State of Delaware

Child Protection Accountability Commission (CPAC)

Children's Justice Act

Annual Progress Report and Grant Application

And

2018 Three-Year Assessment Report

May 31, 2018

State of Delaware
Child Protection Accountability Commission
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Table of Contents

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 on the Task Force.
Major Robert McLucas, New Castle County Police Department		Major Robert McLucas represents the New Castle County Police Department on the Task Force.
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.
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.

Name and Title	Task Force Designation	Description
Allan De Jong, M.D., Medical Director, 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 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 continuum of prevention services, early intervention services, and mental health and substance abuse (behavioral health) treatment programs 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.
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.
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.

Name and Title	Task Force Designation	Description
Nicole Magnusson	Adult former victims of child abuse and or neglect	Ms. Magnusson is a Communications Assistant at the Office of the Attorney General Matthew P. Denn. She was appointed to CPAC after the statutory changes were approved on July 15, 2014.
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 Chair of the Child Placement Review Board; (8) The Secretary of the Department of Education; (9) The Director of the Division of Prevention and Behavioral Health Services; (10) The Chair of the Domestic Violence Coordinating Council; (11) The Superintendent of the Delaware State Police; (12) The Chair of the Child Death Review Commission; (13) The Investigation Coordinator, as defined in § 902 of this title; (14) One youth or young adult who has experienced foster care in Delaware,

appointed by the Secretary of the Department; (15) One Representative from the Office of Defense Services, appointed by the Chief Defender; and (16) Seven 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 4 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 Coordinator, 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, who monitors 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 7 committees: Abuse Intervention, 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 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: To implement the Memorandum of Understanding (MOU) 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 reporting by school employees, the movement of children in foster care in and out of schools and the sharing of information. In addition, a training curriculum around the MOU should be developed and available to all new persons as they come into the system; 2. To improve collaboration overall between the child welfare system and education, and ensure that it is available on an ongoing basis, including in a web-based format; and 3. To look at educational outcomes for children in foster care and explore 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.

iii. Meeting Frequency and Minutes

The Task Force meets on a quarterly basis to oversee the work of its 7 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 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 Application, Annual Report 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 2017-May 2018)

i. Description of Activities Using CJA Funds

a. Activity: Contract with a Training Coordinator

Description: The Task Force contracted with a Training Coordinator 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 responsibilities of the Training Coordinator include: identifying training needs; annually updating and revising the mandatory reporting training programs; providing in-person mandatory reporting training to educators and general professional audiences; collaborating with educators and the medical community to make the mandatory reporting trainings available on their professional development systems; facilitating train-the-trainer sessions; 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; and staffing the CPAC Abuse Intervention and Training Committees. The position was contracted by OCA, on behalf of CPAC, and no benefits were provided.

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. Develop a training program for members of the judiciary addressing the impact of crimes of violence and other forms of abuse on non-verbal children who experience or witness such. Offer training across disciplines; 3. Develop and provide advanced training programs annually for members of the MDT. This shall include: drug and alcohol abuse; abusive head trauma; safety & medical assessments; warning signs & indicators of abuse and torture; and, developmental, psychological & emotional impact of abuse; and, 4. Consider modification to Delaware law to include an education requirement for medical professionals that incorporates the appropriate evaluation and management of a child suspected of child abuse and neglect as per the guidelines of the AAP, ACR, AAFP and ACEP. It shall emphasize: assignment of an appropriate provider; comprehensive history taking; and complete age appropriate exam, including disrobing, radiologic survey, and sexual assault evaluation.

Description of Evaluation Work

Evaluation Methods: At each meeting of the CPAC Abuse Intervention Committee, the Training Coordinator reports out on the last two quarter's accomplishments and activities. The OCA Chief Policy Advisor/CJA Coordinator meets with the Training Coordinator monthly and evaluates the contract every six months.

Output: The Training Coordinator worked an average of 36 hours a week. On August 3, 2017, the Training Coordinator facilitated a Train-the-Trainer session for approximately 10 trainers on the revised curriculum for the mandatory reporting trainings. In addition, the Training Coordinator facilitated 27% of the in-person mandatory reporting trainings for educators and 12% of the in-person mandatory reporting trainings for general community and professional audiences during the 12-month period. Approximately, 283 professionals received training from the Training Coordinator. The Training Coordinator also staffed the Training Committee on June 9, 2017, October 13, 2017, January 12, 2018, and April 13, 2018, and the Abuse Intervention Committee on February 27, 2018. Finally, the Training Coordinator provided administrative support for the Delaware Multidisciplinary Team Course and CornerHouse On-Site Basic Forensic Interview Training on December 11-15, 2017 and the Sex Offenders: Responding to Crimes Against Children Training on May 2, 2018.

Outcome: Improved coordination of training programs provided by or sponsored by the Task Force.

b. Activity: Provide Ongoing Comprehensive Training to Multidisciplinary Team Members

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 three topics: the MOU for the Multidisciplinary Response to Child Abuse and Neglect, forensic interviewing and child sexual abuse. The training was targeted to the Division of Family Services (DFS), Office of the Investigation Coordinator, statewide law enforcement agencies, criminal/civil Deputy Attorneys General from the Department of Justice (DOJ), Children's Advocacy Center forensic interviewers and clinicians, and related child welfare partners such as hospital based Sexual Assault Nurse Examiners.

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. Implement MOU between DSCYF, DOJ, Law Enforcement, and CAC

and develop a training program on the best practice guidelines for investigating and prosecuting these cases; and, 3. Research and develop best practices and/or trainings to help professionals recognize and appropriately respond to cases of child torture. Specific examples from the Child Abuse and Neglect (CAN) Panel will be utilized.

***These recommendations are aligned with the State of Delaware Child and Family Services Plan (CFSP) - 2018 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: The Task Force uses 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. During this reporting period, the Child Abuse and Neglect Panel had 72 findings and 106 strengths related to the MDT Response (See Appendix B: Child Abuse and Neglect Panel Findings and Strengths – MDT Response). The Office of the Investigation Coordinator monitored 1,513 cases (19 deaths, 66 serious physical injury cases, and 1,428 sexual abuse cases). Any issues with non-compliance of the MOU were brought to the attention of individual agencies. In addition, surveys were used as the evaluation method for the training programs on forensic interviewing and child sexual abuse. (See Appendix C: CornerHouse On-Site Basic Forensic Interview Training and Sex Offenders: Responding to Crimes Against Children).

Output: Cpl. Adrienne Owen from the Delaware State Police, Diane Klecan from the Children's Advocacy Center, and Rosalie Morales from the Office of the Child Advocate conducted three Train-the-Trainer sessions on the MOU for the Multidisciplinary Response to Child Abuse and Neglect. The sessions were held on November 9, 2017 in New Castle County, December 4, 2017 in Kent County and December 6, 2017 in Sussex County. The trainings were attended by a total of 40 representatives from the following agencies: the Division of Family Services, Office of the Investigation Coordinator, statewide law enforcement agencies, the DOJ Special Victims Unit, Children's Advocacy Center, and the medical community. The mobile application has 257 active users.

The Delaware Multidisciplinary Team Course and CornerHouse On-Site Basic Forensic Interview Training were held on December 11-15, 2017. Thirty-four professionals from

[1] State of Delaware CFSP 2018 APSR is available at: https://kids.delaware.gov/pdfs_archive/fs/fs-cfsp-apsr-2018.pdf

statewide law enforcement agencies, DFS, and DOJ participated in the MDT Course on the first day. It featured a discussion about the MDT approach in Delaware and the revised MOU. Dr. Allan De Jong, a Task Force member, presented on the medical aspects in child physical and sexual abuse cases, and Sgt. Eric Sherkey and Detective Charles Levey from the New Castle County Police Department discussed corroborating evidence in child abuse cases. Then, Julie Stauffer, a Forensic Interviewer at CornerHouse, provided the 3.5 day forensic interview training to 25 participants.

Eighty-six participants attended the Sex Offenders: Responding to Crimes Against Children Training on May 2, 2018. Cory Jewell Jensen, a consultant who spent 35 years evaluating and providing treatment services to adult sex offenders, facilitated the training. The training was attended by representatives from the following agencies: Children's Advocacy Center, DOJ, DFS, Division of Prevention & Behavioral Health Services, Division of Youth Rehabilitative Services, Office of the Child Advocate/Court Appointed Special Advocate Program (CASA), statewide law enforcement jurisdictions, and other community providers.

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

Description: Scholarships were provided to representatives from the multidisciplinary team 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 DFS, Office of the Investigation Coordinator, statewide law enforcement agencies, criminal/civil Deputy Attorneys General from the DOJ, Children's Advocacy Center forensic interviewers and clinicians, and related child welfare partners such as hospital based Sexual Assault Nurse Examiners.

Recommendation: 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. Develop and provide advanced training programs annually for members of the MDT. This shall include: drug and alcohol abuse; abusive head trauma; safety & medical assessments; warning signs & indicators of abuse and torture; and, developmental, psychological & emotional impact of abuse.

Description of Evaluation Work

Output: Two representatives from the Office of the Investigation Coordinator received partial scholarships to attend the 29th Crimes Against Children Conference from August 7-10, 2017. Five representatives attended the 34th International Symposium on Child Abuse from March 20-22, 2018. The representatives were from the Delaware State Police, New Castle County Police Department, Office of the Investigation Coordinator and the Office of the Child Advocate (Child Abuse and Neglect Review Specialist). The Chief Policy Advisor/CJA Coordinator and the Executive Director of CPAC attended the 2018 National Child Death Review Meeting: Helping Communities Celebrate More Birthdays on May 7-10, 2018. Another three representatives will be attending the 16th International Conference on Shaken Baby Syndrome/Abusive Head Trauma on September 16-18, 2018, and five representatives will be attending the 30th Annual Crimes Against Children Conference on August 13-16, 2018.

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.

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 and other agency's learning management systems, as appropriate.

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. Consider modification to Delaware law to include an education requirement for medical professionals that incorporates the appropriate evaluation and management of a child suspected of child abuse and neglect as per the guidelines of the AAP, ACR, AAFP and ACEP. It shall emphasize: a. Assignment of an appropriate provider; b. Comprehensive history taking; and c. Complete age appropriate exam, including disrobing, radiologic survey, and sexual assault evaluation.

Description of Evaluation Work

Evaluation Methods: Surveys were used as the evaluation method for the mandatory reporting trainings (See Appendix D: Mandatory Reporting Training Evaluations).

Output: Staff from DFS, DOJ, OCA/CASA, Office of Child Care Licensing, Office of the Investigation Coordinator and Domestic Violence Coordinating Council conducted in-person training sessions for 431 educators and 443 participants from general professional audiences. For the web-based training on OCA's Online Training System, 446 participants completed the training for general community and professional audiences, 270 completed the training for educators, and 256 completed the training for medical professionals. Another 7,515 educators completed the web-based training through the Department of Education's Blackboard course management system. Christiana Care Heath System employees completed the web-based training on their learning management system; 755 completed the training for general community and professional audiences and 65 completed the training for medical professionals.

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

e. 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: mandatory reporting, Child Abuse and Neglect 101, Delaware's Child Protection Registry, Extended Jurisdiction, Youth Engagement in Court, and the Family Court Called: You've Been Appointed.

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. Implement MOU between DSCYF, DOJ, Law Enforcement, and CAC and develop a training program on the best practice guidelines for investigating and prosecuting these cases; 3. Research and develop best practices and/or trainings to help professionals recognize and appropriately respond to cases of child torture. Specific examples from the CAN Panel will be utilized; 4. Develop a training program for members of the judiciary addressing the impact of crimes of violence and other forms of abuse on non-verbal children who experience or witness such. Offer training across disciplines; 5. Develop and provide advanced training programs annually for members of the MDT. This shall include: a. Drug and Alcohol Abuse; b. Abusive Head Trauma; c. Safety & Medical Assessments; d. Warning Signs & Indicators of Abuse and Torture;

and, e. Developmental, psychological & emotional impact of abuse; and, 6. Consider modification to Delaware law to include an education requirement for medical professionals that incorporates the appropriate evaluation and management of a child suspected of child abuse and neglect as per the guidelines of the AAP, ACR, AAFP and ACEP. It shall emphasize: a. Assignment of an appropriate provider; b. Comprehensive history taking; and c. Complete age appropriate exam, including disrobing, radiologic survey, and sexual assault evaluation.

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 13,900 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.

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

f. 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.

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: Chief Policy Officer/CJA Coordinator and Executive Director of CPAC attended the National Citizen Review Panel Conference from May 10-12, 2017. In addition, the Chief Policy Officer/CJA Coordinator and Training Coordinator attended the CJA Grantee Meeting on August 10-11, 2017.

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 - 2018 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 DFS 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. This is accomplished 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 96 findings and 25 strengths related to the safety and risk assessment (See Appendix E: Child Abuse and Neglect Panel Findings and Strengths – Safety and Risk Assessment). In addition, the CPAC CAN Steering Committee makes quarterly recommendations to the Governor and the General Assembly as a result of these findings, and the reports resulting from the Child Abuse and Neglect Panel reviews are available at the following link: https://courts.delaware.gov/childadvocate/cpac/cpac_reports.aspx.

   As mentioned previously, the Office of the Investigation Coordinator monitored 1,513 cases during this reporting period (19 deaths, 66 serious physical injury cases, and 1,428 sexual abuse cases). Any issues related to safety or risk assessment were brought to the immediate attention of the Division of Family Services administration. Lastly, the Task Force identified two recommendations related to Safety and Risk Assessment in its 2018 Three-Year Assessment. Please see Section II: Three-Year Assessment Report for additional information.

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 DFS Director, Trenee Parker and the Child Abuse Investigation Coordinator, Jennifer Donahue, championed the Committee's efforts. The group continued to receive In-Depth Technical Assistance for Substance Exposed Infants from the National Center on Substance Abuse and Child Welfare. The Plan of Safe Care template was developed and a pilot program was implemented at several birth hospitals across the state. The Child Abuse Investigation Coordinator, through data exchanges with DFS, also tracked the number of infants with prenatal substance exposure. In calendar year 2017, there were 450 notifications to DFS. In addition, the bill pertaining to substance exposed infants (Aiden's Law), which was introduced during a prior legislative session, passed on May 8, 2018. This bill formalizes a uniform, collaborative response protocol for the development of a Plan of Safe Care for infants with prenatal substance exposure and their affected family or caregivers (See Appendix F: House Bill 140).

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, DFS held an annual stakeholder meeting on March 26, 2018 to present program accomplishments and priorities, review performance measures and gather stakeholder input to inform the coming year's strategic planning. DFS aligns the Child and Family Service Review (CFSR) Program Improvement Plan (PIP) with the CFSP. Ninety-six stakeholders were invited, including the Court Improvement Program (CIP) Coordinator, the CJA Coordinator, and Chief of the Nanticoke Indian Association. Fifty-one stakeholders attended representing community service agencies, advocates, Department of Justice, Family Court, Administration for Children and Families Region III, foster parents, supervisors, caseworkers and aged out foster youth. 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. Comments and suggested edits to the CFSP-2019 edition were accepted until April 27, 2018. 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 CASA, 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. The Chief Policy Advisor/CJA Coordinator also participates on the CFSP/Safety PIP along with representatives from the Division of Family Services and Department of Justice. Lastly, during its 2018 Three-Year Assessment, the Task Force was charged with reviewing the goals and objectives of the CFSP/APSR to determine if any aligned with its prioritized recommendations. Please see Section II: Three-Year Assessment Report for additional information.

C. Prior Year Line Item Budget Expenditures (May 2017-May 2018)

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 FFY15 grant award was received in September 2015. However, CPAC did not begin obligating those funds until October 1, 2016; the remaining funds will be obligated and liquidated by September 30, 2017. As a result of this practice, both FFY15 and FFY16 funds were used during the reporting period. As such, partial budgets will be listed below.

FFY15 (Grant Award $88,789) **May 1, 2017 - September 30, 2017**		**FFY16 (Grant Award $88,978)** **October 1, 2017 – May 15, 2018**		
Funding Activity	**Total**	**Funding Activity**	**Total**	**Grand Total**
Training Coordinator	$20,250.00	Training Coordinator	$27,506.80	$47,756.80
Comprehensive Training to MDT	$1,440.02	Comprehensive Training to MDT	$12,274.13	$13,714.15
MDT Scholarships	$1,195.85	MDT Scholarships	$10,177.01	$11,372.86
Web-based training for child welfare community	$2,113.00	Web-based training for child welfare community	$3,378.00	$5,491.00
CJA Grantee Meeting/National Citizen Review Panel Conference	$2,658.38	CJA Grantee Meeting/National Citizen Review Panel Conference	$2,060.10	$4,718.48
Total FFY15 Funds	**$27,657.25**	**Total FFY16 Funds**	**$55,396.04**	**$83,053.29**

D. Application for Proposed Activities (September 2018-September 2019)

i. Description of Proposed Activities Using CJA Funds

a. Activity: Contract with a Training Coordinator

Description: The Task Force will contract with a Training Coordinator 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. Provide in-person mandatory reporting training to educators and general professional audiences; 4. Facilitate 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 and facilitate 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. Staffing the CPAC Abuse Intervention and Training Committees.

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: At each meeting of the CPAC Abuse Intervention Committee, the Training Coordinator will report out on the last two quarter's

accomplishments and activities. The OCA Chief Policy Advisor/CJA Coordinator will meet with the Training Coordinator monthly and evaluate the contract every six months.

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 DFS, Office of the Investigation Coordinator, statewide law enforcement agencies, criminal/civil Deputy Attorneys General from DOJ, 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 education on the coordination of medical services and safety planning during a child's hospital admission as part of the ongoing training on the MOU for the MDT Response to Child Abuse and Neglect; 2. Provide education on the revised MDT Case Review Protocol as part of the ongoing training on the MOU for the MDT Response to Child Abuse and Neglect; 3. Conduct county-based trainings for law enforcement agencies on conducting doll re-enactments in child abuse and neglect death and near death cases; 4. Promote use of the mobile application on the MOU for the MDT Response to Child Abuse and Neglect; and, 5. Sponsor a one-day conference with the Court Improvement Program 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. In addition, the revised MDT Case Review Protocol supports experimental, model and demonstration programs which may improve the prompt and successful resolution in these cases (Appendix G: MDT Case Review Protocol).

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, LE and the identified medical coordinator of care for children of any age who present to the hospital and where child abuse or neglect is suspected; b. Develop a protocol or plan for meetings between MDT and medical providers on immediate safety plan during child's hospital admission; c. Develop a protocol or plan to seek medical examinations at the children's hospital for victims, siblings and other children in the home, 6 months or younger, when child abuse or neglect is suspected; or contact the designated medical services provider within 24 hours if the examination occurred elsewhere; d. Develop a protocol or plan to assign a detective to review complaints of child abuse or neglect involving children, 6 months or younger, prior to closing the case; e. Consider other recommendations that were not prioritized as follows: Assist the MDT in receiving all medical records, including preliminary and subsequent medical findings and photographic documentation of injuries, through use of the identified medical coordinator of care in the hospital; Allow in-house forensic nurse examiners to be accessible to the MDT 24 hours a day in the children's hospital and other hospitals in Delaware; 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 MOU. In addition, Survey Monkey will be used to evaluate the training programs.

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

Description: DFS is providing full day workshop in each county on SDM Safety Assessment and Safety Planning. The training is targeted for DFS investigators and supervisors. Participants will receive an overview of the foundations of the SDM system along with the importance of using SDM definitions. In addition, participants will have an opportunity to learn and practice the use of the safety assessment and creating rigorous behaviorally based safety agreements.

Goal(s): Improve safety assessment and planning in the civil response to cases of child abuse and neglect cases.

Objective(s): Hire a professional videographer to record one of the full day sessions and develop a web-based training for DFS staff.

Reform of State Systems: This activity contributes to the reform of State protocols and procedures to provide comprehensive protection to children.

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 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 whether the refresher training has improved the safety decisions.

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

Description: Representatives from the multidisciplinary team will be given 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 DFS, Office of the Investigation Coordinator, statewide law enforcement agencies, criminal/civil Deputy Attorneys General from the DOJ, Children's Advocacy Center forensic interviewers and clinicians, 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.

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 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.

f. 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: mandatory reporting, Child Abuse and Neglect 101, Delaware's Child Protection Registry, Extended Jurisdiction, Youth Engagement in Court, and the Family Court Called: You've Been Appointed.

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. Contract with TraCorp 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 Coordinator and the comments about technical issues listed in the survey results.

g. 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 2018-September 2019)

FFY17 (Grant Award $88,956)	
Funding Activity	**Total**
Training Coordinator	$35,000.00
Comprehensive Training to MDT	$30,000.00
Refresher Training on SDM Safety Assessment and Safety Planning	$1,125.00
MDT Scholarships	$14,331.00
Web-based training for child welfare community	$5,000.00
CJA Grantee Meeting/National Citizen Review Panel Conference	$3,500.00
Total FFY17 Funds	**$88,956.00**

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, 2018

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 2017 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

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

II. Three-Year Assessment Report

A. Overview of Task Force

Delaware's Task Force, the Child Protection Accountability Commission (CPAC) was established by an Act of the Delaware General Assembly in 1997 following the death of a 4-year-old boy named Bryan Martin. Bryan's death demonstrated the need for multidisciplinary collaboration and accountability in Delaware's child protection system. As a result, Delaware enacted the Child Abuse Prevention Act of 1997 (16 Del. C., Ch. 9), which made significant changes in the way in which Delaware investigates child abuse and neglect. The Child Abuse Prevention Act also established an interdisciplinary forum for dialogue and reform. That forum is CPAC, which endeavors to foster a community of cooperation, accountability and multidisciplinary collaboration. CPAC brings together 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 FFY08, CPAC became the Children's Justice Act (CJA) State Task Force. Although the statutory duties of the Commission were in place prior to CPAC's designation as the State Task Force, the duties support the guidelines outlined in the CJA grant and are as follows (16 Del. C. § 931(b)):

> (1) Examine and evaluate the policies, procedures, and effectiveness of the child protection system and make recommendations for changes therein, focusing specifically on the respective roles in the child protection system of the Division of Family Services, the Division of Prevention and Behavioral Health Services, the Office of the Attorney General, the Family Court, the medical community, and law-enforcement agencies.
>
> (2) Recommend changes in the policies and procedures for investigating and overseeing the welfare of abused, neglected, and dependent children.
>
> (3) Advocate for legislation and make legislative recommendations to the Governor and General Assembly.
>
> (4) Access, develop, and provide quality training to the Division of Family Services, Deputy Attorneys General, Family Court, law-enforcement officers, the medical community, educators, day-care providers, and others on child protection issues.
>
> (5) Review and make recommendations concerning the well-being of Delaware's abused, neglected, and dependent children including issues relating to foster care, adoption,

mental health services, victim services, education, rehabilitation, substance abuse, and independent living.

(6) Provide the following reports to the Governor:

a. An annual summary of the Commission's work and recommendations, including work of the Office of the Child Advocate, with copies thereof sent to the General Assembly.

b. A quarterly written report of the Commission's activities and findings, in the form of minutes, made available also to the General Assembly and the public.

(7) Investigate and review deaths or near deaths of abused or neglected children.

(8) Coordinate with the Child Death Review Commission to provide statistics and other necessary information to the Child Death Review Commission related to the Commission's investigation and review of deaths of abused or neglected children.

(9) Meet annually with the Child Death Review Commission to jointly discuss the public recommendations generated from reviews conducted under § 932 of this title. This meeting shall be open to the public.

(10) Adopt rules or regulations for the administration of its duties or this subchapter, as it deems necessary.

B. Overview of System Improvements from 2015 Three-Year Assessment

i. Progress Towards Implementing Recommendations

In its 2015 Three-Year Assessment Report, the Task Force prioritized 16 recommendations related to policy and training to improve the processes by which Delaware responds to cases of child abuse and neglect. CPAC's accomplishments are highlighted below.

a. Policy

Five of the recommendations related to policy, and progress was made on 4 of the 5 recommendations. In particular, the Division of Family Services (DFS) was tasked with two of the recommendations. As a result, DFS convened a workgroup and updated its policy and procedure on collateral contacts. However, DFS deferred any action on the recommendation about developing policies and procedures to ensure that information from mental health, substance abuse, and domestic violence assessments were incorporated into safety planning. DFS is not able to develop a mechanism to alert case workers to follow up after referrals or services are requested without additional resources. The Task Force was responsible for implementing the remaining policy recommendations. In February 2017, the revised Memorandum of Understanding (MOU) for the Multidisciplinary Response to Child Abuse and Neglect was approved, and it included a checklist to help professionals recognize and appropriately respond to cases of child torture. A Train-the-Trainer Session was held on the MOU with statewide multidisciplinary team (MDT) members, and the Task Force anticipates ongoing training. Lastly, the Joint Committee on Substance-Exposed Infants and Medically Fragile Children was created in FY15. The group is currently receiving In-Depth Technical Assistance for Substance Exposed Infants from the National Center on Substance Abuse and Child Welfare. In addition, the Plan of Safe Care template was developed and a pilot program was implemented at several birth hospitals across the state. While much has been accomplished by this Committee, the work is expected to continue. As a result, this recommendation will be carried over for the next three-year period.

ii. Training

Five additional recommendations related to the development of training programs for members of the MDT and the judiciary. The first recommendation, support of training and education initiatives related to the investigation and prosecution of child abuse and neglect cases using a MDT approach, was carried over from the 2012 Three-Year Assessment. Although the Task Force has offered regular training opportunities to the

MDT on topics such as forensic interviewing, child sexual abuse, and sudden unexpected infant death investigations, ongoing training and education will always be needed for those who investigate or prosecute reports of child abuse and neglect. As such, CPAC agreed that this recommendation must remain a priority for the Task Force. The next two recommendations required the Task Force to offer specific, advanced training programs to members of the MDT and the judiciary, and both were accomplished through workshops offered at the 2015 and 2017 Protecting Delaware's Children Conference. The final two recommendations involved training for DFS staff by the Department of Justice (DOJ) Family Division; the Family Division is responsible for providing legal representation to DFS in Family Court. Regular training has been occurring, and it includes a discussion about DOJ services available to DFS, circumstances under which DFS should seek legal advice and resources available to compel cooperation of families.

iii. Other

The Task Force also identified six recommendations that were not policy or training related. Three of the recommendations involved evaluating DFS practices regarding Structured Decision Making (SDM) and history and conducting an analysis of system improvements to determine the impact to child death and near death cases. In response to the recommendations, DFS implemented a process to flag cases at the Report Line based on history and specific risk factors. As a result, cases transferred to investigation may require a critical framework or higher level of supervision by DFS. Additional updates were made to the DFS Family and Child Tracking System to make it easier for workers to access the chronological history of the family. Further, to address the recommendation about enhancing communication between DFS and DOJ, the agencies scheduled quarterly meetings between DFS leadership and Deputies in the DOJ Family Division and Special Victims Unit. The Task Force also recommended supporting DOJ budgetary requests for felony level prosecutors. As a result, the Task Force Chair and Executive Director sent a letter to the Joint Finance Committee requesting funding for the DOJ Special Victims Unit, and this request has been made annually. Finally, it was recommended that Delaware Code be modified to include an education requirement for medical professionals. Ultimately, the mandatory reporting training for medical professionals was updated to include components related to the evaluation and management of suspected victims of child abuse and neglect.

C. Overview of Process Used to Complete 2018 Three-Year Assessment

i. Background

The Task Force is vested with state statutory authority to investigate and review deaths or near deaths of abused or neglected children. This responsibility was transferred from the Child Death Revision Commission (CDRC) to CPAC on September 10, 2015, and CPAC authorized the Child Abuse and Neglect Panel to conduct the confidential investigations and retrospective reviews on its behalf. Historically, CPAC has identified its system challenges and areas that need reform from the system-wide findings arising from these retrospective reviews, and CPAC meets annually with CDRC to jointly discuss the findings and to identify recommendations for system improvement as per 16 Del. C. § 931(b)(9). The Task Force uses this forum as its three-year assessment.

ii. Planning and Data Analysis

CPAC and CDRC staff met on three to four separate occasions to plan its annual meeting, the 2018 Joint Retreat. The staff arranged for Abby Collier from the National Center for the Review and Prevention of Child Deaths to facilitate the meeting and agreed to the following agenda: a review of prior accomplishments, presentations on national initiatives and local data, transitions to break out groups to analyze the findings and develop recommendations, and prioritizing the recommendations and developing an action plan. In addition to drafting an agenda, the group prepared and reviewed statistics, strengths and findings, and other necessary information related to the investigation and review of 41 deaths and near deaths of abused or neglected children. These cases were from incidents that occurred between May 2016 and July 2017, and the result was 267 findings and 194 strengths across system areas. The staff agreed that the CPAC Abuse Intervention Committee would be responsible for reviewing the findings and determining the four priority areas (and groups) at its next meeting. A presentation was also developed by the CPAC Data Manager and another data analyst to provide the Task Force with an overview of the types of cases, profiles of the victim and perpetrators in these cases, the civil and criminal response, and the trends identified (See Appendix H: Presentation on Delaware Data). Additionally, CDRC staff contributed data on unsafe sleeping related deaths. Staff also reviewed the strategic plans for the Court Improvement Program and the Child Family and Services Plan (CFSP) to determine if any of the goals and objectives aligned. After review, the staff determined that the 2015-2019 CFSP Strategic Plan aligned more closely and should be given to the groups at the retreat to help draft the recommendations (See Appendix I: 2015-2019 CFSP Strategic Plan).

Next, at the quarterly Task Force meeting on February 14, 2018, the Executive Director gave an overview of the agenda for the Joint Retreat and asked Task Force members, who participated in prior retreats, for input. It was requested that the retreat be organized into fewer groups and for the packets with the findings to be distributed in advance of the meeting.

On February 27, 2018, the CPAC Abuse Intervention Committee met and reviewed the 267 findings from the Child Abuse and Neglect Panel reviews. The Committee identified four break out groups for the retreat: Home Visiting Programs/Infants with prenatal substance exposure, MDT Response - Medical Exams/MDT Interpretation of Medical Findings, MDT Response - Criminal Investigations, and DFS Safety Agreements and Risk Assessment. Following this meeting, CPAC staff prepared the findings associated with the four priority areas (See Appendix J: Findings Grouped by Priority Area).

iii. Annual Meeting/Retreat

On April 25, 2018, CPAC and CDRC convened its 2018 Joint Retreat. Approximately 57 members from CPAC, CDRC and the Child Abuse and Neglect Panel participated in the meeting. First, Tania Culley welcomed the group and summarized the Task Force's prior accomplishments. Next, Ms. Culley and Anne Pedrick provided an overview of the 41 deaths and near deaths of abused or neglected children, which included the types of cases, profiles of the victim and perpetrators in these cases, the civil and criminal response, and the trends identified. This was followed by a presentation by Abby Collier on the national initiatives by the National Center for the Review and Prevention of Child Deaths.

Next, the Task Force members and representatives from CDRC and the Child Abuse and Neglect Panel broke into 4 groups, based on the priority areas listed above. The groups were tasked with reviewing the findings associated with each category, considering the recommendations made by the Task Force in the last year to determine if the activities were ongoing, reviewing the 2015-2019 CFSP Strategic Plan, and identifying 3 to 5 recommendations. Each group was asked to identify the agency that will receive the recommendation, what they will be asked to do (implement, design and manage), and the target date for implementation. Once the recommendations were drafted, a representative from each group reported out. Then, Ms. Collier asked the Task Force members and others to individually vote on their top four recommendations to identify a prioritized list. Five prioritized recommendations for system improvement were identified, along with 7 additional recommendations and 10 ongoing recommendations from the prior annual meeting. Following the meeting, CPAC staff drafted the action plan with all of the recommendations. On May 23, 2018, the Task Force approved the 2018-2019 Action Plan. It was also approved by CDRC on May 11, 2018.

D. Recommendations from 2018 Three-Year Assessment

1. Overview of Task Force Recommendations

As a result of the 2018 Joint Retreat, CPAC and CDRC established an Action Plan with its five prioritized recommendations for system improvement (See Appendix K: 2018-2019 Action Plan). CPAC was tasked with addressing three of the five recommendations, so only those recommendations will be listed below. The other two recommendations are prevention focused and not appropriate under the grant. Seven additional recommendations were identified during the Joint Retreat, and these are also listed in the Action Plan. Three of those recommendations are appropriate under the grant, and as such are included below. Finally, CPAC and CDRC included 10 ongoing recommendations that were established at the 2016 CPAC and CDRC annual meeting. Those recommendations are also listed. Lastly, two recommendations were carried over from prior assessments since both remain a priority for the Task Force. In total, 18 policy and training recommendations are listed below, and the recommendations are also listed in order of priority under each topical area.

a. Policy - Investigative, administrative, and judicial handling of cases of child abuse and neglect

1. Recommend to the Delaware Police Chiefs' Council that all police departments supply their departments with cameras to document child abuse.

2. Revise the DFS non-relative/relative home safety assessment form, build it into the DFS case management system as part of the SDM Caregiver Safety Assessment when a home assessment is indicated, and provide training.

   **Aligned with 2015-2019 CFSP Strategic Plan*

b. Policy - Experimental, model, and demonstration programs for testing innovative approaches and techniques

1. Create a Joint Committee on Substance-Exposed and Medically Fragile Children to address the following recommendations:
   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 neglect statute.

c. Conduct universal drug screenings for infants in all birthing facilities in the state.
d. Revise the 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.
e. Refer medically fragile children to evidence-based home visiting programs via Healthy Families America, prior to discharge.
f. Include the standards developed by DHMIC's Standards of Care Committee on neonatal abstinence and guidelines for management.

**This recommendation was carried over from the 2015 Three-Year Assessment and its aligned with 2015-2019 CFSP Strategic Plan*

2. Advocate for compliance with statutory caseload mandates as required by 29 Del. C. § 9015 and continue to work on promising practices and strategies for recruitment and retention of the child welfare workforce.
    a. Reconvene the CPAC Caseload/Workloads Committee to review treatment caseloads and state standards.
    b. Consider adjusting DFS caseloads based on complexity of the cases to better utilize staff strengths and balance workload.
    c. Explore the use of differential response for domestic violence, substance exposed infants, and chronic neglect cases accepted by DFS.
    d. Include caseloads in its prioritized list of CPAC funding requests to be submitted to the Governor and General Assembly each fiscal year.

3. Advocate for increased funding to the DOJ Special Victims Unit, which has statewide jurisdiction of all felony level, criminal child abuse cases including those involving serious physical injury, death or sexual abuse of a child to ensure the same level of victim service and MDT collaboration in all counties.

4. Develop a MDT protocol for removal of life support cases.

5. Establish a process between DFS and Family Court in cases where guardianship petitions are filed to ensure legal protections are in place for the child and the needs of the child are being addressed.

6. Utilize the Division of Substance Abuse and Mental Health (DSAMH)/DSCYF partnership and Casey Family Programs to better assist high risk families involved

in the child welfare system, with risk factors such as mental health, substance abuse and domestic violence, and to identify appropriate services for children and caregivers.

c. Policy - Reform of State laws, ordinances, regulations, protocols and procedures

1. Revive the CPAC CAN Best Practices Workgroup to integrate the following into MOU training, or in the development of protocols to address coordination of medical services and the MDT as follows:
   a. Develop a protocol or plan to coordinate hospital discharge between DFS, LE and the identified medical coordinator of care for children of any age who present to the hospital and where child abuse or neglect is suspected.
   b. Develop a protocol or plan for meetings between MDT and medical providers on immediate safety plan during child's hospital admission.
   c. Develop a protocol or plan to seek medical examinations at the children's hospital for victims, siblings and other children in the home, 6 months or younger, when child abuse or neglect is suspected; or contact the designated medical services provider within 24 hours if the examination occurred elsewhere.
   d. Develop a protocol or plan to assign a detective to review complaints of child abuse or neglect involving children, 6 months or younger, prior to closing the case.
   e. Consider other recommendations that were not prioritized as follows:
      - Assist the MDT in receiving all medical records, including preliminary and subsequent medical findings and photographic documentation of injuries, through use of the identified medical coordinator of care in the hospital.
      - Allow in-house forensic nurse examiners to be accessible to the MDT 24 hours a day in the children's hospital and other hospitals in Delaware.
      - Provide a list of direct contact numbers for all forensic nurse examiner teams and identified medical coordinators of care to the MDT.

   **Aligned with 2015-2019 CFSP Strategic Plan*

2. Consider and draft the following legislation:
   a. Add Child Abuse First and Second degrees to the list of violent felonies and enhance the sentencing penalties;

b. Create a negligent mens rea for child abuse and create a statute to address those who enable child abuse;
c. Modification of the crime of Murder by Abuse or Neglect;
d. Resolve inconsistencies in Title 11 due to the differing definitions of physical injury and serious physical injury;
e. Consideration of enhanced sentencing penalties for the crime of Rape involving a child to include a life sentence.

3. Finalize and implement the DOJ comprehensive case management system. The system must be capable of producing current information regarding the status of any individual case, and must be capable of producing reports on case outcomes. The system must also allow the DOJ to track the caseloads of its Deputies and staff, so that informed resource allocation decisions can be made, and must ensure cross-referencing of all cases within the DOJ which share similar interested parties.

d. Training - Investigative, administrative, and judicial handling of cases of child abuse and neglect

1. Support of training and education initiatives related to the investigation and prosecution of child abuse and neglect cases using a MDT approach.

**This recommendation was carried over from the 2012 Three-Year Assessment and its aligned with 2015-2019 CFSP Strategic Plan*

2. 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.

3. Ensure Child Abuse and Neglect Panel findings are being addressed with local law enforcement agencies through either the MDT Case Review process, Police Chiefs' Council or the Office of the Investigation Coordinator.

4. Provide supervisory training to DFS supervisors that is specific to child welfare and case management utilizing a national evidence-based curriculum.

e. Training - Experimental, model, and demonstration programs for testing innovative approaches and techniques

No training recommendations were identified under this topical area.

f. Training - Reform of State laws, ordinances, regulations, protocols and procedures

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

2. Provide ongoing training on the SDM Risk Assessment tool to reinforce the policy and ensure consistent application

   **Aligned with 2015-2019 CFSP Strategic Plan*

3. 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.

   **Aligned with 2015-2019 CFSP Strategic Plan*

E. Plan to Incorporate Recommendations

In its 2018-2019 Action Plan, CPAC and CDRC have identified both a responsible agency and timeframe for implementing the recommendations. For the 18 recommendations identified above, CPAC has tasked committees/workgroups under the Task Force or individual agencies with addressing the recommendations, and at its quarterly meetings, the Task Force will monitor the progress and request updates.

The Task Force has already begun to see progress on many of its recommendations. For instance, the Joint Committee on Substance-Exposed and Medically Fragile Children plans to monitor implementation of Aiden's Law and provide training sessions to DFS staff and medical providers. The Plan of Safe Care Hospital Pilot program will also be expanded to all hospitals statewide. In addition, the CPAC CAN Best Practices Workgroup will begin meeting again in July 2018 to develop a plan on the coordination of medical services and safety planning during a child's hospital admission. The Workgroup will also address the other policy and training recommendations related to the MDT. Another workgroup under the Task Force, De-Escalation of Life Support, has drafted a Protocol for De-Escalation of Life Support for Children in the Custody of the Department of Services for Children, Youth, and their Families. This protocol will be reviewed and approved by CPAC in the next fiscal year.

Planning is underway for the county-based trainings for law enforcement agencies on conducting doll re-enactments in child abuse and neglect death and near death cases. In addition, the CPAC Protecting Delaware's Children Conference Workgroup is planning a one-day event with the Court Improvement Program and other partners on topics relevant to professionals involved in the investigative, administrative, and civil and criminal judicial handling of child abuse and neglect cases. The conference is scheduled for April 2, 2019.

