State of Delaware

Child Protection Accountability Commission (CPAC)

Children's Justice Act

Annual Progress Report and Grant Application

May 31, 2017

State of Delaware
Child Protection Accountability Commission
c/o Office of the Child Advocate
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CPAC STAFF

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Mission Statement

The Child Protection Accountability Commission's overall statutory mission 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)).

Purpose and Background

Delaware's Child Protection Accountability Commission (CPAC or the Commission) 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 pointed to deficiencies in the child protection system that could only be remedied through the collaborative efforts of Delaware's many child welfare agencies. 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 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. CPAC, an interdisciplinary forum for dialogue and reform, 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.

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I. Governor's Letter

STATE OF DELAWARE
OFFICE OF THE GOVERNOR
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DOVER, DELAWARE 19901

JOHN CARNEY
GOVERNOR

PHONE (302) 744-4101
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May 31, 2017

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

Dear Acting Commissioner Goldstein:

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 2016 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 Carney
Governor

II. Task Force Membership and Function

Name and Title	Task Force Designation	Description
Colonel Nathaniel McQueen, Jr., Superintendent, Delaware State Police **Captain Robert McLucas, New Castle County Police Department**	Law Enforcement Community	Colonel McQueen represents the Delaware State Police on the Task Force. Captain 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 **Abigail Layton, Esquire, Deputy Attorney General, Department of Justice**	Prosecuting Attorney	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. 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.
Allan De Jong, M.D., Medical Director, Alfred I. duPont Hospital for Children	Health Professional	Dr. De Jong is a pediatrician and the Medical Director of the Children at Risk Evaluation (CARE) Program at the Alfred I. duPont Hospital for Children.

Name and Title	Task Force Designation	Description
Susan Cycyk, M.Ed., Director, Division of Prevention and Behavioral Health Services	Mental Health Professional	Ms. Cycyk 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.
Carla Benson-Green, Director, Division of Family Services	Child Protective Service Agency	Ms. Benson-Green 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.
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.
Jennifer Davis, Education Associate, Student Services and Special Populations, 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)).	Ms. Davis is an Education Associate and oversees Student Services and Special Populations at the Department of Education. In this capacity, she serves as the State Coordinator for the Education of Children in Foster Care. Prior to the federal Every Student Succeeds Act, Ms. Davis served as the State Coordinator for Homeless Children and Youth until October 2016. She participates in one of the Committees under the Task Force. John Hulse the new State Coordinator for Homeless Children and Youth will be joining one of the Committees under the Task Force in July 2017.

In Delaware, CPAC serves as the federally mandated Citizen Review Panel and CJA State Task Force. As a result, CPAC fulfills specific statutory requirements for each. For CJA, CPAC is required to maintain a multidisciplinary Task Force on children's justice as specified in Section 107(c)(1) of CAPTA to remain eligible for CJA grant funds. Delaware's Task Force membership is designated under section 931(a) of Title 16 of the Delaware Code. On July 15, 2014, the statute was amended to add two representatives required under CAPTA: a youth or young adult who has experienced foster care in Delaware and a Delaware attorney who represents parents in child welfare proceedings. Previously, these representatives only participated in a number of long-term Committees or Workgroups under the Task Force.

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.

A. Structure

While the Office of the Child Advocate (OCA) has many statutory duties, legal representation of children is a significant part of OCA's mission. OCA accomplishes its charge to represent children through the employment of four full-time Deputy Child Advocates, contract Child Attorneys, a substantial and dedicated pool of volunteer Child Attorneys supervised by a Managing Attorney, and a robust and committed pool of community volunteers that serve as Court Appointed Special Advocates (CASA) and are supervised by CASA Coordinators. The CASA Program moved from Family Court to OCA on March 6, 2017.

Another statutory responsibility is assisting the Office of the Investigation Coordinator (IC). The IC was established in the wake of Dean Ammons' Independent Review of the Earl Brian Bradley Case, a pediatrician convicted of sexually abusing multiple child victims in Delaware. Dean Ammons was tasked with reviewing the State's policies and statutory and administrative

procedures governing child sexual abuse and exploitation while in turn making recommendations that "foster a child protection community of collaboration and accountability to better protect Delaware's children from predators." As a result of Dean Ammons' Independent Review, the Governor's Committee on the Protection of Children was established in order to address recommendations relating to multidisciplinary collaboration and coordination. In 2013, legislation was put forth, drafted by the Committee, and ultimately championed by CPAC, creating the Office of the Investigation Coordinator. The IC has the authority to track any case of child abuse or neglect, and is required to monitor each reported case, both intra-familial and extra-familial, involving the death of, serious physical injury to, or allegations of sexual abuse of a child from inception to final criminal and civil disposition. The IC transferred from the Department of Services for Children, Youth and Their Families to OCA on April 20, 2016.

In addition to overseeing OCA, the Child Advocate serves as the Executive Director of CPAC, and OCA is required to provide staff support to the Commission. OCA staff who provide significant support to CPAC include a contract Training Coordinator, a contract Data Analyst and a Chief Policy Advisor/CJA Coordinator. In fact, the 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: drafting the Application, Annual Report and Three-Year Assessment; preparing quarterly reports for the Abuse Intervention Committee on behalf of CPAC; 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. Since October 1, 2012, the Criminal Justice Council, with assistance from the Administrative Office of the Courts, has supported OCA with the fiscal management of the grant. The Criminal Justice Council is also responsible for the financial reporting on behalf of CPAC.

To improve the manner in which the CJA grant is administered, 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.

B. Meeting Frequency and Minutes

The CPAC Abuse Intervention Committee meets twice a year to receive progress updates on the goals identified in the Three-Year Assessment and to report this progress to CPAC. CPAC also convenes quarterly meetings to discuss the work of its 7 Committees: Abuse Intervention; Child Abuse and Neglect Steering Committee; Data Utilization; Education; Legislative; Substance-

Exposed Infants/Medically Fragile Children; and Training. The Child Abuse Medical Response, Child Torture and Permanency for Adolescents Committees concluded its work during the reporting period. The progress reports from each quarterly meeting can be found in the CPAC Quarterly Meeting minutes (See Appendix A: CPAC Quarterly Meeting Minutes).

III. Prior Year Activities and Performance Report (May 1, 2016-April 30, 2017)

In its 2015-2017 Three-Year Assessment Report, CPAC prioritized 16 recommendations related to policy and training to improve the processes by which Delaware responds to cases of child abuse and neglect. The five policy recommendations related to the child protective service agency's (Division of Family Services or DFS) collateral policy and procedure; substance-exposed infants and medically fragile children; mental health, domestic violence, and substance abuse assessments; the revised Memorandum of Understanding (MOU) for the Multidisciplinary Response to Child Abuse and Neglect; and cases of child torture. Five additional recommendations related to the development of training programs for members of the multidisciplinary team (MDT) and the judiciary. Lastly, six recommendations involved evaluating DFS practices and system improvements; communication between DFS and the Department of Justice (DOJ); resource constraints for DOJ; and modifying Delaware statute related to training for medical professionals on the recognition of child abuse and neglect. A complete outline of the 2015-2017 priorities can be found in the CJA Annual Progress Report and Grant Application and 2015-2017 Three-Year Assessment Report. The report is available at the following link: http://courts.delaware.gov/childadvocate/docs/2015CJA-Application_Attachments.pdf.

During the second year of the 2015-2017 grant period, CPAC focused its efforts on the following activities: Child Abuse and Neglect Best Practices Guidelines; Child Abuse and Neglect Death and Near Death Reviews; Guidelines for the Child Abuse Medical Response; Best Practices for Responding to Child Torture; Response to Substance-Exposed Infants and Medically Fragile Children; Protecting Delaware's Children: A Multidisciplinary Conference and Advanced Training Course for Child Welfare Professionals; Data to Inform System Improvements in the Processing of Child Abuse Cases; Training Coordinator Position; Mandatory Reporting Training; Online Training System, Surveys, Training Software and Videography Services; and CJA Grantee Meeting/National Citizen Review Panel Conference. The planning and execution of these activities was carried out by CPAC through one of its Committees. Additionally, the Executive Director, Chief Policy Advisor/CJA Coordinator, Training Coordinator, Data Analyst, Child Abuse Investigation Coordinator and a Deputy Child Advocate provided administrative support to the Committees and its Workgroups. The progress on these activities will be described further below.

1. **Activity:** Develop Child Abuse and Neglect (CAN) Best Practice Guidelines

   Output: CPAC approved the creation of the CAN Best Practices Workgroup under the CPAC Training Committee in July 2013. Since then, the Workgroup has been meeting to draft revisions to the MOU for the Multidisciplinary Response to Child Abuse and Neglect. Historically, the MOU has outlined the roles and responsibilities of the Department of Services

for Children, Youth and Their Families (DSCYF), Children's Advocacy Center (CAC), DOJ, and Delaware Police Departments in the investigation and prosecution of child abuse cases.[1] However, the MOU lacked best practice protocols for a multidisciplinary response to child abuse and neglect cases in Delaware. During the reporting period, the Workgroup continued to develop its 6 protocols for the following types of cases: Physical Injury to a Child; Serious Physical Injury to a Child; Child Death; Child Sexual Abuse; Child Neglect; and Juvenile Trafficking. The themes addressed in the MOU included cross reporting to the MDT, joint responses, forensic interviews, crime scene investigations, medical exams and transportation of victims. To support communication and collaboration between all involved parties, the group added the following signatory agencies: Division of Forensic Science, Alfred I. duPont Hospital for Children, and the Office of the Investigation Coordinator.

Outcome: During this reporting period, in February 2017, CPAC approved the MOU for the Multidisciplinary Response to Child Abuse and Neglect (See Appendix B: MOU for the Multidisciplinary Response to Child Abuse and Neglect). The MDT is able to access the MOU and all the resources on the CPAC/OCA website at the following link (towards bottom of page): http://courts.delaware.gov/childadvocate/cpac/cpac_reports.aspx. In addition, the Chief Policy Advisor/CJA Coordinator developed a mobile application to allow the MDT to access the document in the field. The mobile application can be downloaded by iPhone and Android users on the App Store and Play Store by searching "DE MOU" (See Appendix C: Mobile Application Screen Shots). A 45-minute overview of the finalized MOU was provided by Adrienne Owen, a corporal at the Delaware State Police, to approximately 130 participants at Protecting Delaware's Children: A Multidisciplinary Conference and Advanced Training Course for Child Welfare Professionals on April 25, 2017 (See Appendix D: MOU Overview). At the end of the reporting period, the MOU had not been executed since additional signatures are still needed. A county-based training program is also being planned and developed by the Workgroup.

Evaluation: Participants at Protecting Delaware's Children were asked to participate in a survey to evaluate their overall satisfaction with the conference and the individual workshop sessions. Eighteen respondents who attended the Advanced Training Course on April 25, 2017 submitted a survey response, and 86% strongly agreed or agreed that they have a basic understanding of the revised MOU. The conference and survey results will be discussed in further detail in section 6.

Need: To provide standardized best practice guidelines and ongoing comprehensive training to those who investigate, prosecute or otherwise respond to reports of child sexual abuse, death, and near death cases.[2]

[1] The Division of Family Services is a division within the Department of Services for Children, Youth and Their Families.
[2] Taken from the Report on the Joint Committee on the Investigation and Prosecution of Child Abuse.

Funding Required: CJA funds were used to pay for the rental of facilities, speaker fees and costs of meals and refreshments for Protecting Delaware's Children.

2. **Activity:** Review of Child Abuse and Neglect Death and Near Death Cases

Output: During FY16, CPAC was 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 Review Commission to CPAC on September 10, 2015. Then, at its meeting of October 14, 2015, CPAC ratified the Child Abuse and Neglect (CAN) Steering Committee and CAN Panel. In addition, CPAC authorized the CAN Panel to conduct the confidential investigations and retrospective reviews on behalf of CPAC and charged the CAN Steering Committee with providing oversight of these duties. As such, all activities of the CAN Steering Committee and CAN Panel are statutorily confidential. However, the statute allows for the Commission to release system-wide findings and recommendations arising from an investigation and review to the Governor, General Assembly and public. Since then, CPAC has relied on the work of the CAN Panel to evaluate the effectiveness of the MDT response and determine the priorities for system change.

Outcome: Between May 2016 and February 2017, CPAC approved the CAN Panel's systemic findings in 54 cases and forwarded its action steps to the Governor. There were 35 unduplicated children – 11 deaths and 24 near deaths. The reports, which include the summary information and systemic findings and strengths, are available to the public on the CPAC/OCA website at the following link: http://courts.delaware.gov/childadvocate/cpac/cpac_reports.aspx.

Evaluation: For this reporting period, the reviews resulted in 250 findings across system areas and 44 strengths (See Appendix E: Reviews of Child Deaths and Near Deaths due to Abuse and Neglect). Additionally, in September 2016, CPAC and the Child Death Review Commission (CDRC) convened a retreat to provide an update on the priorities established in the 2015-2017 Three-Year Assessment Report and to establish an action plan for the upcoming year. The two Commissions again relied on the findings from the CAN Panel to establish its priorities. Specifically, 303 findings across 6 system areas were discussed. These findings stemmed from the review of 41 child deaths and near deaths due to abuse and neglect for incidents that occurred between January 2015 and May 2016. In its new action plan for 2016-2017, CPAC and CDRC established 31 recommendations for system improvement. At its February 8, 2017 quarterly meeting, CPAC and its partner agencies shared an update on the status of its recommendations (See Appendix F: 2016-2017 Action Plan).

Need: To investigate and review deaths or near deaths of abused or neglected children.[3]

[3] House Bill 136 was signed on September 10, 2015, which provided for the transfer of the Child Abuse and Neglect Panel from the CDRC to CPAC.

Funding Required: None to date.

3. **Activity:** Develop Guidelines for the Child Abuse Medical Response

   Output: The CPAC Child Abuse Medical Response Committee was created in July 2014 in response to concerns that the number of forensic medical examinations in non-acute child abuse cases had significantly dropped. At the same time, the Commission concluded that there was an exigent need to increase the number of child abuse medical experts in the state. For years, Dr. De Jong has served as the state's only child abuse medical expert, until a second child abuse medical expert was hired by the Alfred I. duPont Hospital for Children in August 2016. Thus, the Committee was charged with recommending both a methodology to increase the state's resources and a statewide protocol for determining the need for medical evaluations in child abuse cases. The Committee continued meeting during the reporting period and finalized the draft guidelines. The Committee submitted the guidelines to CPAC for final approval in August 2016, and the approved guidelines were forwarded to the CAN Best Practices Workgroup for inclusion in the MOU for the Multidisciplinary Response to Child Abuse and Neglect.

   Outcome: CPAC approved the guidelines, but not all components will be implemented due to a lack of resources. The guidelines were included in the MOU for the Multidisciplinary Response to Child Abuse and Neglect, but it is noted in the MOU that certain components will be implemented at a later date (See Appendix G: Delaware Multidisciplinary Team Guidelines for Child Abuse Medical Response). In response to the state's resources, the Committee found that the network of providers for urgent medical care was sufficient to meet demand; however, for non-acute cases, the Committee determined that additional resources were required to meet the current need in two of Delaware's three counties and the anticipated demand resulting from implementation of the guidelines. With only two child abuse medical experts in Delaware to evaluate non-acute child abuse cases statewide, CPAC determined that not all components of the guidelines could be implemented until a plan is in place to increase the state's resources. To date, CPAC has not been able to identify any state or federal funds to secure forensic medical examinations for non-acute child abuse cases. The local children's hospital has applied for a federal grant to secure the funding. Dr. Allan De Jong, a Task Force Member, provided a 30-minute workshop on the guidelines to approximately 100 participants at Protecting Delaware's Children: A Multidisciplinary Conference and Advanced Training Course for Child Welfare Professionals on April 26, 2017 (See Appendix H: Child Abuse and Neglect Investigative Tools). This was a combined workshop that also discussed the Common Elements of Child Torture and the Juvenile Trafficking Pre-Assessment Checklist.

Evaluation: Participants at Protecting Delaware's Children were asked to participate in a survey to evaluate their overall satisfaction with the conference and the individual workshop sessions. Fifteen respondents who attended the workshop submitted a survey response. The responses were as follows: 87% rated the workshop as excellent; 67% strongly agreed that the facilitators were well organized in their presentation of the course material; 60% strongly agreed the presenters demonstrated a thorough knowledge of the subject matter; and 53% strongly agreed that their knowledge and understanding of the subject matter increased. The conference and survey results will be discussed in further detail in section 6.

Need: To provide standardized best practice guidelines and ongoing comprehensive training to those who investigate, prosecute or otherwise respond to reports of child sexual abuse, death, and near death cases

Funding Required: CJA funds were used to pay for the rental of facilities, speaker fees and costs of meals and refreshments for Protecting Delaware's Children.

4. **Activity:** Develop Best Practices for Responding to Cases of Child Torture

Output: The Child Torture Committee was created by CPAC and CDRC at a joint meeting in May 2014 after child torture emerged as a recurring theme in systemic findings from the reviews of child deaths and near deaths due to abuse and neglect. Some issues identified in these child torture cases included a lack of cross-reporting, medical assessments for children and collateral contacts with professionals, and limited adherence to the interviewing protocol, safety assessment policy, and the MOU for the Multidisciplinary Response to Child Abuse and Neglect. The Committee began meeting in October 2014 to research and develop best practices to help professionals recognize and appropriately respond to cases of child torture. The Committee completed its work on April 18, 2016 and forwarded the checklist for Common Elements of Child Torture to the CAN Best Practices Workgroup for inclusion in the MOU for the Multidisciplinary Response to Child Abuse and Neglect.

Outcome: During this reporting period, Sgt. Reginald Laster, a representative from the New Castle County Police Department, provided a 30-minute workshop on the Common Elements of Child Torture to approximately 100 participants at Protecting Delaware's Children: A Multidisciplinary Conference and Advanced Training Course for Child Welfare Professionals on April 26, 2017 (See Appendix H: Child Abuse and Neglect Investigative Tools). This was a combined workshop that also discussed the Guidelines for the Child Abuse Medical Response and the Juvenile Trafficking Pre-Assessment Checklist.

Evaluation: Participants at Protecting Delaware's Children were asked to participate in a survey to evaluate their overall satisfaction with the conference and the individual workshop sessions. Fifteen respondents who attended the workshop submitted a survey response. The

responses were as follows: 87% rated the workshop as excellent; 67% strongly agreed that the facilitators were well organized in their presentation of the course material; 60% strongly agreed the presenters demonstrated a thorough knowledge of the subject matter; and 53% strongly agreed that their knowledge and understanding of the subject matter increased. The conference and survey results will be discussed in further detail in section 6.

Need: To provide standardized best practice guidelines and ongoing comprehensive training to those who investigate, prosecute or otherwise respond to reports of child sexual abuse, death, and near death cases.

Funding Required: CJA funds were used to pay for the rental of facilities, speaker fees and costs of meals and refreshments for Protecting Delaware's Children.

5. **Activity:** Response to Substance-Exposed Infants and Medically Fragile Children

Output: 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 deaths and near deaths due to abuse and neglect. During the reporting period, the Committee continued meeting and submitted an application for Substance Exposed Infant In-Depth Technical Assistance (SEI-IDTA) to the National Center on Substance Abuse and Child Welfare (NCSACW). In addition, the bill pertaining to substance exposed infants, which was introduced during the last legislative session was not successful due to the fiscal note attached. However, CPAC revised the bill, and it was re-introduced in April 2017. The bill was also renamed Aiden's Law in recognition of an infant, who was reviewed by the CAN Panel and died as a result of abuse in Delaware (See Appendix I: House Bill 140). This bill creates a new chapter 9A, "Infants with Prenatal Substance Exposure." As such, substance exposed infants are no longer in the "abuse of children" chapter of the Code. Per the recommendation of IDTA leaders, this bill identifies this population as "infants with prenatal substance exposure," instead of "substance exposed infants." In accordance with CAPTA language, this bill requires "notifications" to DFS, not "reports" as used for abuse or neglect cases. The bill clarifies that a "notification" to DFS under this section does not constitute a report of abuse or neglect. The bill adds new definitions for "infants with prenatal substance exposure," and "substance abuse." Since states have been granted flexibility in defining the terms and phrases in CAPTA and the Comprehensive Addiction and Recovery Act (CARA), the definition of "withdrawal symptoms" is the same as last year's bill. It includes the exception that mothers who are taking a prescription drug under the care of a doctor, and are in compliance with the directions for the prescription, and there are no other risk factors to the infant, are not to be reported to DFS. The bill allows DFS to refer a case to a Contracted Agency for services and development/monitoring of the plan of safe care. In accordance with CAPTA and CARA, the bill requires DFS to document the SEI data.

Outcome: In September 2016, CPAC was notified that its application for IDTA was approved. Delaware was one of 10 states that participated in the Policy Academy in February 2017. During the two-day Academy, representatives from Delaware worked with other states and national experts to develop Delaware's "State Action Plan" for SEIs and their families, and four goals were identified (See Appendix J: Delaware Action Plan). IDTA experts, Jill Gresham and Ken DeCerchio, will be conducting a site visit in Delaware on May 17 and 18, 2017. Additionally, on April 26, 2017, Judge Lynn Tepper, Florida's 6th Judicial Circuit, Pamela Jimenez RN, Christiana Care Health System, and Wendy M. Felts, APRN, St. Francis Healthcare presented a plenary session on the national and local perspective of responding to infants/toddlers and parents impacted by substance abuse to approximately 450 participants at Protecting Delaware's Children: A Multidisciplinary Conference and Advanced Training Course for Child Welfare Professionals.

Evaluation: Participants at Protecting Delaware's Children were asked to participate in a survey to evaluate their overall satisfaction with the conference and the individual workshop sessions. Ninety-eight respondents who attended the conference on April 26, 2017 submitted a survey response. Of the 77 participants who attended the plenary session, their responses were as follows: 65% rated the session as excellent or good; 95% strongly agreed or agreed that the facilitators were well organized in their presentation of the course material; 97% strongly agreed or agreed the presenters demonstrated a thorough knowledge of the subject matter; and 88% strongly agreed or agreed that their knowledge and understanding of the subject matter increased. The conference and survey results will be discussed in further detail in section 6.

Need: To develop policies and procedures to address the needs of infants born with and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure; or a Fetal Alcohol Spectrum Disorder.[4]

Funding Required: CJA funds were used to pay for the rental of facilities, speaker fees and costs of meals and refreshments for Protecting Delaware's Children.

6. **Activity:** Plan and Facilitate Protecting Delaware's Children: A Multidisciplinary Conference and Advanced Training Course for Child Welfare Professionals

   Output: CPAC partnered with multiple agencies to host Protecting Delaware's Children: A Multidisciplinary Conference and Advanced Training Course for Child Welfare Professionals on April 25-26, 2017 at the Chase Center in Wilmington, DE. The conference was geared towards law enforcement, prosecutors, judges, attorneys, case workers, therapists, educators, community providers and medical professionals who regularly respond to allegations of child abuse and neglect in Delaware. It featured twenty workshops from national and local experts

[4] 42 *U.S.C.* §5106(a)(b), as amended by the CAPTA Reauthorization Act of 2010 (P.L. 111-320).

who addressed multidisciplinary collaboration and various aspects of child abuse. The following workshops were offered related to CJA: Trends in Substance Abuse: Opiate Abuse; Sex Offenders: What Judges, Lawyers, Investigators and Child Advocates Should Know; Child Abuse & Neglect Investigative Tools; Learning to Listen…Defusing a Hostile Situation; Early Childhood Courts: A step beyond Community Collaboration & a Trauma-informed approach; New Trends in Substance Abuse: Cocaine, Alcohol, and other "legal" substances; Selection, Engagement and Seduction of Children and Adults by Child Molesters; Investigating Infant/Child Deaths: the Responsibilities of the First Responder; March 2017 Court Improvement Program Leading Practices Final Report; Social Networking: the Good, the Bad, the Ugly!; Human Trafficking, Sextortion, and Social Media; What Sex Offenders Can Teach Us About Interviewing; and Weighing Safety & Connection in Families Experiencing Domestic Violence. A one-day Advanced Training Course was also offered for MDT members involved in the investigation and prosecution of child abuse cases. First, participants were given a brief introduction to the MOU for the Multidisciplinary Response to Child Abuse and Neglect between the DSCYF, CAC, Alfred I. duPont Hospital for Children, DOJ, Delaware Police Departments, Division of Forensic Science, and Office of the Investigation Coordinator. In addition, national experts taught participants how to conduct sudden unexpected infant death investigations, which included visually recreating an infant death scene using a doll; explaining the reenactment to the caregiver; demonstrating the infant's positions; photographing the reenactment; and debriefing the family. Several doll re-enactment kits were distributed to law enforcement agencies and the Division of Forensic Science. The conference brochure is available on the CPAC/OCA website for additional information: http://courts.delaware.gov/childadvocate/docs/April2017PDCBrochure1.pdf

Outcome: 453 professionals attended the two-day conference. 112 professionals with direct responsibility for the investigation and prosecution of child abuse cases attended the advanced training course.

Evaluation: 112 respondents submitted an evaluation and the results revealed the following: 99% of respondents strongly agreed or agreed that the conference was well organized; 99% of respondents strongly agreed or agreed that the conference sessions were appropriate and informative; 95% of respondents strongly agreed or agreed that the workshops will help them perform their jobs more effectively; and 97% of respondents strongly agreed or agreed that the content was at an appropriate level for their background and experience.

18 of the 112 respondents also attended the advanced training course and the results revealed the following: 86% strongly agreed or agreed that they have a basic understanding of the revised MOU; 71% of respondents strongly agreed or agreed that their knowledge of sudden unexpected infant death investigations increased; 57% of respondents strongly agreed or agreed the facilitators demonstrated a thorough knowledge of the subject matter; and 79% of

respondents strongly agreed or agreed the facilitators were well organized in the presentation of the course material (See Appendix K: Protecting Delaware's Children Evaluation).

Need: To provide standardized best practice guidelines and ongoing comprehensive training to those who investigate, prosecute or otherwise respond to reports of child sexual abuse, death, and near death cases.

Funding Required: CJA funds were used to pay for the rental of facilities, speaker fees and costs of meals and refreshments for Protecting Delaware's Children.

7. **Activity:** Utilize Data to Inform System Improvements in the Investigation and Prosecution of Child Abuse Cases

   Output: CPAC has historically requested data from its Task Force members to measure Delaware's Child Protection System. However, there was no structure in place to uniformly present, analyze and interpret the data. In October 2011, CPAC approved the creation of the Data Utilization Committee and charged the Committee with developing dashboards for measuring Delaware's child protection system. In August 2015, the Family Court authorized the use of federal Court Improvement Program (CIP) funding to hire a contractual employee to support the collection and assessment of data by CPAC. The Data Analyst is housed at the OCA, and supports the work of CPAC and CIP. During the reporting period, the Data Analyst was responsible for performing the following activities: staffing the Data Utilization Committee; planning and conducting varied statistical studies on relevant issues that impact child well-being outcomes; working with stakeholders to collect already existing data related to child welfare measures; preparing the CPAC Dashboard; analyzing, interpreting and identifying child welfare data trends; and ensuring that the data received and presented by CPAC is in a format that is useful in the development of informed, and evidence based, policy. Additionally, the Data Utilization Committee continued to meet on a quarterly basis to review and analyze the following data dashboards: 1. Caseloads; 2. Processing of Child Abuse Cases; 3. Children in DSCYF Custody; 4. Permanency Outcomes; 5. Extended Jurisdiction; 6. Dual Status Youth; 7. Education Outcomes for Children in Foster Care; and 8. Re-Entry/Recurrence of Maltreatment (See Appendix L: CPAC Dashboard). At each CPAC meeting, the Chief Policy Advisor/CJA Coordinator or Data Analyst provided a quarterly report of the data and presented system wide child welfare trends. The Data Analyst has been transitioning the dashboards to an online platform to create interactive dashboards, which will feature data over a longer period. This online format will be unveiled on the CPAC/OCA website in the next reporting period.

   Outcome: In addition to the 10 charts on DFS caseloads, the Processing of Child Abuse section features 15 data points to assess the investigation and prosecution of child abuse cases in

Delaware. This data is provided by the DFS, Office of the Investigation Coordinator, CAC, DOJ Special Victims Unit, and CAN Panel.

Evaluation: At the quarterly Data Utilization Committee meetings, the Committee evaluates each data point in the CPAC Dashboard to determine its relevance and impact on outcomes for children. The trends are then reported at the CPAC meeting. During the February 2017 CPAC meeting, the Data Analyst reported the statewide caseload average for DFS investigation workers increased by 27% since the prior quarter. Similarly, the statewide caseload average for DFS treatment workers increased by 14% since the prior quarter, and as a result, the caseloads were above standard. In addition, the Data Analyst discussed the cases open by the Office of the Investigation Coordinator during the quarter. Of the 175 cases opened, 160 were sexual abuse, 9 were serious physical injury and 6 were death. The Office of the Investigation Coordinator's caseload increased from 347 to 407 cases since the 9/16 quarter. The Data Analyst also reviewed the CAC data. Overall, the number of cases received has been decreasing over the past two quarters. The decrease is most noticeable in the 12/16 quarter for intra-familial sexual abuse cases. As a result of the data, the Chair and Executive Director of CPAC wrote a letter to the Delaware General Assembly's Joint Finance Committee and included the Children's Advocacy Center, DOJ Special Victims Unit and Division of Family Services as its funding priorities.

Need: To develop dashboards for measuring Delaware's child protection system; to present the dashboards to the Task Force for regular review; and to use the dashboards to inform system improvement and CPAC initiatives.

Funding Required: None to Date.

8. **Activity:** Contract with a Training Coordinator

Output: The Training Coordinator was contracted by OCA, on behalf of CPAC, and worked an average of 36 hours a week, 52 weeks per year. During the reporting period, the Training Coordinator was responsible for the following: providing technical support to users on OCA's online training system; updating the mandatory reporting training for educators, general community and professional audiences, and medical providers; collaborating with representatives from the Department of Education and a local hospital to make the trainings available on their professional development system; utilizing available software to develop web-based mandatory reporting training programs; facilitating a train the trainer session to increase the number of trainers; providing onsite mandatory reporting training to educators and general professional audiences; maintaining the number of professionals trained; organizing and handling the registration and evaluation for Protecting Delaware's Children; and staffing the Abuse Intervention Committee and Training Committee.

Outcome: The Training Coordinator facilitated 46% of the onsite mandatory reporting trainings for educators and 15% of the onsite mandatory reporting trainings for general community and professional audiences during the 12-month period. Approximately, 429 professionals received training from the Training Coordinator.

Evaluation: 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.

Need: To facilitate and/or coordinate the CPAC approved trainings for professional audiences; expand on the use of web-based training; evaluate and enhance existing trainings; and maintain a tally of persons trained.

Funding Required: CJA funds were used to support the contractual position.

9. **Activity:** Train Professionals on the Recognition and Reporting of Child Abuse and Neglect

Output: The Mandatory Reporting Workgroup under the CPAC Training Committee updated its mandatory reporting training program for educators, general community and professional audiences and medical providers. Both onsite and web-based formats are available for each training program; all web-based training can be accessed through OCA's online training system at http://ocade.server.tracorp.com/. For public schools, the Department of Education's Blackboard course management system hosts the web-based training for educators. A train the trainer was facilitated by the Training Coordinator in August 2016 to increase the number of professionals trained to facilitate the mandatory reporting training in Delaware. Staff from the DSCYF, DOJ, CPAC/OCA, CASA, Office of Child Care Licensing, Office of the Investigation Coordinator and Domestic Violence Coordinating Council conducted several onsite training sessions for educators and general professional audiences.

Outcome: For the general training, approximately 7 onsite trainings were provided to 239 participants, and 297 participants completed the training online and submitted an evaluation. For the educator training, approximately 18 onsite trainings were provided to 862 participants, and 7,607 participants completed the web-based training through the Department of Education's Blackboard course management system and submitted an evaluation. In addition, 117 participants completed the web-based training on OCA's online training system. For the medical training, 4,613 participants completed the training online and submitted an evaluation.

Evaluation: For the online general training, 297 respondents submitted an evaluation and the results revealed the following: 93% of respondents correctly identified who is mandated to report child abuse or neglect in Delaware; 91% of respondents correctly identified where to

report suspicions of child abuse or neglect; 98% of respondents correctly identified the types of cases that must be reported to DFS; 98% of respondents correctly identified that failure to report may result in civil penalties and an investigation by the DOJ; and 98% of respondents correctly identified the person with the direct knowledge must make a report (See Appendix M: Online Training Evaluations for General Professionals).

For the online educator training, 7,607 respondents submitted an evaluation and the results revealed the following: 90% of respondents correctly identified who is mandated to report child abuse or neglect in Delaware; 93% of respondents correctly identified where to report suspicions of child abuse or neglect; 98% of respondents correctly identified the types of cases that must be reported to DFS; 98% of respondents correctly identified that failure to report may result in civil penalties and an investigation by the DOJ; and 99% of respondents correctly identified the person with the direct knowledge must make a report (See Appendix N: Online Training Evaluation for Educators). These responses improved from the prior reporting period.

For the online medical training, 4,613 respondents submitted an evaluation and the results revealed the following: 98% of respondents agreed the learning objectives were met; 98% of respondents agreed they are able to describe the reporting law and reporting procedure for Delaware; 98% of respondents agreed they recognize the relationship between physical and behavioral indicators and suspicion of child abuse and neglect; 98% of respondents agreed they are able to use minimal fact questions when indicators are observed and/or a disclosure is made; 98% of respondents agreed they know how to respond appropriately when children disclose allegations of abuse or neglect; 96% of respondents agreed they can identify what information to expect from DFS following a report of child abuse or neglect; 98% of respondents agreed they have acquired a basic understanding of the civil and criminal definitions in statute for the various types of child maltreatment; and 97% of respondents agreed they have a better understanding of the reporting obligations under the Medical Practice Act (See Appendix O: Online Training Evaluation for Medical Professionals).

Please note that the onsite evaluations for the general professional and educator trainings were not provided. Due to some transition by staff at DSCYF, the onsite training evaluations were not entered into Survey Monkey during this reporting period, and it was not brought to the attention of the Chief Policy Advisor/CJA Coordinator.

Need: To provide mandatory training regarding the statutory reporting obligations for all mandatory reporters, especially for Licensees under the Medical Practices Act.[5]

Funding Required: None to Date.

[5] Recommendation forwarded to CPAC from the Dean Ammons Report on the Earl Brian Bradley Case.

10. **Activity:** Develop, Evaluate, and Analyze In-Person and Web-Based Training Programs Using an Online Training System, Training Software, Surveys and Videography Services

    Output: The web-based mandatory reporting and the cross-education training programs are created using Adobe Captivate 8 software or videography services (professional or students). These training are made available on OCA's online training system, which is hosted by TraCorp. Surveys for both web-based and in-person trainings are created through Survey Monkey.

    Outcome: OCA's online training system has provided web-based training and resources to over 12,900 users since its inception in 2012.

    Need: To expand on the use of web-based training; evaluate and enhance existing trainings; and maintain a tally of persons trained.

    Funding Required: CJA funds were used to maintain the online training system, and the professional videographer was provided a nominal fee for his services.

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

    Output: The Chief Policy Officer/CJA Coordinator and Executive Director of CPAC attended the CJA Grantee Meeting on August 29-30, 2016. Chief Policy Officer/CJA Coordinator and Executive Director of CPAC also plan to attend the National Citizen Review Panel Conference on May 10-12, 2017 in Anchorage, AL.

    Outcome: Delaware was selected by the conference planning committee to present a workshop at the May 2017 National Citizen Review Panel Conference titled *From Review to Action: How Delaware has improved the State's child protection system through the review of individual cases.* Chief Policy Officer/CJA Coordinator, Executive Director of CPAC and Linda Shannon, Program Manager - Intake & Investigation at the Division of Family Services will give the presentation.

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

    Funding Required: CJA funds were used to cover travel and per diem expenses for the Chief Policy Advisor/CJA Coordinator and Executive Director of CPAC.

IV. Prior Year Budget Expenditures (May 1, 2016-April 30, 2017)

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 FFY14 and FFY15 funds were used during the reporting period. As such, partial budgets will be listed below for both federal fiscal years.

FFY14 (Grant Award $89,091) **May 1, 2016 - September 30, 2016**		**FFY15 (Grant Award $88,789)** **October 1, 2016 - April 30, 2017**	
Funding Activity	**Total**	**Funding Activity**	**Total**
Training Coordinator	$25,634.10	Training Coordinator	$20,050.20
CJA Grantee Meeting	$2,462.68	CJA Grantee Meeting/National Citizen Review Panel Conference	$1,924.20
Best Practices for Responding to Child Torture[6]	$6,017.26	Protecting Delaware's Children	$23,665.16
Online Training System, Surveys, Training Software & Videographer/Online Training Development	$3,166.00	MDT Scholarships	$1,486.99
		Online Training System, Surveys, Training Software & Videographer/Online Training Development	$2,362.00
Total FFY14 Funds	**$37,280.04**	**Total FFY15 Funds**	**$49,488.55**

[6] Outstanding invoices were received from the Delaware Presentation at 13th Hawaii International Training Summit. This activity was recorded in the Grant Application for FFY15 CJA Annual Progress Report and Grant Application.

V. Grant Application (May 1, 2017 - April 30, 2018)

A. Proposed Funding Activities ($88,978.00 - FFY16 Grant Award)

1. Training Coordinator

Description: The CJA grant will continue to provide for the services of one full time (36 hours a week, 52 weeks per year) Training Coordinator that will be located at OCA and supervised by the Chief Policy Advisor/CJA Coordinator. This position will be contracted by OCA and no benefits will be provided. The Training Coordinator will be responsible for providing administrative support to CPAC primarily for all child abuse intervention training activities related to the CJA grant.

Approaches: The Training Coordinator will provide technical support to users on OCA's online training system; update the mandatory reporting training for educators, general community and professional audiences, and medical professionals; utilize available software to develop web-based mandatory reporting training and other child abuse intervention training programs; facilitate a train the trainer session to provide trainers with an update on the changes to the mandatory reporting training curriculum; collaborate with other professionals and a professional videographer to develop additional web-based trainings; provide onsite mandatory reporting training to educators and general community and professional audiences; maintain data on the number of individuals trained; chair the Cross-Education Workgroup; and staff the Abuse Intervention Committee, Training Committee, and MDT Workgroup.

Budget: $48,378.00

Evaluation: The training evaluation results, through Survey Monkey or OCA's online training system, will be used to determine if the programs created by the Training Coordinator are effective or ineffective. Also, the Training Coordinator's contract is evaluated every 6 months by the Chief Policy Advisor/CJA Coordinator. At each meeting of the CPAC Abuse Intervention Committee, the Training Coordinator reports out on the last two quarter's accomplishments and activities.

