators and prosecutors responsible for the most difficult child abuse and neglect cases – Six investigators and 1 prosecutor attended the 35th International Symposium on Child Abuse from March 19-21, 2019.

4. Enhanced recognition and reporting of child abuse and neglect - The 2019 Onsite Mandatory Reporting Trainings for medical professionals, educators, and general professional audiences were revised during the reporting period. Once approved by the Mandatory Reporting Workgroup, the onsite trainings will be implemented.

5. Miscellaneous Information: Use this area to provide CJC with any additional information that you believe is pertinent.

n/a

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

May 2018 - May 2019

FINDINGS

	*Current	Grand Total
MDT Response	**92**	**92**
Communication	2	2
Crime Scene	13	13
Documentation	6	6
Doll Re-enactment	2	2
General - Civil Investigation	2	2
General - Criminal Investigation	11	11
General - Criminal Investigation / Civil Investigation	3	3
Intake with DOJ	5	5
Interviews - Adult	13	13
Interviews - Child	11	11
Medical Exam	15	15
Prosecution/ Pleas/ Sentence	2	2
Reporting	7	7
Grand Total	**92**	**92**

**Current - within one year of incident.*

Child Protection Accountability Commission
Child Abuse and Neglect Panel
Findings Detail and Rationale
May 2018 - May 2019

FINDINGS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			92
	Communication		2
		The federal law enforcement agency communicated to DFS that there was insufficient evidence of child abuse and neglect, and this contradicted the findings from the medical expert. This had a significant impact on the civil investigation.	1
		The MDT was initially told that there was no evidence of injuries or concerns for bruising. It is unclear whether this information was relayed by a member of the medical team.	1
	Crime Scene		13
		No scene investigation was completed by the law enforcement agency.	3
		The SUIDI form was not fully completed by the law enforcement agency, and it may have impacted the cause and manner.	1
		No scene investigation was documented by the law enforcement agency. In addition, measurements and photographs were not obtained from the scene related to the alleged fall.	1
		The law enforcement agency did not complete evidentiary blood draws on the child after the child ingested a prescription drug.	4
		No scene investigation was completed by the law enforcement agency. As a result, the scene was not photographed and no evidence was collected.	2
		The law enforcement agency did not obtain a search warrant for the home to collect other corroborative evidence.	1
		The SUIDI form was not completed by the medical examiner's unit despite a discussion with the law enforcement agency and an agreement to complete the tool.	1
	Documentation		6
		There was no documentation in the police report by the lead detective.	3
		There was no documentation by DFS after a supervisor was notified about the child's death by the Division of Forensic Science.	1
		There was no documentation in the police report by the lead detective. The caseload for the detectives assigned to this law enforcement jurisdiction was high and may have had an impact on the documentation.	1
		There was no documentation by the DFS case worker that a lock box to store the prescription medications was observed.	1
	Doll Re-enactment		2
		No doll re-enactment was completed by the law enforcement agency.	2
	General - Civil Investigation		2
		An immediate report was not made to the law enforcement agency by the DFS caseworker, and it impacted the initial MDT response to the near death investigation.	1

	The DFS case worker was not aware of the criminal no contact order between the non-related caregivers.	1
General - Criminal Investigation		11
	The law enforcement agency did not complete evidentiary blood draws on the mother or child after the child tested positive for illicit drugs.	1
	The law enforcement agency did not complete an evidentiary blood draw on the child after the child tested positive for the prescription drug.	1
	There was not an immediate call to the Criminal Investigations Unit by the law enforcement agency. As a result, the agency initially declined to respond.	1
	The law enforcement agency delayed sending the parents' blood kits to the Division of Forensic Science. As a result, the toxicology results were delayed.	1
	There was not a MDT response to the near death incident in compliance with the MOU and statute, and the LE agency declined to come to the children's hospital.	1
	There was not a MDT response to the near death incident in compliance with the MOU and statute.	3
	There was not an immediate call to the Criminal Investigations Unit by the law enforcement agency. Instead, the initial responding officer attempted to close the case as unfounded with no crime.	1
	There was not an initial MDT response to the near death incident in compliance with the MOU and statute.	1
	There was a significant delay by the law enforcement agency in submitting the parents' blood sample to the Division of Forensic Science.	1
General - Criminal Investigation / Civil Investigation		3
	For the prior investigation, there was not a strong MDT response to an unexplained burn involving the same victim.	1
	There was not a strong MDT response to the near death investigation due to the following: lack of communication; lack of coordinated response between after-hours worker and LE, including joint interviews; and inaccurate information provided about DFS history.	1
	For the near death investigation, there was not a MDT response to the incident in compliance with the MOU and statute.	1
Intake with DOJ		5
	The law enforcement agency did not notify the DOJ Special Victims Unit of the near death incident.	4
	The law enforcement agency did not notify the DOJ Special Victims Unit of the death incident.	1
Interviews - Adult		13
	DFS conducted interviews with parents prior to police response.	1
	DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	5
	DFS and the law enforcement agency did not conduct joint interviews with the suspects and witnesses.	1
	DFS and the law enforcement agency did not conduct joint interviews with the suspects and witnesses.	1
	The DFS after-hours worker conducted interviews with the suspects without the law enforcement agency present, potentially impacting the criminal investigation.	1

	The DFS after-hours workers interviewed the parents together and asked questions about domestic violence despite the active no contact order.	1
	The DFS after-hours workers interviewed the suspects without the law enforcement agency present, potentially impacting the criminal investigation.	1
	The after-hours worker declined to participate in the joint interview by LE at the hospital.	1
	Interviews did not occur with all adults in the home where the near death incident occurred. These adults were also prescribed the medication that the child ingested.	1
Interviews - Child		11
	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
	Forensic interviews did not occur with the young siblings who were present during the near death incident since the parent was uncooperative. However, a subpoena should have been considered.	1
	The father's girlfriend's young child was not observed during the near death investigation.	1
	The older sibling who was present in the home during the near death incident was not observed or interviewed by the second shift DFS case worker.	1
	Forensic interview did not occur with the mother's child who resided in the home with the victim, and there was a delay by the MDT in scheduling the forensic interview that occurred with the father's child.	1
	Forensic interview did not occur with the young child who visited the home where the death incident occurred, and the child's parent was a witness to the death incident.	1
	Forensic interview did not occur with the older sibling who was present during the near death incident despite the victim's injuries resulting from neglect and the significant DFS history.	1
	Forensic interview did not occur with the young child who was present during the near death incident.	1
	Forensic interview did not occur with the young victim.	1
	The DFS caseworker did not conduct a comprehensive interview with the victim. It was limited to the allegations.	1
	Forensic interview did not immediately occur with the young victim.	1
Medical Exam		15
	The DFS caseworker did not independently contact the child abuse medical expert to discuss the medical findings. As a result, the case worker made decisions to modify the safety agreement and close the case based on the information relayed by the federal law enforcement agency	1
	The federal law enforcement agency delayed obtaining the findings from its medical expert for several months.	1
	The young siblings who were present during the near death incident were not medically evaluated.	1
	The DFS caseworker did not independently contact the child's PCP to discuss the visit for the injury to the child's limb.	1

	The young children who were present in the two households during the near death incident were not medically evaluated.	1
	The DFS caseworker did not independently contact the concussion clinic to discuss the medical findings.	1
	There was a miscommunication by the MDT about the timeline for the injury, and it impacted decisions by the MDT.	1
	The older sibling who was present in the home during the near death incident was not medically evaluated.	3
	The infant was not referred for a full workup by the child abuse medical expert until six days after the incident.	1
	The young child who visited the home where the death incident occurred was not medically evaluated.	1
	For the prior investigation, the DFS caseworker did not independently contact the child abuse medical expert to discuss the medical findings. It was concluded that the injury was non-accidental.	1
	The DFS caseworker did not independently contact the child abuse medical expert to discuss the medical findings and to determine if the mechanism of injury was consistent with a fall. There was also no confirmation that the child was seen for the follow-up visit.	1
	There was no follow up with the child abuse medical expert by the MDT to discuss possible explanations for the serious physical injuries to the young child.	1
Prosecution/ Pleas/ Sentence		2
	The SENTAC guidelines' presumptive sentence for crimes against children should be greater.	1
	There was sufficient evidence to move forward with the prosecution based on mother's admission; however, the case was Nolle Prossed.	1
Reporting		7
	The call to the DFS Report Line was delayed by the law enforcement agency, and, as a result, DFS did not have an opportunity to observe the interviews.	1
	The law enforcement agency did not make a report to DFS Report Line for allegations of abuse regarding the sibling. Instead, the information was reported to the assigned case worker.	1
	The MDT did not make a report to DFS Report Line after the sibling made a disclosure during the forensic interview.	1
	The law enforcement agency did not make a report to the DFS Report Line for the near death incident.	1
	Prior to the death incident, there were 4 recent verbal disputes between the parents in which the law enforcement agency responded. One incident involved the children being present, and there was no report to the DFS Report Line.	1
	The Division of Forensic Science did not make a report to the DFS Report Line for the death incident.	1
	The law enforcement agency did not make a report to the DFS Report Line for the death incident.	1
Grand Total		**92**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

May 2018 - May 2019

STRENGTHS		
	***Current**	**Grand Total**
MDT Response	**141**	**141**
Crime Scene	1	1
Documentation	4	4
General - Civil Investigation	29	29
General - Criminal Investigation	24	24
General - Criminal/Civil Investigation	47	47
Home Visiting Programs	1	1
Interviews - Adults	2	2
Interviews - Child	12	12
Medical Exam	21	21
Grand Total	**141**	**141**

**Current - within one year of incident.*

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

Child Protection Accontability Commission
Child Abuse and Neglect Panel
Strengths Detail and Rationale
May 2018 - May 2019

STRENGTHS

System Area	Strength	Rationale	Count of #
MDT Response			141
	Crime Scene		1
		The law enforcement agency sought assistance from the landlord to obtain photos of the scene.	1
	Documentation		4
		The law enforcement agency thoroughly documented the investigation case events.	2
		The DFS case worker thoroughly documented the investigation case events.	1
		The DFS after-hours case worker thoroughly documented the case events, to include identifying next steps.	1
	General - Civil Investigation		29
		The law enforcement agency thoroughly documented the investigation case events.	1
		There was good communication between the DFS case worker and the medical team.	1
		Upon the child's hospital admission, the parents were restricted from having visitation with the child without DFS approval.	1
		The DFS Report Line requested that the child not be discharged without consultation with DFS.	1
		NCIC background checks were completed for the out-of-state family members.	1
		Following the miscommunication and premature case closure, DFS held a team meeting where the safety agreement was re-implemented, and consultation was completed with the Deputy Attorney General regarding re-opening the case.	1
		The DFS case worker confirmed that prescription pills were available in various colors depending on the dosage.	1
		There was good communication between the DFS investigation and treatment workers.	1
		During the prior investigation, the DFS caseworker educated Mother on infant safe sleep practices.	2
		During the prior investigation, the DFS case worker educated Mother on infant safe sleep practices.	1
		The after-hours DFS case worker challenged the law enforcement agency and medical staff to ensure certain interventions were completed despite early assumptions that the injury was accidental.	1
		The DFS case worker communicated with multiple parties regarding the suspect's young child, and there was strong attention to his well-being.	1
		The DFS case worker consulted with an out of state child protective services agency as it was known that the family resided in that state for some time.	1
		The DFS case worker and medical team immediately identified the medical consents needed for the child as Mother was incapacitated. Both parties worked with the Courts to ensure maternal grandparents obtained emergency guardianship in order to make the medical decisions on the child's behalf.	1
		The DFS case worker educated Mother on infant safe sleep practices when the parents advised of co-sleeping with the child and sibling.	1

	The DFS case worker ensured Mother obtained a lockbox to store her prescription medications.	1
	The DFS case worker educated Mother on infant safe sleep practices.	3
	The DFS treatment caseworker educated Mother on infant safe sleep practices.	1
	During the near death investigation, there was excellent collaboration between the investigation and treatment caseworkers, to include a thorough investigation, timely and quality contact with the family, and appropriate follow up services for the child's medical care and Father's substance abuse treatment.	1
	In the prior investigation, the DFS caseworker conducted a thorough investigation, to include referral to an evidence-based home visiting program, good communication with said home visiting program, collaterals with Mother's substance abuse treatment facility, and a Framework.	1
	In the prior investigation, the DFS caseworker conducted a thorough investigation, to include medical evaluations of the children, referral to an early intervention program, and education of Mother on infant safe sleep practices.	1
	Following the report to the DFS Report Line by another party, the hotline worker contacted the initial treating hospital to gather additional information regarding the near death incident.	1
	For the previous report, the DFS caseworker educated Mother on infant safe sleep practices.	1
	Both DFS caseworkers for the prior reports educated Mother on infant safe sleep practices.	1
	The DFS caseworker conducted a thorough investigation, to include a child safety agreement, home assessments, medical evaluation and forensic interview of the sibling, a family team meeting, and a Framework, which recommended transferring the case to treatment.	1
	During the death investigation, the DFS caseworker made contact with the caregivers of Mother and Father's other children.	1
General - Criminal Investigation		24
	The law enforcement agency thoroughly documented the investigation case events.	1
	The law enforcement agency requested a legal blood draw of the child for evidentiary purposes.	2
	The MDT provided the child abuse medical expert with its initial investigative findings, including the doll reenactment video.	1
	The federal law enforcement agency initiated a no contact order between the father and child.	1
	The law enforcement agency completed the video-recorded doll reenactment expeditiously.	1
	The law enforcement agency set up surveillance to determine if the parents were violating the no contact order.	1
	In a screened out hotline report, the law enforcement agency provided information from the lethality assessment.	1
	The law enforcement agency requested evidentiary blood draw of the child.	1
	The law enforcement agency proceeded with the case investigation despite the injury occurring on the military base and military authorities undecided if they were taking the case.2	1
	The law enforcement agency conducted a scene investigation and a video-recorded doll reenactment expeditiously.2	1

	The law enforcement agency provided the Father's explanation for the injuries to the CARE Team, and this information helped the medical team to understand the complexity of the fall.	1
	The law enforcement agency conducted blood draws after it was suspected that the parents were intoxicated while co-sleeping with the child.	1
	There was good follow-up relating to Mother's substance abuse history.	1
	The law enforcement agency conducted a blood draw for Mother after it was suspected that she was under the influence while co-sleeping with the child.	1
	The law enforcement agency requested blood draw of Mother during the criminal investigation.	1
	The law enforcement agency rescheduled the doll reenactment to accommodate the forenisc investigator.	1
	The law enforcement agency conducted a blood draw for Mother after it was discovered that she had a history of substance abuse.	1
	The law enforcement agency conducted blood draws of the foster parents during the death investigation.	1
	The law enforcement agency collaborated with out of state authorities to conduct a scene investigation of Father's temporary residence and to interview Father's supervisor.	1
	The Criminal DAG recommended that the medical exam include weight and height measurements for the sibling to exclude the young child as an alleged perpetrator.	1
	Law enforcement and DOJ requested hair follicle testing for the child to determine ingestion of illicit substances.	1
	The law enforcement agency conducted a thorough investigation to include a scene investigation, multiple interviews, and search warrants for the child's medical equipment, Father's cell phone, and his social media pages.	1
	The law enforcement agency conducted a thorough investigation to include multiple interviews, blood draw of the parents, scene investigation, doll reenactment, photo and video documentation, and intake with the DAG.	1
General - Criminal/Civil Investigation		47
	A joint investigation was conducted by the MDT to include a coordinated home visit and interviews, and communication with the CARE Team at the children's hospital.	1
	There was good initial communication and collaboration between the MDT, to include state and federal law enforcement agencies, DFS, and hospitals.	1
	There was good collaboration between DFS and the law enforcement agency.	1
	There was excellent communication between DFS, the law enforcement agency, and the child abuse medical expert. As a result, a discharge planning meeting occurred for the child.	1
	There was good communication and collaboration between the MDT throughout the case and multiple investigations.	1
	Great collaborative response between the medical CARE Team, DFS, and the law enforcement agency during the near death investigation, to include an MDT meeting with all parties present.	1
	There was good collaboration and consistent communication between DFS and the law enforcement agency.	1

	Great collaborative response between the medical CARE Team, DFS, and the law enforcement agency during the near death investigation, to include joint interviews and an MDT meeting with all parties present.	1
	Great collaborative response between the DFS investigation and treatment case workers, and the law enforcement agency during the near death investigation, to include interagency communication, joint response to the home, joint interviews, thorough documentation, and an independent consultation with the child abuse medical expert.	1
	There was good communication between the assigned DFS case worker and the law enforcement detective.	1
	There was a strong MDT response to the death investigation by the after-hours case worker and the law enforcement agency, to include joint responses to locate the young child residing in the home where the incident occurred and joint interviews.	1
	There was good communication between the DFS case worker, the law enforcement agency, and the medical team.	1
	As the case was reported to the traffic division of DOJ, notification to the MDT members by the Investigation Coordinator allowed the Special Victim's Unit to consult with the traffic division regarding cases such as this involving serious injury to a child(ren).	1
	There was good and consistent communication between the DFS case worker, the law enforcement agency, and the DOJ.	2
	There was good and consistent communication between the DFS case worker and the law enforcement agency.	1
	Great collaborative response between DFS, the law enforcement agency, and the forensic investigator during the death investigation, to include joint interviews and doll reenactment.	1
	There was good collaboration between the DFS case worker and the law enforcement agency, to include joint interviews and the case worker observing the doll reenactment.	1
	There was good collaboration and consistent communication between the DFS case worker and the law enforcement agency.	1
	There was great collaborative response between the DFS case worker and the law enforcement agency during the near death investigation, to include interagency communication, joint response to the hospital, joint interviews, thorough documentation, and consultation with the child abuse medical expert.	1
	There was excellent communication between the DFS case worker, the law enforcement agency, and the medical team during the near death investigation, as well as follow up medical care for the child.	1
	The MDT requested the young sibling be video-recorded during play time to rule out aggressive behaviors as reported by the parents.	1
	A joint investigation was conducted by the MDT to include a coordinated response to the hospital, and excellent communication between the DFS case worker and the law enforcement agency throughout the investigation.	1
	There was great collaborative response and ongoing communication between the medical CARE Team, DFS, DOJ, and the law enforcement agency during the near death investigation, to include joint interviews and an MDT meeting with all parties present.	1

	There was great collaborative response and communication between DFS, DOJ, and the law enforcement agency during the death investigation, to include joint interviews, forensic interviews of the children, medical evaluations, and sharing of interagency information, specifically the contract agency and Institutional Abuse investigation reports.	1
	There was good collaboration among the MDT during the near death investigations, to include interagency communication, joint interviews, thorough documentation, and consultation with the child abuse medical expert.	1
	There was good communication between the medical team, DFS, and the law enforcement agency.	1
	There was a great collaborative response between the medical CARE Team, DFS, DOJ, and the law enforcement agency during the near death investigation, to include a joint response to the hospital, joint interviews, and consultation with the child abuse medical expert.	1
	There was good communication between the DFS and the law enforcement agency. DFS was particularly helpful in sharing the DFS history on the family.	1
	There was excellent MDT collaboration and response to the death investigation, to include joint interviews, and coordination of all children in and out of the home being medically evaluated and forensic interviews conducted.	1
	There was strong and consistent communication between the medical team, the DFS caseworker, the law enforcement agency, and the DOJ.	1
	There was excellent communication and collaboration with the medical team, DFS, the law enforcement agency, and the DOJ. The medical team was an integral part of the MDT.	2
	There was excellent communication and collaboration between the MDT and the out of state authorities, to include the child protective services agency and law enforcement.	2
	There was good collaboration between the child abuse medical expert, the DFS caseworker, and the law enforcement detective during the investigation, as well as follow up medical care for the child.	1
	There was good collaboration and consistent communication between DFS, the law enforcement agency, and the DOJ.	1
	There was good MDT response to the near death investigation between DFS and the law enforcement agency.	1
	During the death investigation, there was good collaboration and consistent communication between DFS, the law enforcement agency, and the DOJ.	1
	There was excellent communication between DFS, the law enforcement agency, the child abuse medical expert, and the DOJ.	1
	There was excellent collaboration and communication between DFS, the law enforcement agency, and the DOJ.	1
	During the near death investigation, there was excellent collaboration and consistent communication between DFS, law enforcement, DOJ, and the child abuse medical expert.	1
	There was a strong MDT response to the near death investigation by the DFS caseworker and the law enforcement agency, to include joint interviews and a joint response to the home.	1

	Despite delayed notification to DFS, there was good collaboration and communication between DFS and the law enforcement agency.	1
	There was great MDT communication between DFS, the law enforcement agency, the medical examiner's office, and the DOJ, to include an MDT meeting with all parties present.	1
	There was good communication between DFS, the law enforcement agency, and the DOJ.	1
	There was great MDT communication and collaboration between DFS, the law enforcement agency, and DOJ, to include joint responses to the hospital, joint interviews and MDT participation in the intake.	1
Home Visiting Programs		1
	During the two investigations, the DFS caseworkers referred Mother to an evidence-based home visiting program.	1
Interviews - Adults		2
	A forensic interview was scheduled and held at the CAC for the young child residing in the home where the incident occurred, and a second interview was scheduled and held after the initial interview could not be completed.	1
	Joint interviews were completed with the parents, initially at the hospital and later at the police station.	1
Interviews - Child		12
	A forensic interview was scheduled and held at the CAC for the siblings residing in the home where the incident occurred.	2
	A second forensic interview was scheduled and held at the CAC after the young sibling disclosed physical abuse to Mother by her paramour.	1
	A forensic interview was scheduled and held at the CAC for the siblings residing in the home where the incident occurred. The interviews were conducted within 24 hours.	1
	The after-hours DFS case worker pushed for forensic interviews to be conducted for the siblings residing in the home.	1
	Forensic interviews were scheduled and held at the CAC for the siblings residing in the home where the incident occurred.	1
	A forensic interview was scheduled and held at the CAC for the sibling residing in the home where the incident occurred.	3
	Forensic interview was scheduled and held at the CAC for the young sibling residing in the home where the incident occurred. The interview was conducted within 24 hours.	2
	As the family initially refused to allow forensic interviews of the other children residing in the home, subpoenas were issued to enforce the interviews.	1
Medical Exam		21
	The DFS case worker ensured the child's sibling was medically evaluated.	4
	The child received a follow up medical evaluation at the children's hospital, and there was excellent communication between DFS, the law enforcement agency, and the child abuse medical expert.	1

	The DFS case worker ensured the child's siblings were medically evaluated.	4
	The assigned DFS case worker ensured the older sibling was also drug tested.	1
	The DFS case worker ensured the suspect's young child was medically evaluated.	1
	The after-hours DFS case worker ensured the child's siblings were medically evaluated.	1
	The DFS case worker ensured the child's siblings were medically evaluated. The medical evaluation included a toxicology screen and skeletal survey.	1
	The hospital social worker and the DFS case worker communicated prior to giving an update to the family, and this helped the family understand the need for the hospital admission.	1
	The DFS case worker ensured the child's siblings were medically evaluated.	1
	The DFS case worker ensured the child's sibling was medically evaluated. The DFS case worker also recommended that a follow-up medical evaluation be conducted by the child abuse medical expert.	1
	During the near death investigation, the DFS caseworker ensured the child's sibling was medically evaluated. The medical evaluation included a forensic nurse exam and a skeletal survey.	1
	During the death investigation, the DFS case worker ensured the surviving siblings were medically evaluated.	1
	For the near death report, the DFS caseworker ensured the siblings were medically evaluated.	1
	Despite the ED physician adamantly declining to complete a skeletal survey during the sibling's medical evaluation, the DFS caseworker pushed to ensure one was completed.	1
	The DFS caseworker ensured medical evaluations were completed for the other children residing in the home at the time of the near death incident.	1
Grand Total		**141**

STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
C/O OFFICE OF THE CHILD ADVOCATE
900 KING STREET, SUITE 210
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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**

STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
C/O OFFICE OF THE CHILD ADVOCATE
900 KING STREET, SUITE 210
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GINGER L. WARD
CHAIR

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

August 8, 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 21 cases at its August 8, 2018 meeting.[1]

Nine of the cases (four deaths and five near deaths) had been previously reviewed and were awaiting the completion of prosecution. Seven of the cases were ultimately prosecuted, and resulted in two convictions for Murder by Abuse or Neglect 1st, one conviction of Child Abuse 1st, one conviction of Child Abuse 2nd, 3 Felony Endangering the Welfare, and 3 Misdemeanor Endangering the Welfare.

The 12 remaining cases were from deaths or near deaths that occurred between September 2017 and February 2018. 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 four days to 2 years old with 2 deaths and 10 near deaths. The children were abused via poisoning (drug ingestion), abusive head trauma,

[1] 16 Del. C. § 932.

fractures, or unsafe sleep conditions. These twelve cases resulted in 79 strengths and 89 current findings across system areas.

During this time period, significant findings were again made regarding the MDT response to these cases. Thirty-eight findings showed significant breakdowns within a few of the investigations involving many elements of the new MOU for the MDT Response to Child Abuse and Neglect. More broadly across several cases, breakdowns occurred in having siblings of victims interviewed and medically evaluated. At the same time, 51 strengths were noted with several investigations, and CPAC intends to utilize examples from the excellent investigative work that has happened in those cases to provide additional training on the MOU. For trends regarding siblings, the CPAC Child Abuse and Neglect Best Practices workgroup will be tasked with formulating a solution.

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, 26 findings remained again primarily focused on breakdowns in safety agreements. CPAC and DFS continue to partner to improve these agreements, and DFS has scheduled additional staff trainings in the coming months. 30 strengths were also noted with DFS workers performing diligent investigations in a few of these most difficult cases. These positive examples will also be highlighted in trainings.

The most significant issue continues to be 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 10 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 is grateful that the General Assembly included in the State budget the 30 additional frontline positions. However, the funding of these positions is but the first step in a complicated recruitment and retention plan.

CPAC continues to encourage the State to consider opportunities to make these positions attractive with funding, hazard pay, technologic support (including Surface Pros) as well as consider creative solutions such as a Children's Corp similar to the Teach for America model. There are investigators carrying 40 to 50 cases with a

statutory standard of 11. Several workers have resigned under the pressure. contributing to the turnover rate and escalating caseloads for those that remain. It is critical that we all collectively ensure that once we tackle this crisis by employing and retaining frontline workers, 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 8 child abuse or neglect deaths and 17 near deaths. In 2017, 13 children died and another 30 almost died from abuse or neglect in Delaware. Three of the children reflected in this letter are from 2018 – the balance is from 2017. 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. 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
August 8, 2018

INITIALS

	*Current	**Prior	Grand Total
Legal	**1**		**1**
Court Hearings/ Process	1		1
MDT Response	**38**	**1**	**39**
Communication	2		2
Crime Scene	2		2
Documentation	2		2
Doll Re-enactment	1		1
General - Civil Investigation		1	1
General - Criminal Investigation	5		5
Intake with DOJ	1		1
Interviews - Adult	5		5
Interviews - Child	8		8
Medical Exam	9		9
Reporting	3		3
Medical	**14**		**14**
Home Visiting Programs	3		3
Medical Exam / Standard of Care - Birth	1		1
Medical Exam/ Standard of Care - ED	4		4
Medical Exam/ Standard of Care - Films	1		1
Medical Exam/ Standard of Care - Forensics	1		1
Medical Exam/Standard of Care - Birth	3		3
Reporting	1		1
Risk Assessment/ Caseloads	**18**	**1**	**19**
Caseloads	10		10
Collaterals	3		3
Risk Assessment - Alternative Response	1		1
Risk Assessment - Screen Out		1	1
Risk Assessment - Tools	3		3
Risk Assessment - Unsubstantiated	1		1
Safety/ Use of History/ Supervisory Oversight	**14**	**1**	**15**
Completed Incorrectly/ Late	4		4
Inappropriate Parent/ Relative Component	4	1	5
No Safety Assessment of Non-Victims	1		1
Oversight of Agreement	5		5
Unresolved Risk	**4**		**4**
Child - Medical	1		1
Contacts	2		2
Domestic Violence	1		1
Grand Total	**89**	**3**	**92**

FINALS

	*Current	Grand Total
MDT Response	**1**	**1**
Doll Re-enactment	1	1
Medical	**4**	**4**
Medical Exam / Standard of Care - Birth	1	1
Medical Exam/ Standard of Care - Urgent Care	2	2
Transport	1	1
Risk Assessment/ Caseloads	**1**	**1**
Collaterals	1	1
Grand Total	**6**	**6**

**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

August 8, 2018

INITIALS

System Area	Finding	PUBLIC Rationale	Sum of #
Legal			1
	Court Hearings/ Process		1
		DFS, OCA and DOJ Civil agreed to rescind custody of the child and sibling(s) to the parents despite the mother's noncompliance with safety agreements and court ordered bail conditions, current mental health issues and ongoing concerns of domestic violence.	1
MDT Response			39
	Communication		2
		The law enforcement agency did not maintain ongoing collaboration or communication with DFS.	1
		The federal law enforcement agency communicated to DFS that there was insufficient evidence of child abuse and neglect, and this contradicted the findings from the medical expert. This had a significant impact on the civil investigation.	1
	Crime Scene		2
		No scene investigation was completed by the law enforcement agency.	1
		The law enforcement agency did not document whether any prescription medications were found at the scene.	1
	Documentation		2
		There was minimal documentation in the police report by the lead detective.	1
		There was no documentation in the police report by the lead detective.	1
	Doll Re-enactment		1
		No doll re-enactment was completed by the law enforcement agency.	1
	General - Civil Investigation		1
		In the prior investigation, the young child disclosed that she was punched, choked and dragged; however, it was not handled as a multidisciplinary case. There was no medical intervention, no forensic interview, and no follow up with the child to confirm that the alleged perpetrator did not have access to the child.	1
	General - Criminal Investigation		5
		The law enforcement agency did not complete evidentiary blood draws on the mother or child after the child tested positive for illicit drugs.	1
		The law enforcement agency did not complete an evidentiary blood draw on the child after the child tested positive for the prescription drug.	1
		There was a significant delay by the law enforcement agency in submitting the relative caregiver's blood sample to the Division of Forensic Science.	1
		The law enforcement agency assigned the investigation to a detective that is not responsible for handling child death cases.	1
		The law enforcement agency did not immediately respond to the hospital emergency department, and as a result, a joint investigation did not occur initially.	1

Intake with DOJ		1
	The law enforcement agency did not notify the DOJ Special Victims Unit of the near death incident.	1
Interviews - Adult		5
	DFS and the law enforcement agency did not conduct joint interviews with the suspects and witnesses.	1
	DFS and the law enforcement agency did not conduct joint interviews with the suspects and witnesses.	1
	The DFS after-hours worker conducted interviews with the suspects without the law enforcement agency present, potentially impacting the criminal investigation.	1
	The DFS after-hours workers interviewed the parents together and asked questions about domestic violence despite the active no contact order.	1
	The law enforcement agency did not audio record its interview with the mother.	1
Interviews - Child		8
	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.	2
	The MDT did not consider compelling the family to cooperate with the forensic interviews.	1
	Forensic interviews did not occur with the young siblings who were present during the near death incident since the parent was uncooperative. However, a subpoena should have been considered.	1
	The victim's sibling was not interviewed or observed during the death investigation. This child was not present in the relative caregiver's home where the incident occurred.	1
	The father's girlfriend's young child was not observed during the near death investigation.	1
	The older sibling who was present in the home during the near death incident was not observed or interviewed by the second shift DFS case worker.	1
	Forensic interview did not occur with the mother's child who resided in the home with the victim, and there was a delay by the MDT in scheduling the forensic interview that occurred with the father's child.	1
Medical Exam		9
	The DFS caseworker did not independently contact the child abuse medical expert to discuss the medical findings. As a result, the case worker made decisions to modify the safety agreement and close the case based on the information relayed by the federal law enforcement agency	1
	The federal law enforcement agency delayed obtaining the findings from its medical expert for several months.	1
	The young siblings who were present during the near death incident were not medically evaluated.	1
	The young children who were present during the death incident were not medically evaluated.	1
	The DFS caseworker did not independently contact the child's PCP to discuss the visit for the injury to the child's limb.	1
	The young children who were present in the two households during the near death incident were not medically evaluated.	1
	The DFS caseworker did not independently contact the concussion clinic to discuss the medical findings.	1
	There was a miscommunication by the MDT about the timeline for the injury, and it impacted decisions by the MDT.	1

		The older sibling who was present in the home during the near death incident was not medically evaluated.	1
	Reporting		3
		The call to the DFS Report Line was delayed by the law enforcement agency, and, as a result, DFS did not have an opportunity to observe the interviews.	2
		The law enforcement agency did not make a report to DFS Report Line for allegations of abuse regarding the sibling. Instead, the information was reported to the assigned case worker.	1
Medical			14
	Home Visiting Programs		3
		Home Visiting Services were not in place at the time of the near death incident.	2
		The victim sustained injuries consistent with Abusive Head Trauma, and physical therapy (PT) services were recommended. However, it has been several months since medical discharge and PT services are still not in place due to insufficient resources.	1
	Medical Exam / Standard of Care - Birth		1
		The birth hospital did not submit the commitment form signed by the mother to the All Babies Cry program. Therefore, the parents did not receive a prevention call six weeks after birth.	1
	Medical Exam/ Standard of Care - ED		4
		The hospital emergency department did not initiate the telemedicine consult with the children's hospital.	1
		The hospital emergency department inaccurately listed the infant's cause of death as Sudden Infant Death Syndrome (SIDS) prior to the autopsy being completed.	1
		The hospital emergency department did not make a report to the DFS Report Line when the child's blood test was positive.	1
		Despite a brief resolved unexplained event and an increase in head circumference, neuroimaging was not considered during the child's admission.	1
	Medical Exam/ Standard of Care - Films		1
		The child's PCP ordered a three-view x-ray, which is the standard of care; however, only two images were taken by the imaging center. No fractures were initially found as a result.	1
	Medical Exam/ Standard of Care - Forensics		1
		A forensic nurse evaluation was not considered by the initial treating hospital even though the infant presented with bruising to the cheek.	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
		Mother has a history of positive urine drug screens for marijuana, but she was not tested for marijuana at the infant's birth.	1
		No referrals were made by the birth hospital after it was suspected that the mother was using illicit drugs in the bathroom, and the infant was being observed for signs of withdrawal.	1

	Reporting		1
		The victim was seen at two hospital emergency departments for drug ingestion, and neither hospital made a report to the DFS Report Line.	1
Risk Assessment/ Caseloads			19
	Caseloads		10
		The DFS case workers were over the investigation and treatment (a portion of the time) caseload statutory standards while the cases were open. However, the caseload did not negatively impact the DFS response in those cases.	1
		The DFS case workers were over the investigation and treatment caseload statutory standards while the cases were open. It does not appear that the caseload negatively impacted the DFS response to the investigation; however, the caseload appears to have had a negative impact on the treatment 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 had a negative impact on the DFS response in the case.	2
		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.	2
		The case worker was over the investigation caseload statutory standards the entire time the case was open. However, the caseload did not negatively impact the DFS response in the death investigation.	1
		The DFS case workers were over the investigation and treatment caseload statutory standards while the cases were open, and the caseloads negatively impacted those cases.	1
		The DFS case worker was over the investigation caseload statutory standards while the case was open. However, the caseload did not negatively impact the DFS response in the near death investigation.	1
		The DFS case worker was over the investigation caseload statutory standards while the case was open. However, the caseload did not negatively impact the DFS response in the near death investigation. Treatment was not above standard.	1
	Collaterals		3
		History with the out of state child protective services agency was not checked until DFS was court ordered to do so.	1
		For the death investigation, a collateral contact was attempted with the physician prescribing the relative caregiver's pain medication, but there was no follow through by the case worker when a response was not received.	1
		During the prior investigation, a collateral contact with the PCP was not completed for the children, and there was no communication with the PCP regarding the safety agreement.	1
	Risk Assessment - Alternative Response		1
		Consistent with DFS Policy, the SDM Screening Assessment screened out the prior report for investigation since the domestic violence was not chronic and/or severe. Since differential response is not available for this population, no intervention was provided.	1

	Risk Assessment - Screen Out	1
	The DFS Report Line screened out a prior hotline report, which alleged that the victim was born substance exposed. The following risk factors were not considered: DFS history and mother's substance abuse and mental health history.	1
	Risk Assessment - Tools	3
	For the near death investigation, the SDM Risk Assessment was not completed correctly. The father's substance abuse and previous cases were not taken into consideration, and as a result, the risk was scored as moderate.	1
	For the near death incident, the SDM Risk Assessment was not completed correctly. The policy override for a severe non-accidental injury was not selected, so the case was closed.	1
	In the near death investigation, the SDM Risk Assessment was not completed correctly. The policy override for non-accidental injury to a non-verbal child was not selected, so the case was closed.	1
	Risk Assessment - Unsubstantiated	1
	There was no finding of abuse or neglect in the investigation despite the perpetrator's admission of guilt and criminal charges.	1
Safety/ Use of History/ Supervisory Oversight		15
	Completed Incorrectly/ Late	4
	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
	DFS entered into a safety agreement with a third party, but a home assessment was not initially conducted and the contact did not occur in person.	1
	The SDM Safety Assessment was not completed correctly for the death incident. No safety threats were identified.	1
	For the near death incident, the caseworker identified the victim as safe with agreement in the SDM safety assessment. However, the initial safety agreement did not consider the hospitalized victim. There was clear communication that mom should not have contact with him though.	1
	Inappropriate Parent/ Relative Component	5
	In the prior investigation, DFS completed a safety agreement with a relative, who had criminal and DFS histories.	1
	For the death investigation, the second-shift DFS worker completed a safety agreement with the same relative, who had criminal and DFS histories. The agreement was not reassessed by the assigned worker.	1
	For the near death incident, DFS completed a safety agreement with a participant, who was not ruled out as a suspect.	1
	For the near death incident, DFS completed a safety agreement with the parents, who were not ruled out as suspects.	1
	For the near death incident, safety was not reassessed once the medical findings suggested a different timeline for the injury. DFS continued to safety plan with the mother, who could not be ruled out as a suspect.	1

	No Safety Assessment of Non-Victims		1
		During the near death investigation, the case worker did not assess whether the relative caregiver had child(ren) residing in his/her home. As a result, safety was not assessed for the relative caregiver's child.	1
	Oversight of Agreement		5
		The SDM Safety Agreement was not re-evaluated in a timely manner.	1
		There was a lack of oversight and communication between the assigned investigation worker and active treatment worker despite multiple risk factors for the relative caregiver.	1
		The treatment worker's first contact with the family was delayed, and the child safety agreement was not reviewed in a timely manner. The near death incident was reported several days later.	1
		The SDM Safety Agreement was not re-evaluated in a timely manner. It was reviewed in the first 30 days but subsequent reviews were not timely.	1
		DFS completed a safety agreement with the father and agreed that the victim could reside in his care, without visiting the home.	1
Unresolved Risk			4
	Child - Medical		1
		The DFS case worker delayed referring the child to an early intervention program.	1
	Contacts		2
		There was minimal contact with the children for several months during the active treatment case.	1
		Prior to closing the near death investigation, the case worker visited the sibling to complete a 30 day contact and no interview was conducted. In addition, the other children were not seen.	1
	Domestic Violence		1
		DFS involved the father in the safety agreement, which included him being responsible for supervising the visits between the mother and victim, despite the concerns of domestic violence.	1
Grand Total			**92**

FINALS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			1
	Doll Re-enactment		1
		No doll re-enactment was completed by the law enforcement agency.	1
Medical			4
	Medical Exam / Standard of Care - Birth		1
		The midwife did not respond to the home after she received notification of the infant's birth.	1
	Medical Exam/ Standard of Care - Urgent Care		2
		The victim was seen at an urgent care facility for a suspected head injury and referred to the emergency department. However, the child was never seen by a physician, and the physician did not sign off on the child's medical records until eleven days after the evaluation.	1

		The physician assistant at the urgent care facility did not consider a differential diagnosis of abuse despite the young child presenting with a head injury.	1
	Transport		1
		Despite the head injury with concern for swelling, the urgent care facility allowed the mother to transport the child to the emergency department (ED). However, a call was made to the ED to relay concerns.	1
Risk Assessment/ Caseloads			1
	Collaterals		1
		There was no documentation of collateral contacts with relatives or providers to support the case worker closing the case against the risk score.	1
Grand Total			**6**

TOTAL FINDINGS **98**

Child Abuse and Neglect Panel

Strengths Summary

August 8, 2018

INITIALS		
	***Current**	**Grand Total**
Legal	**2**	**2**
Court Hearings/ Process	2	2
MDT Response	**51**	**51**
General - Civil Investigation	13	13
General - Criminal Investigation	15	15
General - Criminal/Civil Investigation	11	11
Interviews - Adults	2	2
Interviews - Child	3	3
Medical Exam	7	7
Medical	**9**	**9**
Documentation	2	2
Home Visiting Programs	2	2
Medical Exam/Standard of Care - CARE	2	2
Medical Exam/Standard of Care - ED	1	1
Medical Exam/Standard of Care - EMS	2	2
Risk Assessment/ Caseloads	**9**	**9**
Collaterals	5	5
Risk Assessment - Substantiated	3	3
Risk Assessment - Tools	1	1
Safety/ Use of History/ Supervisory Oversight	**6**	**6**
Completed Correctly/On Time	5	5
Custody/Guardianship Petitions	1	1
Unresolved Risk	**2**	**2**
Child - Medical	1	1
Substance Abuse	1	1
Grand Total	**79**	**79**

*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

Prepared 7/16/2018

Child Abuse and Neglect Panel

Strengths Detail and Rationale

August 8, 2018

INITIALS

System Area	Strength	Rationale	Count of #
Legal			2
	Court Hearings/ Process		2
		Both parents consented to placement on the Child Protection Registry at the Adjudicatory Hearing.	1
		The One Judge, One Family policy ensured the Judge had a broad perspective of the family history throughout the multiple case filings.	1
MDT Response			51
	General - Civil Investigation		13
		Safety agreements were implemented for the child during hospitalization, as well as for Father's older children who resided with their biological mother.	1
		The DFS case worker confirmed the child was seen by the primary care physician the day of the near death incident as reported by the parents.	1
		The DFS treatment case worker maintained quality contact with Mother, and referred Mother for a mental health evaluation.	1
		During the death investigation, the DFS case worker completed a safety agreement with the relative caregiver, and it included a stipulation about not co-sleeping with her young child.	1
		There was good communication between the DFS case worker and the medical team.	1
		Upon the child's hospital admission, the parents were restricted from having visitation with the child without DFS approval.	1
		The DFS Report Line requested that the child not be discharged without consultation with DFS.	1
		NCIC background checks were completed for the out-of-state family members.	1
		Following the miscommunication and premature case closure, DFS held a team meeting where the safety agreement was re-implemented, and consultation was completed with the Deputy Attorney General regarding re-opening the case.	1
		The DFS case worker confirmed that prescription pills were available in various colors depending on the dosage.	1
		There was good communication between the DFS investigation and treatment workers.	1
		During the prior investigation, the DFS caseworker educated Mother on infant safe sleep practices.	2
	General - Criminal Investigation		15
		The Criminal Deputy Attorney General (DAG) was present during the scene investigation.	1
		There was excellent collaboration between the law enforcement agency and the forensic investigators.	1
		The forensic investigator researched the manufacturer of the air mattress and reported the death to the Product Safety Council.	1
		The law enforcement detective conducted blood draws of the parents as they self-reported marijuana use.	1
		LE and the forensic investigator conducted a doll reenactment with the relative caregiver and completed the SUDI form.	1
		The law enforcement agency conducted a blood draw of the relative caregiver.	1

	The law enforcement agency provided the relative caregiver with a pack n' play for her nine-month-old infant.	1
	The MDT provided the child abuse medical expert with its initial investigative findings, including the doll reenactment video.	1
	The federal law enforcement agency initiated a no contact order between the father and child.	1
	The law enforcement agency proceeded with the case investigation despite the injury occurring on the military base and military authorities undecided if they were taking the case.	1
	The law enforcement agency completed the video-recorded doll reenactment expeditiously.	1
	The law enforcement agency set up surveillance to determine if the parents were violating the no contact order.	1
	In a screened out hotline report, the law enforcement agency provided information from the lethality assessment.	1
	The law enforcement agency conducted a scene investigation and a video-recorded doll reenactment expeditiously.	1
	The law enforcement agency requested evidentiary blood draw of the child.	1
General - Criminal/Civil Investigation		11
	There was excellent MDT collaboration and response to the death investigation.	1
	There was good collaboration between LE, DFS, and the medical team during the investigation, as well as with follow up medical care for the child.	1
	There was good initial collaboration between LE, DFS, and DOJ for the death investigation. DOJ was notified of the infant death immediately.	1
	A joint investigation was conducted by the MDT to include a coordinated home visit and interviews, and communication with the CARE Team at the children's hospital.	1
	There was good initial communication and collaboration between the MDT, to include state and federal law enforcement agencies, DFS, and hospitals.	1
	There was good collaboration between DFS and the law enforcement agency.	1
	There was excellent communication between DFS, the law enforcement agency, and the child abuse medical expert. As a result, a discharge planning meeting occurred for the child.	1
	There was good communication and collaboration between the MDT throughout the case and multiple investigations.	1
	Great collaborative response between the medical CARE Team, DFS, and the law enforcement agency during the near death investigation, to include an MDT meeting with all parties present.	1
	There was good collaboration and consistent communication between DFS and the law enforcement agency.	1
	Great collaborative response between the medical CARE Team, DFS, and the law enforcement agency during the near death investigation, to include joint interviews and an MDT meeting with all parties present.	1
Interviews - Adults		2
	During the law enforcement interview, the detective questioned the parents on prior child deaths within the family, and inquired if the parents received infant safe sleep education.	1
	The Deputy Attorney General (DAG) had the recording of the law enforcement interview sent out for translation.	1

	Interviews - Child	3
	A forensic interview was scheduled and held at the CAC for the siblings residing in the home where the incident occurred.	2
	A second forensic interview was scheduled and held at the CAC after the young sibling disclosed physical abuse to Mother by her paramour.	1
	Medical Exam	7
	The DFS case worker ensured Father's older children were medically evaluated.	1
	The DFS case worker ensured the child's sibling was medically evaluated.	2
	The child received a follow up medical evaluation at the children's hospital, and there was excellent communication between DFS, the law enforcement agency, and the child abuse medical expert.	1
	The DFS case worker ensured the child's siblings were medically evaluated.	2
	The assigned DFS case worker ensured the older sibling was also drug tested.	1
Medical		9
	Documentation	2
	The primary care physician's records were well documented.	2
	Home Visiting Programs	2
	The DFS treatment worker referred the child to an early intervention program.	1
	A referral to an early intervention program was made for the child prior to medical discharge.	1
	Medical Exam/ Standard of Care - CARE	2
	In its documentation, the CARE Team considered and debunked two medical myths offered by the parents as the probable cause of the injuries.	1
	The CARE Team was consulted to explore whether the drug was passed through the maternal breastmilk.	1
	Medical Exam/ Standard of Care - ED	1
	The local hospital consulted with the children's hospital about the child's injuries, involved its SANE to take photographs, completed an appropriate workup given the inconsistent history provided by the parents, and admitted the child to allow the MDT to investigate and plan for safety.	1
	Medical Exam/ Standard of Care - EMS	2
	There was good response time and documentation from emergency medical services.	2
Risk Assessment/ Caseloads		9
	Collaterals	5
	Within 48 hours of the incident, the DFS case worker contacted the local hospital to obtain the child's birth history.	1
	The DFS case worker maintained quality contact with the family.	1
	The DFS investigation case worker referred Mother and maternal grandfather for substance abuse evaluations.	1
	The DFS treatment case worker maintained timely and quality contact with the family.	1
	The DFS case worker maintained quality contact with the family during the investigation.	1
	Risk Assessment - Substantiated	3
	Both parents were substantiated for the near death incident; Father for abuse of the child and Mother for failure to protect the child.	1

	DFS substantiated Mother for Life Threatening Medical Neglect as a result of the near death incident.	1
	At the conclusion of its investigations, DFS made appropriate findings against the perpetrator and the non-offending caregiver as a result of the child's injuries and violation of the no contact order.	1
Risk Assessment - Tools		1
	A Framework was completed during the investigation case.	1
Safety/ Use of History/ Supervisory Oversight		6
Completed Correctly/On Time		5
	There was consistent review and modification, when necessary, of the safety agreement by the DFS caseworker.	1
	Following re-implementation of the safety agreement, the DFS case worker physically checked the child for any new bruising/marks and documented the findings.	1
	The DFS case worker implemented a safety agreement while the child was hospitalized, and it required supervised contact between the child and parents at the hospital.	1
	The DFS case worker immediately implemented a safety agreement prohibiting contact between the victim and the alleged perpetrator.	1
	The after-hours DFS case worker implemented a safety agreement while the child was hospitalized prior to the circumstances changing with the timeline.	1
Custody/Guardianship Petitions		1
	DFS petitioned for custody of the child quickly.	1
Unresolved Risk		2
Child - Medical		1
	There was good attention to the victim's well-being by the investigation and treatment case workers.	1
Substance Abuse		1
	The DFS case worker made referrals to a substance abuse treatment provider to address parental risk factors.	1
Grand Total		**79**

STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
C/O OFFICE OF THE CHILD ADVOCATE
900 KING STREET, SUITE 210
WILMINGTON, DELAWARE 19801
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MARY F. DUGAN, ESQUIRE
CHAIR

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

November 14, 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 19 cases at its November 14, 2018 meeting.[1]

Ten of the cases (five deaths and five near deaths) had been previously reviewed and were awaiting the completion of prosecution. All but one of the cases were ultimately prosecuted. Of the seven cases prosecuted in Delaware, the convictions were primarily Endangering the Welfare of a Child and none of the cases resulted in incarceration. For the two children whose cases were prosecuted in Maryland, the Father received 55 years at Level 5 and the Mother received 10 years at Level 5.

The nine remaining cases were from deaths or near deaths that occurred between February 2018 and May 2018. These timely reviews enable CPAC to address current system issues as well as celebrate accomplishments. The children in these 9 cases range in age from two weeks old to three years old with 4 deaths and 5 near deaths.

[1] 16 Del. C. § 932.

The children were primarily victims of abusive head trauma or unsafe sleep conditions. Two of these children were horrifically tortured. These nine cases resulted in 57 strengths and 66 current findings across system areas.

During the last quarter, the largest number of findings were again made regarding the multidisciplinary ("MDT") response to these cases. Twenty-three findings showed significant breakdowns within a few of the investigations involving many elements of the new MOU for the MDT Response to Child Abuse and Neglect. In fact, findings in every area tracked for the MDT response were made this quarter. At the same time, 34 strengths were noted with several investigations. Within the CPAC Training Committee is a workgroup tasked with training on the new MOU. Systems breakdowns involving reporting, documentation, joint interviews, medical exams for siblings, and forensic interviews for children must be addressed and utilized in the training. To the extent breakdowns are occurring with specific jurisdictions, intensive in-person training should be offered by CPAC.

Progress with DFS regarding the use of safety agreements, unresolved risk and risk assessment is again seen this quarter. Thirty-seven findings were made in these categories. This is heartening given the unmanageable caseloads of frontline workers. Once caseloads are subtracted, 28 findings remained again primarily focused on breakdowns in the use of safety agreements. CPAC and DFS continue to partner to improve these agreements, and DFS provided additional staff training in June 2018 on use of the safety assessment to support decisions about the immediate safety of children. Twenty strengths were also noted with DFS workers performing diligent investigations in a few of these most difficult cases. These positive examples will also be highlighted in trainings.

The caseloads of DFS frontline workers continue to merit attention. 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 9 of the 10 recent 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 is grateful that the General Assembly included in the State budget the 30 additional frontline positions. However, the funding of these positions is but the first step in a complicated recruitment and retention plan.