Additionally, in February 2018, the Executive Director and Chair of the Task Force sent a letter to the Joint Finance Committee of the Delaware General Assembly to express the funding priorities for the Task Force for Fiscal Year 2019. Several requests were made regarding DFS caseloads. CPAC urged that the DFS caseload analysis required under 29 Del. C. § 9015 occur this fiscal year, and that it occur on at least a quarterly basis this next fiscal year to ensure that caseloads do not exceed the statutory standards. CPAC also requested that the 30 positions recommended by the Governor to assist the hotline and the front lines of DFS be placed into the final budget. In addition, CPAC asked the Joint Finance Committee to consider both the starting salaries and lack of hazard pay for these most difficult positions that are directly linked to child safety, and that all entities continue to explore how to recruit and retain a committed workforce. To advocate for increased funding to the DOJ Special Victims Unit, CPAC stated that DOJ needs additional Deputies to make the Special Victims Unit a functional statewide unit where all cases

are coordinated and receive the same level of support and oversight, regardless of which county the crime occurs.

DOJ is also making progress on its recommendations. The DOJ Special Victim Unit in New Castle County is piloting the DOJ case management system. The Head of the Special Victim Unit also drafted the legislation modifying the criminal code, and after review by other partners, the draft legislation will be introduced in 2019.

Lastly, DFS has made progress on many of its recommendations. For example, in May 2018, DFS provided 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. Supervisors also received training in October 2017; however, they continue to provide quarterly training at existing meetings for supervisors and managers on various supervisory and management topics. Comprehensive Child Welfare Supervisory training is underway. An evidenced based curriculum has been identified and DFS is working on an implementation plan to commence in August – September 2018.

III. Appendices

State of Delaware Child Protection Accountability Commission
Quarterly Meeting Minutes

WEDNESDAY, MAY 17, 2017
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)(16)
The Hon. Josette Manning	Secretary of Services for Children, Youth & Their Families 16 Del. C. § 931(a)(1)
Carla Benson-Green	Dir., Div. of Family Services 16 Del. C. § 931(a)(2)
Susan Cycyk	Dir., 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)
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)(8)
Corporal 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)
Dr. Allan De Jong	At-large Member - Medical Community 16 Del. C. § 931(a)(16)
Ellen Levin	At-large Member - Child Protection Community 16 Del. C. § 931(a)(16)
Randall Williams	At-large Member - Child Protection Community 16 Del. C. § 931(a)(16)
Captain Robert McLucas	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:

Tania Culley, Esq., Executive Director
Rosalie Morales
Stepfanie Scollo

Members of the Public:

Kecia Blackson	Islanda Finamore, Esq.	Sgt. Reginald Laster	Gwen Stubbolo
Dr. Jenny Bleznak	Meg Garey	Rachael Neff	Ellie Torres, Esq.
Megan Caudell	Jill Gresham	Trenee Parker	Brittany Willard
Ken DeCerchio	Kelly Ensslin, Esq.	Anne Pedrick	Drew Wilson, Esq.
Dr. Stephanie Deutsch	Emily Knearl	Jennifer Perry	

I. CHAIRPERSON'S WELCOME AND INTRODUCTIONS

Ginger Ward opened the meeting and welcomed the attendees.

II. APPROVAL OF MINUTES

The minutes from February 8, 2017 and March 27, 2017 were approved. A motion was made by Dr. Colmorgen to approve the February 8, 2017 minutes as amended, and Susan Cycyk seconded the motion. All others were in favor. A motion was made by Janice Mink to approve the March 27, 2017 minutes as

amended, and Chief Judge Newell seconded the motion. All others were in favor.

III. EXECUTIVE DIRECTOR'S REPORT

Tania Culley, Esq. provided the Executive Director's report. The Court Appointed Special Advocate (CASA) Program's move to OCA on March 6, 2017 was a success. Along with CASA becoming a part of OCA, there were eight (8) attorneys who accepted the OCA Child Attorney contracts. Jennifer Perry, OCA's new Investigation Coordinator (IC) Case Review Specialist, was introduced to the Commission. Sam Clancy, Family Crisis Therapist, accepted the position of CASA Coordinator and officially started on May 1, 2017. Stepfanie Scollo, Clerical/Seasonal, accepted the role of Office Manager and officially started on April 10, 2017. The open positions of the Kent Family Crisis Therapist and Clerical/Seasonal will not be filled until the state hiring freeze has been lifted. Additionally, Ms. Culley has been looking into renovations for the 3rd floor suite at 900 King Street. Instead of going through with costly renovations to move all staff, it has been decided that operations staff will only move up to the 3rd floor. In the last two and a half months, 115 children entered DSCYF custody. In addition to the volume of entries causing a concern, there are few CASA volunteers available.

Ms. Culley provided an update on five bills CPAC is championing through the General Assembly this session as well as a bill that impacts CPAC. Jennifer Donahue will provide an update on Aiden's Law – CPAC's other bill. Three bills were introduced yesterday: HB181, which establishes best practices for investigating child abuse cases; HB182, which strengthens confidentiality for CAN Panel Reviews; and, HB183, which strengthens confidentiality for panel reviews by the Child Death Review Commission (CDRC). Two bills have not been assigned bill numbers yet. The first bill gives Family Court the authority to appoint an Educational Decision Maker, and the other establishes the Educational Success for Students Act (ESSA) for children in Foster Care. The last bill, which makes changes to Erin's Law, will be introduced today. The bill requires that students, enrolled in grades pre-kindergarten through 6, receive education on personal body safety, sexual abuse and other forms of child abuse. Ms. Culley reported Prevent Child Abuse Delaware (PCAD) already provides this education to students in the state, and PCAD is requesting a letter of support from CPAC to increase its grant-in-aid funding to $90,000.00 a year. After much discussion about the impact to CPAC, the Division of Family Services (DFS) and the Department of Education (DOE), a motion to support the request by PCAD was made by Janice Mink, and seconded by Dr. Colmorgen. Eight Commissioners voted in support, 3 opposed, and 4 abstained. The motion carried. A second motion was made by Judge Hitch to write a letter to Senator Henry delaying implementation of this education component for students for 2 years, and seconded by Carla Benson-Green. All voted in favor. The motion carried.

Ms. Culley also discussed the priority funding requests for the child welfare system that will be presented in a letter to the Joint Finance Committee. The funding priorities are as follows: infants with prenatal substance exposure (HB140), DFS caseloads and agency cuts, the Children's Advocacy Center's budget, and resources for the Department of Justice (DOJ) Special Victims Unit.

Finally, Ms. Culley addressed the need to revise Delaware's MDT Case Review Protocol, which came about from discussions involving the updated Memorandum of Understanding (MOU) for the Multidisciplinary Response to Child Abuse and Neglect. A motion to create the MDT Case Review Workgroup under the CPAC Training Committee was made by Randy Williams, and the motion was seconded by Janice Mink. All voted in favor. The motion carried. Rosalie Morales will take the lead in organizing the group.

IV. PRESENTATION ON DELAWARE'S IN-DEPTH TECHNICAL ASSISTANCE

Ken DeCerchio and Jill Gresham from the National Center on Substance Abuse and Child Welfare gave a presentation on Delaware's Substance Exposed Infants – In-Depth Technical Assistance (IDTA) initiative. In addition, Jennifer Donahue, Esq., Co-Chair of the Committee on Substance Exposed Infants/Medically Fragile Children, discussed the 4 state goals established though the Policy Academy. Ms. Donahue also provided an update on HB140 or Aiden's Law, which requires notification on infants with prenatal substance exposure. The bill was introduced in the House Judiciary Committee last week.

V. INVESTIGATION COORDINATOR REPORT

Ms. Donahue reported on the activities of the Office of the Investigation Coordinator (IC) for the last quarter. The IC has been receiving data extracts monthly from the Delaware Criminal Justice Information System (DELJIS). As a result, the IC has been monitoring more extra-familial cases, and several instances of failure to report by schools and law enforcement agencies have been identified. DOJ has been notified. Additionally, several extra-familial cases were not included in the data extracts from DFS, but the IC and DFS data team have since resolved this issue. The IC has been participating in the monthly MDT Case Review meetings, including the special case reviews requested by the DOJ. Throughout the quarter, IC Referrals were sent to involved parties for all serious physical injury and death cases.

In addition, Ms. Donahue gave a presentation on the IC data. During the quarter (3/17), the IC opened 210 cases and 630 referrals were received. In the last year, 755 cases were opened by the IC, and the majority were intra-familial sexual abuse (570). At the end of March, 563 cases were being tracked and monitored by the IC. Fifty-four (54) cases were closed in the last quarter, and the civil and criminal outcomes were presented for these cases. Lastly, Ms. Donahue provided the victim and perpetrator profiles for the open cases by maltreatment type.

VI. CPAC DATA DASHBOARD

Brittany Willard, the CPAC Data Analyst, gave a presentation on the quarterly child welfare trends identified by the CPAC Data Utilization Committee. Ms. Willard reported some decrease in the statewide caseload average for investigations as compared to December of last year. The number of fully functioning investigation workers statewide had increased in the same period. In addition, the Beech Street region saw a 97% increase in its investigation caseloads in the past 12 months. At the end of March, the statewide caseload average for treatment showed an 11% decrease since February. The Beech Street and Kent regions were over the caseload standard, but saw some decrease.

In addition, Ms. Willard discussed the DFS Hotline Reports screened in. In the last quarter, there was a 31% increase in the sex abuse reports, a 21% decrease in dependency reports and a 19% decrease in emotional abuse and neglect reports.

Next, the CAN Panel saw an overall increase in the number of cases opened and a higher number of death cases than any quarter for the past year.

Ms. Willard also reviewed the Children's Advocacy Center (CAC) data. The CAC saw a 46% increase in the intra-familial sex abuse and a 27% increase in extra-familial sex abuse.

Additionally, in the last two quarters, there was a decrease in the number of children entering DSCYF custody. Children and youth ages, 0-4 and 13-17, had the highest number of entries. As for the permanency outcomes for children and youth exiting DSCYF custody, there was a decline in reunifications and an increase in the number of children exiting to guardianship for the last quarter.

Ms. Willard discussed the OCA clients with juvenile justice involvement, which now includes the youth represented by the Court Appointed Special Advocates (CASA) Program. The OCA and CASA teen populations were not all that different. In fact, 48% of youth, ages 13 and older, had juvenile justice involvement either before or after entering care.

In the last quarter, the Committee received the updated data on the education outcomes for children in foster care. For the 2015-2016 school year, there was a decline in the special education rates for children in DSCYF custody. There was also a decline in the overall graduation rates.

Lastly, the percentage of children who re-enter care in less than 12 months is below the standard after a few quarters of being above the standard.

VII. CHILD ABUSE AND NEGLECT DEATH/NEAR DEATH REVIEWS

A. CAN CASELOADS REPORT/ADMINISTRATIVE UPDATE

Ms. Culley reported that there were 45 CAN cases open. Of those cases, 20 are in the initial stage and 25 are in the final stage. Twelve (12) initials are being prepared or are pending review. Six (6) cases are scheduled to be reviewed as a final, and 12 are pending prosecution. Ms. Culley also stated that there were 6 deaths this year as compared to the 5 received in 2016. Three (3) of the 6 cases were substance exposed infants and died as a result of bed sharing. Ms. Culley acknowledged the DOJ for the plea deal by one of the defendants in the CAN case that resulted in Aiden's Law.

B. CAN FINDINGS/DETAILS/LETTER TO GOVERNOR

Janice Mink, the CAN Panel Chair, reported on the 12 cases reviewed by the CAN Panel in the last quarter. Six (6) were initials and 6 were finals. Nine (9) of the cases were near deaths, and 3 were deaths. In total, the CAN Panel identified 45 findings and 35 strengths. Ms. Mink discussed the trends identified for the findings and strengths and presented the letter to the Governor. A motion was made by Dr. Colmorgen and seconded by Ms. Donahue to approve the strengths summary and detail, findings summary and detail, and letter to the Governor. All others were in favor.

Ms. Culley asked the Commissioners from law enforcement to ensure their representatives are present for the CAN Panel reviews. Ms. Culley asked Ms. Mink to convey to the Panel that CPAC acknowledged their great work.

VIII. COMMISSIONER REPORTS

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

Secretary Manning shared that DFS had 8 strengths in one of the 12 cases presented to CPAC. She appreciated receiving this feedback and conveyed it to the case worker and supervisor.

I. PREVENTION AND BEHAVIORAL HEALTH

Susan Cycyk provided an update on the final year of the federal system of care grant. The Division of Prevention and Behavioral Health Services (PBH) has put together a Wrap team to serve DFS clients, half of whom are in treatment and the other half in DSCYF custody. They have also rolled out Wrap training and the Wrap approach across the system. PBH has seen great outcomes, such as a reduction in crises and hospitalizations. In addition, PBH wrote a federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant application to provide treatment services to woman with children transitioning out of substance abuse treatment and to train providers. Ms. Cycyk reported that DFS is involved in the development of the Request for Proposal (RFP) for crises services and selection of a crisis provider. Lastly, PBH is funding extended hours in the city of Wilmington for its summer prevention programs.

II. DIVISION OF FAMILY SERVICES

Carla Benson-Green provided an update on the 27 positions reallocated to DFS. The Sussex County and University Plaza positions were filled. Kent County has 2 over hire and 1 supervisor position open, and Beech Street offered 6 of its 9 positions. In addition, Ms. Benson-Green discussed the 699 children in DFS placements and the recent trend of large sibling groups entering care. She mentioned that two of her Program Managers, JoAnn Bruch and Linda Shannon, will be retiring.

Ms. Benson-Green also reported the Administration for Children and Families has approved the Program Improvement Plan (PIP) as of April, and the first quarter of activity begins in August. As part of the PIP, DFS plans to expand the Family Assessment Intervention Response (FAIR) internally and across the state. They are also considering expanding FAIR externally to different age groups and case types (i.e., neglect, domestic violence).

B. FAMILY COURT

Judge Hitch shared the Court Improvement Program (CIP) Leading Practices Report was released in April, and a workshop on the report was presented at the Protecting Delaware's Children Conference. The Court also launched a social services project in New Castle and Sussex Counties, which pairs a social worker with parents to support and engage them early. The goal is to see more parents engaged in the case planning process. Additionally, Rachael Neff, the CIP Grant Manager, is co-chairing the CPAC Caseloads/Workloads Committee, and the group is exploring assistance from the University of Delaware. Judge Hitch also reported the Court has been circulating Quality Hearing Surveys to practitioners in the court room to determine where improvements need to be made. A report will be issued in early summer. Lastly, the Court will train judicial officers on the Comprehensive Education Report in June.

C. DEPARTMENT OF EDUCATION

Susan Haberstroh shared an update on the CPAC Education Committee. DOE's priority is to get the ESSA and Educational Decision Maker legislation passed. In addition, DOE plans to promote the use of the Comprehensive Education Report and provide training.

D. CHILD DEATH REVIEW COMMISSION

Dr. Colmorgen reported CDRC has reviewed and updated all of its external policies. The Bylaws will be completed over the summer. In addition, the Chronic Health Conditions and School Aged Children Committee continues to meet. The backlog has been eliminated for the Fetal Infant Mortality (FIMR) and Child Death Review (CDR) panels. Dr. Colmorgen stated the CDRC Annual Report data was presented and approved at its April Commission meeting, and a copy of the presentation was provided to CPAC. Lastly, Dr. Colmorgen shared Delaware is the second state in the country to require a DFS investigation for any sudden, unexplained death under age 3.

E. INTERAGENCY COMMITTEE ON ADOPTION

In April, Dr. Joseph Crumbley gave a presentation on diverse adoptive families at the 2017 Delaware Adoption Conference. A lot of families came out for the event. The Committee is working on its focus for next year.

F. LAW ENFORCEMENT

No report was provided.

IX. CPAC COMMITTEE REPORTS

A. CASELOADS/ WORKLOADS

Ms. Benson-Green provided an update on the CPAC Caseloads/Workloads Committee. The Committee met twice and is still in the exploratory stage. The group is looking at data and the information provided by system partners. In addition, the Committee is having conversations with the University of Delaware about conducting a caseload/workload study.

B. TRAINING

Ms. Morales reported the CPAC Training Committee last met on March 10th to plan the 2017 Mandatory Reporting Outreach Campaign, provide oversight for the Protecting Delaware's Children Fund and seek updates on the Committee's 6 workgroups. The Committee approved contributing $10,000 from the Protecting Delaware's Children Fund to the 2017 Mandatory Reporting Campaign. The campaign featured 8 billboards through Clear Channel – 2 in Sussex and 6 in New Castle and Kent Counties. The billboards all displayed the Hero logo. There was also a digital campaign through WJBR, which included targeted messages via email and social media sites and public service announcements. After deducting the expenditures from the campaign, there was $13, 319 remaining in Protecting Delaware's Children Fund. Since January, the fund has received $6,921 from the personal income tax

check off.

The Protecting Delaware's Children Conference was held on April 25th and 26th at the Chase Center and attended by approximately 453 professionals. The Advanced Training Course took place on the first day. It was well attended by various law enforcement jurisdictions, DOJ, the Division of Forensic Science, CAC, DFS and the medical community. Cpl. Adrienne Owen provided an overview of the finalized MOU for the multidisciplinary response to child abuse and neglect. Then, national experts, Clay Jansson and Deb Robinson, trained on sudden unexplained infant death investigations, which included how to conduct doll re-enactments and interviews. Several doll kits were distributed to the Division of Forensic Science and law enforcement agencies. The general conference kicked off with the annual Blue Bow Ceremony to commemorate National Child Abuse Prevention Month. Participants had their choice of 20 workshops on various topics. The conference was highly rated by the 100 participants who submitted an evaluation online. The next conference will be April 2019 in Dover, DE.

The MOU was finalized in early April by the CAN Best Practices Workgroup. Since then, Cpl. Owen and Ms. Morales have been obtaining signatures. The MOU and all of its resources will be uploaded to the CPAC website under the reports page. In addition, the mobile application has been completed. It is available for iPhone and Android users on the App Store and Play Store by searching "DE MOU." The CAN Best Practices Workgroup plans to reconvene to develop the county-based training and identify trainers.

The ChildFirst/MDT Workgroup will reconvene to plan the next program for 2018. Additionally, the Mandatory Reporting Workgroup met a few weeks ago to discuss updates to the school training. The revised training will be made available to DOE by early August. The Cross-Education Workgroup has been put on hold due to all of the Committee's other training priorities.

The De-escalation of Life Support Workgroup has met twice so far. At the last meeting, they explored components of the MDT response in cases where a child presents at a hospital with serious, potentially life-threatening injuries. They reviewed current best practices and ways to improve the response. This included discussion about: key information to communicate to DFS in the hotline report; whether parents who are suspected of causing the injuries should be allowed to make decisions; points of contact for hospital and DFS staff; and the recommendation to de-escalate care, hospital staff making the determination and communicating it to parents. Their next meeting is June 14th.

X. PUBLIC COMMENT AND ADJOURNMENT

There was no public comment. The meeting was adjourned at 11:41 p.m.

State of Delaware Child Protection Accountability Commission
Quarterly Meeting Minutes

WEDNESDAY, AUGUST 16, 2017
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)(16)
The Hon. Josette Manning	Secretary of Services for Children, Youth & Their Families 16 Del. C. § 931(a)(1)
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 Joelle Hitch	Family Court 16 Del. C. § 931(a)(4)
Neal Tash	Chair of the Child Placement Review Board 16 Del. C. § 931(a)(7)
The Honorable Susan Bunting	Secretary of the Department of Education 16 Del. C. § 931(a)(8)
Maureen Monagle	Chair of the Domestic Violence Coordinating Council 16 Del. C. § 931(a)(10)
Corporal 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)
Ellen Levin	At-large Member - Child Protection Community 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:

Tania Culley, Esq., Executive Director
Rosalie Morales
Stepfanie Scollo

Members of the Public:

Nicholas Brock	Susan Haberstroh	Susan Murray	Jennifer Perry
Julie Fedele	Eliza Hirst, Esq.	Rachael Neff	Gwen Stubbolo
Islanda Finamore, Esq.	Jaycie Hitch	Leslie Newman	Eleanor Torres, Esq.
Meg Garey	Mariann Kenville-Moore	Anne Pedrick	Brittany Willard

I. CHAIRPERSON'S WELCOME AND INTRODUCTIONS

Ginger Ward opened the meeting and welcomed the attendees.

II. APPROVAL OF MINUTES

The minutes from May 17, 2017 were approved. A motion was made by Dr. Colmorgen to approve the minutes, and Secretary Manning seconded the motion. James Kriner, Esq. abstained, and all others were in favor.

III. EXECUTIVE DIRECTOR'S REPORT/LEGISLATIVE REPORT

Tania Culley, Esq. provided the Executive Director's report. Ms. Culley reported on the two vacancies at OCA, as well as the Wilmington Office's move. In addition to staff vacancies, Court Appointed Special Advocate (CASA) volunteers are needed in New Castle and Kent Counties. Ms. Culley also shared an update on legal representation, and OCA's efforts to ensure a consistent statewide approach to cases. Ms. Culley discussed the number of children entering DSCYF custody across the state. There were 51 in June, 32 in July, and 9 so far in August. The volume in Kent County has been particularly high.

Ms. Culley provided an update on the five bills CPAC championed through the General Assembly this session. House Bill 140, also known as Aiden's Law, did not pass due to fiscal constraints. However, The General Assembly appropriated $285,000 to the Children's Department to implement Plans of Safe Care for infants with prenatal substance exposure. Two bills, Senate Bill 86 and 87, which originated in the CPAC Education Committee, passed. Senate Bill 86 established Family Court authority to appoint an Education Decision Maker for dependent and delinquent children, and Senate Bill 87 updated the school stability law for children in DSCYF Custody to comply with new federal law. Two bills are awaiting signature: HB181, which establishes best practices for investigating child abuse cases; and HB182, which strengthens confidentiality for CAN Panel Reviews. HB183, which strengthens confidentiality for panel reviews by the Child Death Review Commission (CDRC), is also awaiting signature. Lastly, Senate Bill 102, which consolidates all the non-academic trainings for educators, was signed yesterday. It also makes revisions to Erin's law, which requires school employees, students, and parents to receive training on personal body safety. A workgroup will be created under the CPAC Education Committee to implement the non-academic training program for public schools.

CPAC is undergoing a Joint Legislative Oversight and Sunset Review. The Performance Review Questionnaire has been received and must be submitted in October 2017.

IV. PRESENTATION ON DELAWARE'S INITIATIVES ON IMPROVING EDUCATION OUTCOMES FOR CHILDREN IN DSCYF CUSTODY

Secretary Bunting, Susan Haberstroh, and Eliza Hirst, Esq. gave a presentation on the various initiatives of the CPAC Education Committee, Casey Family Programs Grant, and Department of Education. Ms. Haberstroh shared additional information about Senate Bill 102 and the Every Student Succeeds Act (ESSA). Ms. Hirst explained the role of an Education Decision Maker and shared a factsheet. Ms. Hirst also provided an update on the activities under the Casey Family Programs Grant. During Secretary Bunting's presentation, she discussed how DOE is being rebranded as a support agency and mentioned that Delaware was the first state to get its ESSA state plan approved by the federal government.

V. INVESTIGATION COORDINATOR REPORT/SEI Report

Jennifer Donahue. Esq. reported on the activities of the Office of the Investigation Coordinator (IC) for the last quarter. Ms. Donahue shared an update on number of infants born with prenatal substance exposure. She also reported that Children and Families First applied for a Regional Partnership Grant to assist in the development of Plans of Safe Care for these infants and their families through the HOPE (Healthy Outcomes for Parent Engagement) Model. In addition, Ms. Donahue reported on the IC Caseload, which included the cases opened and closed by the IC.

VI. CPAC DATA DASHBOARD

Brittany Willard, the CPAC Data Analyst, 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 interviews, and youth exiting DSCYF custody.

VII. JOINT ACTION PLAN

Ms. Culley reviewed the joint retreat action plan and asked the Commissioners to provide an update on the progress towards the recommendations. Please see the attached 2016-2017 Action Plan for the updates.

VIII. CHILD ABUSE AND NEGLECT DEATH/NEAR DEATH REVIEWS

A. CAN CASELOADS REPORT/ADMINISTRATIVE UPDATE

Ms. Culley reported that there are 54 CAN cases open. Twelve cases are being reviewed by CPAC today. This year, 7 children have died and another 20 have almost died from abuse or neglect. In only 7 months, we have exceeded the 5 deaths from 2016, and we are on track to do the same with the near deaths, as there were 22 last year.

B. CAN FINDINGS/DETAILS/LETTER TO GOVERNOR

Janice Mink, the CAN Panel Chair, reported on the 14 cases reviewed by the CAN Panel in the last quarter. Twelve cases were referred to CPAC, and the Steering Committee held two. Five (5) were initials and 7 were finals. In total, the CAN Panel identified 35 findings and 23 strengths. Ms. Mink discussed the trends identified for the findings and strengths and presented the letter to the Governor. A motion was made by Dr. Colmorgen and seconded by Mr. Kriner to approve the strengths summary and detail, findings summary and detail, and letter to the Governor. All others were in favor.

IX. COMMISSIONER REPORTS

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

With the transition to FOCUS, the Children's Department's new child welfare information system, Secretary Manning asked CPAC to give the Children's Department flexibility with responding to new data requests until January 2018.

I. DIVISION OF FAMILY SERVICES

In Director Carla Benson-Green's absence, Susan Murray shared an update on the Program Managers and new supervisors, Safety Performance Improvement Plan, and the Continuous Quality Improvement System (CQI).

B. DEPARTMENT OF JUSTICE

Abigail Layton, Esq. reported Islanda Finamore, Esq. is working internally to help alleviate the burden on Deputies due to increased caseloads. In addition, the Department of Justice (DOJ) hired an individual to research bullying prevention and awareness in schools. DOJ is working with the University of Delaware to capture the data with the purpose of developing best practices to address bullying in Delaware schools.

Mr. Kriner shared that DOJ posted a position for a new full time Deputy Attorney General in the Special Victims Unit for New Castle County.

C. CHILDREN'S ADVOCACY CENTER

Randall Williams reported that all three centers are undergoing reaccreditation through the National Children's Alliance, and site visits will occur in November. Mr. Williams also provided an updated on the Children's Advocacy Center's (CAC) budget. The CAC had a 10% cut in its funding in this year's budget, and since 2009, the budget has been cut 16% or $171,000. As a result, the CAC has had to leave a forensic interview position vacant. They have also had to triage cases, giving priority to reports of sexual abuse and serious physical injury. In addition, the hours have changed to 8:30 to 4:30, and the 24-7 on-call schedule has been modified. He is also looking at identifying free space in Kent and Sussex Counties, and relocating or combining the offices. Mr. Williams plans on meeting with agency heads from the multidisciplinary teams (MDT) to share the changes. In short, the CAC needs a long-term funding strategy to continue providing services.

Mr. Williams also shared that Nemours/Alfred I. duPont Hospital submitted a concept paper to the Criminal Justice Council to secure funding across the state for medical exams in non-acute cases. This stems from the work of the now inactive CPAC Child Abuse Medical Response Committee, and if approved, the MDT will have resources in Kent and Sussex Counties for medical exams.

X. CPAC COMMITTEE REPORTS

All reports were submitted in writing and included in the email correspondence sent to CPAC.

XI. PUBLIC COMMENT AND ADJOURNMENT

Mariann Kenville-Moore, from the Delaware Coalition on Domestic Violence, shared an update on the Criminal Justice Improvement Committee and re-drafting of the Delaware Code. Due to the significant public policy changes, she asked the Commissioners to review and consider providing comment.

The meeting was adjourned at 11:45 a.m.

State of Delaware Child Protection Accountability Commission
Quarterly Meeting Minutes

WEDNESDAY, NOVEMBER 8, 2017
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)(16)
Carla Benson-Green	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)
Susan Cycyk	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)
Corporal 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)
Ellen Levin	At-large Member - Child Protection Community 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:

Tania Culley, Esq., Executive Director
Rosalie Morales
Stepfanie Scollo

Members of the Public:

Megan Caudell	Caroline Jones	Anne Pedrick
Julie Fedele	Gwen Stubbolo	Rachael Neff
Islanda Finamore, Esq.	Eleanor Torres, Esq.	Meredith Seitz
Meg Garey	Trenee Parker	

I. CHAIRPERSON'S WELCOME AND INTRODUCTIONS

Ginger Ward opened the meeting and welcomed the attendees.

II. APPROVAL OF MINUTES

The minutes from August 16, 2017 were approved. A motion was made by Dr. Colmorgen to approve the minutes, and Janice Mink seconded the motion. All others were in favor. The motion carried.

III. EXECUTIVE DIRECTOR'S REPORT/LEGISLATIVE REPORT

Tania Culley, Esq. provided the Executive Director's report. Ms. Culley shared an update on the two vacancies at OCA. OCA has filled its casual seasonal Data Analyst position, and submitted a request to fill its Kent/Sussex Family Crisis Therapist position. To increase the Court Appointed Special Advocate (CASA) volunteers, Gwen Stubbolo is working on a recruitment strategy for 2018. A new CASA training is being rolled out in 2018 as well. Ms. Culley also reported on OCA's efforts to ensure a consistent statewide approach to cases. Additionally, Ms. Culley discussed the caseloads for Deputy Child Advocates and the number of children entering DSCYF custody across the state. Ms. Culley also shared that OCA is in the process of acquiring a data management system, which is now awaiting approval from the Department of Technology and Information.

On behalf of CPAC, the Performance Review Questionnaire for the Joint Legislative Oversight and Sunset Review was submitted in October 2017.

IV. FY17 ANNUAL REPORT

Rosalie Morales presented the CPAC Annual Report to the Commission and highlighted CPAC's FY17 accomplishments. The motion to approve pending a minor change was made by Janice Mink and seconded by Dr. Colmorgen. All voted in favor. The motion carried.

V. CPAC DATA DASHBOARD

Ms. Morales 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 Office of the Investigation Coordinator, Children's Advocacy Center interviews, and children in DSCYF custody at the end of the quarter.

VI. INVESTIGATION COORDINATOR REPORT/SEI REPORT

Jennifer Donahue. Esq. reported on the activities of the Office of the Investigation Coordinator (IC) for the last quarter. The IC has been working to identify cases not brought to the CAC for a forensic interview, as well as cases not reported to the DFS Report Line. Ms. Donahue also shared an update on the number of infants born with prenatal substance exposure, where a notification was made to DFS. Additionally, Ms. Donahue mentioned the progress of the In-Depth Technical Assistance for Substance Exposed Infants from the National Center on Substance Abuse and Child Welfare. The Plan of Safe Care template and pilot program at several birth hospitals was also discussed.

VII. CHILD ABUSE AND NEGLECT DEATH/NEAR DEATH REVIEWS

A. CAN CASELOADS REPORT/ADMINISTRATIVE UPDATE

Ms. Culley reported that there are 57 CAN cases open. Nine cases are being reviewed by CPAC today. After today, there are 29 cases pending an initial review and 19 cases pending a final review. As of November 1st, 13 children have died and another 25 have almost died from abuse or neglect in this calendar year.

B. CAN FINDINGS/DETAILS/LETTER TO GOVERNOR

Janice Mink, the CAN Panel Chair, reported on the 9 cases reviewed by the CAN Panel in the last quarter. Eight (8) were initials, and there was one final. Of the 8 initials, four of the cases involved a substance exposed infant, and it was recommended that the letter to the Governor be revised to include this information. In total, the CAN Panel identified 32 findings and 21 strengths. Ms. Mink discussed the trends identified for the findings and strengths and presented the letter to the Governor. A motion was made by Dr. Colmorgen and seconded by Dr. De Jong to approve the strengths summary and detail, findings summary and detail, and letter to the Governor with the noted revision. All others were in favor. The motion carried.

VIII. COMMISSIONER REPORTS

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

In Secretary Manning's absence, Ms. Ward shared that Susan Cycyk and Carla Benson-Green have announced their retirements. The Commission acknowledged both women and their service to CPAC.

I. PREVENTION AND BEHAVIORAL HEALTH

Susan Cycyk reported that PBH is struggling to fill its vacancies on the treatment end. Providers are also having difficulty filling their positions. PBH is busy implementing Senate Bill 109, which enables adults and youth to have access to treatment without prior authorization. Ms. Cycyk also shared PBH continues to see success with its wrap-around services. PBH applied for targeted case management services through Medicaid, so the wrap-around approach will be sustained beyond the federal grant award. Lastly, Ms. Cycyk reported that recommendations have been developed by the workgroup charged with addressing services for children with developmental disabilities and mental health issues.

II. DIVISION OF FAMILY SERVICES

Carla Benson-Green shared that the Program Manager vacancies have all been filled. In addition, there are currently 15 vacancies statewide in the regions. Ms. Benson-Green reported that DFS has been approved by OMB to hire staff at 85% of the mid-point salary. At the OMB Budget Hearing, Secretary Manning requested 30 positions, 8 for the Report Line and 22 for treatment workers.

After general discussion about CPAC's funding priorities, a motion was made by Dr. Colmorgen and seconded by Dr. De Jong for the Executive Director and Chair to submit a letter to the Governor, and subsequently to Joint Finance, with CPAC's funding priorities for this fiscal year. Ms. Cycyk, Ms. Benson-Green and Maureen Monagle abstained. All others were in favor. The motion carried.

B. CHILD DEATH REVIEW COMMISION

Dr. Colmorgen reported the Child Death Review Commission (CDRC) 2016 Annual Report was released on July 8, 2017 and is available on the website. The next report will be released in Spring 2018. Kim Liprie started on October 1, 2017 as a full-time staff member at CDRC. In September, CDRC partnered with the Wilmington Police Department (WPD) to initiate the Cops N Cribs program with them. CDRC staff trained all four platoons each Tuesday of the month. The city of Wilmington has had 5 unsafe sleeping deaths this year, which led to the Detectives and WPD Victim Advocates to reach out to CDRC. The Centers for Disease Control will be conducting a site visit in Delaware during the first week of February for the Sudden Death in the Young (SDY) grant.

C. CHILDREN'S ADVOCACY CENTER

Randall Williams shared an update on the Children's Advocacy Center's (CAC) reaccreditation process through the National Children's Alliance. The CAC will have site visits next week. In support of CAC funding, Mr. Williams made comments at the OMB Budget Hearing for the Children's Department. He discussed the impact of the budget cuts to services provided by the CAC and requested that funding be restored.

Dr. De Jong reported that Nemours/Alfred I. duPont Hospital received approval for its Victim of Crime Act (VOCA) grant, which was submitted to the Criminal Justice Council. The grant will allow the children's hospital, in partnership with CPAC, to implement the Guidelines for the Child Abuse Medical Response. Until the program is implemented, Dr. De Jong added that Dr. Deutsch is now taking some referrals of non-acute sexual abuse cases.

D. DOMESTIC VIOLENCE COORDINATING COUNCIL

Maureen Monagle shared that the Domestic Violence Coordinating Council (DVCC) was awarded a sub-grant from the Criminal Justice Council. As a result, the DVCC, in partnership with DFS, will be working with the Safe and Together Institute for the next year.

E. FAMILY COURT

Judge Hitch reported the Court convened a committee to develop a process for informing the judges of the DFS history prior to awarding emergency relief for custody or guardianship petitions. The Court is also working on the Visit Host Guidelines, which will allow more visitation for parents of children in DSCYF Custody outside of the standard work week. Additionally, Judge Hitch shared an update on the social work program in New Castle and Sussex Counties. The social worker continues to work with the Parent Attorney to support the parents, and the Court is conducting a study of 50 cases to determine its effectiveness.

Chief Judge Newell shared an update on the custody report for private guardianship cases. Family Court Form 16(b) has been approved by the Supreme Court and will be implemented in January 2018.

F. LAW ENFORCEMENT

Cpl. Adrienne Owen provided an update on the failure to report cases involving the Delaware State Police. She has discussed the cases with Janice Tigani, Esq. at the Department of Justice, and a process is in place for DSP to receive more timely notifications of the failure to reports from the Office of the Investigation Coordinator. In addition, Cpl. Owen has agreed to contact the School Resource Officers about mandatory reporting since many of these cases involve extra-familial reports occurring between students.

Cpl. Owen share an update on the MOU for the Multidisciplinary Response to Child Abuse and Neglect. A Train-the-Trainer session has been scheduled for each county for all signatory agencies. New Castle County will receive the training tomorrow, and Kent and Sussex Counties will be trained next month. Lastly, Cpl. Owen has been speaking with the community about human trafficking to raise awareness, and she has been discussing the work of the CAN Best Practices Workgroup and the Trafficking Protocol at these events.

IX. CPAC COMMITTEE REPORTS

All reports were submitted in writing and included in the email correspondence sent to CPAC.

X. PUBLIC COMMENT AND ADJOURNMENT

Ellen Levin encouraged members to attend the Children and Families First event on November 14th in which they will be honoring Dr. Colmorgen and Jennifer Donahue, Esq. In addition, Caroline Jones encouraged members to attend the My Blue Duffel Community Service Day hosted by Kind to Kids. They will also be honoring Carla Benson-Green with the Distinguished Service Award.

The meeting was adjourned at 11:02 a.m.

State of Delaware Child Protection Accountability Commission
Quarterly Meeting Minutes

WEDNESDAY, FEBRUARY 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:**
Ginger Ward, Chair	Child Protection Community 16 Del. C. § 931(a)(16)
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)
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)
Corporal 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)
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)
Ellen Levin	At-large Member - Child Protection Community 16 Del. C. § 931(a)(16)
Randall Williams	At-large Member - Child Protection Community 16 Del. C. § 931(a)(16)

Staff:
Tania Culley, Esq., Executive Director
Rosalie Morales
Stepfanie Scollo

Members of the Public:

Megan Caudell	Sue Murray	Eleanor Torres, Esq.
Islanda Finamore, Esq.	Rachael Neff	Brittany Willard
Kim Lipre	Marissa Reed	

I. CHAIRPERSON'S WELCOME AND INTRODUCTIONS

Ginger Ward opened the meeting and welcomed the attendees.

II. APPROVAL OF MINUTES

The minutes from November 12th, 2017 were approved. 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/LEGISLATIVE REPORT

Tania Culley, Esq. provided the Executive Director's report. OCA has filled its casual seasonal Data Analyst position and its Kent/Sussex Family Crisis Therapist position. To increase the Court Appointed Special Advocate (CASA) volunteers, OCA is working on a recruitment strategy. The new CASA training will begin in the Spring of 2018. Ms. Culley also reported on OCA's efforts to ensure a consistent statewide approach to cases. Ms. Culley discussed the caseloads for Deputy Child Advocates and Contract Child Attorneys and the number of children entering DSCYF custody across the state. Ms. Culley also shared that OCA has acquired their new data management system, Apricot, which should be in operation by the summer.

On behalf of CPAC, Ms. Culley and Ms. Morales gave a presentation to the Joint Legislative Oversight and Sunset Committee on February 13, 2018. CPAC Chair, Ginger Ward, was also present. Final recommendations will be presented and released prior to June 30th.

IV. CDRC/CPAC JOINT RETREAT – 4/25/18 – FORMAT AND AGENDA

The Joint Retreat will be held at Troop 2 on April 25, 2018. Ms. Culley gave an overview of the agenda and what to expect at the retreat. Commissioners asked for fewer groups and for the packets with the findings to be distributed in advance of the meeting.

V. INVESTIGATION COORDINATOR REPORT/SEI REPORT

Jennifer Donahue. Esq. reported on 2017 data from the Office of the Investigation Coordinator (IC). She presented on the death, serious physical injury and sexual abuse cases opened in 2017 and reviewed the closed cases for incidents occurring in 2016 and 2017 and provided an analysis of several data points collected on these cases. Ms. Donahue indicated the number of infants born with prenatal substance exposure in 2017, where a notification was made to DFS. Additionally, Ms. Donahue mentioned the progress of the In-Depth Technical Assistance for Substance Exposed Infants from the National Center on Substance Abuse and Child Welfare. The Plan of Safe Care template and pilot program at several birth hospitals was also discussed.

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 Office of the Investigation Coordinator, Children's Advocacy Center interviews, children in DSCYF custody (entries and at the end of the quarter), and permanency outcomes for children.

VII. CHILD ABUSE AND NEGLECT DEATH/NEAR DEATH REVIEWS

A. CAN CASELOADS REPORT/ADMINISTRATIVE UPDATE

Ms. Culley reported that there are 61 CAN cases open with 14 cases before the Commission today for approval. For 2017, 13 children have died and another 30 have almost died from abuse or neglect.