Impact: Creation of a more uniform child abuse intervention curriculum, which ensures that professionals involved in the investigative, administrative and judicial handling of child abuse and neglect cases receive and have access to the same education on trending topics in child welfare.

2. MDT Training

Description: At least annually, regular training and demonstrative tools will be provided to investigators and prosecutors involved in the investigation and prosecution of such cases. Regular training must include developments in the law, as well as the latest advances in investigative and forensic techniques. The training will be targeted to the Division of Family Services, Office of the Investigation Coordinator, statewide law enforcement agencies, criminal/civil Deputy Attorneys General from the Department of Justice, Children's Advocacy Center forensic interviewers and clinicians, and related child welfare partners such as hospital based Sexual Assault Nurse Examiners.

Approaches: A one-day advanced training workshop titled *Sex Offenders: Responding to Crimes Against Children* will be offered in October 2017. Cory Jewell Jensen, MS, senior trainer for CBI Consulting will be facilitating the workshop. Ms. Jewell Jensen spent the last 35 years providing evaluation and treatment services to adult sex offenders and their families in Portland, Oregon. The workshop will be sponsored by CPAC, and the costs will include speaker fees, costs of meals and refreshments and rental of facilities.

In addition, a three-day training will be offered in April 2018. Delaware hopes to partner with the Gundersen National Child Protection Training Center again to offer a three-day version of the ChildFirst® Forensic Interviewing Protocol. The program was last offered in October 2015. The training included the core components of the ChildFirst® program with the exception of the forensic interview protocol. It featured three additional components that are important for first responders in Delaware: Minimal Facts or teaching first responders how to question children prior to the forensic interview at the Children's Advocacy Center; importance of the multidisciplinary team approach and teaching first responders about the Memorandum of Understanding; and the medical aspects of child sexual abuse and physical abuse. If the negotiations are not successful, the workgroup plans to develop its own curriculum. The workshop will be sponsored by CPAC, and the costs will include speaker fees, costs of meals and refreshments and rental of facilities.

Budget: $18,600.00

Evaluation: OCA's online training system or Survey Monkey will be used to evaluate the training program. The evaluations will ask training participants to rate whether they had an increase in knowledge based on the material presented.

Impact: Improve the MDT response in the investigation, prosecution and judicial handling of cases of child abuse and neglect, particularly child sexual abuse, death, and near death cases.

3. MDT Scholarships

Description: Scholarships will be 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.

Approaches: Scholarships will be offered to representatives Division of Family Services, Office of the Investigation Coordinator, statewide law enforcement agencies, criminal/civil Deputy Attorneys General from the Department of Justice, Children's Advocacy Center forensic interviewers and 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.

Budget: $11,000.00

Evaluation: OCA's online training system or Survey Monkey will be used to evaluate the national conferences. Representatives who attend the conference(s) will be asked to participate in a survey to evaluate their overall satisfaction with the conference and to determine if a team should be sent next year.

Impact: Provision of training opportunities to members of the multidisciplinary team who are involved in the investigation, prosecution and judicial handling of cases of child abuse and neglect, particularly child sexual abuse, death, and near death cases.

4. Online Training System, Surveys and Videography Services

Description: Survey Monkey and OCA's online training system will be utilized to collect, evaluate, and analyze CPAC's trainings and to ensure that all CPAC approved trainings are web-based. Additional web-based trainings, including the advanced training courses identified in the three-year assessment, will be developed using available resources.

Approaches: Subject matters experts will be used to develop the advanced training courses. Web-based trainings will be created using Adobe Captivate 8 software or videography services (professional or students). The trainings will be made available on OCA's online training system, which is hosted by TraCorp. All training evaluations will be maintained through Survey Monkey.

Budget: $6,000.00

Evaluation: 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.

Impact: Provision of training opportunities to members of the multidisciplinary team who are involved in the investigation, prosecution and judicial handling of cases of child abuse and neglect, particularly child sexual abuse, death, and near death cases.

5. CJA Grantee Meeting & CRP Conference

Description: Each year, the Children's Bureau convenes the CJA Grantee Meeting, and the CJA Coordinator and Task Force Chairperson are required to participate in one Federally initiated CJA meeting each year that the grant is in effect. Similarly, attendance at the National Citizen Review Panel Conference is necessary due to CPAC's role as the Citizen Review Panel.

Approaches: The Chief Policy Advisor/CJA Coordinator and Executive Director of CPAC attend both conferences annually. Delaware was selected to present a workshop at the May 2017 National Citizen Review Panel Conference titled *From Review to Action: How Delaware has improved the State's child protection system through the review of individual cases.* Chief Policy Officer/CJA Coordinator, Executive Director of CPAC and Linda Shannon, Program Manager - Intake & Investigation at the Division of Family Services will give the presentation.

Budget: $5,000.00

Evaluation: Not applicable.

Impact: Due to the cross over in the activities, the conferences help to develop a distinct path forward in the dual role as the CRP and CJA Task Force, and the Task Force representatives have a better understanding of the obligations under each and where the obligations intersect. The Task Force representatives have a better understanding of the obligations under the CJA grant and an opportunity to network with other states.

B. Awareness of CFSP and APSR

As a strategic planning activity and to align the CFSP with current concerns and the CFSR PIP, the Division of Family Services held an annual stakeholder meeting to review progress and gather stakeholder input on performance and the coming year's strategic planning. The meeting was held March 30, 2017; 77 stakeholders were invited, including the Court Improvement Program Coordinator, Family Court Administration and Chief of the Nanticoke

Indian Association. Forty-five representatives of the child welfare community attended including representatives from community service agencies, the Victim Witness Coordinator from the U.S. Attorney's Office, a foster parent, advocates, attorneys, and Region III staff from the Administration for Children and Families. The Chief Policy Advisor/CJA Coordinator and Court Improvement Program Coordinator were in attendance. The Director, Deputy Director, supervisors, regional managers and program managers from the Division of Family Services also participated. The agenda included a review of the agency's mission and vision, guiding principles, program updates and performance measures. The group gave their input on child welfare strengths and areas of concern. Comments for edits to the CFSP-2017 edition were accepted until April 30, 2017. 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 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

CPAC will continue to make an effort to review the goals and objectives of the CFSP/APSR to identify which are related to the final recommendations listed in the CJA Three-Year Assessment. There appears to be some alignment with the goals and objectives of the CFSP/APSR and the Action Plan that CPAC developed for 2016-2017; however, there does not seem to be as many parallels with the recommendations listed in the three-year assessment from January 2015.

C. Anti-Trafficking Efforts

On June 30, 2014, the Governor signed legislation creating the Human Trafficking Coordinating Council under the DOJ to develop a comprehensive anti-trafficking plan for Delaware. The Council's Juvenile Subcommittee was charged with developing a screening tool to help MDT members identify potential victims of juvenile trafficking. In March 2017, the Subcommittee approved the Juvenile Trafficking Pre-Assessment Checklist. It was then forwarded to the CPAC CAN Best Practices Workgroup for inclusion in the MOU for the Multidisciplinary Response to Child Abuse and Neglect. The checklist was added as part of the Juvenile Trafficking Protocol (See Appendix B: MOU for the Multidisciplinary Response to Child Abuse and Neglect). In addition, Commissioner Loretta Young, Chair of the Juvenile Subcommittee, provided a 30-minute workshop on the Juvenile Trafficking Pre-Assessment Checklist to approximately 100 participants at Protecting Delaware's Children: A Multidisciplinary Conference and Advanced Training Course for Child Welfare Professionals on April 26, 2017. A county-based training program is also being planned and developed by the CPAC CAN Best Practices Workgroup. It will include training on the Juvenile Trafficking Protocol and Juvenile Trafficking Pre-Assessment Checklist.

VI. Certification of Lobbying Form

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

VII. Appendices

State of Delaware Child Protection Accountability Commission
Quarterly Meeting Minutes

WEDNESDAY, MAY 11, 2016
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:
C. Malcolm Cochran, IV, Esq., Chair	Child Protection Community 16 Del. C. § 912 (a)(16)
The Honorable Carla Benson Green	Secretary, Children's Department 16 Del. C. § 912(a)(1)
Shirley Roberts	Dir., Div. of Family Services 16 Del. C. § 912(a)(2)
LaKresha Roberts, Esq.	Two Representatives from the Attorney General's Office 16 Del. C. § 912 (a)(3)
The Honorable Michael K. Newell	Family Court 16 Del. C. § 912(a)(4)
The Honorable Joelle Hitch	Family Court 16 Del. C. § 912(a)(4)
The Honorable Margaret Rose Henry	Senate 16 Del. C. § 912(a)(6)
Susan Haberstroh	Designee for Secretary of the Department of Education 16 Del. C. § 912(a)(8)
Corporal Adrienne Owen	Designee for Superintendent of the Delaware State Police 16 Del. C. § 912 (a)(11)
Dr. Garrett Colmorgen	Chair of the Child Death Review Commission 16 Del. C. § 912(a)(12)
Jennifer Donahue, Esq.	Investigation Coordinator 16 Del. C. § 912(a)(13)
Nicole Byers	Young Adult 16 Del. C. § 912(a)(14)
Mary Lou Edgar	At-large Member - Interagency Committee on Adoption 16 Del. C. § 912(a)(16)
Dr. Allan De Jong	At-large Member - Medical Community 16 Del. C. § 912(a)(16)
Captain Robert McLucas	At-large Member - Law Enforcement 16 Del. C. § 912 (a)(16)
Ellen Levin	At-large Member - Child Protection Community 16 Del. C. § 912 (a)(16)
Janice Mink	At-large Member - Child Protection Community 16 Del. C. § 912 (a)(16)

Staff:
Tania Culley, Esq., Executive Director
Rosalie Morales
Amanda Sipple

Members of the Public:

Shana Cipparone	Mark Hudson, Esq.	Julie Leusner	Cara Sawyer, Esq.
Jennifer Davis	Carrie Hyla	Susan Murray	Ashlee Starratt
Kelly Ensslin, Esq.	Caroline Jones	Rachael Neff	Gwen Stubbolo
Elizabeth Fillingame, Esq.	Leba Kaufmann, Esq.	Leslie Newman	Carolyn Walker
The Hon. Steven Godowsky	Sgt. Reginald Laster	Trenee Parker	

I. CHAIRPERSON'S WELCOME

Mike Cochran, Esq. opened the meeting and welcomed the attendees.

II. APPROVAL OF MINUTES

The minutes from February 10, 2016 were approved.

III. EXECUTIVE DIRECTOR'S REPORT

Mr. Cochran acknowledged Mary Lou Edgar for her service as a CPAC Commissioner. Ms. Edgar will be retiring from A Better Chance for Our Children, and her successor will start in July.

Tania Culley shared that OCA is fully staffed. Mark Hudson, Esq. joined the office as the Sussex County Deputy Child Advocate. The CAN Panel has been fully integrated, and the Investigation Coordinator's Office recently moved over to OCA.

Donations have also increased. OCA has received several donations on behalf of Judge Cooper and Judge Chapman, which support youth in foster care. The New Castle County Family Court Mural Project is scheduled for the week of June 27.

IV. CPAC EDUCATION COMMITTEE AND DEMONSTRATION PROJECT PRESENTATIONS

CPAC Commissioner, Susan Haberstroh, and Eliza Hirst, Esq., OCA Deputy Child Advocate, presented education data for youth in foster care. The co-presenters highlighted that youth in foster care with severe trauma do not perform well in school. In fact, there is a 30% disparity between youth in foster care and the general population in all aspects related to education. Further, every time a youth moves schools, he or she has about a 6-month lag in education. For more information, please refer to the PowerPoint Presentation titled Delaware Education Data for Youth in Foster Care.

In addition, Ms. Haberstroh and Ms. Hirst presented information on the current CPAC Education Committee initiatives. The Comprehensive Education Report, Education Court Report, legislative initiatives, and practical tools, such as FAQs and the New Student Orientation Form, were discussed. The co-presenters also mentioned the Every Student Succeeds Act, which reauthorizes the Elementary and Secondary Education Act of 1965. This Act requires states to publish data on the educational success of youth in foster care. The Committee plans to review the federal language and make policy changes as needed. For more information, please refer to the PowerPoint Presentation titled CPAC Education Committee Initiatives.

V. 10th ANNIVERSARY FOR CPAC CHAIR

Representative Melanie George Smith gave a commemorative speech and presented Mr. Cochran with a House of Representatives Tribute for his 10 years of service as the CPAC Chair. In addition, several CPAC Commissioners offered remarks about Mr. Cochran's impact on the child welfare community. In addition to remarks, Ms. Culley presented Mr. Cochran with a service award.

VI. DOE PRESENTATION

Dr. Steven Godowsky, Secretary of the Department of Education, gave a presentation highlighting public education in Delaware. He discussed the early learning programs, K-12 student success, world language immersion, college-level coursework, college access, career and technical education, effective educators, and school supports. For more information, please refer to the PowerPoint Presentation titled Education in Delaware: Highlights.

VII. INVESTIGATION COORDINATOR'S REPORT

The Commission received a presentation on the Investigation Coordinator's (IC) Quarterly Data Report from Jennifer Donahue, Esq. During the third quarter, 299 cases were opened and 90% of the cases were sexual abuse. In the same quarter, 1,017 cases were closed. At the end of the quarter, the IC had 332 open cases (291 sexual abuse cases, 27 serious physical injury cases, and 14 deaths). In addition to the quarterly overview, Ms. Donahue discussed specific data points for death, serious physical injury and sexual abuse cases, including child and perpetrator profiles, civil findings and criminal findings. Ms. Donahue noted that 64% of sexual abuse cases were not going to prosecution, and in 35 of the closed cases, the criminal investigation had been open for more than two years. At the Commission's direction, Ms. Donahue agreed to address these cases with the individual law enforcement agencies. For additional information, please refer to the PowerPoint Presentation titled Investigation Coordinator Quarterly Report.

VIII. CPAC DASHBOARD

Rosalie Morales gave a presentation on the quarterly child welfare trends identified by the CPAC Data Utilization Committee. Ms. Morales reported the statewide caseload average for investigations has been consistently over the statutory cap of 11 cases for the last year. At the end of March, the average caseload was 15.7, and 78% of fully functioning workers were over standard. The Committee noted that the average investigation caseload at University Plaza was 18.3 in the same period, and 85% of workers were over standard. In the last year, the statewide average for treatment has been at or below the standard, which is 18. In addition, the Committee noted an increasing number of DFS hotline reports in the past few quarters. The number of screened in cases has also increased.

With regards to forensic interviews at the CAC, children, ages 6 and 7, were the most prevalent ages interviewed, and there was a drop-off after age 11 for forensic interviews involving teens.

For children entering DSCYF Custody, the Committee found that the number of children entering custody has been increasing over the past few quarters. This is particularly evident for the 0-4 and 13-17 age groups. In addition, more youth were exiting to guardianship/permanency guardianship in the 3/16 quarter than in the 6/15 quarter. There was a 26% increase in reunifications since 6/15, and there was a decrease in adoptions from the last quarter (12/15). It was noteworthy that there were no children between 11 and 13 with a permanency plan of APPLA. However, there were 2 youth between 14 and 15, which is a violation of federal law and could impact IV-E funding.

Lastly, for children who experienced repeat maltreatment in the last 6 months, the Committee found there was a slight decrease in re-entry rate, but higher than it was in 6/15 quarter. For additional information, please refer to the PowerPoint Presentation titled Data Utilization Committee: Dashboard Presentation.

IX. DSCYF PRESENTATION IN RESPONSE TO CAN FINDINGS

The Commission received a presentation on the DSCYF response to the CAN Panel findings from the Honorable Carla Benson-Green. Secretary Benson-Green highlighted the actions taken by DFS to make system improvements in the following areas: safety plans, unresolved risk and appropriate screening of DFS hotline reports. For additional information, please refer to the PowerPoint Presentation titled CAN Panel Findings: DSCYF Response.

X. CHILD ABUSE AND NEGLECT DEATH/NEAR DEATH REVIEWS

a. CAN CASELOADS REPORT

Ms. Culley reported that the CAN Panel reviewed 14 cases over the last quarter. After today only 37 cases remain open with 18 cases pending prosecution translating to a current workload of 19 cases to be reviewed (10 initials and 9 finals).

b. CAN FINDINGS/DETAILS/JOINT ACTION PLAN

Janice Mink reported on the 90 findings from the most recent CAN Panel reviews. The Commission reviewed the proposed letter to the Governor on the work of the CAN Panel. A motion was made by Dr. Colmorgen and seconded by Judge Hitch to approve the letter, findings summary and findings detail. All voted in favor except for Mr. Cochran who abstained.

Please refer to the letter, findings summary and findings detail for additional information.

XI. CPAC COMMITTEE REPORTS

The CPAC Committee reports will be presented at the Annual CPAC Legislative Meeting on May 25, 2016.

XII. 2016 MEETING DATES

- May 25, 2016 - Annual CPAC Legislative Meeting
- August 10, 2016
- September 25, 2016 - Annual Retreat with CDRC*
- November 9, 2016

All meetings will take place from 9:00 a.m. – 12:00 p.m. at the New Castle County Courthouse in the 12th Floor Conference Room

*Annual Retreat with CDRC will be held at Troop 2, 100 LaGrange Avenue Newark, DE 19701

XIII. PUBLIC COMMENT AND ADJOURNMENT

No public comment.

State of Delaware Child Protection Accountability Commission
Annual Legislative Meeting Minutes

WEDNESDAY, MAY 25, 2016
10:00 AM – 11:30 AM – New Castle County Courthouse
500 King Street, 12th Floor, Wilmington, Delaware

Those in Attendance:

Members of the Commission:	**Statutory Role:**
C. Malcolm Cochran, IV, Esq., Chair	Child Protection Community 16 Del. C. § 912 (a)(16)
LaKresha Roberts, Esq.	Two Representatives from the Attorney General's Office 16 Del. C. § 912 (a)(3)
The Honorable Michael K. Newell	Family Court 16 Del. C. § 912(a)(4)
The Honorable Joelle Hitch	Family Court 16 Del. C. § 912(a)(4)
The Honorable Margaret Rose Henry	Senate 16 Del. C. § 912(a)(6)
Susan Haberstroh	Designee for Secretary of the Department of Education 16 Del. C. § 912(a)(8)
Susan Cycyk	Director of Division of Prevention and Behavioral Health Services 16 Del. C. § 912(a)(9)
Dr. Garrett Colmorgen	Chair of the Child Death Review Commission 16 Del. C. § 912(a)(12)
Jennifer Donahue, Esq.	Investigation Coordinator 16 Del. C. § 912(a)(13)
Nicole Byers	Young Adult 16 Del. C. § 912(a)(14)
Kathryn Lunger, Esq.	Public Defender's Office 16 Del. C. § 912(a)(15)
Dr. Allan De Jong	At-large Member - Medical Community 16 Del. C. § 912(a)(16)
Captain Robert McLucas	At-large Member - Law Enforcement 16 Del. C. § 912 (a)(16)
Randall Williams	At-large Member - Child Protection Community 16 Del. C. § 912 (a)(16)
Janice Mink	At-large Member - Child Protection Community 16 Del. C. § 912 (a)(16)

Staff:
Tania Culley, Esq., Executive Director
Amanda Sipple

Members of the Public:
Addie Asay, Esq.
Karen DeRasmo
Leslie Newman
Cara Sawyer, Esq.

I. CHAIR WELCOME AND INTRODUCTIONS

Mike Cochran, Esq. opened the meeting and welcomed the attendees.

II. REPORT OF THE CPAC LEGISLATIVE COMMITTEE

The Commission reviewed the packet of proposed legislation prepared by the CPAC Legislative Committee to determine which bills within CPAC's purview it would support, oppose or take no position.

a. House Bill 240

A motion was made by Janice Mink to support House Bill 240 and seconded by Randy Williams. All voted in favor except that Susan Haberstroh abstained. The motion carried.

b. House Bill 265

A motion was made by Ms. Mink to take no position on House Bill 265 and seconded by Kathryn Lunger. All voted in favor. The motion carried.

c. House Bill 310

A motion was made by Mr. Cochran to oppose the current bill as written but to work with the bill sponsors to make changes. The motion was seconded by Ms. Lunger, Esquire and all voted in favor except that Chief Judge Newell and Judge Hitch abstained. The motion carried.

d. House Bill 311

A motion was made by Ms. Mink to support House Bill 311 and seconded by Dr. Colmorgen. All voted in favor. The motion carried.

e. House Bill 388

A motion was made by Dr. Colmorgen to support House Bill 388 and seconded by Ms. Mink. All voted in favor except that LaKresha Roberts and Ms. Lunger abstained. The motion carried.

f. Senate Bill 55

A motion was made by Dr. Colmorgen to support Senate Bill 55 and seconded by Ms. Mink. All voted in favor. The motion carried.

g. Senate Bill 188

A motion was made by Mr. Cochran to support Senate Bill 188 and seconded by Mr. Williams. All voted in favor. The motion carried.

h. Senate Bill 207

A motion was made by Mr. Cochran to support Senate Bill 207 and seconded by Ms. Mink. All voted in favor. The motion carried.

i. Senate Bill 213

A motion was made by Mr. Cochran to defer CPAC's position to the CPAC Legislative Committee after amendments are completed. The motion was seconded by Jen Donahue and all voted in favor. The motion carried.

j. Senate Bill 239

A motion was made by Dr. Colmorgen to defer CPAC's position to the CPAC Legislative Committee after amendments are completed. The motion was seconded by Dr. De Jong and all voted in favor. The motion carried.

k. Senate Bill 241

A motion was made by Dr. Colmorgen to take no position on Senate Bill 241 and seconded by Ms. Donahue. All voted in favor except Chief Judge Newell and Judge Hitch abstained. The motion carried.

l. Senate Bill 247

A motion was made by Dr. Colmorgen to support Senate Bill 247 and adopt the bill as a CPAC bill. Mr. Williams seconded the motion. All voted in favor and the motion carried. Staff will communicate to the sponsors that CPAC adopted this bill as it resulted from CPAC committee work.

m. Senate Bill 251

A motion was made by Dr. Colmorgen to oppose House Bill 251 and seconded by Ms. Donahue. All voted in favor and the motion carried.

III. COMMITTEE REPORTS

a. Report of the Medically Fragile/ Substance Exposed Infants Committee

Ms. Donahue discussed the progress of House Bill 319. At this time, partners have agreed to exclude legal drugs in the reporting requirement, as long as medical providers confirm compliance by the mother in a treatment program.

Additionally, Delaware may be chosen to receive In-Depth Technical Assistance for Substance-Exposed Infants. If accepted the assistance will span 18 – 24 months and provide substantial national support and expertise. A motion was made by Dr. Colmorgen and seconded by Nicole Byers to submit the application on behalf of CPAC upon approval of the application by the SEI Committee. All voted in favor and the motion carried. Ms. Donahue will provide updates regarding the application process as they become available.

b. Report of the Permanency for Adolescents Committee – Approval of the Financial Resources Handout

Ms. Culley provided an overview and requested the Commission adopt the Resources for Guardianship and Kinship Guide as a CPAC Document and allow for the guide to be distributed. A motion was made by Ms. Donahue to adopt the guide and approve distribution and was seconded by Ms. Byers. All voted in favor and the motion carried.

c. Report of the Child Torture Committee – Request for Dissolution

A motion was made to approve the dissolution of the Child Torture Committee. All voted in favor and the motion carried.

IV. 2016 MEETING DATES

August 10, 2016
September 25, 2016 Annual Retreat with CDRC*
November 9, 2016

All meetings will take place from 9:00 a.m. – 12:00 p.m. at the New Castle County Courthouse in the 12th Floor Conference Room

*Annual Retreat with CDRC will be held at Troop 2, 100 La Grange Avenue Newark, DE 19701

V. PUBLIC COMMENT AND ADJOURNMENT

No public comment.

State of Delaware Child Protection Accountability Commission
Quarterly Meeting Minutes

WEDNESDAY, AUGUST 10, 2016
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:**
Shirley Roberts	Dir., Div. of Family Services 16 Del. C. § 912(a)(2)
LaKresha Roberts, Esq.	Two Representatives from the Attorney General's Office 16 Del. C. § 912 (a)(3)
The Honorable Joelle Hitch	Family Court 16 Del. C. § 912(a)(4)
Susan Haberstroh	Designee for Secretary of the Department of Education 16 Del. C. § 912(a)(8)
Corporal Adrienne Owen	Designee for Superintendent of the Delaware State Police 16 Del. C. § 912 (a)(11)
Dr. Garrett Colmorgen	Chair of the Child Death Review Commission 16 Del. C. § 912(a)(12)
Jennifer Donahue, Esq.	Investigation Coordinator 16 Del. C. § 912(a)(13)
Nicole Byers	Young Adult 16 Del. C. § 912(a)(14)
Mary Lou Edgar	At-large Member - Interagency Committee on Adoption 16 Del. C. § 912(a)(16)
Dr. Allan De Jong	At-large Member - Medical Community 16 Del. C. § 912(a)(16)
Sgt. Reginald Laster	At-large Member - Law Enforcement 16 Del. C. § 912 (a)(16)
Ellen Levin	At-large Member - Child Protection Community 16 Del. C. § 912 (a)(16)
Randall Williams	At-large Member - Child Protection Community 16 Del. C. § 912 (a)(16)
Janice Mink	At-large Member - Child Protection Community 16 Del. C. § 912 (a)(16)

Staff:			
Tania Culley, Esq., Executive Director			
Rosalie Morales			
Amanda Sipple			
Members of the Public:			
Dr. Stephanie Deutsch	Susan Murray	Gwen Stubbolo	
Kelly Ensslin, Esq.	Rachael Neff	Ed Woomer	
Meg Garey	Leslie Newman	Steven Yeatman	
Carrie Hyla	Trenee Parker		
Caroline Jones	Meredith Seitz		
Marianne Kenville Moore	Ashlee Starratt		

I. CHAIRPERSON'S WELCOME AND INTRODUCTIONS

Janice Mink opened the meeting and welcomed the attendees.

Mary Lou Edgar addressed the Commission regarding her years of service and upcoming retirement. She has been serving the Commission since 1998. Her successor at A Better Chance for Children, Meg Garey, was introduced. Ms. Edgar shared some important words of wisdom including remembering that behind the numbers are children and reminding commissioners to have hope and laughter.

II. APPROVAL OF MINUTES

The minutes from May 11, 2016 were approved with minor changes.

The minutes from May 25, 2016 were approved with minor changes.

III. EXECUTIVE DIRECTOR'S REPORT

Tania Culley, Esq. shared that the part-time Sussex position is again vacant as a result of the person receiving full time employment. The fourth resignation in that position during the past three years due to it being part-time. The Investigation Coordinator's Office has become fully integrated into OCA. Two new contractors have began work under the Casey Family Programs (CFP) grant. Senate Bill 188 is awaiting signature and transfers the Court Appointed Special Advocate (CASA) program to OCA. The bill has a six-month delay. Annual reports are expected to be available in November.

Ms. Culley provided a legislative report to the Commission. House Bill 211 and Senate Bills 55, 188, 198, 207, 213, 216, and 247 are awaiting signature. House Bill 388 and Senate Bill 241 were signed into law. House Bills 240, 265, 310, 311, 319 and 405 and Senate Bills 239 and 251 did not pass. Ms. Mink requested that Commissioners work together to ensure the legislation on substance exposed infants is a priority next legislative session.

IV. INVESTIGATION COORDINATOR'S REPORT

Jennifer Donahue, Esq. reported that Delaware's application for In-Depth Technical Assistance for Substance Exposed Infants (SEI IDTA) was verbally accepted. The technical assistance will be provided over a two- year period, addressing policies and procedures in Delaware for substance exposed infants.

The Commission received a presentation on the Investigation Coordinator's (IC) Quarterly Data Report from Ms. Donahue. At the end of the quarter 250 cases were open with IC. Of those 250 cases, 14 are child deaths, 24 are serious physical injury cases, and 212 are sexual abuse cases. In addition to the quarterly overview, Ms. Donahue discussed specific data points for death, serious physical injury and sexual abuse cases, including child and perpetrator profiles, civil findings and criminal findings. At the Commission's direction, Ms. Donahue addressed cases open for more than one year with specific law enforcement agencies. The outcome of the multi-disciplinary collaboration was the closure of several outstanding cases. For additional information, please refer to the PowerPoint Presentation titled Investigation Coordinator Quarterly Report.

It was requested that the IC provide more detail as to why the DFS investigations were unsubstantiated at the next Commission meeting.

V. CPAC DASHBOARD

Rosalie Morales gave a presentation on the quarterly child welfare trends identified by the CPAC Data Utilization Committee. Ms. Morales reported the statewide caseload average for investigations continues to be well over the statutory cap of 11, currently at 16.6. Investigation caseloads have been over standard for more than a year. In addition, 74% of statewide fully functioning workers were over standard. The

committee noted that the average investigation caseload at University Plaza increased again to 19.3 which puts 76% of workers over standard. During fiscal year 2016, the statewide average for treatment has been at or below the standard, which is 18. In addition, the Committee noted an increase in number of DFS hotline reports and screened in cases from the previous quarter. Regarding forensic interviews at the CAC, the number of extra-familial sexual cases has increased over the fiscal year. Also, notable is the high percentage of referrals received by the CAC in Kent County. Thirty-four percent of the total referrals for the state came from Kent County nearly equal with the number of referrals by New Castle County agencies despite the higher population in New Castle County. Children ages 0 – 4 continue to be the largest population entering DSCYF custody, while the population of adolescent entries has decreased significantly this quarter. During the fourth quarter there was a significant increase in adoptions, however reunification with a parent was the highest occurring permanency outcome for youth exiting foster care. OCA continued to report that more than 50% of the population of children represented by OCA have juvenile justice involvement. OCA was asked to review and provide detail at the committee level regarding the juvenile justice involvement of dual status youth.

VI. COMMISSIONER REPORTS

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

Shirley Roberts reported on the Division of Family Services (DFS) initiative to decrease out of state placements as well as improve permanency outcomes for youth who are at risk of being placed or currently placed in an out of state placement. Caseloads have continued to increase. The continuous increase of caseloads has placed a strain on the workforce and is in part responsible for the increased employee turn-over rate of 11%. In part due to CPAC's advocacy, 27 state FTE positions were reallocated to DFS from other state agencies. Representative Melanie George Smith, worked tirelessly to get these statutorily required positions appropriated to DFS. Ms. Mink suggested that now that a resolution has been provided to improve the investigation caseloads, the Commissioners should review DFS treatment caseload standards at the Joint Retreat in September.

B. DEPARTMENT OF JUSTICE

LaKresha Roberts, Esq. reported that the Department of Justice has created a Special Victims Unit. Led by Josette Manning, Esq., an important task of this new unit will be to create statewide policies and procedures for prosecuting crimes against children and sex crimes against children and adults. A unit is expected be placed in each county.

C. LAW ENFORCEMENT

Sgt. Reginald Laster reported the New Castle County Police Department has seen an increase in criminal cases.

D. OFFICE OF DEFENSE SERVICES

No report was provided.

VII. CHILD ABUSE AND NEGLECT DEATH/NEAR DEATH REVIEWS

A. CAN CASELOADS REPORT/ ADMINISTRATIVE UPDATE

Ms. Culley reported that there are 46 CAN cases open. Of those cases, 18 are in the initial stage and 28 are in the final stage. Sixteen of the cases in the final stage are pending prosecution. None of the open cases are more than a year old. The CAN panel has been invited to participate in the Joint Retreat. The Child Abuse and Neglect Panel/Steering Committee Policy and Procedures have been completed. A motion was made by Dr. Colmorgen and seconded by Judge Hitch to approve the document for use as a CPAC document. All voted in favor. The motion carried.

B. CAN FINDINGS/DETAILS/JOINT ACTION PLAN

Ms. Mink reported on the 31 findings from the most recent CAN Panel reviews. The Commission reviewed the proposed letter to the Governor on the work of the CAN Panel. A motion was made by Dr. Colmorgen and seconded by Dr. De Jong to approve the findings summary and findings detail. All voted in favor. The motion carried. Please refer to the findings summary and findings detail for additional information.

C. LETTER TO THE GOVERNOR

Ms. Mink reviewed the letter to the Governor. A motion was made by Dr. Colmorgen and seconded by Judge Hitch to approve the letter to the Governor. All voted in favor. The motion carried.

VIII. DISCUSSION OF JOINT RETREAT FORMAT

Ms. Culley led discussion regarding the format of the upcoming joint retreat. Commission recommended that the retreat provide time for large and small group work. In addition, legislative and child abuse and neglect prevention opportunities should be considered. Ms. Culley stated that time will be provided for small and large group work.

IX. CPAC COMMITTEE REPORTS

A. CHILD ABUSE MEDICAL RESPONSE COMMITTEE

Randy Williams reported that the Delaware Multidisciplinary Team Guidelines for Child Abuse Medical Response have been approved by the Committee. Mr. Williams submitted a Memo to the Commission summarizing the work of the Committee and advising the Commissioners that there is a lack of medical resources in Kent and Sussex Counties. The Committee recommended that CPAC partner with Nemours/A.I. duPont Hospital for Children to develop a strategy to secure resources. A motion was made by Dr. Colmorgen and seconded by Nicole Byers to endorse the guidelines and establish resources in Kent and Sussex. The Committee requested approval to disband and to task the CPAC Training Committee with creating training on the guidelines. A motion was made by Ms.

Donahue and seconded by Ms. Roberts. All voted in favor. The motion carried.

B. MEDICALLY FRAGILE/ SUBSTANCE EXPOSED INFANTS

No additional report necessary.

C. LEGISLATIVE

No additional report necessary.

X. 2016 MEETING DATES

- August 10, 2016
- September 15, 2016 - Annual Retreat with CDRC*
- November 9, 2016

All meetings will take place from 9:00 a.m. – 12:00 p.m. at the New Castle County Courthouse in the 12th Floor Conference Room

*Annual Retreat with CDRC will be held at Troop 2, 100 LaGrange Avenue Newark, DE 19701

XI. PUBLIC COMMENT AND ADJOURNMENT

No public comment.

State of Delaware Child Protection Accountability Commission
Quarterly Meeting Minutes

WEDNESDAY, NOVEMBER 9, 2016
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. § 912(a)(16)
The Hon. Carla Benson-Green	Secretary of Services for Children, Youth and Their Families 16 Del. C. §912(a)(1)
Shirley Roberts	Dir., Div. of Family Services 16 Del. C. § 912(a)(2)
Susan Cycyk	Dir., Div. of Prevention of Behavioral Health Services 16 Del. C. § 912(a)(9)
Maureen Monagle	Chair of the Domestic Violence Coordinating Council 16 Del. C. § 912(a)(10)
LaKresha Roberts, Esq.	Two Representatives from the Attorney General's Office 16 Del. C. § 912 (a)(3)
The Honorable Joelle Hitch	Family Court 16 Del. C. § 912(a)(4)
Neal Tash	Chair of the Child Placement Review Board
Susan Haberstroh	Designee for Secretary of the Department of Education 16 Del. C. § 912(a)(8)
Corporal Adrienne Owen	Designee for Superintendent of the Delaware State Police 16 Del. C. § 912 (a)(11)
Dr. Garrett Colmorgen	Chair of the Child Death Review Commission 16 Del. C. § 912(a)(12)
Jennifer Donahue, Esq.	Investigation Coordinator 16 Del. C. § 912(a)(13)
Nicole Magnusson	Young Adult 16 Del. C. § 912(a)(14)
Kathryn Lunger, Esq.	One Representative from the Public Defender's Office 16 Del. C. §912(a)(15)
Dr. Allan De Jong	At-large Member - Medical Community 16 Del. C. § 912(a)(16)
Ellen Levin	At-large Member - Child Protection Community 16 Del. C. § 912 (a)(16)
Janice Mink	At-large Member - Child Protection Community 16 Del. C. § 912 (a)(16)

Staff:
Tania Culley, Esq., Executive Director
Rosalie Morales
Amanda Sipple

Members of the Public:

Meg Garey	Leslie Newman	Ashlee Starratt
Carrie Hyla	Trenee Parker	Gwen Stubbolo
Susan Murray	Meredith Seitz	Ellie Torres, Esq.

I. CHAIRPERSON'S WELCOME AND INTRODUCTIONS

Ginger Ward opened the meeting and welcomed the attendees.

II. APPROVAL OF MINUTES

The minutes from August 10, 2016 were approved pending minor changes.

III. EXECUTIVE DIRECTOR'S REPORT

Tania Culley, Esq. provided the executive director's report. At this time 450 children are receiving legal representation through the Office of the Child Advocate (OCA). All Deputy Child Advocates have a full caseload. Two hundred thirty-three attorneys are assigned cases and twenty-seven are available for cases. OCA continues to partner with the Court Appointed Special Advocates (CASA) program to appoint representation to children. Kelly Ensslin, Gwen Stubbolo, and Tania Culley have been meeting to regarding the CASA relocation and will begin sharing details about the merger as they are completed. Legislative items are being circulated with the CPAC Legislative Committee and the legislative agenda is expected to be shared with the Commission at the February Commission Meeting.

IV. INVESTIGATION COORDINATOR'S REPORT

Jennifer Donahue, Esq. reported out on the Investigation Coordinator's (IC) Quarterly Data Report. At the end of the quarter 379 cases were open with IC. Of those 379 cases, 15 are child deaths, 34 are serious physical injuries, and 330 are sexual abuse cases. In addition to the quarterly overview, Ms. Donahue discussed specific data points for death, serious physical injury, and sexual abuse cases, including child and perpetrator profiles, civil findings, and criminal findings.

IC has been meeting with the Department of Justice (DOJ) and Division of Family Services (DFS) to complete a review of substance exposed infant cases from the hotline that have been screened out by DFS. IC was asked to prepare recommendations from the meetings regarding substance exposed infants who are left in the home with safety plans or in the home without the perpetrator.

Ms. Donahue reported that Ashlee Starratt has resigned from her position with the IC and will begin a position with the County Police in December. CPAC Annual Report Review and Approval

The CPAC Annual Report was reviewed by the commission. The report reflects the responsibility of CPAC as the Citizen Review Panel for Delaware in compliance with CAPTA since 2008. The motion to approve pending a minor change was made by Dr. Colmorgen and seconded by Janice Mink. All voted in favor. The motion carried.

V. COMMISSIONER REPORTS

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

Secretary Benson-Green reported that 794 children are DSCYF custody. The department is working to quickly fill vacancies including four supervisor positions, eight positions at Beech, five in University Plaza, six in Kent, and four in Sussex.

I. PREVENTION AND BEHAVIORAL HEALTH

Susan Cycyk reported on Prevention and Behavioral Health. The department started to implement new Medicaid state plan. The division is working with providers to train on the new opportunities and finance plan.