CPAC continues to encourage the State to consider opportunities to make these positions attractive with funding, hazard pay, technologic support (including Surface Pros) as well as consider creative solutions such as a Children's Corp similar to the Teach for America model. There are still investigators carrying 40 to 50 cases with a statutory standard of 11. Workers continue to resign under the pressure contributing to the turnover rate and escalating caseloads for those that remain. It is critical that we all collectively ensure that once we tackle this crisis by employing and retaining frontline workers, 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 13 child abuse or neglect deaths and 29 near deaths. In 2017, 13 children died and another 31 almost died from abuse or neglect in Delaware. All of the recent reviews of children reflected in this letter are from 2018. 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. 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

November 14, 2018

INITIALS

	*Current	Grand Total
MDT Response	**23**	**23**
Communication	1	1
Crime Scene	3	3
Documentation	3	3
General - Criminal Investigation	2	2
General - Criminal Investigation / Civil Investigation	1	1
Interviews - Adult	3	3
Interviews - Child	2	2
Medical Exam	4	4
Reporting	4	4
Medical	**6**	**6**
Medical Exam/Standard of Care - Birth	2	2
Medical Exam/Standard of Care - ED	1	1
Reporting	1	1
Transport	2	2
Risk Assessment/ Caseloads	**17**	**17**
Caseloads	9	9
Risk Assessment - Closed Despite Risk Level	2	2
Risk Assessment - Screen Out	1	1
Risk Assessment - Tools	4	4
Risk Assessment - Unsubstantiated	1	1
Safety/ Use of History/ Supervisory Oversight	**15**	**15**
Completed Incorrectly/ Late	10	10
Inappropriate Parent/ Relative Component	2	2
Oversight of Agreement	1	1
Supervisory Oversight	2	2
Unresolved Risk	**5**	**5**
Contacts	1	1
Domestic Violence	1	1
Multiple	2	2
Supervisory Oversight	1	1
Grand Total	**66**	**66**

FINALS

	*Current	Grand Total
Risk Assessment/ Caseloads	**1**	**1**
Reporting	1	1
Safety/ Use of History/ Supervisory Oversight	**3**	**3**
Completed Incorrectly/ Late	3	3
Grand Total	**4**	**4**

70

**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

November 14, 2018

INITIALS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			23
	Communication		1
		The MDT was initially told that there was no evidence of injuries or concerns for bruising. It is unclear whether this information was relayed by a member of the medical team.	1
	Crime Scene		3
		No scene investigation was completed by the law enforcement agency.	1
		The SUIDI form was not fully completed by the law enforcement agency, and it may have impacted the cause and manner.	1
		No scene investigation was documented by the law enforcement agency. In addition, measurements and photographs were not obtained from the scene related to the alleged fall.	1
	Documentation		3
		There was no documentation in the police report by the lead detective.	1
		There was no documentation by DFS after a supervisor was notified about the child's death by the Division of Forensic Science.	1
		There was no documentation in the police report by the lead detective. The caseload for the detectives assigned to this law enforcement jurisdiction was high and may have had an impact on the documentation.	1
	General - Criminal Investigation		2
		There was not an immediate call to the Criminal Investigations Unit by the law enforcement agency. As a result, the agency initially declined to respond.	1
		The law enforcement agency delayed sending the parents' blood kits to the Division of Forensic Science. As a result, the toxicology results were delayed.	1
	General - Criminal Investigation / Civil Investigation		1
		For the prior investigation, there was not a strong MDT response to an unexplained burn involving the same victim.	1
	Interviews - Adult		3
		DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	2
		The DFS after-hours workers interviewed the suspects without the law enforcement agency present, potentially impacting the criminal investigation.	1
	Interviews - Child		2
		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
		Forensic interview did not occur with the young child who visited the home where the death incident occurred, and the child's parent was a witness to the death incident.	1

	Medical Exam		4
		The older sibling who was present in the home during the near death incident was not medically evaluated.	1
		The infant was not referred for a full workup by the child abuse medical expert until six days after the incident.	1
		The young child who visited the home where the death incident occurred was not medically evaluated.	1
		For the prior investigation, the DFS caseworker did not independently contact the child abuse medical expert to discuss the medical findings. It was concluded that the injury was non-accidental.	1
	Reporting		4
		The MDT did not make a report to DFS Report Line after the sibling made a disclosure during the forensic interview.	1
		The law enforcement agency did not make a report to the DFS Report Line for the near death incident.	1
		Prior to the death incident, there were 4 recent verbal disputes between the parents in which the law enforcement agency responded. One incident involved the children being present, and there was no report to the DFS Report Line.	1
		The Division of Forensic Science did not make a report to the DFS Report Line for the death incident.	1
Medical			6
	Medical Exam/Standard of Care - Birth		2
		The birth hospital rushed the safe sleep education with the family.	1
		Mother was using heroin at the beginning of her pregnancy, but she was not given a urine drug screen at the infant's birth.	1
	Medical Exam/Standard of Care - ED		1
		The abdominal bruising was not documented in the trauma team's notes, and this impacted the initial information that was communicated to the MDT about the child death.	1
	Reporting		1
		The hospital did not report the child death to the DFS Report Line.	1
	Transport		2
		PCP suspected abuse during the well visit, but the infant was permitted to leave with the mother.	1
		PCP allowed the mother to transport the child with suspected head trauma to the hospital emergency department.	1
Risk Assessment/ Caseloads			17
	Caseloads		9
		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.	3

		The caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it is unclear whether the caseload had a negative impact on the DFS response in the case.	2
		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.	2
		The DFS case worker was over the investigation caseload statutory standards while the case was open. However, the caseload did not negatively impact the DFS response in the near death investigation.	1
		The DFS case workers were over the investigation and treatment 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
	Risk Assessment - Closed Despite Risk Level		2
		It does not appear that the linked investigation was considered in the decision to close the prior treatment case. The treatment case was quickly closed after the substantiated incident, and the mother failed to complete her parenting classes.	1
		The SDM Risk Assessment identified the risk as high in the prior investigation. Ongoing service was recommended; however, the case disposition was overridden to close the investigation after a Framework was completed.	1
	Risk Assessment - Screen Out		1
		The call by the hospital to the DFS Report Line was written as a hotline progress note rather than a new report. It appears that multiple calls were made by the hospital that were not documented.	1
	Risk Assessment - Tools		4
		For the near death incident, the SDM Risk Assessment was not completed correctly. The mother's mental health and father's substance abuse was not taken into consideration.	1
		For the near death incident, the SDM Risk Assessment was not completed correctly. The mother's out of state criminal history and child protective services history was not considered.	1
		For the prior investigation, the SDM Risk Assessment was not completed correctly. The risk was scored as moderate; however, it is unclear whether the risk rating had an impact since the case was already active in treatment.	1
		For the near death incident, the SDM Risk Assessment was not completed correctly as the paramour was not included as a caregiver. The case was also closed against the risk since the paramour no longer resided in the home; however, a framework was not considered.	1
	Risk Assessment - Unsubstantiated		1
		For the near death incident, DFS did not consider a Level 4 finding after the child sustained injuries consistent with head trauma. Instead, a Level 3 finding was made.	1
Safety/ Use of History/ Supervisory Oversight			15
	Completed Incorrectly/ Late		10
		For the near death incident, the caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization.	1

		In the prior investigation, DFS entered into a safety agreement with a relative, but an interview and home assessment were not conducted.	1
		The initial safety agreement permitted only unsupervised contact between the suspect, victim and siblings, but it could have been stronger at the time of the initial response.	1
		DFS entered into a safety agreement with a relative, but a home assessment was not initially conducted and the relative was not contacted in person.	1
		DFS entered into a safety agreement with a relative, but a home assessment was not initially conducted.	1
		For the first report involving the drug exposed infant, DFS completed a safety agreement with the mother and another relative prior to completing collateral contacts with substance abuse and mental health providers.	1
		For the prior investigation, DFS entered into a safety agreement with a relative, but a home assessment was not initially conducted.	1
		For the near death incident, DFS entered into a safety agreement with a relative, but a home assessment was not initially conducted.	1
		DFS entered into a safety agreement with a relative at the parents' home, but a home assessment was not initially conducted and the relative was not contacted in person.	1
		For the near death incident, the victim and sibling were initially determined to be safe. However, the victim's injury and DFS history were not considered as safety threats in the SDM Safety Assessment.	1
	Inappropriate Parent/ Relative Component		2
		For the prior investigation, DFS entered into a safety agreement with a relative, who was not an appropriate caregiver due to DFS history and the conditions of the home.	1
		For the near death incident, DFS completed a safety agreement with the mother, who was not ruled out as a suspect.	1
	Oversight of Agreement		1
		The SDM Safety Agreement was not re-evaluated in a timely manner during the near death investigation.	1
	Supervisory Oversight		2
		The safety agreement was terminated without having any face to face contact with the family, and the case worker had no contact with the family for several months after the safety agreement was terminated.	1
		The subsequent safety agreements for the victim could have been stronger. DFS entered into safety agreements with mother and two other participants, and there were several risk factors for mother and minimal oversight of the agreements.	1
Unresolved Risk			5
	Contacts		1
		During the prior investigation, the initial contact did not occur with the victim until 3 months after the referral was received. The caseload may have impacted the worker's attempts to reach the family.	1

	Domestic Violence		1
		Domestic violence was disclosed during the forensic interviews, and a referral to the domestic violence liaison was not considered. The mother was also used to supervise the father's contact with the children.	1
	Multiple		2
		In the prior investigation, the case worker had concerns with mother's compliance with probation, substance abuse and mental health services, and medical care for the infant. No immediate action was taken by the case worker with the exception of transferring the case to treatment for services.	1
		The treatment worker did not identify any safety threats after the mother and children moved into a home with a significant history of child maltreatment and substance abuse concerns.	1
	Supervisory Oversight		1
		The safety agreement was terminated even though the father failed to complete a substance abuse evaluation, and the forensic interviews revealed concerns for substance abuse and domestic violence.	1
Grand Total			**66**

FINALS

System Area	Finding	PUBLIC Rationale	Sum of #
Risk Assessment/ Caseloads			1
	Reporting		1
		During the near death incident, a sibling reported allegations of abuse by the mother's paramour, and the caseworker did not contact the DFS Report Line or conduct an interview with the mother's paramour.	1
Safety/ Use of History/ Supervisory Oversight			3
	Completed Incorrectly/ Late		3
		For the near death incident, the caseworker incorrectly identified the child as safe in the SDM safety assessment. As a result, there was no safety agreement, and second shift authorized the hospital to discharge the child to her mother, the alleged perpetrator.	1
		For the death investigation, DFS completed a safety agreement with the father prior to completing collateral contacts with substance abuse providers.	1
		For the death investigation, DFS completed a safety agreement with the mother prior to completing collateral contacts with substance abuse and other providers.	1
Grand Total			**4**

TOTAL FINDINGS **70**

Child Abuse and Neglect Panel
Strengths Summary
November 14, 2018

INITIALS		
	***Current**	**Grand Total**
Legal	**2**	**2**
Court Hearings/ Process	1	1
DFS Contact with DOJ	1	1
MDT Response	**34**	**34**
Documentation	2	2
General - Civil Investigation	5	5
General - Criminal Investigation	4	4
General - Criminal/Civil Investigation	10	10
Interviews - Adults	1	1
Interviews - Child	5	5
Medical Exam	7	7
Medical	**6**	**6**
Home Visiting Programs	2	2
Medical Exam/Standard of Care - PCP	1	1
Reporting	3	3
Risk Assessment/ Caseloads	**6**	**6**
Collaterals	3	3
Risk Assessment - Tools	2	2
Use of History	1	1
Safety/ Use of History/ Supervisory Oversight	**8**	**8**
Completed Correctly/On Time	1	1
Custody/Guardianship Petitions	1	1
Oversight of Agreement	3	3
Safety Assessment of Non-Victims	2	2
Use of History	1	1
Unresolved Risk	**1**	**1**
Mental Health	1	1
Grand Total	**57**	**57**

FINALS		
	***Current**	**Grand Total**
MDT Response	**2**	**2**
General - Criminal Investigation	1	1
General - Criminal/Civil Investigation	1	1
Grand Total	**2**	**2**

*Current - within 1 year of incident
**Prior - 1 year or more prior to incident

59

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

Child Abuse and Neglect Panel

Strengths Detail and Rationale

November 14, 2018

INITIALS

System Area	Strength	Rationale	Count of #
Legal			2
	Court Hearings/ Process		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 death incident involving a young child residing in the same home.	1
	DFS Contact with DOJ		1
		The DFS case worker consulted with DOJ regarding medical consent for the child.	1
MDT Response			34
	Documentation		2
		The law enforcement agency thoroughly documented the investigation case events.	1
		The DFS case worker thoroughly documented the investigation case events.	1
	General - Civil Investigation		5
		During the prior investigation, the DFS case worker educated Mother on infant safe sleep practices.	1
		The after-hours DFS case worker challenged the law enforcement agency and medical staff to ensure certain interventions were completed despite early assumptions that the injury was accidental.	1
		The DFS case worker communicated with multiple parties regarding the suspect's young child, and there was strong attention to his well-being.	1
		The DFS case worker consulted with an out of state child protective services agency as it was known that the family resided in that state for some time.	1
		The DFS case worker and medical team immediately identified the medical consents needed for the child as Mother was incapacitated. Both parties worked with the Courts to ensure maternal grandparents obtained emergency guardianship in order to make the medical decisions on the child's behalf.	1
	General - Criminal Investigation		4
		The law enforcement agency provided the Father's explanation for the injuries to the CARE Team, and this information helped the medical team to understand the complexity of the fall.	1
		The law enforcement agency conducted blood draws after it was suspected that the parents were intoxicated while co-sleeping with the child.	1
		The law enforcement agency conducted a blood draw for Mother after it was suspected that she was under the influence while co-sleeping with the child.	1
		The law enforcement agency requested blood draw of Mother during the criminal investigation.	1
	General - Criminal/Civil Investigation		10
		Great collaborative response between the DFS investigation and treatment case workers, and the law enforcement agency during the near death investigation, to include interagency communication, joint response to the home, joint interviews, thorough documentation, and an independent consultation with the child abuse medical expert.	1
		There was good communication between the assigned DFS case worker and the law enforcement detective.	1
		There was a strong MDT response to the death investigation by the after-hours case worker and the law enforcement agency, to include joint responses to locate the young child residing in the home where the incident occurred and joint interviews.	1

		There was good communication between the DFS case worker, the law enforcement agency, and the medical team.	1
		As the case was reported to the traffic division of DOJ, notification to the MDT members by the Investigation Coordinator allowed the Special Victim's Unit to consult with the traffic division regarding cases such as this involving serious injury to a child(ren).	1
		There was good and consistent communication between the DFS case worker, the law enforcement agency, and the DOJ.	1
		There was good and consistent communication between the DFS case worker and the law enforcement agency.	1
		Great collaborative response between DFS, the law enforcement agency, and the forensic investigator during the death investigation, to include joint interviews and doll reenactment.	1
		There was good collaboration between the DFS case worker and the law enforcement agency, to include joint interviews and the case worker observing the doll reenactment.	1
		There was good collaboration and consistent communication between the DFS case worker and the law enforcement agency.	1
	Interviews - Adults		1
		A forensic interview was scheduled and held at the CAC for the young child residing in the home where the incident occurred, and a second interview was scheduled and held after the initial interview could not be completed.	1
	Interviews - Child		5
		A forensic interview was scheduled and held at the CAC for the siblings residing in the home where the incident occurred. The interviews were conducted within 24 hours.	1
		The after-hours DFS case worker pushed for forensic interviews to be conducted for the siblings residing in the home.	1
		Forensic interviews were scheduled and held at the CAC for the siblings residing in the home where the incident occurred.	1
		A forensic interview was scheduled and held at the CAC for the sibling residing in the home where the incident occurred.	2
	Medical Exam		7
		The DFS case worker ensured the child's siblings were medically evaluated.	2
		The DFS case worker ensured the suspect's young child was medically evaluated.	1
		The after-hours DFS case worker ensured the child's siblings were medically evaluated.	1
		The DFS case worker ensured the child's siblings were medically evaluated. The medical evaluation included a toxicology screen and skeletal survey.	1
		The hospital social worker and the DFS case worker communicated prior to giving an update to the family, and this helped the family understand the need for the hospital admission.	1
		The DFS case worker ensured the child's siblings were medically evaluated.	1
Medical			6
	Home Visiting Programs		2
		A referral to an early intervention program was made for the child prior to medical discharge.	1
		Home visiting services were initiated for the family during the Mother's pregnancy. She presented to a local hospital and a visiting nurse identified her as high risk.	1
	Medical Exam/ Standard of Care - PCP		1
		The PCP obtained the child's birth records following the near death incident.	1

Reporting		3
	The birthing hospital made a referral to the DFS Child Abuse and Neglect Report Line at the time of Mother's release from incarceration, with concerns of Mother being overwhelmed with caring for the infant while treating her own substance abuse and mental health issues. At this time, the infant remained in the neonatal intensive care unit (NICU).	1
	The PCP made a referral to the DFS Child Abuse and Neglect Report Line, and advised that Mother was en route to the children's hospital with the child.	1
	The hospital made a report to the DFS Child Abuse and Neglect Report Line despite this type of injury being rare for children.	1
Risk Assessment/ Caseloads		6
Collaterals		3
	Strong collateral contacts were completed during the current and prior DFS investigations.	1
	The DFS treatment case worker maintained quality contact with the family, and ensured appropriate referrals were made for Mother and child.	1
	Strong collaterals were completed, to include Mother's OB/Gyn physician.	1
Risk Assessment - Tools		2
	A Framework was completed during the investigation case.	1
	During the prior investigation, a Framework was completed.	1
Use of History		1
	The DFS case worker consulted with an out of state child protection agency regarding any history for the step-father.	1
Safety/ Use of History/ Supervisory Oversight		8
Completed Correctly/On Time		1
	The DFS case worker implemented a safety agreement while the child was hospitalized, and it required supervised contact between the child and the mother at the hospital.	1
Custody/Guardianship Petitions		1
	During the near death incident, the DFS investigation case worker immediately petitioned for custody.	1
Oversight of Agreement		3
	There was consistent review and modification, when necessary, of the safety agreement(s) by the DFS caseworker.	1
	The DFS case worker reassessed safety when new information was received from Mother's substance abuse treatment facility.	1
	There was consistent review and modification, when necessary, of the safety agreement by the DFS case worker.	1
Safety Assessment of Non-Victims		2
	The after-hours DFS case worker immediately implemented a safety agreement for the two siblings residing in the home.	1
	The after-hours DFS case worker implemented safety agreements for the children and ensured home assessments were completed for all participants.	1
Use of History		1
	Upon receipt of the second hotline call following the child's birth, an investigation case was opened.	1

Unresolved Risk			1
	Mental Health		1
		The suspect's young child was not intially recommended for therapy until the DFS supervisor provided additional information regarding the child's adverse childhood experiences.	1
Grand Total			**57**

FINALS

System Area	Strength	Rationale	Count of #
MDT Response			2
	General - Criminal Investigation		1
		There was good follow-up relating to Mother's substance abuse history.	1
	General - Criminal/Civil Investigation		1
		There was good and consistent communication between the DFS case worker, the law enforcement agency, and the DOJ.	1
Grand Total			**2**

TOTAL STRENGTHS **59**

STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
C/O OFFICE OF THE CHILD ADVOCATE
900 KING STREET, SUITE 210
WILMINGTON, DELAWARE 19801
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MARY F. DUGAN, ESQUIRE
CHAIR

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

March 26, 2019

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 20 cases at its March 26, 2019 meeting.[1]

Nine of the cases (three deaths and six near deaths) had been previously reviewed and were awaiting the completion of prosecution. Six of the cases were ultimately prosecuted. The eleven remaining cases were from deaths or near deaths that occurred between May 2018 and July 2018. These timely reviews enable CPAC to address current system issues as well as celebrate accomplishments. Other than one sibling group, the children range in age from two months old to two years old with 4 deaths and 7 near deaths. The children were primarily victims of abuse. These eleven cases resulted in 53 strengths and 33 current findings across system areas.

The cases reviewed and reflected in this letter coincide with CPAC concluding trainings statewide on the new Memorandum of Understanding for the

[1] 16 Del. C. § 932.

multidisciplinary ("MDT") response to these cases. For this quarter, 27 strengths were noted for the MDT while only 8 findings were made. CPAC should continue its efforts to train the MDT on best practices and to reach as many jurisdictions as possible. CPAC should also continue its efforts to provide access to local and national conferences for frontline responders.

Progress with DFS regarding the use of safety agreements, unresolved risk and risk assessment is again seen this quarter. Only 21 findings were made in these categories. This is very encouraging given the unmanageable caseloads of frontline workers. Once caseloads are subtracted, 13 findings remained again primarily focused on the use of safety agreements. CPAC and DFS continue to partner to improve these agreements, and DFS provided additional staff training in June 2018 on use of the safety assessment to support decisions about the immediate safety of children. The cases seen here occurred close in time to that training and the impact is evident. Sixteen strengths were also noted with DFS workers performing thorough investigations. These positive examples will continue to be highlighted in trainings, both locally and nationally.

The caseloads of DFS frontline workers continue to merit attention. CPAC continues to be grateful for the leadership in tackling the complex issues that face DFS in the recruitment and retention of frontline child welfare workers. In 8 of the 11 recent cases contained in this letter, the DFS worker was significantly over the statutory caseload standard. CPAC continues to support additional frontline positions to ensure statutory compliance. There are still investigators carrying 40 plus cases with a statutory standard of 11. Workers continue to resign under the pressure contributing to the turnover rate and escalating caseloads for those that remain. It is critical that we all collectively ensure that once we tackle this crisis by employing and retaining frontline workers, 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.

In 2018, Delaware experienced 14 child abuse or neglect deaths and 34 near deaths. 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. 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

Strengths Summary

March 26, 2019

INITIALS		
	***Current**	**Grand Total**
MDT Response	**27**	**27**
Documentation	2	2
General - Civil Investigation	5	5
General - Criminal Investigation	5	5
General - Criminal/Civil Investigation	9	9
Interviews - Adults	1	1
Interviews - Child	2	2
Medical Exam	3	3
Medical	**10**	**10**
Home Visiting Programs	4	4
Medical Exam/Standard of Care - Birth	1	1
Medical Exam/Standard of Care - CARE	2	2
Medical Exam/Standard of Care - ED	3	3
Risk Assessment/ Caseloads	**2**	**2**
Collaterals	1	1
Risk Assessment - Substantiated	1	1
Safety/ Use of History/ Supervisory Oversight	**8**	**8**
Completed Correctly/On Time	4	4
Oversight of Agreement	3	3
Supervisory Oversight	1	1
Unresolved Risk	**6**	**6**
Domestic Violence and Parenting	1	1
Home Visiting Programs	3	3
Mental Health	2	2
Grand Total	**53**	**53**

FINALS		
	***Current**	**Grand Total**
MDT Response	**1**	**1**
General - Criminal/Civil Investigation	1	1
Grand Total	**1**	**1**

TOTAL STRENGTHS 54

**Current - within 1 year of incident*

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

Child Abuse and Neglect Panel

Strengths Detail and Rationale

March 26, 2019

INITIALS

System Area	Strength	Rationale	Count of #
MDT Response			27
	Documentation		2
		The law enforcement agency thoroughly documented the investigation case events.	1
		The DFS after-hours case worker thoroughly documented the case events, to include identifying next steps.	1
	General - Civil Investigation		5
		The law enforcement agency thoroughly documented the investigation case events.	1
		The DFS case worker educated Mother on infant safe sleep practices when the parents advised of co-sleeping with the child and sibling.	1
		The DFS case worker ensured Mother obtained a lockbox to store her prescription medications.	1
		The DFS case worker educated Mother on infant safe sleep practices.	2
	General - Criminal Investigation		5
		The law enforcement agency thoroughly documented the investigation case events.	1
		The law enforcement agency conducted a blood draw for Mother after it was discovered that she had a history of substance abuse.	1
		The law enforcement agency conducted blood draws of the foster parents during the death investigation.	1
		The law enforcement agency collaborated with out of state authorities to conduct a scene investigation of Father's temporary residence and to interview Father's supervisor.	1
		The Criminal DAG recommended that the medical exam include weight and height measurements for the sibling to exclude the young child as an alleged perpetrator.	1
	General - Criminal/Civil Investigation		9
		There was great collaborative response between the DFS case worker and the law enforcement agency during the near death investigation, to include interagency communication, joint response to the hospital, joint interviews, thorough documentation, and consultation with the child abuse medical expert.	1
		There was excellent communication between the DFS case worker, the law enforcement agency, and the medical team during the near death investigation, as well as follow up medical care for the child.	1
		The MDT requested the young sibling be video-recorded during play time to rule out aggressive behaviors as reported by the parents.	1
		A joint investigation was conducted by the MDT to include a coordinated response to the hospital, and excellent communication between the DFS case worker and the law enforcement agency throughout the investigation.	1
		There was great collaborative response and ongoing communication between the medical CARE Team, DFS, DOJ, and the law enforcement agency during the near death investigation, to include joint interviews and an MDT meeting with all parties present.	1
		There was great collaborative response and communication between DFS, DOJ, and the law enforcement agency during the death investigation, to include joint interviews, forensic interviews of the children, medical evaluations, and sharing of interagency information, specifically the contract agency and Institutional Abuse investigation reports.	1
		There was good collaboration among the MDT during the near death investigations, to include interagency communication, joint interviews, thorough documentation, and consultation with the child abuse medical expert.	1
		There was good communication between the medical team, DFS, and the law enforcement agency.	1

	There was a great collaborative response between the medical CARE Team, DFS, DOJ, and the law enforcement agency during the near death investigation, to include a joint response to the hospital, joint interviews, and consultation with the child abuse medical expert.	1
Interviews - Adults		1
	Joint interviews were completed with the parents, initially at the hospital and later at the police station.	1
Interviews - Child		2
	Forensic interview was scheduled and held at the CAC for the young sibling residing in the home where the incident occurred. The interview was conducted within 24 hours.	2
Medical Exam		3
	The DFS case worker ensured the child's sibling was medically evaluated.	2
	The DFS case worker ensured the child's sibling was medically evaluated. The DFS case worker also recommended that a follow-up medical evaluation be conducted by the child abuse medical expert.	1
Medical		10
Home Visiting Programs		4
	A referral to an early intervention program was made for the child prior to medical discharge.	1
	The child abuse medical expert referred the child to an early intervention program.	1
	A referral to an early intervention program was made for the child prior to medical discharge by the birthing hospital.	1
	A referral for home visiting services was made for the child prior to medical discharge by the birthing hospital.	1
Medical Exam/ Standard of Care - CARE		2
	Follow-up medical evaluation of the young sibling included a skeletal survey, as well as measurements of the child due to aggressive behaviors reported by the parents. This would assist in determining if the young child was capable of causing injury to the infant.	1
	The child abuse medical expert met with the family to explain the child's injuries and consistently stated the child's injuries resulted from abusive head trauma.	1
Medical Exam/ Standard of Care - ED		3
	The initial treating hospital emergency department provided a comprehensive medical response to the child prior to transfer to the children's hospital.	1
	The trauma, social work, and CARE Team consults were conducted in the emergency department preventing any delays in admission, treatment, or report to DFS.	1
	While the child's injuries appeared to be consistent with a fall, a differential diagnosis of abusive head trauma/non-accidental trauma was considered by the children's hospital.	1
Medical Exam/Standard of Care - Birth		1
	Plan of safe care meetings were held prior to medical discharge of the child.	1
Risk Assessment/ Caseloads		2
Collaterals		1
	There was good follow-up and collaterals completed by the DFS case worker relating to Mother's mental health and substance abuse.	1
Risk Assessment - Substantiated		1
	At the conclusion of the investigation, DFS made appropriate findings against the perpetrator as a result of the child's injuries.	1

Safety/ Use of History/ Supervisory Oversight			8
	Completed Correctly/On Time		4
		The DFS case worker implemented a safety agreement while the child was hospitalized, and it restricted contact between the child and the parents at the hospital.	2
		The DFS case worker implemented a safety agreement while the child was hospitalized, and it required supervised contact between the child, the parents, and the maternal grandmother at the hospital.	1
		The DFS case worker implemented safety agreements for the surviving children in the home, and it restricted contact between the children and the foster parents, as well as included safeguarding the pool.	1
	Oversight of Agreement		3
		There was consistent review and modification, when necessary, of the safety agreement by the DFS case worker.	1
		There was consistent review, and modification, when necessary, of the safety agreement by the DFS case worker.	1
		There was consistent review and modification, when necessary, of the safety agreement by the DFS case worker. The safety agreement was MDT-informed.	1
	Supervisory Oversight		1
		There was strong adminitrative oversight during the investigation and treatment cases as the parents and relatives were adamant that the child was not abused, and as a result, the safety agreements were not necessary.	1
Unresolved Risk			6
	Domestic Violence and Parenting		1
		The DFS treatment case worker referred Mother to the domestic violence liaison and a Family Interventionist.	1
	Home Visiting Programs		3
		The DFS case worker referred the child to an early intervention program.	2
		The DFS case worker addressed the no-show at the early intervention program appointment with Mother, and had Mother contact to reschedule during a visit.	1
	Mental Health		2
		The DFS treatment worker referred the parents for mental health evaluations.	1
		Civil DOJ recommended the DFS case worker make referrals for mental health evaluations for the parents due to their presumed cognitive delays.	1
Grand Total			**53**

FINALS

System Area	Strength	Rationale	Count of #
MDT Response			1
	General - Criminal/Civil Investigation		1
		There was good communication between the DFS and the law enforcement agency. DFS was particularly helpful in sharing the DFS history on the family.	1
Grand Total			**1**
TOTAL STRENGTHS			**54**

Child Abuse and Neglect Panel

Findings Summary

March 26, 2019

INITIALS

	*Current	**Prior	Grand Total
Legal	**1**		**1**
DFS Contact with DOJ	1		1
MDT Response	**8**		**8**
Crime Scene	2		2
Doll Re-enactment	1		1
General - Criminal Investigation / Civil Investigation	1		1
Interviews - Adult	1		1
Interviews - Child	1		1
Medical Exam	1		1
Reporting	1		1
Medical	**3**	**1**	**4**
Medical Exam/Standard of Care - Birth	1	1	2
Medical Exam/Standard of Care - PCP	1		1
Reporting	1		1
Risk Assessment/ Caseloads	**13**		**13**
Caseloads	8		8
Collaterals	3		3
Risk Assessment - Closed Despite Risk Level	1		1
Risk Assessment - Tools	1		1
Safety/ Use of History/ Supervisory Oversight	**8**		**8**
Completed Incorrectly/ Late	3		3
Inappropriate Parent/ Relative Component	2		2
Oversight of Agreement	1		1
Reporting	1		1
Use of History	1		1
Grand Total	**33**	**1**	**34**

**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

Prepared 2/9/2019

Child Abuse and Neglect Panel

Findings Detail and Rationale

March 26, 2019

INITIALS

System Area	Finding	PUBLIC Rationale	Sum of #
Legal			1
	DFS Contact with DOJ		1
		DFS did not consult with the Civil DAG to determine whether or not custody should be sought for the young child with a serious physical injury and failure to thrive and for a sibling with similar malnutrition concerns.	1
MDT Response			8
	Crime Scene		2
		No scene investigation was completed by the law enforcement agency.	1
		The law enforcement agency did not complete evidentiary blood draws on the child after the child ingested a prescription drug.	1
	Doll Re-enactment		1
		No doll re-enactment was completed by the law enforcement agency.	1
	General - Criminal Investigation / Civil Investigation		1
		There was not a strong MDT response to the near death investigation due to the following: lack of communication; lack of coordinated response between after-hours worker and LE, including joint interviews; and inaccurate information provided about DFS history.	1
	Interviews - Adult		1
		The after-hours worker declined to participate in the joint interview by LE at the hospital.	1
	Interviews - Child		1
		Forensic interview did not occur with the older sibling who was present during the near death incident despite the victim's injuries resulting from neglect and the significant DFS history.	1
	Medical Exam		1
		The older sibling who was present in the home during the near death incident was not medically evaluated.	1
	Reporting		1
		The law enforcement agency did not make a report to the DFS Report Line for the death incident.	1
Medical			4
	Medical Exam/Standard of Care - Birth		2
		The birth hospital did not submit the commitment form signed by the mother to the All Babies Cry program. Therefore, the parents did not receive a prevention call six weeks after birth.	1
		The birth hospital documented suspected abuse for the mother, but there was no other information documented in the record.	1
	Medical Exam/Standard of Care - PCP		1
		The PCP did not consider a differential diagnosis of abuse despite the rapid increase in the child's head circumference. The PCP had a relationship with the family, and it may have influenced the plan of care.	1

	Reporting		1
		The young child and sibling were being followed by the PCP for Failure to Thrive. Despite a decline in their weight, concern with feedings and multiple hospitalizations, the PCP did not make a report to the DFS Report Line.	1
Risk Assessment/ Caseloads			13
	Caseloads		8
		The DFS caseworker was over the investigation caseload statutory standard during the prior investigation, 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 the entire time the case was open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	3
		The DFS family and institutional abuse caseworkers were 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 DFS caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it is unclear whether the caseload had a negative impact on the DFS response in the case.	1
		The DFS caseworker was over the investigation caseload statutory standards the entire time the current case was open. However, it is unclear whether the caseload had a negative impact on the DFS response in the case.	1
		The DFS caseworkers were over the investigation caseload statutory standards during the current and prior investigations. However, it does not appear that the caseload negatively impacted the DFS response to those cases.	1
	Collaterals		3
		The supervisor closed the prior investigation against the risk score despite not having the collateral information from the substance abuse provider.	1
		In the prior investigation, the home visiting agency reported concerns that the parents were under the influence, and the case worker addressed the concerns by phone and not in person.	1
		At the close of the near death investigation, a Framework was completed and recommended a collateral with the substance abuse provider. However, no collateral was completed, and the case was closed against the risk score.	1
	Risk Assessment - Closed Despite Risk Level		1
		The SDM Risk Assessment identified the risk as high at the conclusion of the prior investigation. Ongoing service was recommended; however, the case disposition was overridden to close the investigation and a Framework was not considered.	1
	Risk Assessment - Tools		1
		In the prior investigation, the SDM Risk Assessment was not completed correctly. The risk was scored as moderate; however, the parents' substance abuse issues were not rated.	1

Safety/ Use of History/ Supervisory Oversight			8
	Completed Incorrectly/ Late		3
		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
		In the prior investigation, a safety agreement was not implemented for the infant born with prenatal substance exposure despite safety threats being present due to the current circumstances and DFS history.	1
		In the prior investigation, DFS completed a safety agreement with the father prior to completing collateral contacts with substance abuse providers.	1
	Inappropriate Parent/ Relative Component		2
		For the near death incident, DFS completed a safety agreement with relatives, who were not ruled out as suspects.	1
		After the near death incident, DFS entered into a safety agreement allowing mother only supervised contact with the child by an appropriate adult. However, the safety intervention did not adequately address the safety threat as no other participants were identified.	1
	Oversight of Agreement		1
		DFS terminated the safety agreement without consideration of the following: infant with injuries resulting from neglect, new report of domestic violence, collateral information from the substance abuse provider, and the family's significant DFS history.	1
	Reporting		1
		The agency contracted to monitor the child's placement failed to make a hotline report to the DFS Report Line after the child sustained an injury to his forehead.	1
	Use of History		1
		DFS custody could have been considered much earlier for the young child and sibling due to the serious physical injury to one child and failure to thrive, decline in weight and multiple hospitalizations for both children.	1
Grand Total			**34**

STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
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MARY F. DUGAN, ESQUIRE
CHAIR

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

May 22, 2019

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 19 cases at its May 22, 2019 meeting.[1]

Three of the cases (one death and two near deaths) had been previously reviewed and were awaiting the completion of prosecution. Two of the cases were prosecuted resulting in three misdemeanor Endangering the Welfare pleas and one Assault 2nd plea. For the Assault 2nd, the parent received eighteen months in jail. The others resolved with probation. As a result, CPAC made a finding that the SENTAC guideline's presumptive sentence should be greater in child abuse cases.

The sixteen remaining cases were from deaths or near deaths that occurred between July 2018 and October 2018. Of these cases, eight will have no further review and only one was prosecuted. The death that was prosecuted resulted in a plea to felony Endangering the Welfare with five months in jail. These timely reviews enable CPAC

[1] 16 Del. C. § 932.

to address current system issues as well as celebrate accomplishments. Other than one sibling group, the children range in age from three weeks old to six years old with 4 deaths and 12 near deaths. The children were victims of poisoning, unsafe sleep and physical abuse. These sixteen cases resulted in 70 strengths and 80 current findings across system areas.

For this quarter, 34 strengths and 29 findings were noted for the MDT. While increased collaboration and investigation is occurring in the traditional child abuse cases, findings demonstrate a struggle with promptly invoking the MOU in cases such as poisoning or unsafe sleep. CPAC should continue its efforts to train the MDT on best practices and refresh all jurisdictions on the MOU and mandatory reporting laws. CPAC should also continue its efforts to provide access to local and national conferences for frontline responders, and identify advanced trainings for poisoning and unsafe sleep.

Medical findings this quarter merit attention. Medical professionals continue to be educated on reporting child abuse and neglect. However, this quarter had 11 medical findings, with most focusing on failure to report. Training was improved and delivered by CPAC in early 2019 to all Delaware physicians and it is hopeful that training will serve as a reminder as to these obligations.

Some progress with DFS regarding the use of safety agreements, unresolved risk and risk assessment is again seen this quarter. Thirty-nine findings were made in these categories. Once caseloads are subtracted, 26 findings remained again primarily focused on the improper completion of the safety assessment or involving inappropriate caregivers in safety agreements. CPAC will continue to pursue with DFS ongoing coaching in this area. DFS did provide additional staff training in June 2018 on use of the safety assessment to support decisions about the immediate safety of children. The cases seen here occurred close in time to that training – strengths are seen in this area, but there is still room for coaching. Twenty-four strengths were also noted with DFS workers performing thorough investigations. Many other strengths in frontline DFS workers were also seen in the MDT response categories. These positive examples will continue to be highlighted in trainings, both locally and nationally to encourage best practices.

The caseloads of DFS frontline workers continue to merit attention. CPAC continues to be grateful for the leadership in tackling the complex issues that face DFS in the

recruitment and retention of frontline child welfare workers. In 13 of the 16 recent cases contained in this letter, the DFS worker was significantly over the statutory caseload standard. CPAC continues to support additional frontline positions to ensure statutory compliance. There are still investigators carrying 40 plus cases with a statutory standard of 11. Workers continue to resign under the pressure, contributing to the turnover rate and escalating caseloads for those that remain. It is critical that we all collectively ensure that once we tackle this crisis by employing and retaining frontline workers, 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.

In 2018, Delaware experienced 14 child abuse or neglect deaths and 34 near deaths. In 2019, Delaware has thus far seen 6 deaths and 10 near deaths. 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. 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

Strengths Summary

May 22, 2019

INITIALS		
	***Current**	**Grand Total**
Legal	**2**	**2**
Court Hearings/ Process	2	2
MDT Response	**34**	**34**
General - Civil Investigation	9	9
General - Criminal Investigation	4	4
General - Criminal/Civil Investigation	14	14
Home Visiting Programs	1	1
Interviews - Child	1	1
Medical Exam	5	5
Medical	**10**	**10**
Home Visiting Programs	1	1
Medical Exam/Standard of Care - Birth	3	3
Medical Exam/Standard of Care - CARE	2	2
Medical Exam/Standard of Care - ED	2	2
Medical Exam/Standard of Care - PCP	1	1
Medical Exam/Standard of Care - Specialists	1	1
Risk Assessment/ Caseloads	**12**	**12**
Collaterals	5	5
Reporting	3	3
Risk Assessment - Substantiated	3	3
Use of History	1	1
Safety/ Use of History/ Supervisory Oversight	**10**	**10**
Completed Correctly/On Time	3	3
Custody/Guardianship Petitions	1	1
Oversight of Agreement	3	3
Safety Assessment of Non-Victims	1	1
Supervisory Oversight	2	2
Unresolved Risk	**2**	**2**
Contacts	1	1
Home Visiting Programs	1	1
Grand Total	**70**	**70**

FINALS		
	***Current**	**Grand Total**
Risk Assessment/ Caseloads	**1**	**1**
Collaterals	1	1
Grand Total	**1**	**1**

TOTAL STRENGTHS 71

**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

Strengths Detail and Rationale

May 22, 2019

INITIALS

System Area	Strength	Rationale	Count of #
Legal			2
	Court Hearings/ Process		2
		There was good collaboration between the Civil DAG and Child Attorney throughout the civil legal response.	1
		During the death investigation, there was good and consistent communication between the DFS case worker, the Civil DAG, and the Child Attorney throughout the civil legal response.	1
MDT Response			34
	General - Civil Investigation		9
		There was good communication between the DFS case worker and the medical team.	1
		The DFS case worker educated Mother on infant safe sleep practices.	1
		The DFS treatment caseworker educated Mother on infant safe sleep practices.	1
		During the near death investigation, there was excellent collaboration between the investigation and treatment caseworkers, to include a thorough investigation, timely and quality contact with the family, and appropriate follow up services for the child's medical care and Father's substance abuse treatment.	1
		In the prior investigation, the DFS caseworker conducted a thorough investigation, to include referral to an evidence-based home visiting program, good communication with said home visiting program, collaterals with Mother's substance abuse treatment facility, and a Framework.	1
		In the prior investigation, the DFS caseworker conducted a thorough investigation, to include medical evaluations of the children, referral to an early intervention program, and education of Mother on infant safe sleep practices.	1
		Following the report to the DFS Report Line by another party, the hotline worker contacted the initial treating hospital to gather additional information regarding the near death incident.	1
		For the previous report, the DFS caseworker educated Mother on infant safe sleep practices.	1
		Both DFS caseworkers for the prior reports educated Mother on infant safe sleep practices.	1
	General - Criminal Investigation		4
		The law enforcement agency requested a legal blood draw of the child for evidentiary purposes.	2
		Law enforcement and DOJ requested hair follicle testing for the child to determine ingestion of illicit substances.	1
		The law enforcement agency conducted a thorough investigation to include a scene investigation, multiple interviews, and search warrants for the child's medical equipment, Father's cell phone, and his social media pages.	1
	General - Criminal/Civil Investigation		14
		There was excellent MDT collaboration and response to the death investigation, to include joint interviews, and coordination of all children in and out of the home being medically evaluated and forensic interviews conducted.	1
		There was strong and consistent communication between the medical team, the DFS caseworker, the law enforcement agency, and the DOJ.	1
		There was excellent communication and collaboration with the medical team, DFS, the law enforcement agency, and the DOJ. The medical team was an integral part of the MDT.	2
		There was excellent communication and collaboration between the MDT and the out of state authorities, to include the child protective services agency and law enforcement.	2

	There was good collaboration between the child abuse medical expert, the DFS caseworker, and the law enforcement detective during the investigation, as well as follow up medical care for the child.	1
	There was good collaboration and consistent communication between DFS, the law enforcement agency, and the DOJ.	1
	There was good MDT response to the near death investigation between DFS and the law enforcement agency.	1
	During the death investigation, there was good collaboration and consistent communication between DFS, the law enforcement agency, and the DOJ.	1
	There was excellent communication between DFS, the law enforcement agency, the child abuse medical expert, and the DOJ.	1
	There was excellent collaboration and communication between DFS, the law enforcement agency, and the DOJ.	1
	During the near death investigation, there was excellent collaboration and consistent communication between DFS, law enforcement, DOJ, and the child abuse medical expert.	1
	There was a strong MDT response to the near death investigation by the DFS caseworker and the law enforcement agency, to include joint interviews and a joint response to the home.	1
	Home Visiting Programs	1
	During the two investigations, the DFS caseworkers referred Mother to an evidence-based home visiting program.	1
	Interviews - Child	1
	A forensic interview was scheduled and held at the CAC for the sibling residing in the home where the incident occurred.	1
	Medical Exam	5
	The DFS case worker ensured the child's sibling was medically evaluated.	1
	During the near death investigation, the DFS caseworker ensured the child's sibling was medically evaluated. The medical evaluation included a forensic nurse exam and a skeletal survey.	1
	During the death investigation, the DFS case worker ensured the surviving siblings were medically evaluated.	1
	For the near death report, the DFS caseworker ensured the siblings were medically evaluated.	1
	Despite the ED physician adamantly declining to complete a skeletal survey during the sibling's medical evaluation, the DFS caseworker pushed to ensure one was completed.	1
Medical		10
	Home Visiting Programs	1
	A referral to home visiting services was made prenatally for the Mother by the medical insurance provider.	1
	Medical Exam/ Standard of Care - CARE	2
	The child abuse medical expert met with the MDT and explained the organ procurement process to alleviate any fear the MDT may have had relating to the potential disruption of evidence by the process.	1
	As recommended by new research, magnetic resonance imaging (MRI) was completed of the brain and the full spine, rather than only the cervical spine, at the admitting hospital.	1
	Medical Exam/ Standard of Care - ED	2
	Given the child's presentation and lack of medical history, differential diagnosis was considered. A complete and comprehensive work-up was completed, to include consultation with the child abuse medical expert.	1
	The children's hospital followed its physical abuse pathway workup for the infant presenting with a bone fracture.	1
	Medical Exam/ Standard of Care - PCP	1
	During follow-up visit with the child's PCP, the nurse contacted DFS to confirm Mother's statement that she had been cleared for unsupervised contact with the child.	1

	Medical Exam/Standard of Care - Birth	3
	In the prior investigation, plan of safe care meetings were held prior to medical discharge of the child.	1
	For the previous report, a plan of safe care meeting was held prior to medical discharge of the child.	1
	Plan of safe care meetings were held at the birth of the child and prior to medical discharge of the child.	1
	Medical Exam/Standard of Care - Specialists	1
	The hospital social worker served as liaison between the organ donor program and the MDT investigators, and intervened when necessary to advocate for the child while on life support.	1
Risk Assessment/ Caseloads		12
	Collaterals	5
	The DFS treatment caseworker maintained quality contact with Mother and had good follow-up relating to Mother's substance abuse history.	1
	During the near death investigation, the DFS investigation caseworker and the treatment caseworker completed collaterals with Mother's substance abuse treatment provider.	1
	Strong collaterals were completed, to include parents' pain management doctors and Father's mental health treatment provider.	1
	Strong collateral contacts were completed during the prior investigation.	1
	The DFS case worker maintained quality contact with the family during the prior investigation. The contact was both announced and unannounced.	1
	Reporting	3
	The DFS caseworker made a report to the National Human Trafficking Hotline for the children.	3
	Risk Assessment - Substantiated	3
	At the conclusion of its investigation, DFS made an appropriate finding against Mother as a result of the children's injuries.	2
	At the conclusion of its investigation, DFS made appropriate findings against the perpetrator and the non-offending caregiver as a result of the child's injuries and failure to seek medical treatment.	1
	Use of History	1
	The DFS caseworker consulted with two out of state child protection agencies and completed National Crime Information Center (NCIC) checks for the adults residing in the household.	1
Safety/ Use of History/ Supervisory Oversight		10
	Completed Correctly/On Time	3
	Although verbally, not in writing, Mother's contact with the children was immediately restricted by DFS and law enforcement.	2
	The DFS caseworker traveled to Father's out of state home to conduct an assessment prior to modifying the child safety agreement.	1
	Custody/Guardianship Petitions	1
	During the near death investigation, DFS sought custody of the children quickly.	1
	Oversight of Agreement	3
	There was consistent review, and modification, when necessary, of the safety agreement by the DFS case worker.	1
	There was consistent review and modification, when necessary, of the safety agreement by the DFS caseworker. The caseworker was also seeing the family monthly.	1

		During the prior investigation, there was consistent review, and modification, when necessary of the safety agreement by the DFS case worker.	1
	Safety Assessment of Non-Victims		1
		The DFS caseworker implemented a child safety agreement with the siblings residing outside the home. The safety agreement was reviewed and modified, when necessary.	1
	Supervisory Oversight		2
		Due to the extenuating circumstances of the case, the DFS supervisor was very involved with the near death investigation.	2
Unresolved Risk			2
	Contacts		1
		During the death investigation, best interest meetings were held with the older sibling's school when there was a change in placement.	1
	Home Visiting Programs		1
		During the prior investigation, the DFS case worker referred the sibling to an early intervention program.	1
Grand Total			**70**

FINALS

System Area	Strength	Rationale	Count of #
Risk Assessment/ Caseloads			1
	Collaterals		1
		The DFS permanency caseworker maintained quality contact with the adoptive family.	1
Grand Total			**1**
TOTAL STRENGTHS			**71**

Child Abuse and Neglect Panel

Findings Summary

May 22, 2019

INITIALS

	*Current	**Prior	Grand Total
Legal	**1**		**1**
DFS Contact with DOJ	1		1
MDT Response	**29**		**29**
Crime Scene	7		7
Documentation	2		2
General - Civil Investigation	1		1
General - Criminal Investigation	5		5
General - Criminal Investigation / Civil Investigation	1		1
Intake with DOJ	3		3
Interviews - Adult	5		5
Interviews - Child	4		4
Medical Exam	1		1
Medical	**11**	**1**	**12**
Medical Exam/Standard of Care - Birth	1		1
Medical Exam/Standard of Care - CARE	1		1
Regulations/Policies	1		1
Reporting	8	1	9
Risk Assessment/ Caseloads	**20**		**20**
Caseloads	13		13
Collaterals	3		3
Risk Assessment - Closed Despite Risk Level	1		1
Risk Assessment - Tools	2		2
Risk Assessment - Unsubstantiated	1		1
Safety/ Use of History/ Supervisory Oversight	**15**		**15**
Completed Incorrectly/ Late	9		9
Inappropriate Parent/ Relative Component	4		4
No Safety Assessment of Non-Victims	1		1
Oversight of Agreement	1		1
Unresolved Risk	**4**		**4**
Contacts	1		1
Substance Abuse	1		1
Substance-Exposed Infant	2		2
Grand Total	**80**	**1**	**81**

FINALS

	*Current	Grand Total
MDT Response	**2**	**2**
Crime Scene	1	1
Prosecution/ Pleas/ Sentence	1	1
Grand Total	**2**	**2**

83

*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

Prepared 5/2/2019

Child Abuse and Neglect Panel

Findings Detail and Rationale

May 22, 2019

INITIALS

System Area	Finding	PUBLIC Rationale	Sum of #
Legal			1
	DFS Contact with DOJ		1
		DFS did not consider immediately filing for custody of the young victim and her siblings after the medical evaluation confirmed serious physical injuries to a young special needs child. The family also had several risk factors including: multiple children under age 3, substance abuse, domestic violence, mental illness, and criminal and DFS history.	1
MDT Response			29
	Crime Scene		7
		No scene investigation was completed by the law enforcement agency.	1
		The law enforcement agency did not complete evidentiary blood draws on the child after the child ingested a prescription drug.	3
		No scene investigation was completed by the law enforcement agency. As a result, the scene was not photographed and no evidence was collected.	2
		The SUIDI form was not completed by the medical examiner's unit despite a discussion with the law enforcement agency and an agreement to complete the tool.	1
	Documentation		2
		There was no documentation in the police report by the lead detective.	1
		There was no documentation by the DFS case worker that a lock box to store the prescription medications was observed.	1
	General - Civil Investigation		1
		An immediate report was not made to the law enforcement agency by the DFS caseworker, and it impacted the initial MDT response to the near death investigation.	1
	General - Criminal Investigation		5
		There was not a MDT response to the near death incident in compliance with the MOU and statute, and the LE agency declined to come to the children's hospital.	1
		There was not a MDT response to the near death incident in compliance with the MOU and statute.	3
		There was not an immediate call to the Criminal Investigations Unit by the law enforcement agency. Instead, the initial responding officer attempted to close the case as unfounded with no crime.	1
	General - Criminal Investigation / Civil Investigation		1
		For the near death investigation, there was not a MDT response to the incident in compliance with the MOU and statute.	1
	Intake with DOJ		3
		The law enforcement agency did not notify the DOJ Special Victims Unit of the near death incident.	3
	Interviews - Adult		5
		DFS conducted interviews with parents prior to police response.	1
		DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	3

		Interviews did not occur with all adults in the home where the near death incident occurred. These adults were also prescribed the medication that the child ingested.	1
	Interviews - Child		4
		Forensic interview did not occur with the young child who was present during the near death incident.	1
		Forensic interview did not occur with the young victim.	1
		The DFS caseworker did not conduct a comprehensive interview with the victim. It was limited to the allegations.	1
		Forensic interview did not immediately occur with the young victim.	1
	Medical Exam		1
		The DFS caseworker did not independently contact the child abuse medical expert to discuss the medical findings and to determine if the mechanism of injury was consistent with a fall. There was also no confirmation that the child was seen for the follow-up visit.	1
Medical			12
	Medical Exam/Standard of Care - Birth		1
		The infant was born with prenatal substance exposure, and the birth hospital did not confirm the mother's prescription.	1
	Medical Exam/Standard of Care - CARE		1
		The child was discharged by the trauma center without a full CARE team assessment and evaluation.	1
	Regulations/Policies		1
		An organ donor program was not following their policies around talking to families about harvesting organs.	1
	Reporting		9
		The outpatient rehabilitation therapist failed to make a report to the DFS Report Line after it was noted that the special needs child presented with leg swelling and tenderness.	1
		There was no report to the DFS Report Line by staff at the birth hospital after the child's sibling was born with prenatal substance exposure.	1
		Staff at the two hospitals, where the child was treated, did not report the near death incident to the DFS Report Line.	1
		The walk in clinic failed to make a report to the DFS Report Line after it was noted that the young child presented with bruises to his face.	1
		The emergency department made a delayed report to the DFS Report Line despite a young child with head trauma.	1
		The treating hospital did not report the child death to the DFS Report Line.	1
		The Division of Forensic Science delayed making a report to the DFS Report Line for the death incident, and it may have impacted the joint response in the case.	1
		The child's young sibling sustained a skull fracture, and the DFS Report Line had no documentation of a report by the treating hospital.	1
		The children's hospital delayed making a report to the DFS Report Line for the near death incident.	1

Risk Assessment/ Caseloads			20
	Caseloads		13
		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 DFS 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.	2
		The DFS caseworker was over the investigation caseload statutory standards the entire time the current case was open. However, it is unclear whether the caseload had a negative impact on the DFS response in the case.	2
		The DFS caseworkers were over the investigation caseload statutory standards during the current and prior investigations. The caseload does appear to have had a negative impact on the response in one prior case; however, it was unclear whether the caseload had a negative impact on the DFS response in the other cases, including the death investigation.	1
		The DFS caseworkers were over the investigation caseload statutory standards during the current and prior investigations. However, it is unclear whether the caseload had a negative impact on the DFS response in these cases.	2
		The DFS caseworkers were over the investigation caseload statutory standards during the current and prior investigations. The caseload does appear to have had a negative impact on the response in one prior case; however, it does not appear that the caseload negatively impacted the DFS response to the death investigation.	1
		The DFS caseworker was over the investigation caseload statutory the entire time the current case was open, and the caseload appears to have had a negative impact on the response in 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 had a negative impact on the DFS response in the case.	2
		The caseworkers were over the investigation caseload statutory standards the entire time the cases were open, and the caseload appears to have had a negative impact on the response in the prior case. There was no impact in the death investigation.	1
	Collaterals		3
		History with the out of state child protective services agency was not checked by the DFS caseworker.	1
		For the prior investigation, a collateral contact was not completed with the physician prescribing the mother's benzodiazepine.	1
		The primary care physician noted the young sibling's skull fracture in its collateral contact with DFS; however, the DFS caseworker did not follow up to gather additional details about the injury.	1
	Risk Assessment - Closed Despite Risk Level		1
		The SDM Risk Assessment identified the risk as high at the conclusion of the prior investigation. Ongoing service was recommended; however, the case disposition was overridden to close the investigation. It was not clear whether substance abuse treatment services were in place for the parents.	1
	Risk Assessment - Tools		2
		In the prior investigation, the SDM Risk Assessment was not completed correctly. The risk was scored as moderate; however, the DFS history was not considered.	1

	For the near death investigation, the policy override was not considered for the SDM Risk Assessment. As a result, the risk was scored as moderate and the case was closed.	1
Risk Assessment - Unsubstantiated		1
	For the prior investigation, DFS did not consider a finding of medical neglect despite the mother's delay in seeking medical care for her special needs child.	1
Safety/ Use of History/ Supervisory Oversight		15
Completed Incorrectly/ Late		9
	For the prior report, the case worker did not complete the SDM safety assessment correctly, and there was no safety agreement. The victim was permitted to remain in the home with a primary caregiver, who had significant DFS history and a child in foster care.	1
	For the near death investigation, the case worker did not complete the SDM safety assessment correctly, and there was no safety agreement. Mother was verbally told that she was permitted no contact with the children.	1
	In the prior investigation, the case worker did not complete the SDM safety assessment correctly, and there was no safety agreement. The victim was evaluated for bruising to his face and abuse could not be ruled out.	1
	For the near death investigation, the case worker did not complete the SDM safety assessment correctly, and there was no safety agreement. As a result, there was no follow up about use of a lock box to store the medications.	1
	For the death investigation, DFS entered into a safety agreement with a relative, but an interview and home assessment was not conducted to assess her ability to act as a safety participant.	1
	For the near death investigation, DFS did not conduct a home assessment prior to the infant's discharge from the hospital.	1
	The SDM Safety Assessment was not completed correctly for the near death incident. The safety threat for access to dangerous objects in the house was marked no, and the child was determined to be safe.	1
	For the near death investigation, DFS entered into a safety agreement with several participants, but interviews were not conducted with these participants to assess their ability to act as a safety participant.	1
	For the near death incident, the child was released to the mother with a child safety agreement. However, it did not adequately address the safety threat.	1
Inappropriate Parent/ Relative Component		4
	For the near death incident, DFS completed a safety agreement with a relative, who was not ruled out as a suspect.	1
	Following the report of a substance-exposed infant, DFS entered into a safety agreement with the father. However, he was not an appropriate caregiver due to DFS and criminal history.	1
	Following the report of an infant with prenatal substance exposure, DFS entered into a safety agreement with the father. However, he was not an appropriate caregiver due recent DFS and substance abuse history.	1
	For the near death investigation, DFS entered into a safety agreement with a relative. However, she was not an appropriate caregiver due to her ongoing substance abuse.	1

	No Safety Assessment of Non-Victims		1
		The DFS caseworker left the siblings in the home with the alleged perpetrator when the victim was taken to the hospital for an immediate medical evaluation. As a result, the alleged perpetrator fled with the siblings.	1
	Oversight of Agreement		1
		For the case involving the infant with prenatal substance exposure, DFS terminated the safety agreement; however, the mother's substance abuse issues continued to be an ongoing risk factor.	1
Unresolved Risk			4
	Contacts		1
		Prior to the death incident, DFS received a report involving illegal drug activity in the home, and the initial contact did not occur with the victim until almost 3 months after the referral was received.	1
	Substance Abuse		1
		DFS did not evaluate substance abuse issues for mother by requesting that she complete a substance abuse evaluation or by verifying her prescribed medications after the sibling was born with prenatal substance exposure.	1
	Substance-Exposed Infant		2
		A plan of safe care was not completed for the siblings who were born with prenatal substance exposure during the active treatment case.	1
		A plan of safe care was not completed for the infant born with prenatal substance exposure.	1
Grand Total			**81**

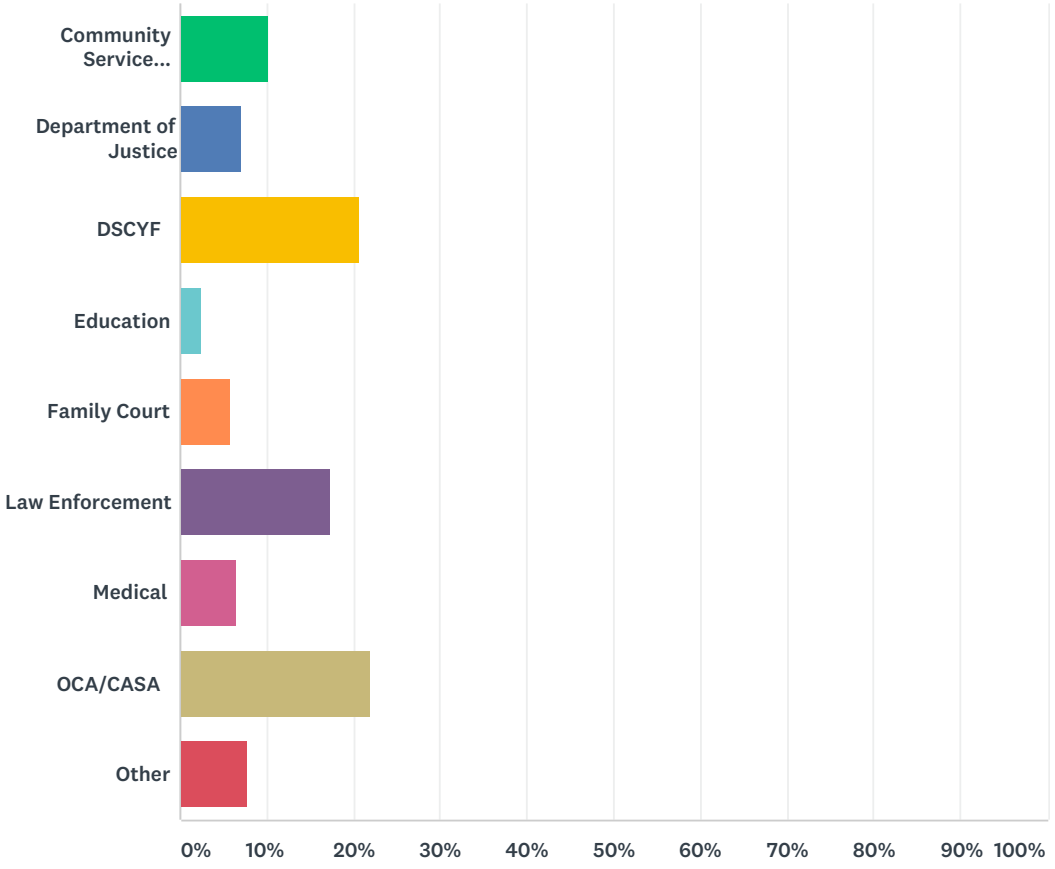
FINALS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			2
	Crime Scene		1
		The law enforcement agency did not obtain a search warrant for the home to collect other corroborative evidence.	1
	Prosecution/ Pleas/ Sentence		1
		The SENTAC guidelines' presumptive sentence for crimes against children should be greater.	1
Grand Total			**2**

TOTAL FINDINGS **83**

Q1 Please select your discipline:

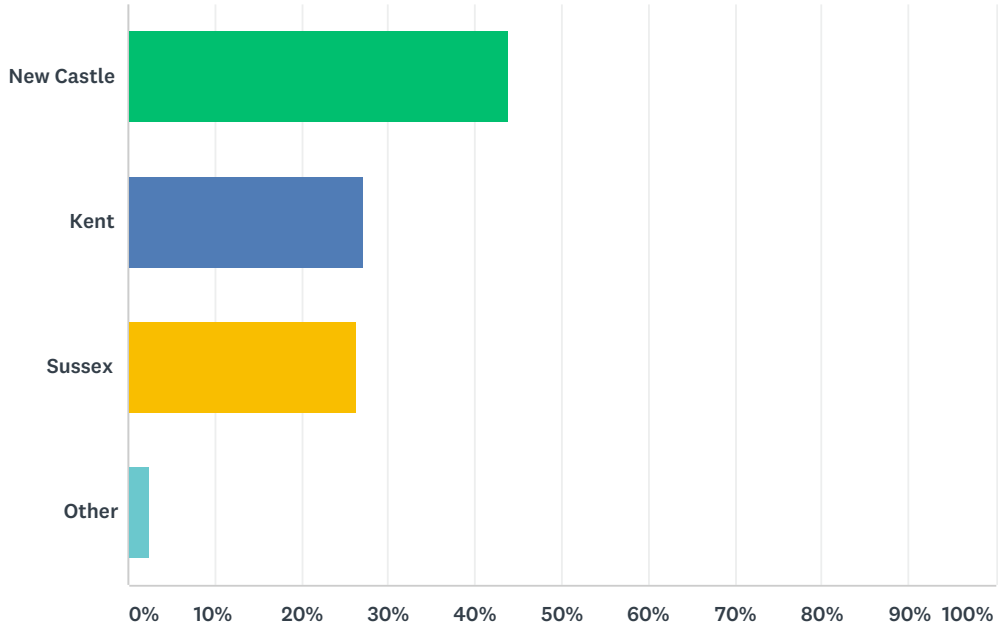
Answered: 155 Skipped: 0



ANSWER CHOICES	RESPONSES	
Community Service Provider	10.32%	16
Department of Justice	7.10%	11
DSCYF	20.65%	32
Education	2.58%	4
Family Court	5.81%	9
Law Enforcement	17.42%	27
Medical	6.45%	10
OCA/CASA	21.94%	34
Other	7.74%	12
TOTAL		155

Q2 Please select your county:

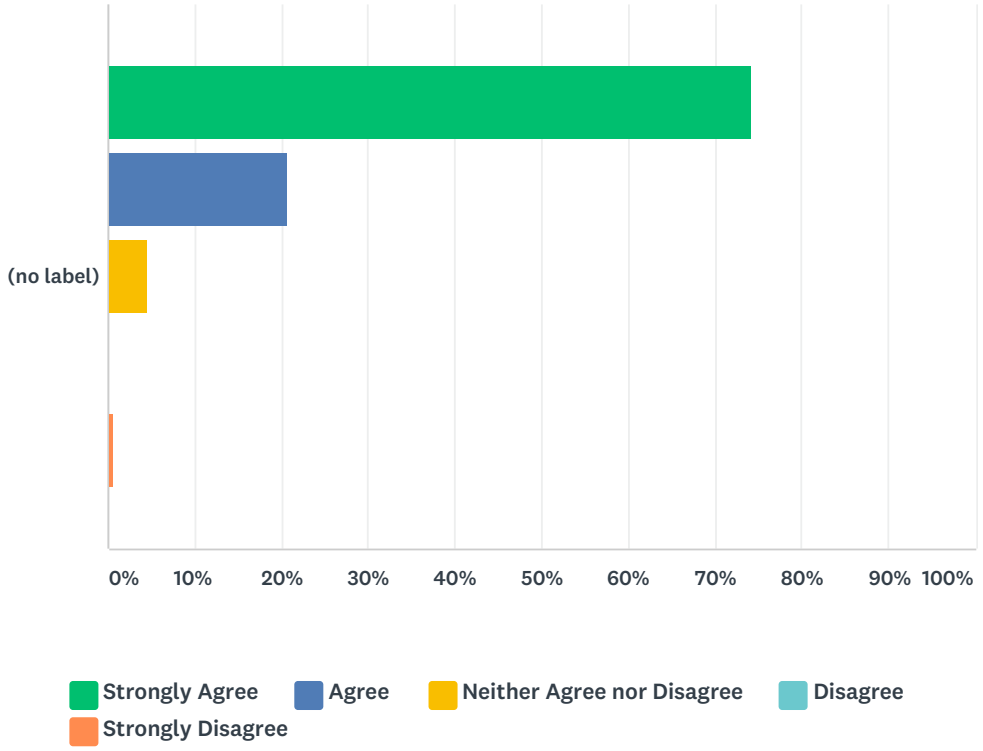
Answered: 155 Skipped: 0



ANSWER CHOICES	RESPONSES	
New Castle	43.87%	68
Kent	27.10%	42
Sussex	26.45%	41
Other	2.58%	4
TOTAL		155

Q3 Registration through EventBrite was efficient.