B. CAN FINDINGS/DETAILS/LETTER TO GOVERNOR

Ms. Morales reported on the 14 cases reviewed by the CAN Panel in the last quarter. 12 cases (3 deaths and 9 near deaths) were reviewed by the Panel for the first time. The 12 cases resulted in 49 strengths and 73 findings across system areas. The Governor's letter outlines how the strengths and findings were distributed and the solutions CPAC has identified to address the system issues. Dr. Colmorgen motioned to approve the letter to the Governor and Randy Williams seconded his motion. All other members voted in favor.

VIII. COMMISSIONER REPORTS

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

I. DIVISION OF FAMILY SERVICES

Trenee Parker shared an update on the DFS Caseloads, the impact of case worker turnover and the strategies to hire additional case workers. In addition, Ms. Parker discussed the transition to FOCUS and how the Division has been navigating the issues with its implementation.

B. CHILDREN'S ADVOCACY CENTER

Randall Williams shared an update on the OMB Budget Hearing for the Children's Department. He previously discussed the impact of the budget cuts to services provided by the CAC and requested that funding be restored. The funding has since been placed in the Governor's Recommended Budget.

C. DEPARTMENT OF JUSTICE

James Kriner, Esq. reported that a full time deputy was added to the Special Victims Unit in New Castle County. Resources are still needed for Kent and Sussex Counties.

D. PUBLIC DEFENDER'S OFFICE

Kathryn Lunger, Esq. reported that the Office of Defense Services has a package of juvenile justice legislation moving through the General Assembly.

IX. CPAC COMMITTEE REPORTS

A. CASELOADS/ WORKLOADS COMMITTEE

Sue Murray reported that the Committee is working with Delaware State University (DSU) to conduct a Caseloads/Workloads Study with DFS treatment workers. The group was able to adapt the tool used by Colorado during its caseloads/workloads study to include categories specific to Delaware. The purpose of the tool is to determine how long treatment case workers take to complete various tasks. They plan to identify 2 case workers in each region to pilot the survey for two weeks. Once this has been done, Delaware State University will do a focus group to determine if any revisions are needed. Then, the full survey will be rolled out for 4 weeks to all 77 treatment workers statewide, including those in the pilot. Delaware State

University will prepare a report with their analysis, which will be submitted to this Committee and CPAC for approval.

B. EDUCATION COMMITTEE

Susan Haberstroh reported that the Committee continues to oversee a strategic plan to improve outcomes for youth in foster care including trauma-informed programs in schools through a district collaborative in partnership with the grant from Casey Family Programs. In addition, the Committee continues to promote the use of the Comprehensive Education Report. The group is also overhauling the MOU between DOE and DSCYF with updated language regarding reports of abuse/neglect, Every Student Succeeds Act (ESSA), and best interest decisions. Lastly, a new workgroup was created to update the training requirements set forth for school personnel and 60,000 students in grades pre-K through 6th in Senate Bill 102.

C. TRAINING COMMITTEE

Ms. Morales gave an update on the Committee's 7 workgroups. The Protecting Delaware's Children's Conference has been scheduled for April 2, 2019 at Dover Downs. The workgroup will be meeting again in March to begin planning.

Adrienne Owen, Diane Klecan and Rosalie Morales will present a workshop on how Delaware developed the MOU for the Multidisciplinary Response to Child Abuse and Neglect at the Crimes Against Children Conference in Dallas, Texas. At the end of the year, Train-the-Trainer sessions were held in each county with various representatives from the multidisciplinary team (MDT).

The CornerHouse On-site Basic Forensic Interview Training was held in December 2017. Julie Stauffer, a Forensic Interviewer at CornerHouse, provided a three-and-a-half-day training to 34 professionals from Law Enforcement, DFS and DOJ. The training was sponsored by the federal Children's Justice Act Grant, NCCPD and Wilmington University.

The Mandatory Reporting Workgroup met at the end of the year to identify additional approved training topics for school personnel contemplated by Senate Bill 102. These topics include: student on student sexual abuse, child neglect, sexting and child pornography, Stewards of Children, Compassionate Schools and other topics.

The Cross Education Workgroup is preparing an online training program for the domestic violence 101 PowerPoint created by the Domestic Violence Coordinating Council. The Workgroup hopes to have the training available online within the next few months.

The De-Escalation Workgroup has been considering solutions to the barriers around having an independent physician, such as a pediatric neurologist, evaluate a child. The workgroup also discussed implementation of orders de-escalating life support and the aftermath thereof. A final report and protocol is expected in the next 6 months.

The newest workgroup under the Training Committee is MDT Case Review. It's chaired by Jen Donahue and Jim Kriner. The group has met twice so far to discuss changes to the Case Review Protocol in DE.

Currently, only cases referred to the CAC for a forensic interview are put on the Case Review Schedule. The case will be expanded to include all MDT Cases.

X. PUBLIC COMMENT AND ADJOURNMENT

There was no public comment.

The meeting was adjourned at 11:02 a.m.

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

May 2017 - May 2018

FINDINGS

	*Current	Grand Total
MDT Response	**72**	**72**
Communication	4	4
Crime Scene	8	8
Doll Re-enactment	4	4
General - Civil Investigation	4	4
General - Criminal Investigation	5	5
Intake with DOJ	1	1
Interviews - Adult	13	13
Interviews - Child	13	13
Medical Exam	12	12
Prosecution/ Pleas/ Sentence	4	4
Reporting	4	4
Grand Total	**72**	**72**

**Current - within 1 year of incident*

Child Protection Accountability Commission
Child Abuse and Neglect Panel
Findings Detail and Rationale
May 2017 - May 2018

FINDINGS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			72
	Communication		4
		There was no communication with the law enforcement agency by DOJ.	1
		Ongoing communication with the law enforcement agency by DOJ did not occur to determine if additional investigative actions were needed.	1
		There was no documentation that the law enforcement agency and DOJ had ongoing communication about the near death incident.	1
		In the prior investigation, the treatment caseworker gathered information from witnesses about inconsistencies in the stories provided by parents, and this information was not relayed to the caseworker investigating the allegations of abuse.	1
	Crime Scene		8
		No scene investigation was completed by the law enforcement agency.	5
		The law enforcement agency did not obtain a search warrant for the home. The scene was not photographed and no evidence was collected (i.e. bottles and pills).	1
		The law enforcement agency did not obtain measurements from the scene related to an alleged fall.	1
		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		4
		No doll re-enactment was completed by the law enforcement agency.	3
		No official doll re-enactment was completed by the law enforcement agency.	1
	General - Civil Investigation		4
		Although it initially appeared that the injury occurred at the daycare, DFS closed the family case prematurely when none of the parties were completely ruled out as suspects.	1
		During the initial response to near death incident, DFS and LE were not aware of the active PFA between the parents.	1
		At the close of the near death investigation, the mother was deemed to be a protective caregiver by DFS despite indicators that she was downplaying the perpetrator's actions.	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		5
		The surviving children were left unsupervised at the scene with mother after first responders transported the victim to the hospital emergency department.	1

	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
Intake with DOJ		1
	The law enforcement agency had no immediate contact with DOJ after receiving notification of a child death.	1
Interviews - Adult		13
	DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	3
	Interviews were not conducted with other witnesses who had a caregiving responsibility for the child.	1
	During the prior investigation, another relative was utilized to translate the conversation between the caseworker and parent.	1
	During the near death investigation, DFS and LE did not seek assistance from an interpreter to conduct interviews with the mother. Other adults were utilized to translate the conversations.	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		13
	There was a delay in scheduling the forensic interview with the young child, who resided in the home where the incident occurred.	1
	Forensic interview did not occur with the youth who was present during the incident.	1
	There was a delay in referring the young child to a children's advocacy center for a forensic interview.	1
	Forensic interviews did not occur with the older siblings during the death investigation.	1
	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.	2
	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
	The MDT did not consider compelling the family to cooperate with the forensic interviews.	1
Medical Exam		12
	The young sibling was not medically evaluated.	1
	The child abuse medical expert was not contacted directly to discuss the medical findings.	1
	The DFS caseworker did not independently contact the child abuse medical expert to discuss the medical findings. As a result, the explanation provided by the parents was determined to be plausible, and the safety agreement was modified and the case closed.	1
	There was a miscommunication about the CARE Team findings by the MDT. All team members were not aware that the child abuse medical expert concluded that the victim's fractures and areas of bruising were highly concerning for child physical abuse.	1
	Pictures taken by the forensic nurse were not obtained by the DFS caseworker in the prior investigation. This could have prompted the assigned worker to seek input from the child abuse medical expert.	1
	A separate investigation was not immediately opened for the other children in the home of the near death incident, and as a result, it impacted the oversight of the medical exams for these children.	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
Prosecution/ Pleas/ Sentence		4
	All the jail time was suspended for the defendant despite the guilty plea to a violent felony with a presumptive jail sentence.	1
	The sentencing order required the defendant to complete an anger management program and not a certified batterer's treatment program.	1
	Father's charges were not handled in Superior Court. Instead, the charges were screened out to Family Court, and ultimately Nolle Prossed.	1
	Delaware does not have a criminal negligence standard to prosecute these cases under the current child abuse laws.	1

	Reporting		4
		DFS was not notified of the child death until immediately prior to the forensic interview of the young sibling. As a result, DFS was not able to observe any early suspect/witness interviews due to the delayed report by the law enforcement agency.	1
		The DFS Report Line was not contacted despite the victim being present during a DUI and domestic incident involving the alleged perpetrator. This occurred prior to the victim's death, and a hotline report would have given DFS the opportunity to provide an intervention.	1
		The DFS caseworker delayed reporting the near death incident to the law enforcement agency, and as a result, there was no blood draw or crime scene investigation.	1
		The DFS caseworker delayed reporting the child's suspected drug overdose to the law enforcement agency.	1
Grand Total			72

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

May 2017 - May 2018

STRENGTHS			
	***Current**	****Prior**	**Grand Total**
MDT Response	**104**	**2**	**106**
Crime Scene	4		4
Documentation	4		4
General - Civil Investigation	31	2	33
General - Criminal Investigation	22		22
General - Criminal/Civil Investigation	28		28
Interviews - Adults	3		3
Interviews - Child	7		7
Medical Exam	4		4
Prosecution/Pleas/Sentence	1		1
Grand Total	**104**	**2**	**106**

*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 Protection Accountability Commission
Child Abuse and Neglect Panel
Strengths Detail and Rationale
May 2017 - May 2018

STRENGTHS

System Area	Strength	Rationale	Count of #
MDT Response			106
	Crime Scene		4
		Thorough scene investigation was completed by the law enforcement agency.	1
		The law enforcement agency conducted a thorough scene investigation.	1
		The law enforcement agency conducted a thorough scene investigation, which included a search warrant of the parents' phones.	1
		The law enforcement agency conducted a thorough scene investigation, which included a search warrant of the daycare workers' phones.	1
	Documentation		4
		The law enforcement agency documented its contact with victim services.	1
		The law enforcement report clearly documented all investigative steps taken and provided a timeline of events relating to the near death. Records were also obtained from an out of state hospital.	1
		The DFS caseworker thoroughly documented the case events in the near death investigation.	2
	General - Civil Investigation		33
		The DFS caseworker consulted with the child abuse medical expert.	1
		The DFS caseworker immediately followed-up on the hotline report made by the patrol officer regarding a possible violation of the No Contact Order.	1
		DFS identified appropriate family members, and a foster care placement was avoided for the sibling.	1
		Excellent investigation by the DFS caseworker, to include a Framework prior to case closure and medical assessment of the older sibling.	1
		The weekend DFS caseworker reached out to the children's hospital following the allegations, and asked the medical staff to call back if there were additional concerns.	1
		The DFS caseworker maintained great communication with the family.	1
		During the prior investigation, the DFS caseworker appropriately ruled out the child's father due to his criminal and DFS history.	1
		The DFS safety agreement remained in place until collaterals were completed and the criminal investigation concluded.	1
		A thorough investigation was completed by the DFS caseworker, to include a Framework and referral to the drug and alcohol liaison for the mother.	1
		The DFS caseworker conducted a thorough investigation, to include seeking custody of the child, communication with the relative, visitations with maternal and paternal families, and paying special attention to the child's follow up medical care.	1
		Following a new hotline report, the DFS caseworker consulted with the treatment worker handling the active treatment case.	1

	During the near death investigation, the DFS caseworker revisited the child's bruising incident from the prior investigation, and as a result, a finding of abuse was made against the mother.	1
	The DFS caseworker 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
	At the conclusion of the DFS investigation, both parents were substantiated for abuse and neglect despite not knowing who caused the child's injuries.	1
	Upon closure of the prior treatment case when the family moved out of state, the DFS treatment caseworker made a referral to the out of state child protective services agency.	1
	DFS completed two group supervisions and a Framework during the death investigation.	1
	During the death investigation, the DFS caseworker contacted the mother's physician for confirmation of her prescription.	1
	After concern was raised by the CARE Team, DFS immediately transported the child back to the hospital emergency department for a medical evaluation and later sought custody.	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
	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

General - Criminal Investigation		22
	There was good collaboration between the family services and drug squad units.	1
	There was good collaboration between the law enforcement agency and DOJ. The communication and charging decision occurred quickly.	1
	The patrol officer conducting the traffic stop made a hotline report to DFS regarding a possible violation of the No Contact Order.	1
	A thorough infant death investigation was conducted by the law enforcement agency, to include immediate contact with MDT partners, search warrants for multiple areas, photographs of the scene, collection of evidence, and completion of the SUIDI form.	1
	The law enforcement agency conducted thorough witness interviews to include expert medical consultation.	1
	A thorough near death investigation was conducted by the law enforcement agency, to include immediate contact with MDT partners, collaboration with outside law enforcment agencies, search warrants, photographs and measurements of the scene, and creating a timeline of events by corroborating evidence.	1
	A thorough investigation was completed by the law enforcement agency, to include multiple interviews with the suspects and cell phone analysis.	1
	The law enforcement detective was present during the Family Court proceedings.	1
	A thorough investigation was completed by the law enforcement agency, to include multiple interviews with the suspects, cell phone analysis, and social media preservation.	1
	There was excellent collaboration between the two involved law enforcement agencies, to include information sharing and joint interviews..	1
	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
	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

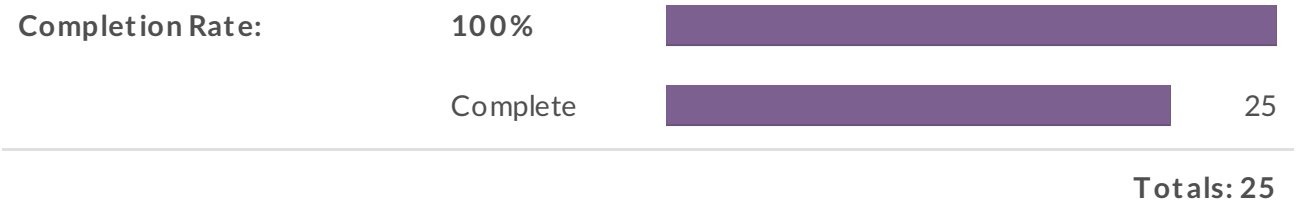
General - Criminal/Civil Investigation		28
	There was great collaboration between the law enforcement agency and the Institutional Abuse caseworker with DFS.	1
	There was great MDT response to the investigation by all parties.	2
	Excellent collaboration between DFS and the law enforcement agency, including consultation with the CARE Team.	1
	There was great collaboration between the law enforcement agency, DFS, and DOJ, and a thorough investigation was conducted despite the initial presentation of the case.	1
	Great collaboration between the MDT members, and response to the death investigation, to include completion of the SUIDI Form, a doll reenactment, toxicology of the mother, forensic interviews of the siblings, and DFS obtaining custody of the siblings.	1
	Great collaboration between the MDT members, and response to the death investigation, to include completion of the SUIDI Form, a doll reenactment, toxicology of the mother, forensic interview of the older sibling, and DFS obtaining custody of the siblings.	1
	Great collaborative response between DFS and the law enforcement agency during the infant death investigation, to include the DFS caseworker observing the law enforcement interviews.	1
	DFS and law enforcement responded jointly and were both present during the witness interviews at the hospital.	1
	Great collaboration between the medical staff, DFS caseworker, and law enforcement agency.	1
	Great collaborative response between the medical facility, DFS, and the law enforcement agency during the near death investigation.	1
	There was clear and concise communication between all parties relating to the no contact order against the mother and her paramour while the child was hospitalized.	1
	Great collaboration between the MDT members to include joint interviews, a hospital meeting, child safety agreement while the child was hospitalized, and timely charging decisions.	1
	There was great MDT collaboration by all parties during the near death investigation, to include consultation with the out of state authorities.	1
	Great collaboration between DFS and the law enforcement agency, to include repsonse to both homes and safety agreements being implemented.	1
	Great collaborative response between the medical CARE Team, DFS, and the law enforcement agency during the near death investigation.	1
	Great collaboration between the MDT members to include joint interviews and consistent communication between all parties.	1
	During the near death investigation, there was a great MDT response to include joint interviews, forensic interviews of other involved children, DFS custody and relative placement of the sibling.	1

	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.	3
	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
	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
Interviews - Adults		3
	The law enforcement agency was able to obtain a partial confession from the defendant.	1
	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		7
	Forensic interview was conducted with the young sibling although no abuse and/or neglect was initially suspected.	1
	All MDT members were present during the forensic interview of the child's older sibling.	1
	A forensic interview was conducted with the sibling despite the child being outside the home at the time of injury.	1
	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		4
	The second-shift DFS caseworker ensured the older sibling was medically evaluated.	1
	The DFS caseworker ensured the child's siblings and other children in the home were medically evaluated.	1
	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.	1

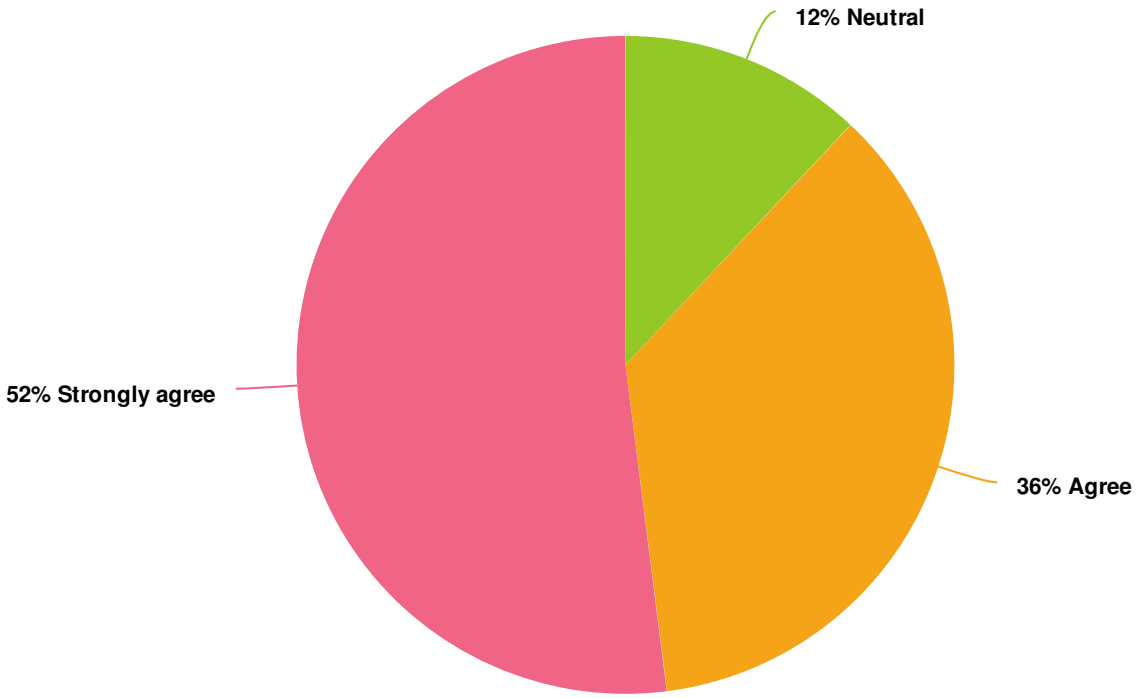
	Prosecution/ Pleas/Sentence	1
	DOJ convened a team meeting with DFS and LE to plan and discuss the ongoing investigation.	1
Grand Total		**106**

Report for On-Site Basic Forensic Interview Evaluation- with Julie Stauffer in Delaware

Response Counts



1. The registration process was clear and straightforward.



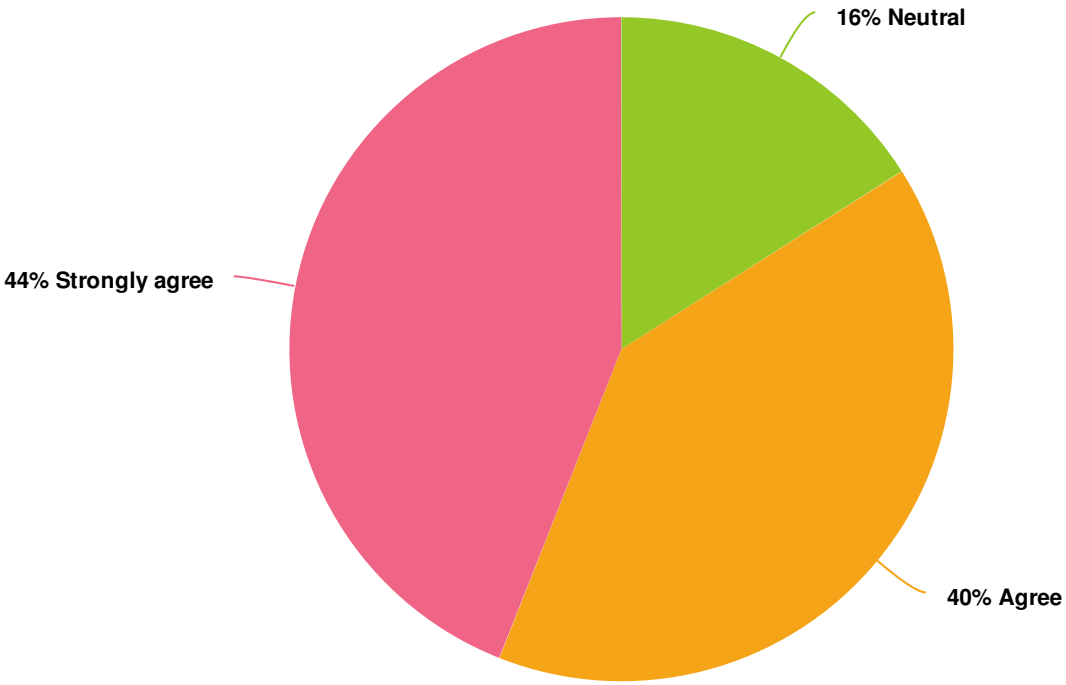
Value	Percent	Responses
Neutral	12.0%	3
Agree	36.0%	9
Strongly agree	52.0%	13

Totals: 25

2. The registration process was clear and straightforward. - comments

Count	Response
1	I did not register myself so I am unable to evaluate that
1	None
1	There was a large amount of information for a short period of time.

3. Advance communication with CornerHouse staff regarding my participation in this training was clear, complete, and timely. Please limit your responses to the registration process and participation information only; separate questions will gather data about your on-line learning experiences.



Value	Percent	Responses
Neutral	16.0%	4
Agree	40.0%	10
Strongly agree	44.0%	11

Totals: 25

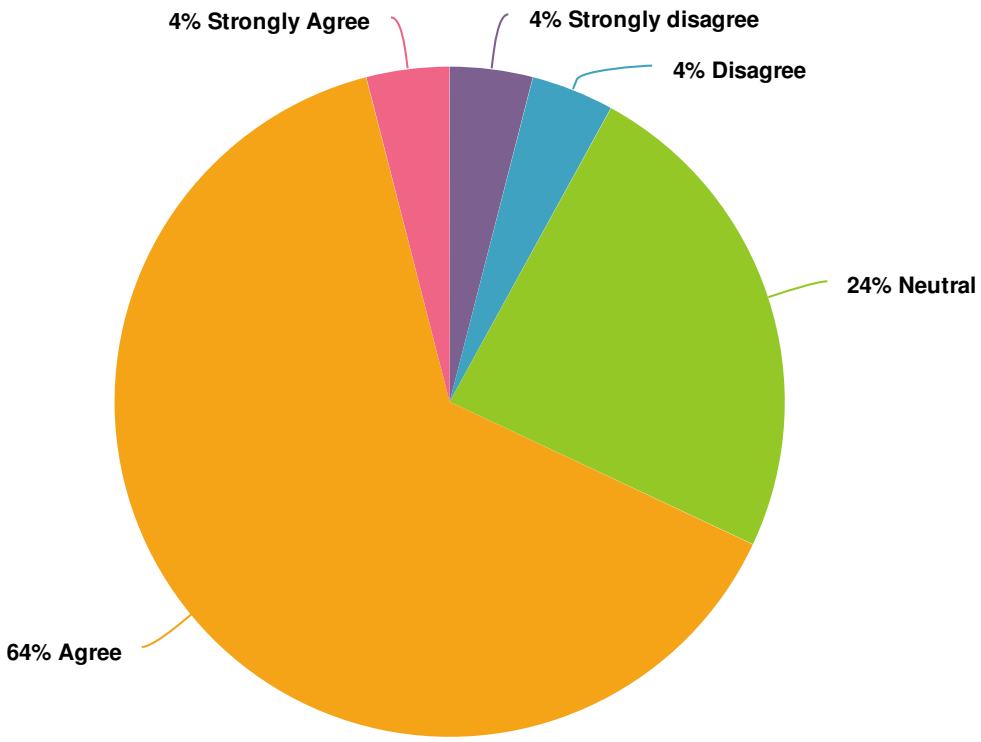
4. Advance communication with CornerHouse staff regarding my participation in this training was clear, complete, and timely. Please limit your responses to the registration process and participation information only; separate questions will gather data about your on-line learning experiences. - comments

Count	Response
1	Didn't have much.
1	None
1	same as first answer

5. Please rate the value of each of the following types of learning activities used during this training. (A score of 1=extremely unsatisfactory; a score of 3=neutral; a score of 5=highly satisfactory.)

	1	2	3	4	5	Responses
Watching video examples of actual interviews Count Row %	0 0.0%	2 8.0%	3 12.0%	8 32.0%	12 48.0%	25
Engaging in role plays with other learners Count Row %	0 0.0%	1 4.0%	8 32.0%	9 36.0%	7 28.0%	25
Listening to the trainer Count Row %	2 8.0%	7 28.0%	7 28.0%	7 28.0%	2 8.0%	25
Completing pre-course readings Count Row %	1 4.0%	2 8.0%	11 44.0%	7 28.0%	4 16.0%	25
Watching the PowerPoint presentations Count Row %	1 4.0%	3 12.0%	10 40.0%	8 32.0%	3 12.0%	25
Listening to and interacting with other learners Count Row %	0 0.0%	1 4.0%	7 28.0%	12 48.0%	5 20.0%	25
Participating in small group or paired activities Count Row %	0 0.0%	1 4.0%	4 16.0%	13 52.0%	7 28.0%	25
Reviewing materials included in the online classroom Count Row %	0 0.0%	4 16.0%	10 40.0%	8 32.0%	3 12.0%	25
Totals Total Responses						25

6. The role play experiences adequately prepared me to conduct an actual forensic interview.



Value	Percent	Responses
Strongly disagree	4.0%	1
Disagree	4.0%	1
Neutral	24.0%	6
Agree	64.0%	16
Strongly Agree	4.0%	1

Totals: 25

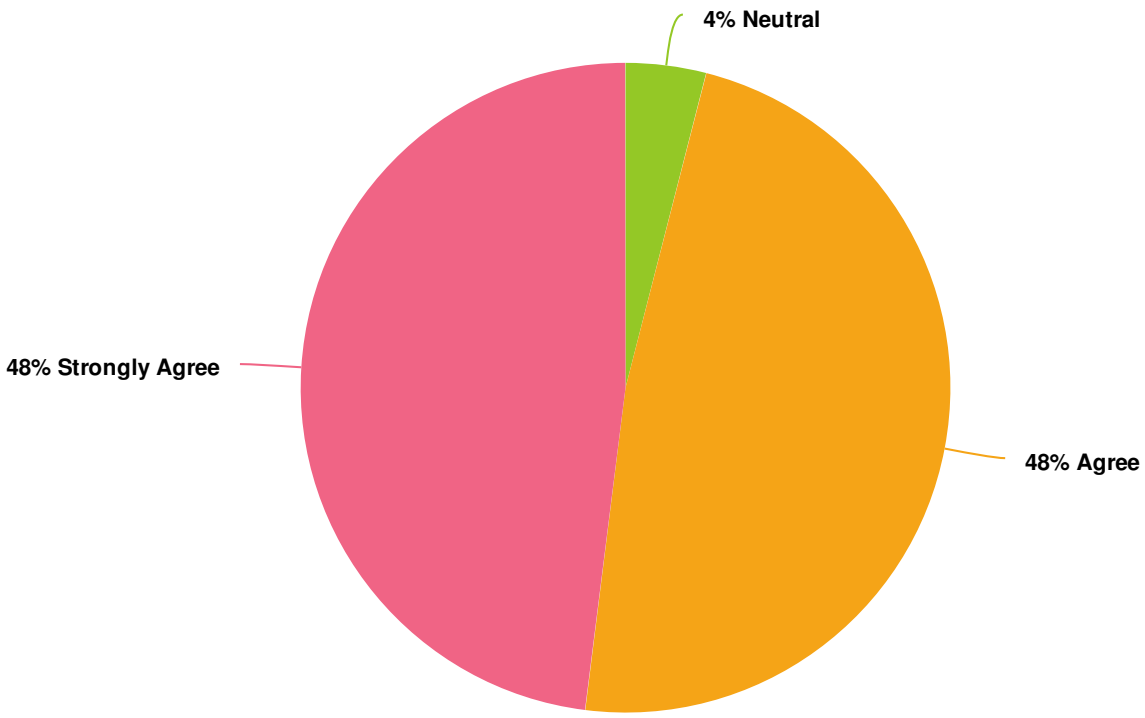
7. Please rate the value of each of the following: (A score of 1=extremely unsatisfactory; a score of 3=neutral; a score of 5=highly satisfactory)

	1	2	3	4	5	Responses
Pre-course online required readings Count Row %	1 4.0%	1 4.0%	11 44.0%	10 40.0%	2 8.0%	25
Pre-course online learning activities Count Row %	1 4.0%	3 12.0%	11 44.0%	7 28.0%	3 12.0%	25
Pre-course suggested reading materials Count Row %	2 8.0%	2 8.0%	11 44.0%	8 32.0%	2 8.0%	25
Ability to complete required activities before in-person learning Count Row %	0 0.0%	3 12.0%	12 48.0%	7 28.0%	3 12.0%	25
Ease of access to the Canvas Online Learning Environment Count Row %	0 0.0%	1 4.0%	13 52.0%	5 20.0%	6 24.0%	25
CornerHouse's use of the Blended Learning style Count Row %	0 0.0%	1 4.0%	11 44.0%	9 36.0%	4 16.0%	25
Totals Total Responses						25

8. If you were unable to complete the online pre-course required readings and activities, please list the primary barrier:

ResponseID	Response
2	Na
4	N/a
5	None
6	There were a lot of readings for each day, which was difficult to complete and still manage outside work during the week.
17	I was unable to login after several attempts made
23	N/A

9. Please respond to the following statement about the content trainer. The primary trainer has expert-level content knowledge.



Value	Percent	Responses
Neutral	4.0%	1
Agree	48.0%	12
Strongly Agree	48.0%	12

Totals: 25

10. Please respond to the following statement about the content trainer. The primary trainer has expert-level content knowledge. - comments

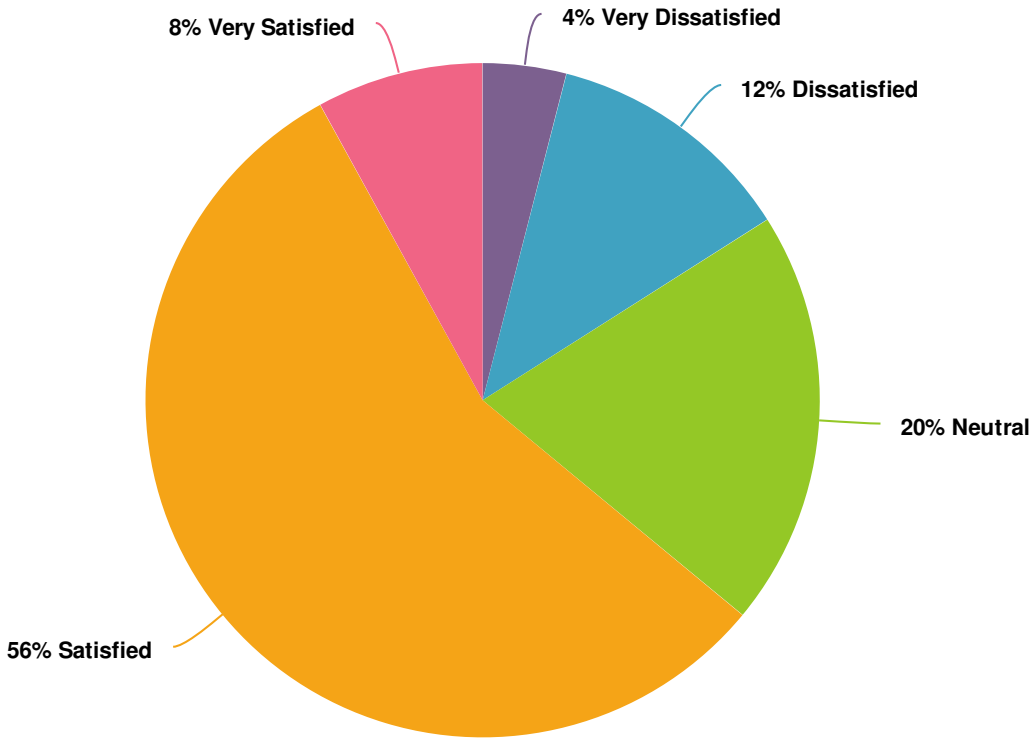
Count	Response
1	I think the trainer was very knowledgeable; however, she just needs to work on her presentation skills to keep the audience engaged.
1	Julie is knowledgeable in Forensic Interviewing, but had difficulty getting the audience to participate.
1	She seemed very nice and extremely knowledgeable, but the course and the way it was presented was extremely boring and way too long.
1	The instructor was very knowledgeable and used experience to assist in teaching the course.
1	Very Knowledgeable.

11. What specific suggestions do you have for the primary trainer(s) that will help them improve their skills?

ResponseID	Response
2	More breaks every hour. Can go faster through slides and concepts. Swelled too much on one topic. Course could be taught in 2 days
3	The trainer had expert knowledge of the material but I feel the material was presented in a way that did not capture my attention and was difficult to focus.
4	I thought the material could be presented more condensed than 4 days
5	"Um" and "ah" every 5-6 seconds while talking became very irritating after 2nd day of training. I completely understand when having to cover that much material but she may want to work on cutting out the "um" and "ah" so much.
6	It was hard to sit through the whole day of someone talking. There were videos and small group assignments but there were not many things to keep people engaged in the conversations. This made it difficult to focus the whole time and be able to sit for the entire day.
7	More role playing activities. Less reading straight from the power point.
8	A course that contained a lot of good material but failed upon delivery. Instructor was not dealing with a shy class in the sense that the group would ask questions when they had them. Despite this, instructor would delay when group did NOT have any questions, and would think of her own questions to ask herself before reaching a point where she feels that she could advance in the lesson. This process of delaying because one feels that not enough questions has been asked quickly loses the attention of the audience. Frequently, I would get together with a small group for an activity and none of the members knew what we were doing as the instructor had lost their attention long prior to instructions
9	Avoid using videos with actor.
10	The material was drawn out much longer and watered down than it needed to be.
12	We were all adults in the training. It was unnecessary to spend 3 hours on one slide and waste time trying to pry more answers out of us.
13	More group activities
14	When we have 3 1/2 days of training, don't keep us right up until the end time or late.

ResponseID	Response
16	She did great.
18	Hatted the interviews with adult actors. Creepy! Other co-workers completed the training (which included forensic interviewing) a few years ago and stated it was fun and interesting. This course was neither. Interesting topic, but so painfully boring and long the way it was presented.
21	engaging the audience. Not relying on Audience feed back to keep the training engaged.
22	do not use examples and video clips of interviews with a adult actor portraying a child. It was very distracting .
25	Felt as if the content could have been covered in less time.
26	Less boring

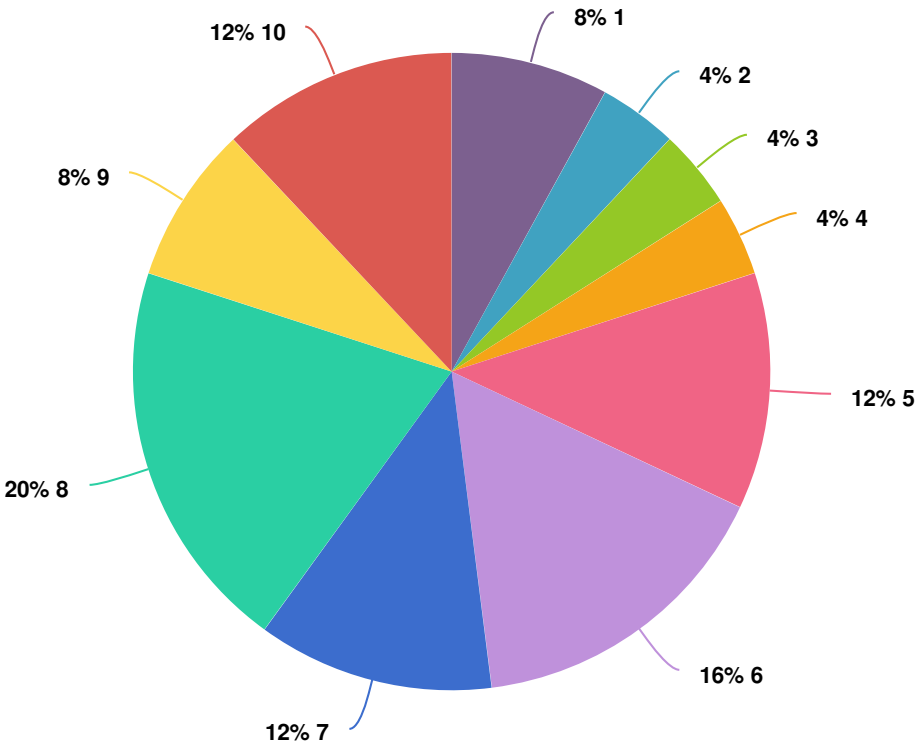
12. Overall, how satisfied are you with the experience you had at this training?



Value	Percent	Responses
Very Dissatisfied	4.0%	1
Dissatisfied	12.0%	3
Neutral	20.0%	5
Satisfied	56.0%	14
Very Satisfied	8.0%	2

Totals: 25

13. How likely are you to recommend this CornerHouse On-Site Basic Forensic Interview Training to other professionals in the field? (A score of 1=not at all likely; a score of 5=neutral; a score of 10=highly likely.)