II. DIVISION OF FAMILY SERVICES

Shirley Roberts reported on the Division of Family Services (DFS) caseloads which have continued to increase. The continuous increase of caseloads has placed a strain on the workforce and is in part responsible for the increased employee turn-over rate of 11%. DFS requests the Commission continue to monitor the caseloads. Investigation caseloads and treatment caseloads are over standard. Ms. Roberts reported that employees over hires are being used to fill some of the vacant positions. Additionally, some senior staff transitioned to telework due to lack of physical work space.

B. FAMILY COURT

Judges Vari, Ranji, and McGiffin are now presiding over cases involving children in foster care or which fall under the purview of the Court Improvement Program (CIP). The Family Court Leading Practices Committee is working to complete a case plan task list for parent attorneys. This task list is meant to assist parent attorneys track planning and will provide a list of abbreviations for parent attorneys.

C. CHILD PLACEMENT REVIEW BOARD

No report was provided.

D. CHILD DEATH REVIEW COMMISSION

Dr. Garrett Colmorgen reported that the Calendar Year 2014 and 2015 Annual Report was released and circulated on November 2, 2016. The 2016 is expected to be released late April 2017 in time for the legislative session. By the end of 2016 there will be no backlog of case reviews, with the exception of cases which are pending prosecution and not older than two years old. Currently, internal and external policies and procedures are under review and will be posted to the agency website after approval by the Child Death Review Commission. At the last Commission meeting, the Commissioners voted to establish a School Nurse Committee to explore the issue of medical action plans not being reinforced or required within the schools. There have been cases where natural deaths occurred as a result of neglect or the child not receiving appropriate care by the parent. This group will evaluate policy and procedures to ensure that these children have the medical care they needed to prevent these unnecessary deaths. This group may recommend legislative change as well.

E. INTERAGENCY COMMITTEE ON ADOPTION

Meg Carey reported that Delaware National Adoption Day will be held at the Delaware Agriculture Museum in Dover, Delaware on November 19th at 1:00 pm. The event will finalize adoptions and recognize 53 other children waiting to be adopted.

F. CHILDREN'S ADVOCACY CENTER

No report was provided.

VI. CPAC DASHBOARD

Rosalie Morales gave a presentation on the quarterly child welfare trends identified by the CPAC Data Utilization Committee. Ms. Morales reported the statewide caseload average for investigations and treatment continues to be over the statutory limits. The averages are at a dangerously high numbers and are cause for concern. The number of youth with another planned permanency living arrangement is at an all-time low at thirty-six. Ms. Morales reported the dashboard is expected to be available online in spring 2017.

VII. CHILD ABUSE AND NEGLECT DEATH/NEAR DEATH REVIEWS

A. CAN CASELOADS REPORT/ ADMINISTRATIVE UPDATE

Ms. Culley reported that there are 45 CAN cases open. Of those cases 20 are in the initial stage and 25 are in the final stage. Fifteen of the cases in the final stage are pending prosecution. None of the open cases are more than one year old.

B. CAN FINDINGS/DETAILS/JOINT ACTION PLAN

Ms. Mink reported on the 58 findings from the most recent CAN Panel reviews. The Commission reviewed the proposed letter to the Governor on the work of the CAN Panel. A motion was made by Dr. Colmorgen and seconded by Dr. De Jong to approve the findings summary and findings detail. All voted in favor. The motion carried. Please refer to the findings summary and findings detail for additional information.

C. LETTER TO THE GOVERNOR

Ms. Mink reviewed the letter to the Governor. A motion was made by Ellen Levin and seconded by Shirley Roberts to approve the letter to the Governor. All voted in favor. The motion carried.

VIII. DISCUSSION OF JOINT RETREAT ACTION PLAN

Ms. Culley presented the joint retreat action plan. The Commissioners were provided some changes and the agreed The Commissioners agreed that a reconvening of the only committee for the action plan was necessary.

IX. GOVERNOR MARKELL PRESENTED CPAC CHAIR WITH TRIBUTE

Governor Markell presented Chair Mike Cochran, Esq. with a tribute for ten years of service to Delaware's children. Mr. Cochran shared that he hopes that the commission keep moving forward with Child Abuse and Abuse Review Panel, Investigation Coordinator reviews, and policy work in order to better serve Delaware's children.

X. CPAC COMMITTEE REPORTS

A. MEDICALLY FRAGILE/SUBSTANCE EXPOSED INFANTS COMMITTEE

The In-Depth Technical Assistance for Substance Exposed Infants (SEI IDTA) officially began on November 3, 2016. Delaware was one of 2 states to be awarded the assistance. On February 7 - 8,

2017, Delaware will send 8 representatives ("Delaware Core Team") to the Policy Academy in Baltimore, MD. Our representatives are from DSCYF, Division of Public Health, DSAMH, Christiana/DHMIC, Substance Use Disorder Treatment Provider, and IC. Our group will work to develop a State Action Plan during the Policy Academy that will address the 3 main goals outlined in our application. In addition to attending the Policy Academy, the technical assistance "change leaders" conduct teleconferences with our Core Team and the larger group from the SEI Committee twice a month. We have developed a "Delaware Services Matrix" that outlines the various programs that already exist in Delaware which will allow us to then integrate the programs to develop a statewide response protocol for substance exposed infants and their families. The Substance Exposed Infants bill will be reintroduced after our team returns from the Policy Academy.

B. EDUCATION COMMITTEE

In December 2015, the Every Student Succeeds Act (ESSA) was signed into law, which included protections to promote school stability for youth in foster care. The Education Committee and its workgroups are overhauling existing legislation and policies to ensure education stability for youth in foster care in Delaware comports with federal changes in the law. Policy work includes overhauling the existing interagency Memorandum of Understanding to ensure school stability for youth in foster care in accordance with ESSA.

The CPAC Education committee also developed a Student Summary form, which has information about the child's grade, discipline, IEP classification (if applicable), number of school placements, credits, and other educational information. The Student Summary will be used as an education court report to ensure that the Family Court is informed of educational progress for youth involved in dependency/neglect proceedings.

In addition, a team which included members of the CPAC Education Committee including Judge Barbara Crowell, Rachael Neff, Eliza Hirst, and Dr. Heather Alford attended Georgetown University's School Justice Partnership Certificate Program. The group received training in September and developed a Capstone Proposal to improve education outcomes for system-involved youth in the Brandywine School District. The Capstone will focus simultaneously on administrative level and school building level efforts to improve awareness of trauma and multi-tiered strategies to support systems involved youth.

A motion was made by Dr. Colmorgen and seconded by Dr. DeJong to respectfully decline to write a letter of support for the grant funding and would at this time state that CPAC may consider it at another time. All voted in favor. The motion carried.

C. TRAINING COMMITTEE

The Protecting Delaware's Children Conference is scheduled for April 25 and 26, 2017. The first day is for the Multidisciplinary Team (MDT) and will provide specialized training. Training kits were purchased through the Child Death Review Commission (CDRC). The second day has room for 500 participants, will have three workshop sessions, and tools for the Memorandum of Understanding. Funding is still needed and necessary in order to cover the costs of the conference. Additionally, the Committee received a quote for the mobile application of $10,000 for completion of the application.

There is no funding to complete the application that would provide first responders with the MDT protocols.

XI. 2017 MEETING DATES

- May 17, 2017
- August 16, 2017
- November 8, 2017

All meetings will take place from 9:00 a.m. – 12:00 p.m. at the New Castle County Courthouse in the 12th Floor Conference Room.

XII. PUBLIC COMMENT AND ADJOURNMENT

Nicole Byers reported that 22 youth from the Delaware Youth Advisory Council (YAC) visited Washington, D.C. and toured U.S. Senator Christopher Coons' office. The group discussed difficulty obtaining driver's licenses as youth in foster care, the cost of car insurance and expunging juvenile records.

State of Delaware Child Protection Accountability Commission
Quarterly Meeting Minutes

WEDNESDAY, FEBRUARY 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)
The Hon. Josette Manning	Secretary of Services for Children, Youth & Their Families 16 Del. C. § 931(a)(1)
Shirley Roberts	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)
James Kriner, Esq.	Two Representatives from the Attorney General's Office 16 Del. C. § 931(a)(3)
Abigail Layton, Esq.	Two Representatives from the Attorney General's Office 16 Del. C. § 931(a)(3)
The Honorable Michael Newell	Family Court 16 Del. C. § 931(a)(4)
The Honorable Joelle Hitch	Family Court 16 Del. C. § 931(a)(4)
Susan Haberstroh	Designee for Secretary of the Department of Education 16 Del. C. § 931(a)(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)
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)
Sgt. Reginald Laster	At-large Member - Child Protection Community 16 Del. C. § 931(a)(16)

Staff:
Tania Culley, Esq., Executive Director
Rosalie Morales
Amanda Sipple

Members of the Public:

Carla Benson-Green	Caroline Jones	Anne Pedrick	Brittany Willard
Kecia Blackson	Jacqueline Mette, Esq.	Stepfanie Scollo	
Islanda Finamore, Esq.	Rachael Neff	Meredith Seitz	
Meg Garey	Leslie Newman	Ellie Torres, Esq.	

I. CHAIRPERSON'S WELCOME AND INTRODUCTIONS

Ginger Ward opened the meeting and welcomed the attendees.

II. APPROVAL OF MINUTES

The minutes from November 9, 2016 were approved.

III. EXECUTIVE DIRECTOR'S REPORT

Tania Culley, Esq. provided the Executive Director's report. The Court Appointed Special Advocate (CASA) Program will officially relocate to the Office of the Child Advocate (OCA) on March 6, 2017. OCA continues to contract with Casey Family Programs to expand the Delaware Compassionate Schools Initiative to other school districts. Jennifer Perry, a DFS Treatment Worker at the Division of Family Services (DFS), accepted the Case Review Specialist position at the Office of the Investigation Coordinator (IC). She will start on February 20th. Rosalie Morales has been provided support since the position was vacated.

In addition, Ms. Culley provided an update on the work of the IC in Jen Donahue's absence. Currently, there are 407 cases being monitored by the IC. During the last quarter, 175 were opened and 116 were closed. Jen Donahue, Esq. completed the 3, 6 and 9 month reviews to receive an update on the criminal response. Ms. Culley also reported Ms. Donahue and the other Delaware Core Team members are currently participating in the In-Depth Technical Assistance Policy Academy to develop and finalize a state action plan for infants with prenatal substance exposure. DFS received 431 reports of infants born substance exposed in 2016. The Committee on Substance Exposed Infants/Medically Fragile Children is finalizing its revisions to the legislation. The bill will be presented to the Commission prior to its submission to the General Assembly.

IV. APPROVAL OF MOU – CPAC TRAINING COMMITTEE

Cpl. Adrienne Owen, Chair of the Training Committee's CAN Best Practices Workgroup, gave a presentation on the revised Memorandum of Understanding (MOU) for the Multidisciplinary Response to Child Abuse and Neglect. Cpl. Owen discussed how the MOU had changed and provided an overview of the document to the Commission. The Division of Forensic Science, Office of the Investigation Coordinator and Alfred I. duPont Hospital for Children were added as signatory agencies. In addition, the revised MOU was organized around the abuse types or best practice protocols rather than by the agencies involved in the multidisciplinary team. The protocols are as follows: Physical Injury to a Child; Serious Physical Injury to a Child; Child Death; Child Sexual Abuse; Child Neglect; and Juvenile Trafficking. Each protocol includes best practices for cross-reporting, information sharing, investigating, prosecuting and providing services to children and families.

A motion to approve the MOU with final edits, subject to signatory review with final circulation via email was made by Judge Hitch and seconded by Chief Judge Newell. All voted in favor. The motion carried.

V. LEGISLATIVE COMMITTEE/CPAC LEGISLATION APPROVAL

Ms. Culley presented three bills. First, the CAN Panel legislation was discussed. Ms. Culley stated the bill clarifies that the reviews of child abuse and neglect deaths and near deaths are confidential and should not be used in any proceedings. It ensures that the committees and panels who do the work on behalf of CPAC are protected. Finally, the bill clarifies that any duties of the State for public disclosure in these cases under the federal Child Abuse Prevention and Treatment Act will not be fulfilled by these confidential reviews conducted by the Commission as Delaware's Citizen Review Panel. A motion was made to approve the bill by Dr. Colmorgen and seconded by Chief Judge Newell. All voted in favor. The motion carried.

The next bill, which was in concept form, related to Mandatory Reporting Training for Contractors. This bill closes a loophole in the child abuse detection and mandatory reporting training by requiring contractors who have direct access to children and student teachers to be trained in mandatory reporting. Ms. Culley stated a second bill will be introduced first by Senator Henry that restructures all of the child safety professional development for schools. Once that bill passes, this bill will be introduced. A motion was made by Dr. Colmorgen and seconded by Randy Williams to approve the bill in concept form.

The Education Decision Maker bill was also discussed. This bill enables, but does not require, the Family Court to appoint an education decision maker for a child in foster care or in the juvenile delinquency system when a parent is unable or unavailable to make education decisions, or the parent consents. The bill appoints a person known to the delinquent or dependent child in order to facilitate academic support and achievement. A motion was made to approve the bill by Chief Judge Newell and seconded by Dr. Colmorgen. All voted in favor. The motion carried.

Ms. Culley added that 4 other significant pieces of legislation will be presented to the Commission, three of which should be CPAC bills. The legislation is as follows: CAN Best Practices, Substance Exposed Infants (Aiden's Law) and Educational Stability for Children in Foster Care, and Child Safety Professional Development for Schools.

To review and approve the above legislation, the Commission agreed to convene a special meeting on Monday, March 27th from 11:00 am to 12:00 pm.

VI. REVIEW OF JOINT RETREAT ACTION PLAN

Ms. Culley reviewed the joint retreat action plan and asked the Commissioners to provide an update on the progress towards the recommendations.

A. LEGAL

Shirley Roberts reported that quarterly meetings are being scheduled with the Department of Justice (DOJ) Family Division for 2017. Refresher training and the availability of DOJ Family Division Deputies for after hours and weekend calls will be discussed. Ms. Culley reported the DOJ Family Division and the Family Court were added to the Investigation Coordinator's contact list. Ms. Morales stated the Training Committee has created a workgroup to develop protocol for removal of life support cases. The Family Court has approved a disclosure form under Rule 16(b)(3) for custody, visitation and guardianship matters to obtain additional information from litigants including DFS history, and it is out for comment with the Bar. The final recommendation regarding the Family Court remaining cognizant of hearing timeframes in complex child abuse cases has been completed.

B. MEDICAL

Ms. Morales reported the revisions to the mandatory reporting training for medical providers has been completed. The Delaware Home Visiting Community Advisory Board meets this month and will consider the recommendation regarding home visiting services; the Delaware Healthy Mother & Infant Consortium will also consider it. The SEI Policy Academy and Committee on Substance Exposed

Infants/Medically Fragile Children are working on priorities, including legislation and development of the plan of safe care.

C. MDT RESPONSE

CPAC has approved the MOU subject to final edits of the signatory agencies. The DOJ case management system was piloted in several units and will soon be available agency-wide. Confidentiality prevents the CAN Panel from sharing details with non-Commissioner agencies, so factual details cannot be provided to police departments as recommended. The presentation to the Police Chiefs' Counsel on the MOU will include discussion of cameras.

As for a prioritized list of CPAC funding requests, the Chair and Executive Director have included the DOJ Special Victims Unit, DFS Caseloads, SEI, and the request for no cuts to Commission services. The CPAC Guidelines for Child Abuse Medical Response need to wait until next year. Lastly, CPAC anticipates that the DOJ child abuse package will be reviewed by the Legislative Committee. Legislation related to the transportation of children to medical exams and modification of the list of crimes in 16 Del. C. 906(e)(3) has been drafted and circulated to CPAC Committees.

D. RISK ASSESSMENT/CASELOADS

Ms. Roberts stated that DFS will reconsider adjusting caseloads based on complexity of the cases after the CPAC Caseloads/Workloads Committee concludes its work. DFS is pursuing grant monies with the Children's Research Center to conduct ongoing training on the SDM Risk Assessment tool in Spring 2017. Ms. Roberts reported that DFS cannot implement differential response for other populations without additional funds. DFS already has tiered risk assessments, and DFS has taken no action to date to investigate all reported cases of suspected child abuse or neglect of children less than one year old.

E. SAFETY/USE OF HISTORY/SUPERVISORY OVERSIGHT

Ms. Roberts stated that DFS added a history event to the last case management system update. Additionally, DFS shares the CAN Panel findings with various leadership teams and workgroups. Ms. Roberts reported the DFS non-relative/relative home safety assessment form has been modified and will be incorporated into the new case management system. The recommendation regarding training for DFS supervisors was also in the Child and Family Services Review Performance Improvement Plan. Training will be targeted for 2018.

F. UNRESOLVED RISK

CPAC supported the Legislative Committee's recommendation to not pursue birth match as prior termination of parental rights is not a strong predictor of subsequent child death in Delaware. The CPAC Caseload/Workloads Committee has reconvened and its first meeting is in February 2017. DFS will continue to pursue its partnership with Division of Substance Abuse and Mental Health (DSAMH) and Casey Family Programs to better assist high risk families, and the IC will be included at the state level meetings. As mentioned previously, DFS is pursuing grant monies with the Children's Research Center, which will include booster training on safety assessments and safety planning. In addition, DFS

will need additional resources/equipment to develop a mechanism that reminds DFS case workers to automatically follow up after referrals or services are requested. The recommendation regarding the provision of home-based and family centered treatment services has been completed. Finally, DFS and Family Court have scheduled a meeting to discuss the issue related to guardianship petitions.

VII. CHILD ABUSE AND NEGLECT DEATH/NEAR DEATH REVIEWS

A. CAN CASELOADS REPORT/ADMINISTRATIVE UPDATE

Ms. Culley reported that there are 44 CAN cases open. Of those cases 19 are in the initial stage and 25 are in the final stage. Twelve of the cases in the final stage are pending prosecution. In 2016, there were 22 near deaths and 5 deaths.

B. CAN FINDINGS/DETAILS/LETTER TO GOVERNOR

Ms. Morales reported on the 12 cases reviewed by the Panel in the last quarter. Seven of the cases were from incidents which occurred between June 2016 and August 2016, and these cases were reviewed by the Panel for the first time. One of the final reviews was from an incident that occurred in 2012. In total, there were 56 findings and 44 strengths. Many of these findings related to the medical response and the use of safety agreements and risk assessment by DFS. These findings are being addressed through the Joint Retreat Action Plan. The Panel noted that in 6 of the 7 cases reviewed for the first time, the DFS investigation worker was over the investigation standard. In all but 1, the worker's caseload did not negatively impact the DFS response. The Panel also noted many strengths in the medical and MDT response.

A motion was made by Randy Williams and seconded by Nicole Magnusson to approve the strengths summary and detail, findings summary and detail, and letter to the Governor. All voted in favor. The motion carried. Please refer to the strengths summary and detail, findings summary and detail, and letter to the Governor for additional information.

VIII. 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 the statewide caseload average for investigations increased by 27% since the prior quarter. Similarly, the statewide caseload average for treatment increased by 14% since the prior quarter, and as a result, the caseloads were above standard.

In addition, Ms. Willard discussed the cases open by the IC during the quarter. Of the 175 cases opened, 160 were sexual abuse, 9 were serious physical injury and 6 were death. The IC caseload increased from 347 to 407 cases since the 9/16 quarter.

Next, Ms. Willard reviewed the CAC data. Overall, the number of cases received has been decreasing over the past two quarters. The decrease is most noticeable in the 12/16 quarter for intra-familial sexual abuse cases.

The Committee noted a significant decline in the number of children entering custody for the 12/16

quarter. The number of youth with another planned permanency living arrangement was similar to the prior quarter at thirty-eight. Lastly, there was a small increase in the percentage of children re-entering foster care in 12 months.

IX. COMMISSIONER REPORTS

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

Secretary Manning acknowledged the administration at the Division of Family Services for their efforts to hire qualified staff to fill the 27 positions.

I. PREVENTION AND BEHAVIORAL HEALTH

Susan Cycyk provided an update on the Medicaid state plan, which brought in 5 evidence based practices. Ms. Cycyk stated it resulted in a reduction in hospital stays, residential treatment stays and family disruption. Additionally, the division started the suicide crisis text line. Youth have immediate access to a trained professional. Ms. Cycyk also presented the challenges with implementation. She stated a workgroup was created with the school districts to improve the quality of behavioral health services in the schools. The division has more responsibility for children with developmental disabilities and mental health issues. As a result, a workgroup was created to address the identification of appropriate services for this population.

II. DIVISION OF FAMILY SERVICES

Shirley Roberts provided an update on the 27 positions reallocated to DFS. She mentioned a few of the barriers to getting the positions filled, including lateral transfers, frontline staff moving to supervisory positions, and other vacancies. Ms. Roberts reported that all of the 27 have been filled with the exception of two positions. The first group of hires will finish training in April. To support staff, supervisors are making contact with families. Administrators and managers are meeting every morning to triage cases. Their priority is supporting staff and child safety.

B. DEPARTMENT OF EDUCATION

Susan Haberstroh reported on few of current initiatives of the Education Committee since they overlap with the work of the DOE. Ms. Haberstroh stated they are overhauling laws and policies concerning youth in foster care to comply with federal changes to the Every Student Succeeds Act (ESSA). Youth in foster care have to be separated from homeless youth. In addition, they are finalizing an education court report as a way to track educational outcomes for youth in foster care. Lastly, they 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 a grant from Casey Family Programs. Since January 2016, this initiative has trained over 1,500 educators on trauma and the impact on learning.

C. CHILD PLACEMENT REVIEW BOARD

Kecia Blackson reported that CPRB has had some staff turnover and lost many volunteers due to attrition. In addition, their technology system has started to crash. In October, they engaged a facilitator to do strategic planning, and Ms. Blackson plans to share the goals at the next quarterly meeting.

D. CHILDREN'S ADVOCACY CENTER

Mr. Williams reported the Governor's Recommended Budget for FY2018 reduces the State funding for the CAC. They have not recovered since funding was originally cut in 2001. Mr. Williams requested the Commissioner's support at the upcoming Joint Finance Hearing.

E. OFFICE OF DEFENSE SERVICES

No report was provided.

F. DEPARTMENT OF JUSTICE

The Commission welcomed the new Commissioners from DOJ. Abigail Layton, Esq. is the Director of the Family Division. Ms. Layton led the DOJ's Child Predator Task Force and chaired the Human Trafficking Coordinating Council. Jim Kriner, Esq. now heads the Special Victims Unit. Ms. Layton shared that Islanda Finamore, Esq. has also taken a leadership role in the Child Protection Unit, and Donna Thompson, Esq. will serve as the general counsel for the Children's Department.

X. OTHER CPAC COMMITTEE REPORTS

A. PERMANENCY FOR ADOLESCENTS

Ms. Roberts reported that the Committee last met two weeks ago, and the Committee agreed they have satisfied their charge from CPAC. There are some activities that will be reassigned. Felicia Kellum will continue to work on the benchmarks. DFS will work with DOJ to establish liability protection for foster parents in making decisions. DFS and OCA will be tasked with on educating youth on sex education. Family Court will continue working on dual status youth and youth involvement in court.

Ms. Roberts made a motion to disband the Committee, and it was seconded by Mr. Williams. All voted in favor. The motion carried.

XI. 2017 MEETING DATES

- August 16, 2017
- November 8, 2017

All meetings will take place from 9:00 a.m. – 12:00 p.m. at the New Castle County Courthouse in the 12th Floor Conference Room.

XII. PUBLIC COMMENT AND ADJOURNMENT

There was no public comment. The meeting was adjourned at 12:00 p.m.

State of Delaware Child Protection Accountability Commission
Quarterly Meeting Minutes

MONDAY, MARCH 27, 2017
11:00 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)
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)
Abigail Layton, Esq.	Two Representatives from the Attorney General's Office 16 Del. C. § 931(a)(3)
The Honorable Michael Newell	Family Court 16 Del. C. § 931(a)(4)
The Honorable Joelle Hitch	Family Court 16 Del. C. § 931(a)(4)
Susan Haberstroh	Designee for Secretary of the Department of Education 16 Del. C. § 931(a)(8)
Corporal Adrienne Owen	Designee for Superintendent of the Delaware State Police 16 Del. C. § 931(a)(11)
Jen 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)
Janice Mink	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)
Sgt. Reginald Laster	At-large Member - Child Protection Community 16 Del. C. § 931(a)(16)

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

Members of the Public:

Addie Assay	Leslie Newman	Charles Tate, Esq.
Meg Garey	Anne Pedrick	Donna Thompson, Esq.
Cheryl Heiks	Meredith Seitz	Ellie Torres, Esq.

I. CHAIRPERSON'S WELCOME AND INTRODUCTIONS

Ginger Ward opened the meeting and welcomed the attendees.

II. MOU UPDATE

Rosalie Morales reported that she is working to resolve one item. Once approved, the MOU will be disseminated to all signatory agencies for signature.

III. LEGISLATIVE COMMITTEE/CPAC LEGISLATION APPROVAL

The Commission reviewed the packet of proposed legislation prepared by the CPAC Legislative Committee to determine which bills within CPAC's purview it would support, oppose or take no position.

A. AIDEN'S LAW

A motion was made by Janice Mink to support Aiden's Law and seconded by Judge Hitch. All voted in favor. The motion carried.

B. EVERY STUDENT SUCCEEDS ACT (ESSA)

A motion was made by Abigail Layton, Esq. to support ESSA and seconded by Janice Mink. All voted in favor. The motion carried.

C. CAN BEST PRACTICES

Randy Williams proposed that the Commission strike the accreditation language in the definition of the Children's Advocacy Center.

In addition, Ms. Culley presented three outstanding issues related to the legislation: 1. protection and access to records gathered in the course of the multidisciplinary team (MDT) response and use in civil proceedings; 2. the MDT Case Review process; and, 3. the medical resources to implement the MDT Guidelines for the Child Abuse Medical Response. To address the first issue, draft legislation will be presented at the August meeting. A workgroup will be convened under the Training Committee to evaluate and make recommendations for improving the MDT Case Review process. Lastly, the Office of the Child Advocate will dedicate an intern to research sources of funding and other information to help the Commission secure medical resources.

A motion was made by Janice Mink to support the CAN Best Practices legislation and seconded by Mr. Williams. All voted in favor. The motion carried.

IV. PUBLIC COMMENT AND ADJOURNMENT

There was no public comment. The meeting was adjourned at 12:00 p.m.

STATE OF DELAWARE

MEMORANDUM OF UNDERSTANDING

FOR THE MULTIDISCIPLINARY

RESPONSE TO CHILD ABUSE AND NEGLECT

Between

Department of Services for Children, Youth, and Their Families

♦

Department of Justice

♦

Children's Advocacy Center of Delaware

♦

Division of Forensic Science

♦

Office of the Investigation Coordinator

♦

Nemours/Alfred I. duPont Hospital for Children

♦

Delaware Police Departments

Prepared by
the Child Protection Accountability Commission

February 8, 2017

Prior Revision Dates: 2009, 1998, 1994, 1989 (Original)

TABLE OF CONTENTS

I. MULTIDISCIPLINARY RESPONSE TO CHILD ABUSE IN DELAWARE

Sections 901 and 906(b) of Title 16 of the Delaware Code require the use of a multidisciplinary team (MDT) response to child abuse and neglect cases in the State of Delaware.

DELAWARE CODE

State Response to Reports of Abuse or Neglect[1]

16 Del. C. § 901 states: "The child welfare policy of this State shall serve to advance the best interests and secure the safety of the child, while preserving the family unit whenever the safety of the child is not jeopardized. The child welfare policy of this State extends to all child victims, whether victims of intra-familial or extra-familial abuse and neglect. To that end this chapter, among other things:

(1) Provides for comprehensive and protective services for abused and neglected children;

(2) Mandates that reports of child abuse or neglect be made to the appropriate authorities; and

(3) Requires various agencies in Delaware's child protection system to work together to ensure the safety of children who are the subject of reports of abuse or neglect by conducting coordinated investigations, judicial proceedings and family assessments, and by providing necessary services."

16 Del. C. § 906(b) also states: "It is the policy of this State that the investigation and disposition of cases involving child abuse or neglect shall be conducted in a comprehensive, integrated, multidisciplinary manner that:

(1) Provides civil and criminal protections to the child and the community;

(2) Encourages the use of collaborative decision-making and case management to reduce the number of times a child is interviewed and examined to minimize further trauma to the child; and

(3) Provides safety and treatment for a child and his or her family by coordinating a therapeutic services system."

A. STATEMENT OF PURPOSE

This Memorandum of Understanding (MOU) seeks to establish best practice protocols for a MDT response in the following types of cases: Physical Injury to a Child; Serious Physical Injury to a Child; Child Death; Child Sexual Abuse; Child Neglect; and Juvenile Trafficking. This includes best practices for cross-reporting, investigating, prosecuting and providing services to children and families. The memorandum serves to provide those involved in the investigation, prosecution and intervention of suspected child abuse and neglect cases with guidance based on existing best practice recommendations; however, the facts and circumstances of each case will determine which investigative actions should be taken. The Child Protection

[1] *See* 16 Del. C. §§ 901 and 906(b).

Accountability Commission (CPAC), the commission responsible for creating these best practice protocols, believes that consistency in the approach to these complex cases will greatly increase the effectiveness of Delaware's response to these cases. CPAC acknowledges these guidelines will depend to some degree on the availability of the MDT's resources and the necessity of balancing priorities among multiple cases.

Delaware's MDT, which includes the Department of Services for Children, Youth, and Their Families (DSCYF) – Division of Family Services (DFS), Division of Prevention and Behavioral Health Services (DPBHS), and Division of Youth Rehabilitative Services (DYRS); the Department of Justice (DOJ); the Children's Advocacy Center of Delaware, Inc. (CAC); the Division of Forensic Science (ME); the Office of the Investigation Coordinator (IC); Delaware Hospitals; and Delaware Police Departments (Law Enforcement or LE), recognizes that a coordinated response to child abuse and neglect cases has many benefits for children, families and MDTs. Therefore, in an effort to improve the quality of services and to provide more adequate interventions, these agencies are committed to interagency cooperation and agree to utilize a MDT approach in these cases when possible. MDT intervention begins at the initial report and includes, but is not limited to: first response, pre- and post-interview communications, forensic interviews, consultations, advocacy, evaluation, treatment, case reviews, and prosecution.

This memorandum may be helpful to those wishing to understand the framework for the multidisciplinary team response. However, the primary intended audiences are those involved in the investigation, prosecution and intervention of cases that fall within this MOU. This document does not create any legal rights for anyone including those facing charges or other proceedings arising out of any event covered herein.

B. ADMINISTRATION OF THE MOU

CPAC shall be responsible for the review, dissemination and implementation of this memorandum. As legislative changes are made, the statutory citations will be updated accordingly and electronic versions of the document will be disseminated to all signatory agencies. Should an agency make an internal agency policy or procedure modification that impacts the effectiveness or application of a provision contained in the MOU, that agency will notify CPAC of such policy or procedure modification at the next regularly scheduled CPAC Commission meeting to determine whether a revision to the MOU is warranted. Otherwise, a review will be conducted by CPAC every 3 years to ensure current and best practice.

This memorandum shall become effective upon the signature of all parties and may be modified or terminated by notifying the Chair of CPAC. Modifications or termination may only occur with written agreement by all the parties.

C. DEFINITIONS

- **Abuse**: means causing any physical injury to a child through unjustified force as defined in § 468(1)(c) of this title, torture, negligent treatment, sexual abuse, exploitation, maltreatment, mistreatment or any means other than accident.[2]

- **Cause of Death**: the disease or injury that initiated the train of morbid events leading directly to death.

- **Child**: means a person who has not reached his or her eighteenth birthday.[3]

- **Children's Advocacy Center (CAC):** means a child forensic interviewing center that employs best practices by applying and adhering to nationally recognized standards, and assists in the response to multidisciplinary cases.

- **Child Care Facilities**: include transitional living programs, residential child care, foster homes, licensed child day care facilities, emergency shelters for children, correctional and detention facilities, day treatment programs, all facilities in which a reported incident involves a child/children in the custody of the DSCYF, and all facilities which are operated by the Department.

- **Child Welfare Proceeding**: means any Family Court proceeding and subsequent appeal therefrom involving custody, visitation, guardianship, termination of parental rights, adoption or other related petitions that involve a dependent, neglected or abused child or a child at risk of same as determined by the Family Court.[4]

- **Dependency (or Dependent Child):** means that a person, who has care, custody or control of a child and who does not have the ability and/or financial means to provide for the care of the child, fails to provide necessary care with regard to: food, clothing, shelter, education, health care, medical care or other care necessary for the child's emotional, physical or mental health, or safety and general well-being. This includes a child living in the home of an adult individual who fails to meet the definition of relative on an extended basis without an assessment by DSCYF, or its licensed agency.[5]

- **Extra-familial Child Abuse or Neglect**: involves an alleged perpetrator who is not a member of the child's family or household and the report does not involve institutional abuse/neglect. Extra-familial reports received by DFS are reported to the appropriate law enforcement jurisdiction.

- **Forensic Interview**: a forensic interview is a single session, recorded interview designed to elicit a child's unique information when there are concerns of possible abuse or when the child has witnessed violence against another person. A forensic interview is conducted in a supportive and non-leading manner by a professional trained in a nationally recognized forensic interviewing protocol. Forensic

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[2] *See* 11 Del. C. § 1100(1)
[3] *See* 10 Del. C. § 901(4)
[4] *See* 16 Del. C. § 902(5)
[5] *See* 10 Del. C. § 901(8)

interviews may be observed by representatives of the MDT agencies involved in the investigation (such as law enforcement and the Division of Family Services).

- **Institutional Child Abuse or Neglect**: any child abuse or neglect which has occurred to a child in DSCYF's custody and/or placed in a facility, center or home operated, contracted or licensed by the DSCYF.[6]

- **Intra-familial Child Abuse or Neglect**: any child abuse or neglect committed by: a parent, guardian, or custodian; other members of the child's family or household, meaning persons living together permanently or temporarily without regard to whether they are related to each other and without regard to the length of time or continuity of such residence, and it may include persons who previously lived in the household such as paramours of a member of the child's household; and, any person who, regardless of whether a member of the child's household, is defined as family or a relative.[7]

- **Manner of Death**: the categorization of the death based on cause. The 5 categories are natural, accident, homicide, suicide, and undetermined.

- **Multidisciplinary Case**: means a comprehensive investigation by the multidisciplinary team for any child abuse or neglect report involving death, serious physical injury, physical injury, thuman trafficking of a minor 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.

- **Multidisciplinary Team (MDT)**: means a combination of the following entities as required by law to investigate or monitor multidisciplinary cases – the Division, the appropriate law enforcement agency, the Department of Justice and the Investigation Coordinator. The team may also include others deemed necessary for an effective multidisciplinary response, such as medical personnel, the Division of Forensic Science, a children's advocacy center, the Division of Prevention and Behavioral Health Services, mental health experts and the child's attorney.

- **Neglect (or Neglected Child)**: means that a person, who has care, custody or control of a child and who **does** have the ability and/or financial means to provide for the care of the child, fails to provide necessary care with regard to: food, clothing, shelter, education, health, medical or other care necessary for the child's emotional, physical, or mental health, or safety and general well-being; or chronically and severely abuses alcohol or a controlled substance, is not active in treatment for such abuse, and the abuse threatens the child's ability to receive care necessary for that child's safety and general well-being; or fails to provide necessary supervision appropriate for a child when the child is unable to care for that child's own basic needs or safety, after considering such factors as the child's age, mental ability, physical condition, the length of the caretaker's absence, and the context of the child's environment.[8]

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[6] *See* 10 Del. C. § 901(13)
[7] *See* 10 Del. C. § 901(14)
[8] *See* 10 Del. C. § 901(18)

- **Unjustified Force**: force shall not be justified if it includes, but is not limited to, any of the following: throwing the child, kicking, burning, cutting, striking with a closed fist, interfering with breathing, use of or threatened use of a deadly weapon, prolonged deprivation of sustenance or medication, or doing any other act that is likely to cause or does cause physical injury, disfigurement, mental distress, unnecessary degradation or substantial risk of serious physical injury or death.[9]

D. INVOLVED PARTIES

- **After-Hours Caseworker:** a DFS caseworker who receives calls made to the 24/7 Child Abuse Report Line, and makes responses to said reports when they meet the criteria for a priority 1 or priority 2 response. The After Hours caseworkers respond to the cases on non-traditional work hours including nights, weekends, and holidays.

- **Civil Deputy Attorney General (DAG):** Civil DAGs prosecute civil dependency/neglect cases, termination of parental rights cases, and Child Protection Registry cases in the Family Court of the State of Delaware. Civil DAGs also provide legal representation to DSCYF in Family Court.

- **Criminal Deputy Attorney General (DAG):** Criminal DAGs are lawyers that represent the State of Delaware on behalf of the public and are responsible for the prosecution of criminal cases throughout the State from misdemeanors to murders. This responsibility includes the preparation and presentation of criminal cases before the Superior Court, the Court of Common Pleas, Family Court and in some matters before the Justice of the Peace Courts.

- **DOJ Special Victims Unit Investigator:** means a sworn DOJ employee responsible for assisting DAG's and various Delaware police agencies in conducting pretrial investigations from misdemeanors to felonies. In addition, the employee is responsible for assisting the DOJ with on scene serious physical injury or child death cases.

- **Designated MDT Medical Services Provider:** a physician who has received specialized training in the evaluation and treatment of child abuse.

- **Detective:** a police officer who conducts detailed and often complex investigations into serious felony crimes, which may require the use of specialized resources such as search warrants, subpoenas, electronic data, and evidence collection, for the purpose of arresting and assisting with prosecuting perpetrators of crime. Detectives may specialize in a particular field such as drug crimes, property crimes, fraud, persons/major crimes, youth crimes, family/domestic violence, or homicide.

- **Family Assessment and Intervention Response (FAIR) Caseworker:** a DFS employee responsible for conducting family assessments about reports made to DFS alleging child abuse, neglect or dependency. The employee may also directly provide or coordinate ongoing services, as

[9] *See* 11 Del. C. § 468

needed, beyond the family assessment period for a maximum of ninety days. The FAIR caseworker may be assisted by a Family Service Assistant. FAIR services may also be provided by DFS contract.

- **Family Resource Advocate:** a CAC employee who serves as the primary liaison between the CAC and caregivers for child, adolescents, and adult victims/witnesses seen at the CAC and who is charged with assessing and addressing - through referrals to appropriate community resources - information, support and service needs, including but not limited to, mental health and social services. The Family Resource Advocate serves as a member of the Multidisciplinary Team (MDT), providing information and insight and advocating for the best interests of the child and family throughout the investigation.