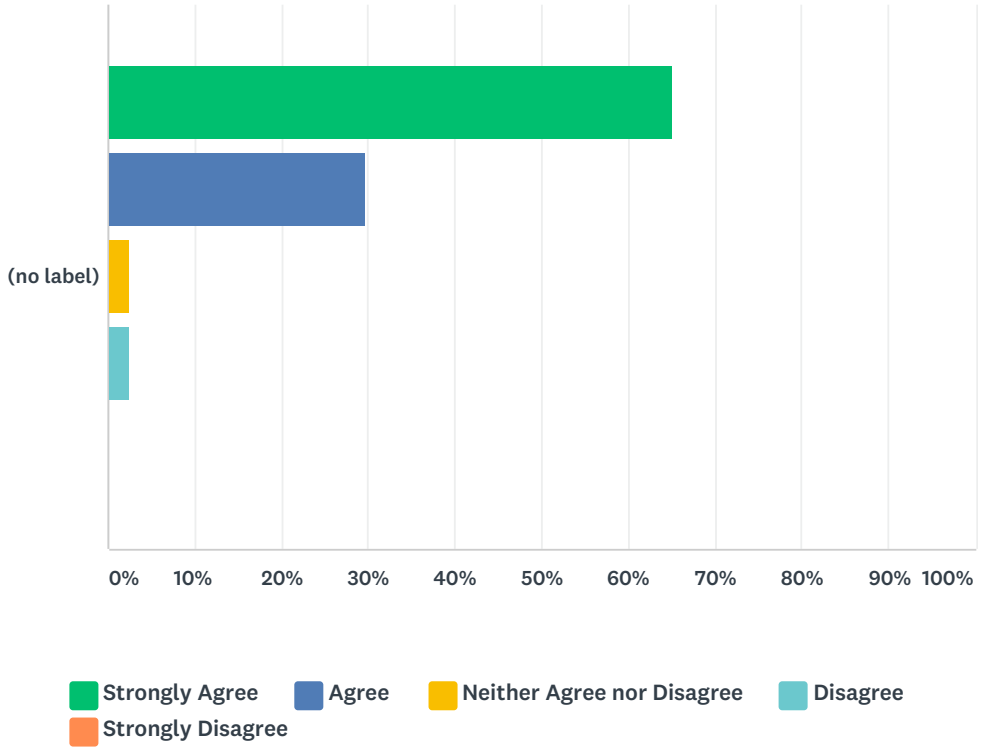
Answered: 155 Skipped: 0



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	74.19% 115	20.65% 32	4.52% 7	0.00% 0	0.65% 1	155	1.32

Q4 The location of the conference was convenient.

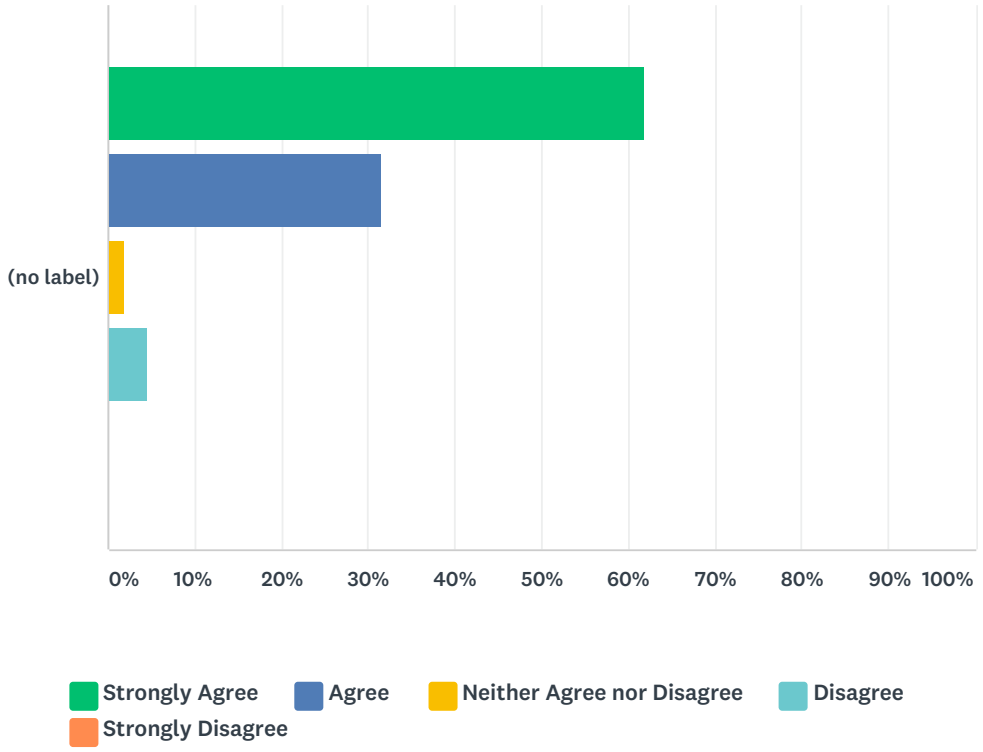
Answered: 155 Skipped: 0



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	65.16% 101	29.68% 46	2.58% 4	2.58% 4	0.00% 0	155	1.43

Q5 The venue and training rooms were clean, organized, and easy to find.

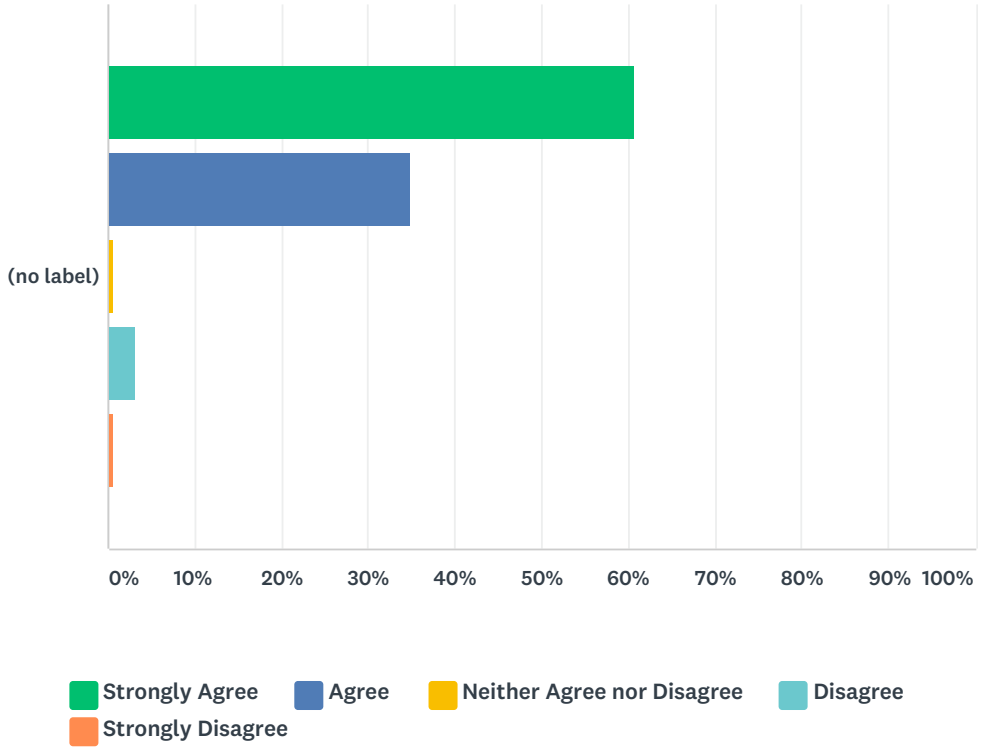
Answered: 155 Skipped: 0



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	61.94% 96	31.61% 49	1.94% 3	4.52% 7	0.00% 0	155	1.49

Q6 I was satisfied with the food and beverages provided during the conference.

Answered: 155 Skipped: 0



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	60.65% 94	34.84% 54	0.65% 1	3.23% 5	0.65% 1	155	1.48

Q7 Please enter any comments about the conference location or venue.

Answered: 61 Skipped: 94

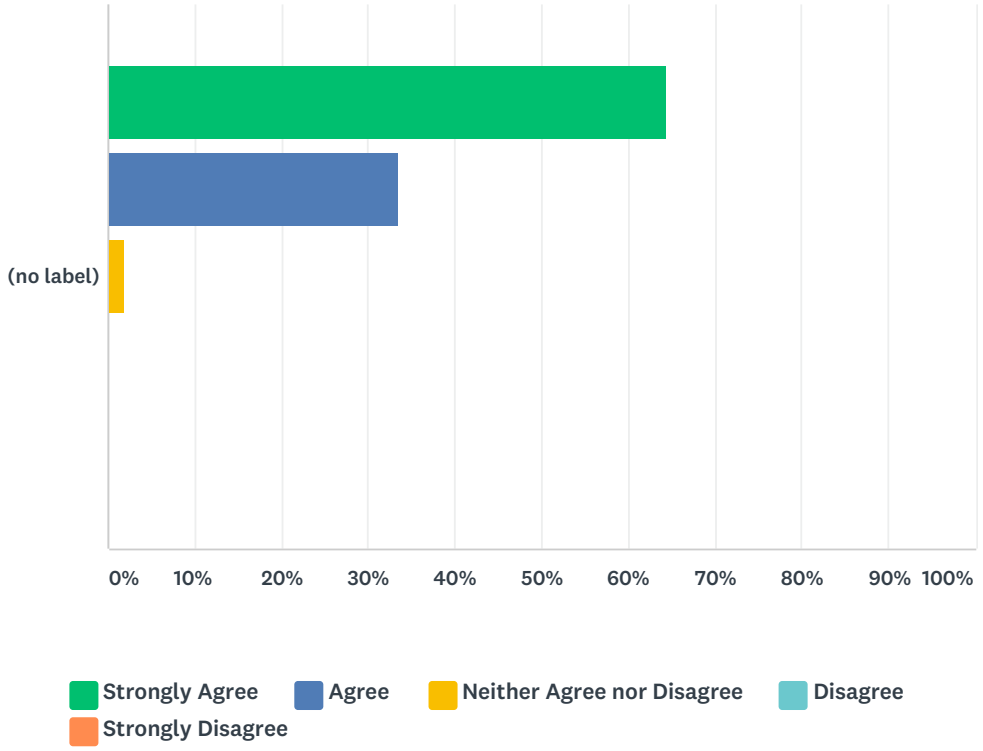
#	RESPONSES	DATE
1	Dover Downs is a great venue as it is in the center of the state allowing people from the farther ends of the state equal distance to travel.	4/17/2019 3:02 PM
2	Air conditioning was too high!	4/16/2019 4:48 PM
3	The location was better than the past two venues I attended	4/11/2019 1:59 PM
4	The location was clean, well set up, and spacious. The food and beverages were ample and very good.	4/11/2019 9:36 AM
5	Very awkward layouts in rooms for breakout sessions made it difficult to see speaker from all tables	4/10/2019 2:11 PM
6	Unfortunately, it was difficult to hear the speakers, especially the first keynote speaker, from the back of the room.	4/10/2019 11:28 AM
7	Great location and convenient to the entire state.	4/10/2019 10:52 AM
8	Was outstanding and far exceeded my expectations! Keynote speakers and workshops were fantastic.	4/10/2019 8:08 AM
9	Great Location! I liked how it was centralized in Dover and I did not have to drive to New Castle/Wilmington area.	4/9/2019 5:16 PM
10	It was difficult to hear in the ballroom. The wait staff cleaned the lunch remains while we were trying to hear the speaker in the afternoon session.	4/9/2019 4:02 PM

11	C	4/9/2019 3:33 PM
12	The audio systems and noise levels in the conference rooms was a problem. One session I left because I couldn't hear my speaker but could hear the speaker next door (homicide). The session in the ballroom was not done when people starting coming back for lunch and they were not respectful that the session was still going on. Maybe keep folks out until the session concludes. The afternoon speaker was soft spoken, did not have a microphone and there was noise from the hall.	4/9/2019 12:53 PM
13	It was great I learned a lot	4/9/2019 11:59 AM
14	It was very chilly in the ballroom. The location itself was very nice and the lunch was excellent. The servers were also very friendly, helpful, and nice.	4/9/2019 9:40 AM
15	I was in the main room for the morning workshop and it was a bit distracting to see and hear all of the commotion while the staff was setting up lunch.	4/9/2019 9:36 AM
16	Location is excellent. As usual, it's freezing cold in the large main room.	4/9/2019 8:51 AM
17	One of the best conferences I've attended in a long time. And one of the few that every speaker was informative and enjoyable to listen to.	4/9/2019 8:28 AM
18	The ballroom was extremely cold.	4/9/2019 8:26 AM
19	N/A	4/9/2019 7:20 AM
20	the complex is very large and spread out; there were no directions in advance to tell us which of the many entrances was for the conference, and there were no signs or directions inside the complex to get us to the meeting area. It took several requests from security guards to find my way.	4/8/2019 9:11 PM
21	The venue was a great size to accommodate the number of people. Perhaps assigned seats would have been better for the initial seating.	4/8/2019 8:40 PM
22	It was very, very cold in all the rooms especially the ballroom	4/8/2019 8:10 PM
23	It was far for me, an hour away.	4/8/2019 6:50 PM
24	I have always enjoyed attending conferences at Dover Downs. They seem to always do it right.. The venue was right on key	4/8/2019 4:39 PM
25	It was cold in the main room most of the conference.	4/8/2019 4:30 PM
26	The Diamond Room at Dover Downs is 1) almost impossible to find since it's in a different part of the building at there are no signs pointing the way, and 2) extremely difficult to access, as there is no stairway that goes all the way up to the 4th floor. As a result, everyone who is trying to get to or leave from the Diamond Room ends up getting stuck waiting for two tiny elevators to shuttle everyone in one small group at a time.	4/8/2019 4:21 PM
27	The rooms on the 4th floor were inconvenient because there are only 2 elevators and no stairs whatsoever.	4/8/2019 4:11 PM
28	Just that it was FREEZING in the ballroom!	4/8/2019 4:06 PM
29	Enjoyed this conference immensely! Best one yet.	4/8/2019 3:37 PM
30	The ballroom was entirely too cold to be able to pay attention to the presenters.	4/8/2019 3:14 PM
31	There were some problems with the sound system. It was hard to hear at the back of the large conference room.	4/8/2019 3:13 PM
32	during one of the sessions held in the ballroom, while the speaker was speaking, the staff was setting up for lunch. They were very noisy. They were walking between tables. It was extremely hard to hear or follow the speaker. Very distracting.	4/8/2019 3:08 PM
33	My last workshop of the day was far away from the lobby, so I forgot to come back and sign for my CEUs. Any help is greatly appreciated, as I would still like to receive them. mrezac@dcadv.org	4/8/2019 2:39 PM
34	Very cold at the venue	4/8/2019 2:39 PM
35	Homicide conference was excellent and super informative. Both speakers were extremely knowledgeable and held everyone's interest.	4/8/2019 2:24 PM

36	Some of the conference rooms were only divided by portable walls/curtains. It was very distracting to be able to hear the adjacent presentation while trying to concentrate on your own presentation. (They must have been using a mike in the other room as it was loud enough to hear). Our presenter was not using a mike. Very distracting.	4/8/2019 2:13 PM
37	I am vegan and gluten free I was able to bring my own food I was able to eat the fruit and vegetables if fresh. If you could accommodate in any way my diet needs it would be great	4/8/2019 2:13 PM
38	The acoustics in the large ballroom are very poor, the Plenary speaker could not be heard in the back of the room. It seemed that the speakers on the side walls were not turned on.	4/8/2019 2:01 PM
39	Venue is convenient with good parking facilities.	4/8/2019 2:00 PM
40	N/A	4/8/2019 1:56 PM
41	As always, it is too cold there.	4/8/2019 1:35 PM
42	Main ballroom was very cold	4/8/2019 1:23 PM
43	None at this time.	4/8/2019 1:11 PM
44	There were a few audio querks but it was still good	4/8/2019 1:09 PM
45	The venue was great!!	4/8/2019 12:48 PM
46	Parking and directions to workshop rooms were not clear.	4/8/2019 12:36 PM
47	Did not like the location of the Diamond Room; across the casino and up to level 4 UHG!	4/8/2019 12:35 PM
48	Diamond room was difficult to get to with only two elevators. The stairs did not reach the third floor easily without going through the buffet which was prohibited.	4/8/2019 12:29 PM
49	very nice location - not crowded tables, food and service was very good -	4/8/2019 12:28 PM
50	Location and venue was appropriate.	4/8/2019 12:23 PM
51	none	4/8/2019 12:23 PM
52	n/a	4/8/2019 12:12 PM
53	Please consider possibly rotating counties in the future. Its not fair for lower Sussex folks or the New Castle County folks to have it in the same county every year.	4/8/2019 12:11 PM
54	Very difficult to concentrate during sessions held in the Ballroom as the wait staff was cleaning and shuffling dishes.	4/8/2019 12:10 PM
55	Very nice, except that wait staff continually walked in front of speakers with trays disrupting the presentation.	4/8/2019 12:09 PM
56	I have been a DSCYF employee for 4 years now. This was my first conference and I was extremely impressed. I attended the child homicide classes and learned so much. I will be attending in years to come.	4/8/2019 12:09 PM
57	The food wasn't good and it was cold.	4/8/2019 12:07 PM
58	The training rooms upstairs were difficult to get to, too many people waiting to get into the elevators. The dessert was placed in a strange spot.	4/8/2019 12:07 PM
59	The dessert selection was not great and it should've been a part of lunch.	4/8/2019 12:06 PM
60	Temp was a little cold.	4/8/2019 12:05 PM
61	NA	4/8/2019 12:05 PM

Q8 The conference was well organized.

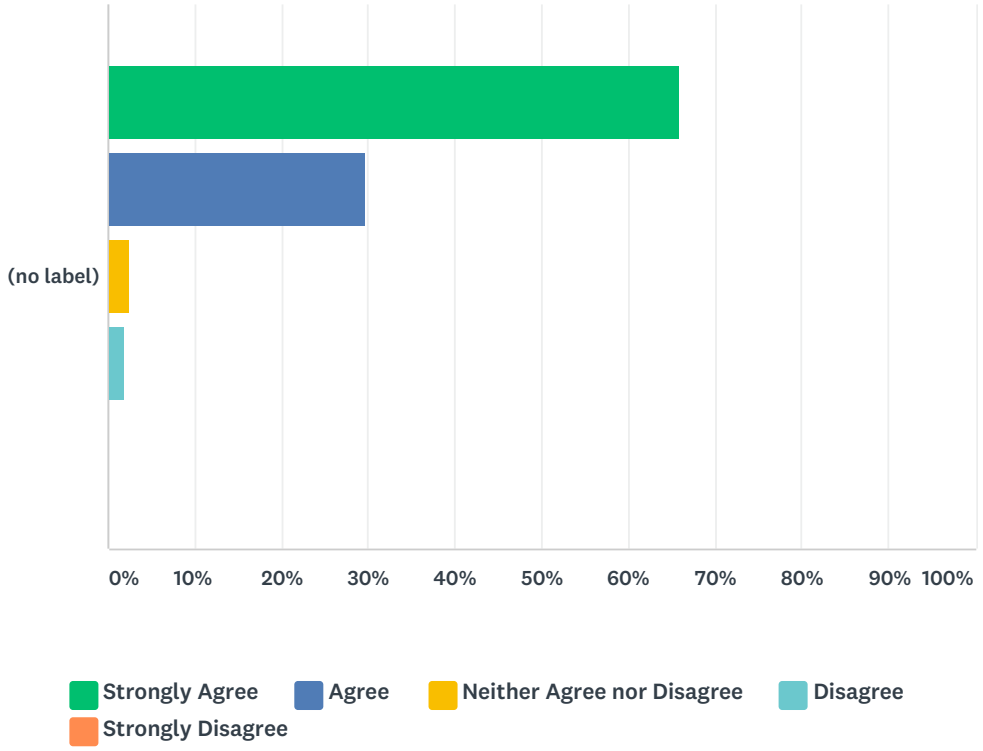
Answered: 155 Skipped: 0



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	64.52% 100	33.55% 52	1.94% 3	0.00% 0	0.00% 0	155	1.37

Q9 The content of the conference sessions was appropriate and informative.

Answered: 155 Skipped: 0



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	65.81% 102	29.68% 46	2.58% 4	1.94% 3	0.00% 0	155	1.41

Q10 Please enter any suggestions for future workshop topics:

Answered: 41 Skipped: 114

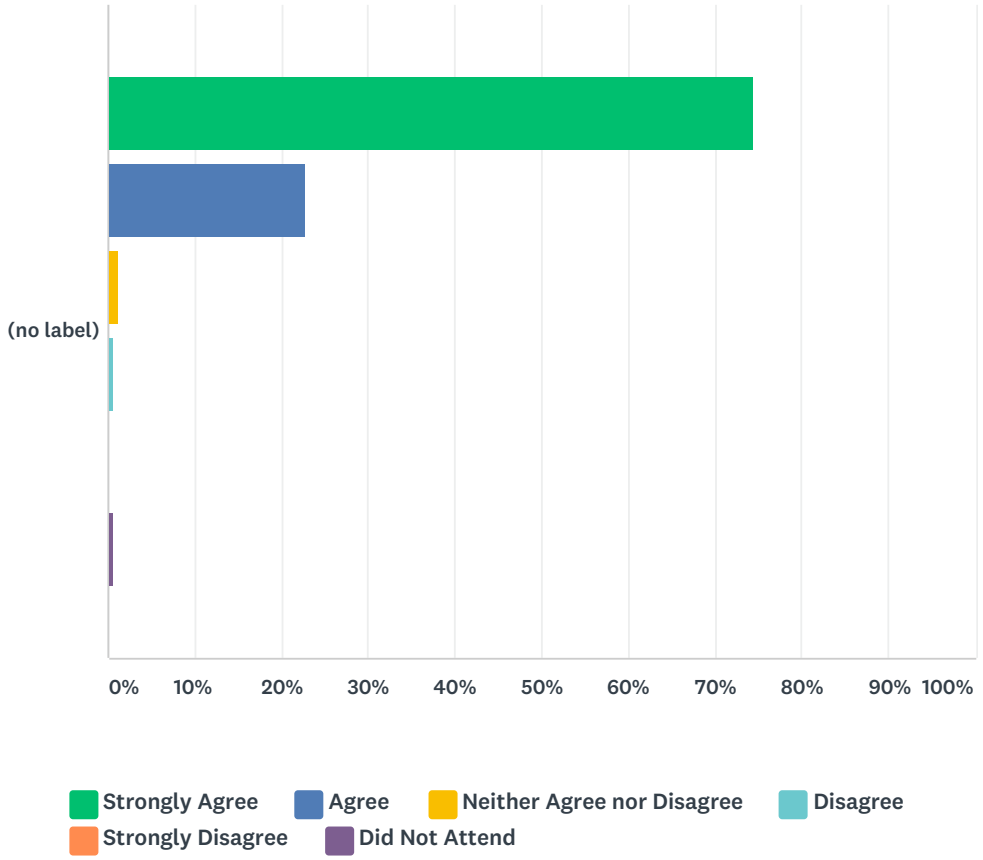
#	RESPONSES	DATE
1	Not at this time	4/16/2019 4:48 PM
2	Implementation of the Family First Prevention Act Developing and recruiting more foster families	4/15/2019 4:33 PM
3	For the presenters in the banquet hall, it was difficult to hear as attendees moved back in from the morning sessions.	4/10/2019 10:52 AM
4	I plan to attend any future conferences.	4/10/2019 8:08 AM
5	I would like to hear from local teams some of the work they are doing to implement trauma informed supports for children and young people in the child welfare system.	4/9/2019 4:02 PM
6	Keep current. Some personal experiences. And updates on Children	4/9/2019 3:33 PM
7	The keynote speakers were wonderful. The conference was well organized and everything flowed smoothly. Would like to have had the handouts or been able to get them from somewhere. If it's possible it was not announced that I heard. Thank you for the hard work in putting this on!	4/9/2019 12:53 PM
8	I very much enjoyed both key note speakers and my morning workshop but wasn't overly impressed with the afternoon workshop.	4/9/2019 9:36 AM
9	Please allow more time for the speakers. I feel that the speakers were not able to give their full presentations based on time constraints. The conference would have been much better as a 2 day conference with more time allowed for the speakers.	4/9/2019 9:01 AM
10	If this is appropriate, I'd like info regarding recognizing gangs.	4/9/2019 8:51 AM

11	N/A	4/9/2019 7:20 AM
12	It was very difficult to hear much of the presentation of the morning keynote speaker because he did not stay close enough to his mike as he walked/paced around; I could not understand much of what he was saying.	4/8/2019 9:11 PM
13	Education in the schools for prevention	4/8/2019 8:40 PM
14	That's tough to beat. The speakers I attended were both victims, we learned from hands on experiences.	4/8/2019 4:39 PM
15	The keynotes were outstanding. The workshops were excellent.	4/8/2019 4:06 PM
16	Your keynote speakers made the difference!	4/8/2019 3:37 PM
17	I would like to hear more about the intersection of DV and Substance Abuse. The S&T Model did a nice highlight of the challenges.	4/8/2019 2:39 PM
18	Everything was perfect!	4/8/2019 2:39 PM
19	Lunch was disorganized and not everyone had somewhere to sit and eat.	4/8/2019 2:24 PM
20	I thought my workshop on "values in the public welfare system" was good and presented was well spoken and knowledgeable. But content was not as I recall in the original description. It was specific to Foster Care and that's not my field. I thought the workshop on "Fatherhood" was very poor. Content was stereotyping "mothers" "fathers" and out of date. As a clinician working with dads I found some of the "research" questionable. Not well organized...didn't learn anything new. Enjoyed catching up with colleagues and hearing about State initiatives. My table thought we could have done well without Mark Yorbrough's presentation. The Registration and check in was wonderful. thank you.	4/8/2019 2:23 PM
21	N/A	4/8/2019 1:56 PM
22	Morning keynote speaker was amazing and would have loved to heard more from him. Overall, the conference was great and not your typical, uninformative training day. Can't wait to attend next year.	4/8/2019 1:23 PM
23	None at this time.	4/8/2019 1:11 PM
24	More state focused programs involved in protecting Delaware's children.	4/8/2019 1:09 PM
25	I was thankful that I choose Investigating Child Homicide Part 1 and Part 2.....the speakers were wonderful. I believe that there should be more on this topic of child homicide. Also, traumatic physical injuries that could mimic child physical abuse.....say a child that is 2 months old comes into the ED with the parent stating that the child rolled off the bed and hit its head.....finger tip bruises are all over the child's chin, bruises to the flank area .....the history does not match the physical findings....	4/8/2019 12:48 PM
26	Burnout speaker was not informative. I believe time could have been better spent on a different topic	4/8/2019 12:36 PM
27	This conference is always well planned and informative. This is one of the only conferences that I return to year after year.	4/8/2019 12:34 PM
28	Amazing presentations, great information was shared and I learned a lot! Thanks for doing a great job!	4/8/2019 12:30 PM
29	Domestic Violence with Children - Law Enforcement working with DFS -	4/8/2019 12:28 PM
30	How Domestic Violence impacts the entire family.	4/8/2019 12:23 PM
31	none	4/8/2019 12:23 PM
32	Afternoon sessions seemed to drag	4/8/2019 12:20 PM
33	Found the ballroom to be overly large for the small group programs. Very difficult to hear. Would prefer that all breakout sessions be in conference rooms.	4/8/2019 12:19 PM
34	Vicarious trauma	4/8/2019 12:14 PM
35	N/a	4/8/2019 12:12 PM
36	I would love to see more information on the Safe and Together Model. It was a great session but there wasn't a lot of interest. The presenter was excellent!	4/8/2019 12:12 PM

37	Please consider condensing things between the morning and afternoon sessions. In my opinion, there was too long of a lunch/keynote break. The afternoon sessions didn't start until 3:00, resulting in a late day for those who had far to travel (because its in the same county every year). If the afternoon session started earlier (say 1:30 at the latest), then folks would be finished at a more reasonable time. Thanks for the opportunity to provide feedback.	4/8/2019 12:11 PM
38	I enjoyed and appreciated the two seminars that I attended; child homicide 1 and 2. However, the presentations that were given before the both seminars (in the main conference room) were dry and difficult to hear. I could have done without the award ceremony and such. Regarding eventbrite. I received several annoying emails from eventbrite after signing up. However, the service was easy to use for registering for the conference.	4/8/2019 12:09 PM
39	I felt this was the best yet.	4/8/2019 12:09 PM
40	There were several workshops I would have liked to attend but couldn't because they overlapped with other workshops. This conference should be multiple days.	4/8/2019 12:08 PM
41	NA	4/8/2019 12:05 PM

Q11 The facilitator was well organized in the presentation of the course material.

Answered: 153 Skipped: 2

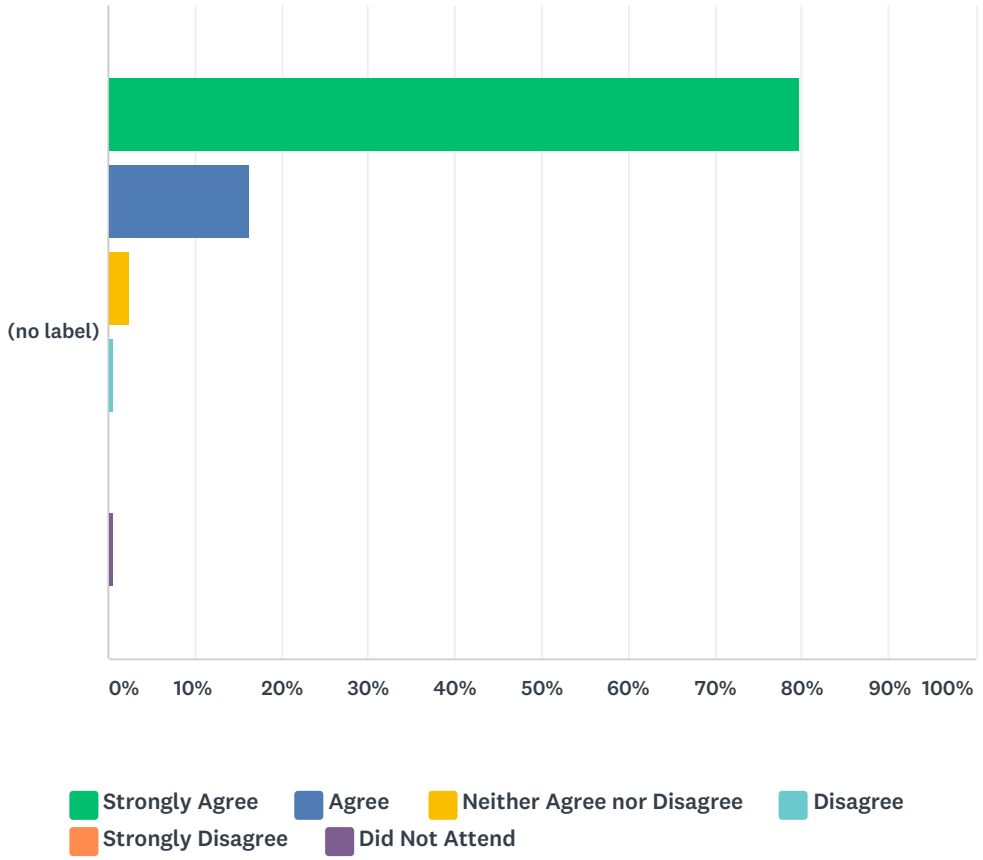


	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	DID NOT ATTEND	TOTAL	WEIGHTED AVERAGE
(no label)	74.51% 114	22.88% 35	1.31% 2	0.65% 1	0.00% 0	0.65% 1	153	1.27

Q12 The facilitator demonstrated a thorough knowledge of the subject

matter.

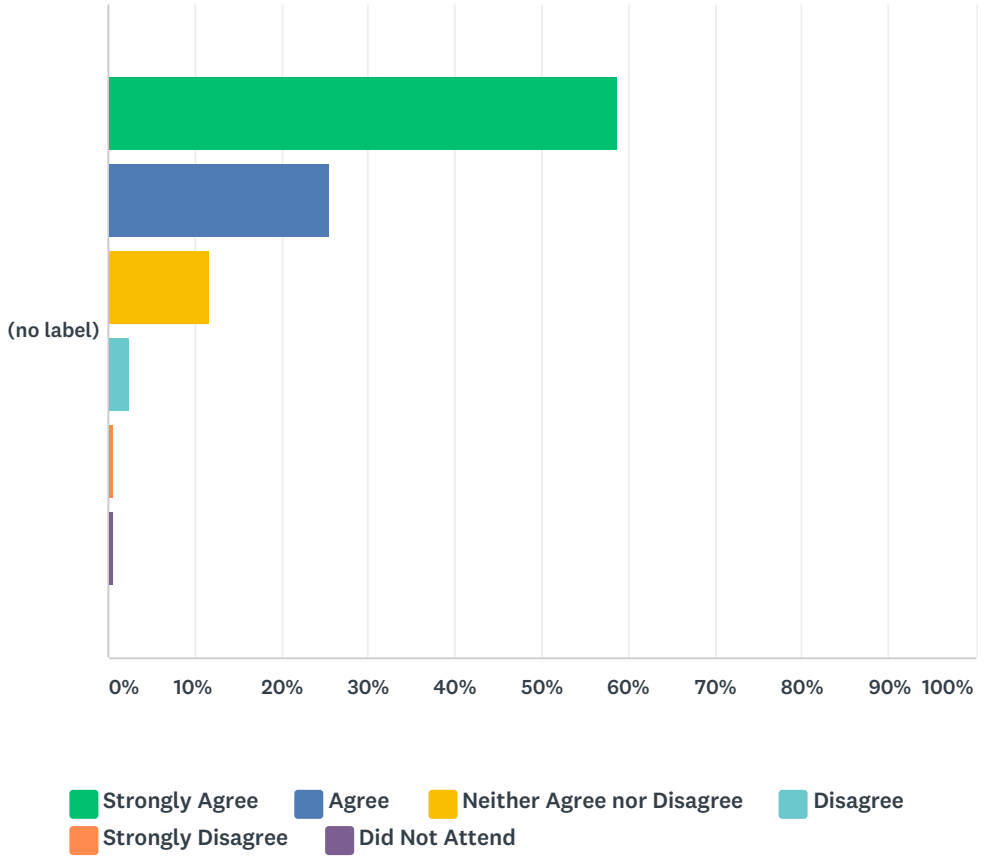
Answered: 153 Skipped: 2



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	DID NOT ATTEND	TOTAL	WEIGHTED AVERAGE
(no label)	79.74% 122	16.34% 25	2.61% 4	0.65% 1	0.00% 0	0.65% 1	153	1.23

Q13 My knowledge and understanding of the subject matter increased as a result of this session.

Answered: 153 Skipped: 2



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	DID NOT ATTEND	TOTAL	WEIGHTED AVERAGE
(no label)	58.82% 90	25.49% 39	11.76% 18	2.61% 4	0.65% 1	0.65% 1	153	1.59

Q14 Please enter any questions, feedback, or takeaways you have from this workshop.

Answered: 57 Skipped: 98

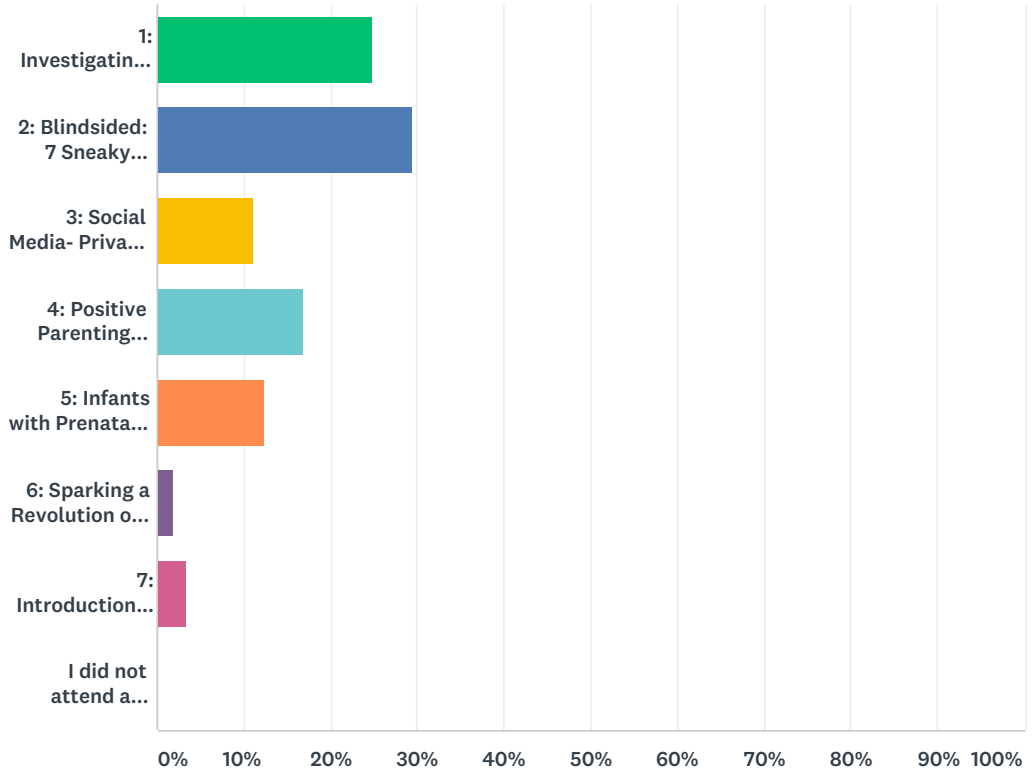
#	RESPONSES	DATE
1	it left a lasting impression	4/19/2019 8:49 PM
2	It would have been beneficial for Kevin to have more time allotted.	4/17/2019 3:03 PM
3	Invite him back!	4/16/2019 4:49 PM
4	Did not think religious note was appropriate at a conference for state employees.	4/15/2019 8:27 AM
5	I was seated in the back and it was difficult to hear what was being said.	4/11/2019 10:01 AM
6	Excellent workshop	4/10/2019 8:04 AM
7	Very good presentation. It was awesome to hear from a victim that is now in the law enforcement/prosecution side of the fence.	4/9/2019 5:17 PM
8	I would have enjoyed the speaker more if I could have heard him easily.	4/9/2019 4:03 PM
9	Keep sound loud clear throughout	4/9/2019 3:35 PM
10	Very informative presentation. I really enjoyed it.	4/9/2019 10:51 AM
11	Great presentation	4/9/2019 10:21 AM

12	He needed more time. He has too much of a story and not enough time to tell it all.	4/9/2019 10:09 AM
13	EXCELLENT!	4/9/2019 9:48 AM
14	He is a very good speaker and his story is one that needs to be told	4/9/2019 9:37 AM
15	He was very difficult to hear. I missed so much of what he said because of the poor sound system. I know he wanted to walk around and his presentation would not have been as compelling if he was at the podium. I wish I could hear him again with full sound.	4/9/2019 9:29 AM
16	As he was walking back and forth, it was sometimes difficult to hear his words.	4/9/2019 8:52 AM
17	Excellent keynote! I rarely go home and talk about a training I've attended but I did with this one. So well done!	4/9/2019 8:29 AM
18	Outstanding Presenters	4/9/2019 7:20 AM
19	The presentation was informative and did a great job at giving us a more in depth look into how easy it is to groom and how it can be mistaken for friendship as a child. And why children don't tell. I give my highest regard and respect for sharing so others can learn.	4/8/2019 8:43 PM
20	I found it very difficult to hear the presenter	4/8/2019 8:10 PM
21	Not much depth to the information. Personal story was dramatic but not useful. When he lowered his voice for effect, could not be heard in the back of the room	4/8/2019 7:18 PM
22	Two things. 1. The facilitator wasn't a tall man and decided to stand on the floor instead of the podium. He did not need to stand behind the lectern but at least on the stage. Those in the back of this large room could barely hear him. Also he felt his story was more important than the 4 learning points which he decided not to tell us. It was fine to hear his story but the 4 teaching points were equally important if not more so. Suggestion shorten story, keep the learning points in.	4/8/2019 4:41 PM
23	nothing to add	4/8/2019 4:40 PM
24	The presenter chose to use a lapel mic so he could walk around, but unfortunately he failed to keep his voice up so those of us in the back of the room frequently had a hard time hearing what he was saying. This continued even after someone notified him that people in the back were having trouble hearing and put a damper on what was otherwise an excellent presentation.	4/8/2019 4:25 PM
25	I will never forget this story. It was an excellent depiction of how predators groom and the impact sexual abuse has on our children. I'm so grateful I had an opportunity to hear him speak	4/8/2019 4:14 PM
26	Loved this presentation. It was personal and real! Gave me better insight to the victim and the perpetrator.	4/8/2019 3:38 PM
27	Great speaker!	4/8/2019 3:09 PM
28	Very powerful lessons from his experience.	4/8/2019 2:40 PM
29	I think many of us were looking for ideas about assisting youth touched by sexual abuse and the speaker was not helpful in that regard.	4/8/2019 2:25 PM
30	Excellent speakers as previously stated.	4/8/2019 2:24 PM
31	I was sorry that when he came to a difficult part his voice went down I could hear him but unfortunately someone yelled from the back if he could speak up it was important that everyone hear the whole story to get the point of his story the good news is that he did speak up	4/8/2019 2:16 PM
32	Very good presentation, I like that he kept it moving and only used his own victimization to enforce the lecture not make it the only focal point.	4/8/2019 2:16 PM
33	He was very interesting.	4/8/2019 2:01 PM
34	I was sitting in the back of the conference room, and could not hear the presentation very well.	4/8/2019 1:44 PM
35	He was excellent, good sense of humor that cushioned the horror of what he suffered. He acknowledged and addressed the initial reaction we might have to what he said.	4/8/2019 1:37 PM
36	He needed more time to continue his story. Victim accounts are motivating to those who work in the field to remember why we do what we do each day.	4/8/2019 1:24 PM
37	I think that the facilitator should have been seen on the big screen or screens so that all could see even in the back and loud enough for all to hear. When the facilitator was speaking and going into his or her emotions they talked low and you could not hear everything.	4/8/2019 1:18 PM

38	I really don't have any more feedback at this time	4/8/2019 12:48 PM
39	informative and entertaining, great combination!!	4/8/2019 12:45 PM
40	Fantastic presenter. I believe hearing real stories from real survivors has a huge impact on those in this field.	4/8/2019 12:40 PM
41	He was a great presenter.	4/8/2019 12:37 PM
42	His message was powerful and informative	4/8/2019 12:37 PM
43	I learned that a sexual pedophile will even go as far as grooming an adult in order to victimize a child.	4/8/2019 12:32 PM
44	Only minor issue is that it was hard to hear him speak when sitting in the back. Maybe the mike could be turned up?	4/8/2019 12:31 PM
45	I thoroughly enjoyed the keynote speaker. Having speakers that have experienced abuse be able to tell you about their experiences is better than hearing statistics and ideas of how to fix the issues we deal with.	4/8/2019 12:30 PM
46	FANTASTIC	4/8/2019 12:21 PM
47	Excellent. Puts a real face on what is to be an adult who was molested as a child.	4/8/2019 12:20 PM
48	The sound was not good at the back of the ballroom	4/8/2019 12:15 PM
49	n/a	4/8/2019 12:13 PM
50	From what I could hear, the speaker did a good job and knew what he was talking about. However, I wasn't able to hear most of his presentation from where I was seated.	4/8/2019 12:11 PM
51	Really enjoyed his presentation/story, however it was difficult to hear him. Not sure if this is because he spoke softly or it was the acoustics/sound system of the venue.	4/8/2019 12:09 PM
52	This presenter was EXCELLENT!! I would listen to his story again. He was awesome!!	4/8/2019 12:09 PM
53	It was hard to hear in the back of the room.	4/8/2019 12:09 PM
54	Really good speaker.	4/8/2019 12:09 PM
55	The "Randy and Me" presentation was very good. He told his story well and even though there were some "tough" parts to his presentation, he was still entertaining and held the audience's attention.	4/8/2019 12:09 PM
56	This speaker was phenomenal. I was so impressed with his presentation. I'm still mulling it over!	4/8/2019 12:08 PM
57	Great speaker. Very powerful	4/8/2019 12:08 PM

Q15 Which workshop did you attend?

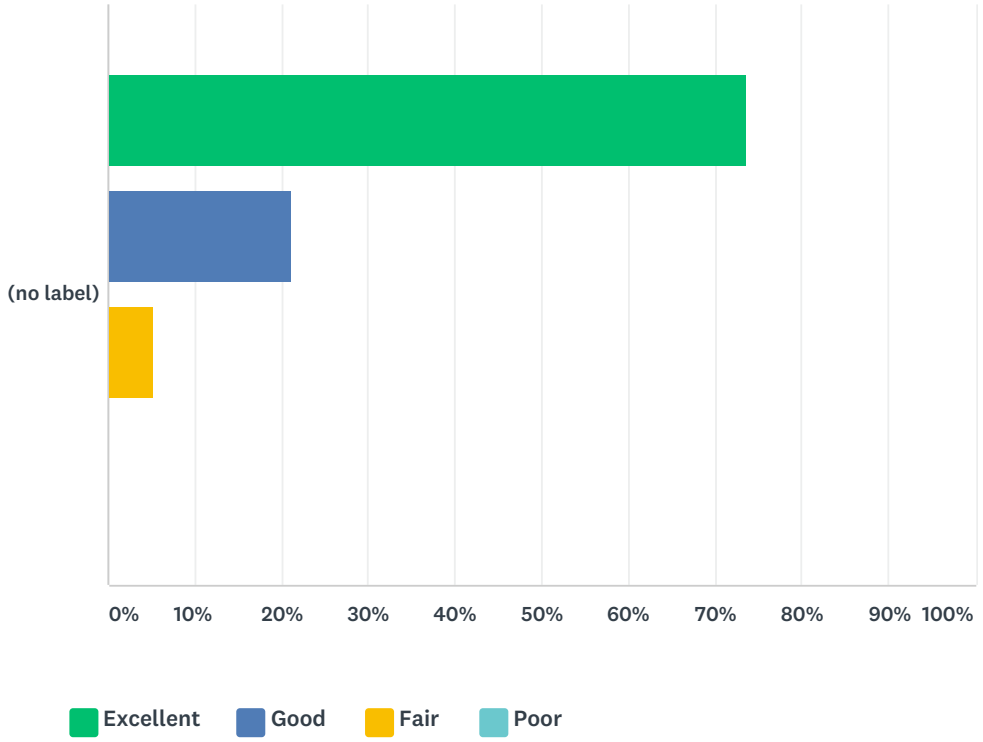
Answered: 153 Skipped: 2



ANSWER CHOICES	RESPONSES	
1: Investigating Child Homicide Cases, Part 1- Nancy Oglesby & Michael Milnor	24.84%	38
2: Blindsided: 7 Sneaky Challenges Facing Survivors of Childhood Sexual Abuse- Kevin Mulcahy	29.41%	45
3: Social Media- Privacy and Safety Considerations- Ed McAndrew	11.11%	17
4: Positive Parenting Interventions to Decrease Harsh Parenting, Reduce Child Behavioral Problems and Improve Family Functioning- Dr. Joanne Wood	16.99%	26
5: Infants with Prenatal Substance Exposure and their Families: Multidisciplinary Collaboration for the Development of Plans of Safe Care for Safety and Services for the Family- Trenee Parker and Jen Donahue	12.42%	19
6: Sparking a Revolution of Values in the Child Welfare System- Vivek Sankaran	1.96%	3
7: Introduction to the Safe & Together Model: Creating Domestic Violence-Informed Child Welfare Systems- Brittany DiBella	3.27%	5
I did not attend a workshop.	0.00%	0
TOTAL		153

Q16 Please rate this workshop.

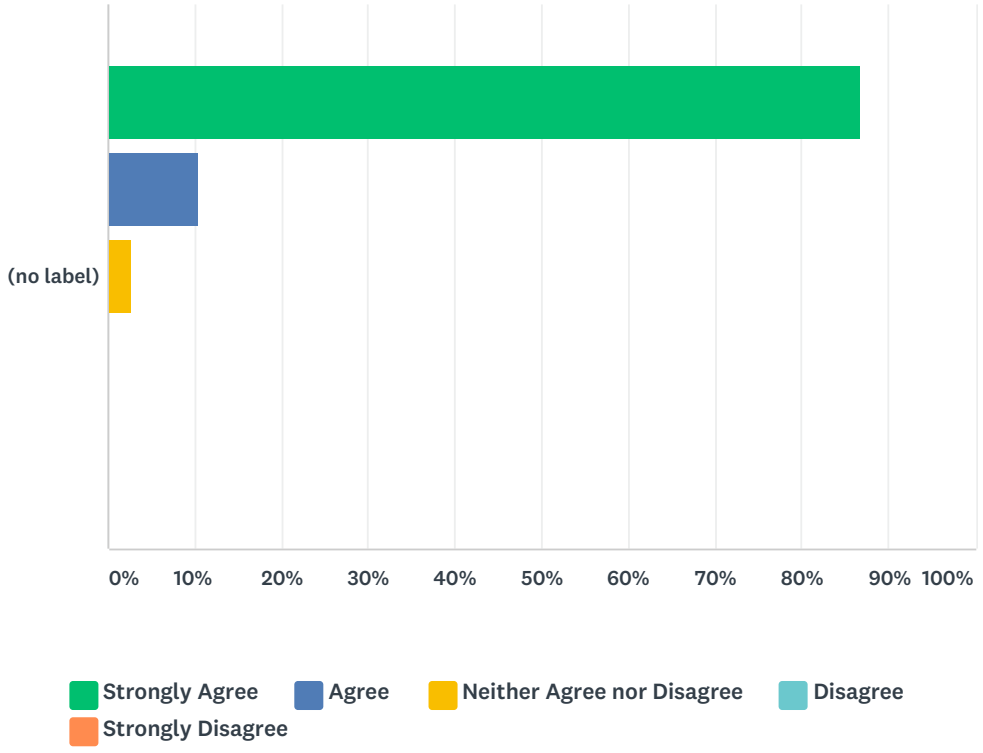
Answered: 38 Skipped: 117



	EXCELLENT	GOOD	FAIR	POOR	TOTAL	WEIGHTED AVERAGE
(no label)	73.68% 28	21.05% 8	5.26% 2	0.00% 0	38	1.32

Q17 The facilitator was organized in the presentation of course materials.