Value		Percent	Responses
1		8.0%	2
2		4.0%	1
3		4.0%	1
4		4.0%	1
5		12.0%	3
6		16.0%	4
7		12.0%	3
8		20.0%	5
9		8.0%	2
10		12.0%	3

Totals: 25

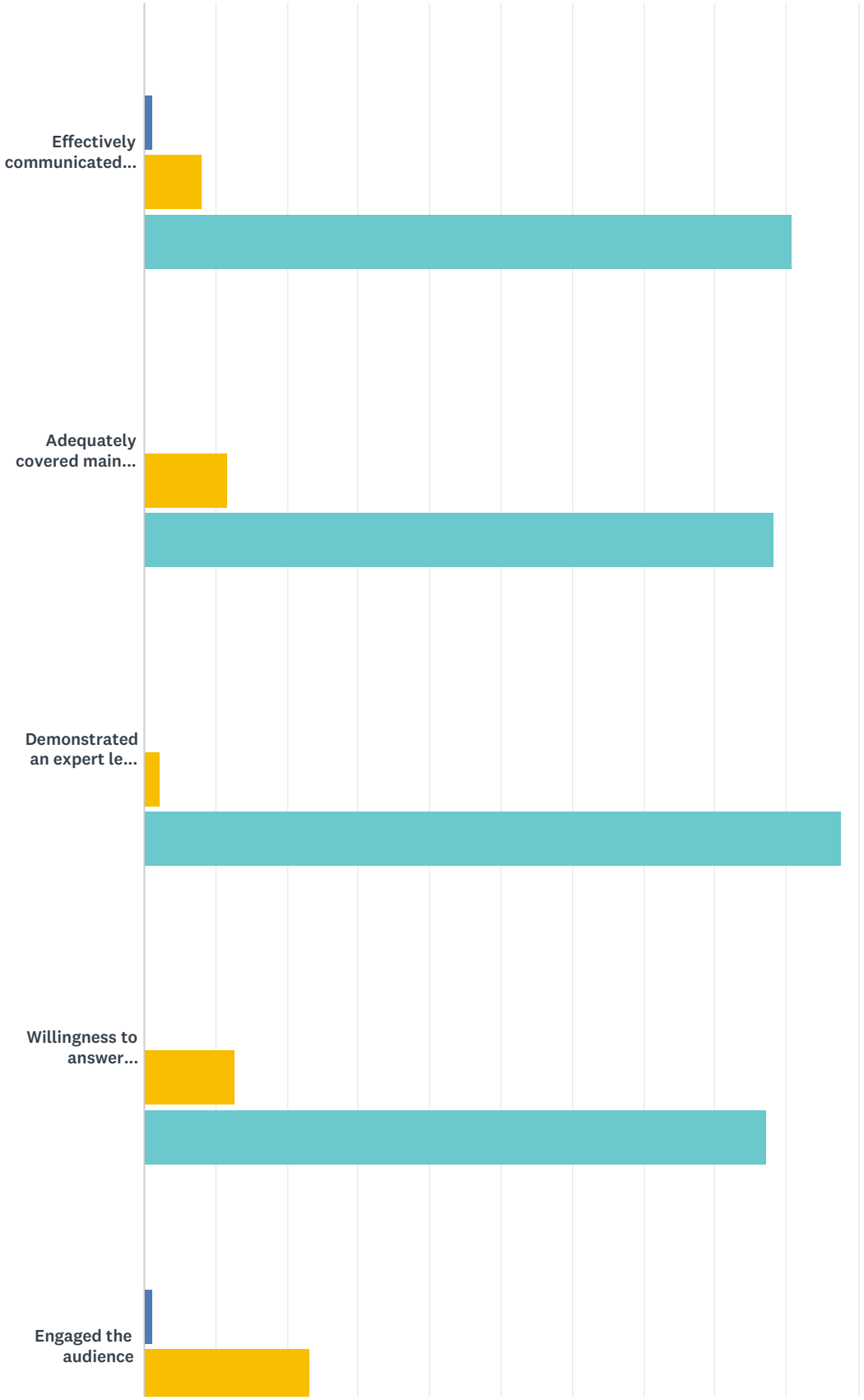
14. The CornerHouse Training Department actively seeks and relies on feedback from our community of learners to continuously improve and grow its programs. Please use this space to give us any other thoughts, ideas, suggestions, praise and opportunities for improvement you would like to give us! Thank you for choosing CornerHouse, and for the work you do to strengthen communities throughout the country.

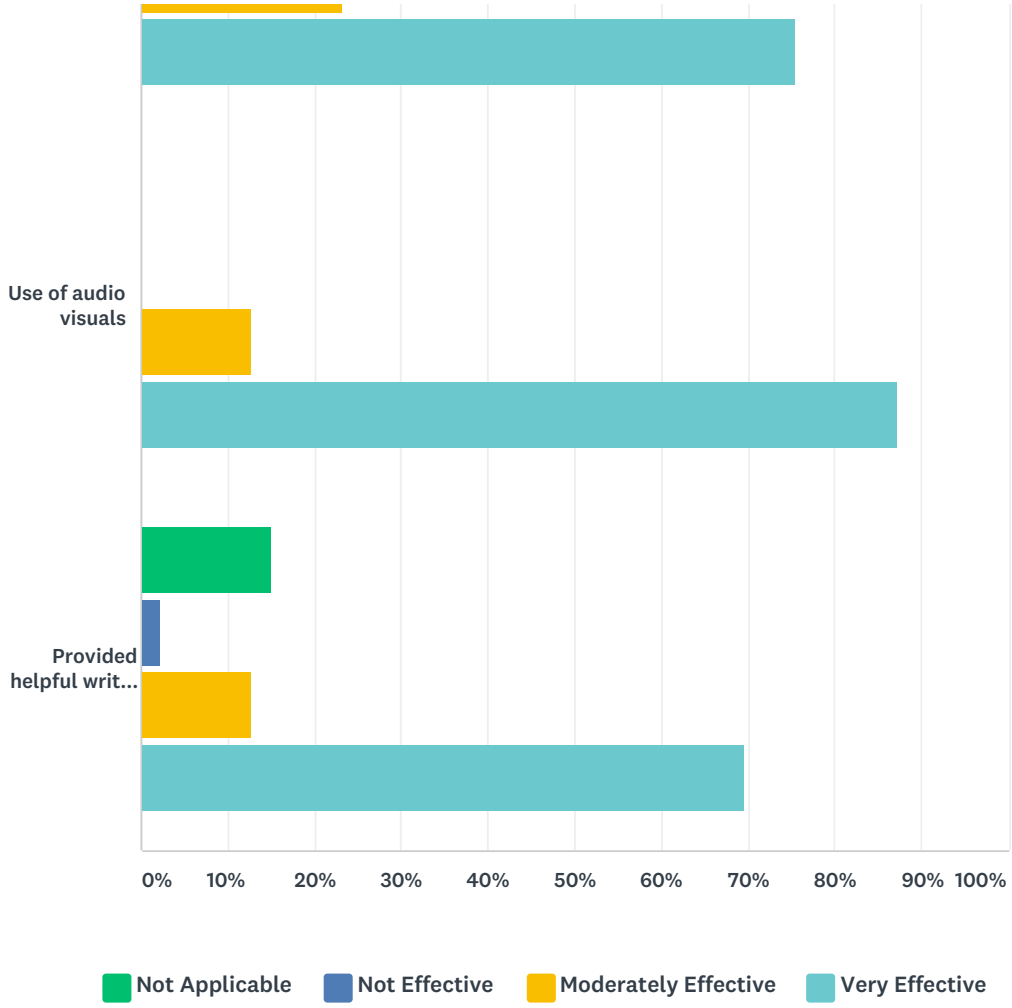
ResponseID	Response
2	Breaks and not dwelling on same concept
3	I would have liked to see more group exercises to keep my attention and better learn the material. I did not like the use of a roleplayer in the recorded videos presented. I feel the presenter was very knowledgeable but with the amount of powerpoint presented and repetitive material this course was drawn out and could have been 2.5 days instead of 3.5.
5	None. Good Course.
6	The trainer was very knowledgeable and showed that she really loves/cares about her work. I would suggest finding ways to make the training part more interactive. A lot of the topics that we spent a long period of time talking about are things that many of the group already knew. I would suggest trying to judge the about of knowledge the group has and tailoring the training to that.
7	This training coarse is useful for officers who would conduct interviews but I feel it could be completed in less days and seemed repetitious.
8	Do not stall and delay your instruction for the sake of filling every last minute of the instruction block.
10	The trainer had extended the criteria longer than it needed to be...if it was more intensive in less time, the material would have "stuck" better.
13	Julie is VERY knowledgeable!
14	I think the training could have been completed in 2 days instead of 3 1/2. It really dragged on. The child interviews were good to see; however, the interview with a child actor was very distracting. It would have been much better if it would have been an actual child. Also, the group activities broke up the lecture time.
16	The trainer did a great job!

ResponseID	Response
17	the training seemed to be a lot in a short period of time. I feel like if students wanted to ask questions then we would never get out of time or be close to finishing
18	Please make it fun and interesting as my co-worker and friend said the course she took several years ago. Already a fascinating subject, but could have been presented so much better. Thank you. Instead of role plays, maybe watch videos (only with real children) stop the video and ask what questions us as interviewers might ask next. Thank you. Lunch was the highlight of the training and it could have also been so much more exciting.
19	Though I did enjoy the training I believe it could have been taught in a shorter amount of time.
22	Training help inform about why CAC interviewers ask the questions in the format they use when interviewing children. This will be helpful in future investigations when a CAC interviewer inquires about what information I am seeking, I will now have a better understanding on how to word my questions.

Q1 Please rate the effectiveness of the instructor on the following:

Answered: 86 Skipped: 0





	NOT APPLICABLE	NOT EFFECTIVE	MODERATELY EFFECTIVE	VERY EFFECTIVE	TOTAL
Effectively communicated information	0.00% 0	1.16% 1	8.14% 7	90.70% 78	86
Adequately covered main topic points	0.00% 0	0.00% 0	11.63% 10	88.37% 76	86
Demonstrated an expert level of knowledge	0.00% 0	0.00% 0	2.33% 2	97.67% 84	86
Willingness to answer questions	0.00% 0	0.00% 0	12.79% 11	87.21% 75	86
Engaged the audience	0.00% 0	1.16% 1	23.26% 20	75.58% 65	86
Use of audio visuals	0.00% 0	0.00% 0	12.79% 11	87.21% 75	86
Provided helpful written material	15.12% 13	2.33% 2	12.79% 11	69.77% 60	86

Q2 What did the instructor do best?

Answered: 62 Skipped: 24

#	RESPONSES	DATE
1	Relaying information and training materials to attendees.	5/17/2018 2:12 PM
2	Very knowledgeable and added some humor to this very heavy topic.	5/17/2018 2:10 PM
3	Reiterated the main topic points.	5/17/2018 2:07 PM
4	Showed video clips related to her topics and assisted with the understanding of the lecture.	5/17/2018 2:05 PM
5	I appreciated the humor that balances the dark subject matter.	5/17/2018 2:02 PM
6	Accurate and backed up information with research.	5/17/2018 1:58 PM
7	Great flow of material and true mastery of the subject matter and research in the field.	5/17/2018 1:57 PM
8	I thought she did great with explaining topics and adding her own experiences.	5/17/2018 1:55 PM
9	Giving examples and pointing out what to look for in the videos.	5/17/2018 1:52 PM
10	Provided relevant videos to support research and slides.	5/17/2018 1:51 PM
11	She was engaging throughout the entire training. Great job!	5/17/2018 1:48 PM
12	Kept everyone interested; nice mix of videos, questions, and slides.	5/17/2018 1:47 PM
13	Fast moving and engaged the audience.	5/17/2018 1:45 PM
14	Kept the audience's attention/kept everyone engaged with the topics.	5/17/2018 1:44 PM
15	Provided insight into how sex offenders think.	5/17/2018 1:42 PM
16	The use of videos was great.	5/17/2018 1:39 PM
17	Incorporate videos.	5/17/2018 1:38 PM
18	Extensive subject matter knowledge.	5/17/2018 1:37 PM
19	This training is very informative. There was a lot of information.	5/17/2018 1:35 PM
20	Ms. Jenson knew what she was talking about and way well educated/informed. She did not have to read from her slides.	5/17/2018 1:28 PM
21	Her narrative of the presentation was very detailed. I like that she didn't just read from the slides.	5/17/2018 1:25 PM
22	She did a great job engaging the class.	5/17/2018 1:23 PM
23	The instructor spoke in terms that the audience could follow.	5/17/2018 1:21 PM
24	Knowledge, engagement, personable.	5/17/2018 1:19 PM
25	Gave an understanding of the thinking of the offenders.	5/17/2018 1:18 PM
26	She knows her info.	5/17/2018 1:17 PM
27	Answering questions and knowing when breaks are needed.	5/17/2018 1:13 PM
28	Kept the audience engaged and commenting on various topics.	5/17/2018 1:11 PM
29	She summarized the multiple data and statistics into an easy to understand conversation.	5/17/2018 1:07 PM
30	Giving the stats of offenders.	5/17/2018 1:02 PM
31	The instructor was knowledgeable of the statistics of male and female offenders.	5/17/2018 1:00 PM
32	She was very knowledgeable on this topic.	5/17/2018 12:56 PM
33	This is a tough topic. The instructor did a good job of keeping it light.	5/17/2018 12:21 PM
34	Expert knowledge and enthusiasm.	5/17/2018 11:52 AM

35	Highly knowledgeable and experienced and brought that to the presentation.	5/17/2018 11:51 AM
36	Spent time on questions from the audience. Very informative and kept the audience's attention.	5/17/2018 11:46 AM
37	Very interesting and engaging.	5/17/2018 11:42 AM
38	Very knowledgeable, friendly, and engaging.	5/17/2018 11:40 AM
39	Knowledge was appreciated. Loved her use of commercial during breaks, they helped me feel comfortable with the information.	5/17/2018 11:37 AM
40	Very interesting lecture, videos, and examples.	5/17/2018 11:34 AM
41	Answered questions and provided an in-depth slide presentation.	5/17/2018 11:33 AM
42	Engaged the audience in the open conversation of talking about sex and crimes against children.	5/17/2018 11:29 AM
43	Read her audience.	5/17/2018 11:26 AM
44	Sharing the preconception of what a sex offender looks like and how they develop.	5/17/2018 11:24 AM
45	Dispelled preconceptions about how sex offenders develop.	5/17/2018 11:23 AM
46	Kept everyone involved with the topic.	5/17/2018 11:21 AM
47	Explaining the statistics of sexual predators.	5/17/2018 11:18 AM
48	Kept our attention and used relevant information.	5/17/2018 11:16 AM
49	The instructor was very knowledgeable about the subject and conveyed her knowledge efficiently and effectively.	5/17/2018 11:15 AM
50	Provided personal experiences from working in the field.	5/17/2018 11:11 AM
51	Clearly knew the topic.	5/17/2018 11:02 AM
52	Engaged audience participation.	5/17/2018 11:01 AM
53	Introducing the mind of a sex offender.	5/17/2018 10:59 AM
54	Love that the material was presented so easily and not read from the Powerpoint. Excellent engagement, good use of humor.	5/17/2018 10:57 AM
55	Valuable info from the perspective of the offender.	5/17/2018 10:52 AM
56	Provided new info and recent statistics.	5/17/2018 10:47 AM
57	Voice tone was great - not too slow, not too fast. Her voice kept my attention.	5/17/2018 10:45 AM
58	Made the material entertaining and accessible. Friendly and approachable affect.	5/17/2018 10:41 AM
59	Mixed it up. Used humor for a difficult subject.	5/17/2018 10:38 AM
60	Knowledgeable of subject matter.	5/17/2018 10:37 AM
61	Kept the audience interested.	5/17/2018 10:30 AM
62	The instructor was knowledgeable about the topic.	5/17/2018 10:28 AM

Q3 List at least one improvement for the instructor.

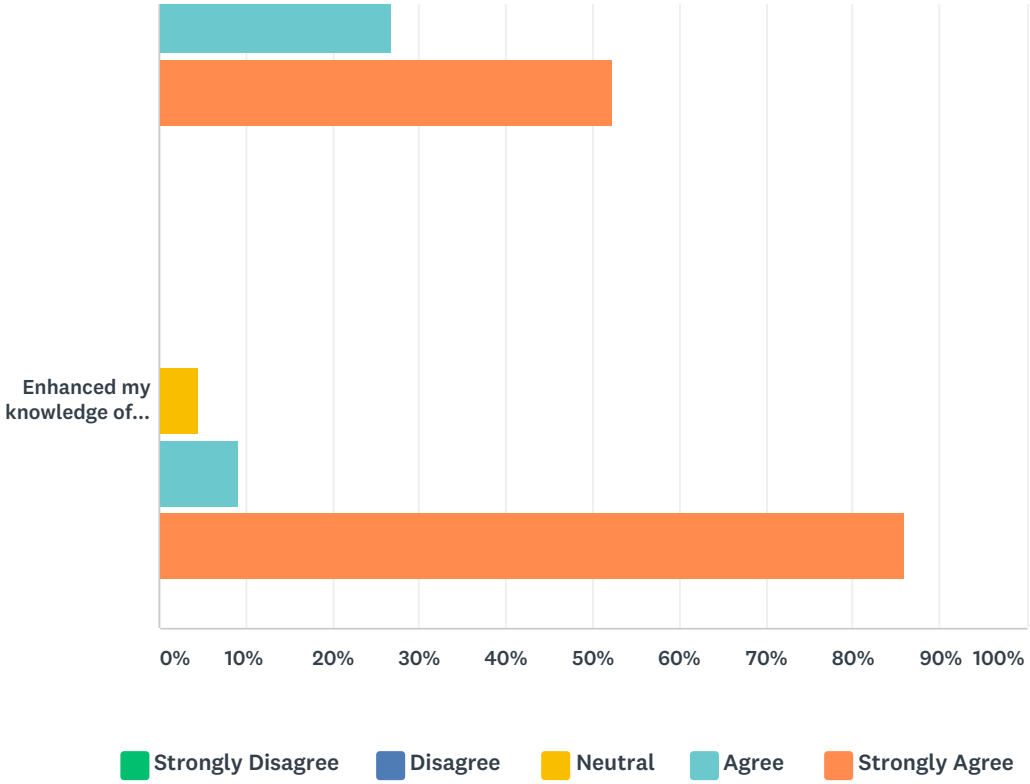
Answered: 40 Skipped: 46

#	RESPONSES	DATE
1	At times the instructors spoke really fast.	5/17/2018 2:12 PM
2	Update the videos of interviews with sex offenders.	5/17/2018 2:12 PM
3	This probably should be a two-day training.	5/17/2018 2:10 PM
4	More time for the response to the crimes.	5/17/2018 2:07 PM
5	Needed to speak more slowly. Needed fewer topics and subtopics. Have extra copies of the slides available.	5/17/2018 2:05 PM
6	Present a better balance of the amount of info/time so that the training is not rushed.	5/17/2018 2:02 PM
7	Need to reduce the number of slides for a day-long presentation.	5/17/2018 1:57 PM
8	Make it more clear that offenders are triggered by "normal" things if they have offended before.	5/17/2018 1:55 PM
9	More information to approach children we suspect may have been abused. We know good/bad touch doesn't work so what will?	5/17/2018 1:51 PM
10	The information did get a little overwhelming.	5/17/2018 1:47 PM
11	Better "ice-breaker videos".	5/17/2018 1:44 PM
12	Would have liked to hear arguments about biological vs. conditioned origins for sex offenders.	5/17/2018 1:42 PM
13	Less Powerpoint, more specific data for Delaware, less reading of the slides.	5/17/2018 1:37 PM
14	The training although very informative was very long. If possible, maybe the training can be broken up into two parts.	5/17/2018 1:35 PM
15	Talk more about laws/regulations.	5/17/2018 1:28 PM
16	A couple more breaks would have been nice.	5/17/2018 1:23 PM
17	Less data and more examples of case histories.	5/17/2018 1:17 PM
18	Speaking louder and clearer.	5/17/2018 1:07 PM
19	To have better audio on videos because it was hard to understand the persons speaking.	5/17/2018 1:02 PM
20	The handouts were very useful, but some portions of the film were outdated, audio wasn't clear enough.	5/17/2018 1:00 PM
21	Talk a little slower. I know it's a lot of info but she talked really fast.	5/17/2018 12:21 PM
22	Less repetitive information. Too much information so fast makes it hard to remember significant information. Like drinking from a firehose. Slow down, focus more on less.	5/17/2018 11:51 AM
23	Not so much about stats.	5/17/2018 11:46 AM
24	Need more dog videos between the sex offenders.	5/17/2018 11:44 AM
25	Perhaps either offering a two-day or maybe a preliminary online webinar to help with time management.	5/17/2018 11:42 AM
26	More time for questions.	5/17/2018 11:34 AM
27	Request for the class to be 2 full days. The instructor is a wealth of knowledge so there are a lot of questions from the class, which takes away from time to cover all material without rushing.	5/17/2018 11:33 AM
28	To share the information throughout the state of Delaware as a mandated training for people who work with child and prevention.	5/17/2018 11:29 AM
29	Flipped through slides too quickly. If you don't have time to show it then take it out.	5/17/2018 11:26 AM
30	More attention to Part III - how to protect kids; less focus on the numerous studies.	5/17/2018 11:23 AM

31	A little less statistics.	5/17/2018 11:02 AM
32	Too many stats/numbers made it overwhelming and confusing at times.	5/17/2018 11:01 AM
33	Talk slower, fewer slides (flip slower).	5/17/2018 10:59 AM
34	Share humorous videos throughout the presentation to lighten things, rather than on breaks. Slow down just a bit and offer an opportunity for questions. Don't tell deer story.	5/17/2018 10:57 AM
35	Training felt rushed in the time allotted.	5/17/2018 10:52 AM
36	Relate it to Delaware laws and issues.	5/17/2018 10:47 AM
37	All was great. Your line of work is so powerful.	5/17/2018 10:45 AM
38	More background on her. What does she do now? Does the tx group in Oregon still exist.help?	5/17/2018 10:41 AM
39	Laws specific to Delaware (i.e. knowing Delaware does not have programs/treatment for sex offenders).	5/17/2018 10:32 AM
40	Engage in more group discussions vs. talking and videos the whole time.	5/17/2018 10:28 AM

Q4 Please indicate your level of agreement with the following statements regarding lecture content:

Answered: 86 Skipped: 0



	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE	TOTAL
Presentation had practical value	0.00% 0	0.00% 0	1.16% 1	24.42% 21	74.42% 64	86
Subject matter was relevant	0.00% 0	0.00% 0	0.00% 0	17.44% 15	82.56% 71	86
Lecture had good balance of practical and theoretical	0.00% 0	0.00% 0	6.98% 6	24.42% 21	68.60% 59	86
Time allocated was adequate	0.00% 0	10.47% 9	10.47% 9	26.74% 23	52.33% 45	86
Enhanced my knowledge of the subject	0.00% 0	0.00% 0	4.65% 4	9.30% 8	86.05% 74	86

Q5 What was the best part of this lecture?

Answered: 60 Skipped: 26

#	RESPONSES	DATE
1	Videos of interviews with sex offenders.	5/17/2018 2:12 PM
2	Lots of great information that is helpful in the work we do.	5/17/2018 2:10 PM
3	Comprehensive in explaining the problem of child sexual abuse in our culture.	5/17/2018 2:07 PM
4	It was interesting to get updates on the current theories in the field.	5/17/2018 2:02 PM
5	Lots of information and knowledge.	5/17/2018 1:59 PM
6	Video clips.	5/17/2018 1:58 PM
7	It was all great - although very disturbing. Videos and PowerPoint information were good.	5/17/2018 1:57 PM
8	I honestly enjoyed all of this, especially the videos.	5/17/2018 1:55 PM
9	Relevance to the audience, knowledge of subject matter.	5/17/2018 1:51 PM
10	It was beneficial.	5/17/2018 1:48 PM
11	The instructor was very knowledgeable and the videos were powerful.	5/17/2018 1:47 PM
12	The information and the way it was presented.	5/17/2018 1:45 PM
13	The interviewing sex offenders portion.	5/17/2018 1:44 PM
14	A different point of view.	5/17/2018 1:42 PM
15	Hearing offenders.	5/17/2018 1:39 PM
16	The research work that is done on sex offenders.	5/17/2018 1:38 PM
17	Videos of perps giving first-hand knowledge/how to groom, etc.	5/17/2018 1:37 PM
18	All of the information, the videos, statistics, slide presentation was beneficial and informative.	5/17/2018 1:35 PM
19	The videos were appropriate for the topics and there was variety. I liked that the instructor knew the material and it was very relatable to everyone's job.	5/17/2018 1:28 PM
20	The different ways the offender seeks victims.	5/17/2018 1:25 PM
21	The presenter's knowledge of the material.	5/17/2018 1:23 PM
22	The video clips and explanation of slides.	5/17/2018 1:21 PM
23	All	5/17/2018 1:19 PM
24	Interview videos.	5/17/2018 1:18 PM
25	Case histories.	5/17/2018 1:17 PM
26	Very informative and eye-opening.	5/17/2018 1:13 PM
27	The interviews and feedback.	5/17/2018 1:11 PM
28	The discussion about the video interviews after the fact.	5/17/2018 1:07 PM
29	Good information.	5/17/2018 1:02 PM
30	The material and lecture was very informative,	5/17/2018 1:00 PM
31	Not many of these types of training are available, so being able to participate was beneficial.	5/17/2018 12:56 PM
32	I learned a lot about what offenders do when victimizing children.	5/17/2018 12:21 PM
33	Good information/statistics that I can use when training new CW/JJ workers. Thank you for coming to Delaware and sharing your knowledge.	5/17/2018 11:51 AM
34	The videos from the perps telling their stories.	5/17/2018 11:46 AM

35	How to interview sex offenders.	5/17/2018 11:44 AM
36	The information presented was helpful to understand the thought process of an offender.	5/17/2018 11:42 AM
37	Learning that the majority of professionals who work with children do not have a clear, accurate understanding of a perpetrator's mindset and the risk they are for future incident and victims. There is never just one incident - behaviors will escalate over time.	5/17/2018 11:40 AM
38	Great job, training was long but she kept the interest.	5/17/2018 11:37 AM
39	All of the examples.	5/17/2018 11:34 AM
40	The example interviews within the presentation.	5/17/2018 11:33 AM
41	The opportunity to opening.	5/17/2018 11:29 AM
42	Resource material; prevention focus.	5/17/2018 11:26 AM
43	The videos of the sex offender groups.	5/17/2018 11:24 AM
44	Opened my eyes to how child molesters operate, and why they are so successful.	5/17/2018 11:23 AM
45	The feedback.	5/17/2018 11:21 AM
46	Crime statistics.	5/17/2018 11:18 AM
47	The videos and discussing events that really happened.	5/17/2018 11:16 AM
48	The audiovisuals.	5/17/2018 11:15 AM
49	Videos from real offenders.	5/17/2018 11:11 AM
50	The videos to demonstrate the topics.	5/17/2018 11:01 AM
51	Hearing personal therapeutic experiences.	5/17/2018 10:59 AM
52	Cory was fantastic! The content was invaluable and training was very effective. It was helpful having the slides ahead of time.	5/17/2018 10:57 AM
53	First-hand knowledge and videos. Very relevant to child welfare field.	5/17/2018 10:52 AM
54	Held my interest - balanced talk/visual. Very knowledgeable and accessible presenter. She read the audience well.	5/17/2018 10:49 AM
55	New information.	5/17/2018 10:47 AM
56	The video clips of sex offenders and their take on why they do what they do.	5/17/2018 10:45 AM
57	Clips and recent studies/statistics. I've seen this presentation before and it has been updated.	5/17/2018 10:41 AM
58	Her passion makes others aware.	5/17/2018 10:38 AM
59	Really happy that she talked about prevention.	5/17/2018 10:30 AM
60	The presenter was able to provide real experiences she had and not just videos.	5/17/2018 10:28 AM

Q6 List at least one improvement for this lecture.

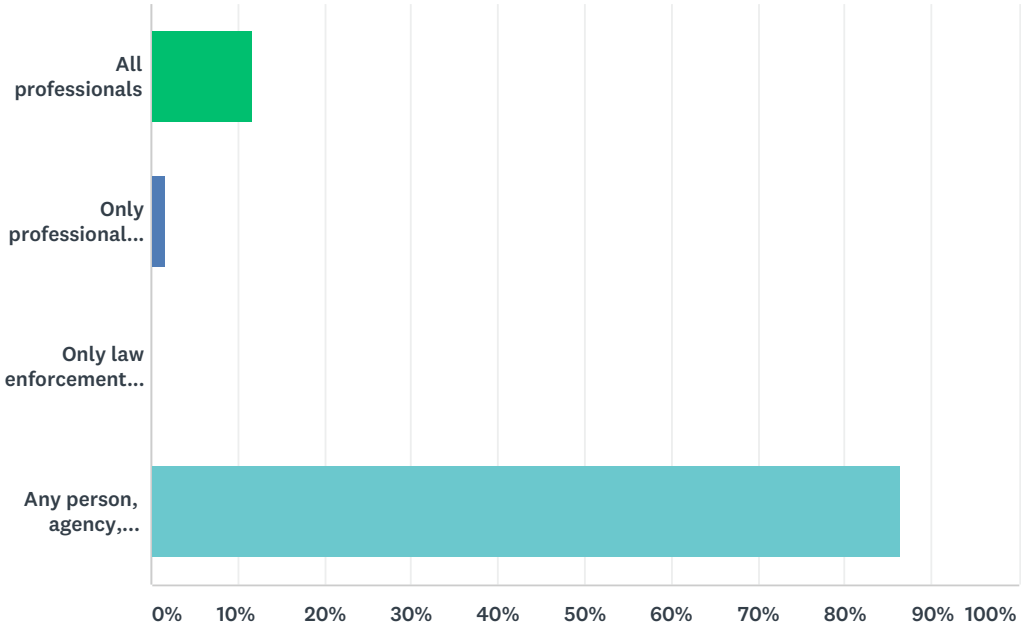
Answered: 37 Skipped: 49

#	RESPONSES	DATE
1	Add more updated videos of interviews with sex offenders.	5/17/2018 2:12 PM
2	A lot of information to get through in one day. Info was interesting but I would like a two-day training.	5/17/2018 2:10 PM
3	At times it seemed that there were big jumps between correlations.	5/17/2018 2:07 PM
4	Statistics and studies need to be more recent.	5/17/2018 2:05 PM
5	More info on types of offenders and how to reintegrate them into their family safely. The audience was more social workers than police.	5/17/2018 2:02 PM
6	A lot of information. This could have been a two-day training (or longer).	5/17/2018 1:59 PM
7	Time allocation.	5/17/2018 1:57 PM
8	A lot of information for one day. Can we make this a two-day training?	5/17/2018 1:55 PM
9	Slow down - often read slides rapidly.	5/17/2018 1:51 PM
10	What treatment interventions work with offenders.	5/17/2018 1:47 PM
11	Newer/updated video clips.	5/17/2018 1:44 PM
12	Lots of info - probably could be a multiple day training.	5/17/2018 1:42 PM
13	Info is heavy for a long day.	5/17/2018 1:39 PM
14	Not an improvement but a suggestion - this should be a mandated training for children service providers. Parents in the community can benefit from this training as well, perhaps in a school event.	5/17/2018 1:35 PM
15	Update the videos; make it more relatable to CPS workers.	5/17/2018 1:28 PM
16	Update videos, the presentation is too long.	5/17/2018 1:25 PM
17	More breaks.	5/17/2018 1:23 PM
18	I think it could be condensed by removing some of the statistics and studies.	5/17/2018 1:17 PM
19	I wish the lecture could have been broken up into two days. There is a lot of information to process all at once. A lot of the videos were of caucasian mem. When engaging communities of color, how do we speak to people about pedophilia when it seems to be a "white male problem"?	5/17/2018 1:13 PM
20	More than a one-day training. It was too much information to absorb.	5/17/2018 1:02 PM
21	The healing process for the victims counseling victims should have been addressed because these victims will be impacted throughout their lifetime.	5/17/2018 1:00 PM
22	Do everything up to interviewing before lunch (9-12), then focus on interviewing (what I think most people would benefit from) from 1-3, or so.	5/17/2018 11:51 AM
23	Too much important information for a one-day session. It felt rushed after lunch.	5/17/2018 11:46 AM
24	Time!	5/17/2018 11:42 AM
25	More current resources (books, studies, videos) to help related to the subject better.	5/17/2018 11:40 AM
26	This should be a 2 two day class so that it is not rushed. Excellent course!	5/17/2018 11:33 AM
27	To update the research for the 21st century. A lot of the research is historical and the conversation about sex is occurring but the research is outdated for prevention.	5/17/2018 11:29 AM
28	Have an offender present at training to answer questions.	5/17/2018 11:18 AM
29	Shorten the length of the presentation.	5/17/2018 11:15 AM

30	Less numbers and statistics in the PowerPoint.	5/17/2018 11:01 AM
31	Fewer studies, more updated interviews, and more diversity,	5/17/2018 10:59 AM
32	Shorter lunch or working lunch to start/end at more convenient times.	5/17/2018 10:57 AM
33	This was a multiple day training.	5/17/2018 10:52 AM
34	Connect with Delaware - too much dry data.	5/17/2018 10:47 AM
35	Better audio. Some of the videos were very hard to hear due to muffled sound.	5/17/2018 10:45 AM
36	Some of the material was repetitive - perhaps a bit longer than needed.	5/17/2018 10:41 AM
37	Sitting through a full day of talking can be difficult.	5/17/2018 10:28 AM

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

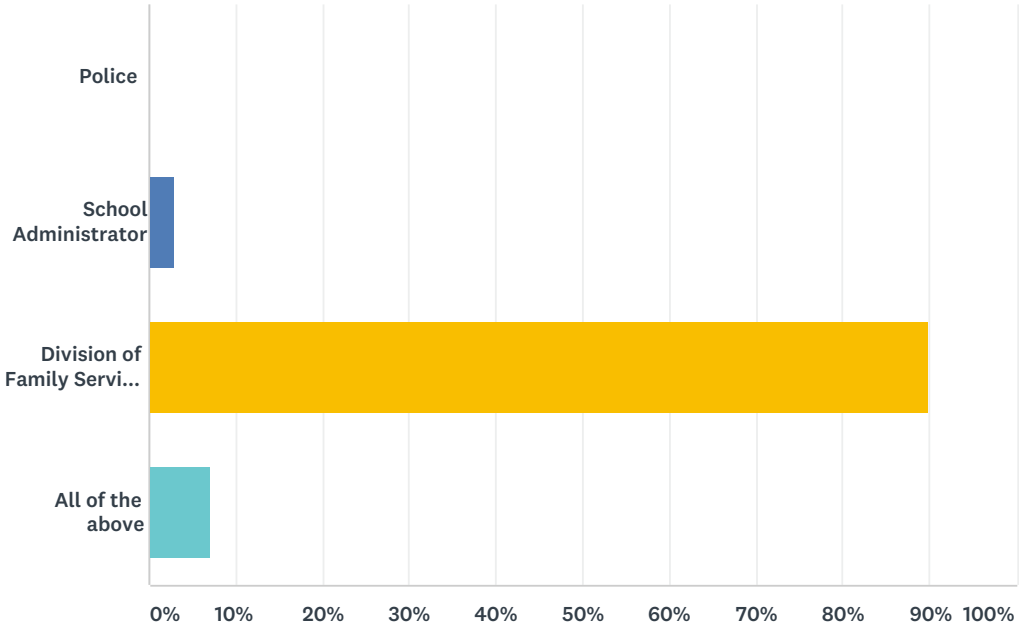
Answered: 7,523 Skipped: 0



ANSWER CHOICES	RESPONSES	
All professionals	11.82%	889
Only professionals that work directly with children (i.e. teachers, physicians)	1.67%	126
Only law enforcement officers	0.04%	3
Any person, agency, organization or entity	86.47%	6,505
TOTAL		7,523

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

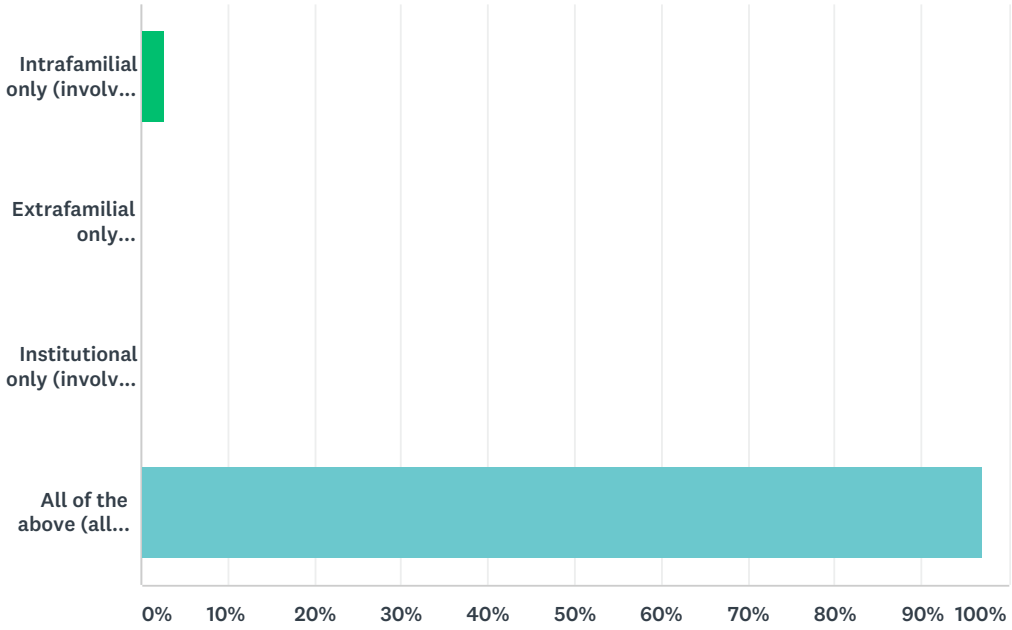
Answered: 7,494 Skipped: 29



ANSWER CHOICES	RESPONSES	
Police	0.20%	15
School Administrator	2.83%	212
Division of Family Services Child Abuse and Neglect Report Line	89.93%	6,739
All of the above	7.05%	528
TOTAL		7,494

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

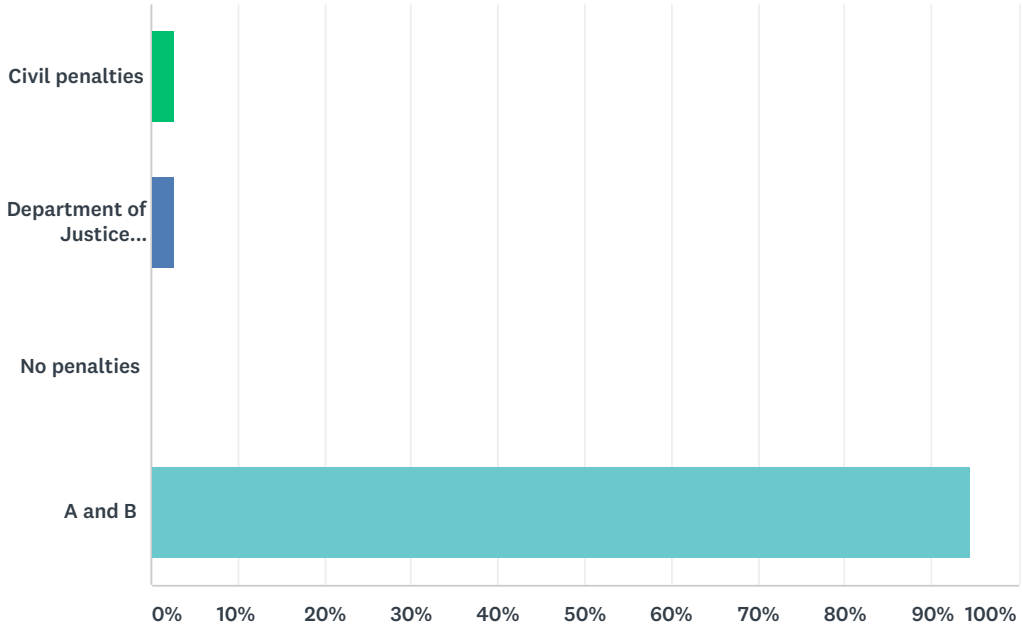
Answered: 7,473 Skipped: 50



ANSWER CHOICES	RESPONSES	
Intrafamilial only (involving parent, guardian, custodian, or member of the household)	2.80%	209
Extrafamilial only (perpetrator is not a member of the household or family)	0.03%	2
Institutional only (involving licensed child placement facilities)	0.09%	7
All of the above (all suspected abuse and neglect of any child, birth to age 18)	97.08%	7,255
TOTAL		7,473

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:

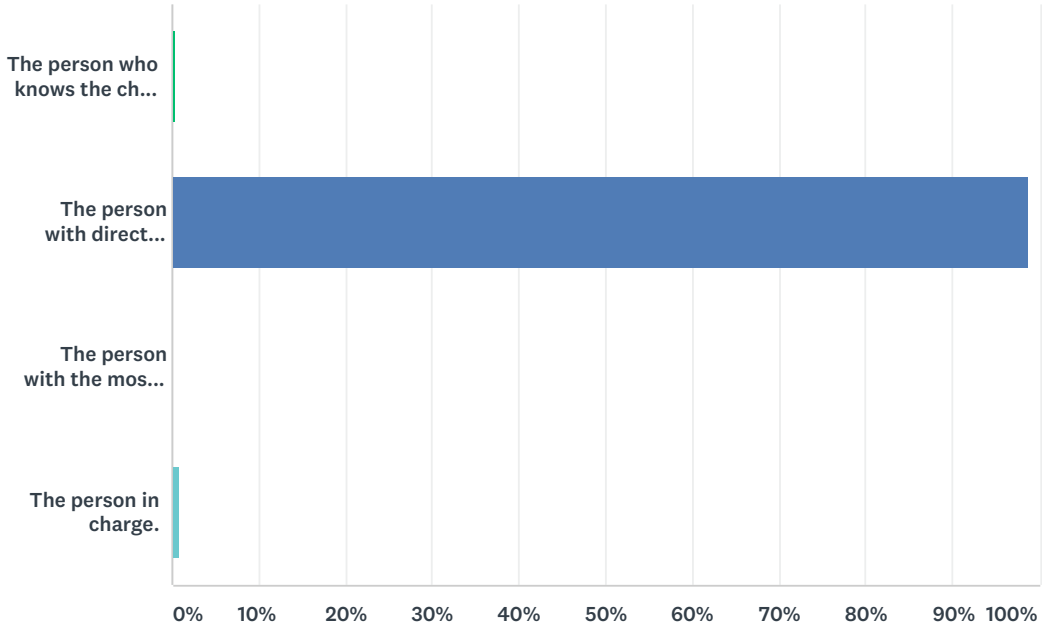
Answered: 7,458 Skipped: 65



ANSWER CHOICES	RESPONSES	
Civil penalties	2.67%	199
Department of Justice investigation	2.67%	199
No penalties	0.07%	5
A and B	94.60%	7,055
TOTAL		7,458

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

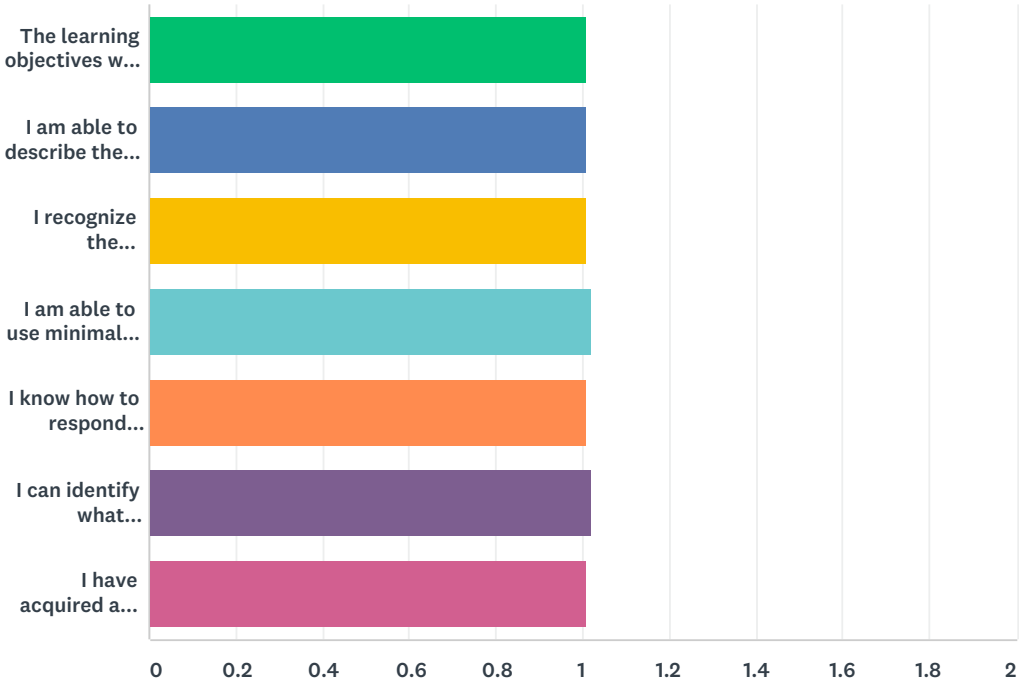
Answered: 7,445 Skipped: 78



ANSWER CHOICES	RESPONSES	
The person who knows the child best.	0.38%	28
The person with direct knowledge.	98.80%	7,356
The person with the most time.	0.04%	3
The person in charge.	0.78%	58
TOTAL		7,445

Q6 Please rate each of the following statements.