- **Forensic Interviewer:** a professional member of the multidisciplinary team who has received specialized training in a nationally recognized forensic interviewing protocol to conduct forensic interviews in a supportive and non-leading manner.

- **Forensic Investigator**: a specially trained individual at the Division of Forensic Science that investigates sudden unexpected and unexplained deaths.

- **Forensic Nurse/Sexual Assault Nurse Examiner:** forensic nursing provides a specialized level of care for victims of interpersonal violence and trauma. Forensic Nurses bridge the gap in the medical-legal care of victims of violence by providing specialized care to patients who have experienced some type of abuse or trauma. A forensic nurse is a RN who has completed Sexual Assault Nurse Examiner training. Forensic Nurses have extensive knowledge in evidence collection and legal testimony expertise. The skill set of a forensic nurse also include documenting patient's medical findings, collection of evidence, evaluating the scope and nature of a patient's injuries, and storage of physical and biological evidence. The Forensic Nurse becomes that liaison between the medical profession and that of the criminal justice system.

- **Forensic Pathologist:** a specially trained physician at the Division of Forensic Science who examines the body of the person who dies suddenly, violently or in an unexplained manner and through the review of events leading to the death and/or physical findings will determine the cause and manner of death.

- **Hotline Caseworker:** a DFS caseworker who receives calls made to the 24/7 Child Abuse Report Line. The caseworker documents the information made by the reporter utilizing a tool to determine whether: (1) the report meets the criteria for investigation or assessment by DFS (screen in), (2) the report indicates an investigation by another entity such as law enforcement is warranted (screen out) or (3) the reported information is documented in the internal information system or forwarded to an active DFS caseworker, if applicable.

- **Institutional Abuse (IA) Caseworker:** a DFS employee responsible for the investigation of allegations of physical and sexual abuse in out-of-home settings. These settings include transitional living programs, residential child care facilities (group homes), foster homes, licensed child day care facilities (child care homes, child care centers), shelters, correctional and detention facilities,

day treatment programs, all facilities at which a reported incident involves a child(ren) in the custody of DSCYF, and all facilities operated by the DSCYF.

- **Investigation Caseworker:** a DFS employee responsible for investigating reports made to DFS alleging child abuse, neglect or dependency. The Investigation caseworker may be assisted by a Family Service Assistant.

- **Investigation Coordinator (IC):** the IC has the authority to track any case of child abuse or neglect, and is required to monitor each reported case, both intra-familial and extra-familial, involving the death of, serious physical injury to, or allegations of sexual abuse of a child from inception to final criminal and civil disposition. The IC reviews and analyzes these cases to ensure the criminal and civil legal response and protection system has followed best practices to achieve punishment for perpetrators and legal protections for victims. In addition, the IC oversees the establishment and maintenance of an independent database case tracking system for cases within the IC purview. The IC is responsible for analyzing collected data and statistics, identifying child welfare system issues and trends, providing pertinent data to the Child Protection Accountability Commission and members of the multidisciplinary team and making recommendations for system improvement in accordance with State and Federal law.

- **Patrol Officer:** a uniformed police officer who provides public assistance and preserves the peace by conducting traffic enforcement, investigating traffic collisions, conducting criminal investigations of misdemeanor crimes and some felony crimes, and apprehending and arresting perpetrators of crime.

- **Special Victims Unit (SVU**): a unit within the Criminal Division of the DOJ, which 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.

- **Treatment Caseworker:** a DFS employee responsible for the provision of case management services to a family that has been substantiated or has been identified at risk for child abuse, neglect or dependency. The services may be provided directly by the Treatment caseworker or involve the coordination of services provided by a DFS contracted provider, community-based provider, DPBHS, DYRS, or another State agency. The Treatment caseworker may be assisted by a Family Service Assistant.

- **Victim Advocate:** professionals trained to support victims of crime.

II. PHYSICAL INJURY TO A CHILD PROTOCOL

A. DEFINITION: Physical Injury to a child shall mean any impairment of physical condition or pain.[10]

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

1. CIVIL OFFENSES

- **Dislocation/sprains requiring medical attention**: means a medically diagnosed displacement of a bone or injury to a ligament or muscle caused by [any individual];[11]

- **Bruises, cuts, lacerations, not requiring intervention by a medical professional**: means injury caused by [any individual] to the body tissue of a child causing discoloration, but without breaking the skin (bruise) or an injury which causes an open wound (cut/laceration) of a child over the age of six months. The injuries did not require medical treatment beyond medical examination and/or were not extensive (size, quantity, and location) on the child's body;[12]

- **Bruises, cuts, lacerations requiring intervention by a medical professional:** means injury caused by [any individual] to the body tissue of a child causing discoloration, but without breaking the skin (bruise) or an injury which causes an open wound (cut/laceration). The injury required medical treatment beyond medical examination and/or was extensive (size, quantity, and locations) on the child's body. All children under the age of six months are included at this level, regardless of the need for medical treatment beyond medical examination or the extensiveness of the injury. Current evidence of historical injuries (perhaps appearing on an x-ray) that would have required medical treatment at the time of the injuries, but which do not necessitate current treatment;[13]

- **Bizarre treatment (requiring medical attention)**: means behavior toward a child by [any individual] that is extreme, or significantly disproportionate to the precipitating event initiated by the child, or would not be perceived as a logical consequence by a reasonable person such as use of or threatened use of a deadly weapon;[14]

- **Other Physical Abuse:** means actions prohibited by 11 Del. C. § 468(1)c. such as striking with a closed fist and kicking or other actions such as biting and pulling hair by [any individual] that have not resulted in observable injury to the child;[15] and,

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[10] *See* 11 Del. C. § 1100(5)
[11] *See* 9.1.5. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.
[12] *See* 8.1.1. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.
[13] *See* 9.1.3. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.
[14] *See* 9.1.2. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.
[15] *See* 8.1.5. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.

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

2. CRIMINAL OFFENSES

- § 601 Offensive Touching; unclassified misdemeanor;
- § 611 Assault in the third degree; class A misdemeanor;
- § 781 Unlawful imprisonment in the second degree; class A misdemeanor;
- § 1102 Endangering the welfare of a child; class G felony or class A misdemeanor;
- § 1103 Child abuse in the third degree; class A misdemeanor; and,
- § 1103A Child abuse in the second degree; class G felony.

C. MULTIDISCIPLINARY RESPONSE

1. CROSS-REPORTING

For the aforementioned civil and criminal offenses, the MDT agencies agree to cross-report and share information regarding the report of abuse.

REPORTS TO DIVISION OF FAMILY SERVICES (DFS)

All suspected child abuse and neglect of any child, from birth to age 18, in the State of Delaware must be reported to the Division of Family Services Child Abuse Report Line (Report Line) at 1-800-292-9582.

DELAWARE CODE

Mandatory Reporting Law[16]

16 Del. C. § 903 states: "Any person, agency, organization or entity who knows or in good faith suspects child abuse or neglect shall make a report in accordance with § 904 of this title…"

In addition, 16 Del. C. § 904 states: "Any report of child abuse or neglect required to be made under this chapter shall be made by contacting the Child Abuse and Neglect Report Line for the Department of Services for Children, Youth and Their Families. An immediate oral report shall be made by telephone or otherwise. Reports and the contents thereof including a written report, if requested, shall be made in accordance with the rules and regulations of the Division, or in accordance with the rules and regulations adopted by the Division. No individual with knowledge of child abuse or neglect or knowledge that leads to a good faith suspicion of child abuse or neglect shall rely on another individual who has less direct knowledge to call the aforementioned Report Line."

[16] *See* 16 Del. C. §§ 903 and 904

Penalty for Violation[17]

16 Del. C. § 914 states: "Whoever violates § 903 of this title shall be liable for a civil penalty not to exceed $10,000 for the first violation, and not to exceed $50,000 for any subsequent violation."

Any person who has **direct knowledge** of suspected abuse must make an immediate report to the Report Line. **Direct knowledge** is obtained through disclosure (child discloses to you), discovery (you witness an act of abuse), or reason to suspect (you have observed behavioral and/or physical signs of child abuse). This report may include situations where multiple disciplines are involved, such as:

- 911 call where emergency medical services and law enforcement are dispatched. A call must be made to the Report Line from both professionals.
- Child makes a disclosure to the school's Family Crisis Therapist and the School Resource Officer. Both professionals must make the call.

The relationship between the child and perpetrator ***does not*** influence whether a report must be made to DFS. All reports, including domestic or intra-familial, institutional, and non-domestic or extra-familial, cases must also be reported to DFS.

Additionally, a separate report must be made to the Report Line for the following reasons:

- Additional suspects have been identified;
- Additional child victims have been identified; or,
- Secondary allegations have been disclosed (i.e. initial report alleged physical abuse and child later disclosed sexual abuse or additional perpetrators have been identified).

If a **secondary allegation is disclosed to the CAC** during the forensic interview process, then the MDT members present shall make a joint report to the DFS Report Line prior to conclusion of the post interview meeting. However, if circumstances prevent the joint report from being made, the MDT shall select a member to make the report on behalf of the team. The designee will make the report immediately and inform the Report Line worker that he/she is making the call on behalf of the applicable MDT agencies.

If known, the following should be provided to the DFS Report Line:

- Demographic information;
- Known information about the following:
    - Child, parents, siblings and alleged perpetrator;

[17] *See* 16 Del. C. § 914

  - The alleged child victim's physical health, mental health, educational status;
  - Medical attention that may be needed for injuries;
  - The way the caregiver and alleged perpetrator's behavior is impacting the care of the child; and,
  - Any circumstances that may jeopardize the child's or DFS worker's safety.

- Facts regarding the alleged abuse and any previous involvement with the family.

- What you are worried about, what is working well, and what needs to happen next to keep the child safe.

Reports received by DFS will either be screened in for investigation as an intra-familial case and/or institutional abuse (IA) case or will be screened out, documented, and maintained in the DFS reporting system.

Reports screened in for investigation by DFS are assigned a priority response time as follows:

- Priority 1 (P1) – Within 24 hours
- Priority 2 (P2) – Within 3 days
- Priority 3 (P3) – Within 10 days

REPORTS TO LAW ENFORCEMENT (LE)

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

DELAWARE CODE[18]

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

16 Del. C. § 906(e)(3) states: "The Division staff shall also contact…the appropriate law-enforcement agency upon receipt of any report under this section and shall provide such agency with a detailed description of the report received."

Other MDT agencies are encouraged to make an immediate report to the appropriate law enforcement jurisdiction to initiate a criminal investigation when appropriate. The law enforcement jurisdiction will determine whether or not a criminal investigative response is appropriate and take the necessary actions.

[18] *See* 16 Del. C. §§ 903 and 906(e)(3)

REPORTS TO DEPARTMENT OF JUSTICE (DOJ)

DFS is required to report offenses identified in the Physical Injury Protocol to the appropriate division at the Department of Justice. Additionally, DFS is required to report all persons, agencies, organizations and entities to DOJ for investigation if they fail to make mandatory reports of child abuse or neglect under 16 Del. C. § 903.

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

If the matter is referred to the Children's Advocacy Center for a forensic interview, the CAC will notify the DOJ, DFS, and LE of the scheduled interview as soon as possible.

DELAWARE CODE[19]

16 Del. C. § 906(e)(3) states: "The Division staff shall also contact the Delaware Department of Justice… upon receipt of any report under this section and shall provide such agency with a detailed description of the report received."

REPORTS TO THE OFFICE OF THE INVESTIGATION COORDINATOR (IC)

No reports are required to the Office of the Investigation Coordinator for the civil offenses identified in the Physical Injury Protocol, unless indicators of child torture are present. For the purposes of conflict resolution, the Office of the Investigation Coordinator may be contacted to initiate or facilitate communication with other members of the MDT.

DELAWARE CODE[20]

16 Del. C. § 906(c)(1)a. states: "The Investigation Coordinator, or the Investigation Coordinator's staff, shall…have electronic access and the authority to track within the Department's internal information system and Delaware's criminal justice information system each reported case of alleged child abuse or neglect."

REPORTS TO PROFESSIONAL REGULATORY BODIES

In keeping with the following statutory requirements, certain MDT members shall make reports to professional regulatory organizations and other agencies upon receipt of reports alleging abuse or neglect by professionals licensed in Delaware.

[19] *See* 16 Del. C. § 906(e)(3)
[20] *See* 16 Del. C. § 906(c)(1)a.

DELAWARE CODE[21]

16 Del. C. § 906(c)(1)c. states the Investigation Coordinator or the Investigation Coordinator's designee shall: "Within 5 business days of the receipt of a report concerning allegations of child abuse or neglect by a person known to be licensed or certified by a Delaware agency or professional regulatory organization, forward a report of such allegations to the appropriate Delaware agency or professional regulatory organization."

16 Del. C. § 906(e)(6) and (f)(4) state the Division and DOJ shall: "Ensure that all cases involving allegations of child abuse or neglect by a person known to be licensed or certified by a Delaware agency or professional regulatory organization, have been reported to the appropriate Delaware agency or professional regulatory organization and the Investigation Coordinator in accordance with the provisions of this section."

24 Del. C. § 1731A(a) states: "Any person may report to the Board information that the reporting person reasonably believes indicates that a person certified and registered to practice medicine in this State is or may be guilty of unprofessional conduct or may be unable to practice medicine with reasonable skill or safety to patients by reason of mental illness or mental incompetence; physical illness, including deterioration through the aging process or loss of motor skill; or excessive use or abuse of drugs, including alcohol. The following have an affirmative duty to report, and must report, such information to the Board in writing within 30 days of becoming aware of the information:

(1) All persons certified to practice medicine under this chapter;

(2) All certified, registered, or licensed healthcare providers;

(3) The Medical Society of Delaware;

(4) All healthcare institutions in the State;

(5) All state agencies other than law-enforcement agencies;

(6) All law-enforcement agencies in the State, except that such agencies are required to report only new or pending investigations of alleged criminal conduct specified in § 1731(b)(2) of this title, and are further required to report within 30 days of the close of a criminal investigation or the arrest of a person licensed under this chapter."

2. INVESTIGATION

For the purpose of conducting an effective joint investigation, communication and coordination should occur among the MDT members as soon as possible and continue throughout the life of the case.

Upon receipt of a report, DFS/LE will communicate and coordinate a response; however, LE will take the lead in the Joint Investigation. Should DFS receive the report first, they must notify LE prior to

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

making contact with any child, caregiver, or alleged perpetrator associated with the investigation in order to maintain the integrity of the case. Should LE receive the complaint first, they must call DFS immediately in order to apprise DFS of the case status and to obtain DFS history with the family. LE agencies needing additional resources may consult with larger jurisdictions.

For all allegations within this Protocol, the MDT will determine from the list below the appropriate investigative actions that have been identified as best practices for responding to child abuse cases.

Investigative Actions	Responsible Agency
Cross-report and coordinate a response between MDT members.	MDT
Establish the location(s) where the incident occurred.	DFS
Identify persons involved and coordinate interviews with child, siblings, caregivers, alleged perpetrator(s), and other witnesses.	DFS and LE
Exchange information regarding complaint, criminal and DFS history.	MDT
Consult with DOJ (particularly for active DFS cases, for cases with DFS history and for cases with complaint and criminal history).	DFS, LE and DOJ
Schedule forensic interview at CAC for any child victims or child witnesses to include siblings and other children in the home.	MDT
Discuss DFS's required notification to the alleged perpetrator of the allegations. Limit the details of the allegations and the maltreatment type.[22]	DFS and LE
Consider consultation with police jurisdictions with more resources.	LE
Assess safety and need for out-of-home interventions of all children.	DFS
Consider Temporary Emergency Protective Custody of child and other children in home.	Medical, LE and DFS
Take photographs of child and child's injuries.	Medical, LE and DFS
Observe and photo/video document the crime scene(s); collect evidence.	LE

[22] The federal Child Abuse Prevention and Treatment Act requires DFS to notify the alleged perpetrator of the complaints or allegations made against him or her at the initial time of contact regardless of how that contact is made (42 U.S.C. 5101 et seq).

Investigative Actions	Responsible Agency
Determine if elements of Child Torture are present (review the checklist on Common Elements of Child Torture).	MDT
Follow Guidelines for Child Abuse Medical Response for child and other children in the home.	DFS, LE and Medical
Utilize victim advocates to connect children and families with appropriate mental health, substance abuse, social services and additional resources.	MDT
Participate in MDT meetings (i.e. case review).	MDT

INTERVIEWS

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

Multiple interviews by multiple interviewers can be detrimental to children and can create issues for successful civil and criminal case dispositions. Use of the CAC to conduct interviews is considered best practice to minimize trauma and re-victimization of child victims and/or child witnesses. Information to consider when discussing who will conduct the interview with the alleged child victim will include:

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

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

In any investigation of criminal conduct occurring at, or related to, a facility or organization where multiple children may have been exposed to, or victimized by, a perpetrator of the conduct being investigated, the MDT must consider the potential that other children have been victimized. Thus, the MDT should schedule and conduct interviews at the CAC of all children between the age of 3 and 12 who may have been exposed to, a victim of, or a witness to the conduct being investigated. Facilities or organizations where multiple children may be exposed to criminal conduct include, but are not limited to, child care centers, schools, and youth athletic organizations. This policy is intended to both define the scope of such investigations and to provide support to children who, by mere circumstance, are, or have been, in the presence of the subject of an investigation.

If LE and DFS are considering using the CAC, but additional information is needed from the child, the **First Responder Minimal Facts Interview Protocol** should be utilized (See Appendix A). If both LE and DFS are present, then a lead interviewer should be identified prior to conducting the interview. This Protocol will still allow DFS to assess the child's safety through its in-house protocols while preserving the criminal investigation.

FIRST RESPONDER

Minimal Facts Interview Protocol

1. **Establish rapport**
2. **Ask limited questions to determine the following:**
   - What happened?
   - Who is/are the alleged perpetrator(s)?
   - Where did it happen?
   - When did it happen?
   - Ask about witnesses/other victims
3. **Provide respectful end**

FORENSIC INTERVIEW AT THE CAC

After making a cross-report, LE, DFS, and/or DOJ may contact the CAC in the jurisdiction where the alleged crime occurred to request a forensic interview. LE and DFS will communicate prior to contacting the CAC to determine who will make the request and the appropriate timeframe for scheduling the interview.

Forensic interviews will be scheduled on a non-urgent basis (within 5 business days) or urgent basis (within 2 business days) subject to the availability of MDT member agencies, children, and their caregivers. Please note that the CAC will accommodate after-hours interviews on an emergency basis as needed. The CAC will acquire interpreter services as needed for the child and/or family. All interviews will be video and audio recorded.

The forensic interviewer will conduct the interview utilizing a nationally recognized forensic interview protocol and forensic interview aids, as appropriate. Members of the MDT may be present for the interview based on availability. MDT members should refrain from engaging in pre-interview contact with the caregiver and child at the CAC to avoid impacting the forensic interview process.

The forensic interviewer will facilitate the CAC process. This process includes pre-interview meetings, the forensic interview, and post-interview meetings. MDT members should be prepared to discuss the following: complaint and criminal history concerning all individuals involved in the case; DFS history; prior forensic interviews at the CAC; current allegations; and strategies for the interview to include introduction of evidence to the child.

During the post-interview team meeting, the MDT may discuss interview outcomes; prosecutorial merit; next investigative steps; and medical, mental health, victim advocacy and safety needs of the child and family. Additionally, the MDT may determine that a multi-session or subsequent interview is required based on the case circumstances and the needs of child.

If a **secondary allegation is disclosed to the CAC** during the forensic interview process, then the MDT members present shall make a joint report to the DFS Report Line prior to conclusion of the post interview meeting. However, if circumstances prevent the joint report from being made, the MDT shall select a member to make the report on behalf of the team. The designee will make the report immediately and inform the Report Line worker that he/she is making the call on behalf of the applicable MDT agencies.

When the MDT meets with the caregiver post-interview, DOJ will take the lead in sharing information related to the interview and possible criminal prosecution.

Following the post-interview meeting, the CAC Family Resource Advocate will facilitate a discussion with the caregiver about social and mental health services and other resources available for the child and/or family. Referrals will be made by the CAC as appropriate.

During the course of an investigation, a MDT meeting may be required to discuss new information obtained by any of the team members. The meeting shall be convened by the IC upon request of any team member. Otherwise, these discussions will take place at regularly scheduled MDT Case Review meetings.

If additional information is needed from the child by a MDT member, then the other team members should be contacted and a follow up forensic interview should be scheduled.

PRESERVATION OF EVIDENCE

LE will establish, examine and document the location(s) of incident as soon as practicable. The crime scene(s) and other corroborative evidence should be photographed or video recorded.

Interviews by LE should be audio recorded and when practicable, video recorded. Forensic interviews with the child and siblings will be video and audio recorded at the CAC. Interviews with caregivers, alleged perpetrator(s), other witnesses, and those children not interviewed at the CAC will be audio recorded and when practicable, video recorded by LE. Any recordings created during the interview process at the CAC will be turned over to LE and LE will thereafter become the agency owning this evidence.

Photographs must be taken to document the number and size of the injuries to the child; scale of injury should be documented in photograph. These photographs will be taken as part of the medical examination process if the child has been transported to a medical facility. This does not preclude LE or DFS from taking photographs as needed for investigative purposes. If no medical examination is required, observation and photographs of the child's injuries will be coordinated between LE and DFS

to prevent further trauma to the child. Please note that smartphones should be used to take photographs only in exigent circumstances.

COMMON ELEMENTS OF CHILD TORTURE

Child torture may not immediately be identified until the abuse and/or neglect results in serious physical injury or death often after multiple interventions for less serious offenses. Therefore, MDT members should consider the elements of child torture in every case and communicate any identified elements to other members of the team.

Cases can be quickly assessed by using the checklist below, and child torture should be considered when several elements are identified, either currently or historically within a case. For instance, child torture should be suspected if a 4-year-old child has linear bruising on the buttocks and a bite mark, parents are reported to be emotionally unattached to the child, and the child has clothing inappropriate for weather conditions. **Please follow the Serious Physical Injury Protocol once child torture is suspected.**

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

Section One: Deprivation of Basic Necessities (at least 1 element)	
☐ **Current or History of Allegations for Neglect**	
☐ Withholding Food ☐ Withholding Water ☐ Withholding Clothing ☐ Subjecting to Extremes of Heat or Cold ☐ Limiting Access to Others ☐ Limiting Access to Routine Medical Care ☐ Forcing Child to Stay Outside for Extended Periods or Sleep Outside	☐ Limiting Access to Toilet ☐ Limiting Access to Personal Hygiene/Bathing ☐ Inability to Move Free of Confinement ☐ Withholding Access to Schooling/Withdrawing to Home School ☐ Sleep Deprivation ☐ Low Body Mass Index ☐ Other:
Section Two: Physical Abuse (at least 2 physical assaults or 1 severe assault)	
☐ **Current or History of Allegations for Physical Abuse**	
☐ Bruising Shaped like Hands, Fingers, or Objects, or Black Eyes ☐ Fractures that are Unexplained and Unusual ☐ Ligature, Binding, and Compression Marks due to Restraints ☐ Contact or Scald Burns to the Skin or Genitalia	☐ Flexion of a Limb or Part of Limb beyond its Normal Range ☐ Human Bite Marks ☐ Force-Feeding ☐ Asphyxiation ☐ Other:
Section Three: Psychological Maltreatment (2 or more elements, can be a single incident)	
☐ **Current or History of Allegations for Psychological Maltreatment**	
☐ Rejection by Caregiver ☐ Terrorizing ☐ Isolating	☐ Exploiting/Corrupting ☐ Unresponsive to Child's Emotional Needs ☐ Shaming/Humiliation

☐ Threats of Harm or Death to Child, Sibling(s) or Pets	☐ Other:
Section Four: Supplemental Items	
☐ **Current or History of Allegations for Sexual Abuse**	
☐ Penile, Digital or Object Penetration of the Anus ☐ Assault to the Genitals ☐ Forcing Sexual Intercourse	☐ Forcing to Remain Naked or Dance ☐ Forcing to Witness or Participate in Sexual Violence against another person ☐ Other
☐ **Forcing Excessive Exercise for Punishment** ☐ **History of Prior Referrals and /or Investigations by the Division of Family Services (DFS)** ☐ **One Child is Targeted** ☐ **Sibling(s) Abused** ☐ **Siblings Join in Blaming Victim and May Lack Empathy** ☐ **Family System is Blended and Both Caregivers Participate in the Alleged Abuse and/or Neglect** ☐ **One Caregiver Fails to Protect** ☐ **No Disclosure is Made by Targeted Child or Siblings** ☐ **Caregivers Provide Reasonable Explanations in Response to Allegations** ☐ **Caregivers Allege Mental Health Issues for Targeted Child (e.g. self-injury) and Report Repeated Attempts to Seek Help**	

TEMPORARY EMERGENCY PROTECTIVE CUSTODY

In accordance with Delaware Code, Physicians, DFS investigators, or LE may take Temporary Emergency Protective Custody of a child in imminent danger of serious physical harm or a threat to life as a result of abuse or neglect for up to 4 hours. DFS may only take Temporary Emergency Protective Custody of a child in a school, day care facility, and child care facility.

Physicians and LE must immediately notify DFS upon invoking this authority. This shall end once DFS responds.

A reasonable attempt shall also be made to advise the parents, guardians or others legally responsible for the child's care, being mindful not to compromise the investigation.

DELAWARE CODE[23]

16 Del. C. § 907(a) and (e) state: "A police officer or a physician who reasonably suspects that a child is in imminent danger of suffering serious physical harm or a threat to life as a result of abuse or neglect and who reasonably suspects the harm or threat to life may occur before the Family Court can

[23] *See* 16 Del. C. § 907(a) and (e)

issue a temporary protective custody order may take or retain temporary emergency protective custody of the child without the consent of the child's parents, guardian or others legally responsible for the child's care… A Division investigator conducting an investigation pursuant to § 906 of this title shall have the same authority as that granted to a police officer or physician… provided that the child in question is located at a school, day care facility or child care facility at the time that the authority is initially exercised."

TRANSPORTATION

If the alleged perpetrator is the caregiver or is unknown, an alternative means of transportation should be provided to the child for medical examinations, forensic interviews at the CAC, and out-of-home interventions. Under these circumstances, DFS or LE may transport the child to the hospital or seek medical transport for the child, and both agencies are entitled to immunity from any liability in accordance with § 4001 of Title 10.

DFS may also transport a child under the following conditions: DFS invokes Temporary Emergency Protective Custody from a school, day care facility or child care facility; DFS obtained a signed consent from the parent; or DFS is currently awarded Temporary Custody by the Family Court.

MEDICAL EXAMINATION

A medical examination may be considered for any child, who is the alleged victim of a physical abuse report, and other children residing in the home. Medical examinations may be conducted to identify, document, diagnose, prevent, and treat medical conditions and/or trauma (resulting from abuse and unrelated to abuse), as well as to assess issues related to patient safety and well-being.

To determine the appropriate medical response for the child and other children in the home, the MDT should follow the **Delaware Multidisciplinary Team Guidelines for Child Abuse Medical Response** (Medical Response Guidelines). Please refer to Appendix "C" for the complete version of the Medical Response Guidelines.

The Medical Response Matrix for Physical Injury cases is listed below. Please note that Step 2 of the Medical Response Matrix and any medical response which involves calling the designated medical services provider will not be implemented until the resources become available.

Abuse Fact Pattern	Medical Response	Time Frame
Patterned bruises, lacerations or burns. (Examples: belt loop, cigarette burn, curling iron, etc.)	**Step 1. IMMEDIATE MEDICAL RESPONSE at discretion of first responder.** **Step 2. Call designated medical services provider.** ***Step 2 to be implemented at later date.***	**Step 1. IMMEDIATE** **Step 2. 24 HR**

Child states he/she has been hit with an object, whipped, punched, slapped, kicked or beaten.	**Step 1. IMMEDIATE MEDICAL RESPONSE at discretion of first responder.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Child appears malnourished or starved and/or demonstrates deprivational behaviors.	**Step 1. IMMEDIATE MEDICAL RESPONSE at discretion of first responder.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Any child suggesting a significant mental health issue such as suicidal ideation or gesture, or severe depression, **regardless of when the last reported contact occurred.**	**Step 1. URGENT RESPONSE OR EMS TRANSPORT to nearest hospital for:** **A) Necessary medical services.** **B) Necessary mental health services.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Siblings or juvenile housemates of child(ren) with injuries or conditions that are being evaluated for abuse or neglect.	Call designated medical services provider. *To be implemented at later date.*	24 HR

Prior to responding to the designated hospitals to seek a medical examination for a child, DFS or LE may call the Forensic Nurse Examiner Program to request a forensic exam and to provide case specific details.

Please remember that DFS has the authority to seek a medical examination for a child victim without the consent of the child's parents or caregiver. For siblings and other children in the home, the American Academy of Pediatrics recommends a timely medical examination for siblings and other children in the home when one child is identified as a victim of abuse.

DELAWARE CODE[24]

16 Del. C. § 906(e)(7) of the Delaware Code states: "The Division shall have authority to secure a medical examination of a child, without the consent of those responsible for the care, custody and control of the child, if the child has been reported to be a victim of abuse or neglect…"

[24] *See* 16 Del. C. § 906(e)(7)

The medical examination should include written record and photographic documentation of injuries. If no medical assessment is conducted, then LE will be responsible for taking the photographs to document the number and size of the injuries. For the purposes of its investigation, DFS may need to take photographs, but every effort should be made by the agencies not to duplicate these efforts. Smartphones should be used to take photographs only in exigent circumstances.

In these cases, the medical providers are charged with determining, based upon a reasonable degree of medical certainty, whether the child's injury is accidental, inflicted or caused by a medical condition. Both the medical examination and information gathered by LE and DFS are used to make this determination. These preliminary medical findings will be provided immediately to LE and DFS upon completion of the examination. Subsequent findings and medical records should be obtained prior to completion of an investigation.

Potential questions that should be asked of the medical provider are listed below. Avoid asking a physician whether it is "possible" that a caregiver's explanation caused the injury, because the answer will always be yes. Instead, use the words "probable, likely or consistent with" when speaking with medical providers and note that medical providers only speak in terms of probability and not absolutes.

COLLECTING THE MEDICAL EVIDENCE[25]

Questions for the Medical Provider

- What is the nature and extent of the child's injury or illness?
- What is the mechanism of injury? What type and amount of force are required to produce the injury?
- Does the history the caregiver provided explain (in whole or in part) the child's injury?
- Have other diagnoses been explored and ruled out, whether by information gathering, examination, or medical tests?
- Could the injury be consistent with an accident?
- Can the timing of the injury be estimated? To what degree of certainty?
- Have all injuries been assessed in light of any exculpatory statements?
- What treatments were necessary to treat the injury or illness?
- What are the child's potential risks from the abusive event?
- What are the long-term medical consequences and residual effects of the abuse?

MDT members should consider the possibility of injuries that were not reported by the child or not readily visible (i.e. internal injuries or age progression of injuries). Be mindful that minor injuries, when paired with a history of alleged abuse or neglect, may be indicative of chronic physical abuse or torture.

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

Prior to discharge, if concerns regarding the child's safety exist, then the medical providers may consider requesting a meeting in accordance with **Hospital High Risk Medical Discharge Protocol** (See Appendix D). The Protocol ensures that children (birth to age 18) with special medical needs, who are active with DFS or have been reported to DFS by Delaware hospitals, are discharged in a planned and safe manner.

In addition to the medical examination for allegations of abuse or neglect, the American Academy of Pediatrics (AAP) recommends that children in foster care receive an initial health screening within 72 hours of placement to identify any immediate medical, mental health and dental needs, and a comprehensive health evaluation within 30 days of placement to review all available medical history, to identify medical conditions and to develop an individualized treatment plan for the child. Additionally, the AAP recommends that the child receive a screening each time the placement changes.[26] The Foster Care Health Program at the Nemours Alfred I. duPont Hospital for Children is the state's specialty clinic, and DFS is responsible for making these referrals as appropriate.

SAFETY ASSESSMENT

DFS is responsible for assessing the safety of the alleged child victim and other children in the home and/or visiting the home during the course of the investigation. If safety threats are present, DFS will consider whether an out-of-home intervention is warranted by safety agreement or custody. For children placed in out-of-home interventions through a safety agreement, DFS will conduct background checks on all individuals in that home and complete home assessments.

LE will notify DFS if removal of a child appears necessary. LE should communicate concerns and information regarding the child's safety that may impact DFS interventions. DFS, not LE, is responsible for making placement decisions when safety threats are present and the child(ren) cannot remain at the current residence. As noted above, for situations in which a child is in imminent danger, then it would be appropriate for LE to take Temporary Emergency Protective Custody.

BEHAVIORAL HEALTH AND SOCIAL SERVICES

The child and family should be connected to any needed behavioral health and social services in order to reduce trauma, promote healing and improve outcomes. Child abuse and neglect can be experienced as traumatic events and can have a lifelong impact on the child and the family if appropriate resources and supportive services are not provided. The social and mental health needs of all should be considered in every case and discussed as part of the MDT meetings throughout the life of the case.

The Division of Prevention and Behavioral Health Services (DPBHS) provides a wide range of individualized, trauma-informed, and community-based behavioral health services to children and families statewide. Every child residing in Delaware can be referred to prevention/early intervention

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

and crisis services which are provided through DPBHS. To refer or receive information about these services call the DPBHS Access Unit at 1-800-722-7710 or the Crisis Service at 1-800-969-4357.

DPBHS provides the outpatient treatment and supportive services to youth who are uninsured or insured by Medicaid through an array of specialized evidence-based practices to promote the best outcomes for children and families. In the event a child needs treatment outside of his/her community (including homes and school), the DPBHS treatment continuum may include day treatment, partial hospitalization program, residential rehabilitative treatment and inpatient hospitalization services.

Children presenting with indicators of trauma who are uninsured or insured by Medicaid should be referred to the Access Unit at DPBHS. Staff in the Access Unit will collect behavioral health and substance abuse information. If the child is in need of services beyond prevention, early intervention or outpatient, staff will complete a service intensity tool (e.g. Child and Adolescent Service Intensity Instrument (CASII) and American Society of Addiction Medicine (ASAM)) and make appropriate referrals for services. For children in need of treatment with private insurance, the families should be referred to their insurance company for information about benefits and providers.

For children entering foster care, the DFS Office of Evidence-Based Practice (OEBP) will conduct a screening to assist in identifying the needed mental health services for children and their families. In addition, if a child in foster care exhibits trauma or symptoms of trauma, the caseworker will alert the OEBP for further Trauma Screening.

MDT members may connect children and their families to these and other services with the assistance of the victim advocates identified below.

VICTIM ADVOCATES

Victim advocates are responsible for assessing the needs of the child and family and connecting them to culturally appropriate resources and services. Victim advocates are available in each of the MDT agencies as follows:

- DSCYF/Division of Family Services – Domestic Violence Liaisons & Substance Abuse Liaisons
- Law Enforcement – Victim Service Specialists
- Department of Justice – Social Workers
- Children's Advocacy Center – Family Resource Advocates
- Hospitals – Social Workers

To ensure there are no gaps in services, victim advocates should communicate with each other and coordinate with mental health and social service providers throughout the course of the investigation and beyond. The roles and responsibilities of the victim advocates will vary among the agencies, so not all advocates will provide the same array services. However, the following constellation of services may be provided as needed: emergency crisis assessment and intervention, risk assessment and safety intervention for caregivers and families, information on Victims Information Notification Everyday (VINE), assistance with filing for emergency financial assistance and education regarding victim's rights, case status updates, court accompaniment, and information and referrals for appropriate social

service agencies (e.g. housing, protective orders, domestic violence intervention, food, transportation, public assistance, and landlord/employer intervention).

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

ARREST

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

When an alleged perpetrator is arrested, a no contact order with the alleged child victim and/or other children in the home may be recommended, as a specific condition of bail and/or other conditions that may be necessary to protect the child(ren) and any other members of the community. Input from DFS should be considered and offered to the issuing judicial officer. LE and/or DFS may contact DOJ to request a modification to the contact conditions of bail. Regardless of contact conditions of bail, DFS will consider an in-home intervention or an out-of-home intervention once safety threats are identified, including safety agreements, custody and placement needs.

Before clearing a case without an arrest, LE consultation with DOJ is recommended. LE will notify DFS upon case closure.

CRIMINAL PROCEEDINGS

DOJ may review the following information (both current and historical):

- All police reports and any other information obtained during the investigation concerning all individuals involved in the case;
- All non-redacted DFS records;
- All medical records pertaining to the child;
- All CAC records; and,
- Inventory and/or copies of any evidence.

The Deputy Attorney General (DAG) will evaluate the case to determine prosecutorial merits and will collaborate with LE to identify additional investigative actions as appropriate.

When two or more Divisions (typically Family & Criminal) within DOJ are involved with a particular case, the DAGs will coordinate with each other to ensure the most appropriate legal outcomes are achieved. The Civil and Criminal DAGs shall communicate regularly regarding the case status. The DAG prosecuting the criminal matter will take the lead in this process.

Before resolution of a criminal proceeding, DOJ should confer with DFS, on active cases, regarding issues impacting child safety, such as vacating the No Contact Order and potential impact to a civil substantiation proceeding prior to completion of the civil investigation. This discussion should also include recommended services and/or evaluations for the perpetrator and child. Upon a criminal conviction where the civil case was unfounded and closed, the Criminal DAG will notify the Civil DAG.

CIVIL DISPOSITION

DFS makes a determination as to whether abuse or neglect has occurred within 45 calendar days. Upon completion of the civil investigation, DFS will make a finding once it has established that a preponderance of the evidence exists; the civil finding is not dependent upon the status or outcome of the criminal case.

DFS is required to give written notice to the alleged perpetrator of its finding. Recognizing that this notice to the alleged perpetrator may impact an active criminal investigation, DFS shall contact LE/DOJ prior to case closure in order to maintain the integrity of the case.

DELAWARE CODE[27]

16 Del. C. § 924(a)(2)b. states: "[The Division shall] advise the person that the Division intends to substantiate the allegations and enter the person on the Child Protection Registry for the incident of abuse or neglect at a designated Child Protection Level."

In addition to the DFS investigation, there may be a civil proceeding in the Family Court, such as if DFS petitions for temporary custody of a child or if the alleged perpetrator appeals a finding by DFS and a Substantiation Hearing is scheduled.

MDT members may be subpoenaed to testify in civil proceedings and/or provide case documentation or evidence subject to any relevant statutory provisions and Court rulings as to the confidentiality and admissibility of said evidence.