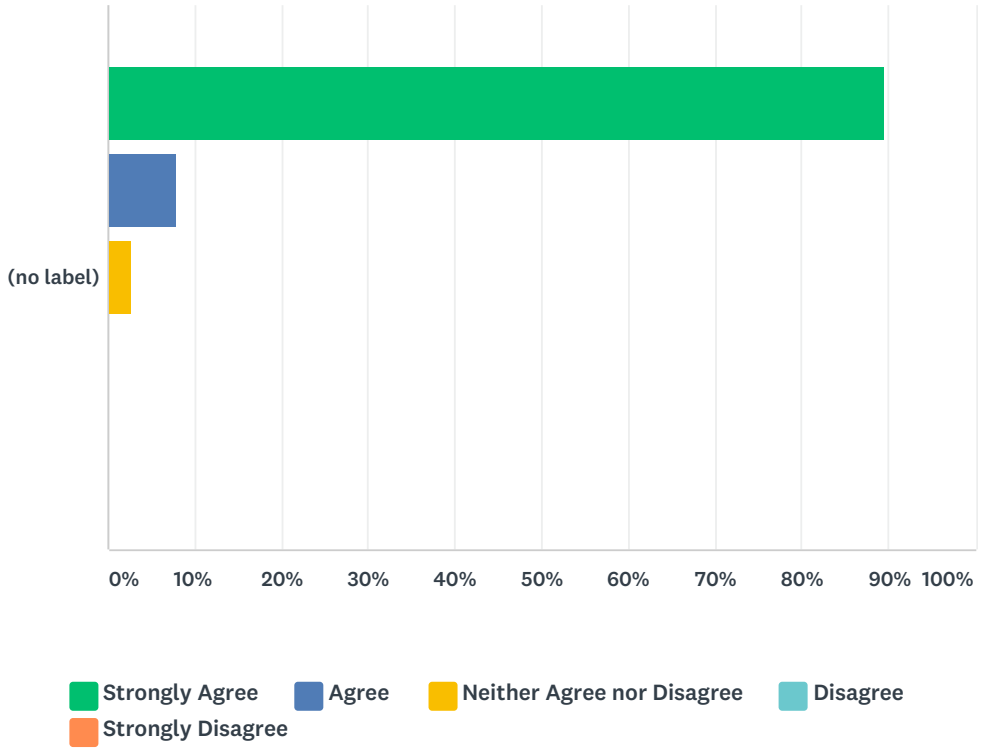
Answered: 38 Skipped: 117



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	86.84% 33	10.53% 4	2.63% 1	0.00% 0	0.00% 0	38	1.16

Q18 The facilitator demonstrated a thorough knowledge of the subject matter.

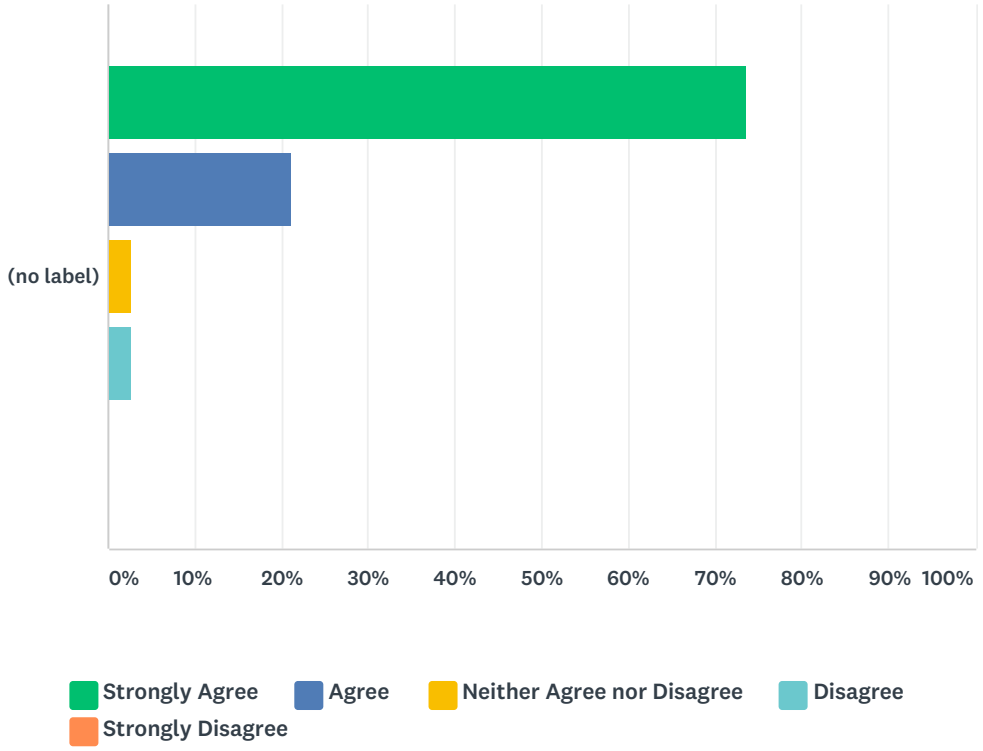
Answered: 38 Skipped: 117



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	89.47% 34	7.89% 3	2.63% 1	0.00% 0	0.00% 0	38	1.13

Q19 My knowledge and understanding of the subject matter increased as a result of this session.

Answered: 38 Skipped: 117



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	73.68% 28	21.05% 8	2.63% 1	2.63% 1	0.00% 0	38	1.34

Q20 Please enter any questions, feedback, or takeaways you have from this workshop.

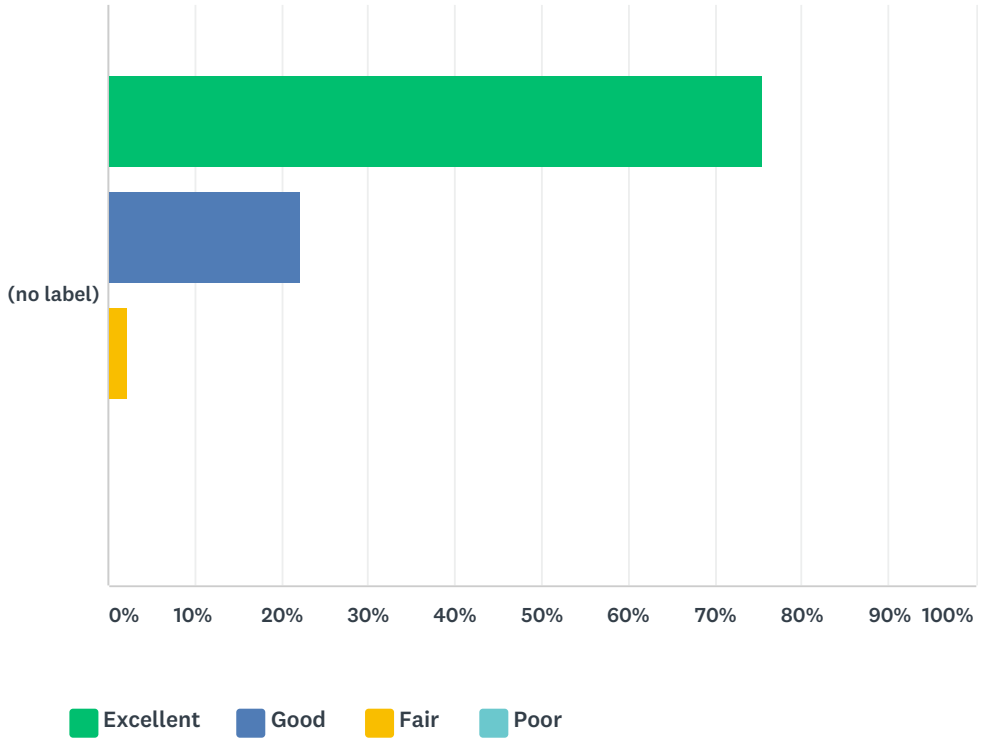
Answered: 11 Skipped: 144

#	RESPONSES	DATE
1	Remarkable workshop presentation!	4/10/2019 8:09 AM
2	Excellent presenters. Provided several examples of real-life situations. Very informative and will help me as a nurse to listen to the details provided by families of potential child abuse victims brought into the ER. One suggestion for this type of setup (Part I and Part II) would be to put a note when signing up for the class that attendees should go to both parts. I thought the topics in each section would be different but actually they started a case example and then I never got to find out what happened because I did not sign up for Part II thinking that it would be different information, not a continuation.	4/9/2019 9:52 AM
3	It was sad to hear how sometimes these investigations affect workers.	4/8/2019 3:40 PM
4	Very informative , I like how they kept it moving and interacted with the audience. It shows that they have worked together before, it made for a very seamless transition between the two presenters.	4/8/2019 2:17 PM
5	The title of the course was broad and misleading. The workshop was heavy on info regarding a small study regarding 911 calls. The best info provided was that all child death scenes should be treated as homocide until it's ruled out.	4/8/2019 2:09 PM
6	This session has made me look at child homicide cases from a different perspective.	4/8/2019 2:01 PM
7	This was an awesome workshop!!!!	4/8/2019 1:03 PM

8	This was the best lecture I've seen in a long time and I'm defiantly taking the info back to Bayhealth to all three ED's	4/8/2019 12:49 PM
9	The presenters of the class brought awareness to SID-(sudden infant death) cases should be looked at more closely, it may result in a homicide case.	4/8/2019 12:37 PM
10	The 9-1-1 call analytics was very interesting...	4/8/2019 12:12 PM
11	Too much focus on 911 calls	4/8/2019 12:06 PM

Q21 Please rate this workshop.

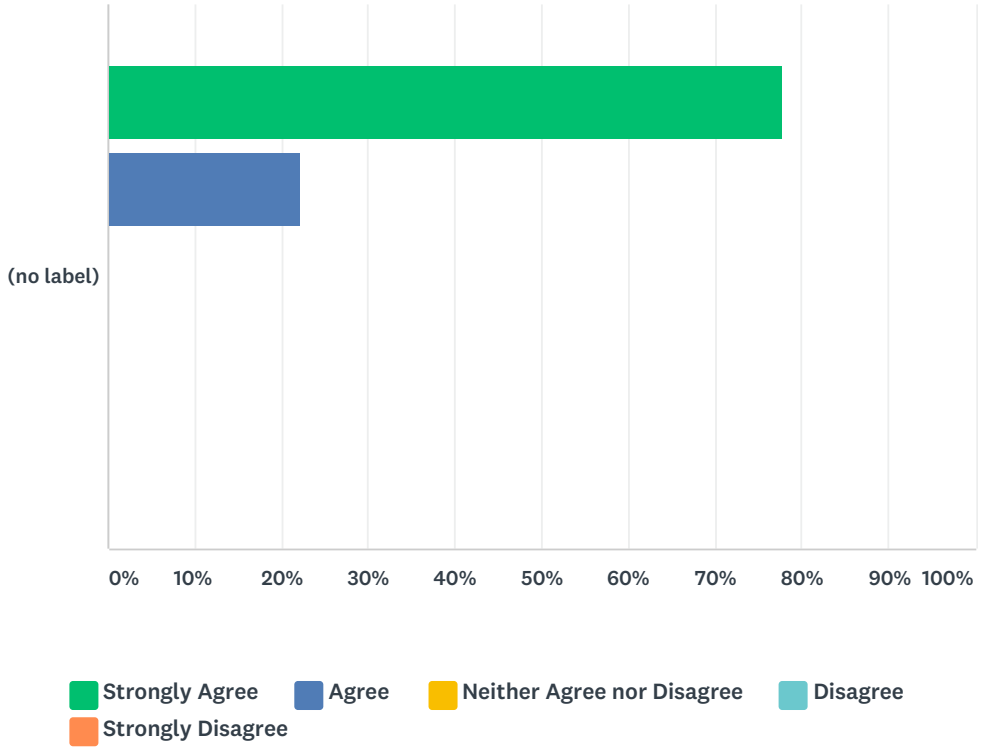
Answered: 45 Skipped: 110



	EXCELLENT	GOOD	FAIR	POOR	TOTAL	WEIGHTED AVERAGE
(no label)	75.56% 34	22.22% 10	2.22% 1	0.00% 0	45	1.27

Q22 The facilitator was organized in the presentation of course materials.

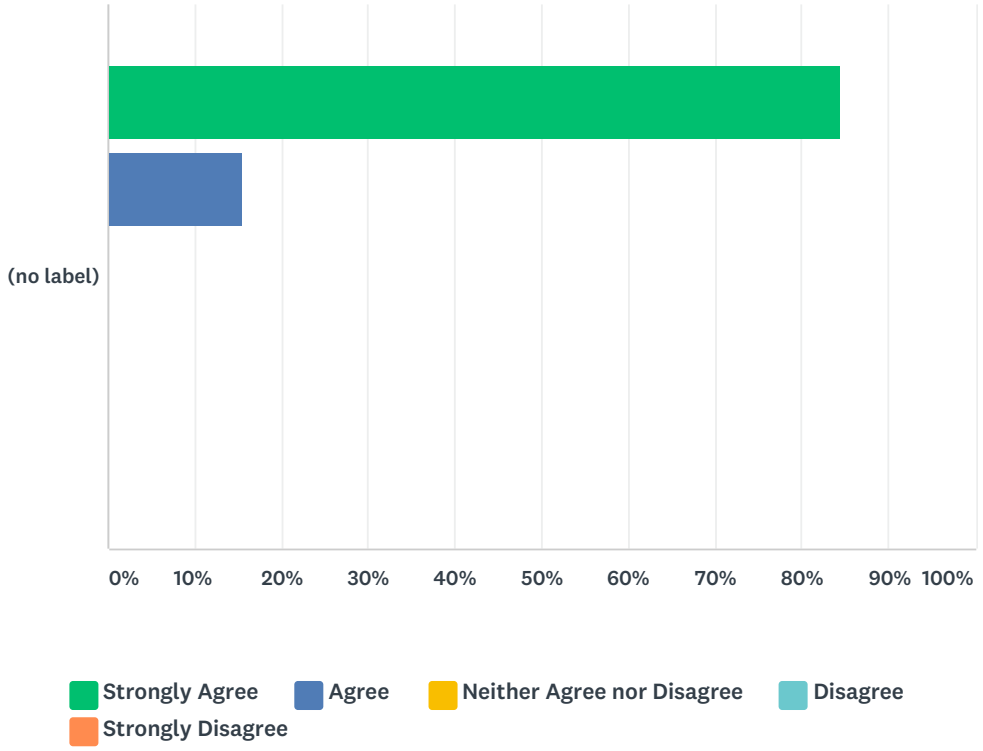
Answered: 45 Skipped: 110



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	77.78% 35	22.22% 10	0.00% 0	0.00% 0	0.00% 0	45	1.22

Q23 The facilitator demonstrated a thorough knowledge of the subject matter.

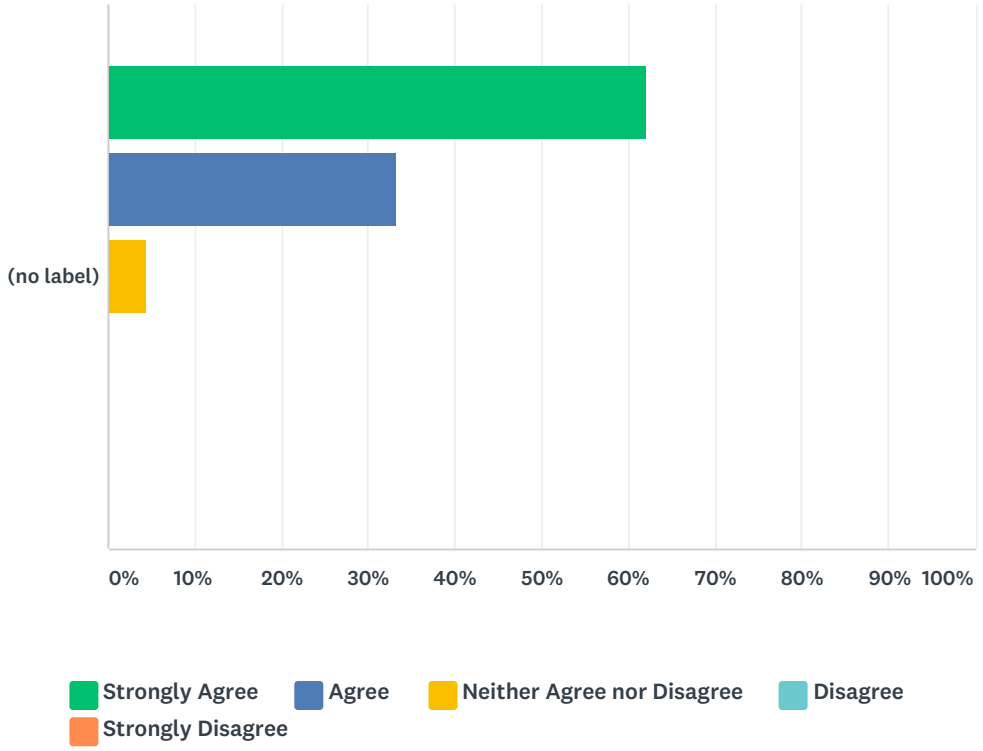
Answered: 45 Skipped: 110



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	84.44% 38	15.56% 7	0.00% 0	0.00% 0	0.00% 0	45	1.16

Q24 My knowledge and understanding of the subject matter increased as a result of this session.

Answered: 45 Skipped: 110



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	62.22% 28	33.33% 15	4.44% 2	0.00% 0	0.00% 0	45	1.42

Q25 Please enter any questions, feedback, or takeaways you have from this workshop.

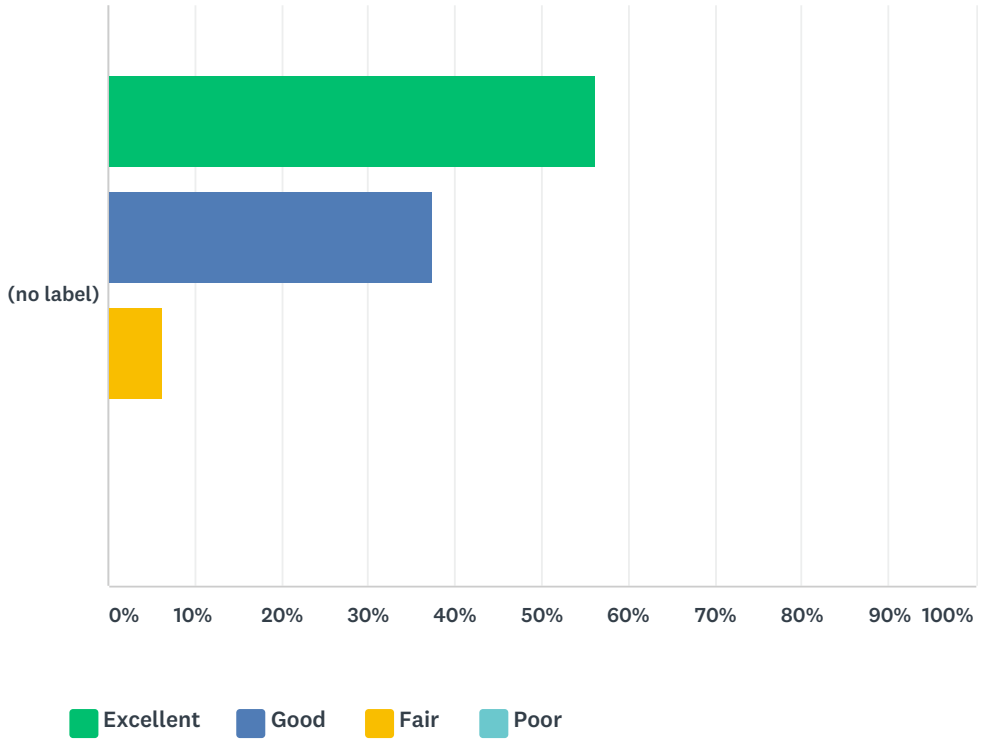
Answered: 16 Skipped: 139

#	RESPONSES	DATE
1	Well presented and thought provoking.	4/16/2019 4:51 PM
2	This was one of the best presentations/trainings I have attended. It was very helpful in describing the feelings/issues that survivors of sexual abuse may face.	4/11/2019 10:02 AM
3	Very informative. I learned a lot.	4/9/2019 5:18 PM
4	This is the workshop I went to when I left the parenting due to sound issues. This information confirmed my practice.	4/9/2019 12:55 PM
5	as a sexual abuse survivor it gave me many things to think about in regards to my own recovery. It actually validated and clarified some things for me personally as I don't really talk about my abuse with people because they just don't understand and it stresses them. Professionally, he gave me a lot to think abut when dealing with victims (children and adults) because sexually abuse its a life changing and challenging.	4/9/2019 9:39 AM
6	Again, the sound system supporting his talk was inadequate.	4/9/2019 9:30 AM
7	Outstanding	4/9/2019 7:21 AM
8	Good session.	4/8/2019 4:43 PM
9	none	4/8/2019 4:41 PM
10	See above comments	4/8/2019 1:38 PM

11	Session was good, just not the right one for my employment.	4/8/2019 1:25 PM
12	One of my favorite parts of the conference	4/8/2019 12:37 PM
13	Would have preferred more written materials.	4/8/2019 12:21 PM
14	He needed a better mike or sound system	4/8/2019 12:15 PM
15	Very good	4/8/2019 12:09 PM
16	Again, this speaker was on point. I learned a lot.	4/8/2019 12:09 PM

Q26 Please rate this workshop.

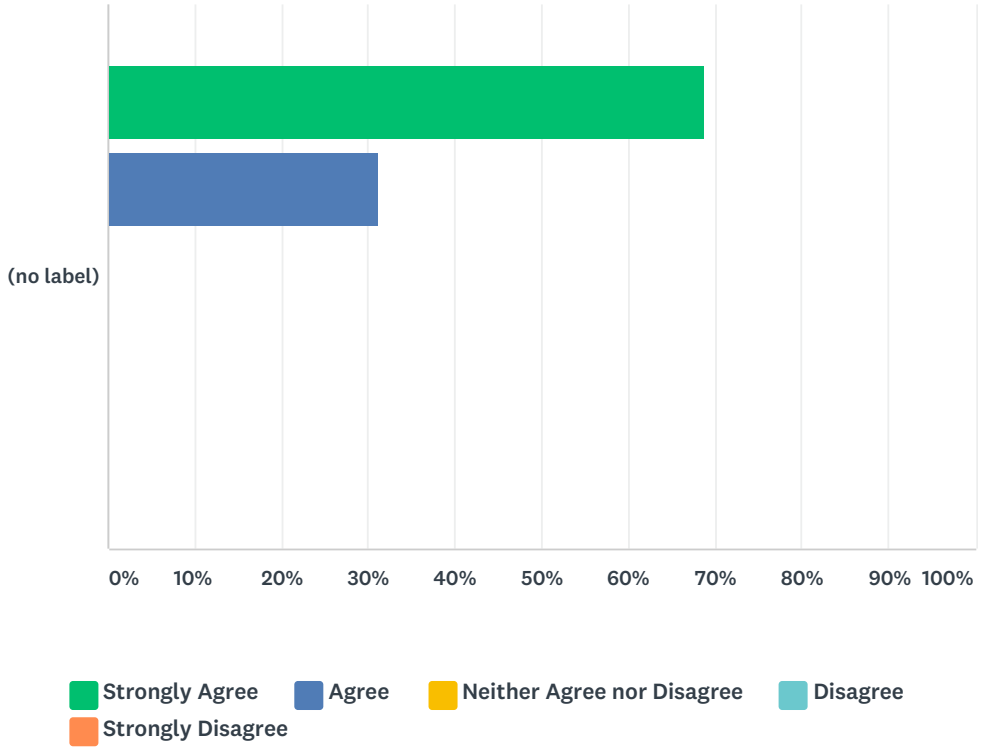
Answered: 16 Skipped: 139



	EXCELLENT	GOOD	FAIR	POOR	TOTAL	WEIGHTED AVERAGE
(no label)	56.25% 9	37.50% 6	6.25% 1	0.00% 0	16	1.50

Q27 The facilitator was organized in the presentation of course materials.

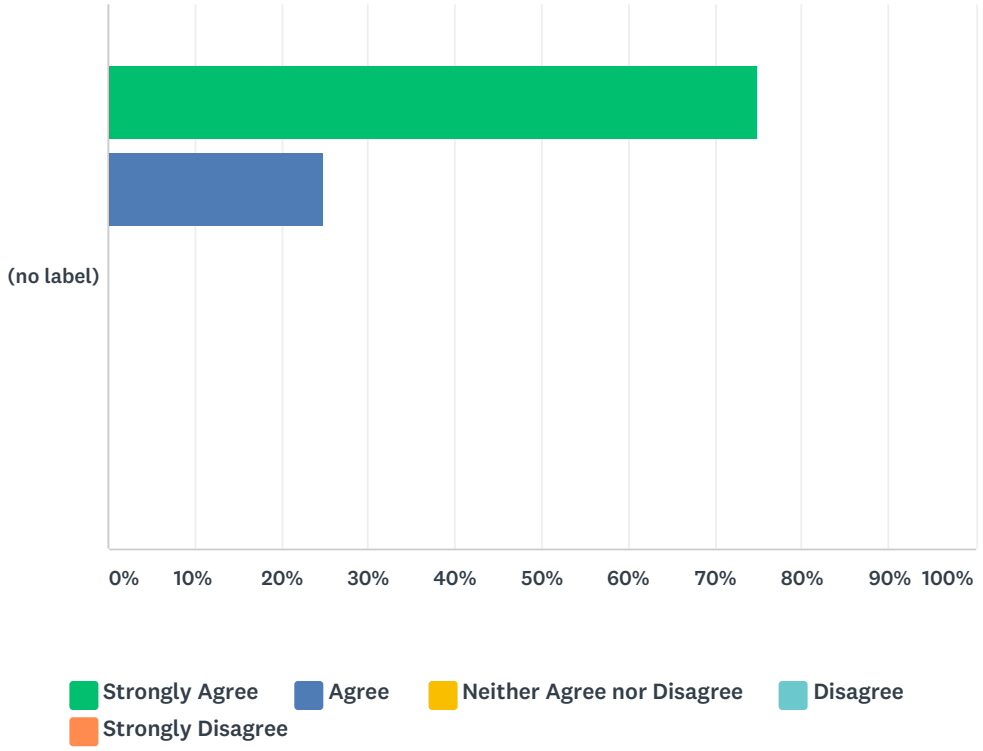
Answered: 16 Skipped: 139



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	68.75% 11	31.25% 5	0.00% 0	0.00% 0	0.00% 0	16	1.31

Q28 The facilitator demonstrated a thorough knowledge of the subject matter.

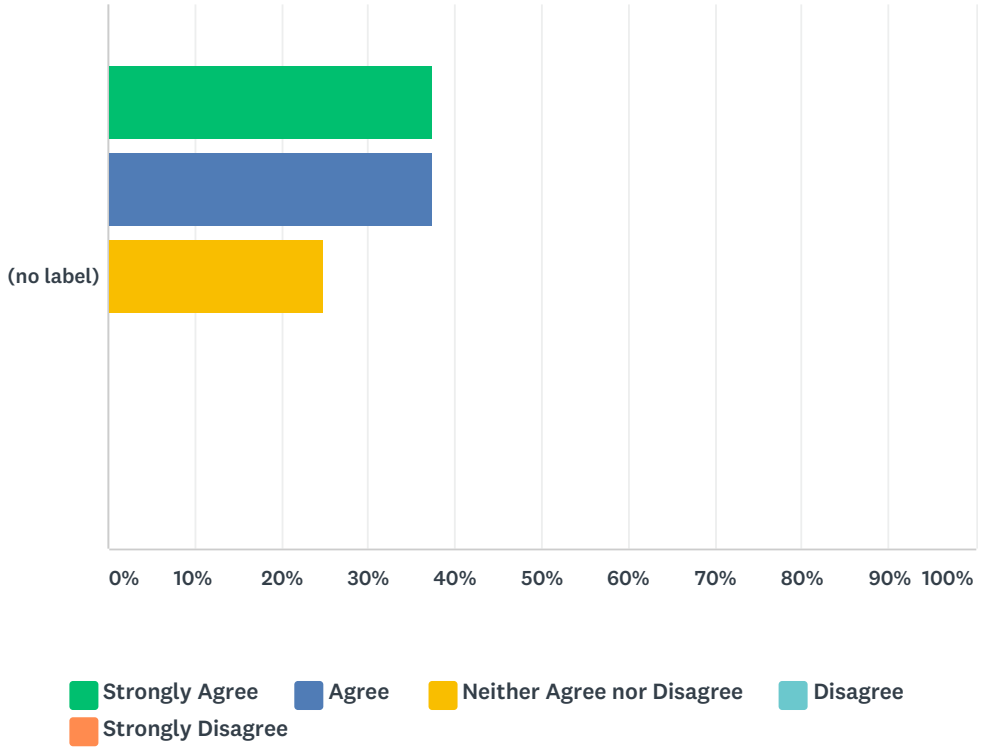
Answered: 16 Skipped: 139



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	75.00% 12	25.00% 4	0.00% 0	0.00% 0	0.00% 0	16	1.25

Q29 My knowledge and understanding of the subject matter increased as a result of this session.

Answered: 16 Skipped: 139



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	37.50% 6	37.50% 6	25.00% 4	0.00% 0	0.00% 0	16	1.88

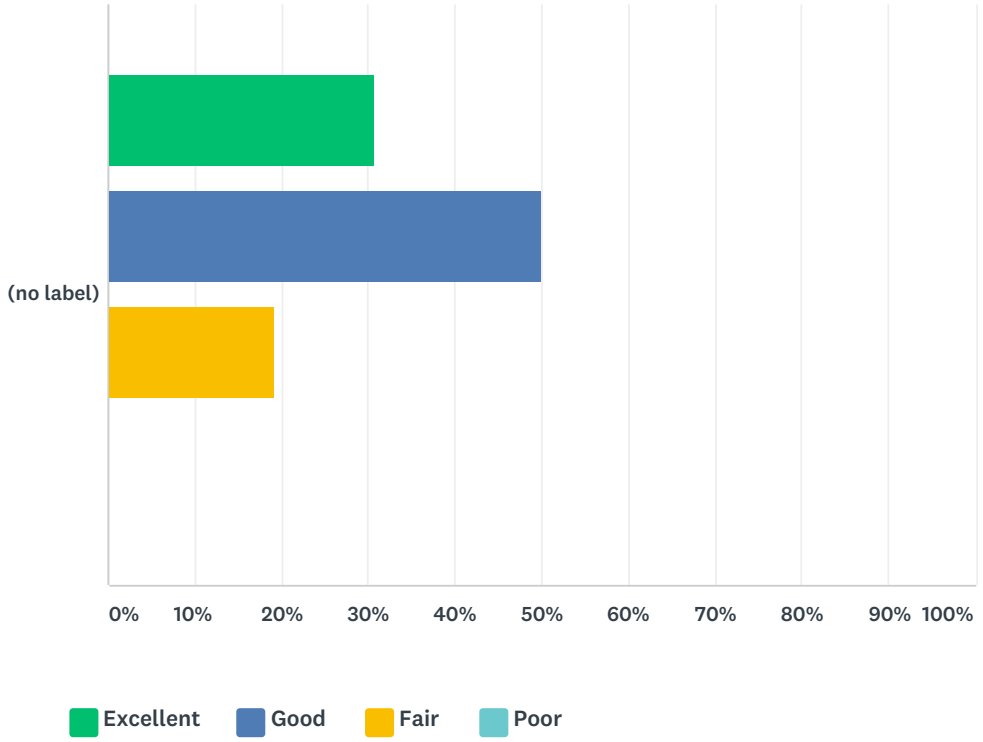
Q30 Please enter any questions, feedback, or takeaways you have from this workshop.

Answered: 3 Skipped: 152

#	RESPONSES	DATE
1	Not what I expected, but interesting information.	4/9/2019 10:10 AM
2	n/a	4/8/2019 12:20 PM
3	It wasn't what I was expecting. I thought it would bring awareness more to the social media that young people are using.	4/8/2019 12:10 PM

Q31 Please rate this workshop.

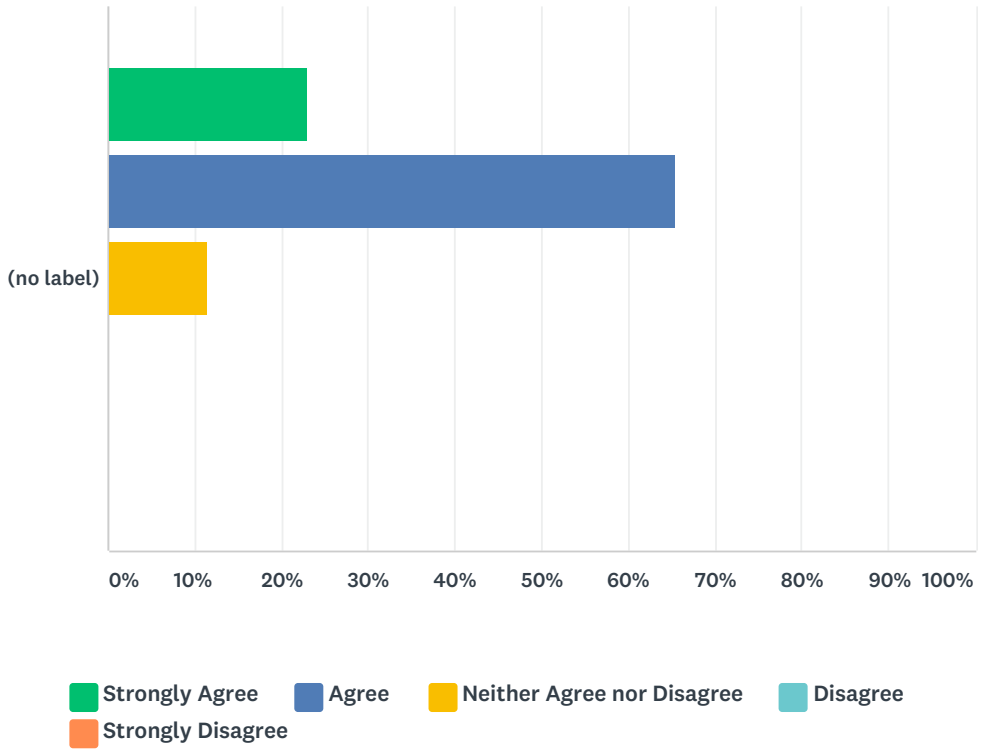
Answered: 26 Skipped: 129



	EXCELLENT	GOOD	FAIR	POOR	TOTAL	WEIGHTED AVERAGE
(no label)	30.77% 8	50.00% 13	19.23% 5	0.00% 0	26	1.88

Q32 The facilitator was organized in the presentation of course materials.

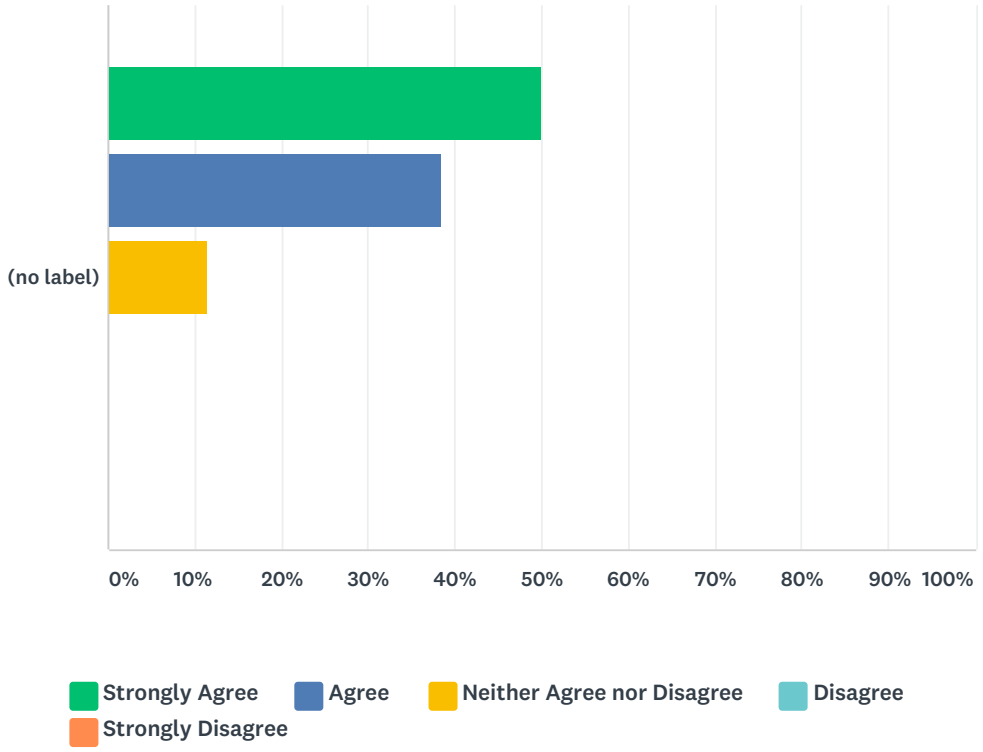
Answered: 26 Skipped: 129



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	23.08% 6	65.38% 17	11.54% 3	0.00% 0	0.00% 0	26	1.88

Q33 The facilitator demonstrated a thorough knowledge of the subject matter.

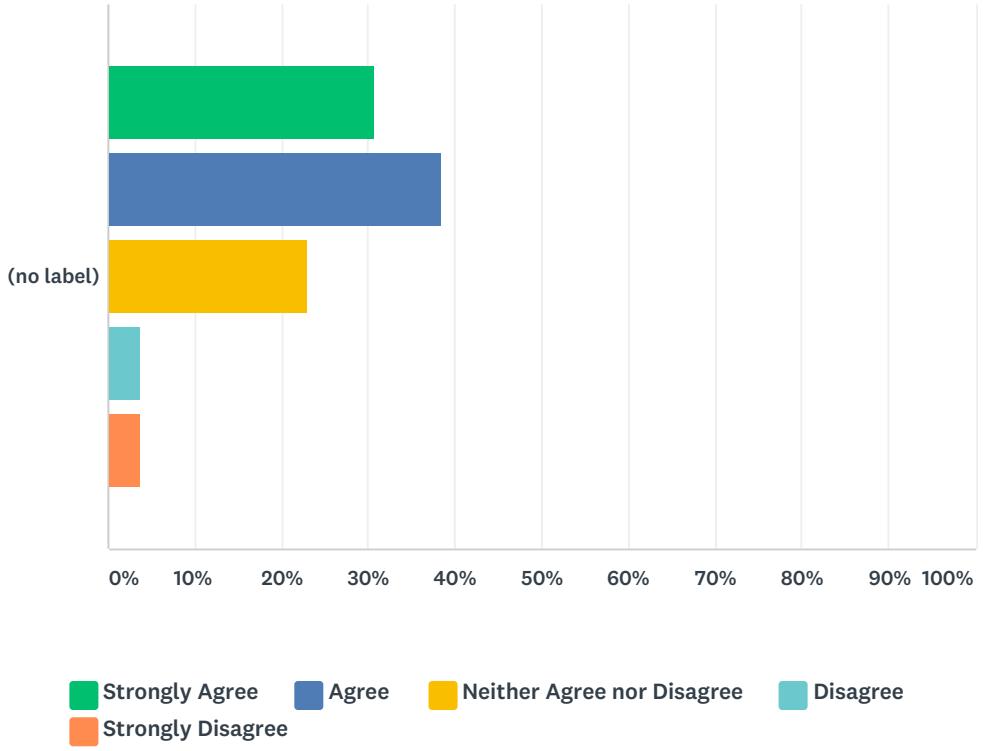
Answered: 26 Skipped: 129



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	50.00% 13	38.46% 10	11.54% 3	0.00% 0	0.00% 0	26	1.62

Q34 My knowledge and understanding of the subject matter increased as a result of this session.

Answered: 26 Skipped: 129



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	30.77% 8	38.46% 10	23.08% 6	3.85% 1	3.85% 1	26	2.12

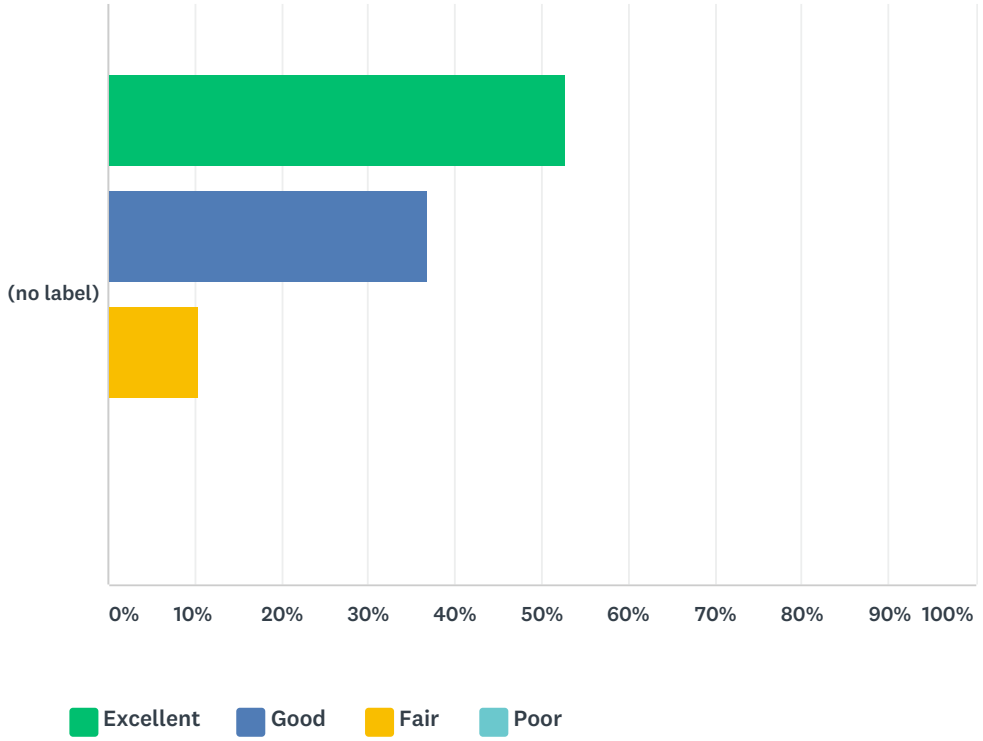
Q35 Please enter any questions, feedback, or takeaways you have from this workshop.

Answered: 9 Skipped: 146

#	RESPONSES	DATE
1	Felt that this was more of a sales pitch for their program.	4/17/2019 4:42 PM
2	There was audio issues; I also think the workshop (during the sign up) should include in its descriptions which employees would benefit the most out of the workshop.	4/15/2019 8:29 AM
3	The session was great. The room was too long so it was hard to engage with other participants.	4/9/2019 4:04 PM
4	The workshop was good, but ruined due to the sound system or lack of. There was a crackling every time she spoke (until the sound system was turned off) and then the next workshop's sound was too loud, it made the whole workshop irritating which is a real shame.	4/9/2019 11:06 AM
5	Visual and sound system was messed up and their sound competed with the neighbor speaker.	4/8/2019 6:53 PM
6	portable microphone created distracting feedback and it took the tech staff a long time to respond.	4/8/2019 2:02 PM
7	There were technical difficulties that were to no fault of the speaker, but it was difficult to hear the speaker sometimes due to muffle from the microphone. Also, I was hoping to learn new parenting techniques or tools to help my clients that struggle with parenting their children that have behavioral issues.	4/8/2019 1:58 PM
8	Felt as though parents are told don't spank, don't do this, don't do that but no information on how it's okay to discipline your children, how to provide structure/routine.	4/8/2019 12:43 PM
9	I was able to take away some suggestions about positive parenting into my personal life.	4/8/2019 12:10 PM

Q36 Please rate this workshop.

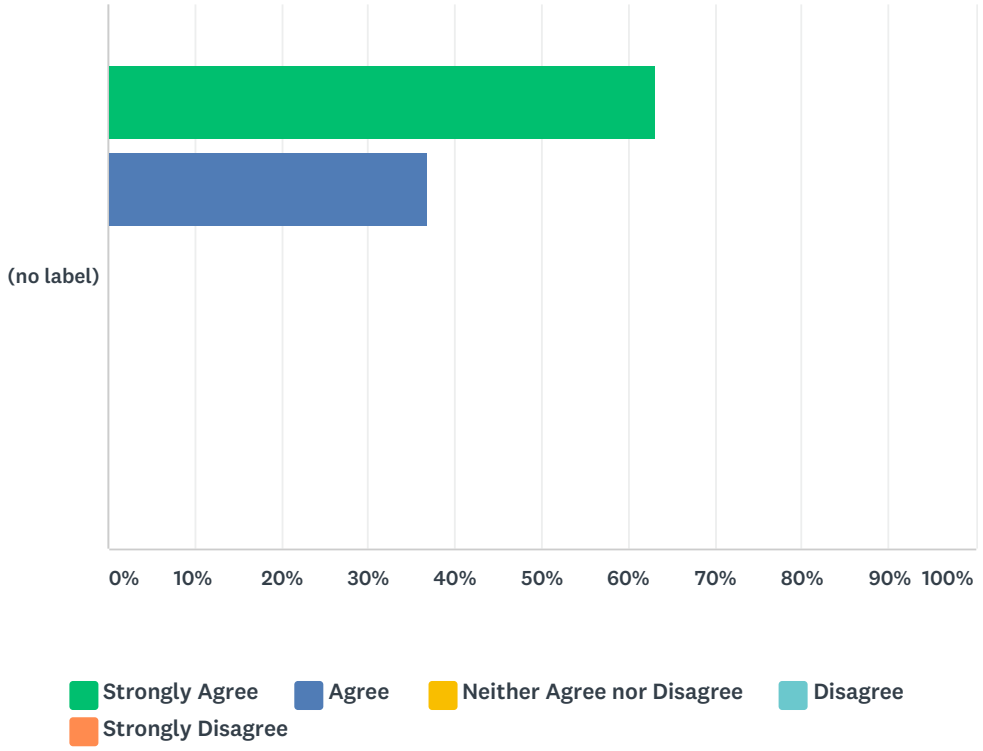
Answered: 19 Skipped: 136



	EXCELLENT	GOOD	FAIR	POOR	TOTAL	WEIGHTED AVERAGE
(no label)	52.63% 10	36.84% 7	10.53% 2	0.00% 0	19	1.58

Q37 The facilitator was organized in the presentation of course materials.

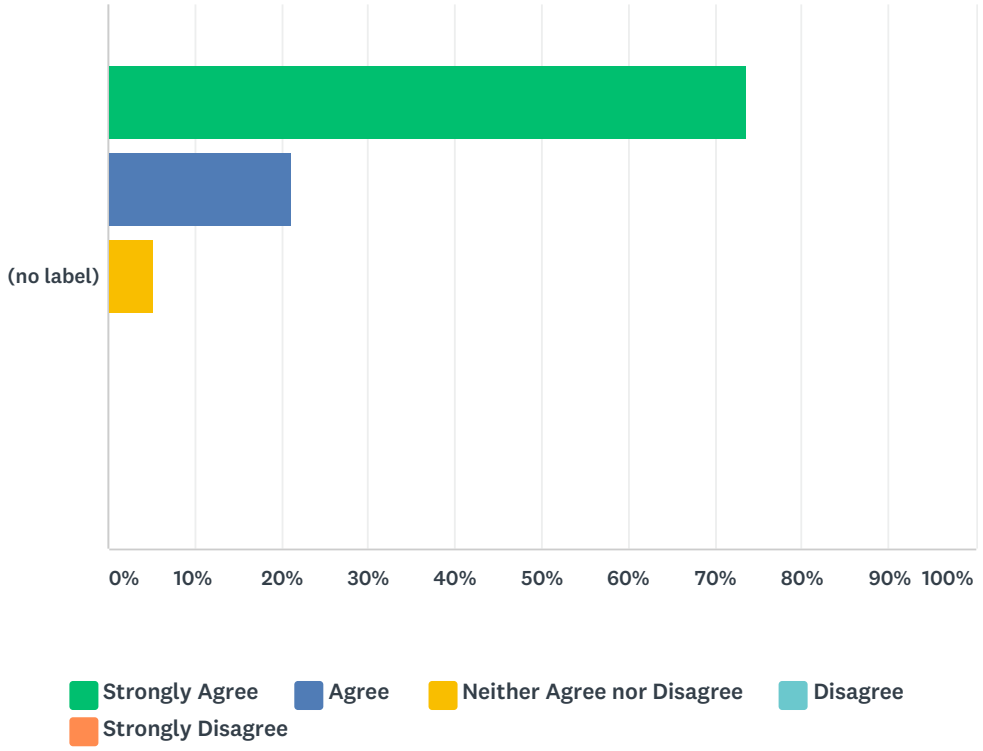
Answered: 19 Skipped: 136



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	63.16% 12	36.84% 7	0.00% 0	0.00% 0	0.00% 0	19	1.37

Q38 The facilitator demonstrated a thorough knowledge of the subject matter.

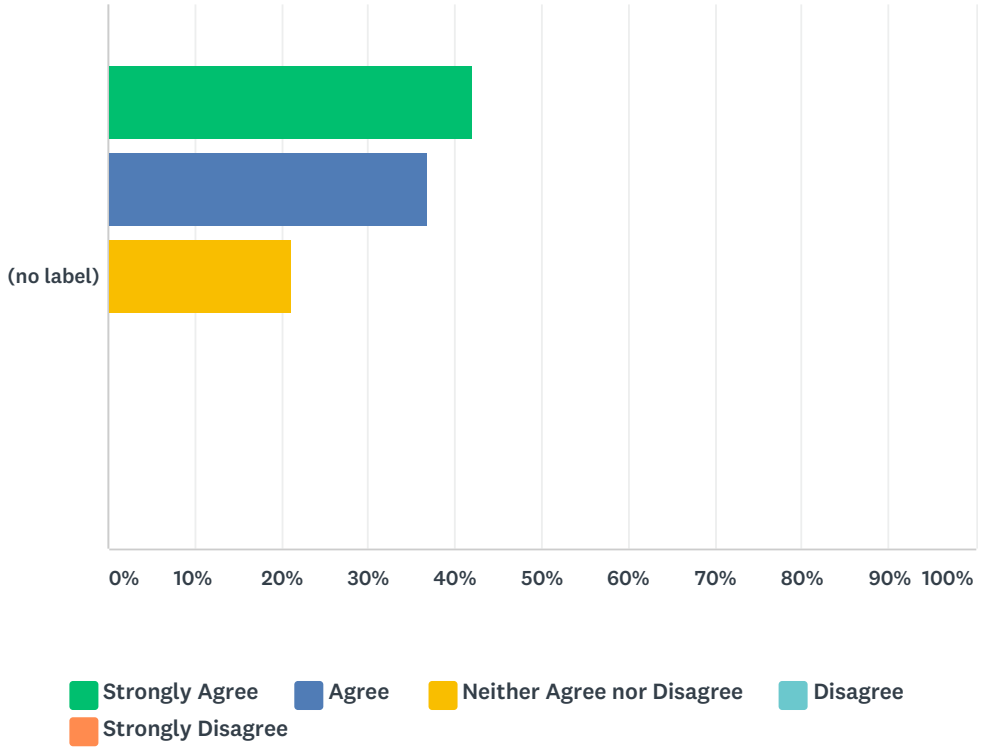
Answered: 19 Skipped: 136



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	73.68% 14	21.05% 4	5.26% 1	0.00% 0	0.00% 0	19	1.32

Q39 My knowledge and understanding of the subject matter increased as a result of this session.

Answered: 19 Skipped: 136



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	42.11% 8	36.84% 7	21.05% 4	0.00% 0	0.00% 0	19	1.79

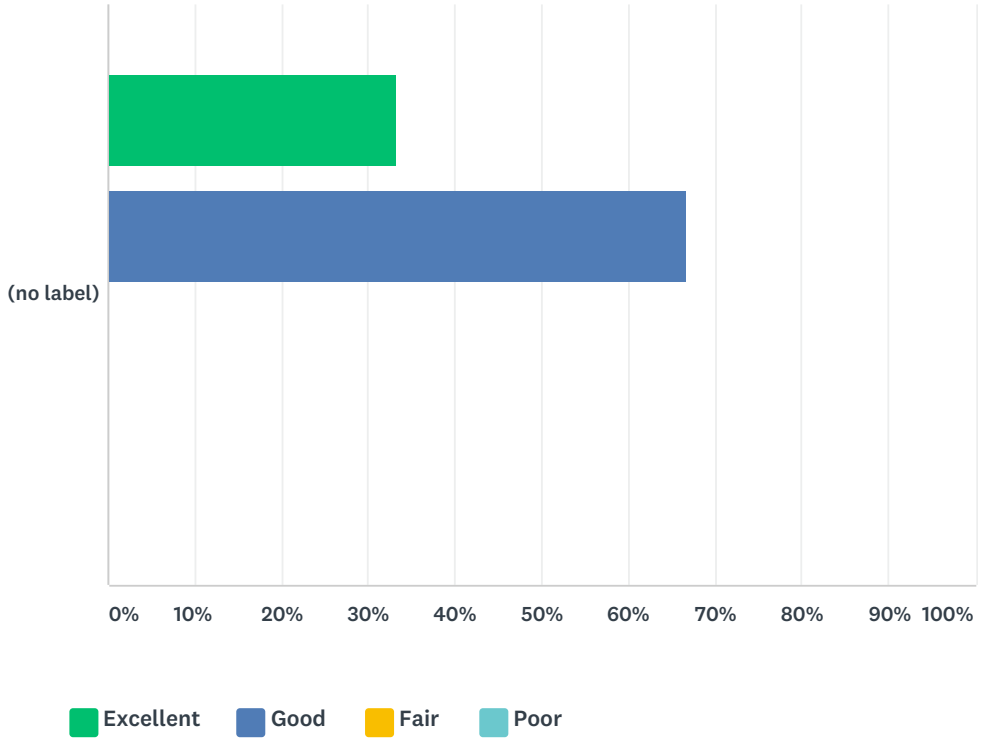
Q40 Please enter any questions, feedback, or takeaways you have from this workshop.

Answered: 6 Skipped: 149

#	RESPONSES	DATE
1	I just received a case they are twins who were born with this problem so it was good	4/9/2019 12:02 PM
2	I expected the session to be substantive as to subject; it turned out to be a recitation of the history of the subject - all administrative and not very substantive.	4/8/2019 9:15 PM
3	Great info for the work being done. Makes what is happening have hope	4/8/2019 8:43 PM
4	A lot of data but no real conclusions.	4/8/2019 7:20 PM
5	This workshop was very helpful in explaining the new law and the help offered during pregnancy, after delivery to get the mothers/infants help and prevent the state from having to take custody	4/8/2019 4:18 PM
6	I wanted to see them dig deeper.	4/8/2019 1:17 PM

Q41 Please rate this workshop.

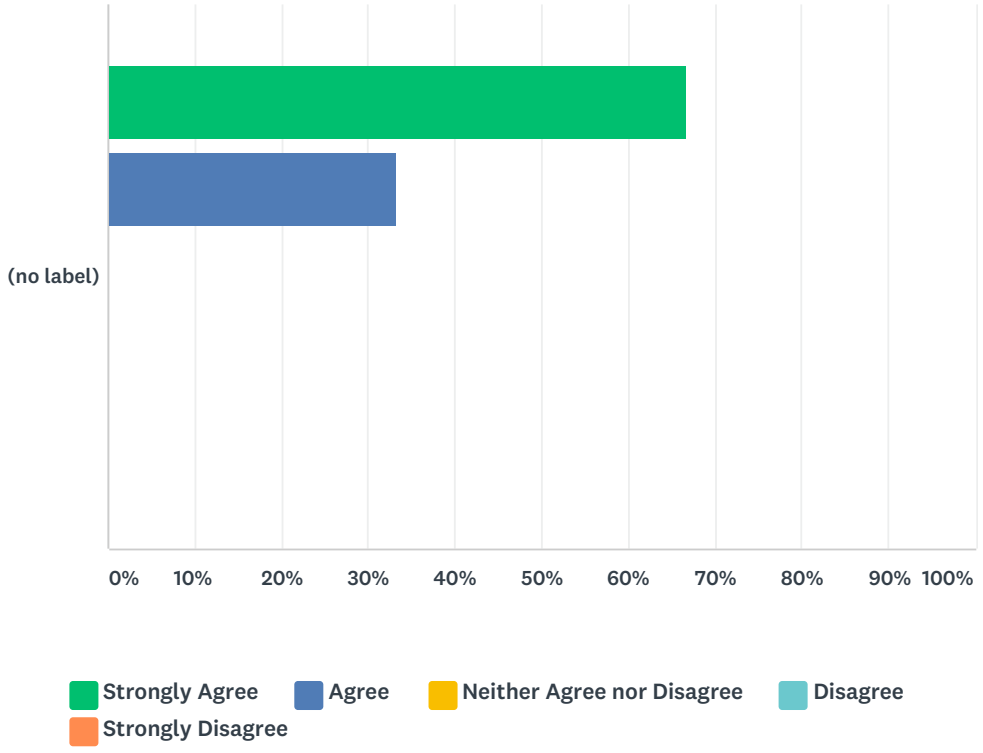
Answered: 3 Skipped: 152



	EXCELLENT	GOOD	FAIR	POOR	TOTAL	WEIGHTED AVERAGE
(no label)	33.33% 1	66.67% 2	0.00% 0	0.00% 0	3	1.67

Q42 The facilitator was organized in the presentation of course materials.