Answered: 7,425 Skipped: 98



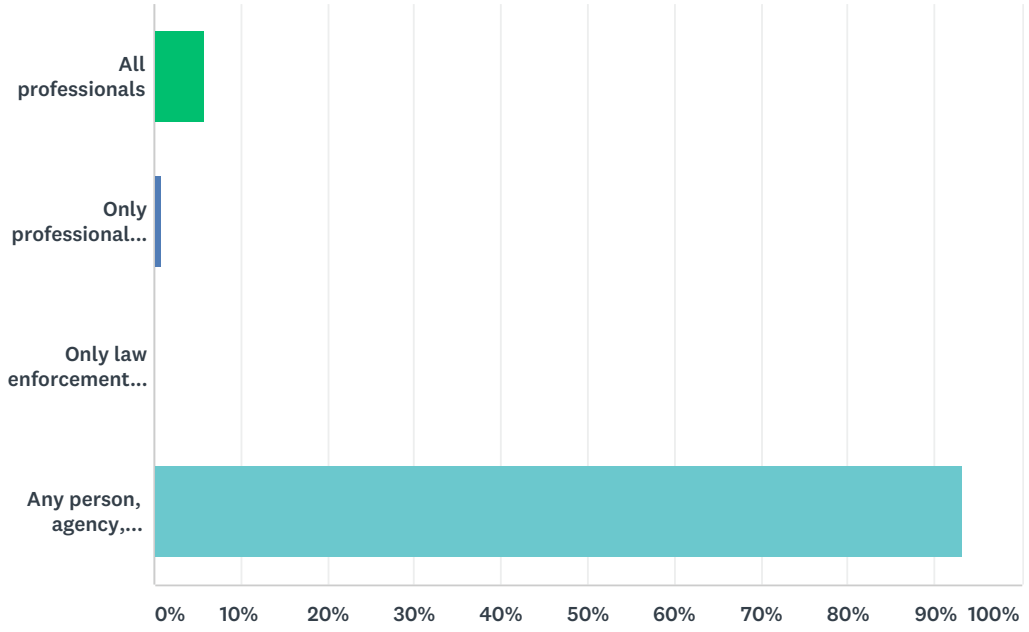
	AGREE	NOT SURE	DISAGREE	TOTAL	WEIGHTED AVERAGE
The learning objectives were met.	99.57% 7,393	0.35% 26	0.08% 6	7,425	1.01
I am able to describe the reporting law and reporting procedure for the State of Delaware.	98.94% 7,346	0.97% 72	0.09% 7	7,425	1.01
I recognize the relationship between physical and behavioral indicators and suspicion of child abuse and neglect.	99.38% 7,379	0.55% 41	0.07% 5	7,425	1.01
I am able to use minimal fact questions when indicators are observed and/or a disclosure is made.	98.41% 7,307	1.41% 105	0.18% 13	7,425	1.02
I know how to respond appropriately when children disclose allegations of abuse or neglect.	99.34% 7,376	0.59% 44	0.07% 5	7,425	1.01
I can identify what information to expect from DFS following a report of child abuse or neglect.	97.67% 7,252	2.21% 164	0.12% 9	7,425	1.02
I have acquired a basic understanding of the civil and criminal definitions in statute for the various types of child maltreatment.	99.42% 7,382	0.50% 37	0.08% 6	7,425	1.01

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

Answered: 553 Skipped: 6,970

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

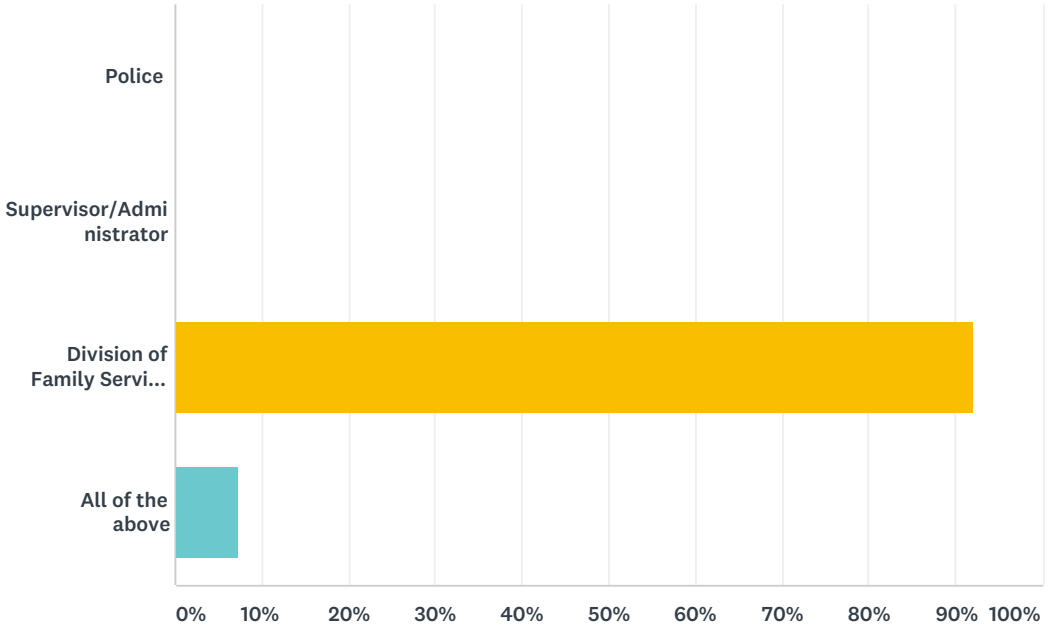
Answered: 1,134 Skipped: 0



ANSWER CHOICES	RESPONSES	
All professionals	5.82%	66
Only professionals that work directly with children (i.e. teachers, physicians)	0.79%	9
Only law enforcement officers	0.09%	1
Any person, agency, organization or entity	93.30%	1,058
TOTAL		1,134

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

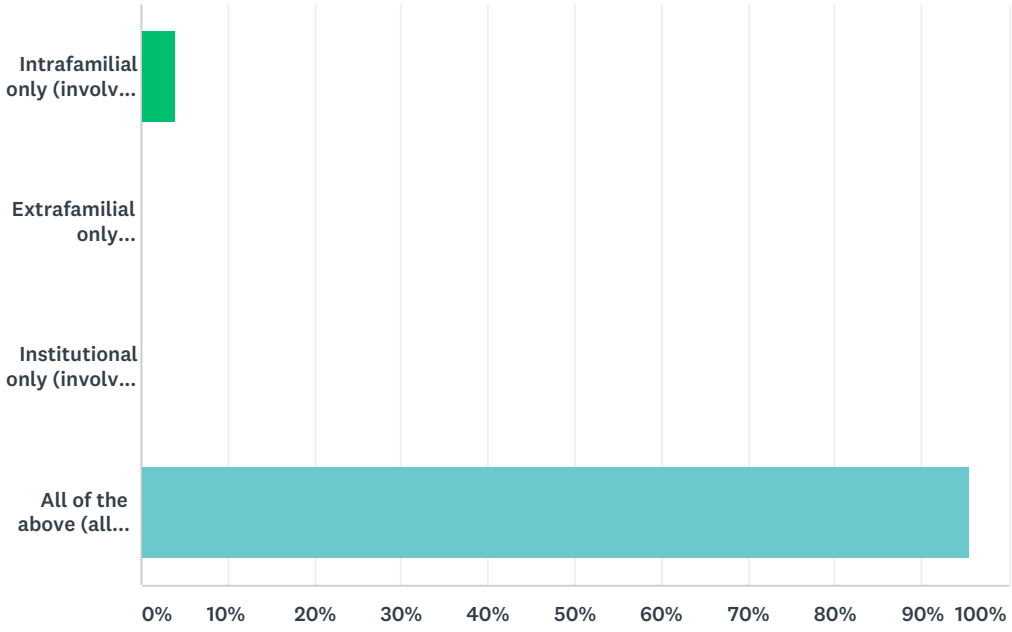
Answered: 1,132 Skipped: 2



ANSWER CHOICES	RESPONSES	
Police	0.18%	2
Supervisor/Administrator	0.27%	3
Division of Family Services Child Abuse and Neglect Report Line	92.14%	1,043
All of the above	7.42%	84
TOTAL		1,132

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

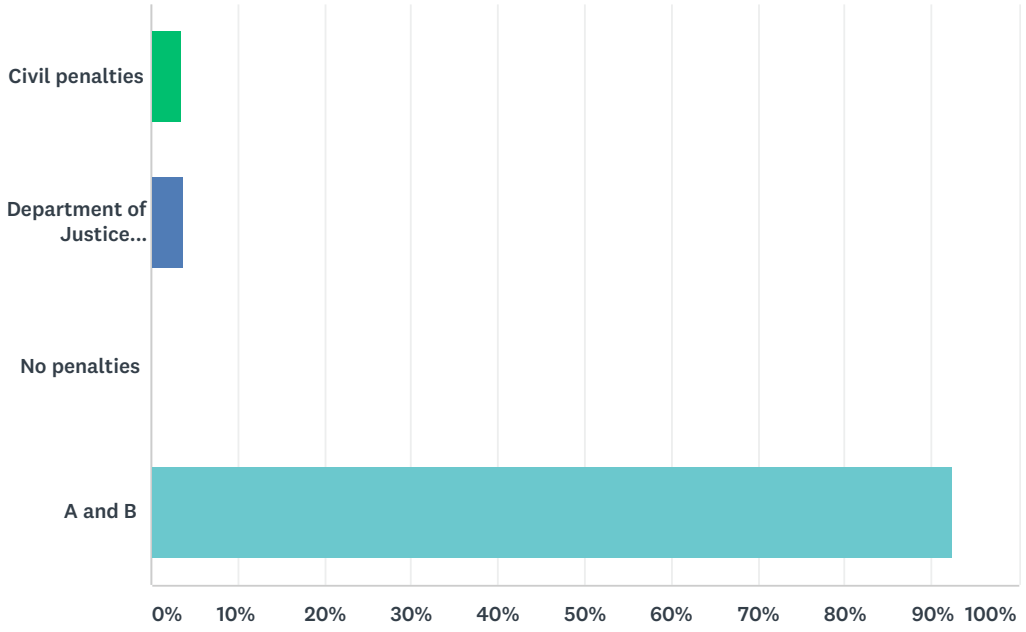
Answered: 1,129 Skipped: 5



ANSWER CHOICES	RESPONSES	
Intrafamilial only (involving parent, guardian, custodian, or member of the household)	3.99%	45
Extrafamilial only (perpetrator is not a member of the household or family)	0.09%	1
Institutional only (involving licensed child placement facilities)	0.27%	3
All of the above (all suspected abuse and neglect of any child, birth to age 18)	95.66%	1,080
TOTAL		1,129

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:

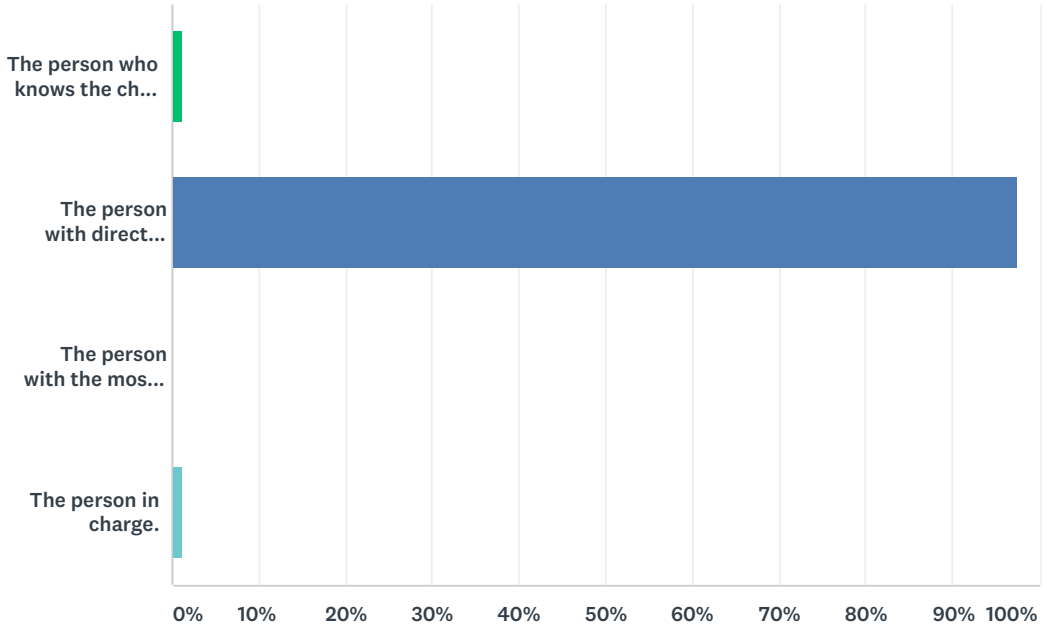
Answered: 1,129 Skipped: 5



ANSWER CHOICES	RESPONSES	
Civil penalties	3.45%	39
Department of Justice investigation	3.72%	42
No penalties	0.27%	3
A and B	92.56%	1,045
TOTAL		1,129

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

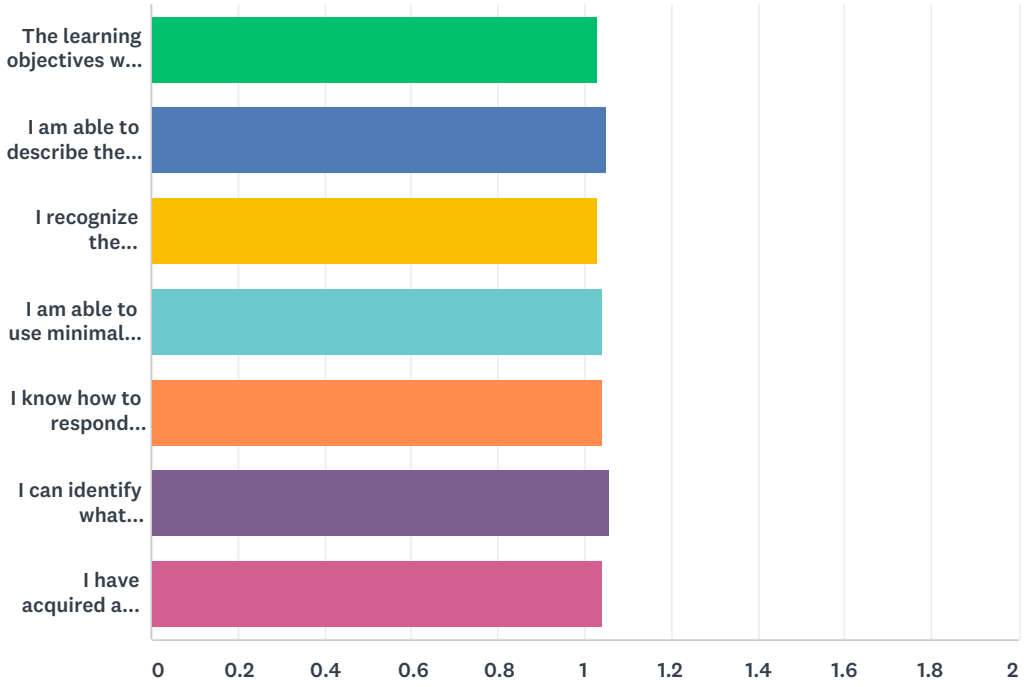
Answered: 1,125 Skipped: 9



ANSWER CHOICES	RESPONSES	
The person who knows the child best.	1.24%	14
The person with direct knowledge.	97.51%	1,097
The person with the most time.	0.09%	1
The person in charge.	1.16%	13
TOTAL		1,125

Q6 Please rate each of the following statements.

Answered: 1,123 Skipped: 11



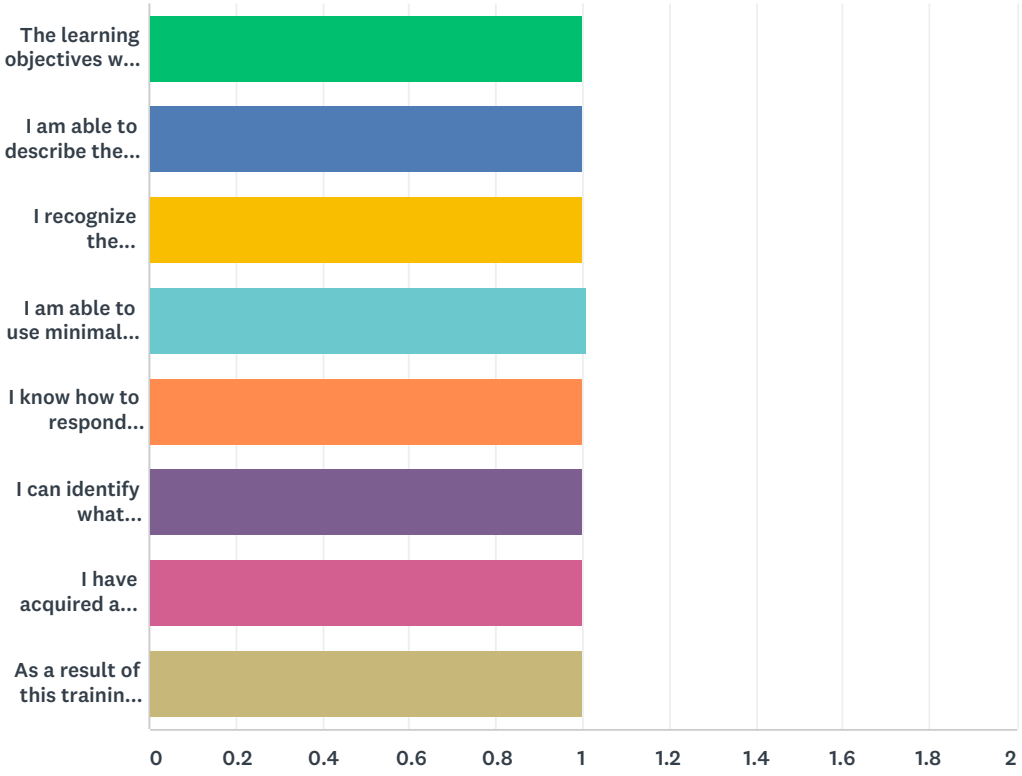
	AGREE	NOT SURE	DISAGREE	TOTAL	WEIGHTED AVERAGE
The learning objectives were met.	98.13% 1,102	1.07% 12	0.80% 9	1,123	1.03
I am able to describe the reporting law and reporting procedure for the State of Delaware.	96.44% 1,083	2.58% 29	0.98% 11	1,123	1.05
I recognize the relationship between physical and behavioral indicators and suspicion of child abuse and neglect.	97.86% 1,099	1.25% 14	0.89% 10	1,123	1.03
I am able to use minimal fact questions when indicators are observed and/or a disclosure is made.	97.06% 1,090	2.05% 23	0.89% 10	1,123	1.04
I know how to respond appropriately when children disclose allegations of abuse or neglect.	97.15% 1,091	1.96% 22	0.89% 10	1,123	1.04
I can identify what information to expect from DFS following a report of child abuse or neglect.	94.75% 1,064	4.19% 47	1.07% 12	1,123	1.06
I have acquired a basic understanding of the civil and criminal definitions in statute for the various types of child maltreatment.	97.33% 1,093	1.78% 20	0.89% 10	1,123	1.04

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

Answered: 147 Skipped: 987

Q1 Please rate each of the following statements.

Answered: 69 Skipped: 0



	AGREE	NOT SURE	DISAGREE	TOTAL	WEIGHTED AVERAGE
The learning objectives were met.	100.00% 69	0.00% 0	0.00% 0	69	1.00
I am able to describe the reporting law and reporting procedure for the State of Delaware.	100.00% 69	0.00% 0	0.00% 0	69	1.00
I recognize the relationship between physical and behavioral indicators and suspicion of child abuse and neglect.	100.00% 69	0.00% 0	0.00% 0	69	1.00
I am able to use minimal fact questions when indicators are observed and/or a disclosure is made.	98.55% 68	1.45% 1	0.00% 0	69	1.01
I know how to respond appropriately when children disclose allegations of abuse or neglect.	100.00% 69	0.00% 0	0.00% 0	69	1.00
I can identify what information to expect from DFS following a report of child abuse or neglect.	100.00% 68	0.00% 0	0.00% 0	68	1.00
I have acquired a basic understanding of the civil and criminal definitions in statute for the various types of child maltreatment.	100.00% 68	0.00% 0	0.00% 0	68	1.00
As a result of this training, I have a better understanding of my reporting obligations under the Medical Practice Act.	100.00% 67	0.00% 0	0.00% 0	67	1.00

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

Answered: 5 Skipped: 64

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

Answered: 8 Skipped: 61

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

May 2017 - May 2018

FINDINGS

	*Current	**Prior	Grand Total
Risk Assessment/ Caseloads	**58**	**5**	**63**
Caseloads	33		33
Collaterals	1	1	2
Communication	1		1
Reporting	2		2
Risk Assessment - Abridged	1		1
Risk Assessment - Closed Despite Risk Level	5	2	7
Risk Assessment - Screen Out	3		3
Risk Assessment - Tools	9	1	10
Risk Assessment - Unsubstantiated	3	1	4
Safety/ Use of History/ Supervisory Oversight	**32**	**1**	**33**
Completed Incorrectly/ Late	22		22
Inappropriate Parent/ Relative Component	3		3
No Safety Assessment of Non-Victims	1		1
Oversight of Agreement	3	1	4
Supervisory Oversight	3		3
Grand Total	**90**	**6**	**96**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

May 2017 - May 2018

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 2017 - May 2018

FINDINGS

System Area	Finding	PUBLIC Rationale	Sum of #
Risk Assessment/	Caseloads		63
	Caseloads		33
		The caseworker was over the investigation caseload statutory standards the entire time the case was open.	5
		The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.	5
		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.	2
		The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.	5
		The caseworkers were over the investigation and treatment caseload statutory standards while the cases were open.	2
		The DFS caseworker was over the investigation caseload statutory standards for a portion of the time while the case was open.	1
		The DFS caseworker and supervisor were over the investigation caseload statutory standards for a portion of the time while the case was open. The supervisor handled the case for a period of the time.	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
	The DFS case workers were over the investigation and treatment (a portion of the time) caseload statutory standards while the cases were open, and it had no impact on the cases. However, the caseload did not negatively impact the DFS response in those cases.	1
Collaterals		2
	During the prior investigaton, a collateral contact with the PCP was not received for the victim, and DFS did not follow up with the PCP to corroborate the information provided by the mother.	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
Communication		1
	DFS relayed information to the court that there were no concerns about the mother; however, the mother's history and self-reported substance abuse were not shared. As a result, the court dismissed the petition by a relative.	1
Reporting		2
	The family moved during the treatment case, and the DFS supervisor delayed making a report to the out of state child protection agency.	2
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		7
	In the prior investigation, the SDM risk assessment identified the risk as high and recommended ongoing service; however, the case was closed. As a result, the family was not provided treatment services prior to the death.	1
	The SDM Risk Assessment identified the risk as high in both the prior and near death investigations. Ongoing service was recommended for both; however, in each investigation, the case disposition was overridden to close the case.	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.	1
	The SDM Risk Assessment identified the risk as high at the conclusion of the death investigation. Ongoing service was recommended; however, the case disposition was overridden to close the investigation.	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. 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		3
	The DFS Report Line screened out the subsequent report regarding the healing rib fractures being found on the repeat x-rays.	1
	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		10
	A framework was not considered for the surviving sibling prior to closing the death investigation. The SDM risk assessment identified the risk as high and recommended ongoing service.	1
	A consult with DOJ or a framework was not considered by DFS despite the presence of multiple risk factors. The infant was born substance exposed and died shortly after being discharged home to the family.	1
	In the prior investigation, the SDM Risk Assessment was not completed correctly. The policy override for severe non-accidental injury was not selected, so the case was closed.	1
	For the near death incident, the hotline report was downgraded to a P2 in contrast with the SDM Response Priority Assessment. It was noted the alleged perpetrator's whereabouts were unknown and the mother had requested an attorney when contacted by the law enforcement agency.	1
	The treatment worker did not complete the SDM Risk Re-assessment, so it was not considered in the decision to close the treatment case.	1
	During the death investigation, several next steps were identified in the initial group supervision and all the steps were not completed by DFS at the end of the investigation (forensic interview, toxicology screen results).	1
	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		4
	The DFS Family and Child Tracking System (FACTS) does not identify cases where abuse has been confirmed but the perpetrator is unknown.	2

	There was no finding of abuse or neglect in the investigation despite the mother's actions, which placed the child at risk and exposed the child to illicit drug use.	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		33
Completed Incorrectly/ Late		22
	In the near death investigation, the case worker incorrectly identified the child as safe in the SDM safety assessment due to her hospitalization.	1
	In the near death investigation, the case worker identified the child as safe with agreement in the SDM safety assessment due to his hospitalization, but no agreement was entered.	1
	For the near death incident, the caseworker incorrectly identified the child as safe in the SDM safety assessment. The child was hospitalized for a head injury, and it was unknown whether the father caused the injury.	1
	For the initial hotline report, the caseworker did not complete the SDM safety assessment correctly. The safety threat for drug-exposed infant was marked no. Initially, there was no agreement entered for the victim or siblings residing in the home.	1
	The caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization. Other risk factors included current/prior infants born substance exposed, history of incarcerations, prostitution and drug use, and significant DFS history.	1
	The caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization. Other risk factors included an infant born substance exposed, prior infant death, history of substance abuse and DFS history involving the siblings.	1
	For the near death incident, the caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization.	1
	The initial safety agreement did not designate another participant to care for the victim or supervise contact. The agreement was later modified to include other relatives.	1
	DFS entered into a safety agreement with participants, but a home assessment was not initially conducted.	1
	For the near death incident, the caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization. The safety threats were also not identified.	1
	For the first referral involving a substance exposed infant, the caseworker did not complete the SDM Safety Assessment correctly. The safety threat for current circumstances combined with history was marked no. Family recently returned from out of state, and the mother had a history of substantiated abuse against young children. No agreement was entered.	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.	2

	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
	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
Inappropriate Parent/ Relative Component		3
	For the near death incident, DFS completed a safety agreement with a relative, who was an alleged perpetrator and not cooperative in the prior investigation. In addition, there was a significant amount of conflict between the mother and the relative.	1
	For the near death incident, DFS initially completed a safety agreement with a participant, who was not ruled out as a suspect, and the young sibling was placed in the care of this participant.	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		4
	During the prior treatment case, the SDM Safety Agreement was not reviewed in a timely manner.	1
	When renewing the child safety agreement, the supervisor was not aware the safety participant was charged with a felony domestic incident with the siblings present and a new DFS case was opened.	1

	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
Supervisory Oversight		3
	In the prior investigation, the safety agreement was amended prior to the case worker having contact with mother's substance abuse treatment provider.	1
	For the death investigation, the caseworker closed the case and modified the safety agreement without contacting mother's substance abuse treatment provider.	1
	In the treatment case, the family lost their housing and were moving out of state. In addition, the family was struggling with the victim's behavior and were considering foster care. There was a lack of supervisory oversight provided during these critical points in the case.	1
Grand Total		**96**

Child Protection Accountability Commission
Child Abuse and Neglect Panel
Strengths Summary
May 2017 - May 2018

STRENGTHS		
	***Current**	**Grand Total**
Risk Assessment/ Caseloads	**16**	**16**
Collaterals	6	6
Hotline Accepted	2	2
Risk Assessment - Alternative Response	1	1
Risk Assessment - Substantiated	2	2
Risk Assessment - Tools	5	5
Safety/ Use of History/ Supervisory Oversight	**9**	**9**
Completed Correctly/On Time	7	7
Custody/Guardianship Petitions	2	2
Grand Total	**25**	**25**

*Current - within 1 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
Strengths Detail and Rationale
May 2017 - May 2018

STRENGTHS

System Area	Strength	Rationale	Count of #
Risk Assessment/ Caseloads			16
	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		2
		Despite no perpetrator being identified and no criminal charges filed, the DFS investigation was substantiated against the mother for abuse.	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		5
		Since an active safety agreement was in place at the conclusion of the prior investigation, DFS completed a Framework with both the investigation and treatment caseworkers.	1
		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

Child Protection Accountability Commission
Child Abuse and Neglect Panel
Strengths Detail and Rationale
May 2017 - May 2018

Safety/ Use of History/ Supervisory Oversight			9
	Completed Correctly/On Time		7
		The DFS investigation involving an infant with substance exposure was thorough. It included a discussion of infant safe sleeping, the safety agreement being initiated during the family meeting with all parties present, the safety agreement being completed in both English and Spanish, and unannounced home visits with the family being conducted.	1
		The modified safety agreement restricted the parents from providing any food or drink to the young sibling during scheduled visitation. All would be provided by the supervising party.	1
		DFS ruled out a relative as a safety agreement participant based on his/her presence in the household where the near death incident occurred. In addition, timely reviews of the safety agreement were completed, and the agreement remained in place through the treatment case.	1
		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			**25**

SPONSOR: Rep. M. Smith & Rep. Briggs King & Rep. Longhurst & Sen. Henry & Sen. Lopez & Sen. Townsend
Reps. Baumbach, Bennett, Bolden, Brady, Dukes, Heffernan, Q. Johnson, Kowalko, Miro, Osienski, Ramone, Spiegelman, Viola, Wilson; Sens. Cloutier, Delcollo, Hansen, Hocker, Lavelle, Marshall, Pettyjohn, Richardson, Sokola, Walsh

HOUSE OF REPRESENTATIVES
149th GENERAL ASSEMBLY

HOUSE BILL NO. 140

AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO INFANTS WITH PRENATAL SUBSTANCE EXPOSURE.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Title 16 of the Delaware Code by inserting a new chapter to read as follows:

Chapter 9B. Infants with Prenatal Substance Exposure.

§ 901B. Purpose.

The child welfare policy of this State shall serve to advance the best interests and secure the safety and well-being of an infant with prenatal substance exposure, while preserving the family unit whenever the safety of the infant is not jeopardized. To further this policy, this chapter:

(1) Requires that notifications of infants with prenatal substance exposure be made to the Division by the healthcare provider involved in the delivery or care of the infant.

(2) Requires a coordinated, service-integrated response by various agencies in this State's health and child welfare systems to work together to ensure the safety and well-being of infants with prenatal substance exposure by developing, implementing, and monitoring a Plan of Safe Care that addresses the health and substance use treatment needs of the infant and affected family or caregiver.

§ 902B. Definitions.

As used in this chapter:

(1) "Division" is as defined in § 902 of this title.

(2) "Family assessment and services" is as defined in § 902 of this title.

(3) "Healthcare provider" is as defined in § 714 of this title.

(4) "Infant with prenatal substance exposure" means a child not more than 1 year of age who is born with and identified as being affected by substance abuse or withdrawal symptoms or a Fetal Alcohol Spectrum Disorder. The

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healthcare provider involved in the delivery or care of the infant shall determine whether the infant is affected by the substance exposure.

(5) "Investigation Coordinator" is as defined in § 902 of this title.

(6) "Internal information system" is as defined in § 902 of this title.

(7) "Plan of Safe Care" or "Plan" means a written or electronic plan to ensure the safety and well-being of an infant with prenatal substance exposure following the release from the care of a healthcare provider by addressing the health and substance use treatment needs of the infant and affected family or caregiver, and monitoring these plans to ensure appropriate referrals are made and services are delivered to the infant and affected family or caregiver. The monitoring of these plans may be time limited based upon the circumstances of each case.

(6) "Substance abuse" means the chronic, habitual, regular, or recurrent use of alcohol, inhalants, or controlled substances as identified in Chapter 47 of this title.

(7) "Withdrawal symptoms" means a group of behavioral and physiological features in the infant that follow the abrupt discontinuation of a drug that has the capability of producing physical dependence. Withdrawal symptoms resulting exclusively from a prescription drug used by the mother or administered to the infant under the care of a prescribing medical professional, in compliance with the directions for the administration of the prescription as directed by the prescribing medical professional, its compliance and administration verified by the healthcare provider involved in the delivery or care of the infant, and no other risk factors to the infant are present, is not included in the definition and does not warrant a notification to the Division under § 903B of this title.

§ 903B. Notification to Division; immunity from liability.

(a) The healthcare provider who is involved in the delivery or care of an infant with prenatal substance exposure shall make a notification to the Division by contacting the Division report line as identified in § 905 of this title.

(b) When two or more persons who are required to make a notification have joint knowledge of an infant with prenatal substance exposure, the telephone notification may be made by one person with joint knowledge who was selected by mutual agreement of those persons involved. The notification must include all persons with joint knowledge of an infant with prenatal substance exposure at the time the notification is made. Any person who has knowledge that the individual who was originally designated to make the notification has failed to do so, shall immediately make a notification.

(c) A notification made under this section is not to be construed to constitute a report of child abuse or neglect under § 903 of this title, unless risk factors are present that would jeopardize the safety and well-being of the infant.

(d) The immunity provisions under § 908 of this title will also apply to this chapter.

§ 904B. Notification information.

(a) Upon receipt of a notification of an infant with prenatal substance exposure, the Division shall enter it into the Division's internal information system.

(b) Upon receipt of a notification of an infant with prenatal substance exposure, the Division shall notify the office of the Investigation Coordinator of the notification in sufficient detail to permit the Investigation Coordinator to undertake its duties as specified in § 906 of this title.

§ 905B. State response to notifications of infants with prenatal substance exposure.

(a) In implementing the Division's role in protecting the safety and well-being of infants with prenatal substance exposure, upon receipt of a notification under § 903B of this title, the Division shall do all of the following:

(1) Determine if the case requires an investigation or family assessment.

(2) Develop a Plan of Safe Care.

(3) Provide copies of the Plan of Safe Care to all agencies and providers involved in the care or treatment of the infant with prenatal substance exposure and affected family or caregiver.

(4) Implement and monitor the provisions of the Plan of Safe Care.

(b) For any case accepted by the Division for investigation or family assessment, the Division may contract for services to comply with § 906 of this title and § 905B of this chapter.

(c) For cases that are not accepted by the Division for investigation or family assessment, or those cases accepted for family assessment where the report does not involve a multidisciplinary case under § 906(e)(3) of this title, but that still meet the definition of an infant with prenatal substance exposure, the Division shall contract for services to do any of the following:

(1) Protect the safety and well-being of the infant with prenatal substance exposure following release from the care of healthcare providers while preserving the family unit whenever the safety of the infant is not jeopardized.

(2) Develop a Plan of Safe Care.

(3) Provide copies of the Plan of Safe Care to all agencies and providers involved in the care or treatment of the infant with prenatal substance exposure and affected family or caregiver.

(4) Implement and monitor the provisions of the Plan of Safe Care.

(5) Provide a final report to the Division to assist the Division in complying with Section 906B of this Chapter.

(d) For any case referred for contracted services under this chapter, the contractor shall immediately notify the Division if it determines that an investigation is required or is otherwise appropriate under § 906 of this title. The contracted

staff who have conducted the assessment may remain involved in the provision of services to the child and family as appropriate.

(e) In implementing the Investigation Coordinator's role in ensuring the safety and well-being of infants with prenatal substance exposure, the Investigation Coordinator, or the Investigation Coordinator's staff, shall have electronic access and the authority to track within the Department's internal information system each notification of an infant with prenatal substance exposure.

§ 906B. Data and reports.

(a) The Division shall document all of the following information in its internal information system for all notifications of infants with prenatal substance exposure under this chapter:

(1) The number of infants identified as being affected by substance abuse, withdrawal symptoms, or Fetal Alcohol Spectrum Disorder.