3. MDT CASE REVIEW

MDT Case Review is the formal process in which the team convenes regularly scheduled meetings in each county to monitor and discuss the case progress, which may include the following:

- Review interview outcomes;
- Discuss, plan and monitor the progress of the investigation;
- Review any medical examinations;
- Discuss child protection and other safety issues;
- Provide input for prosecution and sentencing decisions;
- Discuss emotional support and treatment needs of the child and family members as well as strategies for meeting those needs;
- Assess the families' reactions and response to the child's disclosure and involvement in the criminal justice and/or child protection systems;
- Review criminal and civil case updates, ongoing involvement of the child and family and disposition;

[27] *See* 16 Del. C. § 924(a)(2)b.

- Make provisions for court education and court support;
- Discuss ongoing cultural and special needs issues relevant to the case; and,
- Ensure that all children and families are afforded the legal rights and comprehensive services to which they are entitled.

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

Please see Appendix "F" for an example of a MDT Case Review Protocol utilized in Delaware.

4. CONFIDENTIALITY, INFORMATION SHARING & DOCUMENTATION

The Child Abuse Prevention and Treatment Act (CAPTA) requires that states preserve the confidentiality of all reports and records pertaining to cases that fall within this MOU to protect the privacy rights of the child and family.[28] However, exceptions are permitted in certain limited circumstances, and the Delaware Code provides guidance on who may access the information.

DELAWARE CODE[29]

16 Del. C. § 906(e) states: "The Division shall only release information to persons who have a legitimate public safety need for such information or a need based on the health and safety of a child subject to abuse, neglect or the risk of maltreatment, and such information shall be used only for the purpose for which the information is released."

MDT members are **authorized and encouraged** to communicate information with one another pertaining to families and children in a legal, ethical, professional, and timely manner throughout the course of an investigation in accordance with agency policies and existing agreements (e.g. MOUs). As noted above, applicable state and federal confidentiality laws apply.

To obtain records, the requesting MDT agency must contact the MDT agency from which the records originated. **Information may be shared between MDT agencies; however, records shall only be disseminated by the agency owning those records.** Mental health and substance abuse records are afforded a stricter level of protection under state and federal statutes requiring consent of the parent or pursuant to a subpoena issued by DOJ.

If a criminal or civil proceeding is pending, DOJ may also issue a subpoena for records or for court testimony.

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

Documentation should be specific to case facts and should not include information related to the opinions of the MDT members (i.e., the initial concerns of the investigator as to the strength, strategy, or course of the criminal investigation).

5. CONFLICT RESOLUTION

The MDT shall make every effort to resolve disputes through discussion and negotiation at the lowest levels of agency management. If the dispute cannot be resolved at this level, then the MDT members involved in the dispute shall contact their individual supervisors for assistance. Once the chain of command is exhausted or at the request of one of the supervisors, a team meeting may be scheduled.

III. SERIOUS PHYSICAL INJURY TO A CHILD PROTOCOL

A. DEFINITION: Serious physical injury to a child shall mean physical injury which creates a risk of death, or which causes disfigurement, impairment of health or loss or impairment of the function of any bodily organ or limb, or which causes the unlawful termination of a pregnancy without the consent of the pregnant female;[30]

OR

A near death, as defined in 16 Del. C. § 902(16), shall mean a child is in serious or critical condition as a result of child abuse or neglect as certified by a physician.

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

1. CIVIL OFFENSES

- **Abusive Head Trauma/Shaken Baby Syndrome**: means there has been an inflicted head injury which includes shaken baby and/or an impact injury. It involves some degree of intracranial injury. The most common manifestation is subdural hematoma, but it may include other types of intracranial injuries. There is a risk of serious and permanent brain damage and there may be a significant risk of death. This injury typically involves infants;[31]

- **Blunt Force Trauma**: means serious or life-threatening bruises, cuts, lacerations caused by [any individual] that require medical treatment beyond medical examination;[32]

- **Bone Fracture**: means a medically diagnosed break or crack in a bone or cartilage caused by [any individual];[33]

- **Bullet/Gunshot Wound**;

- **Burn/Scald**: means a medically diagnosed injury intentionally or recklessly inflicted by [any individual] to a child by contacting the child's skin/hair to a flame, hot object, hot liquid, electrical source, or a chemical source;[34]

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[30] *See* 11 Del. C. § 1100(8)
[31] *See* 10.1.19. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml
[32] *See* 10.1.2. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.
[33] *See* 10.1.3. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.
[34] *See* 10.1.4. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.

- **Head Trauma**: means a medically diagnosed serious or life-threatening injury inflicted by [any individual] to a child's face or head;[35]

- **Internal Injury**: means a medically diagnosed serious injury within the abdominal or chest area inflicted by [any individual];[36]

- **Poisoning**: means [any individual] intentionally or recklessly over-medicates or causes a child to ingest alcohol, drugs (legal/illegal) not prescribed for that child, or other toxic substances, resulting in significant and/or enduring functional impairment;[37]

- **Puncture/Stab**: means [any individual] inflicts injury, piercing the child's body with a pointed object, which requires medical treatment beyond medical examination;[38] and,

- **Suffocation**: means [any individual] deliberately interferes with child's ability to breathe, by strangling/choking, smothering or otherwise depriving the child of oxygen;[39] and,

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

2. CRIMINAL OFFENSES

- § 607 Strangulation; penalty; affirmative defense;

- § 612 Assault in the second degree; class D felony;

- § 613 Assault in the first degree; class B felony;

- § 628A Vehicular assault in the second degree; class A misdemeanor;

- § 629 Vehicular assault in the first degree; class F felony;

- § 782 Unlawful imprisonment in the first degree; class G felony;

- § 1102 Endangering the welfare of a child; class G felony;

- § 1103A Child abuse in the second degree; class G felony; and,

- § 1103B Child abuse in the first degree; class B felony.

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[35] *See* 10.1.9. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.
[36] *See* 10.1.10. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml
[37] *See* 10.1.15. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml
[38] *See* 10.1.17. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml
[39] *See* 10.1.20. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml

C. MULTIDISCIPLINARY RESPONSE

1. CROSS-REPORTING

For the aforementioned civil and criminal offenses, the MDT agencies agree to cross-report and share information regarding the report of abuse.

REPORTS TO DIVISION OF FAMILY SERVICES (DFS)

All suspected child abuse and neglect of any child, from birth to age 18, in the State of Delaware must be reported to the Division of Family Services Child Abuse Report Line (Report Line) at 1-800-292-9582.

DELAWARE CODE

Mandatory Reporting Law[40]

16 Del. C. § 903 states: "Any person, agency, organization or entity who knows or in good faith suspects child abuse or neglect shall make a report in accordance with § 904 of this title…"

In addition, 16 Del. C. § 904 states: "Any report of child abuse or neglect required to be made under this chapter shall be made by contacting the Child Abuse and Neglect Report Line for the Department of Services for Children, Youth and Their Families. An immediate oral report shall be made by telephone or otherwise. Reports and the contents thereof including a written report, if requested, shall be made in accordance with the rules and regulations of the Division, or in accordance with the rules and regulations adopted by the Division. No individual with knowledge of child abuse or neglect or knowledge that leads to a good faith suspicion of child abuse or neglect shall rely on another individual who has less direct knowledge to call the aforementioned Report Line."

Penalty for Violation[41]

16 Del. C. § 914 states: "Whoever violates § 903 of this title shall be liable for a civil penalty not to exceed $10,000 for the first violation, and not to exceed $50,000 for any subsequent violation."

Any person who has **direct knowledge** of suspected abuse must make an immediate report to the Report Line. **Direct knowledge** is obtained through disclosure (child discloses to you), discovery (you witness an act of abuse), or reason to suspect (you have observed behavioral and/or physical signs of child abuse). This report may include situations where multiple disciplines are involved, such as:

- 911 call where emergency medical services and law enforcement are dispatched. A call must be made to the Report Line from both professionals.

[40] *See* 16 Del. C. §§ 903 and 904
[41] *See* 16 Del. C. § 914

- A child is brought to a medical provider but requires advanced medical care and is transported to the hospital emergency department. Both the medical provider and emergency department staff must make the call to the Report Line.

The relationship between the child and perpetrator ***does not*** influence whether a report must be made to DFS. All reports, including domestic or intra-familial, institutional, and non-domestic or extra-familial, cases must also be reported to DFS.

Additionally, a separate report must be made to the Report Line for the following reasons:

- Additional suspects have been identified;
- Additional child victims have been identified; or,
- Secondary allegations have been disclosed (i.e. initial report alleged serious physical injury and child later disclosed sexual abuse).

If a **secondary allegation is disclosed to the CAC** during the forensic interview process, then the MDT members present shall make a joint report to the DFS Report Line prior to conclusion of the post interview meeting. However, if circumstances prevent the joint report from being made, the MDT shall select a member to make the report on behalf of the team. The designee will make the report immediately and inform the Report Line worker that he/she is making the call on behalf of the applicable MDT agencies.

If known, the following should be provided to the DFS Report Line:

- Demographic information;
- Known information about the following:
    - Child, parents, siblings and alleged perpetrator;
    - The alleged child victim's physical health, mental health, educational status;
    - Medical attention that may be needed for injuries;
    - The way the caregiver and alleged perpetrator's behavior is impacting the care of the child; and,
    - Any circumstances that may jeopardize the child's or DFS worker's safety.
- Facts regarding the alleged abuse and any previous involvement with the family.
- What you are worried about, what is working well, and what needs to happen next to keep the child safe.

Reports received by DFS will either be screened in for investigation as an intra-familial case and/or institutional abuse (IA) case or will be screened out, documented, and maintained in the DFS reporting system.

Reports screened in for investigation by DFS are assigned a priority response time as follows:

- Priority 1 (P1) – Within 24 hours
- Priority 2 (P2) – Within 3 days
- Priority 3 (P3) – Within 10 days

In most cases, DFS will assign a P1 response if the case involves a child who requires immediate medical attention for a severe injury.

REPORTS TO LAW ENFORCEMENT (LE)

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

DELAWARE CODE[42]

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

16 Del. C. § 906(e)(3) states: "The Division staff shall also contact…the appropriate law-enforcement agency upon receipt of any report under this section and shall provide such agency with a detailed description of the report received."

24 Del. C. § 1762(a) states: "Every person certified to practice medicine who attends to or treats a stab wound; poisoning by other than accidental means; or a bullet wound, gunshot wound, powder burn, or other injury or condition arising from or caused by the discharge of a gun, pistol, or other firearm, or when such injury or condition is treated in a hospital, sanitarium, or other institution, the person, manager, superintendent, or other individual in charge shall report the injury or condition as soon as possible to the appropriate police authority where the attending or treating person was located at the time of treatment or where the hospital, sanitarium, or institution is located."

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

[42] *See* 16 Del. C. § 903 and 906(e)(3) and 24 Del. C. § 1762(a)

REPORTS TO DEPARTMENT OF JUSTICE (DOJ)

DFS is required to report offenses identified in the Serious Physical Injury Protocol to the appropriate division at the Department of Justice. Additionally, DFS is required to report all persons, agencies, organizations and entities to DOJ for investigation if they fail to make mandatory reports of child abuse or neglect under 16 Del. C. § 903.

LE shall call DOJ's Special Victims Unit upon receipt of allegations of serious physical injury to a child.

If the matter is referred to the Children's Advocacy Center for a forensic interview, the CAC will notify the DOJ, DFS, and LE of the scheduled interview as soon as possible.

DELAWARE CODE[43]

16 Del. C. § 906(e)(3) states: "The Division staff shall also contact the Delaware Department of Justice… upon receipt of any report under this section and shall provide such agency with a detailed description of the report received."

REPORTS TO THE OFFICE OF THE INVESTIGATION COORDINATOR (IC)

The Office of the Investigation Coordinator receives reports of serious physical injury through data exchanges with DFS and the Delaware Criminal Justice Information System (DELJIS). Additionally, all MDT members shall provide case specific information as requested by the IC. For the purposes of conflict resolution, the Office of the Investigation Coordinator may be contacted to initiate or facilitate communication with other members of the MDT.

DELAWARE CODE[44]

16 Del. C. § 906(c)(1)a. and b. state: "The Investigation Coordinator, or the Investigation Coordinator's staff, shall…have electronic access and the authority to track within the Department's internal information system and Delaware's criminal justice information system each reported case of alleged child abuse or neglect. Monitor each case involving the death of, serious physical injury to, or allegations of sexual abuse of a child from inception to final criminal and civil disposition, and provide information as requested on the status of each case to the Division, the Department, the Delaware Department of Justice, the Children's Advocacy Center, and the Office of Child Advocate."

16 Del. C. § 905(f) states: "Upon receipt of a report of child abuse or neglect, the Division shall immediately notify the Investigation Coordinator of the report, in sufficient detail to permit the Investigation Coordinator to undertake the Investigation Coordinator's duties, as specified in § 906 of this title."

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

16 Del. C. § 906(d)(2) and (f)(3) state: The law enforcement agency and Delaware Department of Justice investigating a report of child abuse shall "provide information as necessary to the Investigation Coordinator to permit case tracking, monitoring and reporting by the Investigation Coordinator."

REPORTS TO PROFESSIONAL REGULATORY BODIES

In keeping with the following statutory requirements, certain MDT members shall make reports to professional regulatory organizations and other agencies upon receipt of reports alleging abuse or neglect by professionals licensed in Delaware.

DELAWARE CODE[45]

16 Del. C. § 906(c)(1)c. states the Investigation Coordinator or the Investigation Coordinator's designee shall: "Within 5 business days of the receipt of a report concerning allegations of child abuse or neglect by a person known to be licensed or certified by a Delaware agency or professional regulatory organization, forward a report of such allegations to the appropriate Delaware agency or professional regulatory organization."

16 Del. C. § 906(e)(6) and (f)(4) state the Division and DOJ shall: "Ensure that all cases involving allegations of child abuse or neglect by a person known to be licensed or certified by a Delaware agency or professional regulatory organization, have been reported to the appropriate Delaware agency or professional regulatory organization and the Investigation Coordinator in accordance with the provisions of this section."

24 Del. C. § 1731A(a) states any person may report to the Board information that the reporting person reasonably believes indicates that a person certified and registered to practice medicine in this State is or may be guilty of unprofessional conduct or may be unable to practice medicine with reasonable skill or safety to patients by reason of mental illness or mental incompetence; physical illness, including deterioration through the aging process or loss of motor skill; or excessive use or abuse of drugs, including alcohol. The following have an affirmative duty to report, and must report, such information to the Board in writing within 30 days of becoming aware of the information:

(1) All persons certified to practice medicine under this chapter;

(2) All certified, registered, or licensed healthcare providers;

(3) The Medical Society of Delaware;

(4) All healthcare institutions in the State;

(5) All state agencies other than law-enforcement agencies;

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

(6) All law-enforcement agencies in the State, except that such agencies are required to report only new or pending investigations of alleged criminal conduct specified in § 1731(b)(2) of this title, and are further required to report within 30 days of the close of a criminal investigation or the arrest of a person licensed under this chapter.

2. INVESTIGATION

For the purpose of conducting an effective joint investigation, communication and coordination should occur among the MDT members as soon as possible and continue throughout the life of the case.

Upon receipt of a report, DOJ, DFS, and LE will communicate and coordinate a response; however, LE will take the lead in the Joint Investigation. LE agencies needing additional resources may consult with larger jurisdictions.

For all allegations within this Protocol, the MDT will determine from the list below the appropriate investigative actions that have been identified as best practices for responding to child abuse cases.

Investigative Actions	Responsible Agency
Contact the DOJ Special Victims Unit immediately.	LE
Cross-report and coordinate an immediate response between MDT members.	MDT
Establish the location(s) where the incident occurred.	LE
Identify persons involved and coordinate interviews with child, siblings, caregivers, alleged perpetrator(s), and other witnesses.	DFS and LE
Exchange information regarding complaint, criminal and DFS history.	MDT
Consider consultation with police jurisdictions with more resources.	LE
Schedule forensic interviews at CAC for any child victims or child witnesses to include siblings and other children in the home.	MDT
Discuss DFS's required notification to the alleged perpetrator of the allegations. Limit the details of the allegations and the maltreatment type.[46]	DFS and LE
Assess safety and need for out-of-home interventions of all children.	DFS

[46] The federal Child Abuse Prevention and Treatment Act requires DFS to notify the alleged perpetrator of the complaints or allegations made against him or her at the initial time of contact regardless of how that contact is made (42 U.S.C. 5101 et seq).

Investigative Actions	Responsible Agency
Consider Temporary Emergency Protective Custody of child and other children in home.	Medical, LE and DFS
Observe and photo/video document the crime scene(s); collect evidence.	LE
Conduct doll/scene re-enactment and video document.	LE
Obtain consent or search warrant for blood draw if impairment is suspected for alleged perpetrator(s).	LE
Determine if elements of Child Torture are present (review the checklist on Common Elements of Child Torture).	MDT
Follow Guidelines for Child Abuse Medical Response for child and other children in the home.	DFS, LE and Medical
Take photographs of child and child's injuries.	Medical, LE and DFS
Conduct video documentation, with explanation by the medical provider, of any life supporting mechanisms provided to the child.	Medical and LE
Consider Hospital High Risk Medical Discharge Protocol if concerns exist about the child's safety at discharge.	Medical
Notify the Investigation Coordinator's Office of the serious physical injury.	DFS, LE and DOJ
Utilize victim advocates to connect children and families with appropriate mental health, substance abuse, social services and additional resources.	MDT
Complete pre-arrest intake with DOJ.	LE and DOJ
Participate in MDT meetings (i.e. case review).	MDT

INTERVIEWS

LE will conduct interviews with caregivers, alleged perpetrator(s), and other witnesses and will provide prior notice to DFS to allow for observation. Additionally, all interviews shall be audio recorded, and when practicable, video recorded by LE. DFS must receive clearance from LE before conducting follow up interviews for the purpose of gathering information relevant to the civil investigation. In the event that a LE response is delayed, DFS may obtain basic information from the family to assess the child's safety until LE arrives to conduct the interviews.

Child victims and witnesses to include siblings and other children in the home, ages 3 to 12, should be interviewed at the CAC in cases that fall within the Serious Physical Injury Protocol. This does not preclude interviews of children under 3, who are verbal, or youth between the ages of 13 and 18. Multiple interviews by multiple interviewers can be detrimental to children and can create issues for successful civil and criminal case dispositions. Use of the CAC to conduct interviews is considered best practice to minimize trauma and re-victimization of child victims and/or child witnesses.

In any investigation of criminal conduct occurring at, or related to, a facility or organization where multiple children may have been exposed to, or victimized by, a perpetrator of the conduct being investigated, the MDT must consider the potential that other children have been victimized. Thus, the MDT should schedule and conduct interviews at the CAC of all children between the age of 3 and 12 who may have been exposed to, a victim of, or a witness to the conduct being investigated. Facilities or organizations where multiple children may be exposed to criminal conduct include, but are not limited to, child care centers, schools, and youth athletic organizations. This policy is intended to both define the scope of such investigations and to provide support to children who, by mere circumstance, are, or have been, in the presence of the subject of an investigation.

If additional information is needed prior to scheduling the forensic interview with the child, the **First Responder Minimal Facts Interview Protocol** should be utilized (See Appendix A). If both LE and DFS are present, then a lead interviewer should be identified prior to conducting the interview. This Protocol will still allow DFS to assess the child's safety through its in-house protocols while preserving the criminal investigation.

FIRST RESPONDER

Minimal Facts Interview Protocol

1. **Establish rapport**
2. **Ask limited questions to determine the following:**
   - What happened?
   - Who is/are the alleged perpetrator(s)?
   - Where did it happen?
   - When did it happen?
   - Ask about witnesses/other victims
3. **Provide respectful end**

FORENSIC INTERVIEW AT THE CAC

After making a cross-report, LE, DFS, and/or DOJ may contact the CAC in the jurisdiction where the alleged crime occurred to request a forensic interview. LE and DFS will communicate prior to contacting the CAC to determine who will make the request and the appropriate timeframe for scheduling the interview.

Forensic interviews will be scheduled on a non-urgent basis (within 5 business days) or urgent basis (within 2 business days) subject to the availability of MDT member agencies, children, and their caregivers. Please note that the CAC will accommodate after-hours interviews on an emergency basis as needed. The CAC will acquire interpreter services as needed for the child and/or family. All interviews will be video and audio recorded.

The forensic interviewer will conduct the interview utilizing a nationally recognized forensic interview protocol and forensic interview aids, as appropriate. Members of the MDT may be present for the interview based on availability. MDT members should refrain from engaging in pre-interview contact with the caregiver and child at the CAC to avoid impacting the forensic interview process.

The forensic interviewer will facilitate the CAC process. This process includes pre-interview meetings, the forensic interview, and post-interview meetings. MDT members should be prepared to discuss the following: complaint and criminal history concerning all individuals involved in the case; DFS history; prior forensic interviews at the CAC; current allegations; and strategies for the interview to include introduction of evidence to the child.

During the post-interview team meeting, the MDT may discuss interview outcomes; prosecutorial merit; next investigative steps; and medical, mental health, victim advocacy and safety needs of the child and family. Additionally, the MDT may determine that a multi-session or subsequent interview is required based on the case circumstances and the needs of child.

If a **secondary allegation is disclosed to the CAC** during the forensic interview process, then the MDT members present shall make a joint report to the DFS Report Line prior to conclusion of the post interview meeting. However, if circumstances prevent the joint report from being made, the MDT shall select a member to make the report on behalf of the team. The designee will make the report immediately and inform the Report Line worker that he/she is making the call on behalf of the applicable MDT agencies.

When the MDT meets with the caregiver post-interview, DOJ will take the lead in sharing information related to the interview and possible criminal prosecution.

Following the post-interview meeting, the CAC Family Resource Advocate will facilitate a discussion with the caregiver about social and mental health services and other resources available for the child and/or family. Referrals will be made by the CAC as appropriate.

During the course of an investigation, a MDT meeting may be required to discuss new information obtained by any of the team members. The meeting shall be convened by the IC upon request of any team member. Otherwise, these discussions will take place at regularly scheduled MDT Case Review meetings.

If additional information is needed from the child by a MDT member, then the other team members should be contacted and a follow up forensic interview should be scheduled.

PRESERVATION OF EVIDENCE

LE will establish, examine and document the location(s) of incident as soon as practicable. The crime scene(s) and other corroborative evidence should be collected and photographed or video recorded.

Interviews by LE should be audio recorded and when practicable, video recorded. Forensic interviews with the child and siblings will be video and audio recorded at the CAC. Interviews with caregivers, alleged perpetrator(s), other witnesses, and those children not interviewed at the CAC will be audio recorded and when practicable, video recorded by LE. Any recordings created during the interview process at the CAC will be turned over to LE and LE will thereafter become the agency owning this evidence.

LE will conduct a doll and scene re-enactment with the alleged perpetrator to provide a visual demonstration of the mechanism of injury. This re-enactment will be video documented and conducted at the scene when possible. DFS and DOJ may observe the re-enactment.

Photographs must be taken to document the number and size of the injuries to the child; scale of injury should be documented in photograph. These photographs will be taken as part of the medical examination process if the child has been transported to a medical facility. This does not preclude LE or DFS from taking photographs as needed for investigative purposes. Please note that smartphones should be used to take photographs only in exigent circumstances.

If life supporting mechanisms are utilized, then LE will video document these efforts to include the explanation by the medical provider.

For circumstances where impairment of the alleged perpetrator(s) is suspected, consent to draw blood will be attempted by LE. Otherwise, a search warrant will be obtained.

COMMON ELEMENTS OF CHILD TORTURE

Child torture may not immediately be identified until the abuse and/or neglect results in serious physical injury or death often after multiple interventions for less serious offenses. Therefore, MDT members should consider the elements of child torture in every case and communicate any identified elements to other members of the team.

Cases can be quickly assessed by using the checklist below, and child torture should be considered when several elements are identified, either currently or historically within a case. For instance, child torture should be suspected if a 4-year-old child has current unexplained fracture, linear bruising was observed on the buttocks two months prior, and parent is withholding food, threatening the child, and isolating the child from family.

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

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

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

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

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

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

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

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

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

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

Section Four: Supplemental Items

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

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

☐ **Forcing Excessive Exercise for Punishment**

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

☐ **One Child is Targeted**

☐ **Sibling(s) Abused**

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

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

☐ **One Caregiver Fails to Protect**

☐ **No Disclosure is Made by Targeted Child or Siblings**

☐ **Caregivers Provide Reasonable Explanations in Response to Allegations**

☐ **Caregivers Allege Mental Health Issues for Targeted Child (e.g. self-injury) and Report Repeated Attempts to Seek Help**

TEMPORARY EMERGENCY PROTECTIVE CUSTODY

In accordance with Delaware Code, Physicians, DFS investigators, or LE may take Temporary Emergency Protective Custody of a child in imminent danger of serious physical harm or a threat to life as a result of abuse or neglect for up to 4 hours. DFS may only take Temporary Emergency Protective Custody of a child in a school, day care facility, and child care facility.

Physicians and LE must immediately notify DFS upon invoking this authority. This shall end once DFS responds.

A reasonable attempt shall also be made to advise the parents, guardians or others legally responsible for the child's care, being mindful not to compromise the investigation.

DELAWARE CODE[47]

16 Del. C. § 907(a) and (e) state: "A police officer or a physician who reasonably suspects that a child is in imminent danger of suffering serious physical harm or a threat to life as a result of abuse or neglect and who reasonably suspects the harm or threat to life may occur before the Family Court can issue a temporary protective custody order may take or retain temporary emergency protective custody of the child without the consent of the child's parents, guardian or others legally responsible for the child's care… A Division investigator conducting an investigation pursuant to § 906 of this title shall have the same authority as that granted to a police officer or physician… provided that the child in question is located at a school, day care facility or child care facility at the time that the authority is initially exercised."

TRANSPORTATION

If the alleged perpetrator is the caregiver or is unknown, an alternative means of transportation should be provided to the child for medical examinations, forensic interviews at the CAC, and out-of-home interventions. Under these circumstances, DFS or LE may transport the child to the hospital or seek medical transport for the child, and both agencies are entitled to immunity from any liability in accordance with § 4001 of Title 10.

[47] *See* 16 Del. C. § 907(a) and (e)

DFS may also transport a child under the following conditions: DFS invokes Temporary Emergency Protective Custody from a school, day care facility or child care facility; DFS obtained a signed consent from the parent; or DFS is currently awarded Temporary Custody by the Family Court.

MEDICAL EXAMINATION

A medical examination will be conducted for any child, who is the alleged victim of a serious physical injury report, and considered for other children residing in the home. Medical examinations may be conducted to identify, document, diagnose, prevent, and treat medical conditions and/or trauma (resulting from abuse and unrelated to abuse), as well as to assess issues related to patient safety and well-being.

To determine the appropriate medical response for the child and other children in the home, the MDT should follow the **Delaware Multidisciplinary Team Guidelines for Child Abuse Medical Response** (Medical Response Guidelines). Please refer to Appendix "C" for the complete version of the Medical Response Guidelines.

The Medical Response Matrix for Serious Physical Injury cases is listed below. Please note that Step 2 of the Medical Response Matrix and any medical response which involves calling the designated medical services provider will not be implemented until the resources become available.

Abuse Fact Pattern	Medical Response	Time Frame
Child is 0-6 months of age for any injury.	**Step 1. IMMEDIATE EMS TRANSPORT to nearest hospital.** **Step 2. Call designated medical services provider.**	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Severe or extensive injuries at any age, including but not limited to: head trauma, burns, fractures, chest or abdominal injuries.	**Step 1. IMMEDIATE EMS TRANSPORT to nearest hospital.** **Step 2. Call designated medical services provider.**	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Child appears to be intoxicated, drugged, or otherwise non-responsive or abnormally responsive.	**Step 1. IMMEDIATE EMS TRANSPORT to nearest hospital.** **Step 2. Call designated medical services provider.**	**Step 1. IMMEDIATE** **Step 2. 24 HR**

Step 2 to be implemented at later date.

Any child suggesting a significant mental health issue such as suicidal ideation or gesture, or severe depression, **regardless of when the last reported contact occurred.**	**Step 1. URGENT RESPONSE OR EMS TRANSPORT to nearest hospital for:** **A) Necessary medical services.** **B) Necessary mental health services.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Physical injury or condition that required medical attention or hospitalization and initiated a report to Division of Family Services or law enforcement.	Call designated medical services provider. *To be implemented at later date.*	24 HR
Siblings or juvenile housemates of child(ren) with injuries or conditions that are being evaluated for abuse or neglect.	Call designated medical services provider. *To be implemented at later date.*	24 HR

Prior to responding to the designated hospitals to seek a medical examination for a child, DFS or LE may call the Forensic Nurse Examiner Program to request a forensic exam and to provide case specific details.

Please remember that DFS has the authority to seek a medical examination for a child victim without the consent of the child's parents or caregiver. For siblings and other children in the home, the American Academy of Pediatrics recommends a timely medical examination for siblings and other children in the home when one child is identified as a victim of abuse.

DELAWARE CODE[48]

16 Del. C. § 906(e)(7) states: "The Division shall have authority to secure a medical examination of a child, without the consent of those responsible for the care, custody and control of the child, if the child has been reported to be a victim of abuse or neglect…"

The medical examination should include written record and photographic documentation of injuries. If no medical assessment is conducted, then LE will be responsible for taking the photographs to document the number and size of the injuries. For the purposes of its investigation, DFS may need to take photographs, but every effort should be made by the agencies not to duplicate these efforts. Smartphones should be used to take photographs only in exigent circumstances.

In these cases, the medical providers are charged with determining, based upon a reasonable degree of medical certainty, whether the child's injury is accidental, inflicted or caused by a medical condition. Both the medical examination and information gathered by LE and DFS are used to make this

[48] *See* 16 Del. C. § 906(e)(7)

determination. These preliminary medical findings will be provided immediately to LE and DFS upon completion of the examination. Subsequent findings and medical records should be obtained prior to completion of an investigation.

Potential questions that should be asked of the medical provider are listed below. Avoid asking a physician whether it is "possible" that a caregiver's explanation caused the injury, because the answer will always be yes. Instead, use the words "probable, likely or consistent with" when speaking with medical providers and note that medical providers only speak in terms of probability and not absolutes.

COLLECTING THE MEDICAL EVIDENCE[49]

Questions for the Medical Provider

- What is the nature and extent of the child's injury or illness?
- What is the mechanism of injury? What type and amount of force are required to produce the injury?
- Does the history the caregiver provided explain (in whole or in part) the child's injury?
- Have other diagnoses been explored and ruled out, whether by information gathering, examination, or medical tests?
- Could the injury be consistent with an accident?
- Can the timing of the injury be estimated? To what degree of certainty?
- Have all injuries been assessed in light of any exculpatory statements?
- What treatments were necessary to treat the injury or illness?
- What are the child's potential risks from the abusive event?
- What are the long-term medical consequences and residual effects of the abuse?

MDT members should consider the possibility of injuries that were not reported by the child or not readily visible (i.e. internal injuries or age progression of injuries). Be mindful that minor injuries, when paired with a history of alleged abuse or neglect, may be indicative of chronic physical abuse or torture.

Prior to discharge, if concerns regarding the child's safety exist, then the medical providers may consider requesting a meeting in accordance with Hospital High Risk Medical Discharge Protocol (See Appendix D). The Protocol ensures that children (birth to age 18) with special medical needs, who are active with DFS or have been reported to DFS by Delaware hospitals, are discharged in a planned and safe manner.

In addition to the medical examination for allegations of abuse or neglect, the American Academy of Pediatrics (AAP) recommends that children in foster care receive an initial health screening within 72 hours of placement to identify any immediate medical, mental health and dental needs, and a comprehensive health evaluation within 30 days of placement to review all available medical history, to identify medical conditions and to develop an individualized treatment plan for the child. Additionally,

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

the AAP recommends that the child receive a screening each time the placement changes.[50] The Foster Care Health Program at the Nemours Alfred I. duPont Hospital for Children is the state's specialty clinic, and DFS is responsible for making these referrals as appropriate.

SAFETY ASSESSMENT

DFS is responsible for assessing the safety of the alleged child victim and other children in the home and/or visiting the home during the course of the investigation. In cases where the injuries sustained to a non-verbal child victim are unexplained or inconsistent, DFS shall consider whether an out-of-home intervention is warranted by safety agreement or custody. For children placed in out-of-home interventions through a safety agreement, DFS will conduct background checks on all individuals in that home and complete home assessments.

LE will notify DFS if removal of a child appears necessary. LE should communicate concerns and information regarding the child's safety that may impact DFS interventions. DFS, not LE, is responsible for making placement decisions when safety threats are present and the child(ren) cannot remain at the current residence. As noted above, for situations in which a child is in imminent danger, then it would be appropriate for LE to take Temporary Emergency Protective Custody.

BEHAVIORAL HEALTH AND SOCIAL SERVICES

The child and family should be connected to any needed behavioral health and social services in order to reduce trauma, promote healing and improve outcomes. Child abuse and neglect can be experienced as traumatic events and can have a lifelong impact on the child and the family if appropriate resources and supportive services are not provided. The social and mental health needs of all should be considered in every case and discussed as part of the MDT meetings throughout the life of the case.

The Division of Prevention and Behavioral Health Services (DPBHS) provides a wide range of individualized, trauma-informed, and community-based behavioral health services to children and families statewide. Every child residing in Delaware can be referred to prevention/early intervention and crisis services which are provided through DPBHS. To refer or receive information about these services call the DPBHS Access Unit at 1-800-722-7710 or the Crisis Service at 1-800-969-4357.

DPBHS provides the outpatient treatment and supportive services to youth who are uninsured or insured by Medicaid through an array of specialized evidence-based practices to promote the best outcomes for children and families. In the event a child needs treatment outside of his/her community (including homes and school), the DPBHS treatment continuum may include day treatment, partial hospitalization program, residential rehabilitative treatment and inpatient hospitalization services.

Children presenting with indicators of trauma who are uninsured or insured by Medicaid should be referred to the Access Unit at DPBHS. Staff in the Access Unit will collect behavioral health and

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

substance abuse information. If the child is in need of services beyond prevention, early intervention or outpatient, staff will complete a service intensity tool (e.g. Child and Adolescent Service Intensity Instrument (CASII) and American Society of Addiction Medicine (ASAM)) and make appropriate referrals for services. For children in need of treatment with private insurance, the families should be referred to their insurance company for information about benefits and providers.

For children entering foster care, the DFS Office of Evidence-Based Practice (OEBP) will conduct a screening to assist in identifying the needed mental health services for children and their families. In addition, if a child in foster care exhibits trauma or symptoms of trauma, the caseworker will alert the OEBP for further Trauma Screening.

MDT members may connect children and their families to these and other services with the assistance of the victim advocates identified below.

VICTIM ADVOCATES

Victim advocates are responsible for assessing the needs of the child and family and connecting them to culturally appropriate resources and services. Victim advocates are available in each of the MDT agencies as follows:

- DSCYF/Division of Family Services – Domestic Violence Liaisons & Substance Abuse Liaisons
- Law Enforcement – Victim Service Specialists
- Department of Justice – Social Workers
- Children's Advocacy Center – Family Resource Advocates
- Hospitals – Social Workers

To ensure there are no gaps in services, victim advocates should communicate with each other and coordinate with mental health and social service providers throughout the course of the investigation and beyond. The roles and responsibilities of the victim advocates will vary among the agencies, so not all advocates will provide the same array services. However, the following constellation of services may be provided as needed: emergency crisis assessment and intervention, risk assessment and safety intervention for caregivers and families, information on Victims Information Notification Everyday (VINE), assistance with filing for emergency financial assistance and education regarding victim's rights, case status updates, court accompaniment, and information and referrals for appropriate social service agencies (e.g. housing, protective orders, domestic violence intervention, food, transportation, public assistance, and landlord/employer intervention).

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

ARREST

LE should call DOJ's Special Victims Unit upon receipt of allegations of serious physical injury to a child. Communication with DOJ should be ongoing throughout the criminal investigation and prior to charging, whenever possible to ensure the best outcome for the criminal case.

When an alleged perpetrator is arrested, a no contact order with the alleged child victim and/or other children in the home may be recommended, as a specific condition of bail and/or other conditions that may be necessary to protect the child(ren) and any other members of the community. Input from DFS should be considered and offered to the issuing judicial officer. LE and/or DFS may contact DOJ to request a modification to the contact conditions of bail. Regardless of contact conditions of bail, DFS will consider an in-home intervention or an out-of-home intervention once safety threats are identified, including safety agreements, custody and placement needs.

Before clearing a case without an arrest, LE consultation with DOJ shall occur. LE will notify DFS upon case closure.

CRIMINAL PROCEEDINGS

DOJ may review the following information (both current and historical):

- All police reports and any other information obtained during the investigation concerning all individuals involved in the case;
- All non-redacted DFS records;
- All medical records pertaining to the child;
- All CAC records; and,
- Inventory and/or copies of any evidence.

The Deputy Attorney General (DAG) will evaluate the case to determine prosecutorial merits and will collaborate with LE to identify additional investigative actions as appropriate.

When two or more Divisions (typically Family & Criminal) within DOJ are involved with a particular case, the DAGs will coordinate with each other to ensure the most appropriate legal outcomes are achieved. The Civil and Criminal DAGs shall communicate regularly regarding the case status. The DAG prosecuting the criminal matter will take the lead in this process.

Before resolution of a criminal proceeding, DOJ should confer with DFS, on active cases, regarding issues impacting child safety, such as vacating the No Contact Order and potential impact to a civil substantiation proceeding prior to completion of the civil investigation. This discussion should also include recommended services and/or evaluations for the perpetrator and child. Upon a criminal conviction where the civil case was unfounded and closed, the Criminal DAG will notify the Civil DAG.

CIVIL DISPOSITION

DFS makes a determination as to whether abuse or neglect has occurred within 45 calendar days. Upon completion of the civil investigation, DFS will make a finding once it has established that a preponderance of the evidence exists; the civil finding is not dependent upon the status or outcome of the criminal case.

DFS is required to give written notice to the alleged perpetrator of its finding. Recognizing that this notice to the alleged perpetrator may impact an active criminal investigation, DFS shall contact LE/DOJ prior to case closure in order to maintain the integrity of the case.

DELAWARE CODE[51]

16 Del. C. § 924(a)(2)b. states: "[The Division shall] advise the person that the Division intends to substantiate the allegations and enter the person on the Child Protection Registry for the incident of abuse or neglect at a designated Child Protection Level."

In addition to the DFS investigation, there may be a civil proceeding in the Family Court, such as if DFS petitions for temporary custody of a child or if the alleged perpetrator appeals a finding by DFS and a Substantiation Hearing is scheduled.

MDT members may be subpoenaed to testify in civil proceedings and/or provide case documentation or evidence subject to any relevant statutory provisions and Court rulings as to the confidentiality and admissibility of said evidence.