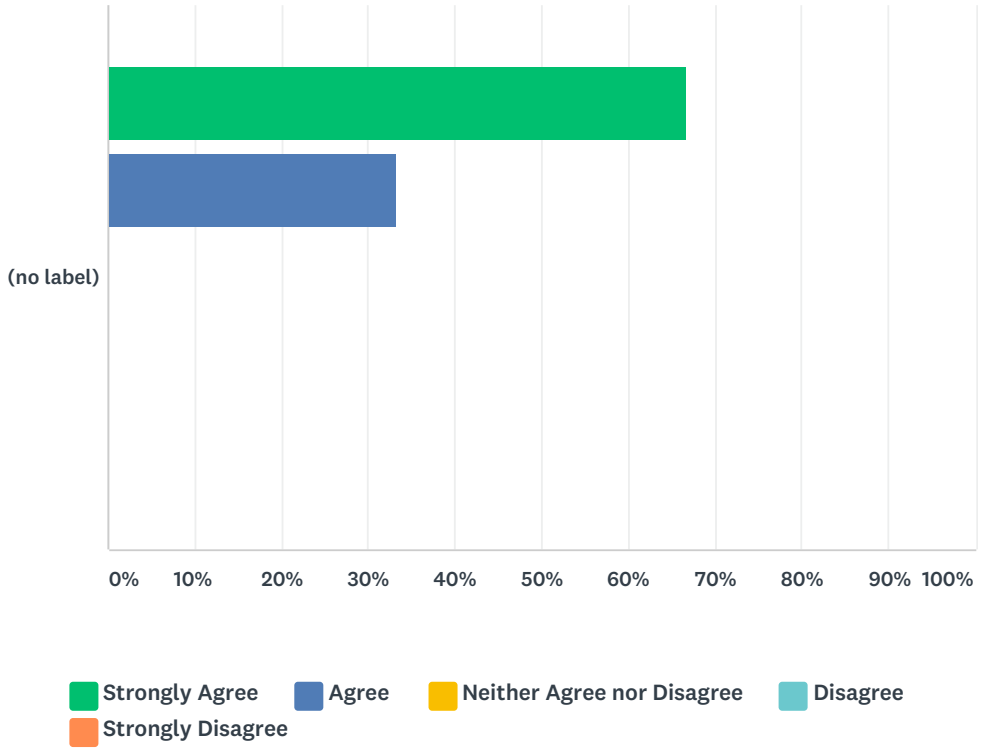
Answered: 3 Skipped: 152



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	66.67% 2	33.33% 1	0.00% 0	0.00% 0	0.00% 0	3	1.33

Q43 The facilitator demonstrated a thorough knowledge of the subject matter.

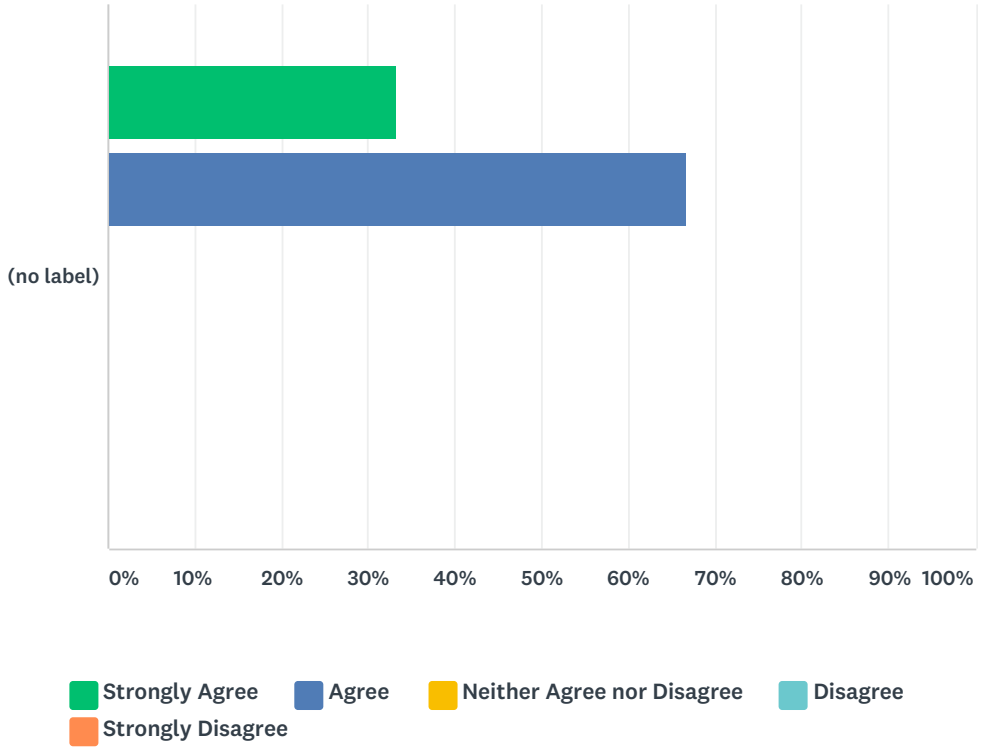
Answered: 3 Skipped: 152



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	66.67% 2	33.33% 1	0.00% 0	0.00% 0	0.00% 0	3	1.33

Q44 My knowledge and understanding of the subject matter increased as a result of this session.

Answered: 3 Skipped: 152



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	33.33% 1	66.67% 2	0.00% 0	0.00% 0	0.00% 0	3	1.67

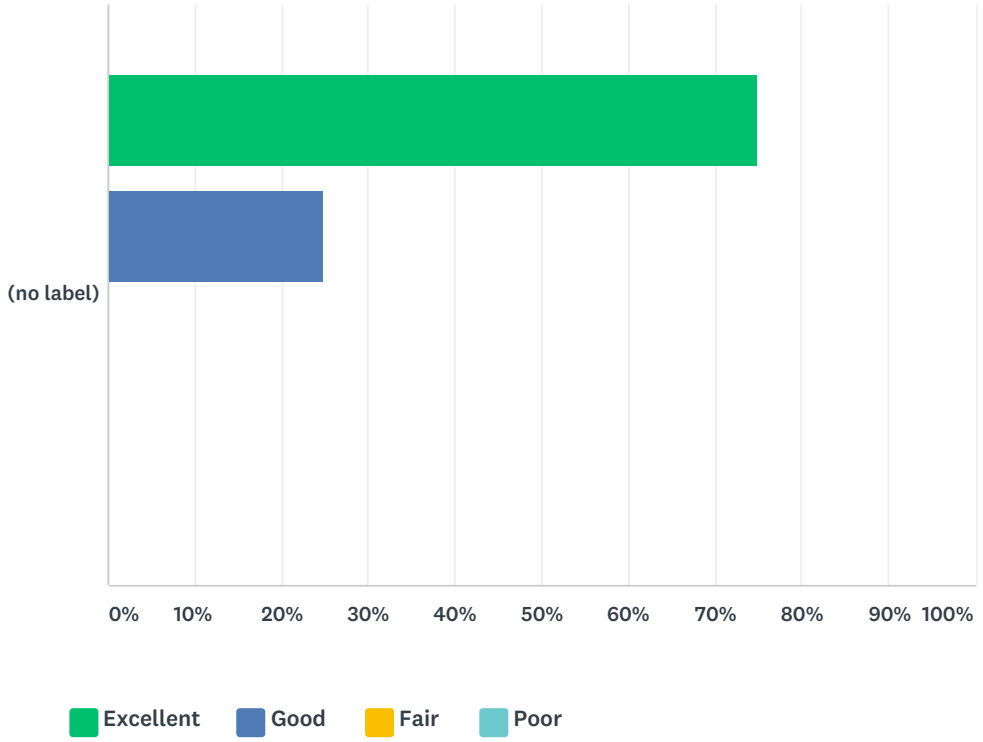
Q45 Please enter any questions, feedback, or takeaways you have from this workshop.

Answered: 1 Skipped: 154

#	RESPONSES	DATE
1	I had no idea that it was centered on Foster Care issues. Not my area but presented was engaging.	4/8/2019 2:26 PM

Q46 Please rate this workshop.

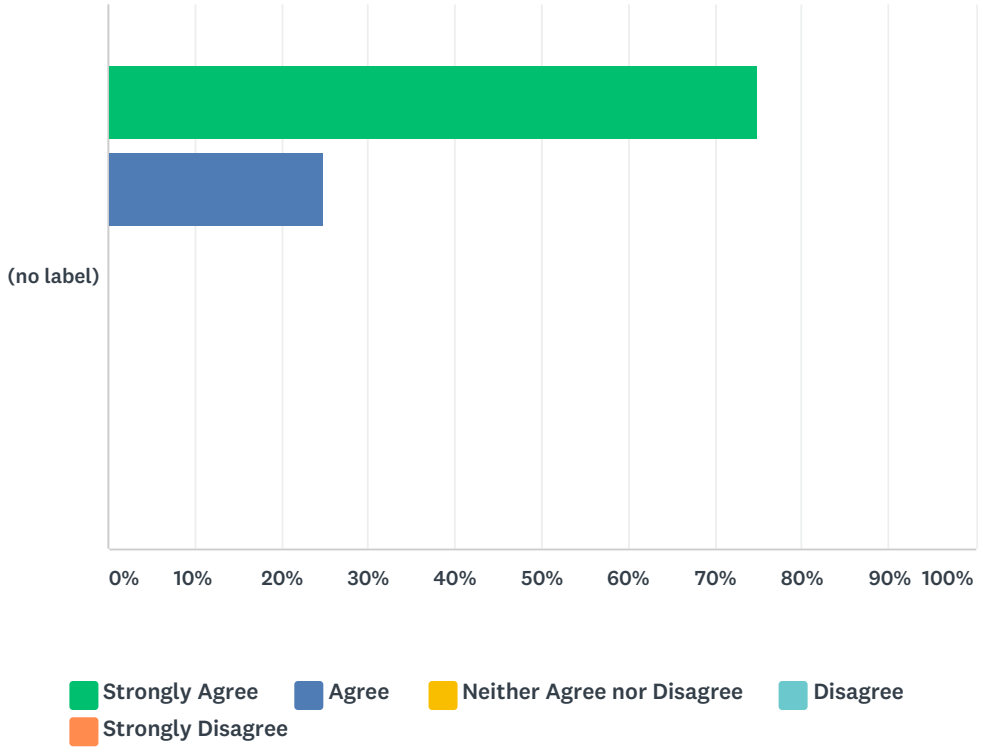
Answered: 4 Skipped: 151



	EXCELLENT	GOOD	FAIR	POOR	TOTAL	WEIGHTED AVERAGE
(no label)	75.00% 3	25.00% 1	0.00% 0	0.00% 0	4	1.25

Q47 The facilitator was organized in the presentation of course materials.

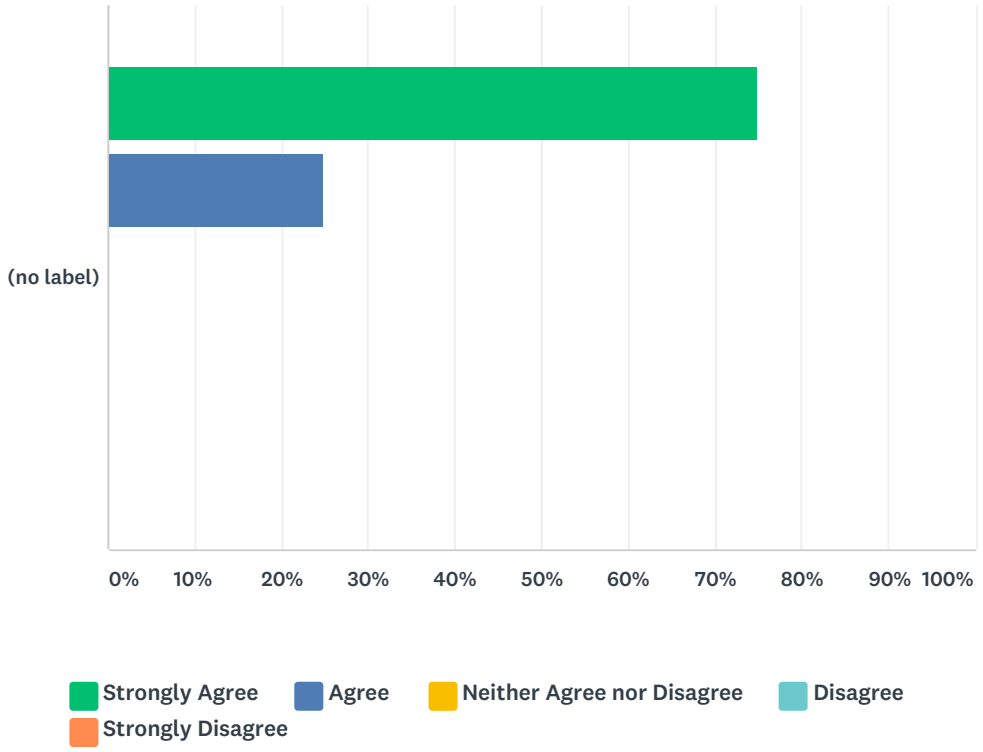
Answered: 4 Skipped: 151



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	75.00% 3	25.00% 1	0.00% 0	0.00% 0	0.00% 0	4	1.25

Q48 The facilitator demonstrated a thorough knowledge of the subject matter.

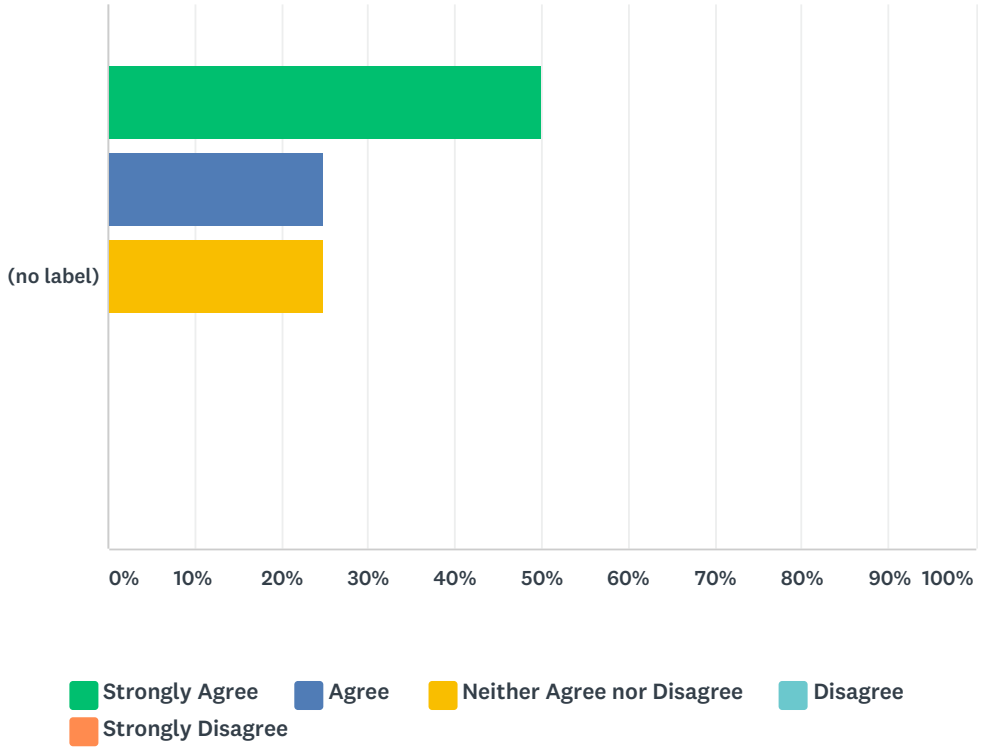
Answered: 4 Skipped: 151



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	75.00% 3	25.00% 1	0.00% 0	0.00% 0	0.00% 0	4	1.25

Q49 My knowledge and understanding of the subject matter increased as a result of this session.

Answered: 4 Skipped: 151



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	50.00% 2	25.00% 1	25.00% 1	0.00% 0	0.00% 0	4	1.75

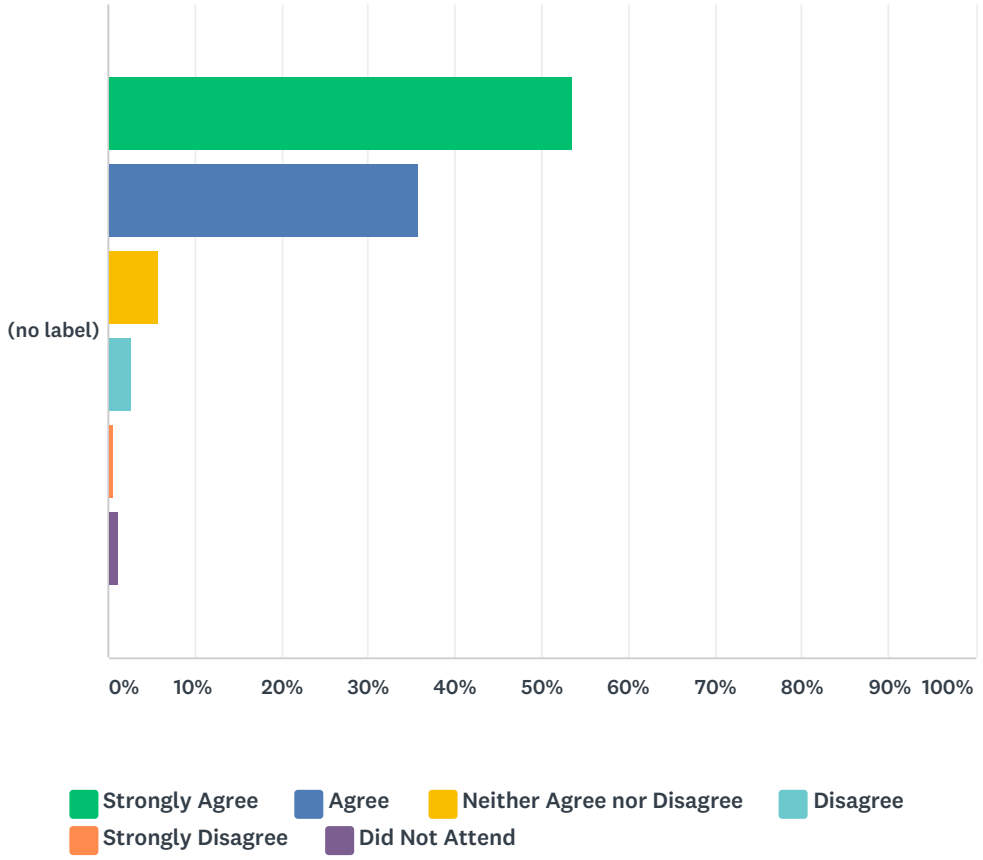
Q50 Please enter any questions, feedback, or takeaways you have from this workshop.

Answered: 1 Skipped: 154

#	RESPONSES	DATE
1	It was an excellent workshop! I wish more people had attended the session. There was a lot of relevant information about child welfare and DV!	4/8/2019 12:13 PM

Q51 The facilitator was well organized in the presentation of the course material.

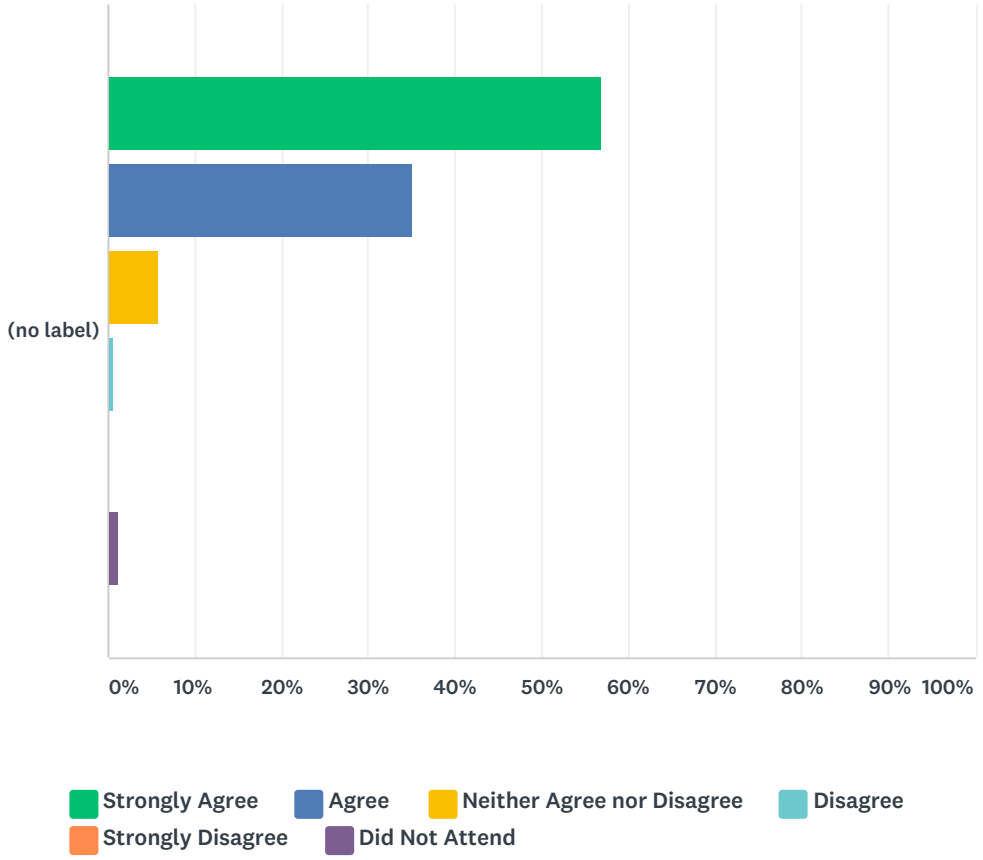
Answered: 151 Skipped: 4



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	DID NOT ATTEND	TOTAL	WEIGHTED AVERAGE
(no label)	53.64% 81	35.76% 54	5.96% 9	2.65% 4	0.66% 1	1.32% 2	151	1.57

Q52 The facilitator demonstrated a thorough knowledge of the subject matter.

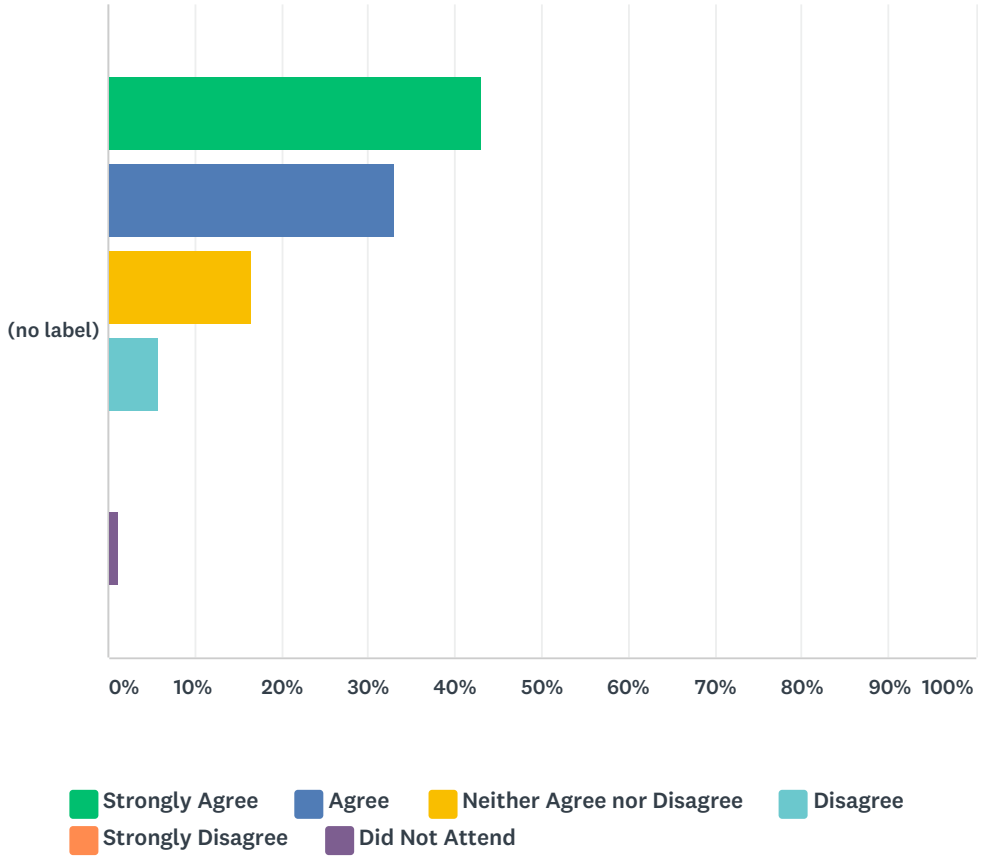
Answered: 151 Skipped: 4



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	DID NOT ATTEND	TOTAL	WEIGHTED AVERAGE
(no label)	56.95% 86	35.10% 53	5.96% 9	0.66% 1	0.00% 0	1.32% 2	151	1.48

Q53 My knowledge and understanding of the subject matter increased as a result of this session.

Answered: 151 Skipped: 4



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	DID NOT ATTEND	TOTAL	WEIGHTED AVERAGE
(no label)	43.05% 65	33.11% 50	16.56% 25	5.96% 9	0.00% 0	1.32% 2	151	1.83

Q54 Please enter any questions, feedback, or takeaways you have from this workshop.

Answered: 46 Skipped: 109

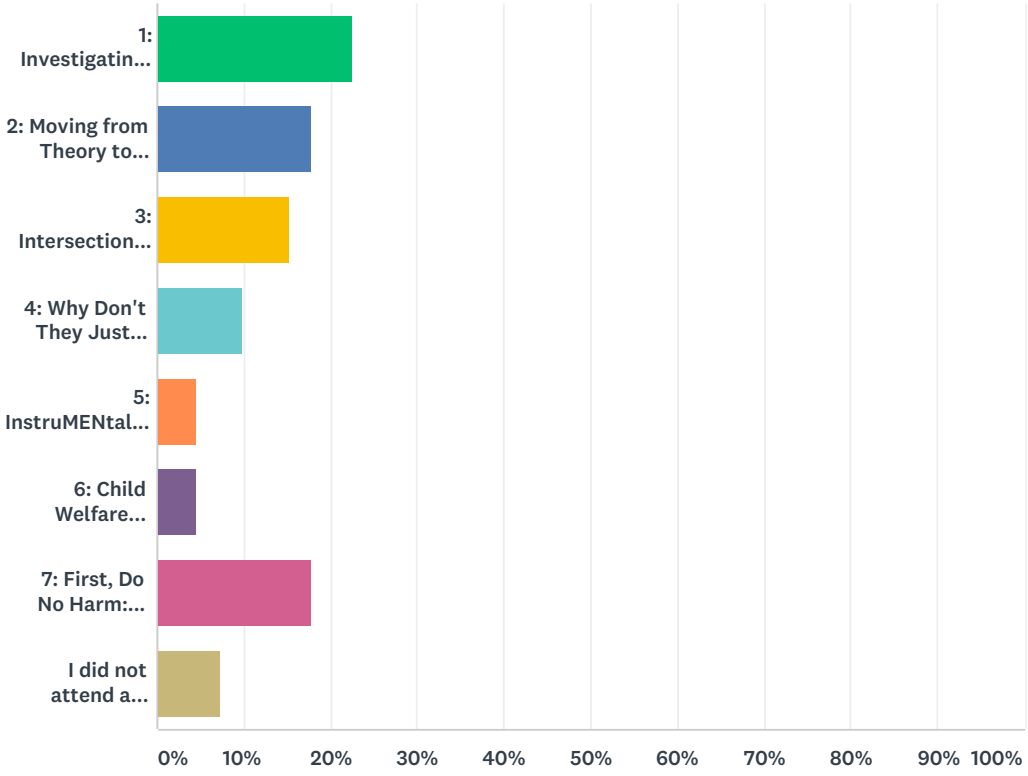
#	RESPONSES	DATE
1	He helped me to identify burn out.	4/16/2019 4:54 PM
2	Did not think religious note was appropriate at a conference for state employees.	4/15/2019 8:29 AM
3	The 'FINGER" portion seemed a bit rushed.	4/11/2019 10:03 AM
4	Unfortunately, I felt the speaker spent too much time on the background of the issue and not enough on the remedy for burnout.	4/10/2019 11:31 AM
5	Great presentation	4/10/2019 10:53 AM
6	Great!	4/10/2019 8:09 AM
7	Great Afternoon Keynote especially after lunch! I learned a lot from his presentation.	4/9/2019 5:18 PM
8	I found the whole issue of the speaker having lost his daughter distressing and distracting from the topic. He kept saying she had been killed but it sounded like she died in a terrible accident. It was so horrifying. I thought his use of humor was wonderful and so funny even with the horror of his daughter's death.	4/9/2019 4:07 PM
9	Visaual. Very good. Humor. Great for afternoon	4/9/2019 3:38 PM

10	Loved how he inserted humor with quality information!	4/9/2019 12:56 PM
11	Hilarious!	4/9/2019 10:10 AM
12	He was a very good presenter. He brought a lot of humor to a difficult and stressful topic!	4/9/2019 9:40 AM
13	Sound system again.	4/9/2019 9:31 AM
14	Outstanding	4/9/2019 7:21 AM
15	Very easy to understand and take back to work.	4/8/2019 8:44 PM
16	Difficult to hear at times.	4/8/2019 8:12 PM
17	Entertaining, but do not know what it had to do with the overall theme of the conference. It did nothing for me.	4/8/2019 7:21 PM
18	Only session I took notes in.	4/8/2019 4:44 PM
19	none	4/8/2019 4:41 PM
20	It helped us laugh and relieve some stress and it was a good reminder of what we need to do to take care of ourselves	4/8/2019 4:19 PM
21	Entertaining speaker	4/8/2019 4:12 PM
22	Loved the F.I.N.G.E.R mnemonic!	4/8/2019 3:42 PM
23	Major pass for me.	4/8/2019 2:27 PM
24	A little too long.	4/8/2019 2:26 PM
25	Very personable man, I met him before his presentation and he was a sincere man, I was surprised to learn of his daughters accident. I would have not known of his hardships by his upbeat attitude.	4/8/2019 2:19 PM
26	AMAZING SPEAKER! Definitely one of the highlights of the conference.	4/8/2019 2:00 PM
27	I was sitting in the back of the room, and it was difficult to hear the presentation.	4/8/2019 1:45 PM
28	Contained too much obvious material--not worth all the time that was given to the presentation.	4/8/2019 1:39 PM
29	Was engaging and interesting but not sure his burnout was solely from his work, sounded more like grief	4/8/2019 1:27 PM
30	He definitely over shared from his personal experience. As a result, I think people who may suffer from burnout would feel that if they didn't lose a child they should just be able to cope.	4/8/2019 1:25 PM
31	Nice issue to address because it is often over looked; but can greatly impact decisions made.	4/8/2019 12:49 PM
32	This was a great way to let employee's relax their minds and bodies since the things we were discussing are so emotionally heavy. I think Supervisor's in the room should keep in mind that self care of their staff is important.	4/8/2019 12:44 PM
33	He was folksy and that was about it m	4/8/2019 12:40 PM
34	I think the facilitator hit a key point of recognizing burnout symptoms.	4/8/2019 12:39 PM
35	Waste of time	4/8/2019 12:38 PM
36	At first, I didn't like this session. I didn't think it was helpful or worthwhile. Then, as the presentation continued and I did start to laugh--A LOT!-- I began to see the point and realized that having it after lunch was a great idea! We forget to laugh sometimes	4/8/2019 12:32 PM
37	Speaker provided too much of an entry not leaving time for what to do with burnout	4/8/2019 12:31 PM
38	even though I liked his presentation, it could have been done in half the time or during lunch and we could have had more time for another session (3 rotations)	4/8/2019 12:22 PM
39	n/a	4/8/2019 12:20 PM
40	Loved the speaker. For the first time I realized that burn out just doesn't happen at work, it's all that a person has to deal with	4/8/2019 12:17 PM
41	The presentation was a great reminder to practice self-care! The Chewbacca mom was probably my favorite part.	4/8/2019 12:14 PM

42	He was very entertaining and it was a workshop that you didn't have to think about and use your brain. The presentation was long and by the end I was ready for it to be over. I feel he could have used less examples.	4/8/2019 12:13 PM
43	Could not hear very well in the back half of ball room.	4/8/2019 12:11 PM
44	This gentleman tried too hard to be funny and to me he wasn't. I can't really remember what he talked about!	4/8/2019 12:11 PM
45	Got off to a rough start but was great by the end	4/8/2019 12:10 PM
46	this is my third time hearing him and it is beneficial every time.	4/8/2019 12:09 PM

Q55 Which workshop did you attend?

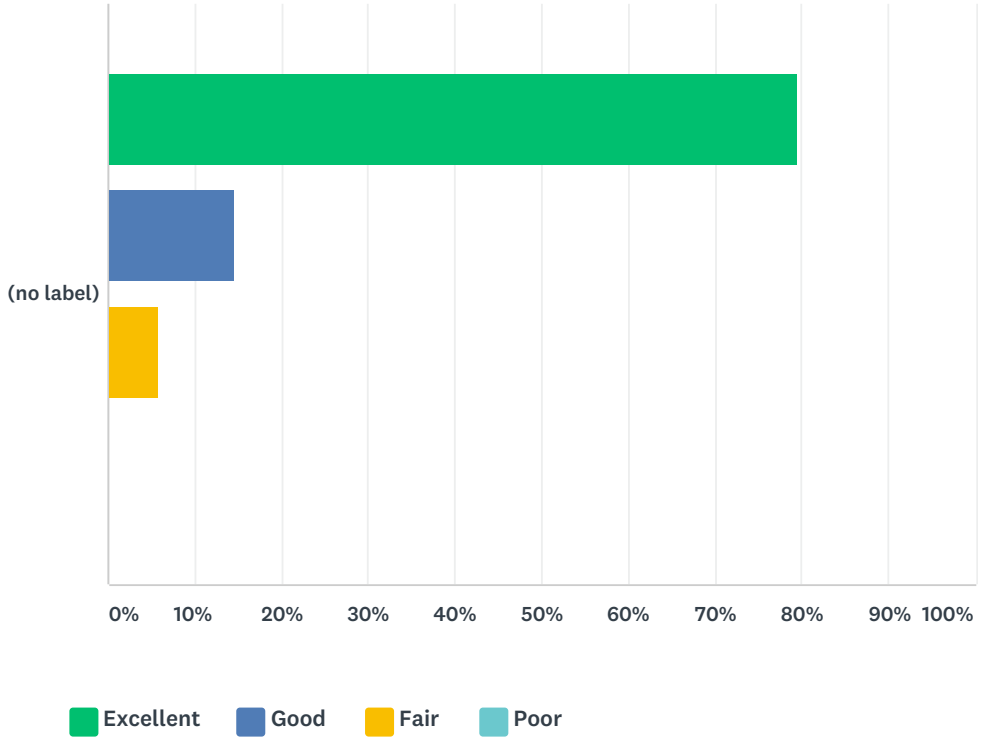
Answered: 151 Skipped: 4



ANSWER CHOICES	RESPONSES	
1: Investigating Child Homicide Cases, Part 2- Nancy Oglesby and Michael Milnor	22.52%	34
2: Moving from Theory to Practice: Implementing Trauma Responsive Approaches- Alisha Saulsbury	17.88%	27
3: Intersections: How to Address Domestic Violence Cases that Intersect with Substance Abuse and/or Mental Health- Brittany DiBella	15.23%	23
4: Why Don't They Just Leave?- Barbara Amaya	9.93%	15
5: InstruMENtal: Recognizing the Importance of the Male Role in Child Welfare- Marcus Stallworth	4.64%	7
6: Child Welfare Caseloads: A National and Local Perspective- Julie Collins, Vicky Kelly, Sue Murray, and Rachael Neff	4.64%	7
7: First, Do No Harm: Understanding Medical Child Abuse- Dr. Stephanie Anne Deutsch	17.88%	27
I did not attend a workshop.	7.28%	11
TOTAL		151

Q56 Please rate this workshop.

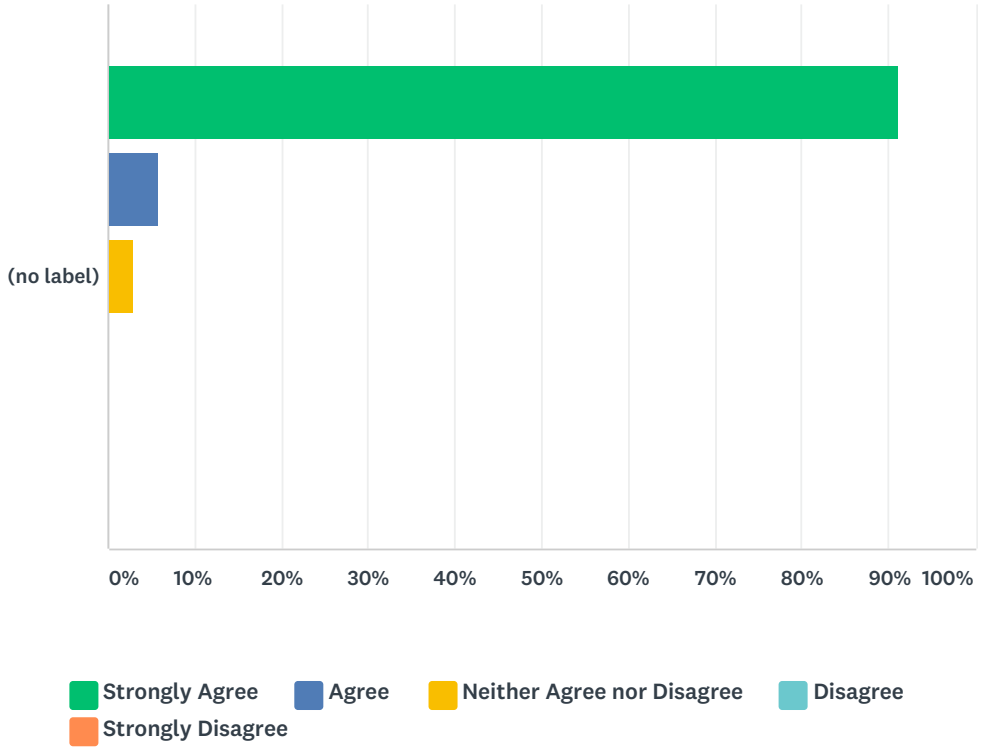
Answered: 34 Skipped: 121



	EXCELLENT	GOOD	FAIR	POOR	TOTAL	WEIGHTED AVERAGE
(no label)	79.41% 27	14.71% 5	5.88% 2	0.00% 0	34	1.26

Q57 The facilitator was organized in the presentation of course materials.

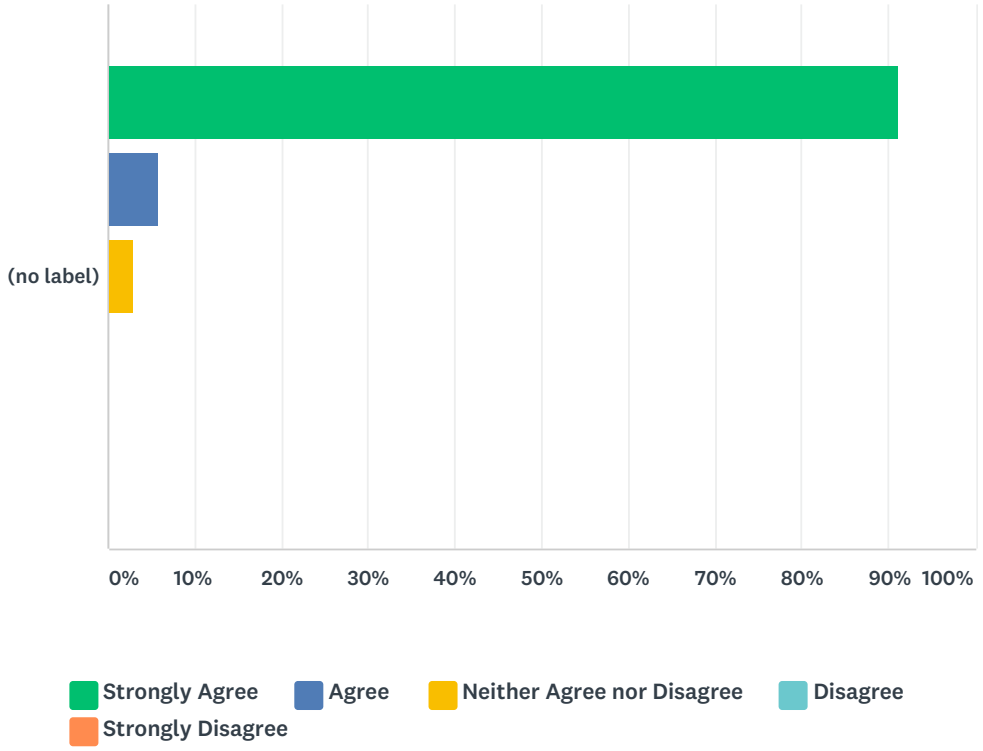
Answered: 34 Skipped: 121



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	91.18% 31	5.88% 2	2.94% 1	0.00% 0	0.00% 0	34	1.12

Q58 The facilitator demonstrated a thorough knowledge of the subject matter.

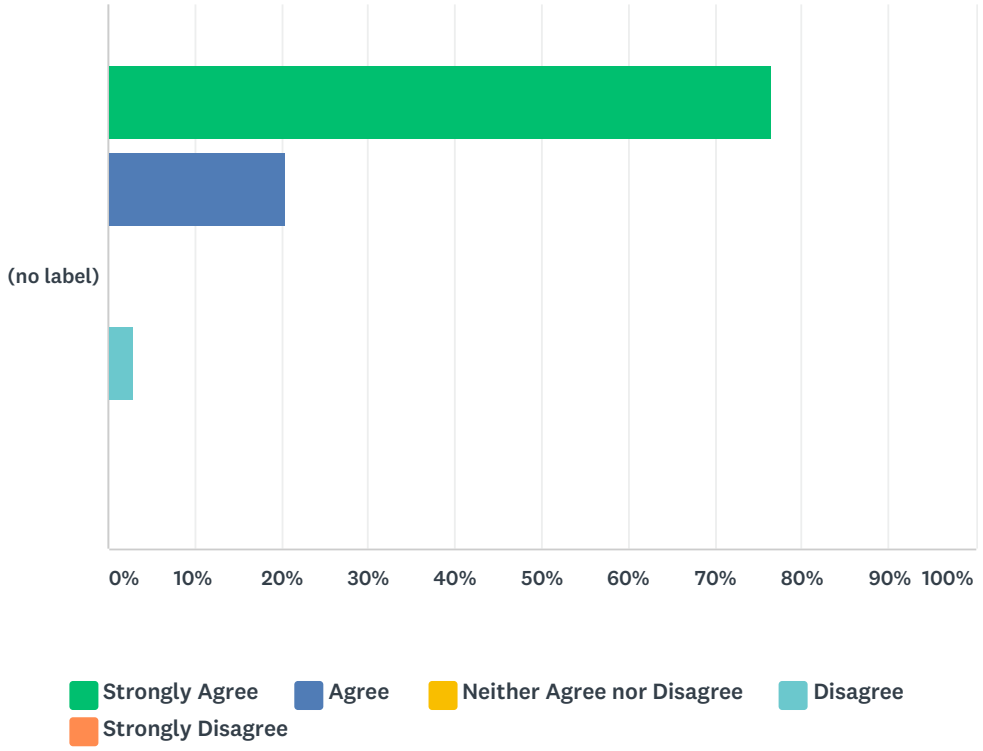
Answered: 34 Skipped: 121



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	91.18% 31	5.88% 2	2.94% 1	0.00% 0	0.00% 0	34	1.12

Q59 My knowledge and understanding of the subject matter increased as a result of this session.

Answered: 34 Skipped: 121



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	76.47% 26	20.59% 7	0.00% 0	2.94% 1	0.00% 0	34	1.29

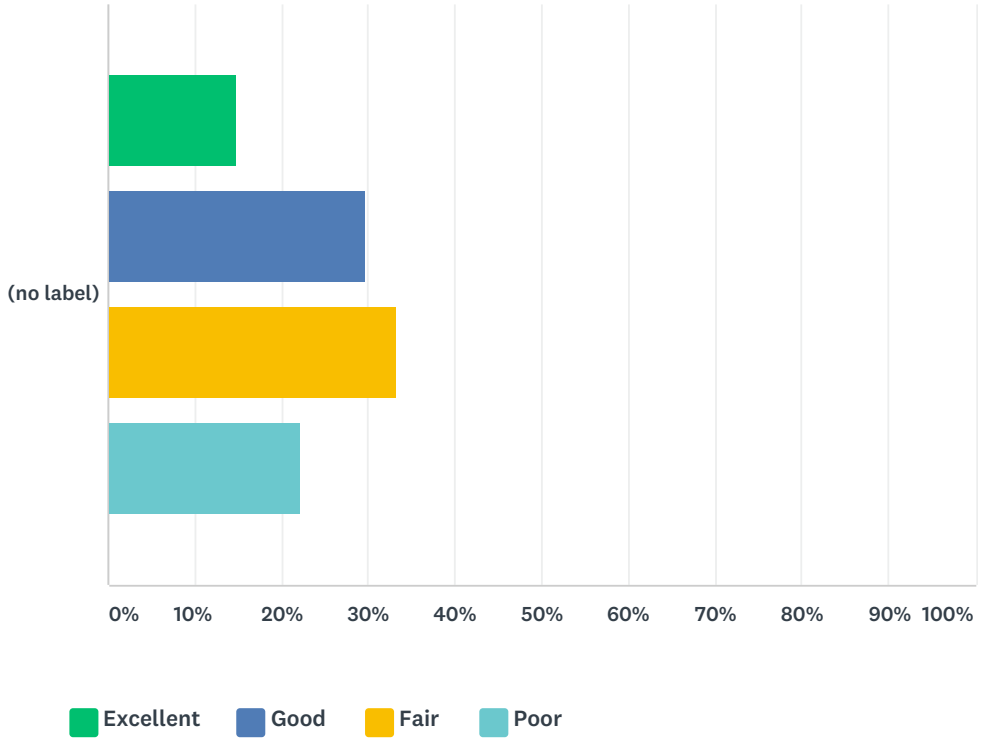
Q60 Please enter any questions, feedback, or takeaways you have from this workshop.

Answered: 5 Skipped: 150

#	RESPONSES	DATE
1	Same as before, great!	4/10/2019 8:10 AM
2	Very good presentation after lunch. I attended the first part so it was a good transition from the 1st session to the 2nd.	4/8/2019 2:20 PM
3	The speakers were engaging and their case examples interesting.	4/8/2019 2:11 PM
4	What data is available of homicide cases involving children against children left alone by careless supervision.	4/8/2019 12:42 PM
5	Excellent case study!	4/8/2019 12:15 PM

Q61 Please rate this workshop.

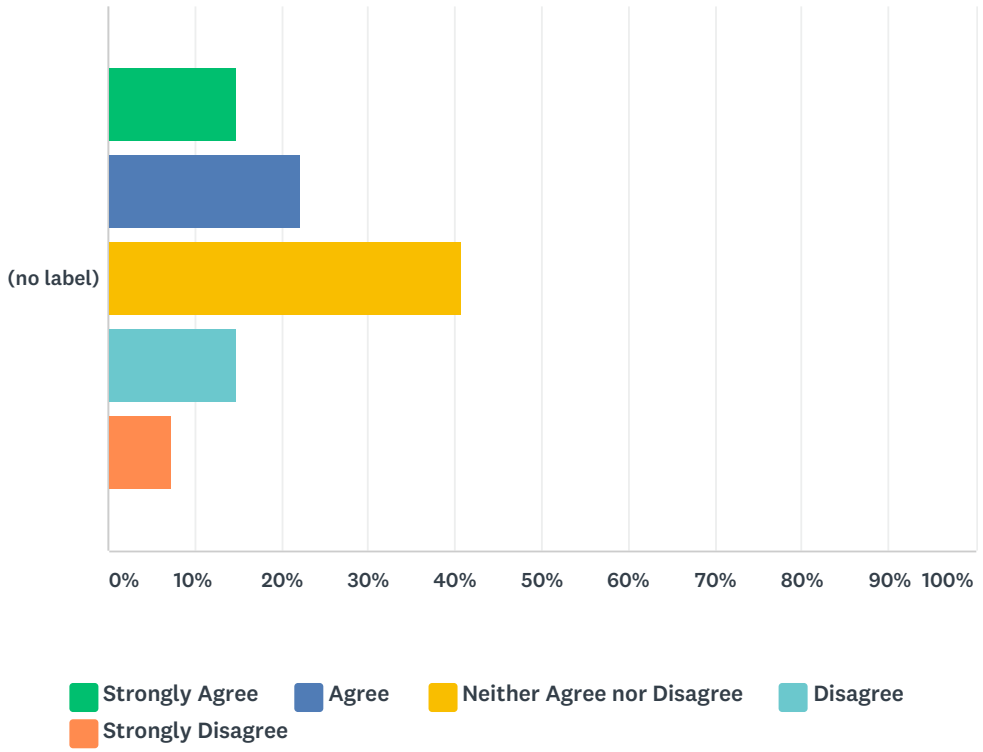
Answered: 27 Skipped: 128



	EXCELLENT	GOOD	FAIR	POOR	TOTAL	WEIGHTED AVERAGE
(no label)	14.81% 4	29.63% 8	33.33% 9	22.22% 6	27	2.63

Q62 The facilitator was organized in the presentation of course materials.

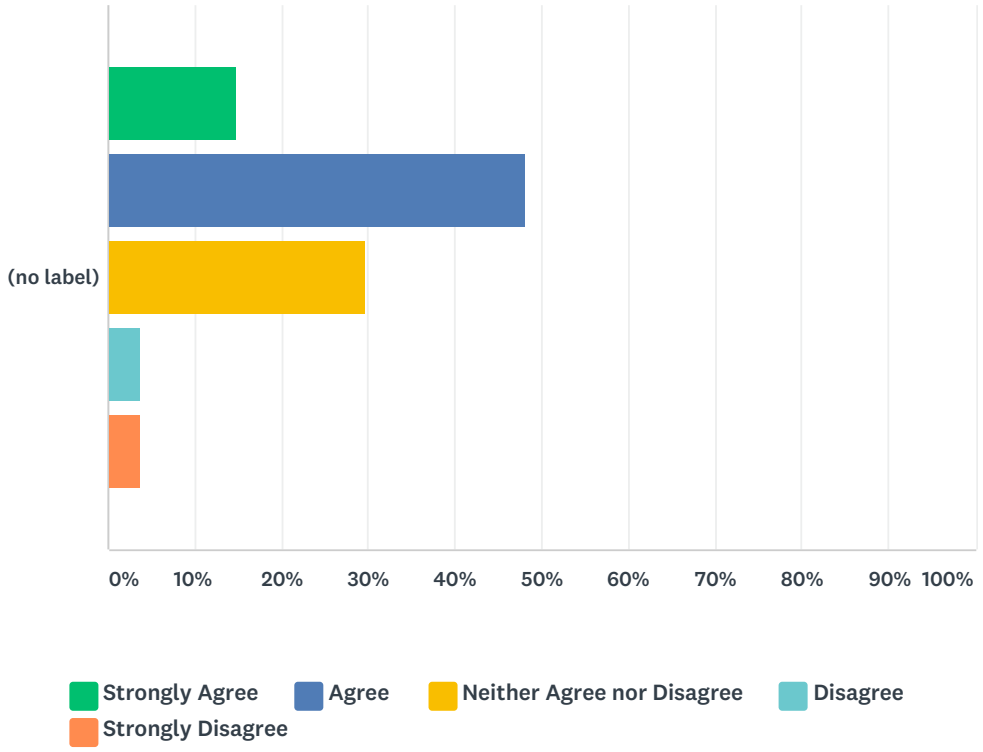
Answered: 27 Skipped: 128



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	14.81% 4	22.22% 6	40.74% 11	14.81% 4	7.41% 2	27	2.78

Q63 The facilitator demonstrated a thorough knowledge of the subject matter.

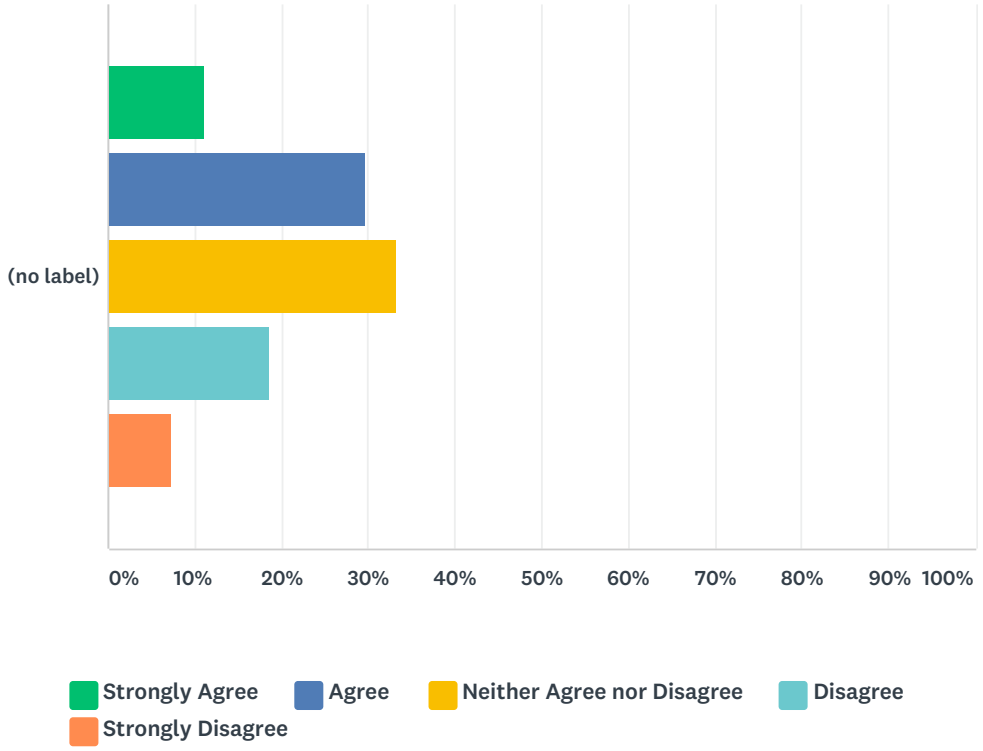
Answered: 27 Skipped: 128



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	14.81% 4	48.15% 13	29.63% 8	3.70% 1	3.70% 1	27	2.33

Q64 My knowledge and understanding of the subject matter increased as a result of this session.

Answered: 27 Skipped: 128



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	11.11% 3	29.63% 8	33.33% 9	18.52% 5	7.41% 2	27	2.81

Q65 Please enter any questions, feedback, or takeaways you have from this workshop.

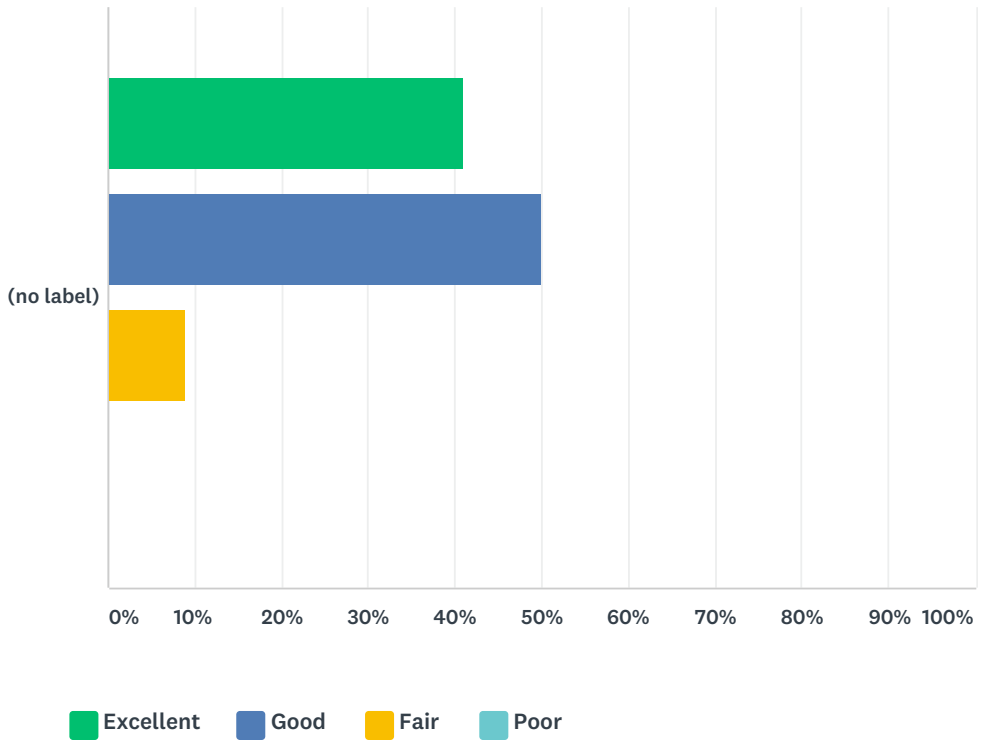
Answered: 15 Skipped: 140

#	RESPONSES	DATE
1	realize she was a fill-in, but I did not get anything out the workshop and it seemed as she was using her experiences to illustrate points that were not clearly communicated. Appeared to be reading from a sheath of papers. Extremely poor presentation. This was the most disappointing as I am looking for education on responding to situations given the state emphasis on trauma informed response and care.	4/10/2019 10:57 AM
2	I could not hear well. With the dim lighting and lack of a good sound system, I found it hard to engage in the material.	4/9/2019 4:08 PM
3	I didn't care for this speaker and I had a very difficult time staying focused and engaged with her presentation.	4/9/2019 9:42 AM
4	N/A	4/9/2019 7:22 AM
5	I understand it was substitute but was not good at all.	4/8/2019 6:55 PM
6	Somewhat scattered presentation. Visuals would have been helpful. Not easy to related or listen to a verbal lecture these days.	4/8/2019 4:49 PM
7	She was a stand in and wasn't fully prepared. SHe also mostly talked about prisons and prisoners.	4/8/2019 4:08 PM
8	Left within 20 minutes. No presentation material. Just rambling. .	4/8/2019 1:26 PM
9	wished the original presenter was there, it seemed as if this presenter was asked at the last minute and seemed to drag, several people left 1/2 way through the session	4/8/2019 12:23 PM

10	Somewhat unfair as presenter was a last minute replacement. She was clearly knowledgeable, but had no written material to emphasize her points.	4/8/2019 12:23 PM
11	The speakers couldn't make it so someone filled it for her.Also the space was too large	4/8/2019 12:22 PM
12	I almost fell asleep during this presentation. Sorry! I also had to leave early because of a prior obligation.	4/8/2019 12:12 PM
13	I was so disinterested and confused by her presentation that I ended up leaving early.	4/8/2019 12:11 PM
14	it was a tough room to hold a workshop in (Ballroom).	4/8/2019 12:10 PM
15	The facilitator was a fill in. Not sure if the session went as planned but it did not seem to follow the title.	4/8/2019 12:07 PM

Q66 Please rate this workshop.