(2) The number of infants for whom a Plan of Safe Care was developed, implemented and monitored.

(3) The number of infants for whom referrals were made for appropriate services, including services for the affected family or caregiver.

(4) The implementation of such Plans to determine whether and in what manner local entities are providing, in accordance with state requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver.

(b) The Department of Health and Social Services, the Investigation Coordinator and healthcare providers shall assist the Division in complying with this section.

(c) In addition to any required federal reporting requirements, the Division, with assistance from the Department of Health and Social Services and the Investigation Coordinator, shall provide an annual report to the Child Protection Accountability Commission and Child Death Review Commission summarizing the aggregate data gathered on infants with prenatal substance exposure.

(d) To protect the privacy of the affected family or caregivers, including the infant named in a report, this chapter is subject to the privacy and confidentiality provisions in § 906 and § 909 of this title.

Section 2. This Act shall be known and may be cited as "Aiden's Law."

SYNOPSIS

This non-punitive, public-health oriented bill seeks to codify certain sections of the federal law known as the Child Abuse Prevention and Treatment Act (CAPTA), as amended by the Comprehensive Addiction and Recovery Act (CARA), that requires states to have policies and procedures in place to address the needs of infants born with and identified as being affected by substance abuse, withdrawal symptoms, or Fetal Alcohol Spectrum Disorder, including a requirement that healthcare providers involved in the delivery or care of such infant notify the child protection services system. This bill

formalizes a uniform, collaborative response protocol for the development of a Plan of Safe Care for infants with prenatal substance exposure and their affected family or caregivers.

STATE OF DELAWARE

MULTIDISCIPLINARY TEAM CASE REVIEW PROTOCOL

I. INTRODUCTION

Case review is the formal process in which the multidisciplinary team (MDT) convenes regularly scheduled meetings to monitor and assess its independent and collective effectiveness in response to child abuse, child neglect and child death cases. The process facilitates best practices by encouraging mutual accountability and helping to assure that children's physical, mental and emotional needs are met sensitively, effectively and in a timely manner.

Case review is intended to examine and monitor cases that are being actively investigated by the MDT. It is recognized that MDT cases involving child victims are some of the most difficult cases to investigate. Therefore, it is beneficial to conduct periodic meetings among members of the MDT to share information, coordinate appropriate services to child victims, discuss the status of ongoing investigations, and facilitate efficient and appropriate disposition of cases.

It is imperative that representatives of the MDT actively participate in the case review process. It is contemplated that the following members of the MDT will attend case reviews:

Representatives of the Children's Advocacy Center (CAC)
Investigation Coordinator (IC) or IC Case Review Specialist
Representatives of Department of Services for Children, Youth and Families (DSCYF – DFS/IA, PBH, YRS)
Representatives of Law Enforcement (LE)
Representatives of the Department of Justice (DOJ)
Representatives of Nemours A.I. duPont Hospital for Children (Medical)
Representatives of mental health agencies (MH)

It is vital that all those who participate in the MDT Case Review Meetings understand the importance of ensuring the confidentiality of the information discussed at the meetings. Sensitive information is discussed which could vastly affect the lives of both the adults and children. Participating agencies must rely on their own applicable policies to guide their actions regarding information sharing, but all should adhere to

the standards set forth in the Memorandum of Understanding for the MDT Response to Child Abuse and Neglect. Accordingly, MDT members shall not discuss with the public or any unauthorized person any information or personal opinions gained as a result of participating in or observing the Case Review Meeting. MDT members will, at each meeting, sign the MDT Case Review Confidentiality Agreement indicating that he/she attended the MDT Case Review Meeting on that date and understands his/her responsibility for ensuring the confidentiality of the information discussed at the meeting.

The purpose of this protocol is to outline a case review process, including establishing case selection criteria, defining standard case and special case reviews, and establishing the responsibilities for coordination, facilitation, participation and documentation of the process.

II. CASE SELECTION CRITERIA FOR THE CASE REVIEW PROCESS

A. Multidisciplinary Cases

All multidisciplinary cases, as defined in Ch. 9 of Title 16 of the Delaware Code[1], shall be case reviewed, unless excluded herein or closed by the MDT.

B. Presumptively Excluded Cases

The following cases are presumptively excluded from the case review process and will not be placed on a case review calendar:

- Identified victim is an adult (unless the alleged perpetrator is known to be involved in another active investigation involving a child); or
- Courtesy interviews conducted by the CAC at the request of an out of state agency for which no Delaware agency has open investigation.

C. Administrative Closure of Cases

Any case that is otherwise subject to the case review process may be removed from the process by an Administrative Closure. Administrative Closure may occur when there is agreement by DOJ and either LE or DFS. Administrative Closure may occur at any time, including at the post-forensic interview meeting, as long as the required MDT members are present and in agreement with closure. Administrative Closure is effective when the agencies provide a closure form (See attachment A) to CAC and IC. The CAC will include cases that are administratively closed on its Case Closure List.

D. Discretionary Selection

Notwithstanding sections B and C above, any case involving a child victim that is otherwise excluded or administratively closed may be scheduled for a case review

[1] "Multidisciplinary case" means a comprehensive investigation by the multidisciplinary team for any child abuse or neglect report involving death, serious physical injury, physical injury, human trafficking of a child, torture or sexual abuse, which if true, would constitute a criminal violation against a child, or an attempt to commit any such crime, even if no crime is ever charged. (As amended August 30, 2017 http://delcode.delaware.gov/sessionlaws/ga149/chp144.shtml; subject to future amendments).

if, in the opinion of any member of the MDT, the case would benefit from the case review process. The MDT member will notify the CAC Center Coordinator of his/her request and the case will be placed on a review calendar in accordance with Section III below.

III. TYPES OF CASE REVIEWS: STANDARD AND SPECIAL

A. Standard Case Review

1. **Description**: Standard Case Review shall be held to discuss an ongoing investigation, allow members of the MDT to share information about the case and monitor the status as it relates to their own investigation. Every MDT case that is not presumptively excluded or administratively closed will be periodically reviewed at a Standard Case Review.

2. **Scheduling**: Standard Case Review will be conducted on a monthly basis in each county for cases from the respective counties.[2] A case will be placed on a calendar within 60 days of the date of the forensic interview or, for cases that did not include a CAC forensic interview but are being referred by a MDT member, within 60 days of the date of referral. A case will not be reviewed more frequently than every 60 days or less frequently than every 180 days, unless otherwise agreed to by the MDT members. Associated cases will be scheduled for the same case review meeting to the extent practicable.

3. **Notification and Document Preparation**: The CAC Project Coordinator (PC) will notify the MDT of the cases scheduled to be reviewed by sending a confidential email to each identified MDT representative[3], no less than 15 days prior to the Standard Case Review meeting, the following documents:

    - Case Review Summary Lists
    - Agency Review Forms
    - Case Review Meeting Agendas

4. **Attendance**: All members of the MDT are required to be in attendance when a case they are handling is being reviewed. It is sufficient that a representative with knowledge about the status of the case be present at the Standard Case Review from the following agencies:

    - Representatives of the Children's Advocacy Center (CAC)
    - Investigation Coordinator (IC) or IC Case Review Specialist

[2] In Sussex County, case review is held at the Children's Advocacy Center in Georgetown, DE. In Kent County, case review is held at the Children's Advocacy Center in Dover, DE. In New Castle County, case review is held at the Department of Justice in Wilmington, DE.

[3] Each MDT agency will select a representative to receive case review documents and provide updates at the case review meeting.

- Representatives of Department of Services for Children, Youth and Families (DSCYF – DFS/IA, PBH, YRS)
- Representatives of Law Enforcement (LE)
- Representatives of the Department of Justice (DOJ)
- Representatives of Nemours A.I. duPont Hospital for Children (Medical)
- Representatives of mental health agencies (MH)

5. Facilitation and Discussion: At each meeting, the CAC PC will distribute the MDT Case Review Confidentiality Agreement for signature by the MDT members in attendance. The CAC Center Coordinator will facilitate the meeting by presenting each case listed on the meeting agenda. Each MDT member will have the opportunity to present updates or new information, address any questions, discuss concerns and provide suggestions. Generally, Standard Case Reviews meetings may include the following:
    - Discuss initial report and forensic interview outcomes;
    - Discuss and monitor the progress of both the civil and criminal investigations, including plans for future actions;
    - Discuss any history with the MDT agencies, including cases monitored by the IC;
    - Review any medical examinations of the victim(s);
    - Discuss child protection and other safety issues;
    - Provide input for prosecution and sentencing decisions;
    - Discuss emotional support and treatment needs of the child victim and family members;
    - Discuss ongoing cultural and special needs issues in the case;
    - Assess court advocacy, preparation and victim compensation needs; and,
    - Ensure that all children and families are afforded the legal rights and comprehensive services to which they are entitled.

6. Actions by the MDT: After each case discussion, the MDT representatives will determine whether a case will continue on the Standard Case Review calendar and, if so, the date of the next review; be referred to the Special Case Review calendar (see Section B below); or will be closed to the case review process. A representative from the DOJ must be present at the meeting for a case to be closed. Each MDT representative present at the case review meeting will be responsible for relaying the details of the discussion to the appropriate individual within their agency/organization who is personally handling or investigating the case.

7. Documentation: During each case review meeting, the CAC PC will document each MDT member's status, disposition, and comments relating to each case. The CAC PC will enter this information into the CAC Case Management System within 3 business days after the case review meeting. Cases remaining open in the case review process will be added to a future case

review meeting agenda as requested by the MDT, which will include on-going information from prior case reviews. For cases that are closed at the case review meeting, the CAC PC will prepare and email each identified MDT representative a Closure Summary within 3 business days after the case review meeting.

B. Special Case Review

1. Description: Special Case Review may be held to comprehensively discuss the ongoing investigation of a case with the purpose exchanging information regarding each agency's investigation and to facilitate efficient and appropriate disposition of cases. A Special Case Review is more time consuming and, therefore, fewer cases will be placed on this calendar. Special Case Review is in addition to the Standard Case Review and a case will not be removed from a Standard Case Review process because it is placed on a Special Case Review.

2. Scheduling: At the request of any member of the MDT at any time, a case may be scheduled for a Special Case Review if it is determined that the case would benefit from a comprehensive discussion regarding the status of the case. The MDT member will notify the Investigation Coordinator (IC) or IC Case Review Specialist of his/her request and the case will be placed on a Special Case Review calendar within 60 to 90 days. Special Case Reviews will be held, to the extent possible, in conjunction with Standard Case Reviews. There shall be separate time and schedule for the Special Case Review. No more than 4 cases shall be placed on a given Special Case Review Calendar.

3. Notification and Document Preparation: The CAC PC will notify the MDT of the cases scheduled to be reviewed by sending a confidential email to each identified MDT representative[4], within 3 business days of the request for the Special Case Review meeting, the following documents:

    - Case Review Summary Lists
    - Agency Review Forms
    - Case Review Meeting Agendas

4. Attendance: Since a Special Case Review involves a more comprehensive discussion of the case, MDT members with firsthand knowledge of the case must be in attendance when their case is being reviewed.[5] It is required that the following individuals participate:

    - Assigned Deputy Attorney General

[4] Each MDT agency will select a representative to receive case review documents and provide updates at the case review meeting.
[5] Attendance via Skype will be considered as an alternative to in person attendance at Special Case Reviews.

- Assigned DFS Worker and Supervisor
- Law Enforcement - Chief Investigating Officer
- Investigation Coordinator or IC Case Review Specialist
- A member of the CARE[6] Team (if involved in case)
- A member of mental health agency
- Representative from Children's Advocacy Center

5. Facilitation and Discussion: At each meeting, the CAC PC will distribute the MDT Case Review Confidentiality Agreement for signature by the MDT members in attendance. The Investigation Coordinator (IC) or IC Case Review Specialist, will facilitate the meeting by presenting each case listed on the meeting agenda. Each MDT member will have the opportunity to present updates or new information, address any questions, discuss concerns and provide suggestions. Generally, Special Case Review meetings may include the following:
    - Discuss, plan, and monitor the progress of both the civil and criminal investigations, including plans for future actions;
    - Discuss child protection and other safety issues;
    - Provide input for prosecution and sentencing decisions;
    - Review any medical examinations of the victim(s);
    - Discuss emotional support and treatment needs of the child victim and family members; and,
    - Discuss any case concerns by any MDT member.

6. Actions by the MDT: After each case discussion, the MDT members will determine whether a case will continue on the Special Case Review calendar and, if so, the date of the next review; the date of the next Standard Case Review; or will be closed to the case review process.

7. Documentation: During each case review meeting, the CAC PC will document each MDT member's status, disposition, and comments relating to each case. The CAC PC will enter this information into the CAC Case Management System within 3 business days after the case review meeting. Cases remaining open in the case review process will be added to a future case review meeting agenda as requested by the MDT, which will include on-going information from prior case reviews. For cases that are closed at the case review meeting, the CAC PC will prepare and email each MDT member a Closure Summary within 3 business days after the case review meeting.

IV. MISCELLANEOUS

A. CAC Forensic Interviews Cancelled

1. The CAC shall maintain a list of clients whose interview was cancelled and not rescheduled. The list shall include the name and date of birth of the child

[6] Child At Risk Evaluation Team at A.I. duPont Hospital for Children

client, the name of the referring agency, and the date of the scheduled CAC forensic interview.

2. The CAC shall forward the list of clients, whose case age has reached 30 days, to the DOJ SVU Director and IC on a monthly basis for review. The DOJ will make a determination as to whether a CAC forensic interview will be re-scheduled and held, or whether the case will be closed via Closure Form submitted to the CAC Center Coordinator by the DOJ.
3. If neither a CAC forensic interview is re-scheduled and held or a Closure Form is submitted to the CAC within 90 days of the date the client list was forwarded to the DOJ SVU Director and IC, the case will automatically be placed on the Standard Case Review schedule.

B. **IC Cases without CAC Involvement**

1. IC shall notify the CAC Center Coordinator in the appropriate county of any multidisciplinary case that was not referred for a CAC forensic interview but would benefit from the case review process.
    - Any multidisciplinary case referred to IC in which there has been no CAC forensic interview and no criminal charges have been filed within 90 days of the date of referral to IC.
2. IC will forward a Referral Form (see attachment ___) to the CAC Center Coordinator requesting either a Standard Case Review or Special Case Review. The case shall be placed on the appropriate calendar within 60 days of the IC referral.

C. Non-Compliance by MDT Member: Dispute Resolution

1. In the spirit of multidisciplinary teamwork, it is expected that team members will actively participate in the case review process and will maintain openness to feedback from each member involved with each case.
2. For those MDT members that are non-compliant with the case review process, the IC will utilize the documents provided by the CAC to make this determination.
3. IC will attempt resolution by contacting the non-compliant MDT member and his/her immediate supervisor. If resolution cannot successfully be reached, then IC will contact the highest ranking individual in the agency or organization.
4. Thereafter, if resolution cannot be reached at that level, the IC is authorized to take any of the following actions for cases involving law enforcement agencies:
    - Contact the Delaware Police Chiefs' Council;
    - Contact elected officials within the agency jurisdiction; or
    - Contact the Delaware Council on Police Training.
5. IC will also provide a quarterly report to the Child Protection Accountability Commission (CPAC), the state commission responsible for oversight of the Memorandum of Understanding, to provide notification to CPAC, the General Assembly and Governor of all MDT members who are noncompliant with the MOU and MDT Case Review Protocol.

State of Delaware

Multidisciplinary Team Case Review Protocol

Adopted by the

Child Protection Accountability Commission

2018

Contributors:

Camden Police Department, Cpl. Jason Kane
Children's Advocacy Center of Delaware, Randall Williams/Diane Klecan
Delaware State Police, Lt. Gerald Windish/Sgt. Adam Wright/Sgt. Don Coleman
Department of Justice, James Kriner, Esq./Victoria Witherell, Esq.
Division of Family Services, Sue Murray/Diana Fraker/ Stacy Northam-Smith/Jaime Zebroski
Georgetown Police Department, Det. Bradley Cordrey
Nemours A.I. duPont Hospital for Children, Dr. Stephanie Deutsch
New Castle County Police Department, Sgt. James Leonard
Office of the Child Advocate, Rosalie Morales
Office of the Investigation Coordinator, Jen Donahue, Esq./Jen Perry
Wilmington Police Department, Sgt. Ron Mullin/Det. Joe Miller

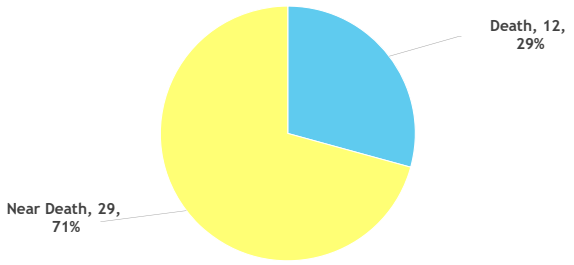
CPAC/CDRC Joint Retreat

Delaware Data

April 25, 2018

1

Type of Case, CAN Cases (41)



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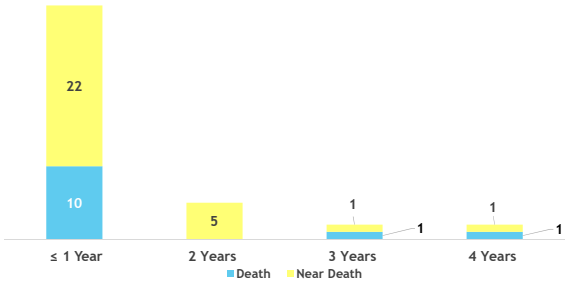
Victim Characteristics

CAN Cases (41)

3

Victim Age Group, CAN Cases (41)



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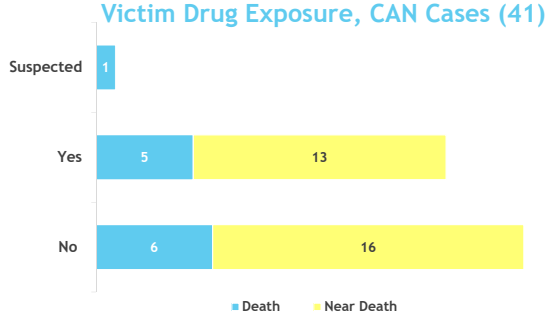
Victim Drug Exposure, CAN Cases (41)



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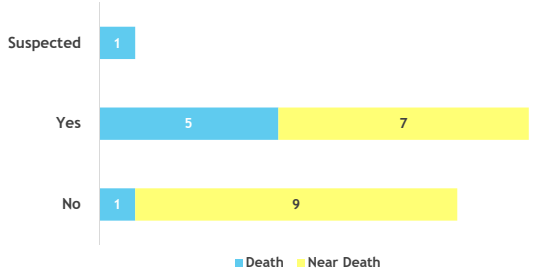
Victim Drug Exposure, 0-6 Month Old Victims, CAN Cases (23)



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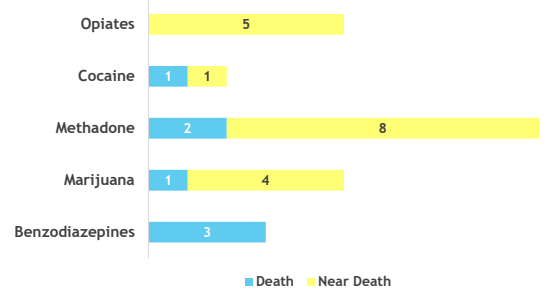
Type of Drug Exposure, Drug Exposed Victims, CAN Cases (18)



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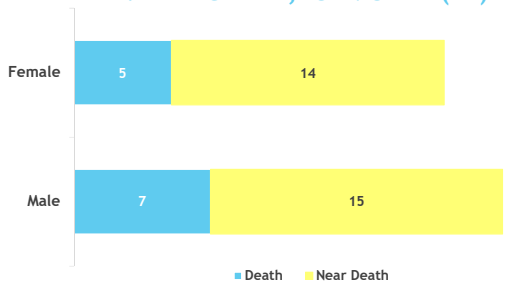
Victim Gender, CAN Cases (41)



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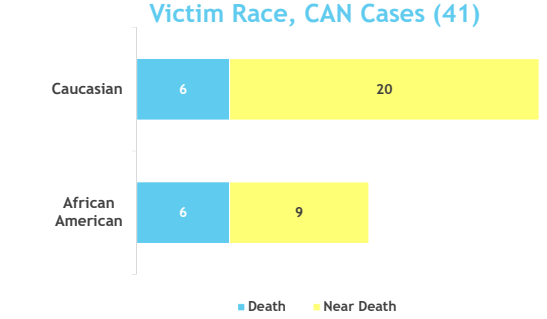
Victim Race, CAN Cases (41)



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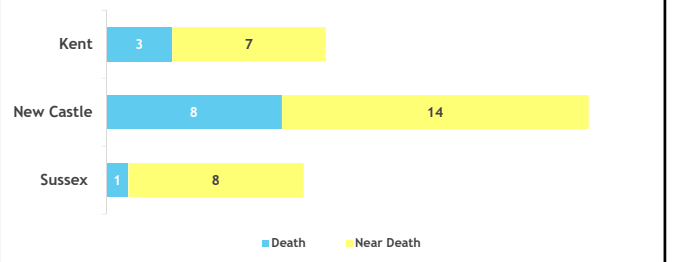
County of Incident, CAN Cases (41)



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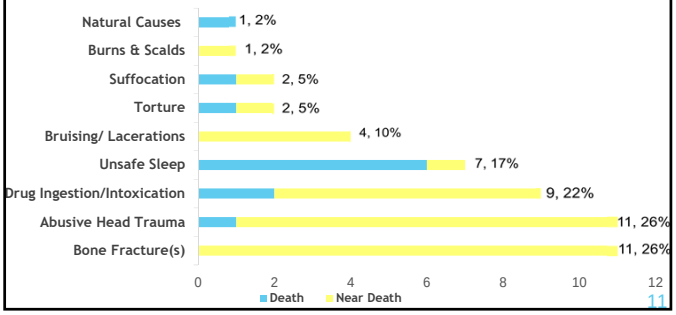
Injury Type, CAN Cases (41)



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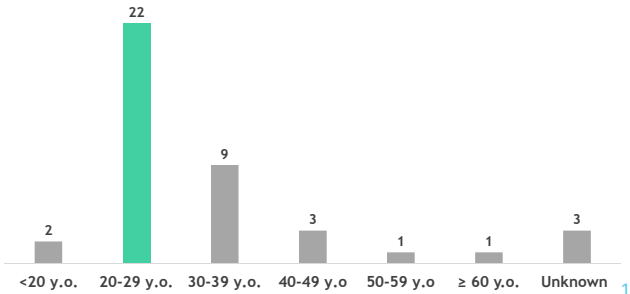
Perpetrator Characteristics

CAN Cases (41)

12

Perpetrator Age Group, CAN Cases (41)



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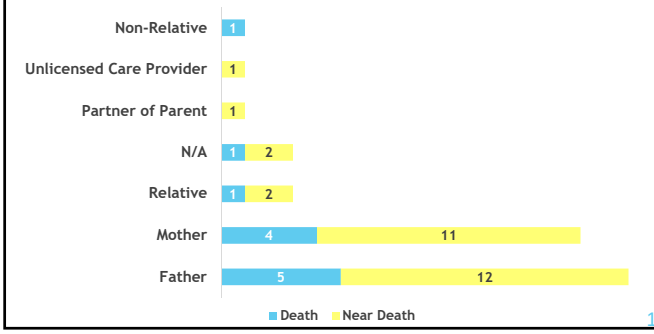
Perpetrator Relation to Victim, CAN Cases (41)



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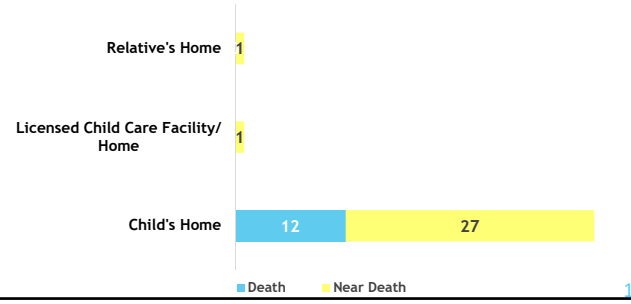
Location of Incident, CAN Cases (41)



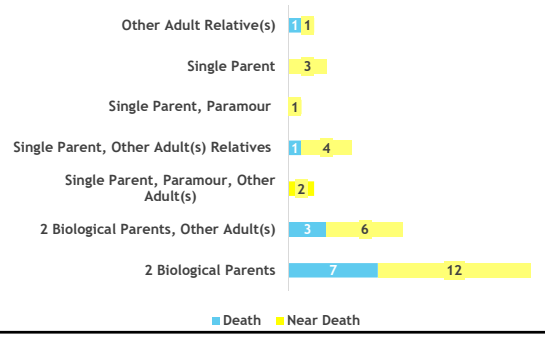
15

Household Characteristics

CAN Cases (41)

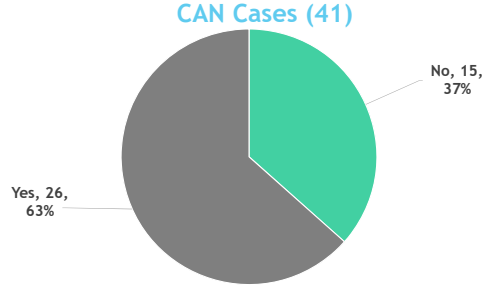
16

Household Makeup, CAN Cases (41)



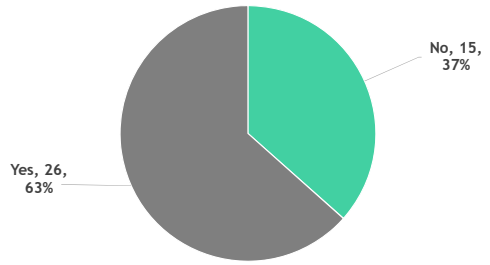
17

Household Criminal History, CAN Cases (41)



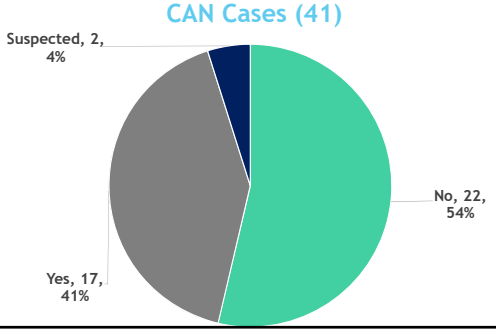
18

Household Substance Abuse History, CAN Cases (41)



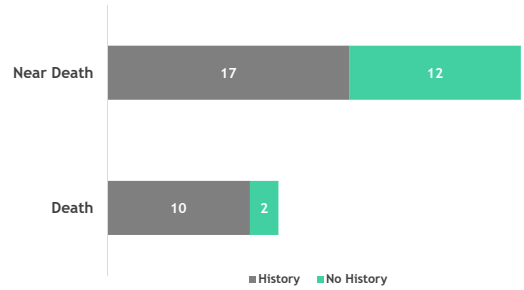
19

Household Mental Health History, CAN Cases (41)



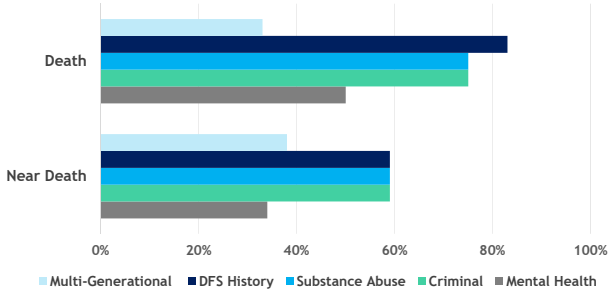
20

History With DFS, CAN Cases (41)



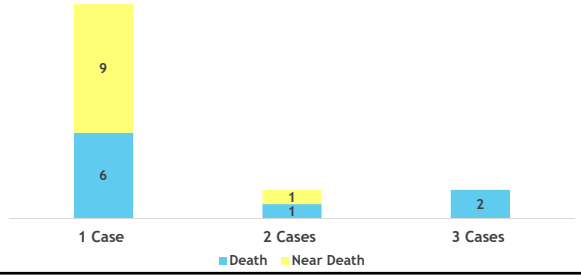
21

Household History, CAN Cases (41)



22

Cases Active with DFS 1 Year Prior to Incident, CAN Cases (19)



23

In Sum…

Majority of the Victims :

- Are from New Castle County
- Caucasian
- 0-6 Months of Age
- Are abused/ neglected at their 2 Parent Household (both bio parents)
  - By their mothers &/or fathers, who are 20-29 years of age.
  - & most commonly suffer from AHT and Bone Fractures.
- More than half lived in a household where there was criminal history, DFS history & history of substance abuse

24

Child Deaths in Delaware

2016-2017

26

CAN Panel Deaths

N=12

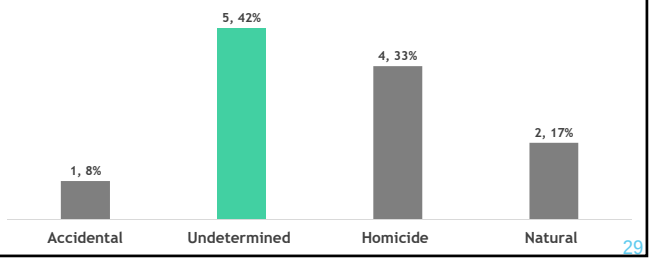
27

Victim Age Group, CAN Death Cases (12)

Age Group	# of Cases	Percentage
< 1 Year	7	58%
1 Year	3	25%
3 Years	1	8%
4 Years	1	8%

28

Division of Forensic Science, Manner of Death, CAN Death Cases (12)



29

OCA / CAN Explanation, CAN Death Cases (12)

Manner of Death	Cause of Death	OCA/ CAN Brief Description	# of Cases
Homicide	Acute Morphine Intoxication	Drug Intoxication/ Ingestion	1
	Out of State	Drug Intoxication/ Ingestion	1
	Homicidal Violence	Suffocation	1
	Multiple Blunt Force Injuries	Torture	1
Natural	Brain Death	Natural Causes	1
	Subdural Hematoma	AHT w/ Retinal Hemorrhage	1
Undetermined	SUDI	Unsafe Sleep	2
	Undetermined	Unsafe Sleep	3
Accidental	Suffocation Due to Overlay	Unsafe Sleep	1

30

In Sum…

Majority of the Death Cases:

- Victims were less than 1 year old, more specifically under 3 months.
- Incidents resulting in death were due to Unsafe Sleep with substance abuse concerns as a risk factor

31

Child Death Review Commission Deaths

N=12

Delaware CDRC REVIEW & PREVENTION OF CHILD DEATHS

32

Child Deaths in Delaware, CDRC

56 total deaths during this time period:

- 28 CDR Panel
  - *3 Joint Reviews*
- 28 SDY Panel
  - *8 Joint Reviews*

33

Age Group, Child Deaths (12)

Age Group	# of Cases
3 months and under	7
4-12 months	2
7-12 years	2
13-17 years	1

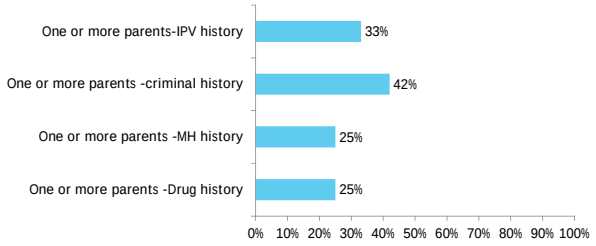
34

Manner of Death, Child Deaths (12)

Manner of Death	# of Cases
Natural	2
Unsafe Sleeping	9
Accidental	1

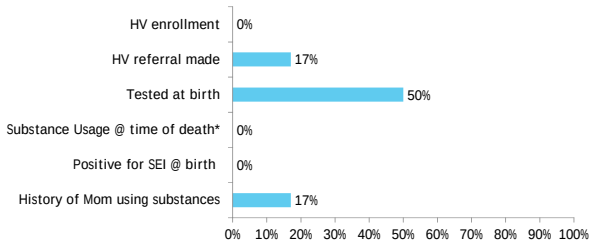
35

Household History, Child Deaths (12)



36

Substance Abuse & Exposure, Child Deaths (12)

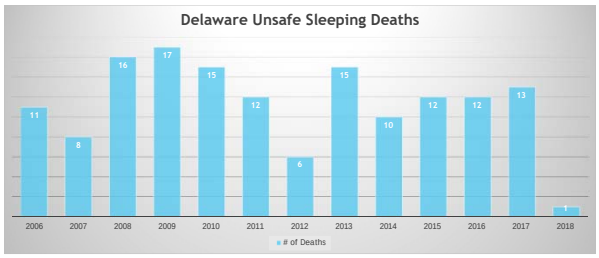


37

Unsafe Sleeping Deaths

38

Unsafe Sleeping Deaths by Year, CDRC



39

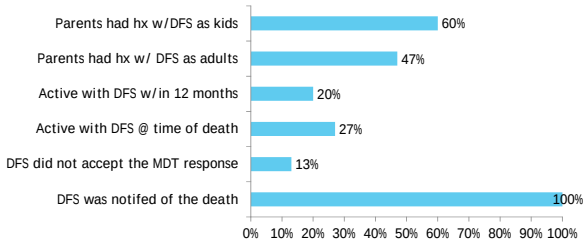
Infant Profile, Unsafe Sleeping Deaths (15)

Age Group	# of Cases
0-2 months	12
3-6 months	2
7-12 months	1
County of Residence	**# of Cases**
NCC	8
Kent	4
Sussex	3

Race	# of Cases
White	5
Black	10
Marital Status of Parents	**# of Cases**
Single	3
Married	1
Couple	8
Sex	**# of Cases**
Female	5
Male	10

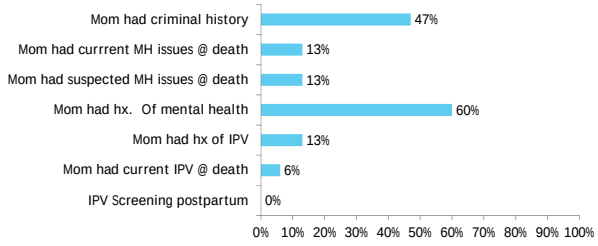
40

History with DFS, Unsafe Sleeping Deaths (15)



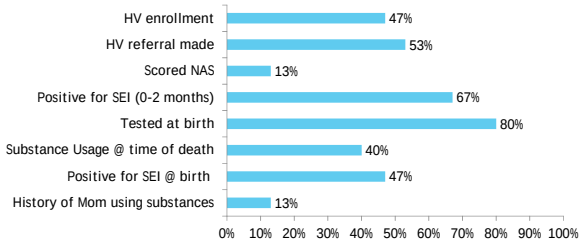
41

Mother's History, Unsafe Sleeping Deaths (15)



42

Substance Exposure & Referrals, Unsafe Sleeping Deaths (15)



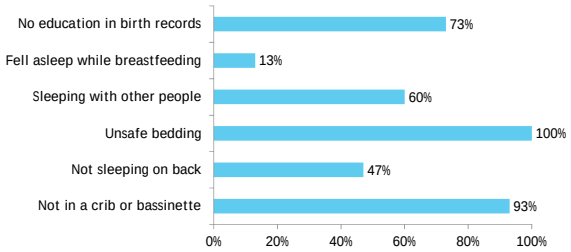
43

Home Visiting, Unsafe Sleeping Deaths (15)

Evidenced Based Home Visiting	# of Cases
HV Referral	8
HV Enrollment	7
HFA	1
Parents Declined	2
Not yet made contact with family	4

44

Details, Unsafe Sleeping Deaths (15)



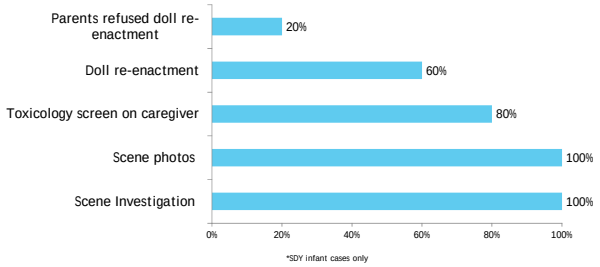
45

Drug Exposure Types, Unsafe Sleeping Deaths (15)

Types of Substances at Death	# of Cases
Opiates	1
Cocaine	1
Marijuana	3
Meth	3
Benzodiazepines	2
Alcohol	1
Nicotine	1

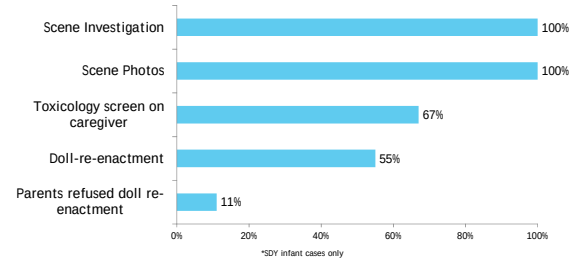
46

MDT Response, Unsafe Sleeping Deaths (15)



47

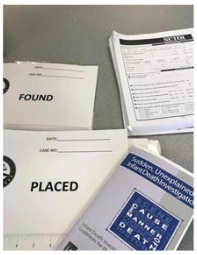
MDT Response (No Joint Review), Unsafe Sleeping Deaths (9)



48

One of the SDY Goals

An increase in death scene investigations with doll reenactments performed. Doll reenactments increase data completeness and understanding of risk and protective factors which can then be shared with stakeholders.