3. MDT CASE REVIEW

MDT Case Review is the formal process in which the team convenes regularly scheduled meetings in each county to monitor and discuss the case progress, which may include the following:

- Review interview outcomes;
- Discuss, plan and monitor the progress of the investigation;
- Review any medical examinations;
- Discuss child protection and other safety issues;
- Provide input for prosecution and sentencing decisions;
- Discuss emotional support and treatment needs of the child and family members as well as strategies for meeting those needs;
- Assess the families' reactions and response to the child's disclosure and involvement in the criminal justice and/or child protection systems;
- Review criminal and civil case updates, ongoing involvement of the child and family and disposition;
- Make provisions for court education and court support;
- Discuss ongoing cultural and special needs issues relevant to the case; and,
- Ensure that all children and families are afforded the legal rights and comprehensive services to which they are entitled.

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

[51] *See* 16 Del. C. § 924(a)(2)b.

Please see Appendix "F" for an example of a MDT Case Review Protocol utilized in Delaware.

4. CONFIDENTIALITY, INFORMATION SHARING & DOCUMENTATION

The Child Abuse Prevention and Treatment Act (CAPTA) requires that states preserve the confidentiality of all reports and records pertaining to cases that fall within this MOU to protect the privacy rights of the child and family.[52] However, exceptions are permitted in certain limited circumstances, and the Delaware Code provides guidance on who may access the information.

DELAWARE CODE[53]

16 Del. C. § 906(e) states: "The Division shall only release information to persons who have a legitimate public safety need for such information or a need based on the health and safety of a child subject to abuse, neglect or the risk of maltreatment, and such information shall be used only for the purpose for which the information is released."

MDT members are **authorized and encouraged** to communicate information with one another pertaining to families and children in a legal, ethical, professional, and timely manner throughout the course of an investigation in accordance with agency policies and existing agreements (e.g. MOUs). As noted above, applicable state and federal confidentiality laws apply.

To obtain records, the requesting MDT agency must contact the MDT agency from which the records originated. **Information may be shared between MDT agencies; however, records shall only be disseminated by the agency owning those records.** Mental health and substance abuse records are afforded a stricter level of protection under state and federal statutes requiring consent of the parent or pursuant to a subpoena issued by DOJ.

If a criminal or civil proceeding is pending, DOJ may also issue a subpoena for records or for court testimony.

Documentation should be specific to case facts and should not include information related to the opinions of the MDT members (i.e., the initial concerns of the investigator as to the strength, strategy, or course of the criminal investigation).

5. CONFLICT RESOLUTION

The MDT shall make every effort to resolve disputes through discussion and negotiation at the lowest levels of the agencies. If the dispute cannot be resolved at this level, then the MDT members involved in the dispute shall contact their individual supervisors for assistance. Once the chain of command is

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

exhausted or at the request of one of the supervisors, a team meeting may be scheduled. Additionally, the Investigation Coordinator's Office may be contacted to initiate or facilitate communication with other members of the MDT.

IV. CHILD DEATH PROTOCOL

A. DEFINITION: Death shall mean the loss of life of a child under the age of 18.

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

1. CIVIL OFFENSES

- **Death in which abuse or neglect is suspected**;
- **Cause of death is under criminal investigation** (unexpected/unexplained);
- **Intoxicated/impaired caregiver bed-sharing with an infant** (12 months or younger);
- **Poisoning**: means [any individual] intentionally or recklessly over-medicates or causes a child to ingest alcohol, drugs (legal/illegal) not prescribed for that child, or other toxic substances, resulting in significant [death];[54]
- **Death occurred in a child care facility**; and,
- **Torture** (10 Del. C. § 901(1)b.3).

2. CRIMINAL OFFENSES

- § 630 Vehicular homicide in the second degree; class D felony; minimum sentence; juvenile offenders;
- § 630A Vehicular homicide in the first degree; class C felony; minimum sentence; juvenile offenders;
- § 631 Criminally negligent homicide; class E felony;
- § 632 Manslaughter; class B felony;
- § 633 Murder by abuse or neglect in the second degree; class B felony;
- § 634 Murder by abuse or neglect in the first degree; class A felony;
- § 635 Murder in the second degree; class A felony;
- § 636 Murder in the first degree; class A felony; and

[54] *See* 10.1.15. DFS CPR Regulations

- § 1102 Endangering the welfare of a child; class E felony.

C. MULTIDISCIPLINARY RESPONSE

1. CROSS-REPORTING

For the aforementioned civil and criminal offenses, the MDT agencies agree to cross-report and share information regarding the report of a child death.

REPORTS TO DIVISION OF FAMILY SERVICES (DFS)

All suspected child abuse and neglect of any child, from birth to age 18, in the State of Delaware must be reported to the Division of Family Services Child Abuse Report Line (Report Line) at 1-800-292-9582.

DELAWARE CODE

Mandatory Reporting Law[55]

16 Del. C. § 903 states: "Any person, agency, organization or entity who knows or in good faith suspects child abuse or neglect shall make a report in accordance with § 904 of this title…"

In addition, 16 Del. C. § 904 states: "Any report of child abuse or neglect required to be made under this chapter shall be made by contacting the Child Abuse and Neglect Report Line for the Department of Services for Children, Youth and Their Families. An immediate oral report shall be made by telephone or otherwise. Reports and the contents thereof including a written report, if requested, shall be made in accordance with the rules and regulations of the Division, or in accordance with the rules and regulations adopted by the Division. No individual with knowledge of child abuse or neglect or knowledge that leads to a good faith suspicion of child abuse or neglect shall rely on another individual who has less direct knowledge to call the aforementioned Report Line."

Penalty for Violation[56]

16 Del. C. § 914 states: "Whoever violates § 903 of this title shall be liable for a civil penalty not to exceed $10,000 for the first violation, and not to exceed $50,000 for any subsequent violation."

Any person who has **direct knowledge** of suspected abuse must make an immediate report to the Report Line. **Direct knowledge** is obtained through disclosure (child discloses to you), discovery (you witness an act of abuse), or reason to suspect (you have observed behavioral and/or physical signs of child abuse). This report may include situations where multiple disciplines are involved, such as:

[55] *See* 16 Del. C. § 903 and 904
[56] *See* 16 Del. C. § 914

- Emergency medical services and law enforcement are dispatched to a child found unresponsive as a result of bed-sharing with a caregiver. A call must be made to the Report Line from both professionals.
- A child is transported to the hospital emergency department by a parent for accidental ingestion of medications. Both emergency department staff and the responding patrol officer must make the call to the Report Line.

The relationship between the child and perpetrator ***does not*** influence whether a report must be made to DFS. All reports, including domestic or intra-familial, institutional, and non-domestic or extra-familial, cases must also be reported to DFS.

Additionally, a separate report must be made to the Report Line for the following reasons:

- Additional suspects have been identified;
- Additional child victims have been identified; or,
- Secondary allegations have been disclosed (i.e. initial report was for a child death and upon medical assessment of other children in the home, injuries were identified to another child).

If a **secondary allegation is disclosed to the CAC** during the forensic interview process, then the MDT members present shall make a joint report to the DFS Report Line prior to conclusion of the post interview meeting. However, if circumstances prevent the joint report from being made, the MDT shall select a member to make the report on behalf of the team. The designee will make the report immediately and inform the Report Line worker that he/she is making the call on behalf of the applicable MDT agencies.

If known, the following should be provided to the DFS Report Line:

- Demographic information;
- Known information about the following:
    - Child, parents, siblings and alleged perpetrator;
    - The alleged child victim's physical health, mental health, educational status;
    - Medical attention that may be needed for injuries;
    - The way the caregiver and alleged perpetrator's behavior is impacting the care of the child; and,
    - Any circumstances that may jeopardize the child's or DFS worker's safety.
- Facts regarding the alleged abuse and any previous involvement with the family.
- What you are worried about, what is working well, and what needs to happen next to keep the child safe.

Reports received by DFS will either be screened in for investigation as an intra-familial case and/or institutional abuse (IA) case or will be screened out, documented, and maintained in the DFS reporting system.

Reports screened in for investigation by DFS are assigned a priority response time as follows:

- Priority 1 (P1) – Within 24 hours
- Priority 2 (P2) – Within 3 days
- Priority 3 (P3) – Within 10 days

In most cases, DFS will assign a P1 response if the case involves a child death.

REPORTS TO LAW ENFORCEMENT (LE)

LE will receive notification of all civil offenses identified in the Child Death Protocol prior to DFS. As a result, a cross-report from DFS is unlikely.

Medical providers shall make an immediate report to the appropriate law enforcement jurisdiction to initiate a criminal investigation in child death cases.

DELAWARE CODE[57]

24 Del. C. § 1762(a) states: "Every person certified to practice medicine who attends to or treats a stab wound; poisoning by other than accidental means; or a bullet wound, gunshot wound, powder burn, or other injury or condition arising from or caused by the discharge of a gun, pistol, or other firearm, or when such injury or condition is treated in a hospital, sanitarium, or other institution, the person, manager, superintendent, or other individual in charge shall report the injury or condition as soon as possible to the appropriate police authority where the attending or treating person was located at the time of treatment or where the hospital, sanitarium, or institution is located."

REPORTS TO DEPARTMENT OF JUSTICE (DOJ)

LE shall call DOJ's Special Victims Unit upon receipt of a child death.

DFS is required to report offenses identified in the Child Death Protocol to the appropriate division at the Department of Justice. Additionally, DFS is required to report all persons, agencies, organizations and entities to DOJ for investigation if they fail to make mandatory reports of child abuse or neglect under 16 Del. C. § 903.

If the matter is referred to the Children's Advocacy Center for a forensic interview, the CAC will notify the DOJ, DFS, and LE of the scheduled interview as soon as possible.

[57] *See* 24 Del. C. § 1762(a)

DELAWARE CODE[58]

16 Del. C. § 906(e)(3) states: "The Division staff shall also contact the Delaware Department of Justice… upon receipt of any report under this section and shall provide such agency with a detailed description of the report received."

REPORTS TO THE OFFICE OF THE INVESTIGATION COORDINATOR (IC)

The Office of the Investigation Coordinator receives reports of child deaths through data exchanges with DFS and the Delaware Criminal Justice Information System (DELJIS). Additionally, all MDT members shall provide case specific information as requested by the IC. For the purposes of conflict resolution, the Office of the Investigation Coordinator may be contacted to initiate or facilitate communication with other members of the MDT.

DELAWARE CODE[59]

16 Del. C. § 906(c)(1)a. and b. state: "The Investigation Coordinator, or the Investigation Coordinator's staff, shall…have electronic access and the authority to track within the Department's internal information system and Delaware's criminal justice information system each reported case of alleged child abuse or neglect. Monitor each case involving the death of, serious physical injury to, or allegations of sexual abuse of a child from inception to final criminal and civil disposition, and provide information as requested on the status of each case to the Division, the Department, the Delaware Department of Justice, the Children's Advocacy Center, and the Office of Child Advocate."

16 Del. C. § 905(f) states: "Upon receipt of a report of child abuse or neglect, the Division shall immediately notify the Investigation Coordinator of the report, in sufficient detail to permit the Investigation Coordinator to undertake the Investigation Coordinator's duties, as specified in § 906 of this title."

16 Del. C. § 906(d)(2) and (f)(3) state: The law enforcement agency and Delaware Department of Justice investigating a report of child abuse shall "provide information as necessary to the Investigation Coordinator to permit case tracking, monitoring and reporting by the Investigation Coordinator."

REPORTS TO DIVISION OF FORENSIC SCIENCE (ME)

LE and medical providers shall immediately report all deaths of children to the Division of Forensic Science.

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

DELAWARE CODE[60]

29 Del. C. § 4706(a) states: It shall be the duty of the person having knowledge of such death or of the person issuing a permit for cremation under § 3162 of Title 16 immediately to notify the Chief Medical Examiner, an Assistant Medical Examiner or a Deputy Medical Examiner, as the case may be, who in turn shall notify the Attorney General of the known facts concerning the time, place, manner and circumstances of such death.

REPORTS TO PROFESSIONAL REGULATORY BODIES

In keeping with the following statutory requirements, certain MDT members shall make reports to professional regulatory organizations and other agencies upon receipt of reports alleging abuse or neglect by professionals licensed in Delaware.

DELAWARE CODE[61]

16 Del. C. § 906(c)(1)c. states the Investigation Coordinator or the Investigation Coordinator's designee shall: "Within 5 business days of the receipt of a report concerning allegations of child abuse or neglect by a person known to be licensed or certified by a Delaware agency or professional regulatory organization, forward a report of such allegations to the appropriate Delaware agency or professional regulatory organization."

16 Del. C. § 906(e)(6) and (f)(4) state the Division and DOJ shall: "Ensure that all cases involving allegations of child abuse or neglect by a person known to be licensed or certified by a Delaware agency or professional regulatory organization, have been reported to the appropriate Delaware agency or professional regulatory organization and the Investigation Coordinator in accordance with the provisions of this section."

24 Del. C. § 1731A(a) states any person may report to the Board information that the reporting person reasonably believes indicates that a person certified and registered to practice medicine in this State is or may be guilty of unprofessional conduct or may be unable to practice medicine with reasonable skill or safety to patients by reason of mental illness or mental incompetence; physical illness, including deterioration through the aging process or loss of motor skill; or excessive use or abuse of drugs, including alcohol. The following have an affirmative duty to report, and must report, such information to the Board in writing within 30 days of becoming aware of the information:

(1) All persons certified to practice medicine under this chapter;

(2) All certified, registered, or licensed healthcare providers;

(3) The Medical Society of Delaware;

[60] *See* 29 Del. C. § 4706(a)
[61] *See* 16 Del. C. § 906(c)(1)c., 906(e)(6), 906(f)(4), and 24 Del. C. § 1731A(a)

(4) All healthcare institutions in the State;

(5) All state agencies other than law-enforcement agencies;

(6) All law-enforcement agencies in the State, except that such agencies are required to report only new or pending investigations of alleged criminal conduct specified in § 1731(b)(2) of this title, and are further required to report within 30 days of the close of a criminal investigation or the arrest of a person licensed under this chapter.

2. INVESTIGATION

For the purpose of conducting an effective joint investigation, communication and coordination should occur among the MDT members as soon as possible and continue throughout the life of the case.

Upon receipt of a report, DOJ, DFS, LE, and ME will communicate and coordinate a response; however, LE will take the lead in the Joint Investigation. LE agencies needing additional resources may consult with larger jurisdictions.

For all allegations within this Protocol, the MDT will determine from the list below the appropriate investigative actions that have been identified as best practices for responding to child abuse cases.

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

Investigative Actions	Responsible Agency
Discuss DFS's required notification to the alleged perpetrator of the allegations. Limit the details of the allegations and the maltreatment type.[62]	DFS and LE
Assess safety and need for out-of-home interventions of all children.	DFS
Consider Temporary Emergency Protective Custody of child and other children in home.	Medical, LE and DFS
Observe and photo/video document the crime scene(s); collect evidence.	LE
Complete Sudden Unexplained Infant Death Investigation (SUIDI) form.	LE and ME
Conduct doll/scene re-enactment and video document.	LE
Obtain consent or search warrant for blood draw if impairment is suspected for alleged perpetrator(s).	LE
Determine if elements of Child Torture are present (review the checklist on Common Elements of Child Torture).	MDT
Follow Guidelines for Child Abuse Medical Response for siblings and other children in the home.	LE, DFS and Medical
Take photographs of child and child's injuries.	Medical, LE and ME
Conduct video documentation, with explanation by the medical provider, of any life supporting mechanisms provided to the child.	Medical and LE
Notify the Investigation Coordinator's Office of the child death.	DFS, LE and DOJ
Utilize victim advocates to connect children and families with appropriate mental health, substance abuse, social services and additional resources.	MDT
Complete pre-arrest intake with DOJ.	LE and DOJ
Participate in MDT meetings (i.e. case review).	MDT

[62] The federal Child Abuse Prevention and Treatment Act requires DFS to notify the alleged perpetrator of the complaints or allegations made against him or her at the initial time of contact regardless of how that contact is made (42 U.S.C. 5101 et seq).

INTERVIEWS

LE will conduct interviews with caregivers, alleged perpetrator(s), and other witnesses and will provide prior notice to DFS to allow for observation. Additionally, all interviews shall be audio recorded, and when practicable, video recorded by LE. DFS must receive clearance from LE before conducting follow up interviews for the purpose of gathering information relevant to the civil investigation. In the event that a LE response is delayed, DFS may obtain basic information from the family to assess the child's safety until LE arrives to conduct the interviews.

Child witnesses to include siblings and other children in the home, ages 3 to 12, should be interviewed at the CAC in cases that fall within the Child Death Protocol. This does not preclude interviews of children under 3, who are verbal, or youth between the ages of 13 and 18. Multiple interviews by multiple interviewers can be detrimental to children and can create issues for successful civil and criminal case dispositions. Use of the CAC to conduct interviews is considered best practice to minimize trauma and re-victimization of child victims and/or child witnesses.

In any investigation of criminal conduct occurring at, or related to, a facility or organization where multiple children may have been exposed to, or victimized by, a perpetrator of the conduct being investigated, the MDT must consider the potential that other children have been victimized. Thus, the MDT should schedule and conduct interviews at the CAC of all children between the age of 3 and 12 who may have been exposed to, a victim of, or a witness to the conduct being investigated. Facilities or organizations where multiple children may be exposed to criminal conduct include, but are not limited to, child care centers, schools, and youth athletic organizations. This policy is intended to both define the scope of such investigations and to provide support to children who, by mere circumstance, are, or have been, in the presence of the subject of an investigation.

If additional information is needed prior to scheduling the forensic interview with child witnesses, the **First Responder Minimal Facts Interview Protocol** should be utilized (See Appendix A). If both LE and DFS are present, then a lead interviewer should be identified prior to conducting the interview. This Protocol will still allow DFS to assess child safety through its in-house protocols while preserving the criminal investigation.

FIRST RESPONDER

Minimal Facts Interview Protocol

1. **Establish rapport**
2. **Ask limited questions to determine the following:**
   - What happened?
   - Who is/are the alleged perpetrator(s)?
   - Where did it happen?
   - When did it happen?
   - Ask about witnesses/other victims
3. **Provide respectful end**

FORENSIC INTERVIEW AT THE CAC

After making a cross-report, LE, DFS, and/or DOJ may contact the CAC in the jurisdiction where the alleged crime occurred to request a forensic interview. LE and DFS will communicate prior to contacting the CAC to determine who will make the request and the appropriate timeframe for scheduling the interview.

Forensic interviews will be scheduled on a non-urgent basis (within 5 business days) or urgent basis (within 2 business days) subject to the availability of MDT member agencies, children, and their caregivers. Please note that the CAC will accommodate after-hours interviews on an emergency basis as needed. The CAC will acquire interpreter services as needed for the child and/or family. All interviews will be video and audio recorded.

The forensic interviewer will conduct the interview utilizing a nationally recognized forensic interview protocol and forensic interview aids, as appropriate. Members of the MDT may be present for the interview based on availability. MDT members should refrain from engaging in pre-interview contact with the caregiver and child at the CAC to avoid impacting the forensic interview process.

The forensic interviewer will facilitate the CAC process. This process includes pre-interview meetings, the forensic interview, and post-interview meetings. MDT members should be prepared to discuss the following: complaint and criminal history concerning all individuals involved in the case; DFS history; prior forensic interviews at the CAC; current allegations; and strategies for the interview to include introduction of evidence to the child.

During the post-interview team meeting, the MDT may discuss interview outcomes; prosecutorial merit; next investigative steps; and medical, mental health, victim advocacy and safety needs of the child and family. Additionally, the MDT may determine that a multi-session or subsequent interview is required based on the case circumstances and the needs of child.

If a **secondary allegation is disclosed to the CAC** during the forensic interview process, then the MDT members present shall make a joint report to the DFS Report Line prior to conclusion of the post interview meeting. However, if circumstances prevent the joint report from being made, the MDT shall select a member to make the report on behalf of the team. The designee will make the report immediately and inform the Report Line worker that he/she is making the call on behalf of the applicable MDT agencies.

When the MDT meets with the caregiver post-interview, DOJ will take the lead in sharing information related to the interview and possible criminal prosecution.

Following the post-interview meeting, the CAC Family Resource Advocate will facilitate a discussion with the caregiver about social and mental health services and other resources available for the child and/or family. Referrals will be made by the CAC as appropriate.

During the course of an investigation, a MDT meeting may be required to discuss new information obtained by any of the team members. The meeting shall be convened by the IC upon request of any team member. Otherwise, these discussions will take place at regularly scheduled MDT Case Review meetings.

If additional information is needed from the child by a MDT member, then the other team members should be contacted and a follow up forensic interview should be scheduled.

PRESERVATION OF EVIDENCE

LE will establish, examine and document the location(s) of incident as soon as practicable. The crime scene(s) and other corroborative evidence (e.g. diapers) should be collected and photographed or video recorded.

LE will complete the Sudden Unexplained Infant Death Investigation (SUIDI) form (See Appendix G). Prior notice will be given to ME to allow for observation.

LE will conduct a doll and scene re-enactment with the alleged perpetrator to provide a visual demonstration of the mechanism of injury and/or death. Prior notice will be given to ME to allow for observation. This re-enactment will be video documented and conducted at the scene when possible. DFS and DOJ may observe the re-enactment.

Interviews by LE should be audio recorded and when practicable, video recorded. Forensic interviews with the child and siblings will be video and audio recorded at the CAC. Interviews with caregivers, alleged perpetrator(s), other witnesses, and those children not interviewed at the CAC will be audio recorded and when practicable, video recorded by LE. Any recordings created during the interview process at the CAC will be turned over to LE and LE will thereafter become the agency owning this evidence.

Photographs must be taken to document the number and size of the injuries to the child; scale of injury should be documented in photograph. These photographs will be taken as part of the medical examination process if the child has been transported to a medical facility. This does not preclude LE and ME from taking photographs as needed for investigative purposes. Please note that smartphones should be used to take photographs only in exigent circumstances.

If life supporting mechanisms were utilized, then LE will video document these efforts to include the explanation by the medical provider. In addition, any evidence collected by medical providers not given to LE will be turned over to the ME.

In nearly all child death cases, the body will be transported to the hospital. In cases where the death is suspicious and the child is pronounced at the hospital, parents and caregivers will not be permitted to touch the body. However, parents and caregivers may be permitted to touch the body with supervision by LE, in consultation with ME, in cases where there is a sudden unexpected infant death (i.e., sudden

infant death syndrome (SIDS), unknown cause, and accidental suffocation in bed).[63] For cases in which the child is pronounced and remains on scene, LE will preserve the body and maintain the scene, not allowing anyone to touch the body until the ME assumes responsibility.

For circumstances where impairment of the alleged perpetrator(s) is suspected, consent to draw blood will be attempted by LE. Otherwise, a search warrant will be obtained.

POST-MORTEM EXAMINATION

The ME will conduct a post-mortem examination of the child in all unexpected and unexplained death cases. LE and DOJ will be contacted prior to the post-mortem examination to allow for observation. A post-mortem computed tomography (CT) scan at designated hospitals may occur prior to the post-mortem examination.

Samples of blood and hair follicles will be collected by ME and tested for drugs and/or toxins. Items unable to be stored by the ME will be turned over to LE for storage, and testing at the discretion of DOJ. Disposal of evidence (e.g. diapers) should be cleared with DOJ to ensure resolution of a criminal proceeding is complete.

COMMON ELEMENTS OF CHILD TORTURE

Child torture may not immediately be identified until the abuse and/or neglect results in serious physical injury or death often after multiple interventions for less serious offenses. Therefore, MDT members should consider the elements of child torture in every case and communicate any identified elements to other members of the team.

Cases can be quickly assessed by using the checklist below, and child torture should be considered when several elements are identified, either currently or historically within a case. For instance, child torture should be suspected if a 4-year-old child has current unexplained fracture, linear bruising was observed on the buttocks two months prior, and parent is withholding food, threatening the child, and isolating the child from family.

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

[63] *See* http://www.cdc.gov/sids/

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

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

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

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

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

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

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

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

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

Section Four: Supplemental Items

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

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

☐ **Forcing Excessive Exercise for Punishment**

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

☐ **One Child is Targeted**

☐ **Sibling(s) Abused**

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

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

☐ **One Caregiver Fails to Protect**

☐ **No Disclosure is Made by Targeted Child or Siblings**

☐ **Caregivers Provide Reasonable Explanations in Response to Allegations**

☐ **Caregivers Allege Mental Health Issues for Targeted Child (e.g. self-injury) and Report Repeated Attempts to Seek Help**

TEMPORARY EMERGENCY PROTECTIVE CUSTODY

In accordance with Delaware Code, Physicians, DFS investigators, or LE may take Temporary Emergency Protective Custody of a child in imminent danger of serious physical harm or a threat to life as a result of abuse or neglect for up to 4 hours. DFS may only take Temporary Emergency Protective Custody of a child in a school, day care facility, and child care facility.

Physicians and LE must immediately notify DFS upon invoking this authority. This shall end once DFS responds.

A reasonable attempt shall also be made to advise the parents, guardians or others legally responsible for the child's care, being mindful not to compromise the investigation.

DELAWARE CODE[64]

16 Del. C. § 907(a) and (e) state: "A police officer or a physician who reasonably suspects that a child is in imminent danger of suffering serious physical harm or a threat to life as a result of abuse or neglect and who reasonably suspects the harm or threat to life may occur before the Family Court can issue a temporary protective custody order may take or retain temporary emergency protective custody of the child without the consent of the child's parents, guardian or others legally responsible for the child's care… A Division investigator conducting an investigation pursuant to § 906 of this title shall have the same authority as that granted to a police officer or physician… provided that the child in question is located at a school, day care facility or child care facility at the time that the authority is initially exercised."

TRANSPORTATION

If the alleged perpetrator is the caregiver or is unknown, an alternative means of transportation should be provided to the child for medical examinations, forensic interviews at the CAC, and out-of-home interventions. Under these circumstances, DFS or LE may transport the child to the hospital or seek medical transport for the child, and both agencies are entitled to immunity from any liability in accordance with § 4001 of Title 10.

[64] *See* 16 Del. C. § 907(a) and (e)

DFS may also transport a child under the following conditions: DFS invokes Temporary Emergency Protective Custody from a school, day care facility or child care facility; DFS obtained a signed consent from the parent; or DFS is currently awarded Temporary Custody by the Family Court.

MEDICAL EXAMINATION

A medical examination will be considered for any other children residing in the home of a deceased child. Medical examinations may be conducted to identify, document, diagnose, prevent, and treat medical conditions and/or trauma (resulting from abuse and unrelated to abuse), as well as to assess issues related to patient safety and well-being.

To determine the appropriate medical response for the other children living in the home, the MDT shall follow the **Delaware Multidisciplinary Team Guidelines for Child Abuse Medical Response** (Medical Response Guidelines). Please refer to Appendix "C" for the complete version of the Medical Response Guidelines.

In cases where other children living in the home are suspected to be injured, the Medical Response Guidelines must be followed using the below Medical Response Matrix for Serious Physical Injury cases. Please note that Step 2 of the Medical Response Matrix and any medical response which involves calling the designated medical services provider will not be implemented until the resources become available.

Abuse Fact Pattern	Medical Response	Time Frame
Child is 0-6 months of age for any injury.	**Step 1. IMMEDIATE EMS TRANSPORT to nearest hospital.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Severe or extensive injuries at any age, including but not limited to: head trauma, burns, fractures, chest or abdominal injuries.	**Step 1. IMMEDIATE EMS TRANSPORT to nearest hospital.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Child appears to be intoxicated, drugged, or otherwise non-responsive or abnormally responsive.	**Step 1. IMMEDIATE EMS TRANSPORT to nearest hospital.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**

Any child suggesting a significant mental health issue such as suicidal ideation or gesture, or severe depression, **regardless of when the last reported contact occurred.**	**Step 1. URGENT RESPONSE OR EMS TRANSPORT to nearest hospital for:** **A) Necessary medical services.** **B) Necessary mental health services.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Physical injury or condition that required medical attention or hospitalization and initiated a report to Division of Family Services or law enforcement.	Call designated medical services provider. *To be implemented at later date.*	24 HR
Siblings or juvenile housemates of child(ren) with injuries or conditions that are being evaluated for abuse or neglect.	Call designated medical services provider. *To be implemented at later date.*	24 HR

Prior to responding to the designated hospitals to seek a medical examination for a child, DFS or LE may call the Forensic Nurse Examiner Program to request a forensic exam and to provide case specific details.

Please remember that DFS has the authority to seek a medical examination for a child victim without the consent of the child's parents or caregiver. For siblings and other children in the home, the American Academy of Pediatrics recommends a timely medical examination for siblings and other children in the home when one child is identified as a victim of abuse.

DELAWARE CODE[65]

16 Del. C. § 906(e)(7) of the Delaware Code states: "The Division shall have authority to secure a medical examination of a child, without the consent of those responsible for the care, custody and control of the child, if the child has been reported to be a victim of abuse or neglect…"

The medical examination should include written record and photographic documentation of injuries. If no medical assessment is conducted, then LE will be responsible for taking the photographs to document the number and size of the injuries. For the purposes of its investigation, DFS may need to take photographs, but every effort should be made by the agencies not to duplicate these efforts. Smartphones should be used to take photographs only in exigent circumstances.

[65] *See* 16 Del. C. § 906(e)(7)

In these cases, the medical providers are charged with determining, based upon a reasonable degree of medical certainty, whether the child's injury is accidental, inflicted or caused by a medical condition. Both the medical examination and information gathered by LE and DFS are used to make this determination. These preliminary medical findings will be provided immediately to LE and DFS upon completion of the examination. Subsequent findings and medical records should be obtained prior to completion of an investigation.

Potential questions that should be asked of the medical provider are listed below. Avoid asking a physician whether it is "possible" that a caregiver's explanation caused the injury, because the answer will always be yes. Instead, use the words "probable, likely or consistent with" when speaking with medical providers and note that medical providers only speak in terms of probability and not absolutes.

COLLECTING THE MEDICAL EVIDENCE[66]

Questions for the Medical Provider

- What is the nature and extent of the child's injury or illness?
- What is the mechanism of injury? What type and amount of force are required to produce the injury?
- Does the history the caregiver provided explain (in whole or in part) the child's injury?
- Have other diagnoses been explored and ruled out, whether by information gathering, examination, or medical tests?
- Could the injury be consistent with an accident?
- Can the timing of the injury be estimated? To what degree of certainty?
- Have all injuries been assessed in light of any exculpatory statements?
- What treatments were necessary to treat the injury or illness?
- What are the child's potential risks from the abusive event?
- What are the long-term medical consequences and residual effects of the abuse?

MDT members should consider the possibility of injuries that were not reported by the child or not readily visible (i.e. internal injuries or age progression of injuries). Be mindful that minor injuries, when paired with a history of alleged abuse or neglect, may be indicative of chronic physical abuse or torture.

Prior to discharge, if concerns exist regarding the safety of other child living in the home of a deceased child, then the medical providers may consider requesting a meeting in accordance with Hospital High Risk Medical Discharge Protocol (See Appendix D). The Protocol ensures that children (birth to age 18) with special medical needs, who are active with DFS or have been reported to DFS by Delaware hospitals, are discharged in a planned and safe manner.

In addition to the medical examination for allegations of abuse or neglect, the American Academy of Pediatrics (AAP) recommends that children in foster care receive an initial health screening within 72

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

hours of placement to identify any immediate medical, mental health and dental needs, and a comprehensive health evaluation within 30 days of placement to review all available medical history, to identify medical conditions and to develop an individualized treatment plan for the child. Additionally, the AAP recommends that the child receive a screening each time the placement changes.[67] The Foster Care Health Program at the Nemours Alfred I. duPont Hospital for Children is the state's specialty clinic, and DFS is responsible for making these referrals as appropriate.

SAFETY ASSESSMENT

DFS is responsible for assessing the safety of the other children in the home and/or visiting the home during the course of the investigation. If safety threats are present, DFS will consider whether an out-of-home intervention is warranted by safety agreement or custody. For children placed in out-of-home interventions through a safety agreement, DFS will conduct background checks on all individuals in that home and complete home assessments.

LE will notify DFS if removal of a child appears necessary. LE should communicate concerns and information regarding the child's safety that may impact DFS interventions. DFS, not LE, is responsible for making placement decisions when safety threats are present and the child(ren) cannot remain at the current residence. As noted above, for situations in which a child is in imminent danger, then it would be appropriate for LE to take Temporary Emergency Protective Custody.

BEHAVIORAL HEALTH AND SOCIAL SERVICES

The child and family should be connected to any needed behavioral health and social services in order to reduce trauma, promote healing and improve outcomes. Child abuse and neglect can be experienced as traumatic events and can have a lifelong impact on the child and the family if appropriate resources and supportive services are not provided. The social and mental health needs of all should be considered in every case and discussed as part of the MDT meetings throughout the life of the case.

The Division of Prevention and Behavioral Health Services (DPBHS) provides a wide range of individualized, trauma-informed, and community-based behavioral health services to children and families statewide. Every child residing in Delaware can be referred to prevention/early intervention and crisis services which are provided through DPBHS. To refer or receive information about these services call the DPBHS Access Unit at 1-800-722-7710 or the Crisis Service at 1-800-969-4357.

DPBHS provides the outpatient treatment and supportive services to youth who are uninsured or insured by Medicaid through an array of specialized evidence-based practices to promote the best outcomes for children and families. In the event a child needs treatment outside of his/her community (including homes and school), the DPBHS treatment continuum may include day treatment, partial hospitalization program, residential rehabilitative treatment and inpatient hospitalization services.

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

Children presenting with indicators of trauma who are uninsured or insured by Medicaid should be referred to the Access Unit at DPBHS. Staff in the Access Unit will collect behavioral health and substance abuse information. If the child is in need of services beyond prevention, early intervention or outpatient, staff will complete a service intensity tool (e.g. Child and Adolescent Service Intensity Instrument (CASII) and American Society of Addiction Medicine (ASAM)) and make appropriate referrals for services. For children in need of treatment with private insurance, the families should be referred to their insurance company for information about benefits and providers.

For children entering foster care, the DFS Office of Evidence-Based Practice (OEBP) will conduct a screening to assist in identifying the needed mental health services for children and their families. In addition, if a child in foster care exhibits trauma or symptoms of trauma, the caseworker will alert the OEBP for further Trauma Screening.

MDT members may connect children and their families to these and other services with the assistance of the victim advocates identified below.

VICTIM ADVOCATES

Victim advocates are responsible for assessing the needs of the child and family and connecting them to culturally appropriate resources and services. Victim advocates are available in each of the MDT agencies as follows:

- DSCYF/Division of Family Services – Domestic Violence Liaisons & Substance Abuse Liaisons
- Law Enforcement – Victim Service Specialists
- Department of Justice – Social Workers
- Children's Advocacy Center – Family Resource Advocates
- Hospitals – Social Workers

To ensure there are no gaps in services, victim advocates should communicate with each other and coordinate with mental health and social service providers throughout the course of the investigation and beyond. The roles and responsibilities of the victim advocates will vary among the agencies, so not all advocates will provide the same array services. However, the following constellation of services may be provided as needed: emergency crisis assessment and intervention, risk assessment and safety intervention for caregivers and families, information on Victims Information Notification Everyday (VINE), assistance with filing for emergency financial assistance and education regarding victim's rights, case status updates, court accompaniment, and information and referrals for appropriate social service agencies (e.g. housing, protective orders, domestic violence intervention, food, transportation, public assistance, and landlord/employer intervention).

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

ARREST

LE should call DOJ's Special Victims Unit upon receipt of a child death. Communication with DOJ should be ongoing throughout the criminal investigation and prior to charging, whenever possible to ensure the best outcome for the criminal case.

When an alleged perpetrator is arrested, a no contact order with the other children in the home shall be recommended, as a specific condition of bail and/or other conditions that may be necessary to protect the child(ren) and any other members of the community. Input from DFS should be considered and offered to the issuing judicial officer. LE and/or DFS may contact DOJ to request a modification to the contact conditions of bail. Regardless of contact conditions of bail, DFS will consider an in-home intervention or an out-of-home intervention once safety threats are identified, including safety agreements, custody and placement needs.

Before clearing a case without an arrest, LE consultation with DOJ shall occur. LE will notify DFS upon case closure.

CRIMINAL PROCEEDINGS

DOJ may review the following information (both current and historical):

- All police reports and any other information obtained during the investigation concerning all individuals involved in the case;
- All non-redacted DFS records;
- All medical records pertaining to the child;
- All CAC records; and,
- Inventory and/or copies of any evidence.

The Deputy Attorney General (DAG) will evaluate the case to determine prosecutorial merits and will collaborate with LE to identify additional investigative actions as appropriate.

When two or more Divisions (typically Family & Criminal) within DOJ are involved with a particular case, the DAGs will coordinate with each other to ensure the most appropriate legal outcomes are achieved. The Civil and Criminal DAGs shall communicate regularly regarding the case status. The DAG prosecuting the criminal matter will take the lead in this process.

Before resolution of a criminal proceeding, DOJ should confer with DFS, on active cases, regarding issues impacting child safety, such as vacating the No Contact Order and potential impact to a civil substantiation proceeding prior to completion of the civil investigation. This discussion should also include recommended services and/or evaluations for the perpetrator and child. Upon a criminal conviction where the civil case was unfounded and closed, the Criminal DAG will notify the Civil DAG.

CIVIL DISPOSITION

DFS makes a determination as to whether abuse or neglect has occurred within 45 calendar days. Upon completion of the civil investigation, DFS will make a finding once it has established that a preponderance of the evidence exists; the civil finding is not dependent upon the status or outcome of the criminal case.

DFS is required to give written notice to the alleged perpetrator of its finding. Recognizing that this notice to the alleged perpetrator may impact an active criminal investigation, DFS shall contact LE/DOJ prior to case closure in order to maintain the integrity of the case.

DELAWARE CODE[68]

16 Del. C. § 924(a)(2)b. states: "[The Division shall] advise the person that the Division intends to substantiate the allegations and enter the person on the Child Protection Registry for the incident of abuse or neglect at a designated Child Protection Level."

In addition to the DFS investigation, there may be a civil proceeding in the Family Court, such as if DFS petitions for temporary custody of a child or if the alleged perpetrator appeals a finding by DFS and a Substantiation Hearing is scheduled.

MDT members may be subpoenaed to testify in civil proceedings and/or provide case documentation or evidence subject to any relevant statutory provisions and Court rulings as to the confidentiality and admissibility of said evidence.

3. MDT CASE REVIEW

MDT Case Review is the formal process in which the team convenes regularly scheduled meetings in each county to monitor and discuss the case progress, which may include the following:

- Review interview outcomes;
- Discuss, plan and monitor the progress of the investigation;
- Review any medical examinations;
- Discuss child protection and other safety issues;
- Provide input for prosecution and sentencing decisions;
- Discuss emotional support and treatment needs of the child and family members as well as strategies for meeting those needs;
- Assess the families' reactions and response to the child's disclosure and involvement in the criminal justice and/or child protection systems;

[68] *See* 16 Del. C. § 924(a)(2)b.