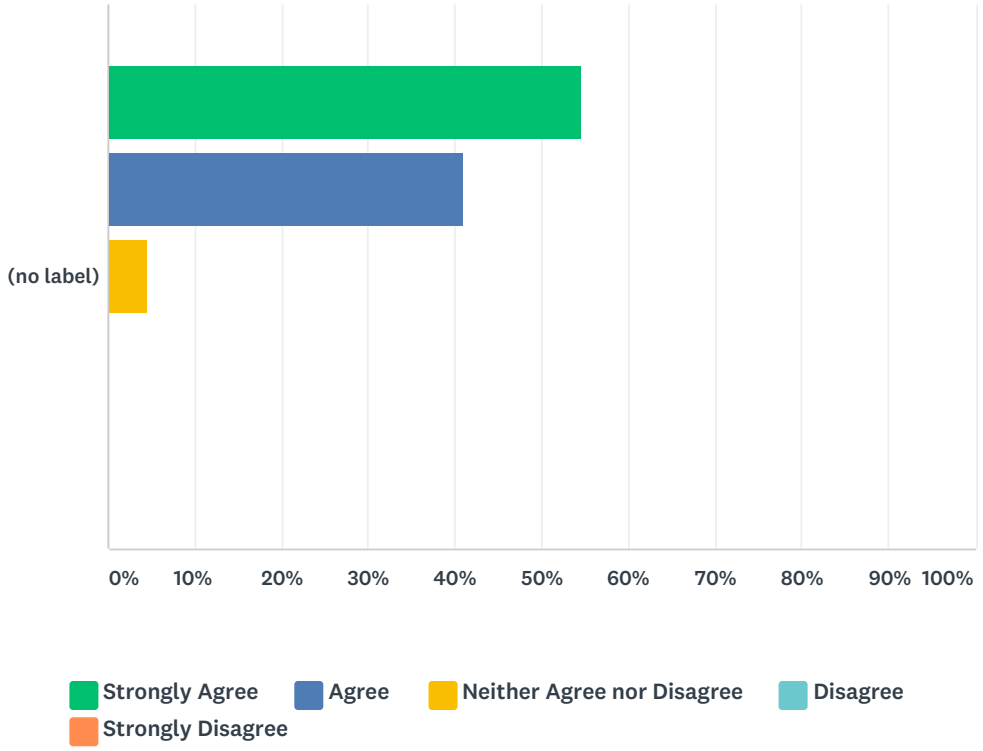
Answered: 22 Skipped: 133



	EXCELLENT	GOOD	FAIR	POOR	TOTAL	WEIGHTED AVERAGE
(no label)	40.91% 9	50.00% 11	9.09% 2	0.00% 0	22	1.68

Q67 The facilitator was organized in the presentation of course materials.

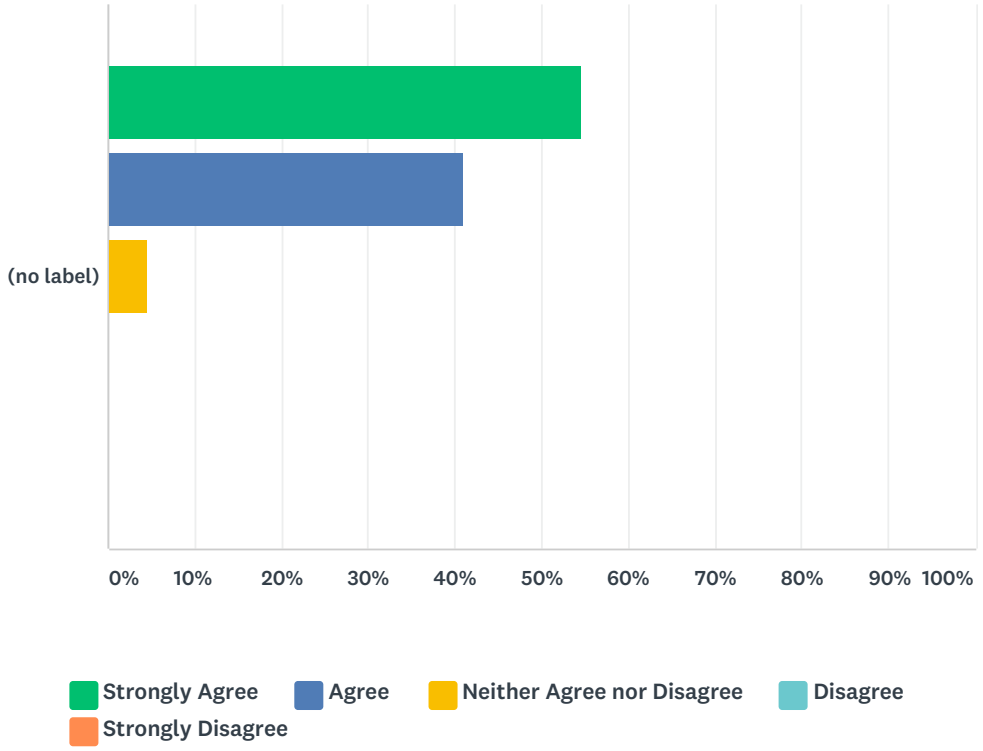
Answered: 22 Skipped: 133



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	54.55% 12	40.91% 9	4.55% 1	0.00% 0	0.00% 0	22	1.50

Q68 The facilitator demonstrated a thorough knowledge of the subject matter.

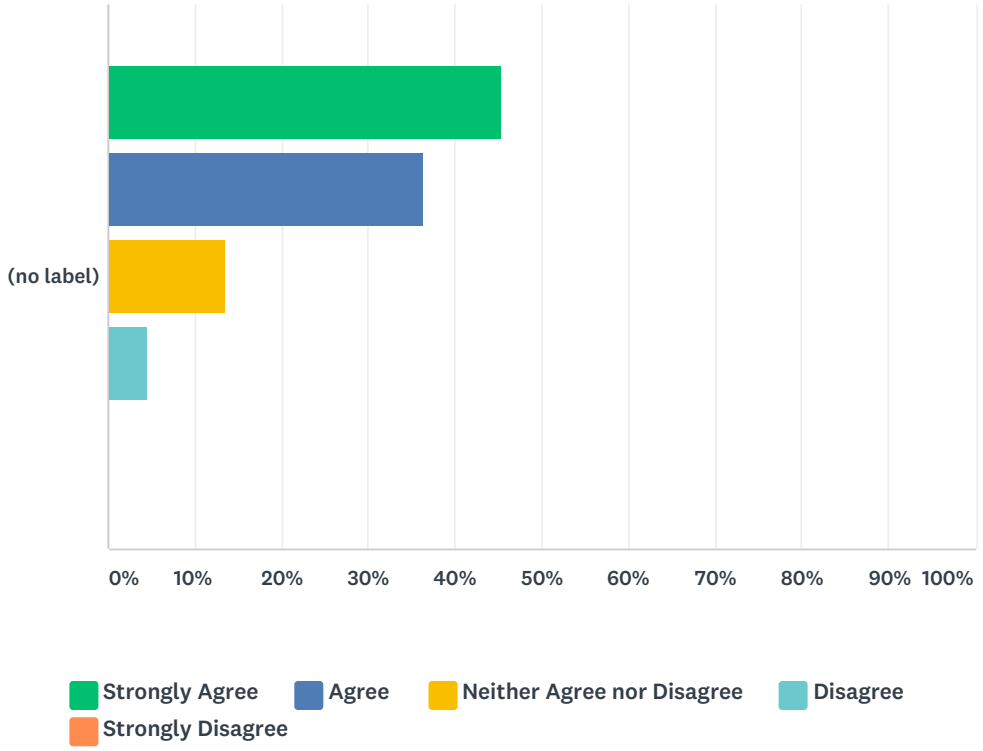
Answered: 22 Skipped: 133



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	54.55% 12	40.91% 9	4.55% 1	0.00% 0	0.00% 0	22	1.50

Q69 My knowledge and understanding of the subject matter increased as a result of this session.

Answered: 22 Skipped: 133



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	45.45% 10	36.36% 8	13.64% 3	4.55% 1	0.00% 0	22	1.77

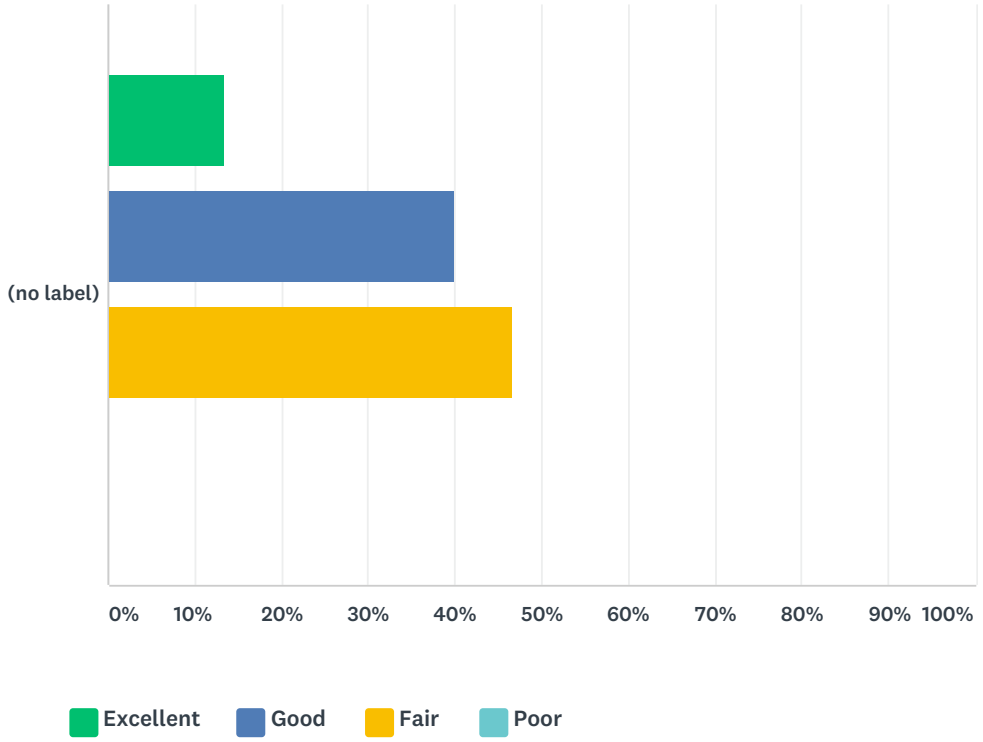
Q70 Please enter any questions, feedback, or takeaways you have from this workshop.

Answered: 6 Skipped: 149

#	RESPONSES	DATE
1	Subject matter did not reflect course title - there was very little discussion of DV/IPV	4/10/2019 2:13 PM
2	Excellent. Challenging group to present to as it was apparent that not everyone had the same basic understanding of DV dynamics and risk. The concepts were helpful though.	4/8/2019 2:43 PM
3	Hard to concentrate on this workshop due to amplification of neighboring presentation which you could clearly hear. Not presenter's fault.	4/8/2019 2:18 PM
4	Social Worker, Brittany was fantastic. She is VERY passionate about her work and is very knowledgeable and informative. It was clear that several attendees in the room do not have adequate training in regards to DV/mental health/substance abuse which is very concerning.	4/8/2019 12:45 PM
5	I wish more time was spent on the topic, instead of practicing in small groups.	4/8/2019 12:38 PM
6	The mapping tool and the case viginette's were great! It's an excellent model and usable right away. It fits and works together well with DFS's safety organized practice.	4/8/2019 12:16 PM

Q71 Please rate this workshop.

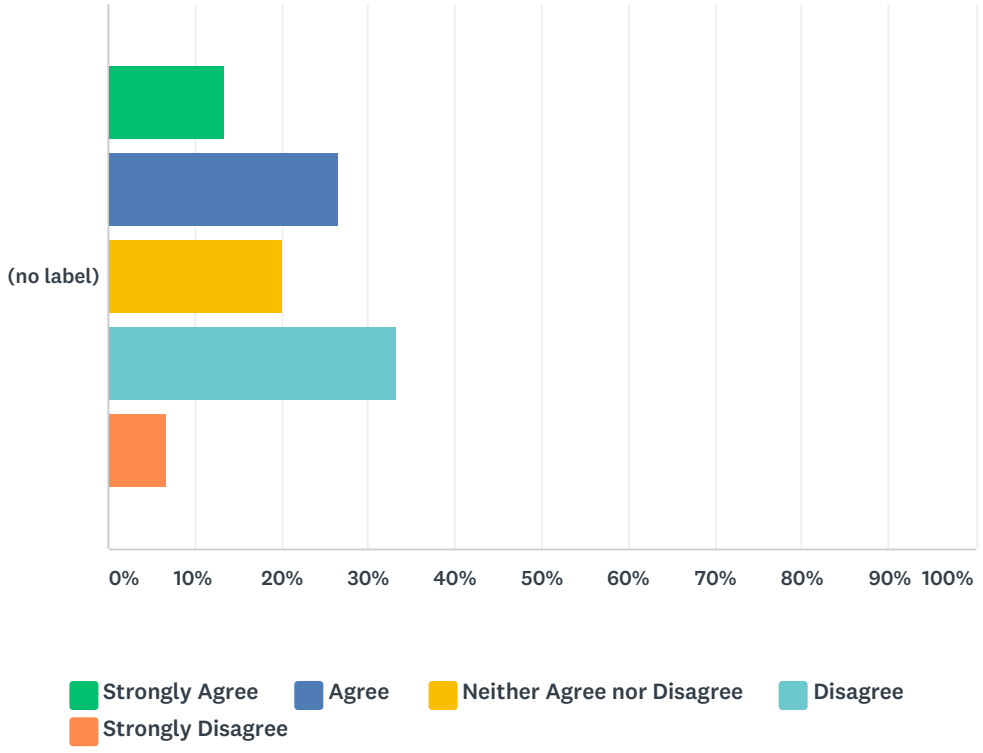
Answered: 15 Skipped: 140



	EXCELLENT	GOOD	FAIR	POOR	TOTAL	WEIGHTED AVERAGE
(no label)	13.33% 2	40.00% 6	46.67% 7	0.00% 0	15	2.33

Q72 The facilitator was organized in the presentation of course materials.

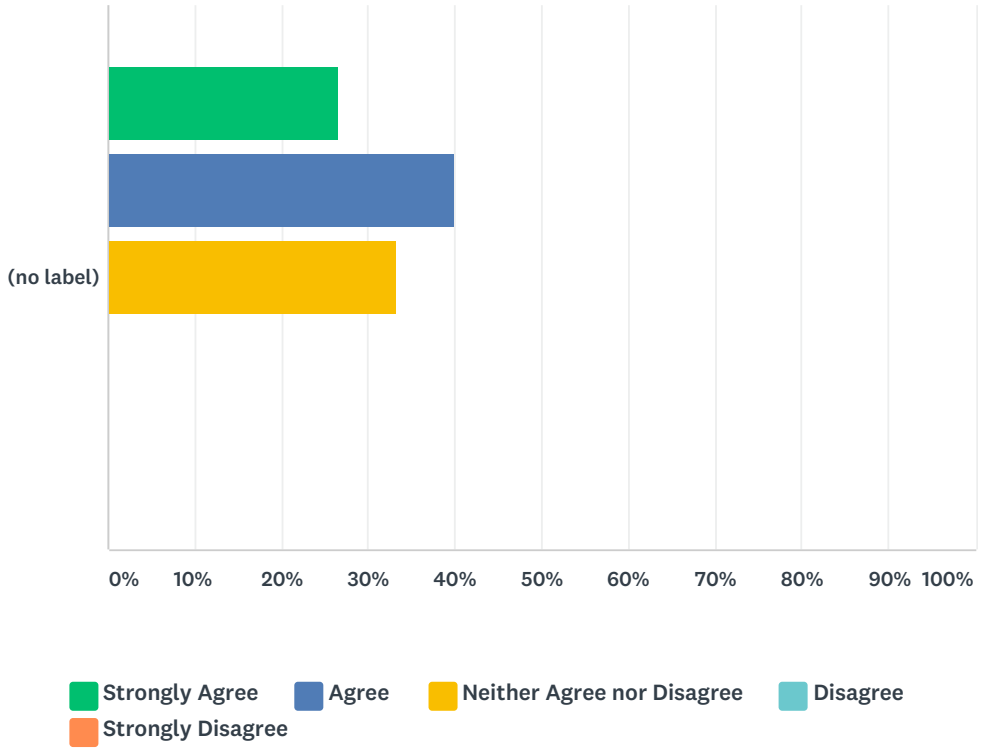
Answered: 15 Skipped: 140



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	13.33% 2	26.67% 4	20.00% 3	33.33% 5	6.67% 1	15	2.93

Q73 The facilitator demonstrated a thorough knowledge of the subject matter.

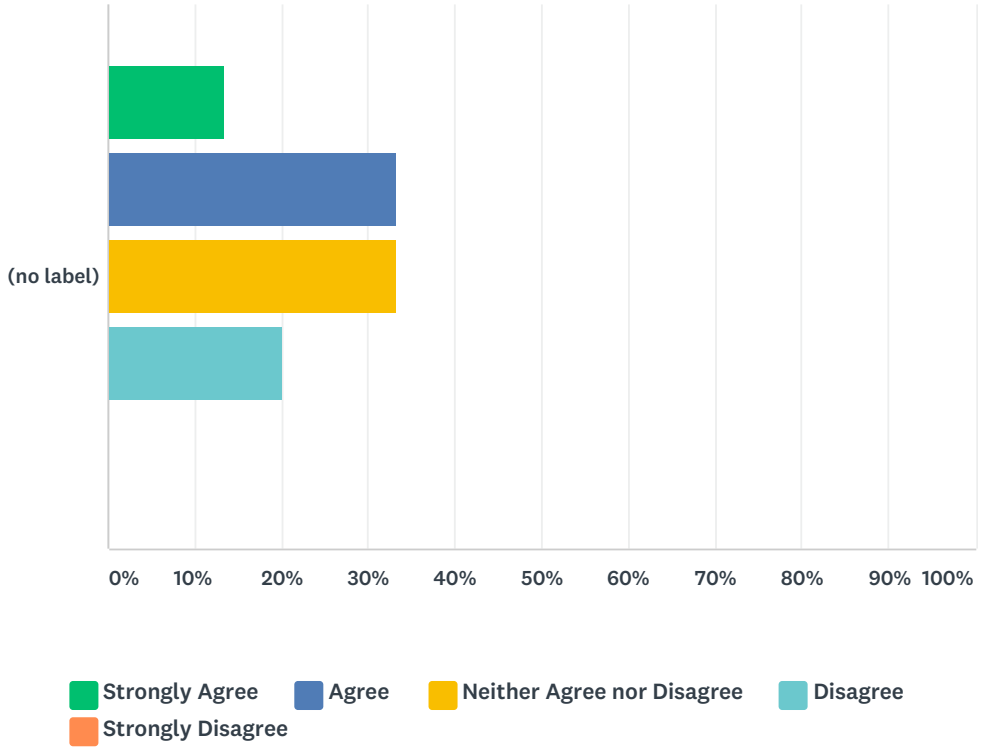
Answered: 15 Skipped: 140



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	26.67% 4	40.00% 6	33.33% 5	0.00% 0	0.00% 0	15	2.07

Q74 My knowledge and understanding of the subject matter increased as a result of this session.

Answered: 15 Skipped: 140



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	13.33% 2	33.33% 5	33.33% 5	20.00% 3	0.00% 0	15	2.60

Q75 Please enter any questions, feedback, or takeaways you have from this workshop.

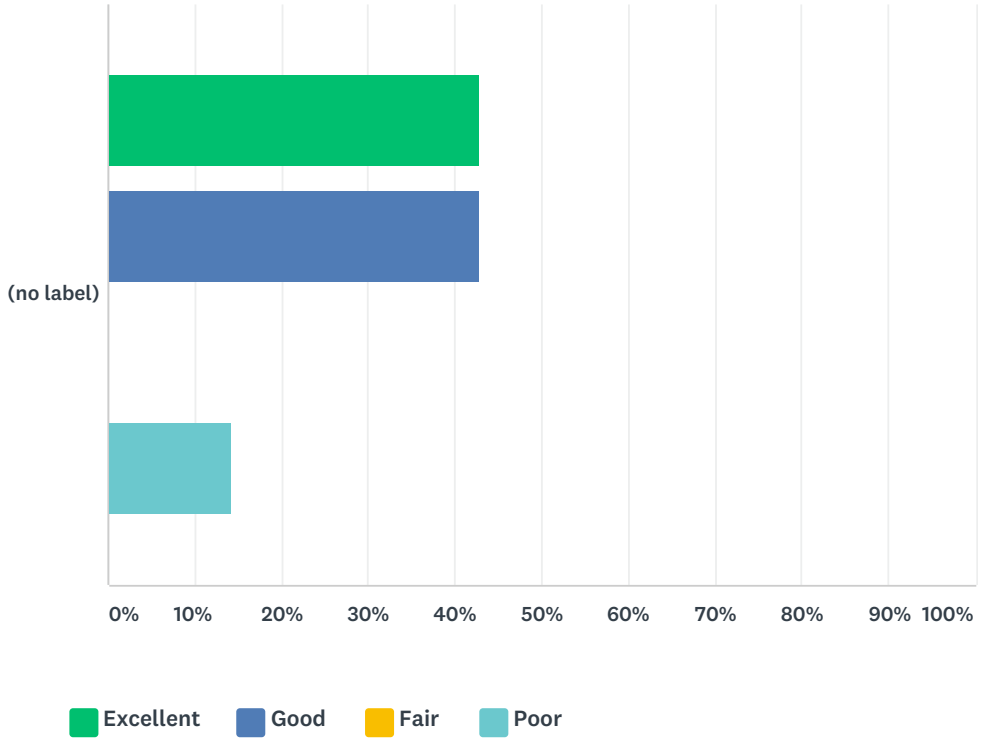
Answered: 8 Skipped: 147

#	RESPONSES	DATE
1	I had seen the presenter's TED talk which seemed to be more informative. The presenter seemed unfamiliar with the power point. She also seemed a little defensive at times, which was uncomfortable.	4/11/2019 10:05 AM
2	She was very disorganized and hard to follow. Although she was obviously well versed in the subject, she was very defensive and really misunderstood/did not answer any question posed to her. She seemed reluctant to get too into details. I left feeling bad for her and not really having any understanding of the content. I think it may be better to have LEOs who deal with trafficking discuss warning signs, ways you can act, etc., instead.	4/10/2019 8:07 AM
3	The facilitator was knowledgeable- as she had been trafficked and experienced a lot. Her slides had too many words to read, but I plan to go online to print them out.	4/9/2019 8:57 AM
4	While the presentation was a little disjointed, the subject and presenter were thoroughly interesting and covered a topic that has recently been taken note of in Delaware. I intend to buy the book.	4/9/2019 8:32 AM
5	none	4/8/2019 4:42 PM
6	Not a very good presenter. I had questions but listening to her non-responsive answers to other questions, I did not think asking would be useful.	4/8/2019 4:15 PM
7	Would have liked to hear more of her story because her thought process and presentation was very scattered and hard to follow.	4/8/2019 1:29 PM

8	Speaker was not used to using PowerPoints and they were very hard to follow. She was very informative about her experiences and gave good information about her experiences which was awesome.	4/8/2019 12:32 PM

Q76 Please rate this workshop.

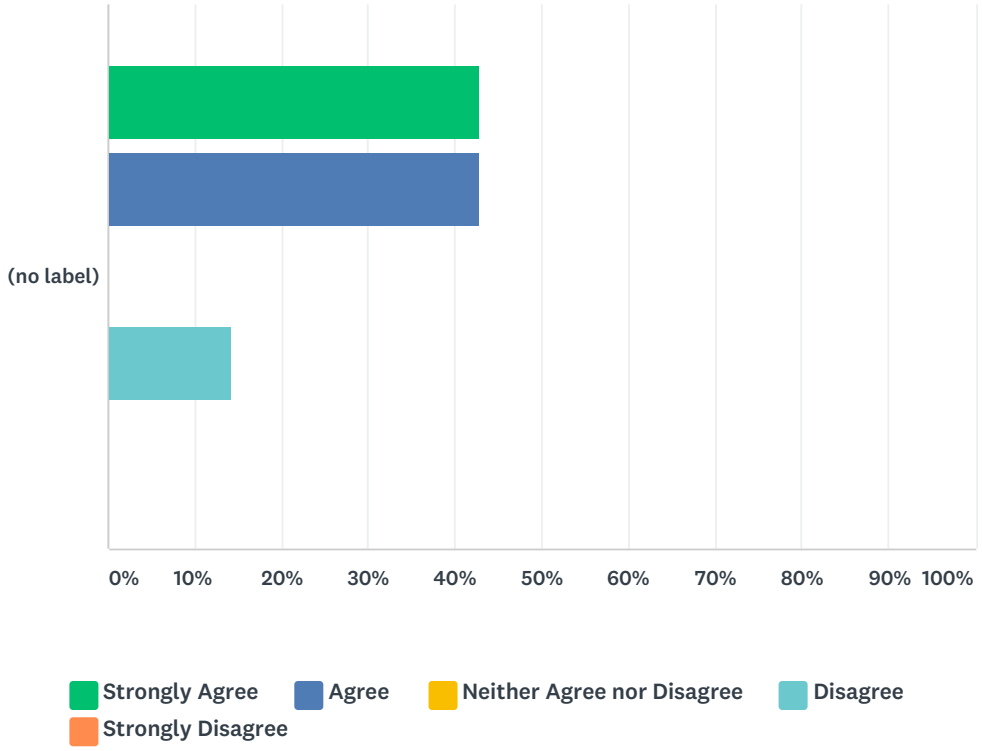
Answered: 7 Skipped: 148



	EXCELLENT	GOOD	FAIR	POOR	TOTAL	WEIGHTED AVERAGE
(no label)	42.86% 3	42.86% 3	0.00% 0	14.29% 1	7	1.86

Q77 The facilitator was organized in the presentation of course materials.

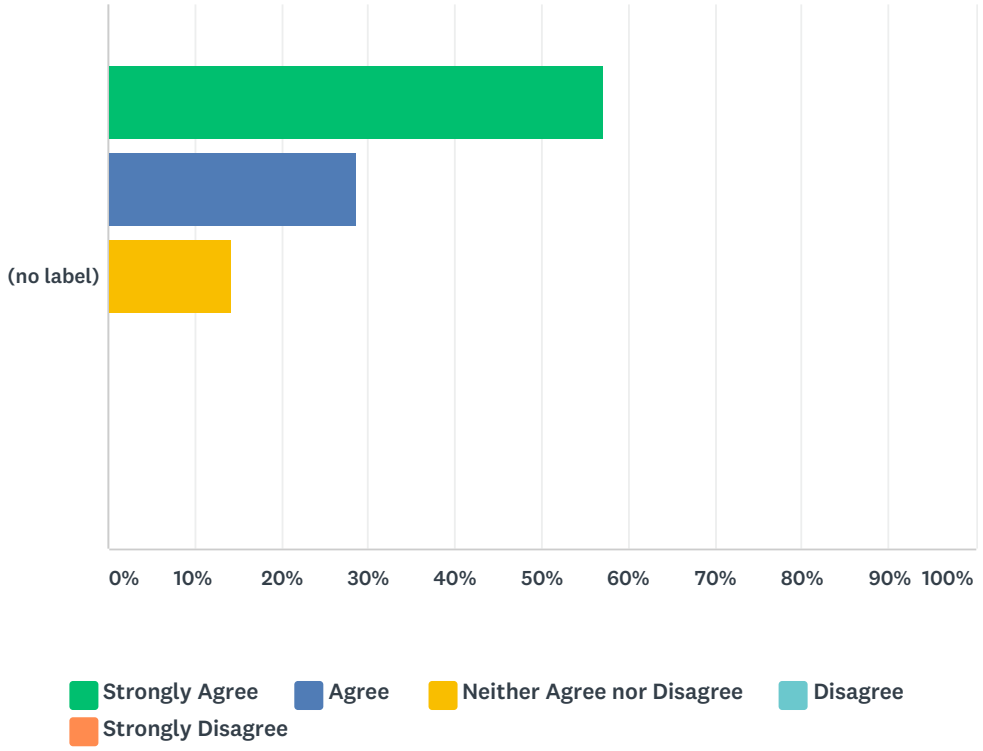
Answered: 7 Skipped: 148



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	42.86% 3	42.86% 3	0.00% 0	14.29% 1	0.00% 0	7	1.86

Q78 The facilitator demonstrated a thorough knowledge of the subject matter.

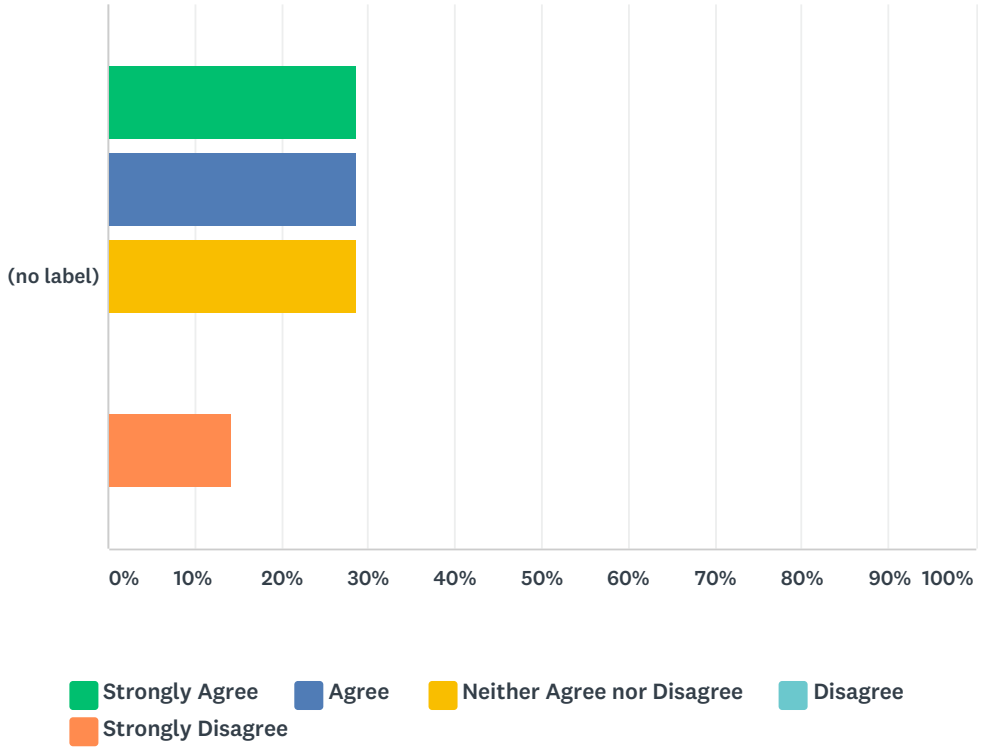
Answered: 7 Skipped: 148



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	57.14% 4	28.57% 2	14.29% 1	0.00% 0	0.00% 0	7	1.57

Q79 My knowledge and understanding of the subject matter increased as a result of this session.

Answered: 7 Skipped: 148



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	28.57% 2	28.57% 2	28.57% 2	0.00% 0	14.29% 1	7	2.43

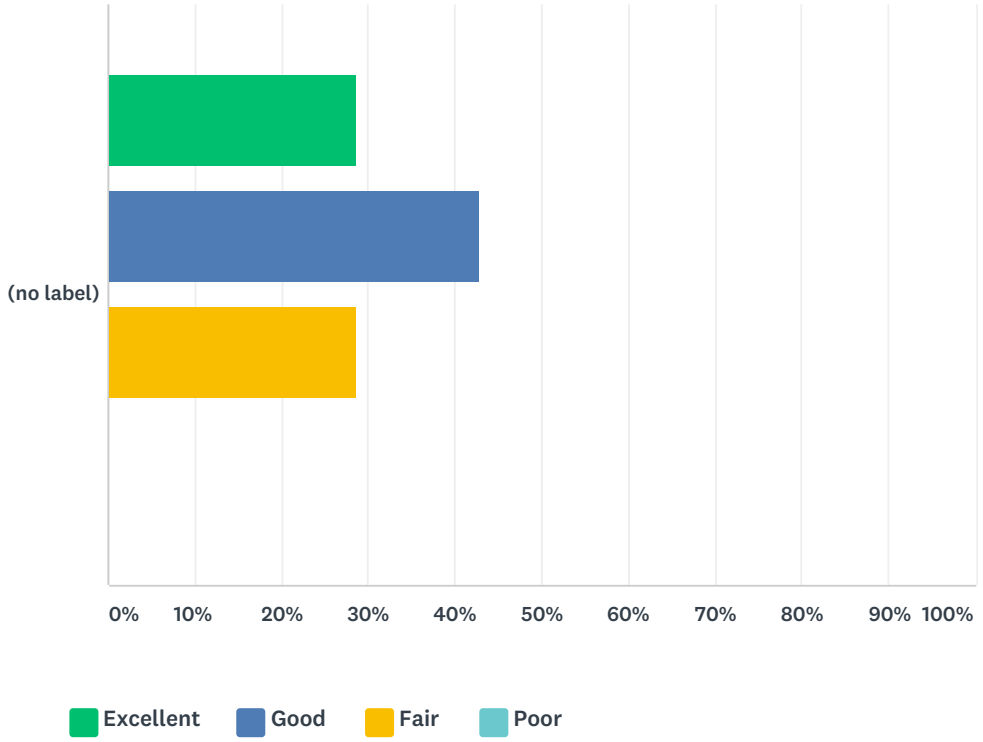
Q80 Please enter any questions, feedback, or takeaways you have from this workshop.

Answered: 4 Skipped: 151

#	RESPONSES	DATE
1	Facilitator said he wanted audience participation but he did most of the talking. I wanted to hear more from the audience.	4/16/2019 4:56 PM
2	I was looking more for information of male models in the family rather than in the agencies.	4/8/2019 7:22 PM
3	It opened my eyes to how we often focus on the mothers to the detriment of the fathers and emphasized the impact on the children.	4/8/2019 4:21 PM
4	For me, the Presenter shared no new content and some data was questionable.	4/8/2019 2:28 PM

Q81 Please rate this workshop.

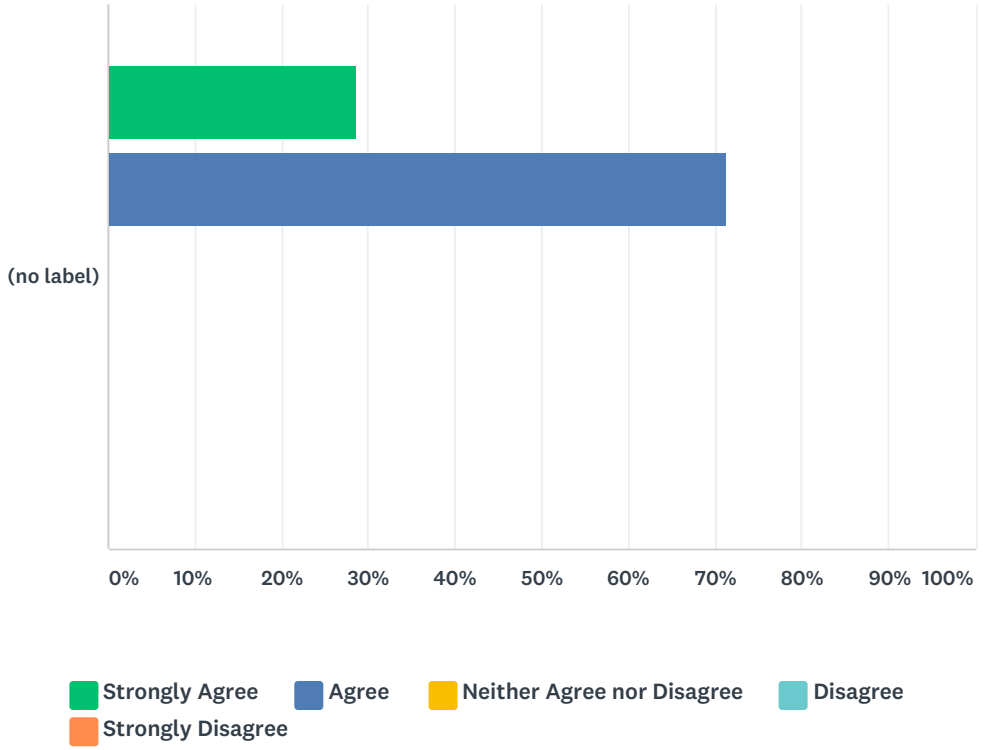
Answered: 7 Skipped: 148



	EXCELLENT	GOOD	FAIR	POOR	TOTAL	WEIGHTED AVERAGE
(no label)	28.57% 2	42.86% 3	28.57% 2	0.00% 0	7	2.00

Q82 The facilitator was organized in the presentation of course materials.

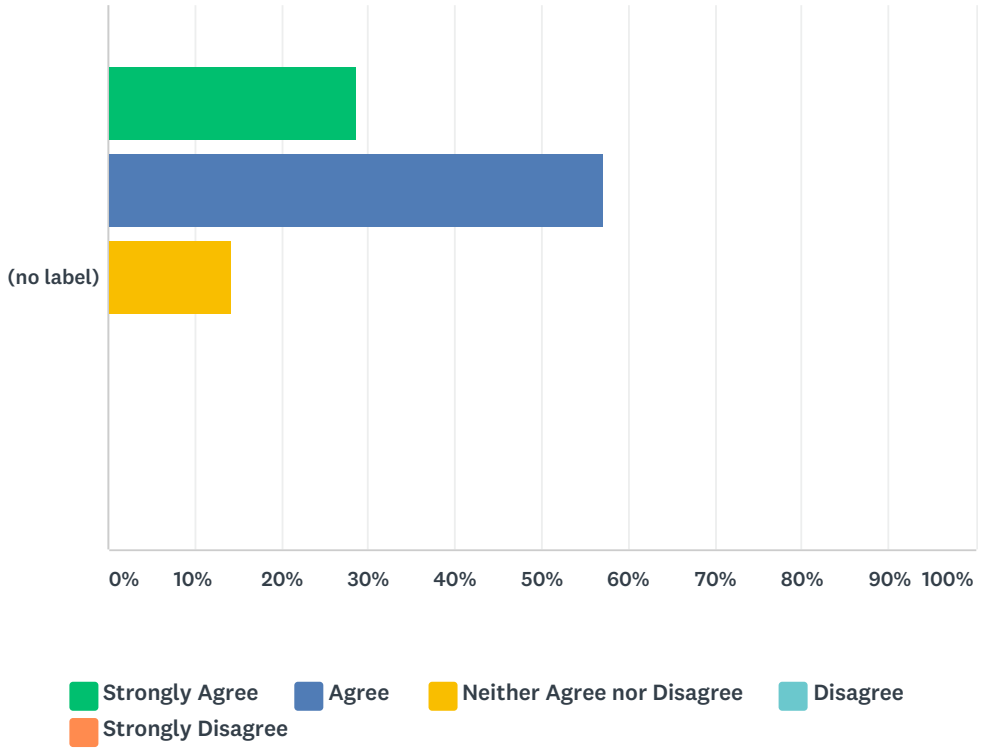
Answered: 7 Skipped: 148



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	28.57% 2	71.43% 5	0.00% 0	0.00% 0	0.00% 0	7	1.71

Q83 The facilitator demonstrated a thorough knowledge of the subject matter.

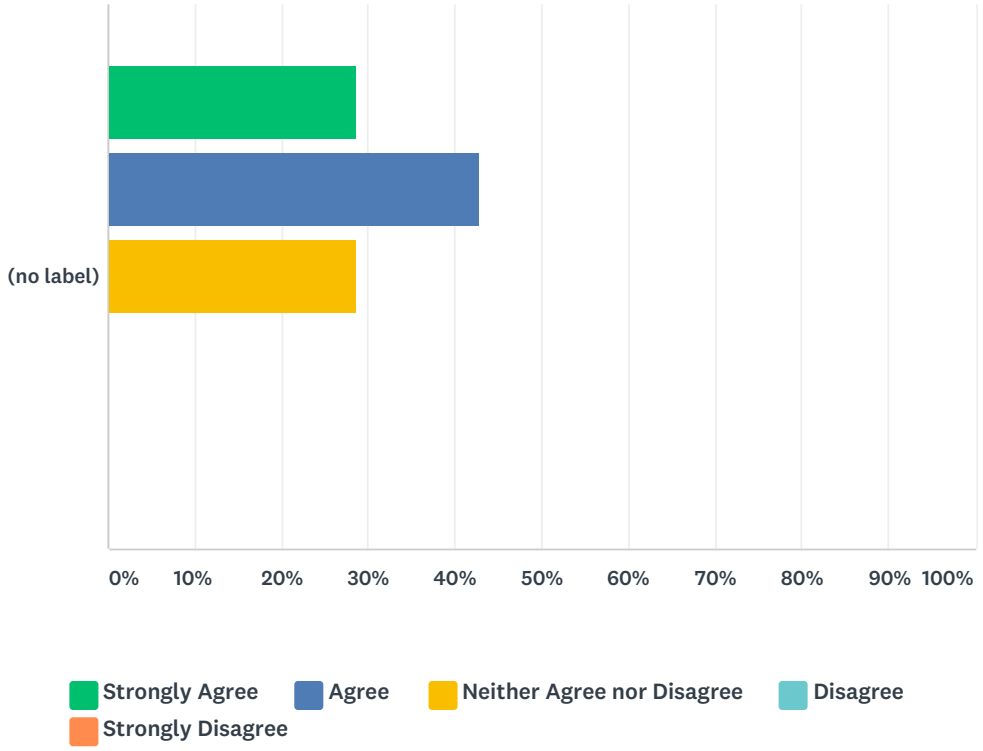
Answered: 7 Skipped: 148



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	28.57% 2	57.14% 4	14.29% 1	0.00% 0	0.00% 0	7	1.86

Q84 My knowledge and understanding of the subject matter increased as a result of this session.

Answered: 7 Skipped: 148



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	28.57% 2	42.86% 3	28.57% 2	0.00% 0	0.00% 0	7	2.00

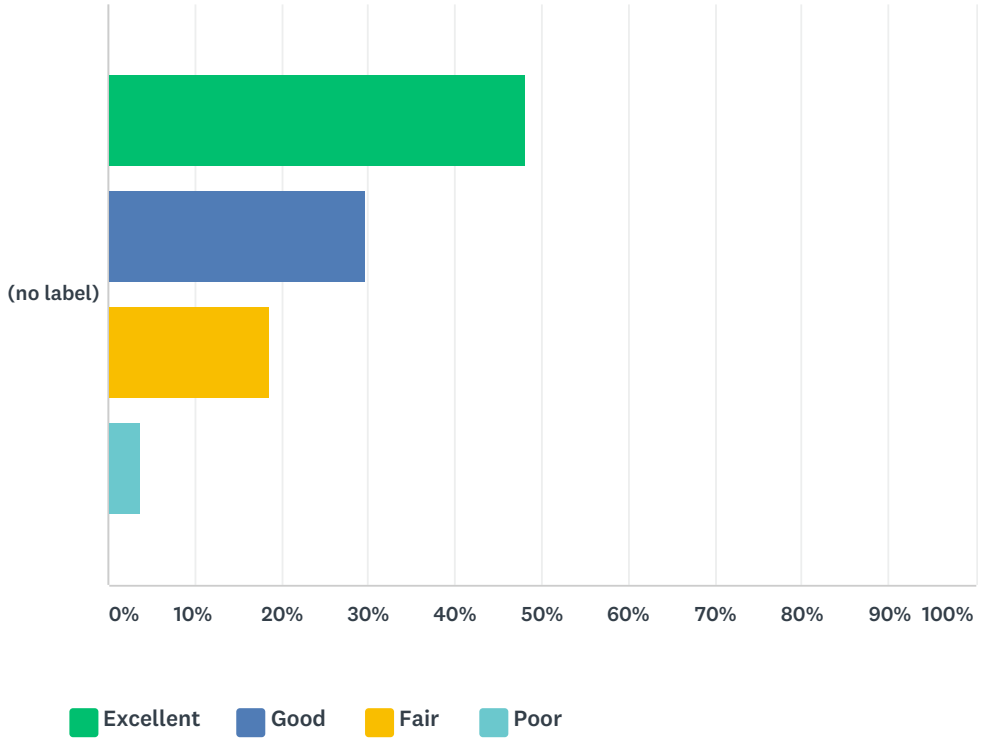
Q85 Please enter any questions, feedback, or takeaways you have from this workshop.

Answered: 2 Skipped: 153

#	RESPONSES	DATE
1	I think it would be best to include who would best benefit from each workshop, as this seemed to be a workshop for higher management/supervisors	4/15/2019 8:30 AM
2	I expected more details, current info, examples, understanding of the fact that EVERY organization has issues of manpower/prioritization, with the only difference here is that lives are at stake. More staff is not always the answer.	4/8/2019 1:34 PM

Q86 Please rate this workshop.

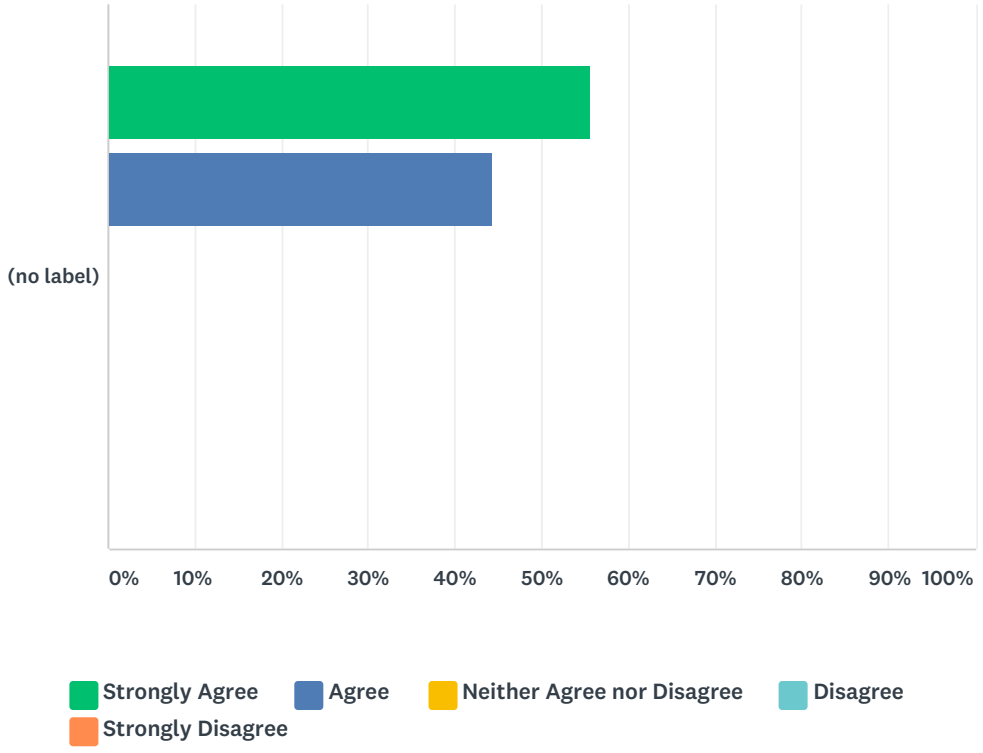
Answered: 27 Skipped: 128



	EXCELLENT	GOOD	FAIR	POOR	TOTAL	WEIGHTED AVERAGE
(no label)	48.15% 13	29.63% 8	18.52% 5	3.70% 1	27	1.78

Q87 The facilitator was organized in the presentation of course materials.

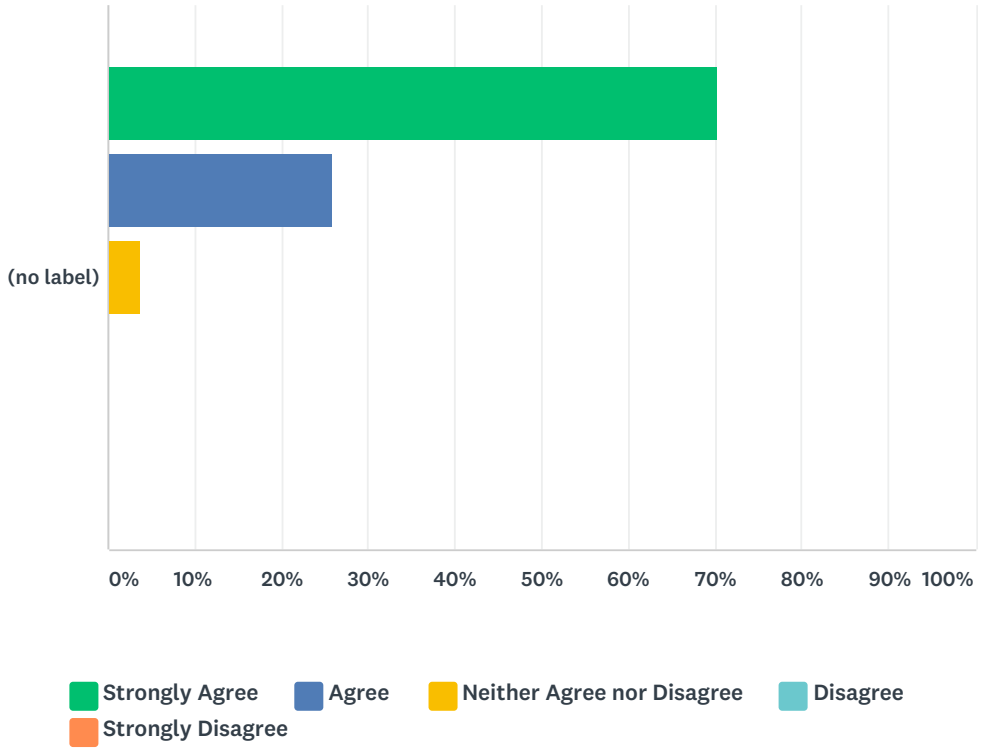
Answered: 27 Skipped: 128



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	55.56% 15	44.44% 12	0.00% 0	0.00% 0	0.00% 0	27	1.44

Q88 The facilitator demonstrated a thorough knowledge of the subject matter.

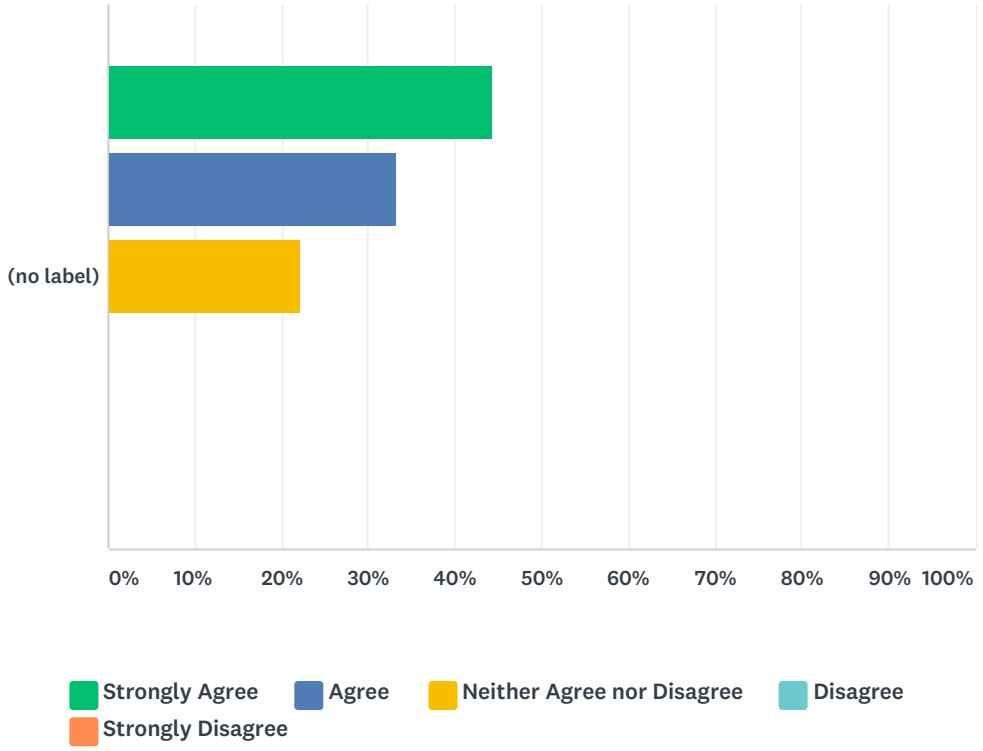
Answered: 27 Skipped: 128



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	70.37% 19	25.93% 7	3.70% 1	0.00% 0	0.00% 0	27	1.33

Q89 My knowledge and understanding of the subject matter increased as a result of this session.

Answered: 27 Skipped: 128



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	44.44% 12	33.33% 9	22.22% 6	0.00% 0	0.00% 0	27	1.78

Q90 Please enter any questions, feedback, or takeaways you have from this workshop.

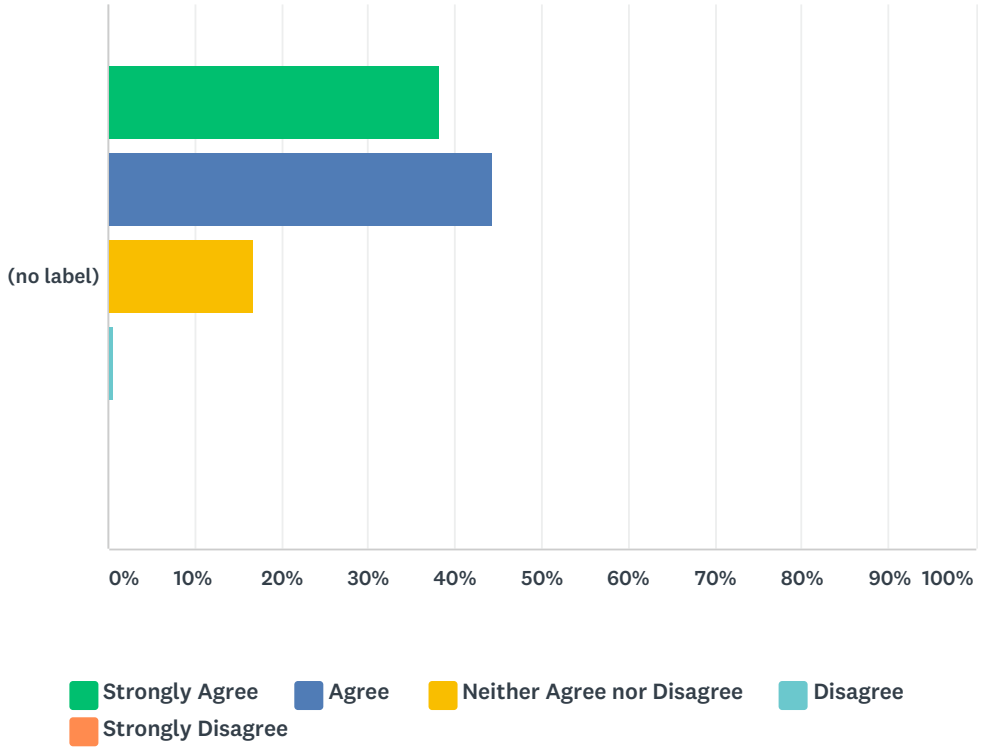
Answered: 8 Skipped: 147

#	RESPONSES	DATE
1	It was a good presentation. The topic was not what I thought it was going to be on unfortunately. The presenter was very educated and knowledgeable on the subject matter, at times I felt like the information was above my head.	4/9/2019 5:20 PM
2	This was valuable information but could have been tweaked for the audience. Especially with investigators (police and DFS) it would have been more helpful to give tips of how to uncover this. Was too medical.	4/9/2019 12:58 PM
3	The presenter was very knowledgeable and informative. However, the synopsis provided when signing up for this class did not give any indication that it would be ONLY on Munchausen. It was presented that it would be on identify child abuse - not an entire discussion on one RARE example of child abuse. The information was very dry and made it hard to keep my attention.	4/9/2019 9:54 AM
4	Loved the presentation but I felt there were too many PowerPoints for one hour.	4/8/2019 3:43 PM
5	Presenter was too technical and completely boring	4/8/2019 3:17 PM
6	I feel that Dr. Deutsch has a wealth of knowledge in regards to this subject but I feel that she read from the slides. The presentation was very monotone and flat. There was no emotion in her presentation. She gave no real life examples on a subject that she deals with daily. I feel that she has a lot to offer if she would just relate this to her daily function.	4/8/2019 12:38 PM
7	Really good.	4/8/2019 12:10 PM

8	The information was good but the presented was very dull. It should have been more interactive and she should've share more examples/	4/8/2019 12:08 PM

Q91 Information provided in the workshops I attended will help me perform my job more effectively.