49

Division of Forensic Science
Cause/Manner of Death, Unsafe Sleeping Deaths

- **Accidental Manner**
  - Positional Asphyxia
  - Suffocation due to Overlay
- **Undetermined Manner**
  - 9 were undetermined
  - 4 were Sudden Unexplained death in Infancy

50

Categorization for SUID Case Registry, Unsafe Sleeping Deaths

- 5 Explained Suffocation with Unsafe Sleep factors
  - 3 of these were overlay
  - 2 ware soft bedding
- 10 Unexplained Unsafe Sleep
  - 7 Unsafe Sleep Factors
  - 3 Possible suffocation (2 soft bedding and 1 overlay)

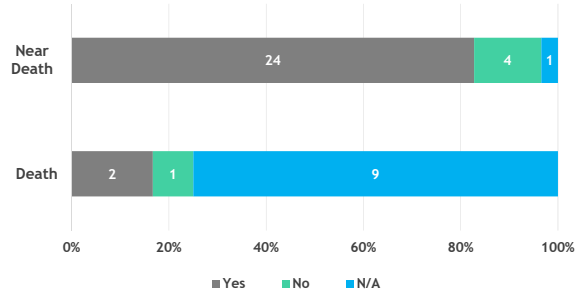
51

Medical Assessments

CAN Cases (41)

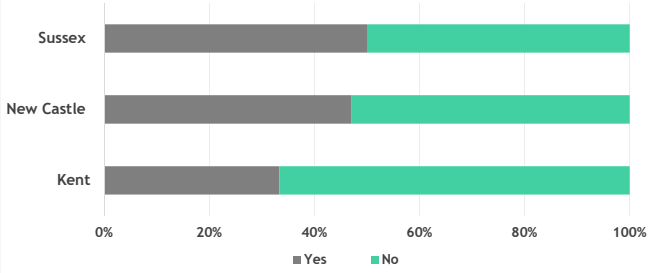
52

CARE Consult / Forensic Exam for Victim, CAN Cases (41)



53

Medical Assessment / SANE for Siblings by County, CAN Cases (27)



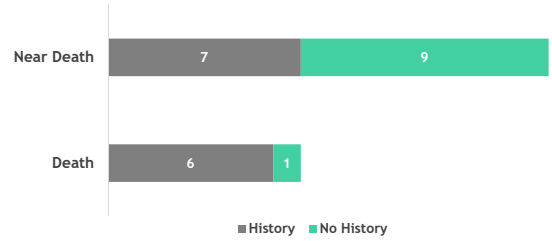
54

Division of Family Services Involvement

CAN Cases (41)

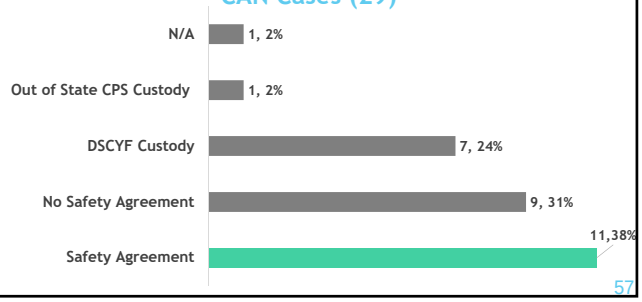
55

History with DFS, 0-6 Month Old Victims, CAN Cases (23)



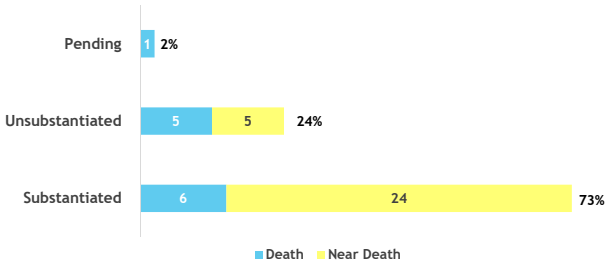
56

Immediate Plan for Victim, Near Death CAN Cases (29)



57

DFS Investigation Outcomes, CAN Cases (41)



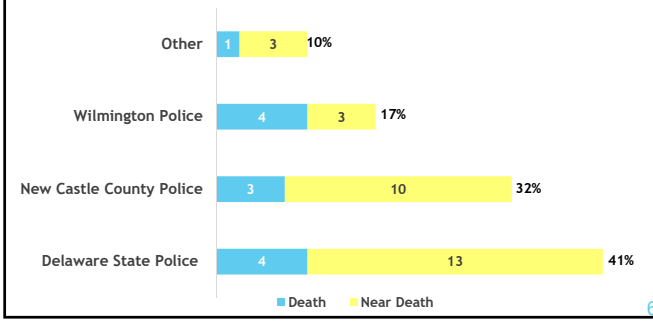
58

Law Enforcement & Department of Justice Involvement

CAN Cases (41)

59

LE Agencies Involved, CAN Cases (41)



60

LE Agency Practices, CAN Cases (41)

DEATH - ALL LE AGENCIES	
Total # of Cases	12
Scene Investigation	**100%** (12/12)
Doll Re-enactment (N=8)	**63%** (5/8)
Scene Photos	**92%** (11/12)

NEAR DEATH -ALL LE AGENCIES	
Total # of Cases	29
Scene Investigation	**72%** (21/29)
Doll Re-enactment (N=17)	**29%** (5/17)
Scene Photos	**69%** (20/29)

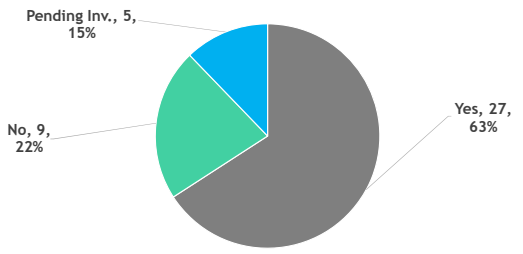
61

LE Agency Practices, CAN Cases (41)

Death & Near Death Cases (All LE Agencies)	
Total # of Cases	41
Scene Investigation	76% (31/41)
Doll Re-enactment (N=25)	40% (10/25)
Scene Photos	73% (30/41)
Initial Suspect Interview (24-48 hrs.)	93% (38/41)
Confession from Perpetrator	7% (3/41)

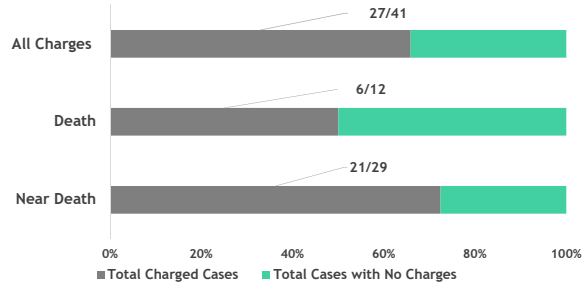
62

Primary Perpetrator Charged, CAN Cases (41)



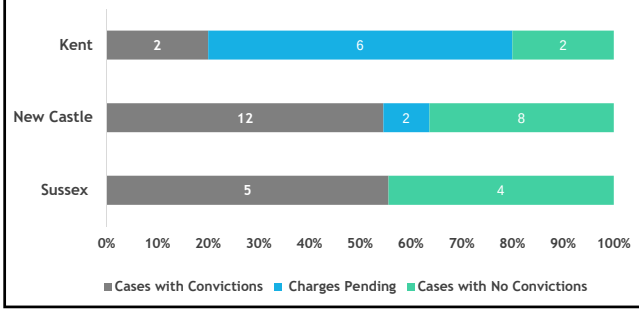
63

Charged Cases by Death or Near Death, CAN Cases (27)



64

Conviction Rates by County, CAN Cases (41)



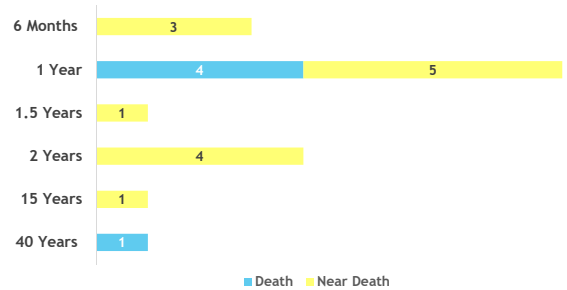
65

Original Charge vs. Conviction, CAN Cases (19)

Original Charge	Conviction	
	Felony	Misdemeanor
Child Abuse 1st (10)	60% (6/10)	40% (4/10)
Child Abuse 2nd (2)	100% (2/2)	----------
Felony Endangering the Welfare of a Child (5)	----------	100% (5/5)
Murder 1st (1)	100% (1/1)	----------
Reckless Endangering 1st (1)	----------	100% (1/1)
TOTAL Convictions	47% (9/19)	53% (10/19)

66

Primary Perpetrator Sentence (19) CAN Cases



67

In Sum…

68

State of Delaware
2015-2019 Child and Family Services Plan
Edition - 2017

2015-2019 Strategic Plan

Based on the 2012 assessment, by the Child Welfare Strategy Group, (of the Annie E. Casey Foundation), the DFS *Outcomes Matter* initiatives, the Child and Family Services Review findings, evaluation of metrics, along with stakeholder comments and partner collaboration, the goals and objectives discussed below are established for 2017. There are several broad principles and priorities supported by this strategic plan. The focus on child safety is paramount at all stages of a case from prevention to permanency. Children deserve to grow up in stable, nurturing and permanent families. Family interventions should be proportionate based on risk and protective factors. Key decisions include family and youth voices. Child welfare systems are strongest when partners share common goals and resources. A skilled and experienced workforce is supported by competency based training, facilitative supervision, community-based services and technology.

A. Safety

Goal: At-risk children are safe and protected from harm

Rationale: Child safety is an agency mandate and a core component of the agency's mission. Data indicates the agency has low rates of recurring maltreatment and abuse/neglect in foster care. The agency strives to continue to protect children with an appropriate and measured response, using evidenced- based decision making tools and family engagement strategies that strengthen the capacity of families to meet their own needs.

Objective: Implement Structured Decision Making (SDM®) across all program areas.

Rationale: SDM® implementation must be completed to ensure consistent and accurate assessment of harm and risk throughout the life of a case. SDM® tools have the highest level of validity and reliability established in the field of child welfare. The National Council on Crime and Delinquency's international evaluation found evidence SDM® lowers maltreatment and maltreatment recurrence rates, while ensuring equity in decision making.

Outcome: Lower rates of child maltreatment and maltreatment recurrence.

Benchmarks:

1. Implement SDM® tools across program areas from intake to permanency. Timeframe: June 2017. Measure: Percent and number of quality assurance reviews for intake, investigation, treatment and permanency cases indicating use of SDM® tools. This benchmark is under review as DFS adopts the federal Child and Family Services Review On-Site Review Instrument.
2. Use a continuous quality improvement framework to monitor and guide implementation of SDM® practice by reviewing DFS data and Quality Assurance case review reports with DFS staff and system partners. Identify areas needing improvement and implement corrective actions. Continue to review performance. Timeframe: June 2016 to September 2019. Measure: Documentation of CQI policy and procedure.
   Production of SDM® data reports from FACTS and case reviews. Meeting minutes documenting findings and recommendations.

3. Until a more comprehensive CQI system is operational, use existing data reports, Quality Assurance case review reports and feedback from DFS staff, trainers and system partners to monitor implementation. Use existing DFS forums to recommend and implement corrective actions through training, supervision and technical assistance. Timeframe: Ongoing until CQI system is operational. Measure: Production of SDM® data reports from FACTS and case reviews; meeting minutes documenting findings, recommendations, actions taken and results.

Objective: Implement Safety-Organized Practice (SOP) across all program areas. Rationale: Family engagement strategies embedded in a comprehensive practice model are best practice in child welfare. SOP is a practice model that integrates the rigorous safety and risk assessments from SDM® into a comprehensive approach to family engagement across the lifespan of a case. SOP uses strengths-based and child-centered principles in a series of family engagement activities that support comprehensive assessment and planning. This objective completes training sessions already in progress. Outcome: Lower rates of child maltreatment and maltreatment recurrence.

Benchmarks:

1. Implement supervisor Learning Circles. Timeframe: June 2017. Measure: Documentation of supervisor Learning Circle sessions.
2. Fully implement Consultation and Information Sharing Framework for group supervision. Timeframe: March 2016. Measure: Percent of case reviews with documented Framework utilization.
3. Use a continuous quality improvement framework to monitor and guide implementation of Safety-Organized Practice by reviewing DFS data and Quality Assurance case review reports with DFS staff and system partners. Identify areas needing improvement and implement corrective actions. Timeframe: June 2016 to September 2019. Measure: Documentation of CQI policy and procedure. Production of SOP data reports from case reviews. Meeting minutes documenting findings and recommendations.
4. Until a CQI system is operational, use existing data reports, Quality Assurance case review reports and feedback from DFS staff, trainers and system partners to monitor implementation. Use existing DFS forums to recommend and implement corrective actions through training, supervision and technical assistance. Timeframe: Ongoing until CQI system is operational. Measure: Production of SOP data reports from case reviews; meeting minutes documenting findings, recommendations, actions taken and results.

Objective: Implement a Differential Response System for at-risk children and families. Rationale: Based on CAPTA requirement, agency is building capacity to respond to reports of abuse and neglect proportionally according to presenting allegations. Delaware exceeded the national average in the percentage of teens in foster care (e.g., in 2012, national average was 38%, yet DE had 48%. Additionally, 79% of these teens were entering foster care for the first time as teens). Outcome: Lower rates of child maltreatment and maltreatment recurrence.

Benchmarks:

1. Develop, implement, and expand a differential response within DFS using Family Assessment and Intervention Response (FAIR) to accepted reports of child abuse and neglect. Timeframe: June 2017. Measure: Number and percent of accepted reports of abuse and neglect receiving FAIR response.
2. Continue the contracted community-based FAIR Program to prevent unnecessary entries of teens into foster care statewide. Timeframe: Ongoing to September 2019. Measure: Number and percent of children and youth receiving community-based FAIR and entering foster care.
3. Use a continuous quality improvement framework to monitor and guide implementation of differential response by reviewing DFS data, Quality Assurance case review reports and contractual performance measures with DFS staff and system partners. Timeframe: June 2016 to September 2019. Measure: Documentation of CQI policy and procedure. Production of FAIR data reports from FACTS and case reviews. Meeting minutes documenting findings and recommendations.
4. Until a CQI system is operational, use existing data reports, Quality Assurance case review reports, contract performance data and feedback from DFS staff, trainers and system partners to monitor implementation. Use existing DFS forums to recommend and implement corrective actions through training, supervision and technical assistance. Timeframe: Ongoing until CQI system is operational. Measure: Production of FAIR data reports from FACTS and case reviews; meeting minutes documenting findings, recommendations, actions taken and results.

Objective: Fully implement Considered Removal Team Decision Making (TDM) model for at-risk children and families to strengthen safety assessment and planning for children at-risk of entry into foster care.

Rationale: Based on AECF assessment findings and early success, agency will continue to expand use of TDM model to prevent placement and support key decisions through family engagement.

Outcome: Lower rates of child maltreatment and maltreatment recurrence. Increased rate of safely diverted foster care entries.

Benchmarks:

1. Continue Considered Removal TDM meetings for DFS custody decisions; strengthen practice of using TDM prior to removal in non-emergency situations. Timeframe: Ongoing to September 2019. Measure: Number and percent of TDM meetings occurring before and after foster care entry.
2. Consider TDM at other key case decision points involving placement changes. Timeframe: June 2017. Measure: Documentation of discussion and decisions for using TDM at replacement.
3. DFS to continue to gather data on timing, attendees, decisions and outcomes of TDM meetings. Use existing DFS forums to recommend and implement corrective actions through training, supervision and technical assistance. Timeframe: Ongoing to September 2019. Measure: Issuance of reports on timing, attendance, decisions and outcomes of TDM meetings.
4. Use a continuous quality improvement framework to monitor and guide implementation of TDM by reviewing DFS data, Quality Assurance case review reports and participant

surveys with DFS staff and system partners. Timeframe: June 2016 to September 2019. Measure: Documentation of CQI policy and procedure. Production of TDM data reports from FACTS and case reviews; meeting minutes documenting findings and recommendations.

Objective: Continue to enhance the knowledge and skill of child welfare staff involved in investigation and treatment of child maltreatment.

Rationale: Training is a vital component of the agency's infrastructure to strengthen professional competencies to protect children and support families. Community professionals, DFS staff and the Child Protection Accountability Commission (CPAC) support continuing training activities.
Outcome: A skilled and competent child welfare system workforce.

Benchmarks:

1. Participate in Multi-Disciplinary Teams through the Children's Advocacy Center, promoting collaboration of child welfare, law enforcement, criminal justice, mental health and medical professionals. Timeframe: Ongoing to September 2019. Measure: Data reports on use of Multi-Disciplinary Teams at the Children's Advocacy Center.
2. Support the education of Multi-Disciplinary Team members through joint training programs such as the Protecting Delaware's Children Conferences, National Conferences on Abuse Head Trauma and related opportunities. Timeframe: Ongoing to September 2019. Measure: Documentation of training events attended by Multi-Disciplinary Team members.
3. Participate in the Joint Investigation Committee of the Child Protection Accountability Commission, which researches and implements best practices in investigation of child maltreatment. Timeframe: Ongoing to September 2019. Measure: Committee meeting minutes.
4. Participate in the Statewide Neonatal Abstinence Syndrome workgroup of the DE Health Mothers and Infants Consortium to address the needs of drug exposed infants. Timeframe: Ongoing to September 2019. Measure: Committee meeting minutes.
5. Continue collaboration with system partners, especially providers of services related to domestic violence and substance abuse (e.g. Division of Substance Abuse and Mental Health, Domestic Violence Coordinating Council, Children's Advocacy Center, Brandywine Counseling, Psychotherapeutic Services Inc., Child Inc., People's Place II) to promote comprehensive assessment of families' needs and integrated service planning. Activities include co-location of staff, multidisciplinary interviewing, community training and interagency agreements. Timeframe: Ongoing to September 2019. Measure: Documentation of collaborative efforts such as meeting minutes, collocation of staff, contracts, Memoranda of Agreement and training events.
6. Monitor effectiveness of child welfare training with participant evaluations. Use existing DFS leadership to monitor DFS training and CPAC Training Committee meetings to evaluate child welfare system curriculum development and topics. Timeframe: Ongoing to September 2019. Measure: Trainee surveys and evaluations.

Objective: Establish policy and provisions to identify, document and serve foster children who also may be victims of sex trafficking.

Rationale: Children and youth in foster care, especially those who runaway, are especially vulnerable to exploitation and minor sex trafficking. The new federal Preventing Sex Trafficking and Strengthening Families Act requires attention to this special population.
Outcome: Delaware victims of sex trafficking are protected from further exploitation and abuse.

Benchmarks:

1. Incorporate sex trafficking policy into new employee training. Train DFS staff statewide on sex trafficking policy. Timeframe: December 2016.
2. Collaborate with law enforcement agencies and Department of Justice to implement protocols to report missing children to law enforcement and entry into the National Crime Information Center. Timeframe: September 2016. Measure: Documentation of reporting missing children to law enforcement for entry into the National Crime Information Center.

Safety Measures:

1. Quality Assurance: Measurement for child safety is a composite of questions in investigation and treatment assessing safety in the child's residence. Goal is 100% will be assessed as safe.
2. National Standard: Absence of maltreatment recurrence. Goal is 94.6% or higher.
3. National Standard: Absence of maltreatment in foster care. Goal is 99.68% or higher.

Delaware reserves the option to revise measures based on release of new national standards and development of internal reports.

B. Permanency

Goal: Children maintain or achieve timely permanency

Rationale: Every child deserves to grow up in a stable, nurturing permanent home. Data for timely permanency goal achievement are mixed.

Objective: Implement family search and engagement practice.

Rationale: AECF assessment and Outcomes Matter initiative identify family engagement strategies and tools vital to timely permanency outcomes such as family preservation, reunification and other permanency outcomes. System data on reunification within 12 months from the most recent removal from home indicates an area needing improvement. Community professionals and caseworkers agree the 2015-2019 CFSP should include strategies to improve timely permanency.
Outcome: Children remain safely in their own homes and exit to timely permanency when in foster care.

Benchmarks:

1. Fully implement statewide strategies, tools and supports to conduct successful family search and engagement activities across all program areas to strengthen family connections and placement options for at-risk children and youth. This includes family team meetings and record mining to locate and contact relatives. CRC to provide

technical assistance with family team meeting training. Timeframe: December 2016. Measure: Percent of initial and current relative foster care placements per the Entry Cohort Longitudinal Database (ECLD).

2. Use a continuous quality improvement framework to monitor and guide implementation of family search and engagement practice by reviewing DFS data and Quality Assurance case review reports with DFS staff and system partners. Identify areas needing improvement and implement corrective actions. Timeframe: June 2016 to September 2019. Measure: Documentation of CQI policy and procedure. Production of SDM® data reports from FACTS and case reviews. Meeting minutes documenting findings and recommendations.
3. Until a CQI system is operational, use existing data reports, Quality Assurance case review reports and feedback from DFS staff, trainers and system partners to monitor implementation of family search and engagement processes and outcomes. Use existing DFS forums to recommend and implement corrective actions through training, supervision and technical assistance. Timeframe: Ongoing until CQI system is operational. Measure: Production of data reports from case reviews; meeting minutes documenting findings, recommendations, actions taken and results.

Objective: Improve foster care placement stability and support adoptive families.
Rationale: Placement stability data indicates an area needing improvement. Early data indicators of *Outcomes Matter* show promising outcomes for early foster care episode placements. DFS, its sister Divisions of Prevention and Behavioral Health Services and Youth Rehabilitative Services are collaborating to expand community-based services for teens. Recent data on children exiting to adoption within 24 months is the best on record; the agency wants to continue timely adoptions.
Outcome: Foster children have lower rates of replacement.

Benchmarks:

1. Recruit in-state foster homes to meet the needs of minorities, teens, siblings groups and children with special needs. Timeframe: Ongoing to September 2019. Measure: Annual number of new foster parents serving minorities, teens, siblings groups and children with special needs.
2. Implement a statewide foster parent recruitment plan. Timeframe: Ongoing to September 2019. Measure: Issuance of plan and annual reporting of progress towards goals and objectives.
3. Continue post-adoption services to strengthen bonding and prevent disruptions. Timeframe: Ongoing to September 2019. Measure: Number and percentage of adopted children re-entering foster care.
5. Use a continuous quality improvement framework to monitor foster care and adoptive placement stability by reviewing DFS data (foster parent recruitment/training and placement stability), foster parent surveys, Quality Assurance case review reports and adoption disruption/dissolution data with DFS staff and system partners. Identify areas needing improvement and implement corrective actions. Timeframe: June 2016 to September 2019. Measure: Documentation of CQI policy and procedure. Production of

placement stability data reports from FACTS and case reviews; meeting minutes documenting findings and recommendations.

6. Until a CQI system is operational, use existing data reports, Quality Assurance case review reports, contractual performance measures and feedback from DFS staff, trainers and system partners to monitor foster parent recruitment, training and placement stability. Use existing DFS forums to recommend and implement corrective actions through training, supervision and technical assistance. Timeframe: Ongoing until CQI system is operational. Measure: Production of data reports from case reviews; meeting minutes documenting findings, recommendations, actions taken and results.

Objective: Improve timely exits to reunification, adoption and guardianship for foster children.
Rationale: Data reports for timely permanency outcomes such as family preservation, reunification and other permanency outcomes are mixed. Agency wants to improve rate of reunification without increasing foster care re-entry rates. AECF assessment recommendations and *Outcomes Matter* identify kinship care programming as a strategy to achieve timely exits. Agency wants to continue strong performance for timely adoptions within 24 months of entering foster care.
Outcome: Shorter lengths of stay in foster care for children exiting to reunification, adoption and guardianship.

Benchmarks:

1. Provide MY LIFE programming to all appropriate foster children and youth; prioritize children with a permanency plan of adoption or APPLA. Timeframe: June 2017. Measure: Number of children and youth by permanency goal receiving MY LIFE services.
2. Research, develop and implement kinship care programming. Timeframe: September 2017. Measure: Number of children placed in approved kinship homes.
3. Collaborate with the Family Court through local and state level meetings and review of DFS and Court Improvement Program (CIP) key measures to strategically plan strengthening legal processes to improve timely permanency. Timeframe: Ongoing to September 2019. Measure: Meeting minutes documenting review of data reports and actions taken.
4. Continue expediting permanency goal review by caseworkers, supervisors, child advocates and local permanency planning committees of children age 5 and younger. Timeframe: Ongoing to September 2019. Measure: Number of children age 5 and younger reviewed by permanency committees before the 9th month.
5. Use a continuous quality improvement framework to monitor exits to permanency by reviewing DFS data, CIP key measures and Quality Assurance case review reports with DFS staff and system partners. Identify areas needing improvement and implement corrective actions. Timeframe: June 2016 to September 2019. Measure: Documentation of CQI policy and procedure. Production of permanency exit data reports from FACTS and case reviews; meeting minutes documenting findings and recommendations.
6. Until a CQI system is operational, use existing data reports, CIP key measures, Quality Assurance case review reports and feedback from DFS staff, trainers and system partners to monitor timely permanency. Use existing DFS and CIP forums to recommend and implement corrective actions through training, supervision and technical assistance.

Timeframe: Ongoing until CQI system is operational. Measure: Production of data reports from FACTS and case reviews; meeting minutes documenting findings, recommendations, actions taken and results.

Objective: Reduce the number of youth exiting foster care at age 18.

Rationale: The number of youth with APPLA goals was 321 for FFY2008, current DFS data states 120 youth with APPLA goals. The agency wants to continue to reduce the number of youth exiting foster care at age 18.

Outcome: Reduced number and percentage of youth exiting foster care at age 18 without permanency.

Benchmarks:

1. DFS Strategic Leadership Team and Policy Review Team to review and assess permanency planning policy for older youth with the goal of APPLA. Timeframe: September 2015. Measure: Documented review of permanency planning policy for older youth with the goal of APPLA by the Strategic Leadership and Policy Review Teams.
2. Analyze system and case specific data on youth served by Family Informed Resource Support Teams (FIRST) to improve services to stabilize in-state placements, support timely permanency and reduce the number of youth exiting foster care at age 18. Timeframe: June 2016 and ongoing. Measure: Report of permanency outcomes on population served by FIRST initiative.

Objective: Strengthen permanency planning for children age 15 and younger.

Rationale: P.L. 113-183, Preventing Sex Trafficking and Strengthening Families Act, limits APPLA goal choices to youth age 16 and older.

Outcome: Increased number and percentage of children and youth age 15 and younger exiting foster care to reunification, adoption or guardianship.

Benchmarks:

1. Use family search and engagement strategies tools and supports to conduct successful family search and engagement activities across all program areas to strengthen family connections and permanency options for at-risk children and youth. This includes family team meetings and record mining to locate and contact relatives. Timeframe: March 2017. Measure: Number and percentage of children exiting to reunification, adoption or guardianship.
2. Review children and youth under the age of 15 at local permanency committees for appropriate goal selection. Timeframe: September 2015. Measure: Number of children and youth age 15 and younger with a goal of APPLA reviewed by local permanency committees.
3. Participate in the Permanency for Adolescents Committee of the Child Protection Accountability Commission, which leads policy efforts to reduce barriers to permanency. Timeframe: Ongoing to end of workgroup. Measure: Meeting minutes documenting attendance and efforts to reduce permanency barriers.
4. Use a continuous quality improvement framework to monitor exits to permanency by reviewing DFS data and Quality Assurance case review reports with DFS staff and system partners. Identify areas needing improvement and implement corrective actions. Timeframe: June 2016 to September 2019. Measure: Documentation of CQI policy and

procedure. Production of permanency exit data reports from FACTS and case reviews; meeting minutes documenting findings and recommendations.

5. Until a CQI system is operational, use existing data reports, Quality Assurance case review reports and feedback from DFS staff, trainers and system partners to monitor timely permanency. Use existing DFS forums to recommend and implement corrective actions through training, supervision and technical assistance. Timeframe: Ongoing until CQI system is operational. Measure: Production of data reports from FACTS and case reviews; meeting minutes documenting findings, recommendations, actions taken and results.

Objective: Continue to work with system partners to identify and reduce barriers to permanency.

Rationale: Community professionals and DFS staff identify joint efforts as necessary to build infrastructure and enhance service array for improved permanency outcomes for children and families.

Outcome: System wide infrastructure and service array supporting timely permanency exits from foster care.

Benchmarks:

1. Participate in the Permanency for Adolescents Committee of the Child Protection Accountability Commission, which leads policy efforts to reduce barriers to permanency. Timeframe: Ongoing to end of workgroup. Measure: Meeting minutes documenting attendance and efforts to reduce permanency barriers.
2. Participate in strategic planning efforts of the Department of Services to Children, Youth and Their Families to promote collaboration and coordinated service delivery to multiple division youth served by child welfare, behavioral health and/or juvenile justice systems. Timeframe: Ongoing to September 2019. Measure: Meeting minutes documenting attendance and coordination of service delivery.
3. DFS leadership to monitor meeting attendance and system partner feedback regarding collaborative effort to reduce barriers to permanency. Ongoing to September 2019. Measure: Meeting minutes and feedback from system partners.

Permanency Measures:

1. Caseworker foster care contacts. Measure 1: Percent of foster children visited each and every month; and, Measure 2: Percent of those visits occurring in the child's residence. Goal for Measure 1 is 95%. Goal for Measure 2 is 50.5%.
2. National Standard: Permanency Composite #4 with component scores.
   - Scaled state composite score. Goal is 101.5 or higher.
   - Of those children in care less than 12 months - percent with 2 placements or less. Goal is 86% or higher.
   - Of those children in care for 12 but less than 24 months - percent with 2 placements or less. Goal is 65.4% or higher.
   - Of those children in care 24 or more months - percent with 2 placements or less. Goal is 41.8% or higher.
3. National Standard: Reunification within 12 months from the most recent removal from home Goal is 75.2% or higher.

4. National Standard: Adoption within 24 months from the most recent removal from home. Goal is 36.6% or higher.
5. Quality Assurance: Measurement is the percent of placement and permanency case reviews agreeing with APPLA (Another Planned Permanent Living Arrangement) goal selection. Goal is 95% or higher.

Delaware reserves the option to revise measures based on release of new national standards and development of internal reports.

C. Well-Being

Goal: Families are empowered to meet their own needs

Rationale: Guiding principles for the CFSP emphasize family engagement in assessment, planning and service delivery to internalize positive change based on strengths and achievements. The AECF assessment and *Outcomes Matter* promote active family engagement strategies to help families plan for their needs.

Objective: Fully engage at-risk families in assessment, planning and service delivery activities.

Rationale: Children and families are more likely to actively engage in a plan in which they had a key role in designing. Key decisions include family and youth voices. AECF assessment and *Outcomes Matter* promote family engagement strategies and tools.
Outcome: Successful and timely assessment, planning and services with parents and youth participation while maintaining safety of children of families served.

Benchmarks:

1. Continue Team Decision Making statewide for children at risk of removal from their homes. Timeframe: Ongoing to September 2019. Measure: Data reports on number, participants, recommendations and outcomes of TDM meetings.
2. DFS Program Support Team to conduct literature reviews, contact states' liaison officers, research evidence-based models as promoted by Child Welfare Information Gateway, Child Welfare League of America and American Humane Society and make recommendations for improving the continuum of family preservation, reunification and support interventions. Timeframe: June 2017. Measure: Documentation of research, findings, recommendations and action taken.
3. Conduct Ice Breaker meetings between biological families and foster parents when children enter care to share information and strengthen child normalcy. Timeframe: June 2016 and ongoing. Measure: Ice Breaker meeting reports and statistics.
4. Use a continuous quality improvement framework to monitor and guide implementation of family engagement practice by reviewing DFS data and Quality Assurance case review reports with DFS staff and system partners. Identify areas needing improvement and implement corrective actions. Timeframe: June 2016 to September 2019. Measure: Documentation of CQI policy and procedure. Production of SOP data reports from FACTS and case reviews. Meeting minutes documenting findings and recommendations.
5. Until a CQI system is operational, use existing data reports, Quality Assurance case review reports and feedback from DFS staff, trainers and system partners to monitor implementation of TDM and SOP. Use existing DFS forums to recommend and implement corrective actions through training, supervision and technical assistance. Timeframe: Ongoing until CQI system is operational. Measure: Production of data

reports from case reviews; meeting minutes documenting findings, recommendations, actions taken and results.

Goal: Youth are empowered to meet their own needs

Rationale: Youth are more successful achieving independence when supported by individualized planning and services. Including youth in system wide planning has resulted in improved services. Rates of high school graduation and employment indicate areas needing improvement.

Objective: Promote timely permanence and increase opportunities available to young people in employment, education, personal and community engagement.

Rationale: Rates of teens aging out of foster care at age 18, high school graduation and employment indicate areas needing improvement. Early success with financial assistance for young adults needs to continue. Strong individual and system planning includes the voice of youth. Education and employment measurements indicate areas needing improvement.

Outcome: Lower rate of foster youth exiting foster care at age 18. Increased graduation and employment rates for young adults. Increased rates of youth reporting personal and community connections.

Benchmarks:

1. Use family search and engagement strategies (e.g. family meetings and record mining) to build connections and supports for foster youth and young adults aging out of foster care. Timeframe: June 2016. Measure: Quality Assurance case review and independent living data reports.
2. Conduct STEPS (Stairways To Encourage Personal Success) for all foster youth age 17 and older to plan a successful transition to adulthood. Timeframe: Ongoing to September 2019. Measure: Quality Assurance case review data reports.
3. Fully fund and implement ASSIST (Achieving Self Sufficiency and Independence through Supported Transition) for young adults (ages 18-20) who are aging out of foster care. Timeframe: June 2017. Measure: Budget allocations for 3 years of ASSIST funding.
4. Continue Opportunity Passport™ programming to provide financial skills and match savings accounts. Timeframe: Ongoing to September 2019. Measure: Documentation of active training and match funds.
5. Partner with the Youth Advisory Council (YAC) to achieve positive outcomes for foster youth and young adults aging out of foster care. Timeframe: Ongoing to September 2019. Measure: Documentation of joint participation in YAC meetings and events.
6. Support the initiative for Youth Involvement in Court and Youth Led Representation led by the Family Court and OCA. Timeframe: Ongoing to September 2019. Measure: Documentation of agency participation in court and DYOI meetings.
7. Review existing foster teen handbook for strengthening youth roles and responsibilities and edit as appropriate. This handbook will be used in the initiatives referenced above in #7. Timeframe: June 2016. Measure: Documented review of current foster teen handbook and appropriate actions to revise.

8. Establish prudent standards for foster parents to ensure developmentally appropriate activities are provided to foster children per Preventing Sex Trafficking and Strengthening Families Act. Timeframe: September 2016. Measure: Issuance of policy.
9. Train foster parents on prudent standards established in #9. Timeframe: December 2016. Measure: Documentation of training events or instructions.
10. Use a continuous quality improvement framework to monitor timely permanency, employment, education and personal/community engagement by reviewing DFS data, Quality Assurance case review reports and youth feedback with DFS staff and system partners. Identify areas needing improvement and implement corrective actions. Timeframe: June 2016 to September 2019. Measure: Documentation of CQI policy and procedure. Production of permanency and independent living data reports; meeting minutes documenting findings and recommendations.
11. Until a CQI system is operational, use existing data reports, Quality Assurance case review reports and feedback from DFS staff, youth and system partners to monitor timely permanency, employment, education, and personal/ community engagement. Use existing DFS and DYOI forums to recommend and implement improvements through training, supervision, resource development and technical assistance. Timeframe: Ongoing until CQI system is operational. Measure: Production of data reports from FACTS, case reviews and independent living; meeting minutes documenting findings, recommendations, actions taken and results.

Goal: Foster children receive appropriate mental health assessment and psychotropic medications

Rationale: Federal law and agency procedures provide mental health screenings and treatment, including assessment of emotional trauma associated with a child's maltreatment and removal from home. The agency is charged with oversight and monitoring psychotropic medication administered to foster children.

Objective: Assess and monitor foster children's health and mental health needs.

Rationale: Agency needs to continue foster care entry mental health screenings and implement tracking systems for individual and system use of psychotropic medications. Outcome: Foster children's health and mental health needs are identified early and are matched with appropriate services.

Benchmarks:

1. Continue Screening and Consultation Unit's assessment of developmental needs and ensure connection to appropriate services to foster children age 5 and younger within 45 days of foster care entry. Timeframe: Ongoing to September 2019. Measure: Foster care entry assessment compliance reports.
2. Continue Screening and Consultation Unit's assessment of foster children within 45 days of entering care for mental health services, using developmentally-appropriate and trauma-informed screening tools. Ensure connection to evidence-based interventions as appropriate. Timeframe: Ongoing to September 2019. Measure: Foster care entry and assessment compliance reports.
3. Partner on a consultation project with Tufts University Medical School, Casey Family Programs, DPBHS and DSCYF Office of Trauma Informed Practice on monitoring and

managing psychotropic medications in foster care. Timeframe: June 2017 with option to extend. Measure: Documentation of findings, recommendations and actions taken.

4. Office of Evidence-Based Practice to monitor and report to DFS' Strategic Leadership Team progress on developing psychotropic medication tracking and establishing oversight standards. Timeframe: Ongoing until September 2019. Measure: Meeting minutes document review of psychotropic medication tracking, standards and actions taken.
5. Use a continuous quality improvement framework to monitor mental health assessment and psychotropic medication by reviewing DFS data, Quality Assurance case review reports and DFS staff and system partner feedback. Identify areas needing improvement and implement corrective actions. Timeframe: June 2016 to September 2019. Measure: Documentation of CQI policy and procedure. Production of psychotropic medication data reports; meeting minutes documenting findings and recommendations.
6. Until a CQI system is operational, monitor Quality Assurance case review reports for identification of needs and provision of appropriate services. Use existing DFS forums to address areas needed improvement and implement corrective action. Timeframe: Ongoing until CQI system is operational. Measure: Production of data reports from Quality Assurance case reviews; meeting minutes documenting findings, recommendations, actions taken and results.

Goal: Improve high school graduation rates for foster youth

Rationale: High school graduation rates are low; agency wants to improve academic performance of foster children and youth.

Objective: Develop and implement a data-based initiative to improve academic performance.

Rationale: High school graduation rates for foster youth are low. DFS to establish system data baselines on academic performance of foster children; collaborate with system partners to identify needs and provide supports to boost academic performance. Outcome: Improved academic performance for foster children and youth.

Benchmarks:

1. Collaborate with schools to share system level educational information on foster children and youth. Timeframe: Ongoing to September 2019. Measure: Documented production of academic reports.
2. Identify, recommend and implement supports for improving academic performance for foster children. Timeframe: December 2015. Measure: Documentation of review of data and resulting recommendations and actions taken.
3. Participate in the Education Committee of the Child Protection Accountability Commission that is focused on system collaboration to address educational needs of children and youth in foster care. Timeframe: Ongoing to end of committee. Measure: Documentation of participation and actions taken in meeting minutes.
4. Use a continuous quality improvement framework to monitor and guide foster children's academic performance by reviewing system level data and using appropriate forums (Department of Education Memorandum of Understanding or CPAC Education

Committee) to recommend and implement improvements. Timeframe: June 2016 to September 2019. Measure: Documentation of CQI policy and procedure. Production of academic data reports. Meeting minutes documenting findings and actions taken.

5. Until a CQI system is operational, monitor Quality Assurance case review reports for identification of educational needs and provision of appropriate services. Use existing DFS forums, CPAC Education Committee and Department of Education Memorandum of Understanding to address areas needed improvement and implement corrective action. Timeframe: Ongoing until CQI system is operational. Measure: Production of data reports from case reviews; meeting minutes documenting findings, recommendations, actions taken and results.

Well-Being Measures:

1. Quality Assurance: Measurement is a composite score of 13 questions from the QA Case Review tools for treatment and placement on identification of needs and services provided. Goal is 90% or higher of case reviews agree needs were identified and appropriate services provided.
2. Quality Assurance: Measurement is composite score of 2 questions from each QA Case Review tool for investigation, treatment and placement for identification of needs and services provided for education, physical and mental health. Goal is 95% or higher of case reviews agree educational and health needs were identified and appropriate services provided.
3. Independent Living Services Report: Measurements for young adults receiving independent living services are percent youth graduating high school or GED program, percent youth employed and percent youth enrolled in post-secondary/vocational programs. Goals are 60% will graduate high school or obtain a GED, 70% will be employed, and 35% will be enrolled in a post-secondary/vocational program.

Delaware reserves the option to revise measures based on release of new national standards and development of internal reports.

D. System Supports

Goal: Provide infrastructure supporting best practice child welfare principles and values

Rationale: The agency identifies an automated case management, continuous quality improvement, workforce training and Quality Assurance Case Review systems as vital foundations to making improvements in outcomes for children, youth and their families.

Objective: Fully implement a new statewide data tracking system.

Rationale: Federal SACWIS requirements and DSCYF business needs drive the design and implementation of a new FACTS II automated system.

Outcome: A fully functional automated system that is SACWIS compliant and meets the business needs of the Department.

Benchmarks:

1. Fully implement FACTS II supporting an integrated child and family tracking system for the Department of Services for Children, Youth and Their Families. Timeframe: October 2017. Measure: Status reports of design, development and implementation of FACTS II.

Objective: Design, resource and implement a continuous quality improvement system that focuses on data driven monitoring of objectives and benchmarks, as indicated, of the Plan with participation by system partners to make adjustments to practice.
Rationale: Federal guidance and agency mission to improve outcomes for children, youth and their families need structured processes to use baseline data, stakeholder input and measured accounting of performance to drive safety, permanency and well-being practice changes.
Outcome: Improved safety, permanency and well-being outcomes based on data informed shared decision making with system partners.

Benchmarks:

1. Obtain technical assistance to provide processes, analysis of data, information and organizational structure supporting objectives of this strategic plan. Timeframe: September 2017. Measure: Documentation of technical assistance.
2. Draft policy and protocols to use data-based information for all levels of staff. Timeframe: September 2017. Measure: Issuance of policy and protocol documents.
3. Draft a communication plan supporting the distribution and use of data-based information. Timeframe: September 2017. Measure: Documentation of a CQI communication plan.
4. Develop training for staff at all levels of the organization on continuous quality improvement. Timeframe: December 2017. Measure: Documentation of a CQI training plan.
5. Implement stakeholder sessions to review data and recommend activities to improve progress towards goals. Timeframe: December 2017. Measure: Stakeholder sessions documented by meeting minutes.

Objective: Provide training and supports for a stable and competent workforce.
Rationale: Staff competencies and skills are vital to implementing Safety-Organized Practice as DFS' practice model.
Outcome: A trained, competent, experienced and stable workforce.