- Review criminal and civil case updates, ongoing involvement of the child and family and disposition;
- Make provisions for court education and court support;
- Discuss ongoing cultural and special needs issues relevant to the case; and,
- Ensure that all children and families are afforded the legal rights and comprehensive services to which they are entitled.

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

Please see Appendix "F" for an example of a MDT Case Review Protocol utilized in Delaware.

4. CONFIDENTIALITY, INFORMATION SHARING & DOCUMENTATION

The Child Abuse Prevention and Treatment Act (CAPTA) requires that states preserve the confidentiality of all reports and records pertaining to cases that fall within this MOU to protect the privacy rights of the child and family.[69] However, exceptions are permitted in certain limited circumstances, and the Delaware Code provides guidance on who may access the information.

DELAWARE CODE[70]

16 Del. C. § 906(e) states: "The Division shall only release information to persons who have a legitimate public safety need for such information or a need based on the health and safety of a child subject to abuse, neglect or the risk of maltreatment, and such information shall be used only for the purpose for which the information is released."

MDT members are **authorized and encouraged** to communicate information with one another pertaining to families and children in a legal, ethical, professional, and timely manner throughout the course of an investigation in accordance with agency policies and existing agreements (e.g. MOUs). As noted above, applicable state and federal confidentiality laws apply.

To obtain records, the requesting MDT agency must contact the MDT agency from which the records originated. **Information may be shared between MDT agencies; however, records shall only be disseminated by the agency owning those records.** Mental health and substance abuse records are afforded a stricter level of protection under state and federal statutes requiring consent of the parent or pursuant to a subpoena issued by DOJ.

If a criminal or civil proceeding is pending, DOJ may also issue a subpoena for records or for court testimony.

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[69] Retrieved on February 6, 2017, from Child Welfare Information Gateway's Factsheet Disclosure of Confidential Child Abuse and Neglect Records: https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/confide/

[70] *See* 16 Del. C. § 906(e)

Documentation should be specific to case facts and should not include information related to the opinions of the MDT members (i.e., the initial concerns of the investigator as to the strength, strategy, or course of the criminal investigation).

5. CONFLICT RESOLUTION

The MDT shall make every effort to resolve disputes through discussion and negotiation at the lowest levels of the agencies. If the dispute cannot be resolved at this level, then the MDT members involved in the dispute shall contact their individual supervisors for assistance. Once the chain of command is exhausted or at the request of one of the supervisors, a team meeting may be scheduled. Additionally, the Investigation Coordinator's Office may be contacted to initiate or facilitate communication with other members of the MDT.

V. CHILD SEXUAL ABUSE PROTOCOL

A. DEFINITION: Sexual abuse means any act against a child that is described as a sex offense in § 761(h) of Title 11.[71]

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

1. CIVIL OFFENSES

- **Exploitation:** occurs when [any individual] behaves unethically toward a child, using the parent's/caregiver's position of power to solicit sexual acts in an attempt to obtain some type of sexual gratification. This category includes situations in which [any individual] prostitutes a child or knowingly permits a child to be "used" by another party, regardless of whether [any individual] receives sexual gratification or other compensation (money, drugs) or no compensation at all;[72]

- **Pornography:** means production or possession of visual material (e.g., pictures, films, video) by [any individual] depicting a child engaged in a sexual act or a simulation of such an act. The visual material involves sexualized content, as opposed to "naked baby" pictures;[73]

- **Sexual Abuse:** means any sexual contact, sexual intercourse, or sexual penetration, as those terms are defined in the Delaware Criminal Code, between [any individual] and a child;[74]

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

- **Verbal Innuendo:** means inappropriate sexualized statements to a child by [any individual] intended to entice or alarm.[75]

2. CRIMINAL OFFENSES

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

- § 765 Indecent exposure in the first degree; class A misdemeanor;

- § 766 Incest; class A misdemeanor;

- § 767 Unlawful sexual contact in the third degree; class A misdemeanor;

- § 768 Unlawful sexual contact in the second degree; class F felony;

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[71] *See* 10 Del. C. § 901(21)
[72] *See* 10.1.8. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.
[73] *See* 10.1.16. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.
[74] *See* 10.1.18. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.
[75] *See* 9.1.12. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.

- § 769 Unlawful sexual contact in the first degree; class D felony;
- § 770 Rape in the fourth degree; class C felony;
- § 771 Rape in the third degree; class B felony;
- § 772 Rape in the second degree; class B felony;
- § 773 Rape in the first degree; class A felony;
- § 774 Sexual extortion; class E felony;
- § 776 Continuous sexual abuse of a child; class B felony;
- § 777A Sex offender unlawful sexual conduct against a child;
- § 778 Sexual abuse of a child by a person in a position of trust, authority or supervision in the first degree; penalties;
- § 778A Sexual abuse of a child by a person in a position of trust, authority or supervision in the second degree; penalties;
- § 787 Trafficking of an individual, forced labor and sexual servitude; class D felony; class C felony; class B felony; class A felony;
- § 1100A Dealing in children; class E felony;
- § 1106 Unlawfully dealing with a child; class B misdemeanor;
- § 1108 Sexual exploitation of a child; class B felony;
- § 1109 Dealing in child pornography; class B felony;
- § 1111 Possession of child pornography; class F felony;
- § 1112A Sexual solicitation of a child; class C felony;
- § 1112B Promoting sexual solicitation of a child; class C felony; class B felony;
- § 1259 Sexual relations in detention facility; class G felony;
- § 1335 Violation of privacy; class A misdemeanor; class G felony; and
- § 1341 Lewdness; class B misdemeanor.

C. MULTIDISCIPLINARY RESPONSE

1. CROSS-REPORTING

For the aforementioned civil and criminal offenses, the MDT agencies agree to cross-report and share information regarding the report of child sexual abuse.

REPORTS TO DIVISION OF FAMILY SERVICES (DFS)

All suspected child abuse and neglect of any child, from birth to age 18, in the State of Delaware must be reported to the Division of Family Services Child Abuse Report Line (Report Line) at 1-800-292-9582.

DELAWARE CODE

Mandatory Reporting Law[76]

16 Del. C. § 903 of the Delaware Code states: "Any person, agency, organization or entity who knows or in good faith suspects child abuse or neglect shall make a report in accordance with § 904 of this title…"

In addition, 16 Del. C. § 904 states: "Any report of child abuse or neglect required to be made under this chapter shall be made by contacting the Child Abuse and Neglect Report Line for the Department of Services for Children, Youth and Their Families. An immediate oral report shall be made by telephone or otherwise. Reports and the contents thereof including a written report, if requested, shall be made in accordance with the rules and regulations of the Division, or in accordance with the rules and regulations adopted by the Division. No individual with knowledge of child abuse or neglect or knowledge that leads to a good faith suspicion of child abuse or neglect shall rely on another individual who has less direct knowledge to call the aforementioned Report Line."

Penalty for Violation[77]

16 Del. C. § 914 states: "Whoever violates § 903 of this title shall be liable for a civil penalty not to exceed $10,000 for the first violation, and not to exceed $50,000 for any subsequent violation."

Any person who has **direct knowledge** of suspected abuse must make an immediate report to the Report Line. **Direct knowledge** is obtained through disclosure (child discloses to you), discovery (you witness an act of abuse), or reason to suspect (you have observed behavioral and/or physical signs of child abuse). This report may include situations where multiple disciplines are involved, such as:

- During a forensic interview for allegations of sexual abuse, a child makes a disclosure of physical abuse. All MDT members must make the call to the Report Line.

[76] *See* 16 Del. C. § 903 and 904
[77] *See* 16 Del. C. § 914

- A child is brought to the hospital emergency department by the parent after being referred by the medical provider. Both the medical provider and emergency department staff must make the call to the Report Line.

The relationship between the child and perpetrator ***does not*** influence whether a report must be made to DFS. All reports, including domestic or intra-familial, institutional, and non-domestic or extra-familial, cases must also be reported to DFS. This includes reports of sexual abuse involving children in state operated or contracted residential facilities. In addition to making a call to the DFS Report Line, the facility staff must also contact the alleged victim's parents or legal guardians, the DFS caseworker for children in DSCYF custody, and the child's attorney or other legal representation. The federal Prison Rape Elimination Act (PREA) requires that staff and contractors in these facilities provide children with a means to privately report sexual abuse and sexual harassment by another child or a staff member/contractor. Children may make anonymous reports to the DFS Report Line.

Additionally, a separate report must be made to the Report Line for the following reasons:

- Additional suspects have been identified;
- Additional child victims have been identified; or,
- Secondary allegations have been disclosed (i.e. initial report alleged sexual abuse and child later disclosed physical abuse).

If a **secondary allegation is disclosed to the CAC** during the forensic interview process, then the MDT members present shall make a joint report to the DFS Report Line prior to conclusion of the post interview meeting. However, if circumstances prevent the joint report from being made, the MDT shall select a member to make the report on behalf of the team. The designee will make the report immediately and inform the Report Line worker that he/she is making the call on behalf of the applicable MDT agencies.

If known, the following should be provided to the DFS Report Line:

- Demographic information;
- Known information about the following:
    - Child, parents, siblings and alleged perpetrator;
    - The alleged child victim's physical health, mental health, educational status;
    - Medical attention that may be needed for injuries;
    - The way the caregiver and alleged perpetrator's behavior is impacting the care of the child; and,
    - Any circumstances that may jeopardize the child's or DFS worker's safety.
- Facts regarding the alleged abuse and any previous involvement with the family.

- What you are worried about, what is working well, and what needs to happen next to keep the child safe.

Reports received by DFS will either be screened in for investigation as an intra-familial case and/or institutional abuse (IA) case or will be screened out, documented, and maintained in the DFS reporting system.

Reports screened in for investigation by DFS are assigned a priority response time as follows:

- Priority 1 (P1) – Within 24 hours
- Priority 2 (P2) – Within 3 days
- Priority 3 (P3) – Within 10 days

REPORTS TO LAW ENFORCEMENT (LE)

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

DELAWARE CODE[78]

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

16 Del. C. § 906(e)(3) states: "The Division staff shall also contact…the appropriate law-enforcement agency upon receipt of any report under this section and shall provide such agency with a detailed description of the report received."

24 Del. C. § 1762(a) states: "Every person certified to practice medicine who attends to or treats a stab wound; poisoning by other than accidental means; or a bullet wound, gunshot wound, powder burn, or other injury or condition arising from or caused by the discharge of a gun, pistol, or other firearm, or when such injury or condition is treated in a hospital, sanitarium, or other institution, the person, manager, superintendent, or other individual in charge shall report the injury or condition as soon as possible to the appropriate police authority where the attending or treating person was located at the time of treatment or where the hospital, sanitarium, or institution is located."

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

[78] *See* 16 Del. C. § 903 and 906(e)(3) and 24 Del. C. § 1762(a)

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

REPORTS TO DEPARTMENT OF JUSTICE (DOJ)

DFS is required to report all civil offenses identified in the Sexual Abuse Protocol to the appropriate division at the Department of Justice. Additionally, DFS is required to report all persons, agencies, organizations and entities to DOJ for investigation if they fail to make mandatory reports of child abuse or neglect under 16 Del. C. § 903.

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

If the matter is referred to the Children's Advocacy Center for a forensic interview, the CAC will notify the DOJ, DFS, and LE of the scheduled interview as soon as possible.

DELAWARE CODE[79]

16 Del. C. § 906(e)(3) states: "The Division staff shall also contact the Delaware Department of Justice… upon receipt of any report under this section and shall provide such agency with a detailed description of the report received."

REPORTS TO THE OFFICE OF THE INVESTIGATION COORDINATOR (IC)

The Office of the Investigation Coordinator receives reports of sexual abuse through data exchanges with DFS and the Delaware Criminal Justice Information System (DELJIS). Additionally, all MDT members shall provide case specific information as requested by the IC. For the purposes of conflict resolution, the Office of the Investigation Coordinator may be contacted to initiate or facilitate communication with other members of the MDT.

DELAWARE CODE[80]

16 Del. C. § 906(c)(1)a. and b. state: "The Investigation Coordinator, or the Investigation Coordinator's staff, shall…have electronic access and the authority to track within the Department's internal information system and Delaware's criminal justice information system each reported case of alleged child abuse or neglect. Monitor each case involving the death of, serious physical injury to, or

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

allegations of sexual abuse of a child from inception to final criminal and civil disposition, and provide information as requested on the status of each case to the Division, the Department, the Delaware Department of Justice, the Children's Advocacy Center, and the Office of Child Advocate."

16 Del. C. § 905(f) states: "Upon receipt of a report of child abuse or neglect, the Division shall immediately notify the Investigation Coordinator of the report, in sufficient detail to permit the Investigation Coordinator to undertake the Investigation Coordinator's duties, as specified in § 906 of this title."

16 Del. C. § 906(d)(2) and (f)(3) state: The law enforcement agency and Delaware Department of Justice investigating a report of child abuse shall "provide information as necessary to the Investigation Coordinator to permit case tracking, monitoring and reporting by the Investigation Coordinator."

REPORTS TO PROFESSIONAL REGULATORY BODIES

In keeping with the following statutory requirements, certain MDT members shall make reports to professional regulatory organizations and other agencies upon receipt of reports alleging abuse or neglect by professionals licensed in Delaware.

DELAWARE CODE[81]

16 Del. C. § 906(c)(1)c. states the Investigation Coordinator or the Investigation Coordinator's designee shall: "Within 5 business days of the receipt of a report concerning allegations of child abuse or neglect by a person known to be licensed or certified by a Delaware agency or professional regulatory organization, forward a report of such allegations to the appropriate Delaware agency or professional regulatory organization."

16 Del. C. § 906(e)(6) and (f)(4) state the Division and DOJ shall: "Ensure that all cases involving allegations of child abuse or neglect by a person known to be licensed or certified by a Delaware agency or professional regulatory organization, have been reported to the appropriate Delaware agency or professional regulatory organization and the Investigation Coordinator in accordance with the provisions of this section."

24 Del. C. § 1731A states any person may report to the Board information that the reporting person reasonably believes indicates that a person certified and registered to practice medicine in this State is or may be guilty of unprofessional conduct or may be unable to practice medicine with reasonable skill or safety to patients by reason of mental illness or mental incompetence; physical illness, including deterioration through the aging process or loss of motor skill; or excessive use or abuse of drugs, including alcohol. The following have an affirmative duty to report, and must report, such information to the Board in writing within 30 days of becoming aware of the information:

(1) All persons certified to practice medicine under this chapter;

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

(2) All certified, registered, or licensed healthcare providers;

(3) The Medical Society of Delaware;

(4) All healthcare institutions in the State;

(5) All state agencies other than law-enforcement agencies;

(6) All law-enforcement agencies in the State, except that such agencies are required to report only new or pending investigations of alleged criminal conduct specified in § 1731(b)(2) of this title, and are further required to report within 30 days of the close of a criminal investigation or the arrest of a person licensed under this chapter.

2. INVESTIGATION

For the purpose of conducting an effective joint investigation, communication and coordination should occur among the MDT members as soon as possible and continue throughout the life of the case.

Upon receipt of a report, DOJ, DFS, and LE will communicate and coordinate a response; however, LE will take the lead in the Joint Investigation. LE agencies needing additional resources may consult with larger jurisdictions.

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

For all allegations within this Protocol, the MDT will determine from the list below the appropriate investigative actions that have been identified as best practices for responding to child abuse cases.

Investigative Actions	Responsible Agency
Cross-report and coordinate a response between MDT members.	MDT
Establish the location(s) where the incident occurred.	LE
Identify persons involved and coordinate interviews with child, siblings, caregivers, alleged perpetrator(s), and other witnesses.	DFS and LE
Exchange information regarding complaint, criminal and DFS history.	MDT
Consider consultation with police jurisdictions with more resources.	LE
Adhere to the federal Prison Rape Elimination Act – Juvenile Facility Standards.	DYRS/Contractors

Investigative Actions	Responsible Agency
Schedule forensic interviews at CAC for any child victims or child witnesses to include siblings and other children in the home.	MDT
Discuss DFS's required notification to the alleged perpetrator of the allegations. Limit the details of the allegations and the maltreatment type.[82]	LE and DFS
Assess safety and need for out-of-home interventions of all children.	DFS
Consider Temporary Emergency Protective Custody of child and other children in home.	Medical, LE and DFS
Observe and photo/video document the crime scene(s); collect evidence.	LE
Determine if elements of Child Torture are present (review the checklist on Common Elements of Child Torture).	MDT
Follow Guidelines for Child Abuse Medical Response for child and other children in the home.	DFS, LE and Medical
Consider Sexual Assault Evidence Collection Kit.	Medical
Consider Hospital High Risk Medical Discharge Protocol if concerns exist about the child's safety at discharge.	Medical
Utilize victim advocates to connect children and families with appropriate mental health, substance abuse, social services and additional resources.	MDT
Complete pre-arrest intake with DOJ.	LE and DOJ
Participate in MDT meetings (i.e. case review).	MDT

INTERVIEWS

LE will conduct interviews with caregivers, alleged perpetrator(s), and other witnesses and will provide prior notice to DFS to allow for observation. Additionally, all interviews shall be audio recorded, and when practicable, video recorded by LE. DFS must receive clearance from LE before conducting follow up interviews for the purpose of gathering information relevant to the civil investigation. In the event that a LE response is delayed, DFS may obtain basic information from the family to assess the child's safety until LE arrives to conduct the interviews.

[82] The federal Child Abuse Prevention and Treatment Act requires DFS to notify the alleged perpetrator of the complaints or allegations made against him or her at the initial time of contact regardless of how that contact is made (42 U.S.C. 5101 et seq).

Child victims and witnesses to include siblings and other children in the home, ages 3 to 12, should be interviewed at the CAC in cases that fall within the Sexual Abuse Protocol. This does not preclude interviews of children under 3, who are verbal, or youth between the ages of 13 and 18. Multiple interviews by multiple interviewers can be detrimental to children and can create issues for successful civil and criminal case dispositions. Use of the CAC to conduct interviews is considered best practice to minimize trauma and re-victimization of child victims and/or child witnesses.

In any investigation of criminal conduct occurring at, or related to, a facility or organization where multiple children may have been exposed to, or victimized by, a perpetrator of the conduct being investigated, the MDT must consider the potential that other children have been victimized. Thus, the MDT should schedule and conduct interviews at the CAC of all children between the age of 3 and 12 who may have been exposed to, a victim of, or a witness to the conduct being investigated. Facilities or organizations where multiple children may be exposed to criminal conduct include, but are not limited to, child care centers, schools, and youth athletic organizations. This policy is intended to both define the scope of such investigations and to provide support to children who, by mere circumstance, are, or have been, in the presence of the subject of an investigation.

If additional information is needed prior to scheduling the forensic interview with the child, the **First Responder Minimal Facts Interview Protocol** should be utilized (See Appendix A). If both LE and DFS are present, then a lead interviewer should be identified prior to conducting the interview. This Protocol will still allow DFS to assess the child's safety through its in-house protocols while preserving the criminal investigation.

FIRST RESPONDER

Minimal Facts Interview Protocol

1. **Establish rapport**
2. **Ask limited questions to determine the following:**
   - What happened?
   - Who is/are the alleged perpetrator(s)?
   - Where did it happen?
   - When did it happen?
   - Ask about witnesses/other victims
3. **Provide respectful end**

FORENSIC INTERVIEW AT THE CAC

After making a cross-report, LE, DFS, and/or DOJ may contact the CAC in the jurisdiction where the alleged crime occurred to request a forensic interview. LE and DFS will communicate prior to contacting the CAC to determine who will make the request and the appropriate timeframe for scheduling the interview.

Forensic interviews will be scheduled on a non-urgent basis (within 5 business days) or urgent basis (within 2 business days) subject to the availability of MDT member agencies, children, and their caregivers. Please note that the CAC will accommodate after-hours interviews on an emergency basis as needed. The CAC will acquire interpreter services as needed for the child and/or family. All interviews will be video and audio recorded.

The forensic interviewer will conduct the interview utilizing a nationally recognized forensic interview protocol and forensic interview aids, as appropriate. Members of the MDT may be present for the interview based on availability. MDT members should refrain from engaging in pre-interview contact with the caregiver and child at the CAC to avoid impacting the forensic interview process.

The forensic interviewer will facilitate the CAC process. This process includes pre-interview meetings, the forensic interview, and post-interview meetings. MDT members should be prepared to discuss the following: complaint and criminal history concerning all individuals involved in the case; DFS history; prior forensic interviews at the CAC; current allegations; and strategies for the interview to include introduction of evidence to the child.

During the post-interview team meeting, the MDT may discuss interview outcomes; prosecutorial merit; next investigative steps; and medical, mental health, victim advocacy and safety needs of the child and family. Additionally, the MDT may determine that a multi-session or subsequent interview is required based on the case circumstances and the needs of child.

If a **secondary allegation is disclosed to the CAC** during the forensic interview process, then the MDT members present shall make a joint report to the DFS Report Line prior to conclusion of the post interview meeting. However, if circumstances prevent the joint report from being made, the MDT shall select a member to make the report on behalf of the team. The designee will make the report immediately and inform the Report Line worker that he/she is making the call on behalf of the applicable MDT agencies.

When the MDT meets with the caregiver post-interview, DOJ will take the lead in sharing information related to the interview and possible criminal prosecution.

Following the post-interview meeting, the CAC Family Resource Advocate will facilitate a discussion with the caregiver about social and mental health services and other resources available for the child and/or family. Referrals will be made by the CAC as appropriate.

During the course of an investigation, a MDT meeting may be required to discuss new information obtained by any of the team members. The meeting shall be convened by the IC upon request of any team member. Otherwise, these discussions will take place at regularly scheduled MDT Case Review meetings.

If additional information is needed from the child by a MDT member, then the other team members should be contacted and a follow up forensic interview should be scheduled.

PRISON RAPE ELIMINATION ACT (PREA)

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

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

PRESERVATION OF EVIDENCE

LE will establish, examine and document the location(s) of incident as soon as practicable. The crime scene(s) and other corroborative evidence should be collected and photographed or video recorded. For sexual abuse allegations involving children in state operated or contracted residential facilities, PREA requires that DYRS staff and its contractors separate the alleged victim and alleged perpetrator, and preserve and protect any crime scene until LE can assume responsibility. This includes asking the alleged victim not to take any action that could destroy physical evidence.

Interviews by LE should be audio recorded and when practicable, video recorded. Forensic interviews with the child and siblings will be video and audio recorded at the CAC. Interviews with caregivers, alleged perpetrator(s), other witnesses, and those children not interviewed at the CAC will be audio recorded and when practicable, video recorded by LE. Any recordings created during the interview process at the CAC will be turned over to LE and LE will thereafter become the agency owning this evidence.

The sexual assault evidence collection kit will be completed by a specially trained Sexual Assault Nurse Examiner/Forensic Nurse Examiner or medical provider. Any photographs necessary to document physical injuries will be completed as part of the medical examination. Items collected by medical providers as part of the forensic evaluation (including the sexual assault evidence kits) will be turned over to LE.

COMMON ELEMENTS OF CHILD TORTURE

Child torture may not immediately be identified until the abuse and/or neglect results in serious physical injury or death often after multiple interventions for less serious offenses. Therefore, MDT members should consider the elements of child torture in every case and communicate any identified elements to other members of the team.

Cases can be quickly assessed by using the checklist below, and child torture should be considered when several elements are identified, either currently or historically within a case. For instance, child torture should be suspected if an 8-year-old child presents with a sexually transmitted infection, cigarette burns

were observed two months prior, and parent is withholding food, threatening the child, and isolating the child from family.

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

Section One: Deprivation of Basic Necessities (at least 1 element)	
☐ **Current or History of Allegations for Neglect**	
☐ Withholding Food ☐ Withholding Water ☐ Withholding Clothing ☐ Subjecting to Extremes of Heat or Cold ☐ Limiting Access to Others ☐ Limiting Access to Routine Medical Care ☐ Forcing Child to Stay Outside for Extended Periods or Sleep Outside	☐ Limiting Access to Toilet ☐ Limiting Access to Personal Hygiene/Bathing ☐ Inability to Move Free of Confinement ☐ Withholding Access to Schooling/Withdrawing to Home School ☐ Sleep Deprivation ☐ Low Body Mass Index ☐ Other:
Section Two: Physical Abuse (at least 2 physical assaults or 1 severe assault)	
☐ **Current or History of Allegations for Physical Abuse**	
☐ Bruising Shaped like Hands, Fingers, or Objects, or Black Eyes ☐ Fractures that are Unexplained and Unusual ☐ Ligature, Binding, and Compression Marks due to Restraints ☐ Contact or Scald Burns to the Skin or Genitalia	☐ Flexion of a Limb or Part of Limb beyond its Normal Range ☐ Human Bite Marks ☐ Force-Feeding ☐ Asphyxiation ☐ Other:
Section Three: Psychological Maltreatment (2 or more elements, can be a single incident)	
☐ **Current or History of Allegations for Psychological Maltreatment**	
☐ Rejection by Caregiver ☐ Terrorizing ☐ Isolating ☐ Threats of Harm or Death to Child, Sibling(s) or Pets	☐ Exploiting/Corrupting ☐ Unresponsive to Child's Emotional Needs ☐ Shaming/Humiliation ☐ Other:
Section Four: Supplemental Items	
☐ **Current or History of Allegations for Sexual Abuse**	
☐ Penile, Digital or Object Penetration of the Anus ☐ Assault to the Genitals ☐ Forcing Sexual Intercourse	☐ Forcing to Remain Naked or Dance ☐ Forcing to Witness or Participate in Sexual Violence against another person ☐ Other
☐ **Forcing Excessive Exercise for Punishment**	
☐ **History of Prior Referrals and /or Investigations by the Division of Family Services (DFS)**	
☐ **One Child is Targeted**	

☐ **Sibling(s) Abused**

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

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

☐ **One Caregiver Fails to Protect**

☐ **No Disclosure is Made by Targeted Child or Siblings**

☐ **Caregivers Provide Reasonable Explanations in Response to Allegations**

☐ **Caregivers Allege Mental Health Issues for Targeted Child (e.g. self-injury) and Report Repeated Attempts to Seek Help**

TEMPORARY EMERGENCY PROTECTIVE CUSTODY

In accordance with Delaware Code, Physicians, DFS investigators, or LE may take Temporary Emergency Protective Custody of a child in imminent danger of serious physical harm or a threat to life as a result of abuse or neglect for up to 4 hours. DFS may only take Temporary Emergency Protective Custody of a child in a school, day care facility, and child care facility.

Physicians and LE must immediately notify DFS upon invoking this authority. This shall end once DFS responds.

A reasonable attempt shall also be made to advise the parents, guardians or others legally responsible for the child's care, being mindful not to compromise the investigation.

DELAWARE CODE[83]

16 Del. C. § 907(a) and (e) state: "A police officer or a physician who reasonably suspects that a child is in imminent danger of suffering serious physical harm or a threat to life as a result of abuse or neglect and who reasonably suspects the harm or threat to life may occur before the Family Court can issue a temporary protective custody order may take or retain temporary emergency protective custody of the child without the consent of the child's parents, guardian or others legally responsible for the child's care… A Division investigator conducting an investigation pursuant to § 906 of this title shall have the same authority as that granted to a police officer or physician… provided that the child in question is located at a school, day care facility or child care facility at the time that the authority is initially exercised."

TRANSPORTATION

If the alleged perpetrator is the caregiver or is unknown, an alternative means of transportation should be provided to the child for medical examinations, forensic interviews at the CAC, and out-of-home interventions. Under these circumstances, DFS or LE may transport the child to the hospital or seek

[83] *See* 16 Del. C. § 907(a) and (e)

medical transport for the child, and both agencies are entitled to immunity from any liability in accordance with § 4001 of Title 10.

DFS may also transport a child under the following conditions: DFS invokes Temporary Emergency Protective Custody from a school, day care facility or child care facility; DFS obtained a signed consent from the parent; or DFS is currently awarded Temporary Custody by the Family Court.

MEDICAL EXAMINATION

A medical examination will be conducted for any child, who is the alleged victim of a sexual abuse report, and considered for other children residing in the home. Medical examinations may be conducted to identify, document, diagnose, prevent, and treat medical conditions and/or trauma (resulting from abuse and unrelated to abuse), as well as to assess issues related to patient safety and well-being.

To determine the appropriate medical response for the child and other children in the home, the MDT should follow the **Delaware Multidisciplinary Team Guidelines for Child Abuse Medical Response** (Medical Response Guidelines). Please refer to Appendix "C" for the complete version of the Medical Response Guidelines.

The Medical Response Matrix for Child Sexual Abuse cases is listed below. Please note that Step 2 of the Medical Response Matrix and any medical response which involves calling the designated medical services provider will not be implemented until the resources become available.

Abuse Fact Pattern	Medical Response	Time Frame
Any type of contact between the child or abuser involving either the child's or abuser's genitals, anus or mouth having occurred **within the past 120 hours (to encompass evidentiary and medical needs).**	**Step 1. URGENT RESPONSE directly to Sexual Assault Nurse Examiner/ Forensic Nurse Examiner Program.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Any child describing sexual assault of abuse with significant genital or anal pain, genital or anal bleeding, sores in the genital or anal areas, and any pre-pubertal girl with a discharge **regardless of when the last reported contact occurred.**	**Step 1. URGENT RESPONSE directly to Sexual Assault Nurse Examiner/ Forensic Nurse Examiner Program.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Any child suggesting a significant mental health issue such as suicidal ideation or gesture, or severe depression, **regardless of when the last reported contact occurred.**	**Step 1. URGENT RESPONSE OR EMS TRANSPORT to nearest hospital for:** **A. Necessary medical services.** **B. Necessary mental health services.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Contact of abuser's mouth with child's genitals or anus. (Reported by child or witnessed by another individual.)	Call designated medical services provider. *To be implemented at later date.*	24 HR

Contact of abuser's genitals with child's genitals or anus or mouth. (Reported by child or witnessed by another individual.)	Call designated medical services provider. ***To be implemented at later date.***	24 HR
Contact of abuser's hands, fingers or objects with child's genital or anus. (Reported by child or witnessed by another individual.)	Call designated medical services provider. ***To be implemented at later date.***	24 HR
Pre-teen sibling of a preteen child confirmed to have STD.	Call designated medical services provider. ***To be implemented at later date.***	24 HR
Any child with genital and/or anal pain or discharge; lesions/bumps/ulcers; bleeding; or painful urination, regardless of type of contact reported by child.	Call designated medical services provider. ***To be implemented at later date.***	24 HR
Any pre-teen child with an abnormal examination or an STD.	Call designated medical services provider. ***To be implemented at later date.***	24 HR

Prior to responding to the designated hospitals to seek a medical examination for a child, DFS or LE may call the Forensic Nurse Examiner Program to request a forensic exam and to provide case specific details.

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

Please remember that DFS has the authority to seek a medical examination for a child victim without the consent of the child's parents or caregiver. For siblings and other children in the home, the American Academy of Pediatrics recommends a timely medical examination for siblings and other children in the home when one child is identified as a victim of abuse.

DELAWARE CODE[84]

16 Del. C. § 906(e)(7) of the Delaware Code states: "The Division shall have authority to secure a medical examination of a child, without the consent of those responsible for the care, custody and control of the child, if the child has been reported to be a victim of abuse or neglect…"

The medical examination should include written record and photographic documentation of injuries. Preliminary medical findings will be provided immediately to LE and DFS upon completion of the examination. Subsequent findings and medical records should be obtained prior to completion of an investigation.

Potential questions that should be asked of the medical provider are listed below. Avoid asking a physician whether it is "possible" that a caregiver's explanation caused the injury, because the answer

[84] *See* 16 Del. C. § 906(e)(7)

will always be yes. Instead, use the words "probable, likely or consistent with" when speaking with medical providers and note that medical providers only speak in terms of probability and not absolutes.

COLLECTING THE MEDICAL EVIDENCE[85]

Questions for the Medical Provider

- What is the nature and extent of the child's injury or illness?
- What is the mechanism of injury? What type and amount of force are required to produce the injury?
- Does the history the caregiver provided explain (in whole or in part) the child's injury?
- Have other diagnoses been explored and ruled out, whether by information gathering, examination, or medical tests?
- Could the injury be consistent with an accident?
- Can the timing of the injury be estimated? To what degree of certainty?
- Have all injuries been assessed in light of any exculpatory statements?
- What treatments were necessary to treat the injury or illness?
- What are the child's potential risks from the abusive event?
- What are the long-term medical consequences and residual effects of the abuse?

MDT members should consider the possibility of injuries that were not reported by the child or not readily visible (i.e. internal injuries or age progression of injuries). Be mindful that minor injuries, when paired with a history of alleged abuse or neglect, may be indicative of chronic physical abuse or torture.

Prior to discharge, if concerns regarding the child's safety exist, then the medical providers may consider requesting a meeting in accordance with Hospital High Risk Medical Discharge Protocol (See Appendix D). The Protocol ensures that children (birth to age 18) with special medical needs, who are active with DFS or have been reported to DFS by Delaware hospitals, are discharged in a planned and safe manner.

In addition to the medical examination for allegations of abuse or neglect, the American Academy of Pediatrics (AAP) recommends that children in foster care receive an initial health screening within 72 hours of placement to identify any immediate medical, mental health and dental needs, and a comprehensive health evaluation within 30 days of placement to review all available medical history, to identify medical conditions and to develop an individualized treatment plan for the child. Additionally, the AAP recommends that the child receive a screening each time the placement changes.[86] The Foster Care Health Program at the Nemours Alfred I. duPont Hospital for Children is the state's specialty clinic, and DFS is responsible for making these referrals as appropriate.

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

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

SAFETY ASSESSMENT

DFS is responsible for assessing the safety of the alleged child victim and other children in the home and/or visiting the home during the course of the investigation. If safety threats are present, DFS will consider whether an out-of-home intervention is warranted by safety agreement or custody. For children placed in out-of-home interventions through a safety agreement, DFS will conduct background checks on all individuals in that home and complete home assessments.

LE will notify DFS if removal of a child appears necessary. LE should communicate concerns and information regarding the child's safety that may impact DFS interventions. DFS, not LE, is responsible for making placement decisions when safety threats are present and the child(ren) cannot remain at the current residence. As noted above, for situations in which a child is in imminent danger, then it would be appropriate for LE to take Temporary Emergency Protective Custody.

BEHAVIORAL HEALTH AND SOCIAL SERVICES

The child and family should be connected to any needed behavioral health and social services in order to reduce trauma, promote healing and improve outcomes. Child abuse and neglect can be experienced as traumatic events and can have a lifelong impact on the child and the family if appropriate resources and supportive services are not provided. The social and mental health needs of all should be considered in every case and discussed as part of the MDT meetings throughout the life of the case.

The Division of Prevention and Behavioral Health Services (DPBHS) provides a wide range of individualized, trauma-informed, and community-based behavioral health services to children and families statewide. Every child residing in Delaware can be referred to prevention/early intervention and crisis services which are provided through DPBHS. To refer or receive information about these services call the DPBHS Access Unit at 1-800-722-7710 or the Crisis Service at 1-800-969-4357.

DPBHS provides the outpatient treatment and supportive services to youth who are uninsured or insured by Medicaid through an array of specialized evidence-based practices to promote the best outcomes for children and families. In the event a child needs treatment outside of his/her community (including homes and school), the DPBHS treatment continuum may include day treatment, partial hospitalization program, residential rehabilitative treatment and inpatient hospitalization services.

Children presenting with indicators of trauma who are uninsured or insured by Medicaid should be referred to the Access Unit at DPBHS. Staff in the Access Unit will collect behavioral health and substance abuse information. If the child is in need of services beyond prevention, early intervention or outpatient, staff will complete a service intensity tool (e.g. Child and Adolescent Service Intensity Instrument (CASII) and American Society of Addiction Medicine (ASAM)) and make appropriate referrals for services. For children in need of treatment with private insurance, the families should be referred to their insurance company for information about benefits and providers.

For children entering foster care, the DFS Office of Evidence-Based Practice (OEBP) will conduct a screening to assist in identifying the needed mental health services for children and their families. In

addition, if a child in foster care exhibits trauma or symptoms of trauma, the caseworker will alert the OEBP for further Trauma Screening.

MDT members may connect children and their families to these and other services with the assistance of the victim advocates identified below.

VICTIM ADVOCATES

Victim advocates are responsible for assessing the needs of the child and family and connecting them to culturally appropriate resources and services. Victim advocates are available in each of the MDT agencies as follows:

- DSCYF/Division of Family Services – Domestic Violence Liaisons & Substance Abuse Liaisons
- Law Enforcement – Victim Service Specialists
- Department of Justice – Social Workers
- Children's Advocacy Center – Family Resource Advocates
- Hospitals – Social Workers

To ensure there are no gaps in services, victim advocates should communicate with each other and coordinate with mental health and social service providers throughout the course of the investigation and beyond. The roles and responsibilities of the victim advocates will vary among the agencies, so not all advocates will provide the same array services. However, the following constellation of services may be provided as needed: emergency crisis assessment and intervention, risk assessment and safety intervention for caregivers and families, information on Victims Information Notification Everyday (VINE), assistance with filing for emergency financial assistance and education regarding victim's rights, case status updates, court accompaniment, and information and referrals for appropriate social service agencies (e.g. housing, protective orders, domestic violence intervention, food, transportation, public assistance, and landlord/employer intervention).

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

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

ARREST

LE should call DOJ's Special Victims Unit upon receipt of allegations of sexual abuse to a child. Communication with DOJ should be ongoing throughout the criminal investigation and prior to charging, whenever possible to ensure the best outcome for the criminal case.

When an alleged perpetrator is arrested, a no contact order with the alleged child victim and/or other children in the home may be recommended, as a specific condition of bail and/or other conditions that may be necessary to protect the child(ren) and any other members of the community. Input from DFS

should be considered and offered to the issuing judicial officer. LE and/or DFS may contact DOJ to request a modification to the contact conditions of bail. Regardless of contact conditions of bail, DFS will consider an in-home intervention or an out-of-home intervention once safety threats are identified, including safety agreements, custody and placement needs.

Before clearing a case without an arrest, LE consultation with DOJ shall occur. LE will notify DFS upon case closure.

CRIMINAL PROCEEDINGS

DOJ may review the following information (both current and historical):

- All police reports and any other information obtained during the investigation concerning all individuals involved in the case;
- All non-redacted DFS records;
- All medical records pertaining to the child;
- All CAC records; and,
- Inventory and/or copies of any evidence.

The Deputy Attorney General (DAG) will evaluate the case to determine prosecutorial merits and will collaborate with LE to identify additional investigative actions as appropriate.