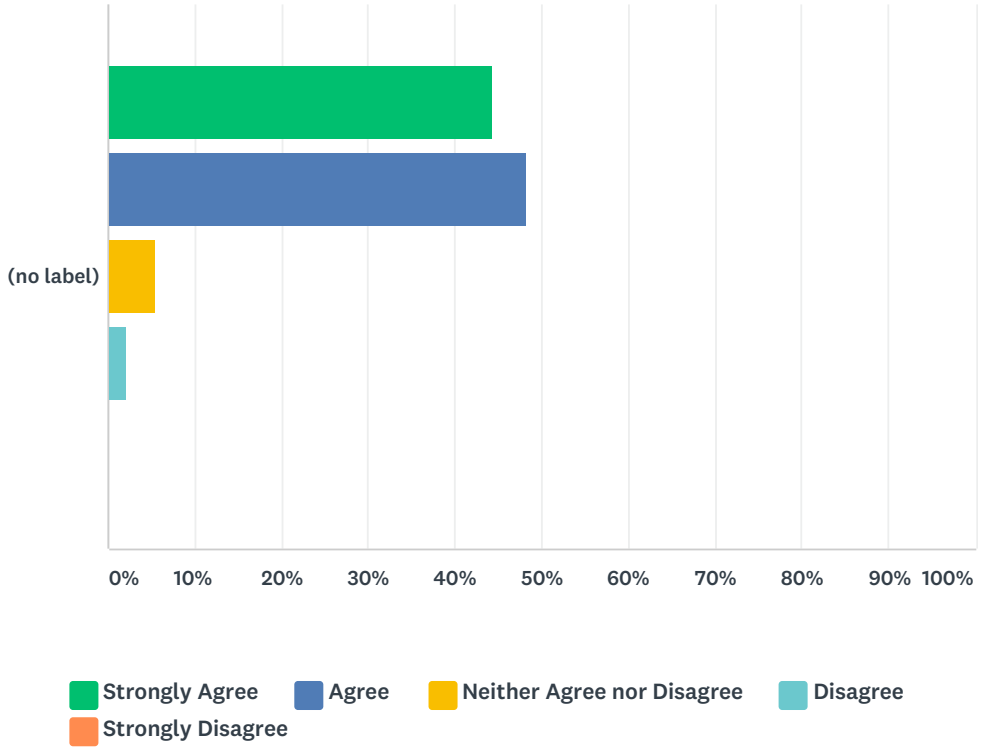
Answered: 149 Skipped: 6



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	38.26% 57	44.30% 66	16.78% 25	0.67% 1	0.00% 0	149	1.80

Q92 In general, the workshop content was at an appropriate level for my background and experience.

Answered: 149 Skipped: 6



	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
(no label)	44.30% 66	48.32% 72	5.37% 8	2.01% 3	0.00% 0	149	1.65

Q93 Thank you for completing this survey. Please use the space below to provide any additional comments about specific workshops or the conference in general:

Answered: 30 Skipped: 125

#	RESPONSES	DATE
1	Great conference, thoroughly enjoyed!	4/15/2019 12:05 PM
2	I would have said that I strongly agree if not for the last workshop. If that one is taken out of the mix, the conference was fantastic.	4/10/2019 10:58 AM
3	This conference was the best I have attended. I believe that might be because there were no politicians speakers, and the keynote speakers were had a thorough knowledge of the material and it was well presented.	4/9/2019 3:53 PM
4	More male involvement	4/9/2019 3:41 PM
5	Introductory remarks were dreadfully boring but great conference anyway.	4/9/2019 10:24 AM
6	Overall the conference was awesome! I learned so much and I can't wait for it to come around again. My suggestions would be to provide more accurate descriptions of the presentations if possible. It would have definitely changed my selections. Also, I really wished I could have heard more of the presentations, so maybe if we cut out the afternoon "burnout" type session or even have a session while eating lunch. I would like the opportunity to learn more while I am there than have so much downtime. I appreciate the effort to provide levity but a conference like this isn't available that often to learning more would be more profitable.	4/9/2019 10:02 AM

7	It would have been nice if they offered CEU credits for Nurses. I was glad to be a part of this excellent day!	4/9/2019 9:54 AM
8	I did like the conference however the only thing I am going to add is that it was a very long day. I had an hour drive in the morning after dropping kids off to school and an hour+ ride home due to traffic.	4/9/2019 9:43 AM
9	If the conference is held at Dover Downs again next time, I strongly recommend a review of sound system capabilities during planning.	4/9/2019 9:33 AM
10	I had to leave early due to call in for work but will be attending the next one for sure	4/8/2019 8:45 PM
11	All around great training! Keep it up...	4/8/2019 4:44 PM
12	Best conference yet!	4/8/2019 3:44 PM
13	Louder microphones or louder sound system for ballroom - difficult to hear	4/8/2019 3:37 PM
14	Wonderful conference!	4/8/2019 2:42 PM
15	I appreciate all the hard work entailed in putting this conference together. Thank you.	4/8/2019 2:29 PM
16	Where you sign up should have a sign pointing toward the desk. I don't think it was clear enough.	4/8/2019 2:28 PM
17	Very well done.	4/8/2019 2:20 PM
18	Great job! Rosie and her team put together another excellent training opportunity for Delaware.	4/8/2019 2:19 PM
19	Overall I would rate the conference as a great conference for professionals that deal with children that suffer from abuse. One recommendation I would make would be to have signs on where the diamond room is located and that you can only take the elevator to get to the diamond room. After the keynote speaker, there were a ton of people trying to fit in one small elevator to get to the 3rd floor conference rooms. Perhaps if there was another way to get there as well that could be made known that way people could get there a little easier. The speakers were very detailed in their presentations and definitely kept my attention. They were both very inspirational! I would recommend bringing them both back for future conferences.	4/8/2019 2:07 PM
20	Can we do it in NC County next time, please? 😁	4/8/2019 1:35 PM
21	On the way home, it occurred to me that the presentations left me feeling depressed.	4/8/2019 1:22 PM
22	With alarming Opioid overdoses cases being reported, I feel like the prevention of misuse of medication should be discussed at elementary school level. I feel that if the children learn at a early years how devastating the effect of misusing drugs is, they will be reluctant to try it in the first place.	4/8/2019 12:53 PM
23	The sessions that I went to Investigating Child Homicide Cases Part 1 & 2 were a police and a prosecutor .....it still pertained to pre hospital as well as hospital through DOCUMENTATION!! I'm always telling staff write what the person says in quotes!! The sessions were truly great!!	4/8/2019 12:52 PM
24	Thank you!!	4/8/2019 12:50 PM
25	I wish this happened every year!	4/8/2019 12:39 PM
26	Bar far the best year yet, thank you.	4/8/2019 12:24 PM
27	n/a	4/8/2019 12:22 PM
28	Would like to hear about generational trauma and abuse and how to break that cycle	4/8/2019 12:18 PM
29	Thank you for having me! It was an excellent conference and I'm looking forward to attending in 2020!	4/8/2019 12:17 PM
30	I always enjoy going to the conference. It is well organized and informative. Keep up the great work!!!	4/8/2019 12:14 PM

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

May 2018 - May 2019

FINDINGS

	*Current	Grand Total
Safety/ Use of History/ Supervisory Oversight	**21**	**21**
Completed Incorrectly/ Late	10	10
Inappropriate Parent/ Relative Component	7	7
No Safety Assessment of Non-Victims	1	1
Oversight of Agreement	2	2
Use of History	1	1
Grand Total	**21**	**21**

**Current - within one year of incident.*

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

Child Protection Accountability Commission
Child Abuse and Neglect Panel
Findings Detail and Rationale
May 2018 - May 2019

FINDINGS

System Area	Finding	PUBLIC Rationale	Sum of #
Safety/ Use of History/ Supervisory Oversight			21
	Completed Incorrectly/ Late		10
		In the prior investigation, a safety agreement was not implemented for the infant born with prenatal substance exposure despite safety threats being present due to the current circumstances and DFS history.	1
		In the prior investigation, DFS completed a safety agreement with the father prior to completing collateral contacts with substance abuse providers.	1
		For the prior report, the case worker did not complete the SDM safety assessment correctly, and there was no safety agreement. The victim was permitted to remain in the home with a primary caregiver, who had significant DFS history and a child in foster care.	1
		For the near death investigation, the case worker did not complete the SDM safety assessment correctly, and there was no safety agreement. Mother was verbally told that she was permitted no contact with the children.	1
		In the prior investigation, the case worker did not complete the SDM safety assessment correctly, and there was no safety agreement. The victim was evaluated for bruising to his face and abuse could not be ruled out.	1
		For the death investigation, DFS entered into a safety agreement with a relative, but an interview and home assessment was not conducted to assess her ability to act as a safety participant.	1
		For the near death investigation, DFS did not conduct a home assessment prior to the infant's discharge from the hospital.	1
		The SDM Safety Assessment was not completed correctly for the near death incident. The safety threat for access to dangerous objects in the house was marked no, and the child was determined to be safe.	1
		For the near death investigation, DFS entered into a safety agreement with several participants, but interviews were not conducted with these participants to assess their ability to act as a safety participant.	1
		For the near death incident, the child was released to the mother with a child safety agreement. However, it did not adequately address the safety threat.	1
	Inappropriate Parent/ Relative Component		7
		For the near death incident, DFS completed a safety agreement with relatives, who were not ruled out as suspects.	1
		After the near death incident, DFS entered into a safety agreement allowing mother only supervised contact with the child by an appropriate adult. However, the safety intervention did not adequately address the safety threat as no other participants were identified.	1
		For the near death incident, DFS completed a safety agreement with a relative, who was not ruled out as a suspect.	1
		Following the report of a substance-exposed infant, DFS entered into a safety agreement with the father. However, he was not an appropriate caregiver due to DFS and criminal history.	1

	Following the report of an infant with prenatal substance exposure, DFS entered into a safety agreement with the father. However, he was not an appropriate caregiver due recent DFS and substance abuse history.	1
	For the near death investigation, DFS entered into a safety agreement with a relative. However, she was not an appropriate caregiver due to her ongoing substance abuse.	1
	For the near death investigation, DFS entered into a safety agreement with a non-related caregiver. However, she was not an appropriate caregiver due to her DFS and criminal histories, and she was not ruled out as a suspect.	1
No Safety Assessment of Non-Victims		1
	The DFS caseworker left the siblings in the home with the alleged perpetrator when the victim was taken to the hospital for an immediate medical evaluation. As a result, the alleged perpetrator fled with the siblings.	1
Oversight of Agreement		2
	DFS terminated the safety agreement without consideration of the following: infant with injuries resulting from neglect, new report of domestic violence, collateral information from the substance abuse provider, and the family's significant DFS history.	1
	For the case involving the infant with prenatal substance exposure, DFS terminated the safety agreement; however, the mother's substance abuse issues continued to be an ongoing risk factor.	1
Use of History		1
	DFS custody could have been considered much earlier for the young child and sibling due to the serious physical injury to one child and failure to thrive, decline in weight and multiple hospitalizations for both children.	1
Grand Total		**21**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

May 2018 - May 2019

STRENGTHS		
	***Current**	**Grand Total**
Safety/ Use of History/ Supervisory Oversight	**14**	**14**
Completed Correctly/On Time	3	3
Custody/Guardianship Petitions	2	2
Oversight of Agreement	6	6
Safety Assessment of Non-Victims	1	1
Supervisory Oversight	2	2
Grand Total	**14**	**14**

**Current - within one year of incident.*

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

Child Protection Accontability Commission
Child Abuse and Neglect Panel
Strengths Detail and Rationale
May 2018 - May 2019

STRENGTHS

System Area	Strength	Rationale	Count of #
Safety/ Use of History/ Supervisory Oversight			14
	Completed Correctly/On Time		3
		Although verbally, not in writing, Mother's contact with the children was immediately restricted by DFS and law enforcement.	2
		The DFS caseworker traveled to Father's out of state home to conduct an assessment prior to modifying the child safety agreement.	1
	Custody/Guardianship Petitions		2
		During the near death investigation, DFS sought custody of the children quickly.	1
		DFS sought input from the Civil DAG and convened a TDM to discuss considerations for DFS custody.	1
	Oversight of Agreement		6
		There was consistent review and modification, when necessary, of the safety agreement by the DFS caseworker.	3
		There was consistent review, and modification, when necessary, of the safety agreement by the DFS case worker.	1
		There was consistent review and modification, when necessary, of the safety agreement by the DFS caseworker. The caseworker was also seeing the family monthly.	1
		During the prior investigation, there was consistent review, and modification, when necessary of the safety agreement by the DFS case worker.	1
	Safety Assessment of Non-Victims		1
		The DFS caseworker implemented a child safety agreement with the siblings residing outside the home. The safety agreement was reviewed and modified, when necessary.	1
	Supervisory Oversight		2
		Due to the extenuating circumstances of the case, the DFS supervisor was very involved with the near death investigation.	2
Grand Total			14

Delaware DFS System Refresher: Safety Assessment and Child Safety Agreements

Trainer: Heather Meitner, NCCD Children's Research Center

One Day Workshop Description 9:00 – 4:00

This workshop will begin with a short overview of the foundations of the SDM system, including system goals, objectives, and characteristics. It will also include a review of the basic concepts of household-based assessments and identification of primary and secondary caregivers. Reminders of the importance of using SDM definitions to promote consistency and ensure fidelity of connection to research, and to offer tips for applying SDM definitions.

The bulk of the workshop will give participants an opportunity to learn and practice the use of the safety assessment in helping to support decisions about the immediate safety of children, during alternative response assessment and investigations and throughout the life of a treatment case. Enhanced practice strategies for conducting a safety assessment in partnership with families will be reviewed and participants will practice creating rigorous behaviorally based safety plans with their own cases.

Key Topics Include:

- The SDM safety assessment: key concepts, child vulnerabilities, and dangers.
- Using the safety assessment to support a balanced evaluation: what's worrying, what's working, and what's next.
- A rigorous and balanced assessment.
- Harm, risk, and goal statements.
- Creating robust Child Safety Agreements.

NCCD Children's Research Center

SDM® System Refresher: Safety Assessment and Child Safety Agreements

Heather Meitner, Senior Program Specialist

Training Agenda

- Introductions, warm-up, and agreements
- Structured Decision Making® (SDM) system review and key concepts
- SDM® safety assessment and child safety agreement with safety-organized practices
- Practice! Practice! Practice!

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Reminder: What is the SDM® System?

An evidence- and research-based decision-support system.

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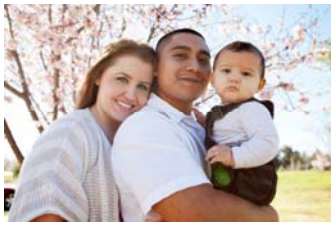
SDM® System Goals for Child Welfare



Reduce subsequent harm

Expedite permanency and safe reunification

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SDM® System for Child Welfare

Objectives

- Structure critical decision points
- Increase consistency in decision making
- Increase accuracy in decision making
- Use data to inform policy and practice

Characteristics

- Reliable
- Valid
- Equitable
- Useful

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Household-Based Assessments

For assessment purposes, a household is not simply a dwelling; it is a *group of people* who have contact with the child.

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Tools Are a Prompt for Practice

- Tools do not make decisions
- People make decisions
- Tools help people make better decisions

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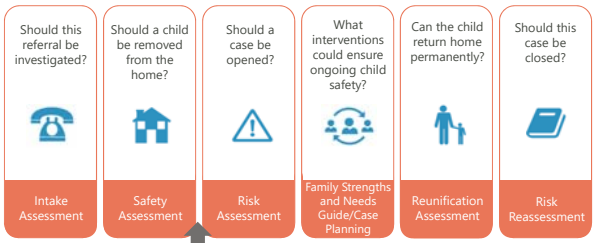
Each Decision Point Relates to a Key Question



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Key Decisions: Fair Assessment/Investigation

- Is the child safe?
- Allegation determination (for investigations)
- Recommended Interventions?

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Danger, Risk, and Needs

Danger
Imminent threat of serious harm

Risk
Indicates likelihood of future maltreatment

Needs
- May be related to danger (safety threat) or risk
- May need to be addressed on family service plan

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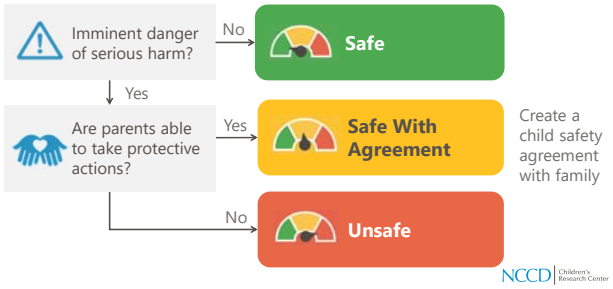
The SDM® Safety Assessment: Five Main Sections

- Child Vulnerabilities
- Safety Threats
- Protective Capacities
- Safety Interventions
- Safety Decision

NCCD Children's Research Center

SDM® Safety Assessment



NCCD Children's Research Center

Safety Assessment: Procedures

- Which cases
- Who
- When
- Decision

NCCD Children's Research Center

Common Mistakes: Safety Assessment

- Definitions
- Incomplete information gathering
- Insufficient exploration of child safety agreement options
- Confusing child safety agreements and case plans
- Completing on wrong household

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- Read to the period
- Examples are not all-inclusive lists
- Be aware of:
  - AND
  - OR
  - and/or
- When unsure, ask others
- "Unasked" is different from "unknown"
- Use clinical judgment and common sense

Child Safety Agreement Versus Family Service Plan

"A safety plan should never include tasks that require demonstration over time."

– Sonja Parker, SCP Consulting

NCCD | Children's Research Center

What is safety-organized practice?

- Developing good working relationships
- Using critical thinking and decision-support tools
- Building collaborative plans to enhance daily child safety

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Ask: What is the role of services?

- Services support caregivers in taking steps toward safety.
- People do need help.
- When workers want families to start using services, be clear to yourself and the family: *What behaviors/actions within the family are you hoping will change as a result of this service*?

Remind them that services **are a means to an end**. That end is sustainable safety for the children!

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Table-Talk Activity

Safety

Danger

Harm

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Safety

Actions of protection taken by a caregiver that address the danger to the child and are demonstrated over time

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The Three Questions and the Safety Assessment

- Child Vulnerability — **What are we worried about?** (harm/danger, complicating factors)
- Safety Threats
- Protective Capacities — **What is working well?** (strengths, safety)
- Safety Interventions
- Safety Decision — **What needs to happen next?** (child safety agreement, next steps)

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Safety Assessment Documentation

You should document:

- Evidence that supports item responses
- Specifics for safety interventions

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Three-Column Mapping

What are we worried about?	What is working well?	What needs to happen next?
Danger/harm, risk, and complicating factors	Safety, protective capacities, and strengths	Creating and sharing harm/risk/goal statements, enhancing a safety network, CSA, and case planning

0 ◄——————————————► 10

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Practice:
Three-Column Mapping

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A Helpful Construct: Impact on the Child

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Gems of Clarity

- **Harm Statements**
- **Risk Statements**
- **Goal Statements**

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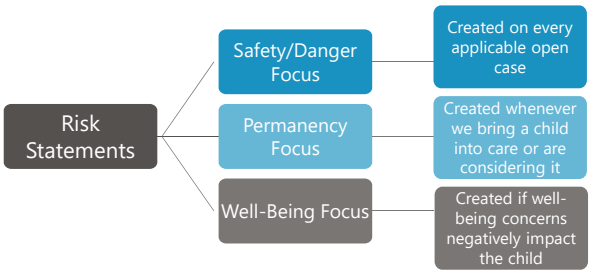
Risk Statements: Addressing Our Mandate



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Risk Statements for Cheryl's Family

Safety/Danger Focus	Rebecca and Lisa could be seriously physically hurt if Cheryl were to become depressed, not ask for help, and try to hurt herself while the girls were with her
Safety/Danger Focus #2	Rebecca and Lisa could be emotionally hurt (scared, shocked, traumatized) if Cheryl were to hurt herself and they were to find her
Permanency Focus	Rebecca and Lisa could be emotionally or socially hurt (scared, confused, miss their mom and each other) when separated from their mother and living outside the home

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Sample Risk Statements for Well-Being

Well-Being Focus *Education*	Thomas, age 12, could worry about his mother, get distracted from his schoolwork, and fail this grade if his father continues to use coercive control and violence against his mother
Well-Being Focus *Hygiene Neglect*	Martina, age 7, could continue to be bullied at school if her mother's depression remains untreated and she cannot help meet Martina's hygiene needs (showering, clean clothes, brushing teeth)
Well-Being Focus *Dental Neglect*	Michael, age 2, could continue having dental issues that may cause serious health issues if his parents continue giving him juice and do not brush his teeth and get him regular dental care

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Child Safety Agreement

- Safety threat
- Family-friendly description
- Safety intervention
- Monitoring
- Signatures

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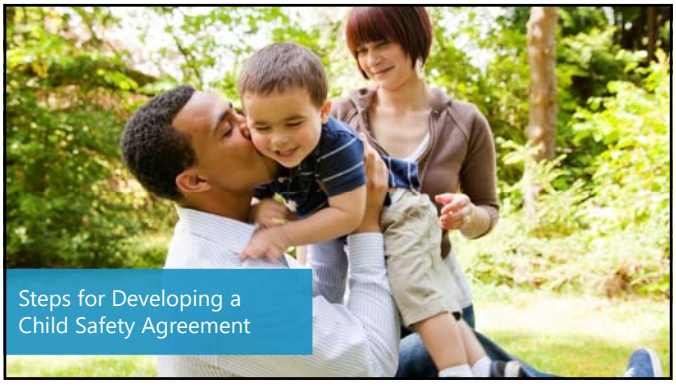

Rating Current Network Use

On a scale of 0 to 10, with 0 being "I never use networks in my work" and 10 being "I use networks 100% of the time," how often do you use networks?

What did you do in your past work that allowed you to place yourself on the scale where you did?

What kept you from placing yourself at a higher number on the scale?

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Identifying the Network

Key Question:
Who in this child's life is interested and able to help keep the child safe?

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A fair use of our authority?

"I understand this is tough and you do not want to do it. But to take the next step, I need to know more people are working together to help keep your child safe. If one person attended our next meeting—to hear all the good things I see you doing and what worries me—who would it be?"

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Cultural Considerations in Forming a Network

Ask
To whom in the community does the family already reach out?

When others in the community faced similar problems, how did they get support?

Do they prefer to open up to people within or outside their culture?

Opening up to others in some way may be a bottom line, but with whom and how can be tailored to individual families and cultural groups

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Working With the Network

- Orienting the network
- Roles and responsibilities
- Network fatigue

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The SMART Formula

Specific

Measurable

Achievable

Relevant

Time-Limited

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Giving the Network an "Out"

Sometimes network members overcommit

Unexpected things come up

Reality-test the plan by asking "what-ifs"

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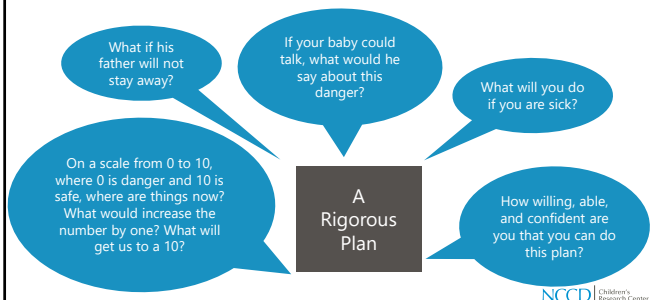
Weather-, Situation-, and Time-Proof the Plan



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A before-and-after child safety agreement example

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Child Safety Agreement Practice

List on Flip Chart

- Child safety agreement objectives that could address the identified safety threat
- Action steps that can help meet those objectives

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Connecting Safety and Risk

Safety Assessment

Informs *what* we are worried about

Risk Assessment

Informs *how worried* we should be

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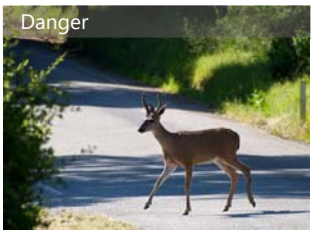
The Difference Between Risk and Danger



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Risk Assessment

Activity: Thinking about risk assessment in practice

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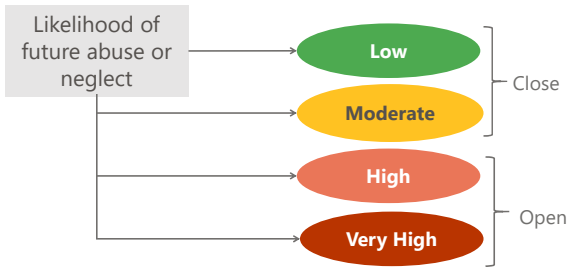
Risk Assessment: How worried should we be?



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SDM® Assessment Post-Investigation Guidance

Safe Low/moderate risk *Do we need to be involved at all?*	**Safe With Agreement** Low/moderate risk *Is the plan working?*	**Unsafe** Low/moderate risk *Is a quick return home possible?*
Safe High/very high risk *What preventive actions can we take?*	**Safe With Agreement** High/very high risk *We need to see the plan working longer*	**Unsafe** High/very high risk *We need sustainable safety before returning home*

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Skills Practice Lab

1. Select one case per group
2. Map it
3. Apply the SDM safety assessment
4. Report out

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Closing Exercise: In Pairs

1. Share one thing you already do really well with families and their networks to bring rigor to safety assessment and child safety agreements.
2. Share two things you will do more often, or do differently, going forward.
3. From whom will you need support to do so? Pair up with an "accountability buddy" and schedule a check-in meeting for next month.

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What worked?

What could be upgraded for next time?

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References

Boffa, J., & Podesta, H. (2004). Partnership and risk assessment in child protection practice. *Protecting Children, 19*(2), 35–49.

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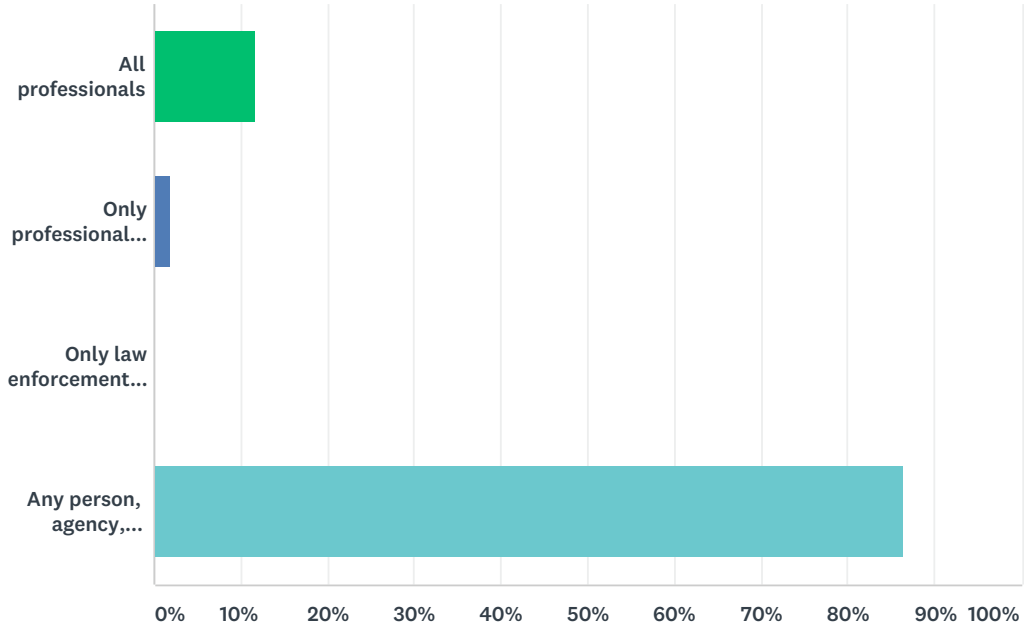
Thank you!

For more info, visit www.nccdglobal.org or contact Heather Meitner, hmeitner@nccdglobal.org

NCCD Children's Research Center

Q1 In Delaware, who is mandated to report known or suspected cases of child abuse or neglect?

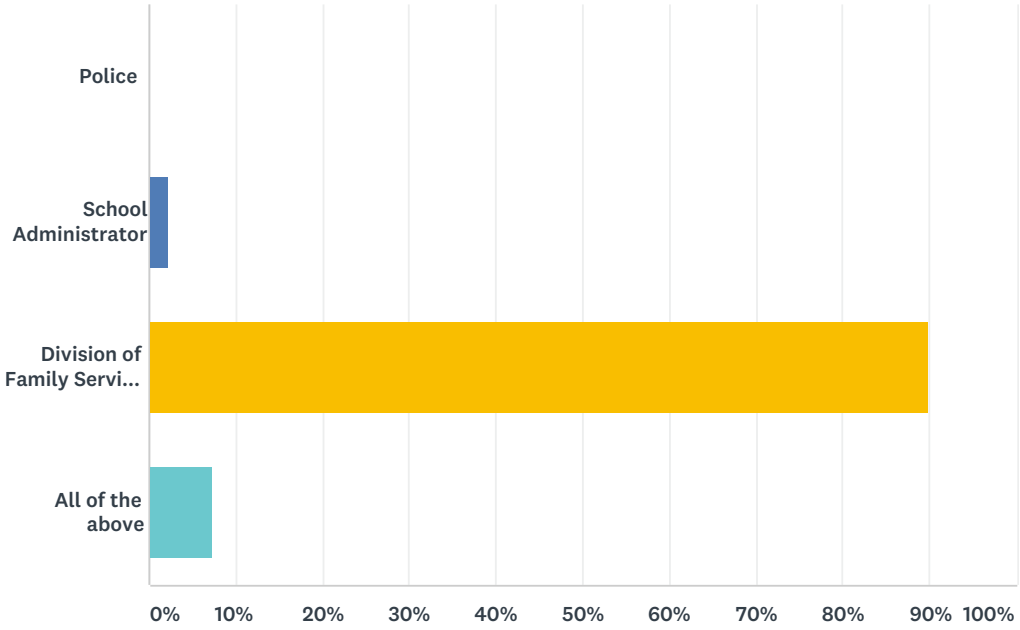
Answered: 7,308 Skipped: 0



ANSWER CHOICES	RESPONSES	
All professionals	11.66%	852
Only professionals that work directly with children (i.e. teachers, physicians)	1.97%	144
Only law enforcement officers	0.03%	2
Any person, agency, organization or entity	86.34%	6,310
TOTAL		7,308

Q2 I am obligated by LAW to FIRST report my suspicions of abuse and neglect to:

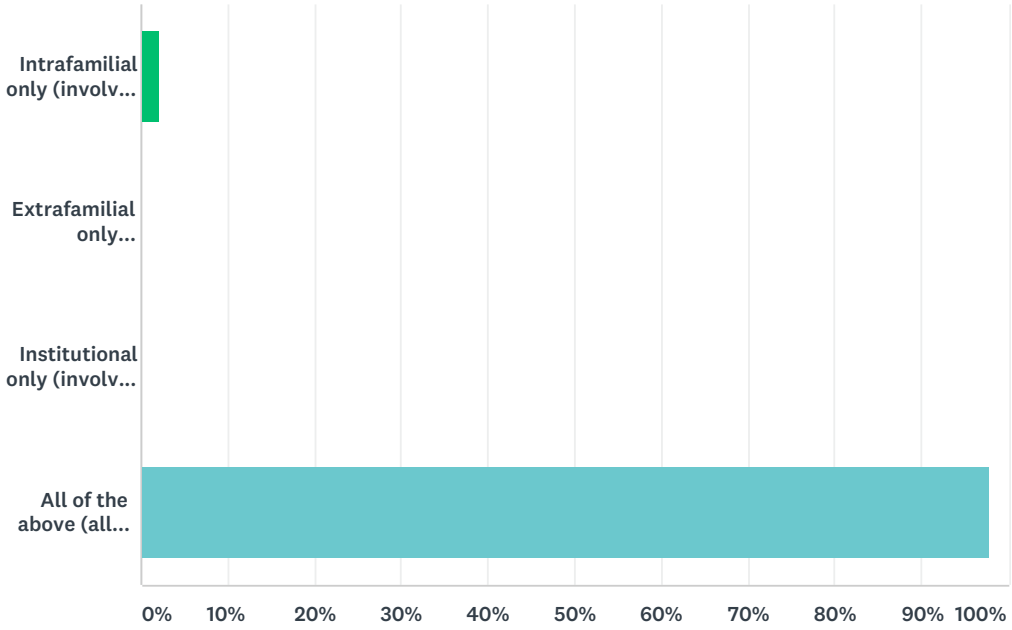
Answered: 7,282 Skipped: 26



ANSWER CHOICES	RESPONSES	
Police	0.29%	21
School Administrator	2.40%	175
Division of Family Services Child Abuse and Neglect Report Line	89.89%	6,546
All of the above	7.42%	540
TOTAL		7,282

Q3 What types of cases must be reported to the Division of Family Services Child Abuse and Neglect Report Line?

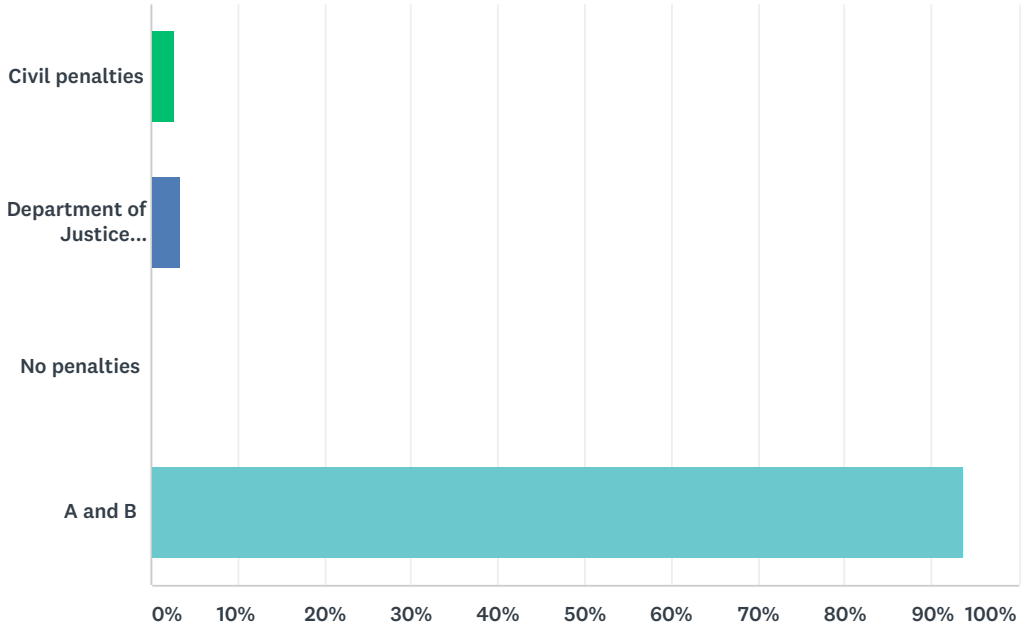
Answered: 7,266 Skipped: 42



ANSWER CHOICES	RESPONSES	
Intrafamilial only (involving parent, guardian, custodian, or member of the household)	2.00%	145
Extrafamilial only (perpetrator is not a member of the household or family)	0.03%	2
Institutional only (involving licensed child placement facilities)	0.12%	9
All of the above (all suspected abuse and neglect of any child, birth to age 18)	97.85%	7,110
TOTAL		7,266

Q4 Failing to report suspicions of abuse or neglect to the Division of Family Services can expose a school employee and school and/or district to:

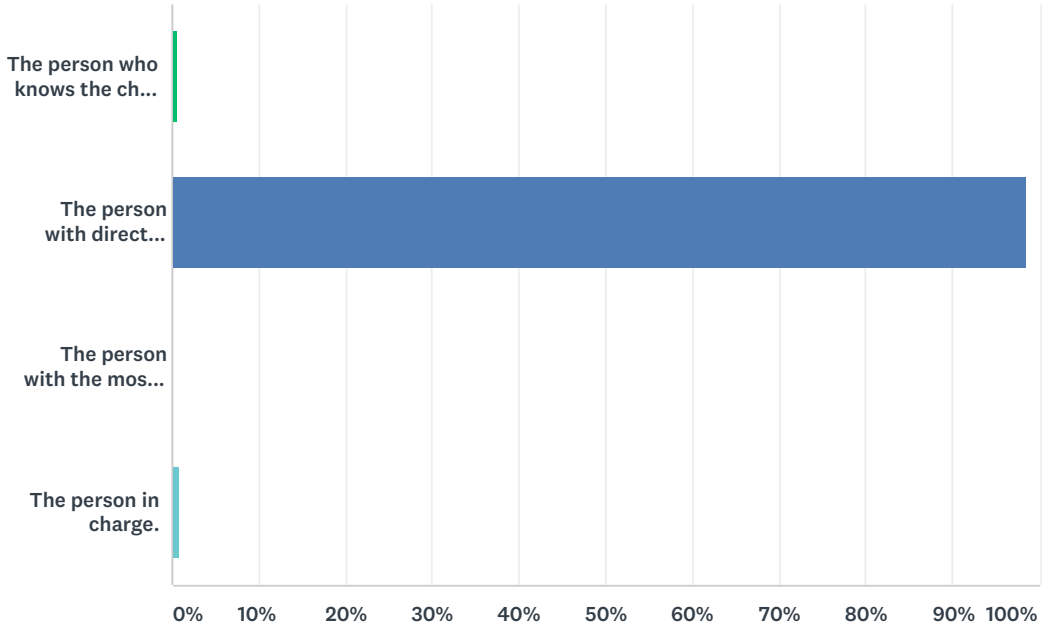
Answered: 7,260 Skipped: 48



ANSWER CHOICES	RESPONSES	
Civil penalties	2.78%	202
Department of Justice investigation	3.44%	250
No penalties	0.07%	5
A and B	93.71%	6,803
TOTAL		7,260

Q5 Which person must make a report to the DFS Child Abuse and Neglect Report Line?

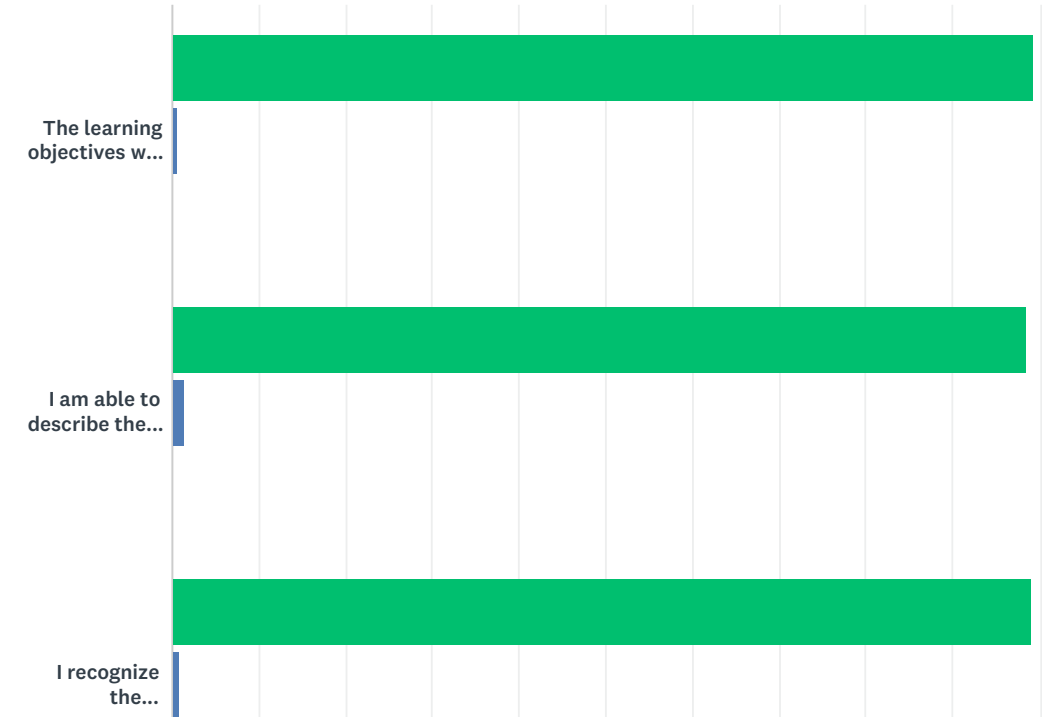
Answered: 7,253 Skipped: 55

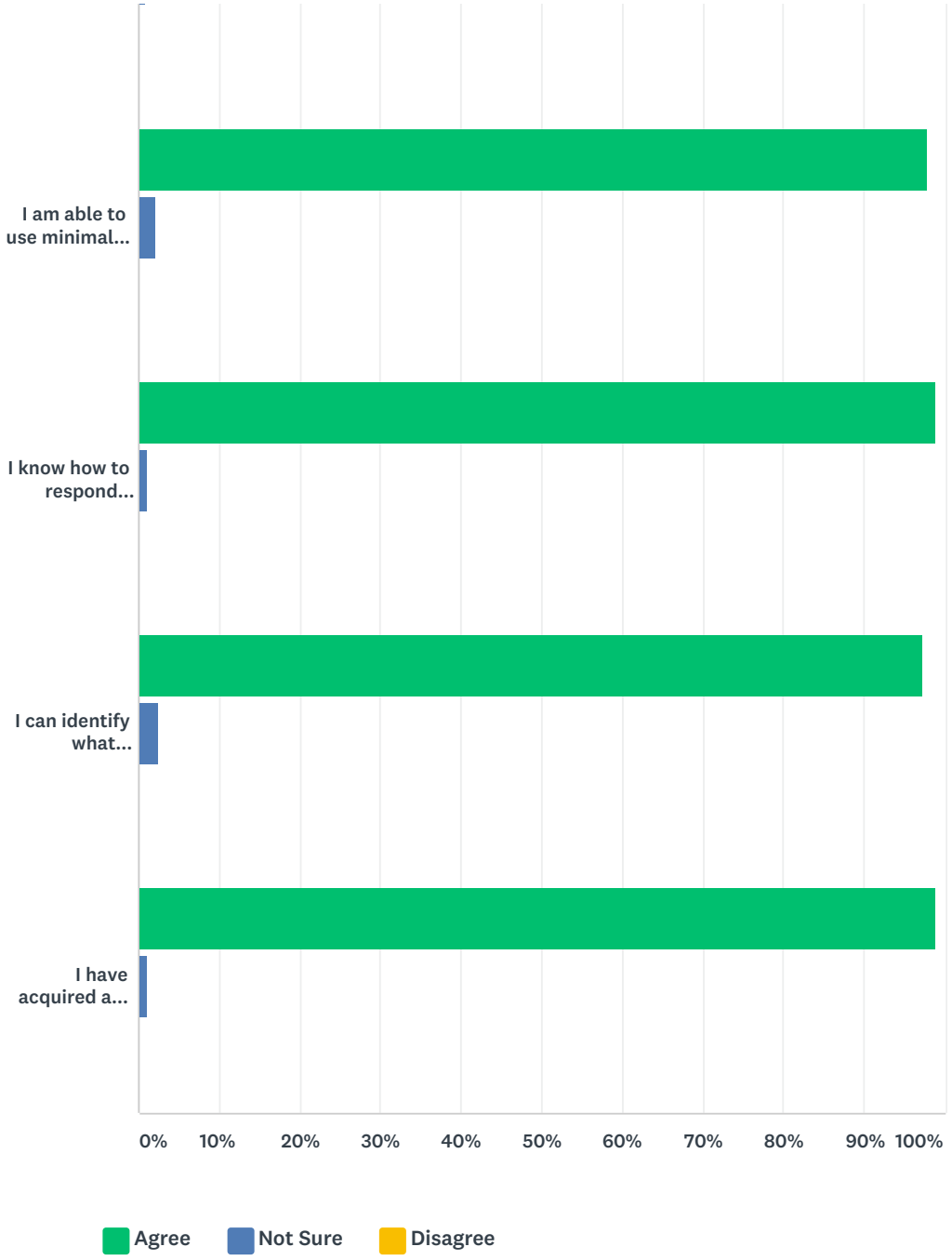


ANSWER CHOICES	RESPONSES	
The person who knows the child best.	0.58%	42
The person with direct knowledge.	98.52%	7,146
The person with the most time.	0.06%	4
The person in charge.	0.84%	61
TOTAL		7,253

Q6 Please rate each of the following statements.

Answered: 7,226 Skipped: 82





	AGREE	NOT SURE	DISAGREE	TOTAL	WEIGHTED AVERAGE
The learning objectives were met.	99.40% 7,183	0.53% 38	0.07% 5	7,226	1.01
I am able to describe the reporting law and reporting procedure for the State of Delaware.	98.49% 7,117	1.43% 103	0.08% 6	7,226	1.02
I recognize the relationship between physical and behavioral indicators and suspicion of child abuse and neglect.	99.14% 7,164	0.82% 59	0.04% 3	7,226	1.01
I am able to use minimal fact questions when indicators are observed and/or a disclosure is made.	97.85% 7,071	1.99% 144	0.15% 11	7,226	1.02
I know how to respond appropriately when children disclose allegations of abuse or neglect.	98.89% 7,146	1.05% 76	0.06% 4	7,226	1.01

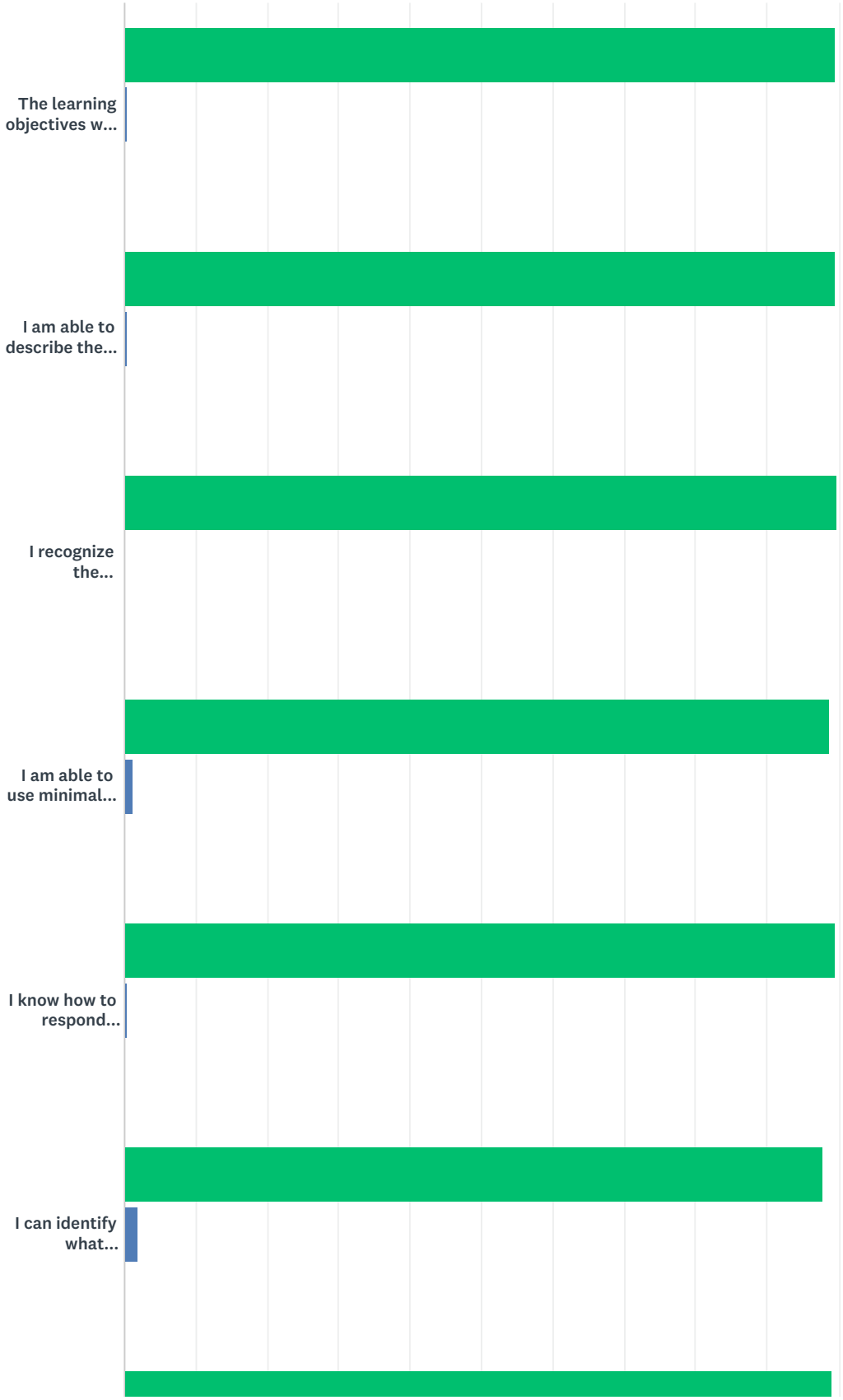
I can identify what information to expect from DFS following a report of child abuse or neglect.	97.30% 7,031	2.60% 188	0.10% 7	7,226	1.03
I have acquired a basic understanding of the civil and criminal definitions in statute for the various types of child maltreatment.	98.96% 7,151	0.97% 70	0.07% 5	7,226	1.01

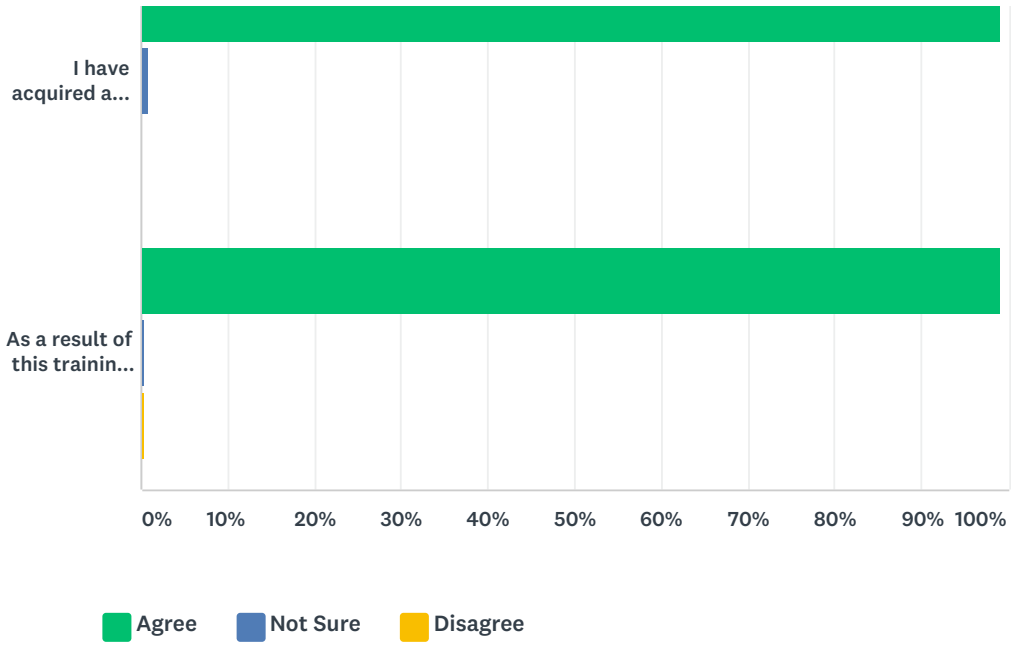
Q7 Please list any recommendations or suggestions for future content (i.e. ways training can be improved)

Answered: 433 Skipped: 6,875

Q1 Please rate each of the following statements.

Answered: 2,743 Skipped: 0





	AGREE	NOT SURE	DISAGREE	TOTAL	WEIGHTED AVERAGE
The learning objectives were met.	99.52% 2,719	0.40% 11	0.07% 2	2,732	1.01
I am able to describe the reporting law and reporting procedure for the State of Delaware.	99.49% 2,726	0.44% 12	0.07% 2	2,740	1.01
I recognize the relationship between physical and behavioral indicators and suspicion of child abuse and neglect.	99.78% 2,735	0.22% 6	0.00% 0	2,741	1.00
I am able to use minimal fact questions when indicators are observed and/or a disclosure is made.	98.72% 2,706	1.20% 33	0.07% 2	2,741	1.01
I know how to respond appropriately when children disclose allegations of abuse or neglect.	99.49% 2,723	0.47% 13	0.04% 1	2,737	1.01
I can identify what information to expect from DFS following a report of child abuse or neglect.	97.99% 2,677	1.90% 52	0.11% 3	2,732	1.02
I have acquired a basic understanding of the civil and criminal definitions in statute for the various types of child maltreatment.	99.09% 2,711	0.91% 25	0.00% 0	2,736	1.01
As a result of this training, I have a better understanding of my reporting obligations under the Medical Practice Act.	99.19% 2,699	0.48% 13	0.33% 9	2,721	1.01

Q2 Please submit any questions you have about the training content here:

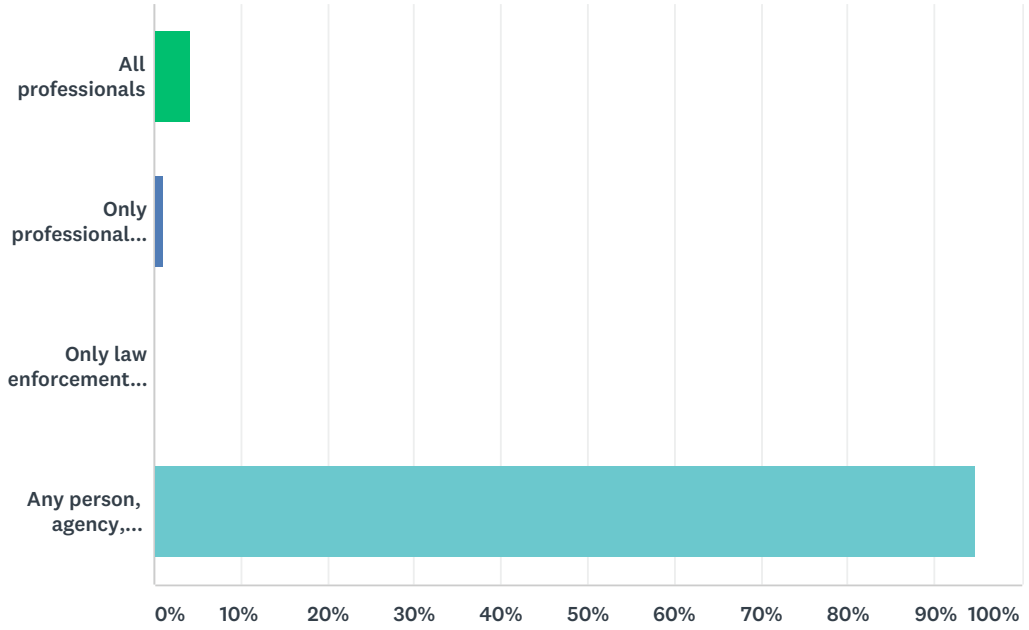
Answered: 286 Skipped: 2,457

Q3 Please list any recommendations or suggestions for future content (i.e. ways training can be improved)

Answered: 360 Skipped: 2,383

Q1 In Delaware, who is mandated to report known or suspected cases of child abuse or neglect?