Benchmarks:

1. Make provisions supporting caseworker coaching and facilitative supervision. Timeframe: March 2016. Measure: Documentation of coaching and facilitative supervision through Quality Assurance case reviews and staff interviews.

Objective: Review and update the Quality Assurance Case Review System
Rationale: Since the implementation of *Outcomes Matter,* DFS' Quality Assurance Case Review System needs to be reviewed and updated.
Outcome: A Quality Assurance Case Review System that includes measures for current practice model activities, processes and outcomes.

Benchmarks:

1. Take appropriate steps to implement a new Quality Assurance system or review current system for sample size, reliability and inclusion of Safety Organized Practice measures. Timeframe: October 2016. Measure: Documented review of case review sampling methodology, inter-rater reliability and SOP updates.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018

Findings Summary:
Home Visiting Programs/Infants with Prenatal Substance Exposure

System Area	*Current	Prior	Grand Total
Unresolved Risk	**4**	**2**	**6**
Substance-Exposed Infant	4	2	6
Medical	**14**	**1**	**15**
Home Visiting Programs	12	1	13
Substance-Exposed Infant	2		2
Grand Total	**18**	**3**	**21**

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018

Findings: Home Visiting Programs/Infants with Prenatal Substance Exposure (21)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
1	16-227	2016	2-year-old	Medical	Home Visiting Programs	Current	Home Visiting Services were not in place at the time of the near death incident or post incident.
2	16-266	2016	3-month-old	Medical	Home Visiting Programs	Current	Home Visiting Services were not in place at the time of the near death incident or post incident.
3	16-290	2016	2-year-old	Medical	Home Visiting Programs	Current	Home Visiting Services were not in place at the time of the near death incident or post incident.
4	16-288	2016	2-month-old	Medical	Home Visiting Programs	Current	Home Visiting Services were not in place at the time of the near death incident, and the child was an appropriate candidate for Healthy Families America.
5	16-367	2016	3-year-old	Medical	Home Visiting Programs	Prior	A Home Visiting referral was not completed for the teen mother at the child's birth.
6	17-0008	2017	23-month-old	Medical	Home Visiting Programs	Current	Home Visiting Services were not in place at the time of the near death incident.
7	17-021	2017	18-month-old	Medical	Home Visiting Programs	Current	Home Visiting Services were not in place at the time of the near death incident or post incident.
8	17-016	2017	14-month-old	Medical	Home Visiting Programs	Current	A Home Visiting referral was not completed after concerns with the victim's development and weight were identified.
9	17-028	2017	7-week-old	Medical	Home Visiting Programs	Current	Home Visiting Services were not in place at the time of the near death incident or post incident.
10	17-030	2017	3-week-old	Medical	Home Visiting Programs	Current	The home visiting program delayed sending the referral to the nurse.
11	17-032	2017	3-month-old	Medical	Home Visiting Programs	Current	Despite a referral to a short-term visiting nurse association, evidence-based Home Visiting Services were not considered following the birth of a substance exposed infant.
12	9-06-17-00022	2017	2-month-old	Medical	Home Visiting Programs	Current	No home visiting referral was made despite the mother's history of substance abuse.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018

Findings: Home Visiting Programs/Infants with Prenatal Substance Exposure (21)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
13	9-06-17-00001	2017	4-year-old	Medical	Home Visiting Programs	Current	No home visiting referral at the time of this child's birth despite Mother being a teen at time of delivery.
14	16-239	2016	2-month-old	Unresolved Risk	Substance-Exposed Infant	Current	No plan of safe care was completed for the infant despite the mother's drug use during the pregnancy. Mother also declined home visiting services after the infant's birth.
15	16-318	2016	1-month-old	Unresolved Risk	Substance-Exposed Infant	Current	No plan of safe care was completed for the infant despite the positive drug screen at birth.
16	16-363	2016	7-month-old	Unresolved Risk	Substance-Exposed Infant	Current	In the prior investigation, there was a delay in safety planning for the substance exposed infant. Other risk factors included a teen mother, substance abuse history and multigenerational history.
17	16-372	2016	1-year-old	Unresolved Risk	Substance-Exposed Infant	Prior	The report involving the substance exposed infant was screened out, in accordance with DFS policy, and no safety planning was completed. Other risk factors included a teen mother with two young children, substance abuse history, domestic violence history, multigenerational history and no involvement with home visiting services.
18	17-004	2017	1-month-old	Unresolved Risk	Substance-Exposed Infant	Current	The prior report involving the victim's substance exposure at birth was screened out since the only concern was that the mother stopped visiting the baby. The prior DFS history was not considered.
19	17-004	2017	1-month-old	Unresolved Risk	Substance-Exposed Infant	Prior	Another prior report involving a substance exposed infant was screened out due to the mother's participation in treatment. However, the mother had prior history involving an infant born substance exposed, and there was a prenatal screen that was concerning.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018

Findings: Home Visiting Programs/Infants with Prenatal Substance Exposure (21)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
20	16-239	2016	2-month-old	Medical	Substance-Exposed Infant	Current	No plan of safe care was completed for the infant despite the mother's drug use during the pregnancy. Mother also declined home visiting services after the infant's birth.
21	16-318	2016	1-month-old	Medical	Substance-Exposed Infant	Current	No plan of safe care was completed for the infant despite the positive drug screen at birth.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018

Findings Summary:
MDT Response - Medical Exams/MDT Interpretation of Medical Findings

System Area	*Current	Grand Total
Medical	**8**	**8**
Medical Exam/ Standard of Care - ED	8	8
MDT Response	**13**	**13**
Medical Exam	13	13
Grand Total	**21**	**21**

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018

Findings: MDT Response - Medical Exams/MDT Interpretation of Medical Findings (21)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
1	17-016	2017	14-month-old	MDT Response	Medical Exam	Current	The DFS caseworker did not independently contact the child abuse medical expert to discuss the medical findings. As a result, the explanation provided by the parents was determined to be plausible, and the safety agreement was modified and the case closed.
2	17-006	2017	4-month-old	MDT Response	Medical Exam	Current	The child abuse medical expert was not contacted directly to discuss the medical findings.
3	16-372	2016	1-year-old	MDT Response	Medical Exam	Current	DFS and LE misinterpreted the findings from the CARE Team consult for the first incident as absolutely consistent with a fall and abuse was ruled out. However, the CARE Team considered the history and totality of the injuries and was suspicious about ongoing abuse and/or neglect.
4	17-016	2017	14-month-old	MDT Response	Medical Exam	Current	There was a miscommunication about the CARE Team findings by the MDT. All team members were not aware that the child abuse medical expert concluded that the victim's fractures and areas of bruising were highly concerning for child physical abuse.
5	18-0001	2017	22-month-old	MDT Response	Medical Exam	Current	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.
6	18-014	2017	4-month-old	MDT Response	Medical Exam	Current	The law enforcement agency did not consult the child abuse medical

Findings: MDT Response - Medical Exams/MDT Interpretation of Medical Findings (21)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
7	16-208	2016	4-month-old	MDT Response	Medical Exam	Current	The half sibling, who was present in the home during the near death incident, was not medically evaluated. Interviews conducted during the criminal investigation confirm that the sibling was present.
8	16-239	2016	2-month-old	MDT Response	Medical Exam	Current	DFS did not immediately seek a medical exam for the sibling when the caseworker responded to the incident involving the burn.
9	16-290	2016	2-year-old	MDT Response	Medical Exam	Current	The young sibling was not medically evaluated.
10	16-290	2016	2-year-old	MDT Response	Medical Exam	Current	The Office of the Investigation Coordinator did not remind the MDT to seek a medical evaluation for the sibling.
11	18-018	2017	4-year-old	MDT Response	Medical Exam	Current	Pictures taken by the forensic nurse were not obtained by the DFS caseworker in the prior investigation. This could have prompted the assigned worker to seek input from the child abuse medical expert.
12	17-025	2017	2-year-old	MDT Response	Medical Exam	Current	A separate investigation was not immediately opened for the other children in the home of the near death incident, and as a result, it impacted the oversight of the medical exams for these children.

Findings: MDT Response - Medical Exams/MDT Interpretation of Medical Findings (21)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
13	9-06-17-00001	2017	4-year-old	MDT Response	Medical Exam	Current	Two DFS referrals were made in due to the child's sibling having an unexplained, healing clavicle fracture. Suspected child abuse was noted, but there was no documentation that the DFS worker consulted with the child abuse expert and what those results were. The child abuse expert did see the child and child abuse was not suspected. Despite this, the DFS supervisor documented the following "still no explanation for healing clavicle fracture. Child was born via c-section and injury during birth unlikely".
14	18-018	2017	4-year-old	Medical	Medical Exam/ Standard of Care - ED	Current	For the prior incident, the child received an evaluation for suspected physical abuse, and the physician concluded the child's injuries may be consistent with the explanation by the parents. However, physical abuse could not be excluded given the child's injuries to his face and ear.
15	18-006	2017	2-month-old	Medical	Medical Exam/ Standard of Care - ED	Current	The infant presented to two hospital emergency departments with multiple bruises and no explanation by the parents. Although a good evaluation was done for suspected physical abuse, it was not communicated to DFS that abuse was suspected.
16	18-006	2017	2-month-old	Medical	Medical Exam/ Standard of Care - ED	Current	A CARE Consult and forensic exam were not considered by the hospital emergency department after the infant presented with multiple bruises.
17	17-010	2017	14-month-old	Medical	Medical Exam/ Standard of Care - ED	Current	There was no official call to the Division of Forensic Science following the child's death. The cause of death was under criminal investigation, and the hospital staff were aware of this.

Findings: MDT Response - Medical Exams/MDT Interpretation of Medical Findings (21)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
18	16-288	2016	2-month-old	Medical	Medical Exam/ Standard of Care - ED	Current	Staff in the hospital emergency department did not take the child's weight. The history given was that a young child was having difficulty feeding.
19	17-032	2017	3-month-old	Medical	Medical Exam/ Standard of Care - ED	Current	The substance exposed infant had hospital admissions post birth, and there were no concerns documented that the infant was at an increased risk of abuse.
20	18-006	2017	2-month-old	Medical	Medical Exam/ Standard of Care - ED	Current	The imaging that was obtained at the hospital emergency department was not submitted immediately to a pediatric radiologist for review.
21	9-06-17-00001	2017	4-year-old	Medical	Medical Exam/ Standard of Care - ED	Current	The community hospital did not have the sibling immediately transported to the children's hospital with the healed clavicle fracture despite the request from DFS. Since the child was placed with the relative caregiver they felt the child was safe and allowed her the discretion to take the sibling to the children's hospital for an ultrasound and evaluation. This did not occur until four days later when the sibling had an appointment at the children's hospital.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018

Findings Summary:
MDT Response - Criminal Investigations

System Area	*Current	Grand Total
MDT Response	**52**	**52**
Communication	4	4
Crime Scene	8	8
Documentation	2	2
Doll Re-enactment	4	4
General - Civil Investigation	3	3
General - Criminal Investigation	5	5
Intake with DOJ	2	2
Interviews - Adult	8	8
Interviews - Child	7	7
Prosecution/ Pleas/ Sentence	6	6
Reporting	3	3
Grand Total	**52**	**52**

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018

Findings: MDT Response - Criminal Investigations (52)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
1	16-364	2016	4-year-old	MDT Response	Communication	Current	The law enforcement agency did not maintain ongoing collaboration or communication with DFS.
2	17-004	2017	1-month-old	MDT Response	Communication	Current	There was no communication with the law enforcement agency by DOJ.
3	17-006	2017	4-month-old	MDT Response	Communication	Current	There was no documentation that the law enforcement agency and DOJ had ongoing communication about the near death incident.
4	18-018	2017	4-year-old	MDT Response	Communication	Current	In the prior investigation, the treatment caseworker gathered information from witnesses about inconsistencies in the stories provided by parents, and this information was not relayed to the caseworker investigating the allegations of abuse.
5	16-208	2016	4-month-old	MDT Response	Crime Scene	Current	No scene investigation was completed by the initial responding law enforcement agency.
6	16-364	2016	4-year-old	MDT Response	Crime Scene	Current	No scene investigation was completed by the law enforcement agency.
7	16-288	2016	2-month-old	MDT Response	Crime Scene	Current	No scene investigation was completed by the law enforcement agency.
8	16-376	2016	2-year-old	MDT Response	Crime Scene	Current	The law enforcement agency did not obtain a search warrant for the home. The scene was not photographed and no evidence was collected.
9	17-016	2017	14-month-old	MDT Response	Crime Scene	Current	No scene investigation was completed by the law enforcement agency.
10	17-028	2017	7-week-old	MDT Response	Crime Scene	Current	The law enforcement agency did not obtain a search warrant for the home. The scene was not photographed and no evidence was collected (i.e. bottles and pills).
11	18-006	2017	2-month-old	MDT Response	Crime Scene	Current	The law enforcement agency did not obtain measurements from the scene related to an alleged fall.
12	9-06-16-00038	2016	3-month-old	MDT Response	Crime Scene	Current	The baby's can of formula was not collected as evidence.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018

Findings: MDT Response - Criminal Investigations (52)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
13	16-364	2016	4-year-old	MDT Response	Documentation	Current	There was minimal documentation in the police report by the law enforcement agency.
14	9-06-17-00001	2017	4-year-old	MDT Response	Documentation	Current	Law enforcement report did not list the medical equipment shown in the scene photos from the death scene.
15	16-208	2016	4-month-old	MDT Response	Doll Re-enactment	Current	No doll re-enactment was completed by the law enforcement agency, despite a confession being obtained from the suspect.
16	16-239	2016	2-month-old	MDT Response	Doll Re-enactment	Current	No doll re-enactment was completed by the law enforcement agency.
17	16-318	2016	1-month-old	MDT Response	Doll Re-enactment	Current	No doll re-enactment was completed by the law enforcement agency.
18	16-639	2016	1-month-old	MDT Response	Doll Re-enactment	Current	The law enforcement agency's evidence detection unit was not present to record the doll re-enactment.
19	17-007	2017	4-month-old	MDT Response	General - Civil Investigation	Current	Although it initially appeared that the injury occurred at the daycare, DFS closed the family case prematurely when none of the parties were completely ruled out as suspects.
20	17-021	2017	18-month-old	MDT Response	General - Civil Investigation	Current	During the initial response to the near death incident, DFS and LE were not aware of the active PFA between the parents.
21	17-019	2017	16-month-old	MDT Response	General - Civil Investigation	Current	At the close of the near death investigation, the mother was deemed to be a protective caregiver by DFS despite indicators that she was downplaying the perpetrator's actions.
22	16-364	2016	4-year-old	MDT Response	General - Criminal Investigation	Current	Limited resources and education impacted the criminal investigation in that abuse was not initially suspected by the law enforcement agency.
23	16-376	2016	2-year-old	MDT Response	General - Criminal Investigation	Current	Despite both parents being observed as impaired, no blood draws were completed for toxicology screens.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018

Findings: MDT Response - Criminal Investigations (52)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
24	17-015	2017	5-week-old	MDT Response	General - Criminal Investigation	Current	The surviving children were left unsupervised at the scene with mother after first responders transported the victim to the hospital emergency department.
25	9-06-16-00038	2016	3-month-old	MDT Response	General - Criminal Investigation	Current	Law enforcement agency's initial report stated that this "appeared to be a case of SIDS at this time".
26	9-06-17-00001	2017	4-year-old	MDT Response	General - Criminal Investigation	Current	No multidisciplinary investigation by LE and DFS for the allegation of the sibling's fractured clavicle. Although the injury could not be proven to be a result of abuse, there was no MDT response. The law enforcement agency did not partner with DFS to investigate, and did not refer to a Detective nor discuss with the Attorney General's office.
27	16-364	2016	4-year-old	MDT Response	Intake with DOJ	Current	The law enforcement agency did not notify the DOJ Special Victims Unit of the near death incident.
28	17-004	2017	1-month-old	MDT Response	Intake with DOJ	Current	The law enforcement agency had no immediate contact with DOJ after receiving notification of a child death.
29	16-208	2016	4-month-old	MDT Response	Interviews - Adult	Current	The case worker called the suspects initially and asked incident based and leading questions. This contact occurred prior to the police response.
30	17-006	2017	4-month-old	MDT Response	Interviews - Adult	Current	During the prior investigation, another relative was utilized to translate the conversation between the caseworker and parent.
31	16-288	2016	2-month-old	MDT Response	Interviews - Adult	Current	DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.
32	16-639	2016	1-month-old	MDT Response	Interviews - Adult	Current	DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews at the hospital. As a result, DFS had difficulty locating the mother and surviving children.

Findings: MDT Response - Criminal Investigations (52)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
33	17-002	2017	1-month-old	MDT Response	Interviews - Adult	Current	DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.
34	17-006	2017	4-month-old	MDT Response	Interviews - Adult	Current	Interviews were not conducted with other witnesses who had a caregiving responsibility for the child.
35	17-016	2017	14-month-old	MDT Response	Interviews - Adult	Current	During the near death investigation, DFS and LE did not seek assistance from an interpreter to conduct interviews with the mother. Other adults were utilized to translate the conversations.
36	17-030	2017	3-week-old	MDT Response	Interviews - Adult	Current	DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.
37	16-364	2016	4-year-old	MDT Response	Interviews - Child	Current	The law enforcement agency did not attend the forensic interview with the victim.
38	16-318	2016	1-month-old	MDT Response	Interviews - Child	Current	Forensic interview did not occur with the youth who was present during the incident.
39	16-363	2016	7-month-old	MDT Response	Interviews - Child	Current	Forensic interview did not occur with the young child, who resided in the home where the incident occurred.
40	16-372	2016	1-year-old	MDT Response	Interviews - Child	Current	There was a delay in scheduling the forensic interview with the young child, who resided in the home where the incident occurred.
41	17-022	2017	2-week-old	MDT Response	Interviews - Child	Current	There was a delay in scheduling the forensic interview with the young child, who resided in the home where the incident occurred.
42	17-022	2017	2-week-old	MDT Response	Interviews - Child	Current	There was a delay in referring the young child to a children's advocacy center for a forensic interview.
43	17-030	2017	3-week-old	MDT Response	Interviews - Child	Current	Forensic interviews did not occur with the older siblings during the death investigation.
44	16-208	2016	4-month-old	MDT Response	Prosecution/ Pleas/ Sentence	Current	All the jail time was suspended for the defendant despite the guilty plea to a violent felony with a presumptive jail sentence.

Findings: MDT Response - Criminal Investigations (52)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
45	16-208	2016	4-month-old	MDT Response	Prosecution/ Pleas/ Sentence	Current	The sentencing order required the defendant to complete an anger management program and not a certified batterer's treatment program.
46	16-364	2016	4-year-old	MDT Response	Prosecution/ Pleas/ Sentence	Current	There was a lack of resources devoted to the criminal investigation by the DOJ.
47	16-290	2016	2-year-old	MDT Response	Prosecution/ Pleas/ Sentence	Current	Father's original felony charges were Nolle Prossed, and he was reindicted on misdemeanors. No communication occurred between DOJ and the law enforcement agency prior to this decision.
48	16-290	2016	2-year-old	MDT Response	Prosecution/ Pleas/ Sentence	Current	Father's charges were not handled in Superior Court. Instead, the charges were screened out to Family Court, and ultimately Nolle Prossed.
49	17-032	2017	3-month-old	MDT Response	Prosecution/ Pleas/ Sentence	Current	Delaware does not have a criminal negligence standard to prosecute these cases under the current child abuse laws.
50	17-005	2017	1-year-old	MDT Response	Reporting	Current	DFS was not notified of the child death until immediately prior to the forensic interview of the young sibling. As a result, DFS was not able to observe any early suspect/witness interviews due to the delayed report by the law enforcement agency.
51	17-019	2017	16-month-old	MDT Response	Reporting	Current	The DFS Report Line was not contacted despite the victim being present during a DUI and domestic incident involving the alleged perpetrator. This occurred prior to the victim's death, and a hotline report would have given DFS the opportunity to provide an intervention.
52	17-022	2017	2-week-old	MDT Response	Reporting	Current	The DFS caseworker delayed reporting the near death incident to the law enforcement agency, and as a result, there was no blood draw or crime scene investigation.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018
Findings Summary:
Safety Agreements and Risk Assessment

System Area	*Current	Prior	Grand Total
Safety/ Use of History/ Supervisory Oversight	**37**	**3**	**40**
Completed Incorrectly/ Late	26	1	27
Inappropriate Parent/ Relative Component	4		4
No Safety Assessment of Non-Victims	2		2
Oversight of Agreement	5	2	7
Risk Assessment/ Caseloads	**64**	**2**	**66**
Caseloads	40		40
Risk Assessment - Closed Despite Risk Level	2	1	3
Risk Assessment - Screen Out	4	1	5
Risk Assessment - Tools	15		15
Risk Assessment - Unsubstantiated	3		3
Grand Total	**101**	**5**	**106**

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018

Findings: Safety Agreements
(40)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
1	16-208	2016	4-month-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	The safety assessment was not completed appropriately for the victim, because it assessed the victim as being safe in the hospital. Safety assessments must assess whether the child is in immediate danger in their home.
2	16-227	2016	2-year-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	In the prior investigation, the father's substance abuse was not identified as a safety threat in the SDM safety assessment despite the child being present during the DUI, the caregiver possessing prescription pills not prescribed, and a disclosure of recent heroin use. The caregiver was permitted to continue providing supervision while the mother worked. The SDM safety assessment was not re-evaluated once a collateral contact revealed ongoing drug use by the father, who was primarily responsible for supervising the child.
3	16-227	2016	2-year-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	For the near death incident, the after-hours case worker incorrectly identified the child as safe in the SDM safety assessment due to his hospitalization. No safety threats were marked.
4	16-239	2016	2-month-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	A safety agreement was completed with the family for the first report involving the sibling, but a SDM safety assessment was not entered into the database until months later. A safety assessment was only entered after a new supervisor was assigned and noted the issue.
5	16-239	2016	2-month-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	Throughout the investigation, DFS entered into several safety agreements with multiple caregivers. The agreements were ineffective in ensuring the child(ren)'s safety.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018

Findings: Safety Agreements
(40)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
6	16-364	2016	4-year-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	The SDM Safety Assessment was not completed correctly for the near death incident. The safety threat for the caregiver not meeting the child's immediate needs was marked no, and the child was determined to be safe.
7	16-288	2016	2-month-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	The SDM safety assessment and safety agreement were completed late, approximately 12 days after the hotline report was received. As a result, a safety agreement was not implemented while the child was in the hospital to restrict contact between the victim and potential suspects.
8	16-318	2016	1-month-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	The DFS safety agreement did not restrict contact between the victim and potential suspects while the child was hospitalized.
9	16-318	2016	1-month-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	In the prior investigation, the case worker did not complete the SDM safety assessment correctly. The safety threat for drug-exposed infant was marked no. No agreement was entered.
10	16-363	2016	7-month-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	In the prior investigation, the caseworker did not complete the SDM Safety Assessment correctly. The safety threat for drug-exposed infant was marked no. No agreement was entered.
11	16-370	2016	3-week-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	The DFS safety agreement did not restrict contact between the victim and potential suspects while the child was hospitalized given father's behavior.
12	16-370	2016	3-week-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	For the near death investigation, the caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018

Findings: Safety Agreements
(40)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
13	16-375	2016	5-month-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	For the near death investigation, the caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization.
14	16-376	2016	2-year-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	For the near death investigation, the caseworker did not specify in the safety agreement that the contact was restricted between the children and potential susptects. The restrictions were only verbally stated.
15	17-007	2017	4-month-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	In the near death investigation, the case worker incorrectly identified the child as safe in the SDM safety assessment due to her hospitalization.
16	17-002	2017	1-month-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	In the near death investigation, the case worker identified the child as safe with agreement in the SDM safety assessment due to his hospitalization, but no agreement was entered.
17	16-376	2016	2-year-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Prior	In the prior investigation, the caseworker did not complete the SDM safety assessment correctly. The safety threat for drug-exposed infant was marked no. No agreement was entered.
18	17-006	2017	4-month-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	For the near death incident, the caseworker incorrectly identified the child as safe in the SDM safety assessment. The child was hospitalized for a head injury, and it was unknown whether the father caused the injury.
19	17-012	2017	11-day-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	The caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization. Other risk factors included current/prior infants born substance exposed, history of incarcerations, prostitution and drug use, and significant DFS history.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018

Findings: Safety Agreements
(40)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
20	17-015	2017	5-week-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	The caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization. Other risk factors included an infant born substance exposed, prior infant death, history of substance abuse and DFS history involving the siblings.
21	17-015	2017	5-week-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	For the initial hotline report, the caseworker did not complete the SDM safety assessment correctly. The safety threat for drug-exposed infant was marked no. Initially, there was no agreement entered for the victim or siblings residing in the home.
22	17-016	2017	14-month-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	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.
23	17-028	2017	7-week-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	For the near death incident, the caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization.
24	17-028	2017	7-week-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	The initial safety agreement did not designate another participant to care for the victim or supervise contact. The agreement was later modified to include other relatives.
25	17-025	2017	2-year-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	DFS entered into a safety agreement with participants, but a home assessment was not initially conducted.
26	17-032	2017	3-month-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	For the near death incident, the caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization. The safety threats were also not identified.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018

Findings: Safety Agreements
(40)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
27	17-030	2017	3-week-old	Safety/ Use of History/ Supervisory Oversight	Completed Incorrectly/ Late	Current	For the first referral involving a substance exposed infant, the caseworker did not complete the SDM Safety Assessment correctly. The safety threat for current circumstances combined with history was marked no. Family recently returned from out of state, and the mother had a history of substantiated abuse against young children. No agreement was entered.
28	16-239	2016	2-month-old	Safety/ Use of History/ Supervisory Oversight	Inappropriate Parent/ Relative Component	Current	Following the death incident, DFS did not conduct a background check with the relative prior to entering into a safety agreement for the sibling. The relative had pending criminal charges, admitted to current substance use, and appeared to be under the influence when the agreement was completed.
29	16-318	2016	1-month-old	Safety/ Use of History/ Supervisory Oversight	Inappropriate Parent/ Relative Component	Current	For the near death incident, DFS completed a safety agreement with relatives, who were the subject of a current DFS investigation, and there was no documentation that a discussion occurred between the two workers to justify the use of caregivers as safety agreement participants.
30	17-022	2017	2-week-old	Safety/ Use of History/ Supervisory Oversight	Inappropriate Parent/ Relative Component	Current	For the near death incident, DFS completed a safety agreement with a relative, who was an alleged perpetrator and not cooperative in the prior investigation. In addition, there was a significant amount of conflict between the mother and the relative.
31	17-016	2017	14-month-old	Safety/ Use of History/ Supervisory Oversight	Inappropriate Parent/ Relative Component	Current	For the near death incident, DFS initially completed a safety agreement with a participant, who was not ruled out as a suspect, and the young sibling was placed in the care of this participant.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018

Findings: Safety Agreements
(40)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
32	16-208	2016	4-month-old	Safety/ Use of History/ Supervisory Oversight	No Safety Assessment of Non-Victims	Current	The safety assessment and agreement did not consider the half sibling. The child did not reside in the home full time, but was present during the incident.
33	16-639	2016	1-month-old	Safety/ Use of History/ Supervisory Oversight	No Safety Assessment of Non-Victims	Current	A safety agreement was not completed with caregivers of the surviving children, and risk factors included the death of a child and suspected substance abuse and mental health issues for the mother.
34	16-290	2016	2-year-old	Safety/ Use of History/ Supervisory Oversight	Oversight of Agreement	Prior	In the prior investigation, DFS modified the safety agreement and agreed that the children could return home, without visiting the home to ensure the conditions had improved. The home visit did not occur for another month.
35	17-030	2017	3-week-old	Safety/ Use of History/ Supervisory Oversight	Oversight of Agreement	Prior	During the prior treatment case, the SDM Safety Agreement was not reviewed in a timely manner.
36	17-030	2017	3-week-old	Safety/ Use of History/ Supervisory Oversight	Oversight of Agreement	Current	When renewing the child safety agreement, the supervisor was not aware the safety participant was charged with a felony domestic incident with the siblings present and a new DFS case was opened.
37	16-239	2016	2-month-old	Safety/ Use of History/ Supervisory Oversight	Oversight of Agreement	Current	DFS had an active investigation with the family for several months, which exceeded the 45-day timeframe. There was no documented reason for the case remaining open that long, and contact with the family was sporadic.
38	17-004	2017	1-month-old	Safety/ Use of History/ Supervisory Oversight	Oversight of Agreement	Current	In the prior investigation, the safety agreement was amended prior to the case worker having contact with mother's substance abuse treatment provider.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018

Findings: Safety Agreements
(40)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
39	9-06-17-00001	2017	4-year-old	Safety/ Use of History/ Supervisory Oversight	Oversight of Agreement	Current	During the DFS investigation after child's spiral fracture, the victim and her sibling were placed in the care of relative, as per a safety agreement. Fifteen days prior to this child's death, the relative caregiver called the DFS caseworker and explained she was overwhelmed and could not take care of the children. No response was documented by DFS worker nor supervisor as to what actions happened between 12/15 and 1/1.
40	9-06-17-00001	2017	4-year-old	Safety/ Use of History/ Supervisory Oversight	Oversight of Agreement	Current	The caseworker's supervisor was out on leave during the course of the investigation. When the supervisor returned, she retired and another supervisor took over the case supervision. However, there was additional movement in supervisors assigned to worker and the turnover seemed to impact the case.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018
Findings: Caseloads (40)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
1	16-203	2016	3-month-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS case workers were over the investigation and treatment caseload statutory standards while the cases were open.
2	16-204	2016	3-month-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS case workers were over the investigation and treatment caseload statutory standards while the cases were open.
3	16-208	2016	4-month-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS case worker was over the investigation caseload statutory standards the entire time the case was open.
4	16-238	2016	1-month-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open, with the exception of a 2-week period.
5	16-239	2016	2-month-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.
6	16-266	2016	3-month-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.
7	16-288	2016	2-month-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards for a portion of time while the case was open.
8	16-290	2016	2-year-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.
9	16-318	2016	1-month-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.
10	16-363	2016	7-month-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018
Findings: Caseloads (40)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
11	16-364	2016	4-year-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards for a portion of time while the case was open.
12	16-367	2016	3-year-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.
13	16-370	2016	3-week-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the treatment caseload statutory standards for the entire time while the case was open.
14	16-372	2016	1-year-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards for a portion of time while the case was open.
15	16-375	2016	5-month-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards for a portion of time while the case was open.
16	16-639	2016	1-month-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS case worker was over the investigation caseload statutory standards the entire time the case was open.
17	17-0008	2017	23-month-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.
18	17-002	2017	1-month-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.
19	17-006	2017	4-month-old	Risk Assessment / Caseloads	Caseloads	Current	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.
20	17-007	2017	4-month-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018
Findings: Caseloads (40)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
21	17-010	2017	14-month-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.
22	17-012	2017	11-day-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.
23	17-013	2017	4-week-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.
24	17-015	2017	5-week-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.
25	17-016	2017	14-month-old	Risk Assessment / Caseloads	Caseloads	Current	The caseworker was over the investigation caseload statutory standards the entire time the case was open.
26	17-019	2017	16-month-old	Risk Assessment / Caseloads	Caseloads	Current	The caseworker was over the investigation caseload statutory standards the entire time the case was open.
27	17-021	2017	18-month-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.
28	17-023	2017	20-month-old	Risk Assessment / Caseloads	Caseloads	Current	The caseworker was over the investigation caseload statutory standards the entire time the case was open.
29	17-024	2017	2-year-old	Risk Assessment / Caseloads	Caseloads	Current	The caseworker was over the investigation caseload statutory standards the entire time the case was open.
30	17-025	2017	2-year-old	Risk Assessment / Caseloads	Caseloads	Current	The caseworker was over the investigation caseload statutory standards the entire time the case was open.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018
Findings: Caseloads (40)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
31	17-026	2017	2-year-old	Risk Assessment / Caseloads	Caseloads	Current	The caseworkers were over the investigation and treatment caseload statutory standards while the cases were open.
32	17-028	2017	7-week-old	Risk Assessment / Caseloads	Caseloads	Current	The caseworkers were over the investigation and treatment caseload statutory standards while the cases were open.
33	17-030	2017	3-week-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker and supervisor were over the investigation caseload statutory standards for a portion of the time while the case was open. The supervisor handled the case for a period of the time.
34	17-032	2017	3-month-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.
35	18-006	2017	2-month-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards for a portion of the time while the case was open.
36	18-018	2017	4-year-old	Risk Assessment / Caseloads	Caseloads	Current	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.
37	9-06-17-00001	2017	4- year-old	Risk Assessment / Caseloads	Caseloads	Current	When the referral for child's spiral fracture was made to DFS, the worker assigned to the case was well over the caseload standards, having an average of 25 at that time.
38	9-06-17-00001	2017	4-year-old	Risk Assessment / Caseloads	Caseloads	Current	Case remained open in DFS investigations for six months.
39	9-06-17-00022	2017	2-year-old	Risk Assessment / Caseloads	Caseloads	Current	DFS investigation case remains open more than 90 days after death.
40	9-06-17-00023	2017	11-year-old	Risk Assessment / Caseloads	Caseloads	Current	The assigned DFS caseworker was above caseload standards through the investigations case.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018

Findings: Risk Assessment (26)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
1	16-318	2016	1-month-old	Risk Assessment / Caseloads	Risk Assessment - Closed Despite Risk Level	Current	In the prior investigation, SDM risk assessment identified the risk as high and recommended ongoing service; however, the case was closed. The rationale was that mother's drug use was situational and her mental health was not a concern.
2	17-004	2017	1-month-old	Risk Assessment / Caseloads	Risk Assessment - Closed Despite Risk Level	Current	In the prior investigation, the SDM risk assessment identified the risk as high and recommended ongoing service; however, the case was closed. As a result, the family was not provided treatment services prior to the death.
3	16-376	2016	2-year-old	Risk Assessment / Caseloads	Risk Assessment - Closed Despite Risk Level	Prior	In two prior investigations, the SDM risk assessment identified the risk as high and recommended ongoing service; however, the cases were closed. As a result, the family was not provided treatment services prior to the near death.
4	16-290	2016	2-year-old	Risk Assessment / Caseloads	Risk Assessment - Screen Out	Prior	DFS screened out the hotline report despite the history with the family and the child sustaining multiple dog bites. The responding law enforcement agency reported its concerns about supervision by mother.
5	17-002	2017	1-month-old	Risk Assessment / Caseloads	Risk Assessment - Screen Out	Current	The DFS Report Line screened out the subsequent report regarding the healing rib fractures being found on the repeat x-rays.
6	9-06-16-00026	2016	8-month-old	Risk Assessment / Caseloads	Risk Assessment - Screen Out	Current	A hotline report was made to DFS as a result of infant's death, which was screened out and not opened in investigations despite the most recent open case with DFS being just six weeks prior to infant's death.
7	9-06-17-00023	2017	11-year-old	Risk Assessment / Caseloads	Risk Assessment - Screen Out	Current	Because the DFS case was not accepted as a full investigation, a substantiation cannot be made of leaving the children in the home alone, under the age of twelve.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018
Findings: Risk Assessment (26)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
8	9-06-17-00020	2017	5-month-old	Risk Assessment / Caseloads	Risk Assessment - Screen Out	Current	DFS did not accept the case for investigation at the time of infant death.
9	16-239	2016	2-month-old	Risk Assessment / Caseloads	Risk Assessment - Tools	Current	Following the death incident, a Team Decision Making meeting was not considered for the young sibling. The safety agreement with the out of state relative was violated, and DFS located the child with an inappropriate caregiver. DFS ultimately petitioned for custody of the sibling several months after the incident.
10	16-363	2016	7-month-old	Risk Assessment / Caseloads	Risk Assessment - Tools	Current	In the prior investigation, DFS did not rate the minor mother as the primary caregiver in the SDM Risk Assessment. Primary caregiver mental health, primary caregiver substance abuse or drug use, and positive toxicology screen at birth were not considered in the neglect index. As a result, the investigation was closed.
11	16-367	2016	3-year-old	Risk Assessment / Caseloads	Risk Assessment - Tools	Current	The call by the PCP to the DFS Report Line was written as a hotline progress note rather than a new report.
12	16-370	2016	3-week-old	Risk Assessment / Caseloads	Risk Assessment - Tools	Current	A Framework during the investigation was not considered to determine the next steps for a young child with serious physical injuries and no history of trauma provided by the
13	17-004	2017	1-month-old	Risk Assessment / Caseloads	Risk Assessment - Tools	Current	A framework was not considered for the surviving sibling prior to closing the death investigation. The SDM risk assessment identified the risk as high and recommended ongoing service.
14	17-012	2017	11-day-old	Risk Assessment / Caseloads	Risk Assessment - Tools	Current	A consult with DOJ or a framework was not considered by DFS despite the presence of multiple risk factors. The infant was born substance exposed and died shortly after being discharged home to the family.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018
Findings: Risk Assessment (26)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
15	17-019	2017	16-month-old	Risk Assessment / Caseloads	Risk Assessment - Tools	Current	In the prior investigation, the SDM Risk Assessment was not completed correctly. The policy override for severe non-accidental injury was not selected, so the case was closed.
16	17-022	2017	2-week-old	Risk Assessment / Caseloads	Risk Assessment - Tools	Current	The SDM Risk Assessment identified the risk as high in both the prior and near death investigations. Ongoing service was recommended for both; however, in each investigation, the case disposition was overridden to close the case.
17	17-024	2017	2-year-old	Risk Assessment / Caseloads	Risk Assessment - Tools	Current	For the near death incident, the hotline report was downgraded to a P2 in contrast with the SDM Response Priority Assessment. It was noted the alleged perpetrator's whereabouts were unknown and the mother had requested an attorney when contacted by the law enforcement agency.
18	17-025	2017	2-year-old	Risk Assessment / Caseloads	Risk Assessment - Tools	Current	The treatment worker did not complete the SDM Risk Re-assessment, so it was not considered in the decision to close the treatment case.
19	17-032	2017	3-month-old	Risk Assessment / Caseloads	Risk Assessment - Tools	Current	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.
20	17-030	2017	3-week-old	Risk Assessment / Caseloads	Risk Assessment - Tools	Current	The SDM Risk Assessment identified the risk as high at the conclusion of the death investigation. Ongoing service was recommended; however, the case disposition was overridden to close the investigation.

Child Protection Accountability Commission/
Child Death Review Commission
JOINT MEETING
April 25, 2018

Findings: Risk Assessment (26)

#	Case #	Year of Incident	Age at Time of Incident	System Area	Finding	Timeframe (current/ prior)	Public Rationale
21	17-030	2017	3-week-old	Risk Assessment / Caseloads	Risk Assessment - Tools	Current	During the death investigation, several next steps were identified in the initial group supervision and all the steps were not completed by DFS at the end of the investigation (forensic interview, toxicology screen results).
22	9-06-16-00026	2016	8-month-old	Risk Assessment / Caseloads	Risk Assessment - Tools	Current	Case closed six weeks prior to the death with unresolved risk remaining in the home.
23	9-06-16-00032	2016	15-year-old	Risk Assessment / Caseloads	Risk Assessment - Tools	Current	Throughout the numerous DFS cases, there did not appear to be any resolution to the unresolved risk until the children were placed in foster care. This family needed a higher level of case management.
24	17-007	2017	4-month-old	Risk Assessment / Caseloads	Risk Assessment - Unsubstantiated	Current	The DFS Family and Child Tracking System (FACTS) does not identify cases where abuse has been confirmed but the perpetrator is unknown.
25	17-013	2017	4-week-old	Risk Assessment / Caseloads	Risk Assessment - Unsubstantiated	Current	The DFS Family and Child Tracking System (FACTS) does not identify cases where abuse has been confirmed but the perpetrator is unknown.
26	17-025	2017	2-year-old	Risk Assessment / Caseloads	Risk Assessment - Unsubstantiated	Current	There was no finding of abuse or neglect in the investigation despite the mother's actions, which placed the child at risk and exposed the child to illicit drug use.

Child Protection Accountability Commission & Child Death Review Commission

2018-2019 Action Plan

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

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

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

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

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

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

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