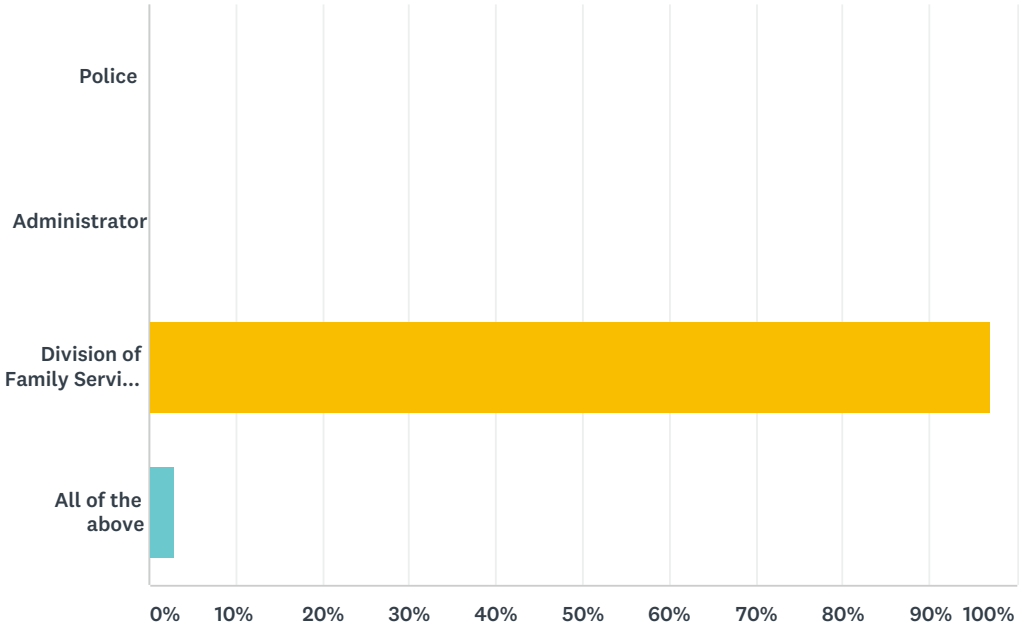
Answered: 212 Skipped: 0



ANSWER CHOICES	RESPONSES	
All professionals	4.25%	9
Only professionals that work directly with children (i.e. teachers, physicians)	0.94%	2
Only law enforcement officers	0.00%	0
Any person, agency, organization or entity	94.81%	201
TOTAL		212

Q2 I am obligated by LAW to FIRST report my suspicions of abuse and neglect to:

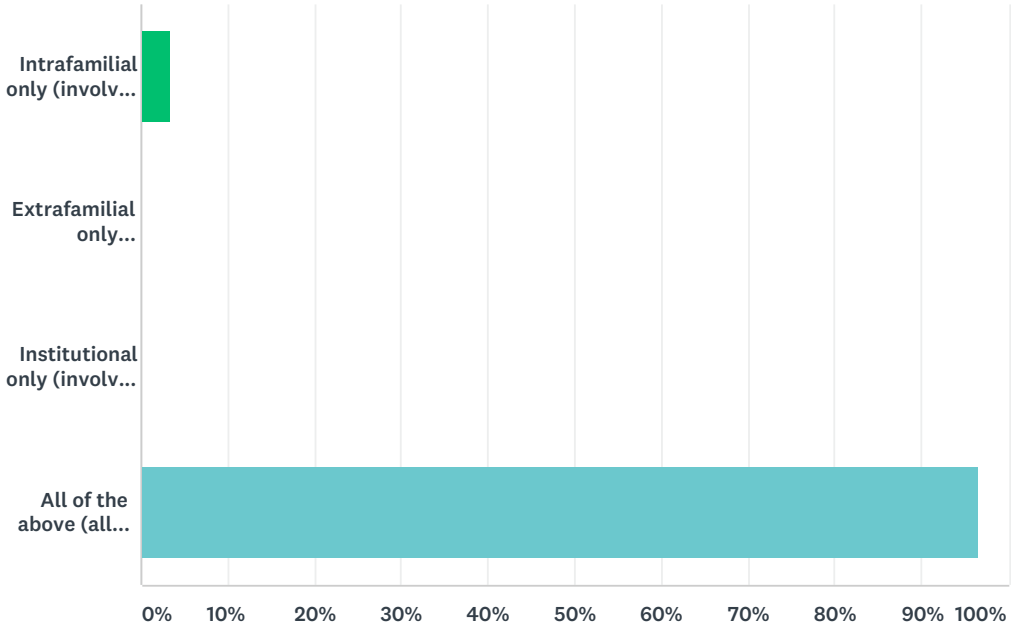
Answered: 210 Skipped: 2



ANSWER CHOICES	RESPONSES	
Police	0.00%	0
Administrator	0.00%	0
Division of Family Services Child Abuse and Neglect Report Line	97.14%	204
All of the above	2.86%	6
TOTAL		210

Q3 What types of cases must be reported to the Division of Family Services Child Abuse and Neglect Report Line?

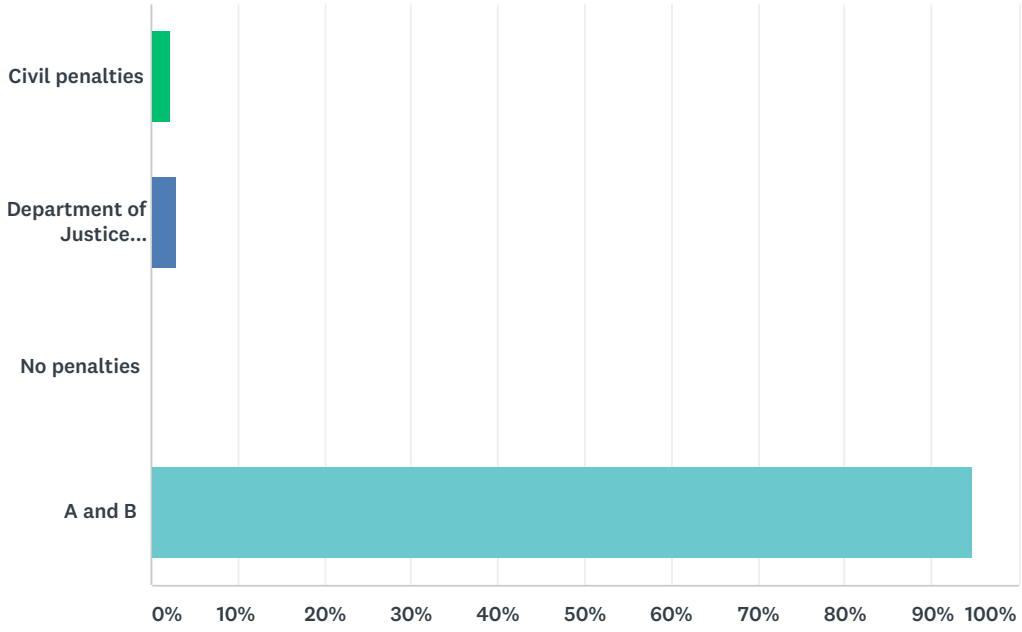
Answered: 209 Skipped: 3



ANSWER CHOICES	RESPONSES	
Intrafamilial only (involving parent, guardian, custodian, or member of the household)	3.35%	7
Extrafamilial only (perpetrator is not a member of the household or family)	0.00%	0
Institutional only (involving licensed child placement facilities)	0.00%	0
All of the above (all suspected abuse and neglect of any child, birth to age 18)	96.65%	202
TOTAL		209

Q4 Failing to report suspicions of abuse or neglect to the Division of Family Services can expose a school employee and school and/or district to:

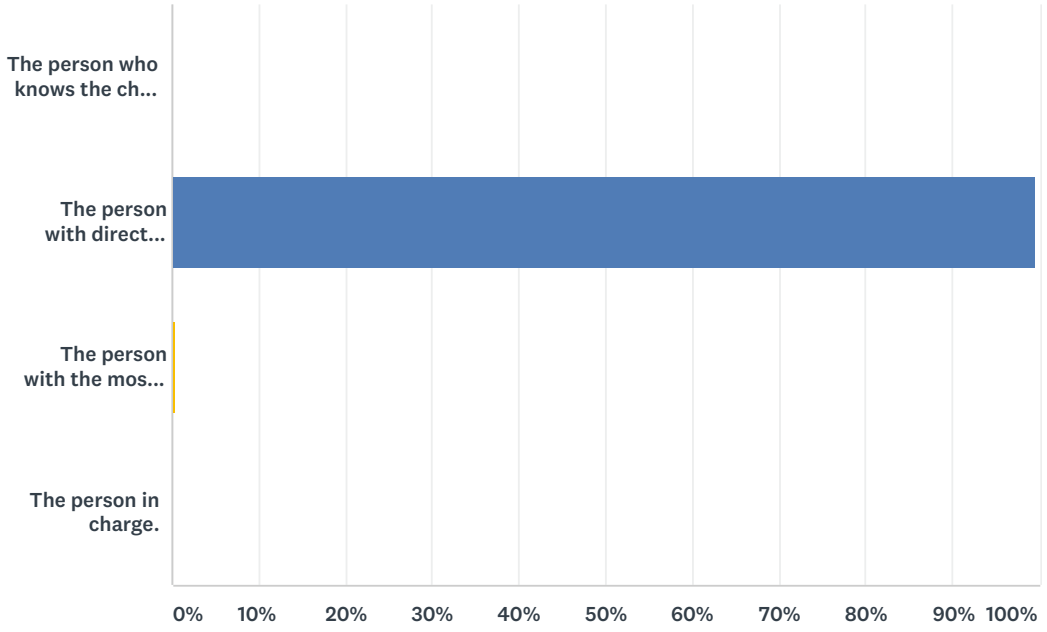
Answered: 209 Skipped: 3



ANSWER CHOICES	RESPONSES	
Civil penalties	2.39%	5
Department of Justice investigation	2.87%	6
No penalties	0.00%	0
A and B	94.74%	198
TOTAL		209

Q5 Which person must make a report to the DFS Child Abuse and Neglect Report Line?

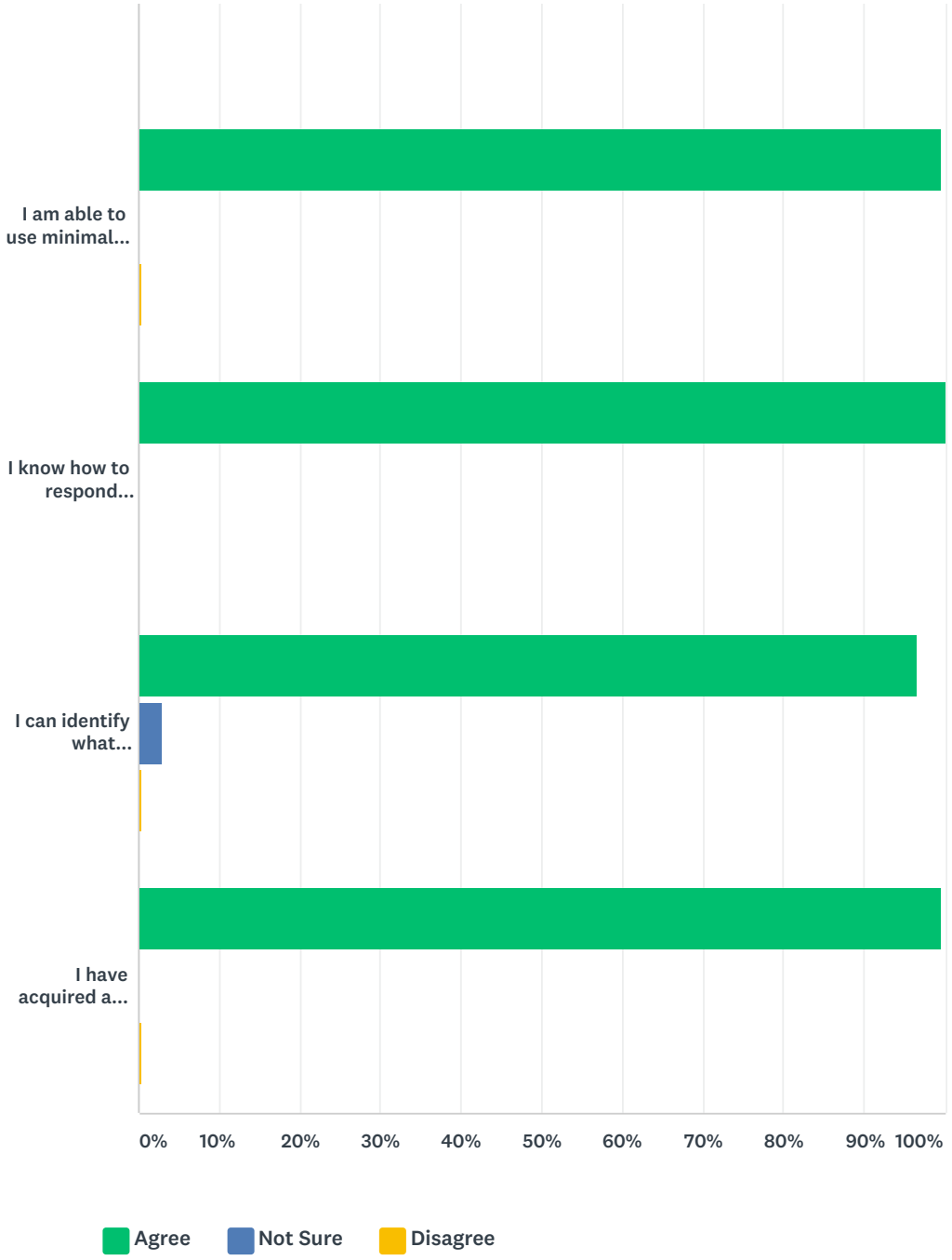
Answered: 208 Skipped: 4



ANSWER CHOICES	RESPONSES	
The person who knows the child best.	0.00%	0
The person with direct knowledge.	99.52%	207
The person with the most time.	0.48%	1
The person in charge.	0.00%	0
TOTAL		208

Q6 Please rate each of the following statements.

Answered: 207 Skipped: 5



	AGREE	NOT SURE	DISAGREE	TOTAL	WEIGHTED AVERAGE
The learning objectives were met.	100.00% 207	0.00% 0	0.00% 0	207	1.00
I am able to describe the reporting law and reporting procedure for the State of Delaware.	99.52% 206	0.48% 1	0.00% 0	207	1.00
I recognize the relationship between physical and behavioral indicators and suspicion of child abuse and neglect.	100.00% 207	0.00% 0	0.00% 0	207	1.00
I am able to use minimal fact questions when indicators are observed and/or a disclosure is made.	99.52% 206	0.00% 0	0.48% 1	207	1.01
I know how to respond appropriately when children disclose allegations of abuse or neglect.	100.00% 207	0.00% 0	0.00% 0	207	1.00

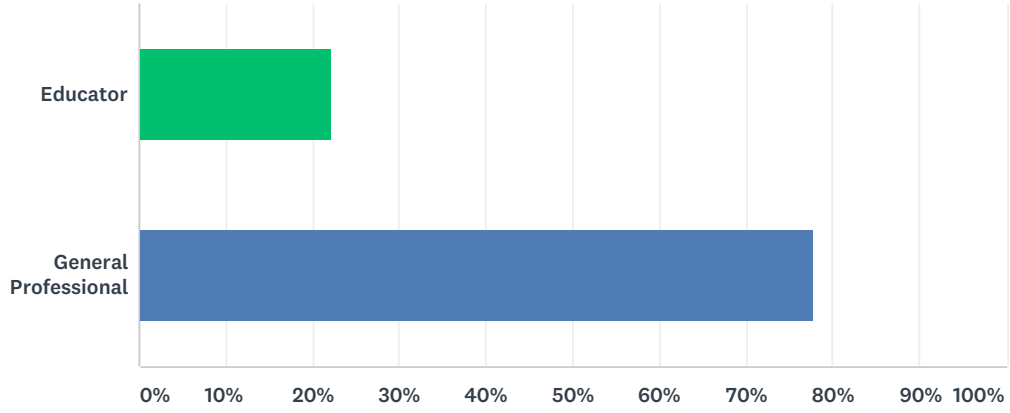
I can identify what information to expect from DFS following a report of child abuse or neglect.	96.62% 200	2.90% 6	0.48% 1	207	1.04
I have acquired a basic understanding of the civil and criminal definitions in statute for the various types of child maltreatment.	99.52% 206	0.00% 0	0.48% 1	207	1.01

Q7 Please list any recommendations or suggestions for future content (i.e. ways training can be improved)

Answered: 30 Skipped: 182

Q1 Please select the reporter group that best describes you.

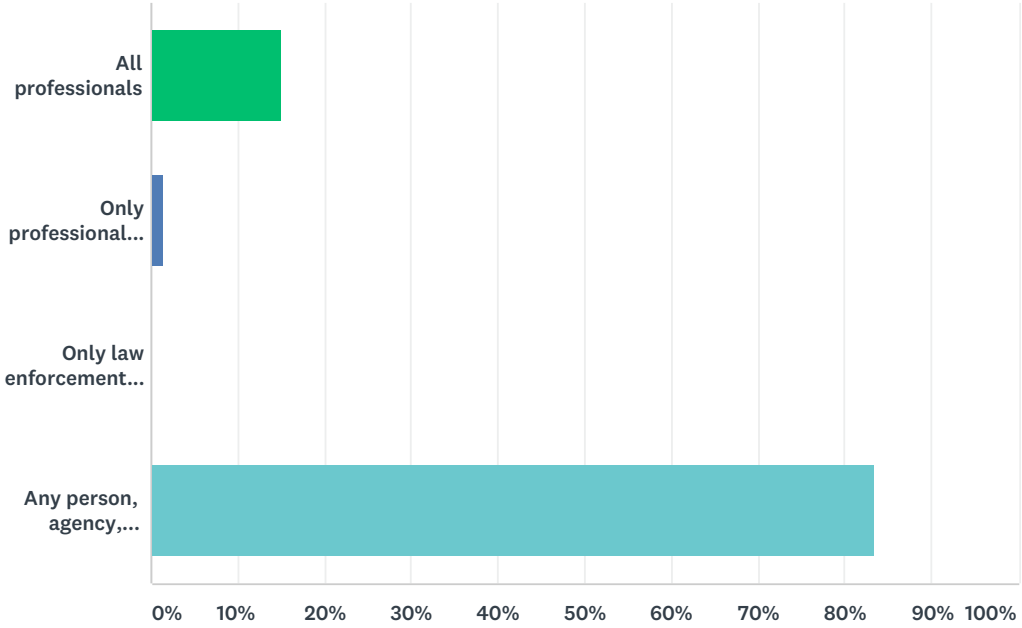
Answered: 342 Skipped: 3



ANSWER CHOICES	RESPONSES	
Educator	22.22%	76
General Professional	77.78%	266
TOTAL		342

Q2 In Delaware, who is mandated to report known or suspected cases of child abuse or neglect?

Answered: 345 Skipped: 0

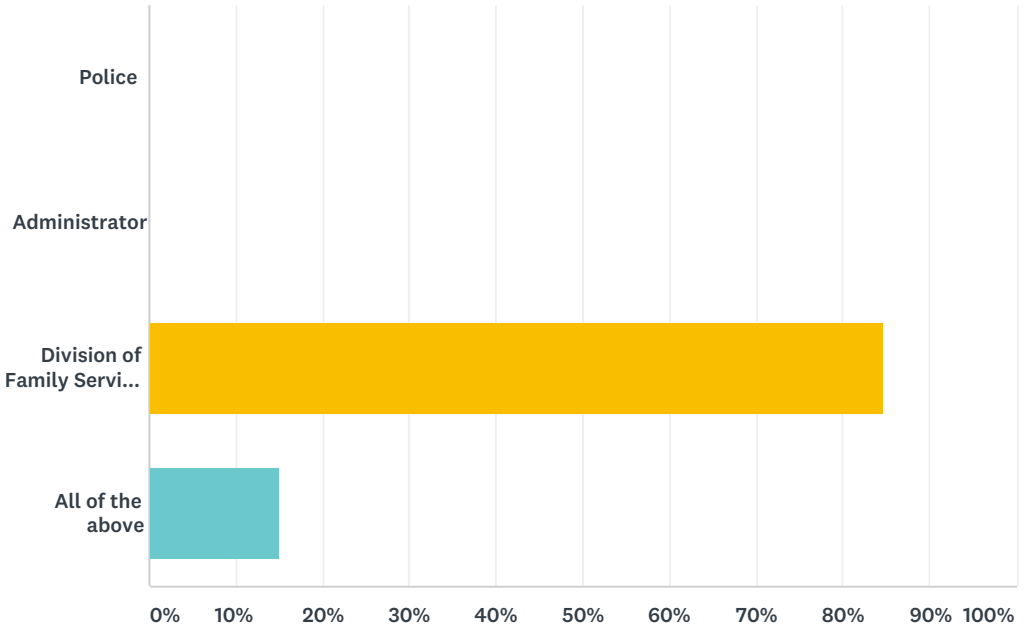


ANSWER CHOICES	RESPONSES	
All professionals	15.07%	52

Only professionals that work directly with children (i.e. teachers, physicians)	1.45%	5
Only law enforcement officers	0.00%	0
Any person, agency, organization or entity	83.48%	288
TOTAL		345

Q3 I am obligated by LAW to FIRST report my suspicions of abuse and neglect to:

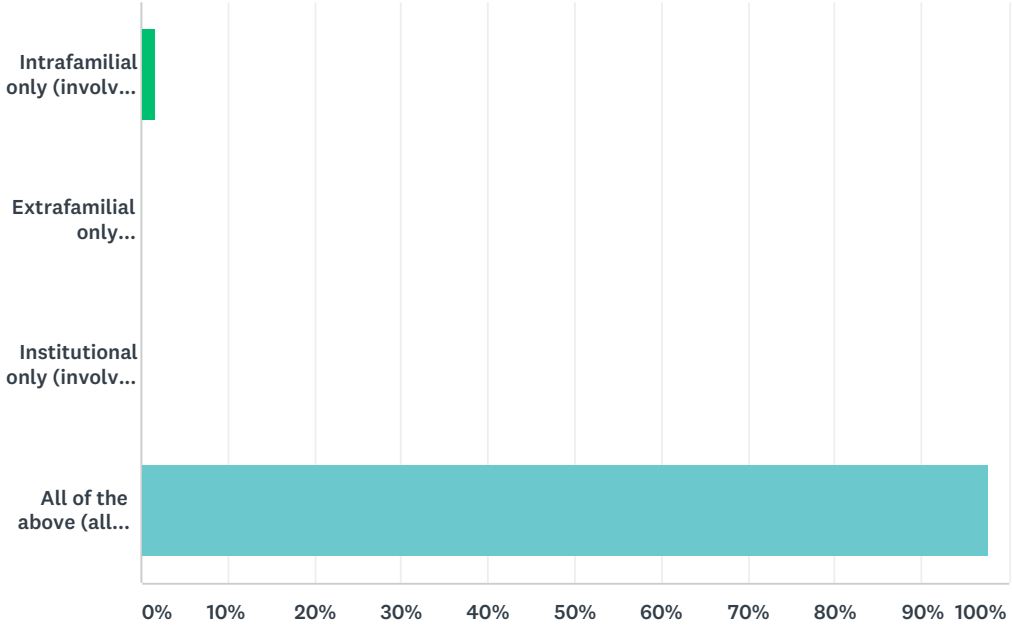
Answered: 345 Skipped: 0



ANSWER CHOICES	RESPONSES	
Police	0.00%	0
Administrator	0.29%	1
Division of Family Services Child Abuse and Neglect Report Line	84.64%	292
All of the above	15.07%	52
TOTAL		345

Q4 What types of cases must be reported to the Division of Family Services Child Abuse and Neglect Report Line?

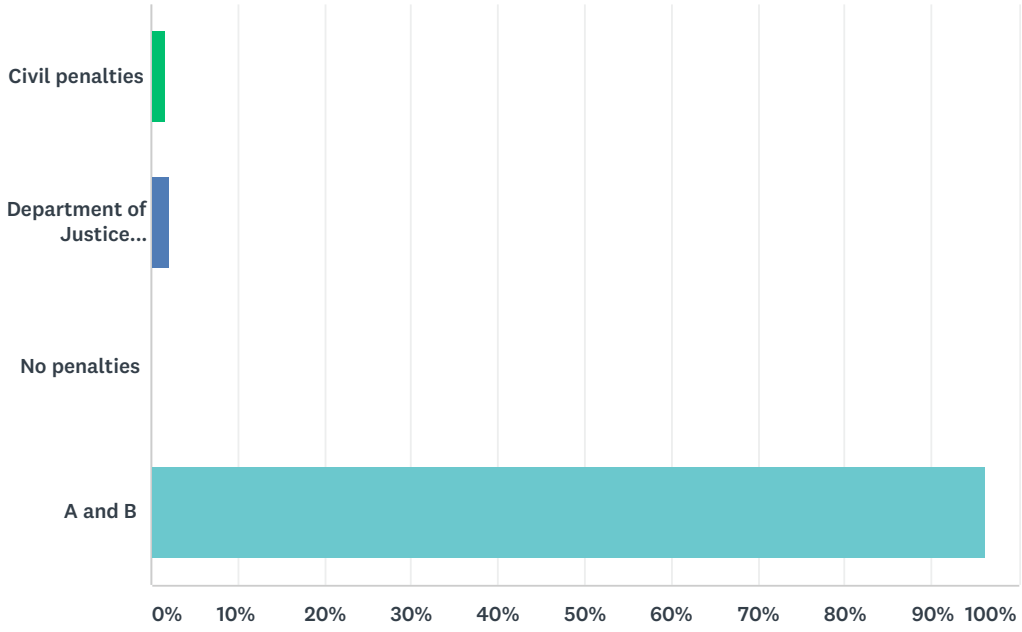
Answered: 343 Skipped: 2



ANSWER CHOICES	RESPONSES	
Intrafamilial only (involving parent, guardian, custodian, or member of the household)	1.75%	6
Extrafamilial only (perpetrator is not a member of the household or family)	0.29%	1
Institutional only (involving licensed child placement facilities)	0.29%	1
All of the above (all suspected abuse and neglect of any child, birth to age 18)	97.67%	335
TOTAL		343

Q5 Failing to report suspicions of abuse or neglect to the Division of Family Services can expose a school employee and school and/or district to:

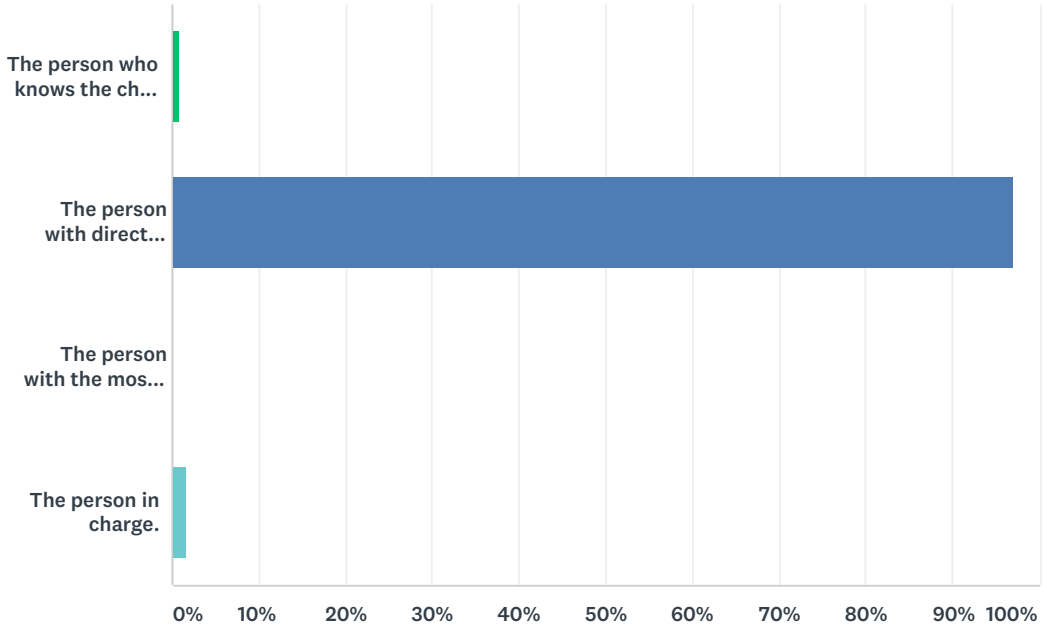
Answered: 343 Skipped: 2



ANSWER CHOICES	RESPONSES	
Civil penalties	1.75%	6
Department of Justice investigation	2.04%	7
No penalties	0.00%	0
A and B	96.21%	330
TOTAL		343

Q6 Which person must make a report to the DFS Child Abuse and Neglect Report Line?

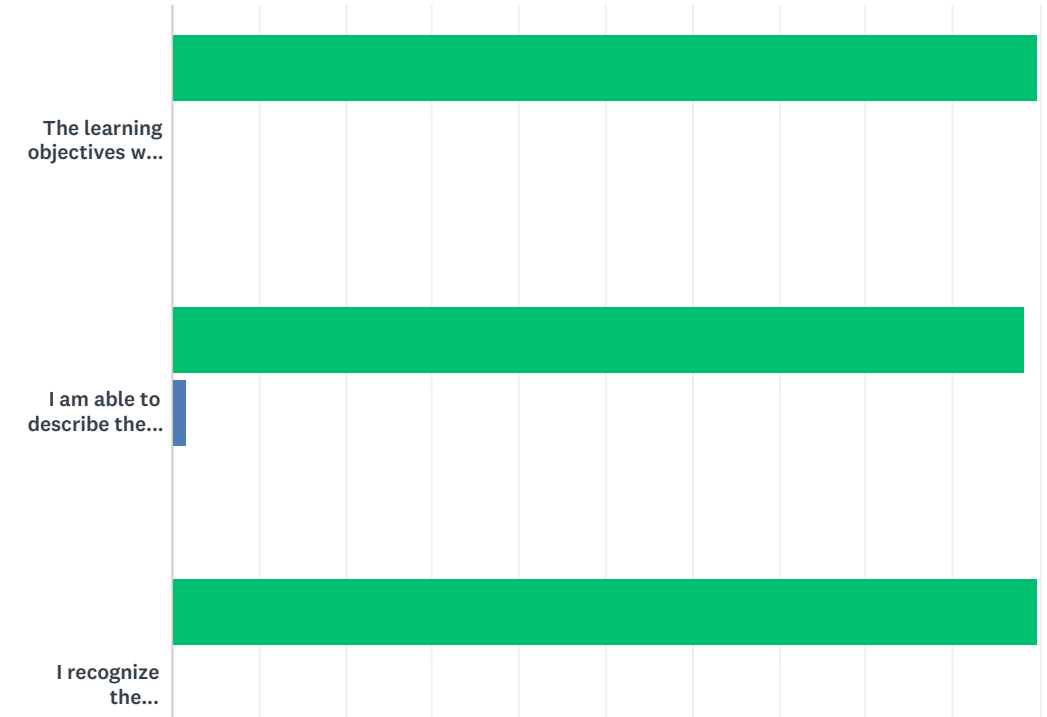
Answered: 343 Skipped: 2

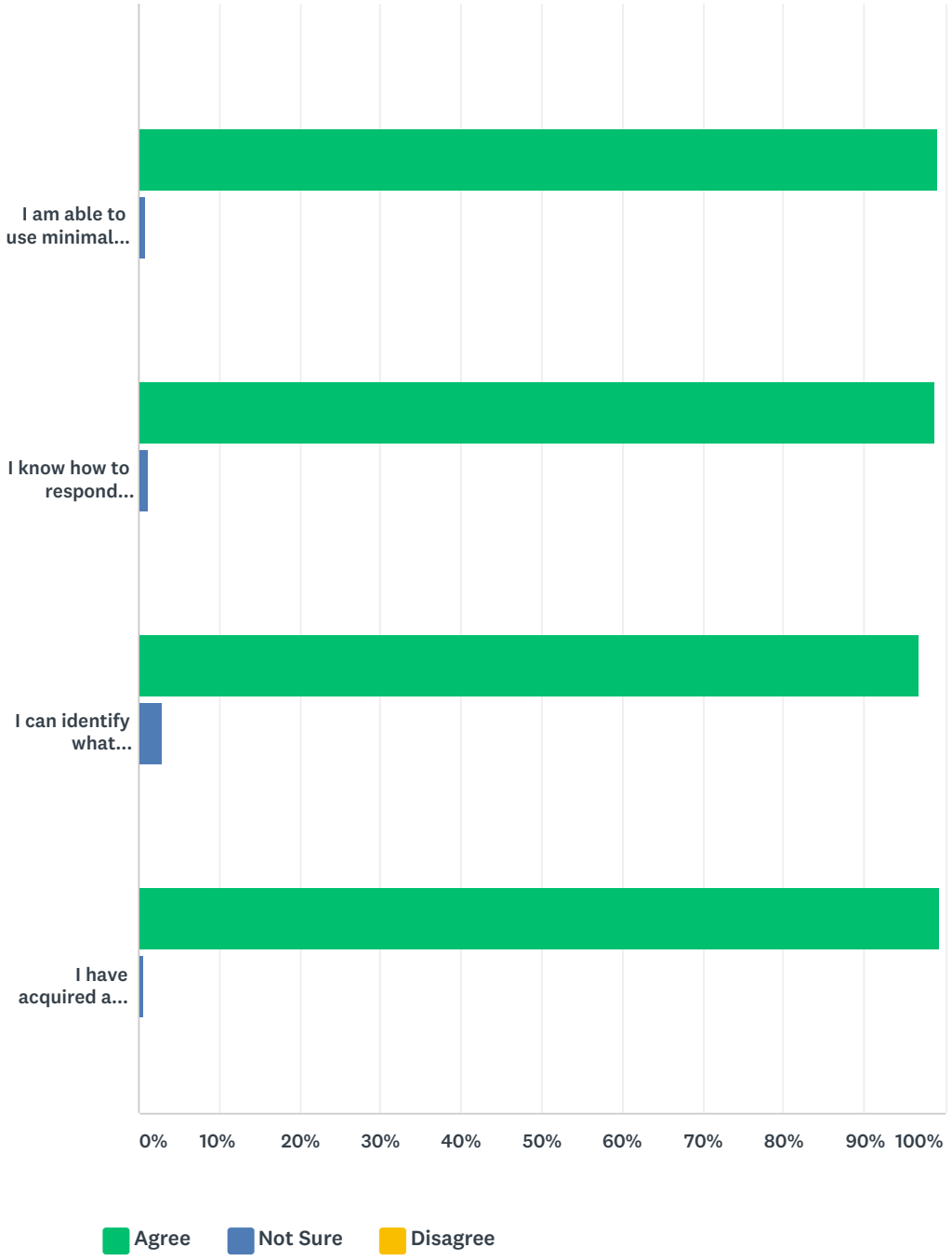


ANSWER CHOICES	RESPONSES	
The person who knows the child best.	0.87%	3
The person with direct knowledge.	97.08%	333
The person with the most time.	0.29%	1
The person in charge.	1.75%	6
TOTAL		343

Q7 Please rate each of the following statements.

Answered: 343 Skipped: 2





	AGREE	NOT SURE	DISAGREE	TOTAL	WEIGHTED AVERAGE
The learning objectives were met.	99.71% 342	0.29% 1	0.00% 0	343	1.00
I am able to describe the reporting law and reporting procedure for the State of Delaware.	98.25% 337	1.75% 6	0.00% 0	343	1.02
I recognize the relationship between physical and behavioral indicators and suspicion of child abuse and neglect.	99.71% 342	0.29% 1	0.00% 0	343	1.00
I am able to use minimal fact questions when indicators are observed and/or a disclosure is made.	99.13% 340	0.87% 3	0.00% 0	343	1.01
I know how to respond appropriately when children disclose allegations of abuse or neglect.	98.83% 339	1.17% 4	0.00% 0	343	1.01

I can identify what information to expect from DFS following a report of child abuse or neglect.	96.79% 332	2.92% 10	0.29% 1	343	1.03
I have acquired a basic understanding of the civil and criminal definitions in statute for the various types of child maltreatment.	99.42% 341	0.58% 2	0.00% 0	343	1.01

Q8 Please list any recommendations or suggestions for future content (i.e. ways training can be improved)

Answered: 55 Skipped: 290

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

May 2018 - May 2019

FINDINGS

	*Current	**Prior	Grand Total
Risk Assessment/ Caseloads	**70**	**1**	**71**
Caseloads	40		40
Collaterals	9		9
Reporting	1		1
Risk Assessment - Alternative Response	1		1
Risk Assessment - Closed Despite Risk Level	4		4
Risk Assessment - Screen Out	1	1	2
Risk Assessment - Tools	11		11
Risk Assessment - Unsubstantiated	3		3
Safety/ Use of History/ Supervisory Oversight	**51**		**51**
Completed Incorrectly/ Late	28		28
Inappropriate Parent/ Relative Component	11		11
No Safety Assessment of Non-Victims	2		2
Oversight of Agreement	6		6
Reporting	1		1
Supervisory Oversight	2		2
Use of History	1		1
Grand Total	**121**	**1**	**122**

*Current - within 1 year of incident
**Prior - 1 year or more prior to incident

Child Protection Accountability Commission
Child Abuse and Neglect Panel
Findings Detail and Rationale
May 2018 - May 2019

FINDINGS

System Area	Finding	PUBLIC Rationale	Sum of #
Risk Assessment/ Caseloads			71
	Caseloads		40
		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.	6
		The DFS case workers were over the investigation and treatment caseload statutory standards while the cases were open. It does not appear that the caseload negatively impacted the DFS response to the investigation; however, the caseload appears to have had a negative impact on the treatment 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 had a negative impact on the DFS response in the case.	4
		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.	4
		The DFS case worker was over the investigation caseload statutory standards while the case was open. However, the caseload did not negatively impact the DFS response in the near death investigation.	1
		The DFS case worker was over the investigation caseload statutory standards while the case was open. However, the caseload did not negatively impact the DFS response in the near death investigation. Treatment was not above standard.	1
		The DFS case workers were over the investigation and treatment 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 caseworker was over the investigation caseload statutory standard during the prior investigation, 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 the entire time the case was open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	5
		The DFS family and institutional abuse caseworkers were 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 DFS caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it is unclear whether the caseload had a negative impact on the DFS response in the case.	1
		The DFS caseworker was over the investigation caseload statutory standards the entire time the current case was open. However, it is unclear whether the caseload had a negative impact on the DFS response in the case.	3
		The DFS caseworkers were over the investigation caseload statutory standards during the current and prior investigations. However, it does not appear that the caseload 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. The caseload does appear to have had a negative impact on the response in one prior case; however, it was unclear whether the caseload had a negative impact on the DFS response in the other cases, including the death investigation.	1
	The DFS caseworkers were over the investigation caseload statutory standards during the current and prior investigations. However, it is unclear whether the caseload had a negative impact on the DFS response in these cases.	2
	The DFS caseworkers were over the investigation caseload statutory standards during the current and prior investigations. The caseload does appear to have had a negative impact on the response in one prior case; however, it does not appear that the caseload negatively impacted the DFS response to the death investigation.	1
	The caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it is unclear whether the caseload had a negative impact on the DFS response in the case.	2
	The caseworkers were over the investigation caseload statutory standards the entire time the cases were open, and the caseload appears to have had a negative impact on the response in the prior case. There was no impact in the death investigation.	1
	The DFS caseworker was over the investigation caseload statutory standards the entire time the current case was open, and the caseload appears to have had a negative impact on the response in the case.	1
	The DFS caseworker assigned to the first report involving the sibling was over the investigation caseload statutory standards, and the caseload appears to have had a negative impact on the response for that incident as there was no documentation regarding the outcome.	1
	The DFS case workers were over the investigation and treatment caseload statutory standards while the cases were open. It is unclear whether the caseload had a negative impact on the DFS response in the near death investigation; however, the caseload appears to have had a negative impact on the treatment worker's contacts.	1
Collaterals		9
	History with the out of state child protective services agency was not checked until DFS was court ordered to do so.	1
	During the prior investigation, a collateral contact with the PCP was not completed for the children, and there was no communication with the PCP regarding the safety agreement.	1
	The supervisor closed the prior investigation against the risk score despite not having the collateral information from the substance abuse provider.	1
	In the prior investigation, the home visiting agency reported concerns that the parents were under the influence, and the case worker addressed the concerns by phone and not in person.	1

	At the close of the near death investigation, a Framework was completed and recommended a collateral with the substance abuse provider. However, no collateral was completed, and the case was closed against the risk score.	1
	History with the out of state child protective services agency was not checked by the DFS caseworker.	1
	For the prior investigation, a collateral contact was not completed with the physician prescribing the mother's benzodiazepine.	1
	The primary care physician noted the young sibling's skull fracture in its collateral contact with DFS; however, the DFS caseworker did not follow up to gather additional details about the injury.	1
	During the investigation, a collateral contact was not completed with the mother's substance abuse treatment provider to confirm her participation in treatment.	1
Reporting		1
	During the near death incident, a sibling reported allegations of abuse by the mother's paramour, and the caseworker did not contact the DFS Report Line or conduct an interview with the mother's paramour.	1
Risk Assessment - Alternative Response		1
	Consistent with DFS Policy, the SDM Screening Assessment screened out the prior report for investigation since the domestic violence was not chronic and/or severe. Since differential response is not available for this population, no intervention was provided.	1
Risk Assessment - Closed Despite Risk Level		4
	It does not appear that the linked investigation was considered in the decision to close the prior treatment case. The treatment case was quickly closed after the substantiated incident, and the mother failed to complete her parenting classes.	1
	The SDM Risk Assessment identified the risk as high in the prior investigation. Ongoing service was recommended; however, the case disposition was overridden to close the investigation after a Framework was completed.	1
	The SDM Risk Assessment identified the risk as high at the conclusion of the prior investigation. Ongoing service was recommended; however, the case disposition was overridden to close the investigation and a Framework was not considered.	1
	The SDM Risk Assessment identified the risk as high at the conclusion of the prior investigation. Ongoing service was recommended; however, the case disposition was overridden to close the investigation. It was not clear whether substance abuse treatment services were in place for the parents.	1
Risk Assessment - Screen Out		2
	The DFS Report Line screened out a prior hotline report, which alleged that the victim was born substance exposed. The following risk factors were not considered: DFS history and mother's substance abuse and mental health history.	1
	The call by the hospital to the DFS Report Line was written as a hotline progress note rather than a new report. It appears that multiple calls were made by the hospital that were not documented.	1

Risk Assessment - Tools		11
	For the near death investigation, the SDM Risk Assessment was not completed correctly. The father's substance abuse and previous cases were not taken into consideration, and as a result, the risk was scored as moderate.	1
	For the near death incident, the SDM Risk Assessment was not completed correctly. The policy override for a severe non-accidental injury was not selected, so the case was closed.	1
	In the near death investigation, the SDM Risk Assessment was not completed correctly. The policy override for non-accidental injury to a non-verbal child was not selected, so the case was closed.	1
	For the near death incident, the SDM Risk Assessment was not completed correctly. The mother's mental health and father's substance abuse was not taken into consideration.	1
	For the near death incident, the SDM Risk Assessment was not completed correctly. The mother's out of state criminal history and child protective services history was not considered.	1
	For the prior investigation, the SDM Risk Assessment was not completed correctly. The risk was scored as moderate; however, it is unclear whether the risk rating had an impact since the case was already active in treatment.	1
	For the near death incident, the SDM Risk Assessment was not completed correctly as the paramour was not included as a caregiver. The case was also closed against the risk since the paramour no longer resided in the home; however, a framework was not considered.	1
	In the prior investigation, the SDM Risk Assessment was not completed correctly. The risk was scored as moderate; however, the parents' substance abuse issues were not rated.	1
	In the prior investigation, the SDM Risk Assessment was not completed correctly. The risk was scored as moderate; however, the DFS history was not considered.	1
	For the near death investigation, the policy override was not considered for the SDM Risk Assessment. As a result, the risk was scored as moderate and the case was closed.	1
	The treatment case was closed with a discretionary override shortly after the investigation concluded. A safety threat was still present, and there was no documentation about the override.	1
Risk Assessment - Unsubstantiated		3
	There was no finding of abuse or neglect in the investigation despite the perpetrator's admission of guilt and criminal charges.	1
	For the near death incident, DFS did not consider a Level 4 finding after the child sustained injuries consistent with head trauma. Instead, a Level 3 finding was made.	1
	For the prior investigation, DFS did not consider a finding of medical neglect despite the mother's delay in seeking medical care for her special needs child.	1

Safety/ Use of History/ Supervisory Oversight		51
	Completed Incorrectly/ Late	28
	For the near death incident, the caseworker incorrectly identified the child as safe in the SDM safety assessment. As a result, there was no safety agreement, and second shift authorized the hospital to discharge the child to her mother, the alleged perpetrator.	1
	For the near death incident, the caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization.	1
	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
	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
	For the near death incident, the caseworker identified the victim as safe with agreement in the SDM safety assessment. However, the initial safety agreement did not consider the hospitalized victim. There was clear communication that mom should not have contact with him though.	1
	DFS completed a safety agreement with the father and agreed that the victim could reside in his care, without visiting the home.	1
	In the prior investigation, DFS entered into a safety agreement with a relative, but an interview and home assessment were not conducted.	1
	The initial safety agreement permitted only unsupervised contact between the suspect, victim and siblings, but it could have been stronger at the time of the initial response.	1
	DFS entered into a safety agreement with a relative, but a home assessment was not initially conducted and the relative was not contacted in person.	1
	For the death investigation, DFS completed a safety agreement with the father prior to completing collateral contacts with substance abuse providers.	1
	For the death investigation, DFS completed a safety agreement with the mother prior to completing collateral contacts with substance abuse and other providers.	1
	DFS entered into a safety agreement with a relative, but a home assessment was not initially conducted.	1
	For the first report involving the drug exposed infant, DFS completed a safety agreement with the mother and another relative prior to completing collateral contacts with substance abuse and mental health providers.	1
	For the prior investigation, DFS entered into a safety agreement with a relative, but a home assessment was not initially conducted.	1
	For the near death incident, DFS entered into a safety agreement with a relative, but a home assessment was not initially conducted.	1
	DFS entered into a safety agreement with a relative at the parents' home, but a home assessment was not initially conducted and the relative was not contacted in person.	1

	For the near death incident, the victim and sibling were initially determined to be safe. However, the victim's injury and DFS history were not considered as safety threats in the SDM Safety Assessment.	1
	In the prior investigation, a safety agreement was not implemented for the infant born with prenatal substance exposure despite safety threats being present due to the current circumstances and DFS history.	1
	In the prior investigation, DFS completed a safety agreement with the father prior to completing collateral contacts with substance abuse providers.	1
	For the prior report, the case worker did not complete the SDM safety assessment correctly, and there was no safety agreement. The victim was permitted to remain in the home with a primary caregiver, who had significant DFS history and a child in foster care.	1
	For the near death investigation, the case worker did not complete the SDM safety assessment correctly, and there was no safety agreement. Mother was verbally told that she was permitted no contact with the children.	1
	In the prior investigation, the case worker did not complete the SDM safety assessment correctly, and there was no safety agreement. The victim was evaluated for bruising to his face and abuse could not be ruled out.	1
	For the near death investigation, the case worker did not complete the SDM safety assessment correctly, and there was no safety agreement. As a result, there was no follow up about use of a lock box to store the medications.	1
	For the death investigation, DFS entered into a safety agreement with a relative, but an interview and home assessment was not conducted to assess her ability to act as a safety participant.	1
	For the near death investigation, DFS did not conduct a home assessment prior to the infant's discharge from the hospital.	1
	The SDM Safety Assessment was not completed correctly for the near death incident. The safety threat for access to dangerous objects in the house was marked no, and the child was determined to be safe.	1
	For the near death investigation, DFS entered into a safety agreement with several participants, but interviews were not conducted with these participants to assess their ability to act as a safety participant.	1
	For the near death incident, the child was released to the mother with a child safety agreement. However, it did not adequately address the safety threat.	1
Inappropriate Parent/ Relative Component		11
	For the near death incident, DFS completed a safety agreement with the parents, who were not ruled out as suspects.	1
	For the near death incident, safety was not reassessed once the medical findings suggested a different timeline for the injury. DFS continued to safety plan with the mother, who could not be ruled out as a suspect.	1
	For the prior investigation, DFS entered into a safety agreement with a relative, who was not an appropriate caregiver due to DFS history and the conditions of the home.	1
	For the near death incident, DFS completed a safety agreement with the mother, who was not ruled out as a suspect.	1

	For the near death incident, DFS completed a safety agreement with relatives, who were not ruled out as suspects.	1
	After the near death incident, DFS entered into a safety agreement allowing mother only supervised contact with the child by an appropriate adult. However, the safety intervention did not adequately address the safety threat as no other participants were identified.	1
	For the near death incident, DFS completed a safety agreement with a relative, who was not ruled out as a suspect.	1
	Following the report of a substance-exposed infant, DFS entered into a safety agreement with the father. However, he was not an appropriate caregiver due to DFS and criminal history.	1
	Following the report of an infant with prenatal substance exposure, DFS entered into a safety agreement with the father. However, he was not an appropriate caregiver due recent DFS and substance abuse history.	1
	For the near death investigation, DFS entered into a safety agreement with a relative. However, she was not an appropriate caregiver due to her ongoing substance abuse.	1
	For the near death investigation, DFS entered into a safety agreement with a non-related caregiver. However, she was not an appropriate caregiver due to her DFS and criminal histories, and she was not ruled out as a suspect.	1
	No Safety Assessment of Non-Victims	2
	During the near death investigation, the case worker did not assess whether the relative caregiver had child(ren) residing in his/her home. As a result, safety was not assessed for the relative caregiver's child.	1
	The DFS caseworker left the siblings in the home with the alleged perpetrator when the victim was taken to the hospital for an immediate medical evaluation. As a result, the alleged perpetrator fled with the siblings.	1
	Oversight of Agreement	6
	The SDM Safety Agreement was not re-evaluated in a timely manner.	1
	The treatment worker's first contact with the family was delayed, and the child safety agreement was not reviewed in a timely manner. The near death incident was reported several days later.	1
	The SDM Safety Agreement was not re-evaluated in a timely manner. It was reviewed in the first 30 days but subsequent reviews were not timely.	1
	The SDM Safety Agreement was not re-evaluated in a timely manner during the near death investigation.	1
	DFS terminated the safety agreement without consideration of the following: infant with injuries resulting from neglect, new report of domestic violence, collateral information from the substance abuse provider, and the family's significant DFS history.	1
	For the case involving the infant with prenatal substance exposure, DFS terminated the safety agreement; however, the mother's substance abuse issues continued to be an ongoing risk factor.	1

	Reporting	1
	The agency contracted to monitor the child's placement failed to make a hotline report to the DFS Report Line after the child sustained an injury to his forehead.	1
	Supervisory Oversight	2
	The safety agreement was terminated without having any face to face contact with the family, and the case worker had no contact with the family for several months after the safety agreement was terminated.	1
	The subsequent safety agreements for the victim could have been stronger. DFS entered into safety agreements with mother and two other participants, and there were several risk factors for mother and minimal oversight of the agreements.	1
	Use of History	1
	DFS custody could have been considered much earlier for the young child and sibling due to the serious physical injury to one child and failure to thrive, decline in weight and multiple hospitalizations for both children.	1
Grand Total		**122**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

May 2018 - May 2019

STRENGTHS		
	***Current**	**Grand Total**
Risk Assessment/ Caseloads	**31**	**31**
Collaterals	16	16
Reporting	3	3
Risk Assessment - Substantiated	7	7
Risk Assessment - Tools	3	3
Use of History	2	2
Safety/ Use of History/ Supervisory Oversight	**36**	**36**
Completed Correctly/On Time	12	12
Custody/Guardianship Petitions	4	4
Oversight of Agreement	13	13
Safety Assessment of Non-Victims	3	3
Supervisory Oversight	3	3
Use of History	1	1
Grand Total	**67**	**67**

**Current - within 1 year of incident*

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

Child Protection Accontability Commission
Child Abuse and Neglect Panel
Strengths Detail and Rationale
May 2018 - May 2019

STRENGTHS

System Area	Strength	Rationale	Count of #
Risk Assessment/ Caseloads			31
	Collaterals		16
		Within 48 hours of the incident, the DFS case worker contacted the local hospital to obtain the child's birth history.	1
		The DFS case worker maintained quality contact with the family.	1
		The DFS investigation case worker referred Mother and maternal grandfather for substance abuse evaluations.	1
		The DFS treatment case worker maintained timely and quality contact with the family.	1
		The DFS case worker maintained quality contact with the family during the investigation.	1
		Strong collateral contacts were completed during the current and prior DFS investigations.	1
		The DFS treatment case worker maintained quality contact with the family, and ensured appropriate referrals were made for Mother and child.	1
		Strong collaterals were completed, to include Mother's OB/Gyn physician.	1
		There was good follow-up and collaterals completed by the DFS case worker relating to Mother's mental health and substance abuse.	1
		The DFS treatment caseworker maintained quality contact with Mother and had good follow-up relating to Mother's substance abuse history.	1
		During the near death investigation, the DFS investigation caseworker and the treatment caseworker completed collaterals with Mother's substance abuse treatment provider.	1
		Strong collaterals were completed, to include parents' pain management doctors and Father's mental health treatment provider.	1
		Strong collateral contacts were completed during the prior investigation.	1
		The DFS case worker maintained quality contact with the family during the prior investigation. The contact was both announced and unannounced.	1
		The DFS permanency caseworker maintained quality contact with the adoptive family.	1
		The DFS investigation caseworker referred Mother and Father for substance abuse evaluations, and completed follow up with the substance abuse provider.	1
	Reporting		3
		The DFS caseworker made a report to the National Human Trafficking Hotline for the children.	3
	Risk Assessment - Substantiated		7
		DFS substantiated Mother for Life Threatening Medical Neglect as a result of the near death incident.	1
		At the conclusion of its investigations, DFS made appropriate findings against the perpetrator and the non-offending caregiver as a result of the child's injuries and violation of the no contact order.	1

	At the conclusion of the investigation, DFS made appropriate findings against the perpetrator as a result of the child's injuries.	1
	At the conclusion of its investigation, DFS made an appropriate finding against Mother as a result of the children's injuries.	2
	At the conclusion of its investigation, DFS made appropriate findings against the perpetrator and the non-offending caregiver as a result of the child's injuries and failure to seek medical treatment.	1
	At the conclusion of its investigation, DFS made an appropriate finding against Father as a result of the child's death.	1
Risk Assessment - Tools		3
	A Framework was completed during the investigation case.	2
	During the prior investigation, a Framework was completed.	1
Use of History		2
	The DFS case worker consulted with an out of state child protection agency regarding any history for the step-father.	1
	The DFS caseworker consulted with two out of state child protection agencies and completed National Crime Information Center (NCIC) checks for the adults residing in the household.	1
Safety/ Use of History/ Supervisory Oversight		36
Completed Correctly/On Time		12
	Following re-implementation of the safety agreement, the DFS case worker physically checked the child for any new bruising/marks and documented the findings.	1
	The DFS case worker implemented a safety agreement while the child was hospitalized, and it required supervised contact between the child and parents at the hospital.	1
	The DFS case worker immediately implemented a safety agreement prohibiting contact between the victim and the alleged perpetrator.	1
	The after-hours DFS case worker implemented a safety agreement while the child was hospitalized prior to the circumstances changing with the timeline.	1
	The DFS case worker implemented a safety agreement while the child was hospitalized, and it required supervised contact between the child and the mother at the hospital.	1
	The DFS case worker implemented a safety agreement while the child was hospitalized, and it restricted contact between the child and the parents at the hospital.	2
	The DFS case worker implemented a safety agreement while the child was hospitalized, and it required supervised contact between the child, the parents, and the maternal grandmother at the hospital.	1
	The DFS case worker implemented safety agreements for the surviving children in the home, and it restricted contact between the children and the foster parents, as well as included safeguarding the pool.	1
	Although verbally, not in writing, Mother's contact with the children was immediately restricted by DFS and law enforcement.	2

	The DFS caseworker traveled to Father's out of state home to conduct an assessment prior to modifying the child safety agreement.	1
Custody/Guardianship Petitions		4
	DFS petitioned for custody of the child quickly.	1
	During the near death incident, the DFS investigation case worker immediately petitioned for custody.	1
	During the near death investigation, DFS sought custody of the children quickly.	1
	DFS sought input from the Civil DAG and convened a TDM to discuss considerations for DFS custody.	1
Oversight of Agreement		13
	There was consistent review and modification, when necessary, of the safety agreement by the DFS caseworker.	4
	There was consistent review and modification, when necessary, of the safety agreement(s) by the DFS caseworker.	1
	The DFS case worker reassessed safety when new information was received from Mother's substance abuse treatment facility.	1
	There was consistent review and modification, when necessary, of the safety agreement by the DFS case worker.	2
	There was consistent review, and modification, when necessary, of the safety agreement by the DFS case worker.	2
	There was consistent review and modification, when necessary, of the safety agreement by the DFS case worker. The safety agreement was MDT-informed.	1
	There was consistent review and modification, when necessary, of the safety agreement by the DFS caseworker. The caseworker was also seeing the family monthly.	1
	During the prior investigation, there was consistent review, and modification, when necessary of the safety agreement by the DFS case worker.	1
Safety Assessment of Non-Victims		3
	The after-hours DFS case worker immediately implemented a safety agreement for the two siblings residing in the home.	1
	The after-hours DFS case worker implemented safety agreements for the children and ensured home assessments were completed for all participants.	1
	The DFS caseworker implemented a child safety agreement with the siblings residing outside the home. The safety agreement was reviewed and modified, when necessary.	1
Supervisory Oversight		3
	There was strong adminitrative oversight during the investigation and treatment cases as the parents and relatives were adamant that the child was not abused, and as a result, the safety agreements were not necessary.	1
	Due to the extenuating circumstances of the case, the DFS supervisor was very involved with the near death investigation.	2
Use of History		1
	Upon receipt of the second hotline call following the child's birth, an investigation case was opened.	1
Grand Total		**67**