When two or more Divisions (typically Family & Criminal) within DOJ are involved with a particular case, the DAGs will coordinate with each other to ensure the most appropriate legal outcomes are achieved. The Civil and Criminal DAGs shall communicate regularly regarding the case status. The DAG prosecuting the criminal matter will take the lead in this process.

Before resolution of a criminal proceeding, DOJ should confer with DFS, on active cases, regarding issues impacting child safety, such as vacating the No Contact Order and potential impact to a civil substantiation proceeding prior to completion of the civil investigation. This discussion should also include recommended services and/or evaluations for the perpetrator and child. Upon a criminal conviction where the civil case was unfounded and closed, the Criminal DAG will notify the Civil DAG.

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

CIVIL DISPOSITION

DFS makes a determination as to whether abuse or neglect has occurred within 45 calendar days. Upon completion of the civil investigation, DFS will make a finding once it has established that a preponderance of the evidence exists; the civil finding is not dependent upon the status or outcome of the criminal case.

DFS is required to give written notice to the alleged perpetrator of its finding. Recognizing that this notice to the alleged perpetrator may impact an active criminal investigation, DFS shall contact LE/DOJ prior to case closure in order to maintain the integrity of the case.

DELAWARE CODE[87]

16 Del. C. § 924(a)(2)b. states: "[The Division shall] advise the person that the Division intends to substantiate the allegations and enter the person on the Child Protection Registry for the incident of abuse or neglect at a designated Child Protection Level."

In addition to the DFS investigation, there may be a civil proceeding in the Family Court, such as if DFS petitions for temporary custody of a child or if the alleged perpetrator appeals a finding by DFS and a Substantiation Hearing is scheduled.

MDT members may be subpoenaed to testify in civil proceedings and/or provide case documentation or evidence subject to any relevant statutory provisions and Court rulings as to the confidentiality and admissibility of said evidence.

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

3. MDT CASE REVIEW

MDT Case Review is the formal process in which the team convenes regularly scheduled meetings in each county to monitor and discuss the case progress, which may include the following:

- Review interview outcomes;
- Discuss, plan and monitor the progress of the investigation;
- Review any medical examinations;
- Discuss child protection and other safety issues;
- Provide input for prosecution and sentencing decisions;
- Discuss emotional support and treatment needs of the child and family members as well as strategies for meeting those needs;
- Assess the families' reactions and response to the child's disclosure and involvement in the criminal justice and/or child protection systems;
- Review criminal and civil case updates, ongoing involvement of the child and family and disposition;
- Make provisions for court education and court support;
- Discuss ongoing cultural and special needs issues relevant to the case; and,

[87] *See* 16 Del. C. § 924(a)(2)b.

- Ensure that all children and families are afforded the legal rights and comprehensive services to which they are entitled.

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

Please see Appendix "F" for an example of a MDT Case Review Protocol utilized in Delaware.

4. CONFIDENTIALITY, INFORMATION SHARING & DOCUMENTATION

The Child Abuse Prevention and Treatment Act (CAPTA) requires that states preserve the confidentiality of all reports and records pertaining to cases that fall within this MOU to protect the privacy rights of the child and family.[88] However, exceptions are permitted in certain limited circumstances, and the Delaware Code provides guidance on who may access the information.

DELAWARE CODE[89]

16 Del. C. § 906(e) states: "The Division shall only release information to persons who have a legitimate public safety need for such information or a need based on the health and safety of a child subject to abuse, neglect or the risk of maltreatment, and such information shall be used only for the purpose for which the information is released."

MDT members are **authorized and encouraged** to communicate information with one another pertaining to families and children in a legal, ethical, professional, and timely manner throughout the course of an investigation in accordance with agency policies and existing agreements (e.g. MOUs). As noted above, applicable state and federal confidentiality laws apply.

To obtain records, the requesting MDT agency must contact the MDT agency from which the records originated. **Information may be shared between MDT agencies; however, records shall only be disseminated by the agency owning those records.** Mental health and substance abuse records are afforded a stricter level of protection under state and federal statutes requiring consent of the parent or pursuant to a subpoena issued by DOJ.

If a criminal or civil proceeding is pending, DOJ may also issue a subpoena for records or for court testimony.

Documentation should be specific to case facts and should not include information related to the opinions of the MDT members (i.e., the initial concerns of the investigator as to the strength, strategy, or course of the criminal investigation).

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[88] Retrieved on February 6, 2017, from Child Welfare Information Gateway's Factsheet Disclosure of Confidential Child Abuse and Neglect Records: https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/confide/

[89] *See* 16 Del. C. § 906(e)

5. CONFLICT RESOLUTION

The MDT shall make every effort to resolve disputes through discussion and negotiation at the lowest levels of the agencies. If the dispute cannot be resolved at this level, then the MDT members involved in the dispute shall contact their individual supervisors for assistance. Once the chain of command is exhausted or at the request of one of the supervisors, a team meeting may be scheduled. Additionally, the Investigation Coordinator's Office may be contacted to initiate or facilitate communication with other members of the MDT.

VI. CHILD NEGLECT PROTOCOL

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

1. Fails to provide necessary care with regard to: food, clothing, shelter, education, health, medical or other care necessary for the child's emotional, physical, or mental health, or safety and general well-being; or

2. Chronically and severely abuses alcohol or a controlled substance, is not active in treatment for such abuse, and the abuse threatens the child's ability to receive care necessary for that child's safety and general well-being; or

3. Fails to provide necessary supervision appropriate for a child when the child is unable to care for that child's own basic needs or safety, after considering such factors as the child's age, mental ability, physical condition, the length of the caregiver's absence, and the context of the child's environment.[90]

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

1. CIVIL OFFENSES

- **Abandonment (Age 10 and Under):** means [any individual] fails to assume or refuses to assume responsibility or to provide basic care for a child on a daily basis;

- **Caregiver/Parent Death:** means a child's primary caregiver/parent died as a result of a murder/suicide due to domestic violence and the child is dependent;

- **Caregiver/Parent Under the Influence:** means incidents reported by law enforcement when a caregiver's/parent's substance abuse impairs his/her ability to supervise, protect or care for the child and the child is dependent or no responsible caregiver is available;

- **Child Left Alone (Age 11 and Under):** means a child has been left alone for an extended period of time or beyond the child's capability to maintain immediate, basic care and safety for self and/or other children under age 11 left in their care and control;

- **Child Witness/Exposure to Domestic Violence in the Household:** means at least one caregiver/parent is a victim or perpetrator of violence that is chronic and/or severe and a child has witnessed in the last 12 months one or more family violence incidents that are consistent with felony-level charges (e.g., resulted in an injury that required or should have resulted in

[90] *See* 10 <u>Del. C.</u> § 901(18)

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

- **Exploitation:** means the parent/caregiver teaches, encourages, or instructs a child to engage in illegal behaviors (e.g., shoplifting, burglary, drug dealing);

- **Hazardous Conditions in Household:** means a child is exposed to deplorable, unsanitary and dangerous living conditions (e.g. exposed electrical wiring, broken windows or stairs, and access to weapons, chemicals or harmful drugs) and these conditions impact the child's health and safety;

- **Inappropriate Confinement:** means the alleged perpetrator has confined the child in a bedroom, basement, or any other space for a period of time that is inappropriate for the child's age and/or vulnerability;[92]

- **Lack of Supervision (Age 6 and Younger):** means the caregiver/parent of a child fails to provide immediate care to ensure the well-being and safety of the child, who is unable to care for him/herself or respond appropriately to an emergency. These are incidents in which the caregiver/parent is physically present, but is not attending to the child due to behaviors such as substance abuse;[93]

- **Life-Threatening Medical Neglect:** means a caregiver's/parent's failure to obtain medical care for a child has resulted in hospitalization and medical diagnosis indicates the medical issue(s) were caused by or could have been prevented by the caregiver/parent;

- **Lock Out:** means the caregiver/parent locked a child aged ten or younger out of the house or locks a child over age ten out of the house on a recurring basis;[94]

- **Runaway:** in-state or out-of-state runaways whose caregiver/parent refuses to resume responsibility for the child's care;

- **Severe Physical Neglect:** means failure by the caregiver/parent of a child to provide for the basic needs (e.g., food, clothing, shelter) of the child, for no apparent financial reason, and this failure could result in bodily harm or death. This category includes inaction by a parent/caregiver or a failure to protect the child that results in severe harm to the child.[95]

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[91] *See* http://kids.delaware.gov/policies/dfs/sdm-DelawareIntakeManual-2015March.pdf
[92] *See* http://kids.delaware.gov/policies/dfs/sdm-DelawareIntakeManual-2015March.pdf
[93] *See* 9.1.6 DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.
[94] *See* http://kids.delaware.gov/policies/dfs/sdm-DelawareIntakeManual-2015March.pdf
[95] *See* 9.1.11 DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.

2. **CRIMINAL OFFENSES**

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

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

C. MULTIDISCIPLINARY RESPONSE

1. CROSS-REPORTING

For the aforementioned civil and criminal offenses, the MDT agencies agree to cross-report and share information regarding the report of neglect.

REPORTS TO DIVISION OF FAMILY SERVICES (DFS)

All suspected child abuse and neglect of any child, from birth to age 18, in the State of Delaware must be reported to the Division of Family Services Child Abuse Report Line (Report Line) at 1-800-292-9582.

DELAWARE CODE

Mandatory Reporting Law[96]

16 Del. C. § 903 states: "Any person, agency, organization or entity who knows or in good faith suspects child abuse or neglect shall make a report in accordance with § 904 of this title…"

In addition, 16 Del. C. § 904 states: "Any report of child abuse or neglect required to be made under this chapter shall be made by contacting the Child Abuse and Neglect Report Line for the Department of Services for Children, Youth and Their Families. An immediate oral report shall be made by telephone or otherwise. Reports and the contents thereof including a written report, if requested, shall be made in accordance with the rules and regulations of the Division, or in accordance with the rules and regulations adopted by the Division. No individual with knowledge of child abuse or neglect or knowledge that leads to a good faith suspicion of child abuse or neglect shall rely on another individual who has less direct knowledge to call the aforementioned Report Line."

Penalty for Violation[97]

16 Del. C. § 914 states: "Whoever violates § 903 of this title shall be liable for a civil penalty not to exceed $10,000 for the first violation, and not to exceed $50,000 for any subsequent violation."

Any person who has **direct knowledge** of suspected neglect must make an immediate report to the Report Line. **Direct knowledge** is obtained through disclosure (child discloses to you), discovery (you witness an act of neglect), or reason to suspect (you have observed behavioral and/or physical signs of child neglect). This report may include situations where multiple disciplines are involved, such as:

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

The relationship between the child and perpetrator ***does not*** influence whether a report must be made to DFS. All reports, including domestic or intra-familial, institutional, and non-domestic or extra-familial, cases must also be reported to DFS.

Additionally, a separate report must be made to the Report Line for the following reasons:

- Additional suspects have been identified;
- Additional child victims have been identified; or,

[96] *See* 16 Del. C. § 903 and 904
[97] *See* 16 Del. C. § 914

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

If a **secondary allegation is disclosed to the CAC** during the forensic interview process, then the MDT members present shall make a joint report to the DFS Report Line prior to conclusion of the post interview meeting. However, if circumstances prevent the joint report from being made, the MDT shall select a member to make the report on behalf of the team. The designee will make the report immediately and inform the Report Line worker that he/she is making the call on behalf of the applicable MDT agencies.

If known, the following should be provided to the DFS Report Line:

- Demographic information;

- Known information about the following:
    - Child, parents, siblings and alleged perpetrator;
    - The alleged child victim's physical health, mental health, educational status;
    - Medical attention that may be needed for injuries;
    - The way the caregiver and alleged perpetrator's behavior is impacting the care of the child; and,
    - Any circumstances that may jeopardize the child's or DFS worker's safety.

- Facts regarding the alleged neglect and any previous involvement with the family.

- What you are worried about, what is working well, and what needs to happen next to keep the child safe.

Reports received by DFS will either be screened in for investigation as an intra-familial case and/or institutional abuse (IA) case or will be screened out, documented, and maintained in the DFS reporting system.

Reports screened in for investigation by DFS are assigned a priority response time as follows:

- Priority 1 (P1) – Within 24 hours
- Priority 2 (P2) – Within 3 days
- Priority 3 (P3) – Within 10 days

REPORTS TO LAW ENFORCEMENT (LE)

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

DELAWARE CODE[98]

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

16 Del. C. § 906(e)(3) states: "The Division staff shall also contact…the appropriate law-enforcement agency upon receipt of any report under this section and shall provide such agency with a detailed description of the report received."

Other MDT agencies are encouraged to make an immediate report to the appropriate law enforcement jurisdiction to initiate a criminal investigation when appropriate. The law enforcement jurisdiction will determine whether or not a criminal investigative response is appropriate and take the necessary actions.

REPORTS TO DEPARTMENT OF JUSTICE (DOJ)

DFS is required to report all civil offenses identified in the Child Neglect Protocol to the appropriate division at the Department of Justice. Additionally, DFS is required to report all persons, agencies, organizations and entities to DOJ for investigation if they fail to make mandatory reports of child abuse or neglect under 16 Del. C. § 903.

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

If the matter is referred to the Children's Advocacy Center for a forensic interview, the CAC will notify the DOJ, DFS, and LE of the scheduled interview as soon as possible.

DELAWARE CODE[99]

16 Del. C. § 906(e)(3) states: "The Division staff shall also contact the Delaware Department of Justice… upon receipt of any report under this section and shall provide such agency with a detailed description of the report received."

REPORTS TO THE OFFICE OF THE INVESTIGATION COORDINATOR (IC)

No reports are required to the Office of the Investigation Coordinator for the civil offenses identified in the Child Neglect Protocol, unless indicators of child torture are present. For the purposes of conflict resolution, the Office of the Investigation Coordinator may be contacted to initiate or facilitate communication with other members of the MDT.

[98] *See* 16 Del. C. § 903 and 906(e)(3)
[99] *See* 16 Del. C. § 906(e)(3)

DELAWARE CODE[100]

16 Del. C. § 906(c)(1)a. of the Delaware Code states: "The Investigation Coordinator, or the Investigation Coordinator's staff, shall…have electronic access and the authority to track within the Department's internal information system and Delaware's criminal justice information system each reported case of alleged child abuse or neglect."

REPORTS TO PROFESSIONAL REGULATORY BODIES

In keeping with the following statutory requirements, certain MDT members shall make reports to professional regulatory organizations and other agencies upon receipt of reports alleging abuse or neglect by professionals licensed in Delaware.

DELAWARE CODE[101]

16 Del. C. § 906(c)(1)c. states the Investigation Coordinator or the Investigation Coordinator's designee shall: "Within 5 business days of the receipt of a report concerning allegations of child abuse or neglect by a person known to be licensed or certified by a Delaware agency or professional regulatory organization, forward a report of such allegations to the appropriate Delaware agency or professional regulatory organization."

16 Del. C. § 906(e)(6) and (f)(4) state the Division and DOJ shall: "Ensure that all cases involving allegations of child abuse or neglect by a person known to be licensed or certified by a Delaware agency or professional regulatory organization, have been reported to the appropriate Delaware agency or professional regulatory organization and the Investigation Coordinator in accordance with the provisions of this section."

24 Del. C. § 1731A(a) states any person may report to the Board information that the reporting person reasonably believes indicates that a person certified and registered to practice medicine in this State is or may be guilty of unprofessional conduct or may be unable to practice medicine with reasonable skill or safety to patients by reason of mental illness or mental incompetence; physical illness, including deterioration through the aging process or loss of motor skill; or excessive use or abuse of drugs, including alcohol. The following have an affirmative duty to report, and must report, such information to the Board in writing within 30 days of becoming aware of the information:

(1) All persons certified to practice medicine under this chapter;

(2) All certified, registered, or licensed healthcare providers;

(3) The Medical Society of Delaware;

(4) All healthcare institutions in the State;

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

(5) All state agencies other than law-enforcement agencies;

(6) All law-enforcement agencies in the State, except that such agencies are required to report only new or pending investigations of alleged criminal conduct specified in § 1731(b)(2) of this title, and are further required to report within 30 days of the close of a criminal investigation or the arrest of a person licensed under this chapter.

2. INVESTIGATION

For the purpose of conducting an effective joint investigation, communication and coordination should occur among the MDT members as soon as possible and continue throughout the life of the case.

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

For all allegations within this Protocol, the MDT will determine from the list below the appropriate investigative actions that have been identified as best practices for responding to child abuse cases.

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

Investigative Actions	Responsible Agency
Discuss DFS's required notification to the alleged perpetrator of the allegations. Limit the details of the allegations and the maltreatment type.[102]	LE and DFS
Assess safety and need for out-of-home interventions of all children.	DFS
Consider Temporary Emergency Protective Custody of child and other children in home.	Medical, LE and DFS
Observe and photo/video document the crime scene(s); collect evidence.	LE
Determine if elements of Child Torture are present (review the checklist on Common Elements of Child Torture).	MDT
Follow Guidelines for Child Abuse Medical Response for child and other children in the home.	DFS, LE and Medical
Take photographs of child and child's injuries.	Medical, LE and DFS
Consult with DOJ (particularly for active DFS cases, for cases with DFS history and for cases with complaint and criminal history).	DFS, LE and DOJ
Utilize victim advocates to connect children and families with appropriate mental health, substance abuse, social services and additional resources.	MDT
Complete pre-arrest intake with DOJ.	LE and DOJ
Participate in MDT meetings (i.e. case review).	MDT

INTERVIEWS

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

[102] The federal Child Abuse Prevention and Treatment Act requires DFS to notify the alleged perpetrator of the complaints or allegations made against him or her at the initial time of contact regardless of how that contact is made (42 U.S.C. 5101 et seq).

Multiple interviews by multiple interviewers can be detrimental to children and can create issues for successful civil and criminal case dispositions. Use of the CAC to conduct interviews is considered best practice to minimize trauma and re-victimization of child victims and/or child witnesses. Information to consider when discussing who will conduct the interview with the alleged child victim will include:

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

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

In any investigation of criminal conduct occurring at, or related to, a facility or organization where multiple children may have been exposed to, or victimized by, a perpetrator of the conduct being investigated, the MDT must consider the potential that other children have been victimized. Thus, the MDT should schedule and conduct interviews at the CAC of all children between the age of 3 and 12 who may have been exposed to, a victim of, or a witness to the conduct being investigated. Facilities or organizations where multiple children may be exposed to criminal conduct include, but are not limited to, child care centers, schools, and youth athletic organizations. This policy is intended to both define the scope of such investigations and to provide support to children who, by mere circumstance, are, or have been, in the presence of the subject of an investigation.

If LE and DFS are considering using the CAC, but additional information is needed from the child, the **First Responder Minimal Facts Interview Protocol** should be utilized (See Appendix A). If both LE and DFS are present, then a lead interviewer should be identified prior to conducting the interview. This Protocol will still allow DFS to assess the child's safety through its in-house protocols while preserving the criminal investigation.

FIRST RESPONDER

Minimal Facts Interview Protocol

1. **Establish rapport**
2. **Ask limited questions to determine the following:**
   - What happened?
   - Who is/are the alleged perpetrator(s)?
   - Where did it happen?
   - When did it happen?
   - Ask about witnesses/other victims
3. **Provide respectful end**

FORENSIC INTERVIEW AT THE CAC

After making a cross-report, LE, DFS, and/or DOJ may contact the CAC in the jurisdiction where the alleged crime occurred to request a forensic interview. LE and DFS will communicate prior to contacting the CAC to determine who will make the request and the appropriate timeframe for scheduling the interview.

Forensic interviews will be scheduled on a non-urgent basis (within 5 business days) or urgent basis (within 2 business days) subject to the availability of MDT member agencies, children, and their caregivers. Please note that the CAC will accommodate after-hours interviews on an emergency basis as needed. The CAC will acquire interpreter services as needed for the child and/or family. All interviews will be video and audio recorded.

The forensic interviewer will conduct the interview utilizing a nationally recognized forensic interview protocol and forensic interview aids, as appropriate. Members of the MDT may be present for the interview based on availability. MDT members should refrain from engaging in pre-interview contact with the caregiver and child at the CAC to avoid impacting the forensic interview process.

The forensic interviewer will facilitate the CAC process. This process includes pre-interview meetings, the forensic interview, and post-interview meetings. MDT members should be prepared to discuss the following: complaint and criminal history concerning all individuals involved in the case; DFS history; prior forensic interviews at the CAC; current allegations; and strategies for the interview to include introduction of evidence to the child.

During the post-interview team meeting, the MDT may discuss interview outcomes; prosecutorial merit; next investigative steps; and medical, mental health, victim advocacy and safety needs of the child and family. Additionally, the MDT may determine that a multi-session or subsequent interview is required based on the case circumstances and the needs of child.

If a **secondary allegation is disclosed to the CAC** during the forensic interview process, then the MDT members present shall make a joint report to the DFS Report Line prior to conclusion of the post interview meeting. However, if circumstances prevent the joint report from being made, the MDT shall select a member to make the report on behalf of the team. The designee will make the report immediately and inform the Report Line worker that he/she is making the call on behalf of the applicable MDT agencies.

When the MDT meets with the caregiver post-interview, DOJ will take the lead in sharing information related to the interview and possible criminal prosecution.

Following the post-interview meeting, the CAC Family Resource Advocate will facilitate a discussion with the caregiver about social and mental health services and other resources available for the child and/or family. Referrals will be made by the CAC as appropriate.

During the course of an investigation, a MDT meeting may be required to discuss new information obtained by any of the team members. The meeting shall be convened by the IC upon request of any team member. Otherwise, these discussions will take place at regularly scheduled MDT Case Review meetings.

If additional information is needed from the child by a MDT member, then the other team members should be contacted and a follow up forensic interview should be scheduled.

PRESERVATION OF EVIDENCE

LE will establish, examine and document the location(s) of incident as soon as practicable. The crime scene(s) and other corroborative evidence should be photographed or video recorded.

Interviews by LE should be audio recorded and when practicable, video recorded. Forensic interviews with the child and siblings will be video and audio recorded at the CAC. Interviews with caregivers, alleged perpetrator(s), other witnesses, and those children not interviewed at the CAC will be audio recorded and when practicable, video recorded by LE. Any recordings created during the interview process at the CAC will be turned over to LE and LE will thereafter become the agency owning this evidence.

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

COMMON ELEMENTS OF CHILD TORTURE

Child torture may not immediately be identified until the abuse and/or neglect results in serious physical injury or death often after multiple interventions for less serious offenses. Therefore, MDT members should consider the elements of child torture in every case and communicate any identified elements to other members of the team.

Cases can be quickly assessed by using the checklist below, and child torture should be considered when several elements are identified, either currently or historically within a case. For instance, child torture should be suspected if a child appears to be severely underweight, is shamed by the parent for developmental delays, and there was a previous report of bite marks. **Please follow the Serious Physical Injury Protocol once child torture is suspected.**

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

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

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

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

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

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

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

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

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

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

Section Four: Supplemental Items

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

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

☐ **Forcing Excessive Exercise for Punishment**

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

☐ **One Child is Targeted**

☐ **Sibling(s) Abused**

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

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

☐ **One Caregiver Fails to Protect**

☐ **No Disclosure is Made by Targeted Child or Siblings**

☐ **Caregivers Provide Reasonable Explanations in Response to Allegations**

☐ **Caregivers Allege Mental Health Issues for Targeted Child (e.g. self-injury) and Report Repeated Attempts to Seek Help**

TEMPORARY EMERGENCY PROTECTIVE CUSTODY

In accordance with Delaware Code, Physicians, DFS investigators, or LE may take Temporary Emergency Protective Custody of a child in imminent danger of serious physical harm or a threat to life as a result of abuse or neglect for up to 4 hours. DFS may only take Temporary Emergency Protective Custody of a child in a school, day care facility, and child care facility.

Physicians and LE must immediately notify DFS upon invoking this authority. This shall end once DFS responds.

A reasonable attempt shall also be made to advise the parents, guardians or others legally responsible for the child's care, being mindful not to compromise the investigation.

DELAWARE CODE[103]

16 Del. C. § 907(a) and (e) state: "A police officer or a physician who reasonably suspects that a child is in imminent danger of suffering serious physical harm or a threat to life as a result of abuse or neglect and who reasonably suspects the harm or threat to life may occur before the Family Court can issue a temporary protective custody order may take or retain temporary emergency protective custody of the child without the consent of the child's parents, guardian or others legally responsible for the child's care… A Division investigator conducting an investigation pursuant to § 906 of this title shall have the same authority as that granted to a police officer or physician… provided that the child in question is located at a school, day care facility or child care facility at the time that the authority is initially exercised."

TRANSPORTATION

If the alleged perpetrator is the caregiver or is unknown, an alternative means of transportation should be provided to the child for medical examinations, forensic interviews at the CAC, and out-of-home interventions. Under these circumstances, DFS or LE may transport the child to the hospital or seek medical transport for the child, and both agencies are entitled to immunity from any liability in accordance with § 4001 of Title 10.

[103] *See* 16 Del. C. § 907(a) and (e)

DFS may also transport a child under the following conditions: DFS invokes Temporary Emergency Protective Custody from a school, day care facility or child care facility; DFS obtained a signed consent from the parent; or DFS is currently awarded Temporary Custody by the Family Court.

MEDICAL EXAMINATION

A medical examination may be considered for any child, who is the alleged victim of a child neglect report, and other children residing in the home. Medical examinations may be conducted to identify, document, diagnose, prevent, and treat medical conditions and/or trauma (resulting from abuse and unrelated to abuse), as well as to assess issues related to patient safety and well-being.

To determine the appropriate medical response for the child and other children in the home, the MDT should follow the **Delaware Multidisciplinary Team Guidelines for Child Abuse Medical Response** (Medical Response Guidelines). Please refer to Appendix "C" for the complete version of the Medical Response Guidelines.

The Medical Response Matrix for Child Neglect cases is listed below. Please note that Step 2 of the Medical Response Matrix and any medical response which involves calling the designated medical services provider will not be implemented until the resources become available.

Neglect Fact Pattern	Medical Response	Time Frame
Drug-endangered children. ▪ **Concerns for heavy parental drug use and/or drug manufacturing or distributing in the home.** ▪ **Child was in the care of intoxicated caregivers (abuse of drugs or alcohol in the home).**	**Step 1. IMMEDIATE MEDICAL RESPONSE at discretion of first responder.** **Step 2. Call designated medical services provider.**	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Child was left unsupervised in environments that are potentially dangerous or lethal.	**Step 1. IMMEDIATE MEDICAL RESPONSE at discretion of first responder.** **Step 2. Call designated medical services provider.**	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Persistent failure to comply with prescribed medical treatment; or suspected harmful overuse of medical services/treatment.	**Step 1. IMMEDIATE MEDICAL RESPONSE at discretion of first responder.** **Step 2. Call designated medical services provider.**	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Child appears malnourished or starved and/or demonstrates deprivational behaviors.	**Step 1. IMMEDIATE MEDICAL RESPONSE at discretion of first responder.** **Step 2. Call designated medical services provider.**	**Step 1. IMMEDIATE** **Step 2. 24 HR**

Step 2 to be implemented at later date.

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

Prior to responding to the designated hospitals to seek a medical examination for a child, DFS or LE may call the Forensic Nurse Examiner Program to request a forensic exam and to provide case specific details.

Please remember that DFS has the authority to seek a medical examination for a child victim without the consent of the child's parents or caregiver. For siblings and other children in the home, the American Academy of Pediatrics recommends a timely medical examination for siblings and other children in the home when one child is identified as a victim of abuse.

DELAWARE CODE[104]

16 Del. C. § 906(e)(7) of the Delaware Code states: "The Division shall have authority to secure a medical examination of a child, without the consent of those responsible for the care, custody and control of the child, if the child has been reported to be a victim of abuse or neglect…"

The medical examination should include written record and photographic documentation of any injuries to the child or the condition and current state of the child. If no medical assessment is conducted, then LE will be responsible for taking the photographs. For the purposes of its investigation, DFS may also need to take photographs, but every effort should be made by the agencies not to duplicate these efforts. Smartphones should be used to take photographs only in exigent circumstances.

In these cases, the medical providers are charged with determining, based upon a reasonable degree of medical certainty, whether the child's injury is accidental, inflicted or caused by a medical condition. Both the medical examination and information gathered by LE and DFS are used to make this

[104] *See* 16 Del. C. § 906(e)(7)

determination. These preliminary medical findings will be provided immediately to LE and DFS upon completion of the examination. Subsequent findings and medical records should be obtained prior to completion of an investigation.

Potential questions that should be asked of the medical provider are listed below. Avoid asking a physician whether it is "possible" that a caregiver's explanation caused the injury or condition. Instead, use the words "probable, likely or consistent with" when speaking with medical providers and note that medical providers only speak in terms of probability and not absolutes.

COLLECTING THE MEDICAL EVIDENCE[105]

Questions for the Medical Provider

- What is the nature and extent of the child's injury or illness?
- What is the mechanism of injury? What type and amount of force are required to produce the injury?
- Does the history the caregiver provided explain (in whole or in part) the child's injury?
- Have other diagnoses been explored and ruled out, whether by information gathering, examination, or medical tests?
- Could the injury be consistent with an accident?
- Can the timing of the injury be estimated? To what degree of certainty?
- Have all injuries been assessed in light of any exculpatory statements?
- What treatments were necessary to treat the injury or illness?
- What are the child's potential risks from the abusive event?
- What are the long-term medical consequences and residual effects of the abuse?

MDT members should consider the possibility of injuries that were not reported by the child or not readily visible (i.e. internal injuries or age progression of injuries). Be mindful that minor injuries, when paired with a history of alleged abuse or neglect, may be indicative of chronic physical abuse or torture.

Prior to discharge, if concerns regarding the child's safety exist, then the medical providers may consider requesting a meeting in accordance with Hospital High Risk Medical Discharge Protocol (See Appendix D). The Protocol ensures that children (birth to age 18) with special medical needs, who are active with DFS or have been reported to DFS by Delaware hospitals, are discharged in a planned and safe manner.

In addition to the medical examination for allegations of abuse or neglect, the American Academy of Pediatrics (AAP) recommends that children in foster care receive an initial health screening within 72 hours of placement to identify any immediate medical, mental health and dental needs, and a comprehensive health evaluation within 30 days of placement to review all available medical history, to identify medical conditions and to develop an individualized treatment plan for the child. Additionally,

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

the AAP recommends that the child receive a screening each time the placement changes.[106] The Foster Care Health Program at the Nemours Alfred I. duPont Hospital for Children is the state's specialty clinic, and DFS is responsible for making these referrals as appropriate.

SAFETY ASSESSMENT

DFS is responsible for assessing the safety of the alleged child victim and other children in the home and/or visiting the home during the course of the investigation. If safety threats are present, DFS will consider whether an out-of-home intervention is warranted by safety agreement or custody. For children placed in out-of-home interventions through a safety agreement, DFS will conduct background checks on all individuals in that home and complete home assessments.

LE will notify DFS if removal of a child appears necessary. LE should communicate concerns and information regarding the child's safety that may impact DFS interventions. DFS, not LE, is responsible for making placement decisions when safety threats are present and the child(ren) cannot remain at the current residence. As noted above, for situations in which a child is in imminent danger, then it would be appropriate for LE to take Temporary Emergency Protective Custody.

BEHAVIORAL HEALTH AND SOCIAL SERVICES

The child and family should be connected to any needed behavioral health and social services in order to reduce trauma, promote healing and improve outcomes. Child abuse and neglect can be experienced as traumatic events and can have a lifelong impact on the child and the family if appropriate resources and supportive services are not provided. The social and mental health needs of all should be considered in every case and discussed as part of the MDT meetings throughout the life of the case.

The Division of Prevention and Behavioral Health Services (DPBHS) provides a wide range of individualized, trauma-informed, and community-based behavioral health services to children and families statewide. Every child residing in Delaware can be referred to prevention/early intervention and crisis services which are provided through DPBHS. To refer or receive information about these services call the DPBHS Access Unit at 1-800-722-7710 or the Crisis Service at 1-800-969-4357.

DPBHS provides the outpatient treatment and supportive services to youth who are uninsured or insured by Medicaid through an array of specialized evidence-based practices to promote the best outcomes for children and families. In the event a child needs treatment outside of his/her community (including homes and school), the DPBHS treatment continuum may include day treatment, partial hospitalization program, residential rehabilitative treatment and inpatient hospitalization services.

Children presenting with indicators of trauma who are uninsured or insured by Medicaid should be referred to the Access Unit at DPBHS. Staff in the Access Unit will collect behavioral health and substance abuse information. If the child is in need of services beyond prevention, early intervention or

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

outpatient, staff will complete a service intensity tool (e.g. Child and Adolescent Service Intensity Instrument (CASII) and American Society of Addiction Medicine (ASAM)) and make appropriate referrals for services. For children in need of treatment with private insurance, the families should be referred to their insurance company for information about benefits and providers.

For children entering foster care, the DFS Office of Evidence-Based Practice (OEBP) will conduct a screening to assist in identifying the needed mental health services for children and their families. In addition, if a child in foster care exhibits trauma or symptoms of trauma, the caseworker will alert the OEBP for further Trauma Screening.

MDT members may connect children and their families to these and other services with the assistance of the victim advocates identified below.

VICTIM ADVOCATES

Victim advocates are responsible for assessing the needs of the child and family and connecting them to culturally appropriate resources and services. Victim advocates are available in each of the MDT agencies as follows:

- DSCYF/Division of Family Services – Domestic Violence Liaisons & Substance Abuse Liaisons
- Law Enforcement – Victim Service Specialists
- Department of Justice – Social Workers
- Children's Advocacy Center – Family Resource Advocates
- Hospitals – Social Workers

To ensure there are no gaps in services, victim advocates should communicate with each other and coordinate with mental health and social service providers throughout the course of the investigation and beyond. The roles and responsibilities of the victim advocates will vary among the agencies, so not all advocates will provide the same array services. However, the following constellation of services may be provided as needed: emergency crisis assessment and intervention, risk assessment and safety intervention for caregivers and families, information on Victims Information Notification Everyday (VINE), assistance with filing for emergency financial assistance and education regarding victim's rights, case status updates, court accompaniment, and information and referrals for appropriate social service agencies (e.g. housing, protective orders, domestic violence intervention, food, transportation, public assistance, and landlord/employer intervention).

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

ARREST

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

When an alleged perpetrator is arrested, a no contact order with the alleged child victim and/or other children in the home may be recommended, as a specific condition of bail and/or other conditions that

may be necessary to protect the child(ren) and any other members of the community. Input from DFS should be considered and offered to the issuing judicial officer. LE and/or DFS may contact DOJ to request a modification to the contact conditions of bail. Regardless of contact conditions of bail, DFS will consider an in-home intervention or an out-of-home intervention once safety threats are identified, including safety agreements, custody and placement needs.

LE consultation with DOJ is recommended regarding charging decisions for complex criminal investigations listed under this Protocol. LE will notify DFS upon case closure.

CRIMINAL PROCEEDINGS

DOJ may review the following information (both current and historical):

- All police reports and any other information obtained during the investigation concerning all individuals involved in the case;
- All non-redacted DFS records;
- All medical records pertaining to the child;
- All CAC records; and,
- Inventory and/or copies of any evidence.

The Deputy Attorney General (DAG) will evaluate the case to determine prosecutorial merits and will collaborate with LE to identify additional investigative actions as appropriate.

When two or more Divisions (typically Family & Criminal) within DOJ are involved with a particular case, the DAGs will coordinate with each other to ensure the most appropriate legal outcomes are achieved. The Civil and Criminal DAGs shall communicate regularly regarding the case status. The DAG prosecuting the criminal matter will take the lead in this process.

Before resolution of a criminal proceeding, DOJ should confer with DFS, on active cases, regarding issues impacting child safety, such as vacating the No Contact Order and potential impact to a civil substantiation proceeding prior to completion of the civil investigation. This discussion should also include recommended services and/or evaluations for the perpetrator and child. Upon a criminal conviction where the civil case was unfounded and closed, the Criminal DAG will notify the Civil DAG.

CIVIL DISPOSITION

DFS makes a determination as to whether abuse or neglect has occurred within 45 calendar days. Upon completion of the civil investigation, DFS will make a finding once it has established that a preponderance of the evidence exists; the civil finding is not dependent upon the status or outcome of the criminal case.

DFS is required to give written notice to the alleged perpetrator of its finding. Recognizing that this notice to the alleged perpetrator may impact an active criminal investigation, DFS shall contact LE/DOJ prior to case closure in order to maintain the integrity of the case.

DELAWARE CODE[107]

16 Del. C. 924(a)(2)b. of the Delaware Code states: "[The Division shall] advise the person that the Division intends to substantiate the allegations and enter the person on the Child Protection Registry for the incident of abuse or neglect at a designated Child Protection Level."

In addition to the DFS investigation, there may be a civil proceeding in the Family Court, such as if DFS petitions for temporary custody of a child or if the alleged perpetrator appeals a finding by DFS and a Substantiation Hearing is scheduled.

MDT members may be subpoenaed to testify in civil proceedings and/or provide case documentation or evidence subject to any relevant statutory provisions and Court rulings as to the confidentiality and admissibility of said evidence.

3. MDT CASE REVIEW

MDT Case Review is the formal process in which the team convenes regularly scheduled meetings in each county to monitor and discuss the case progress, which may include the following:

- Review interview outcomes;
- Discuss, plan and monitor the progress of the investigation;
- Review any medical examinations;
- Discuss child protection and other safety issues;
- Provide input for prosecution and sentencing decisions;
- Discuss emotional support and treatment needs of the child and family members as well as strategies for meeting those needs;
- Assess the families' reactions and response to the child's disclosure and involvement in the criminal justice and/or child protection systems;
- Review criminal and civil case updates, ongoing involvement of the child and family and disposition;
- Make provisions for court education and court support;
- Discuss ongoing cultural and special needs issues relevant to the case; and,
- Ensure that all children and families are afforded the legal rights and comprehensive services to which they are entitled.

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

Please see Appendix "F" for an example of a MDT Case Review Protocol utilized in Delaware.

[107] *See* 16 Del. C. § 924(a)(2)b.

4. CONFIDENTIALITY, INFORMATION SHARING & DOCUMENTATION

The Child Abuse Prevention and Treatment Act (CAPTA) requires that states preserve the confidentiality of all reports and records pertaining to cases that fall within this MOU to protect the privacy rights of the child and family.[108] However, exceptions are permitted in certain limited circumstances, and the Delaware Code provides guidance on who may access the information.

DELAWARE CODE[109]

16 Del. C. § 906(e) states: "The Division shall only release information to persons who have a legitimate public safety need for such information or a need based on the health and safety of a child subject to abuse, neglect or the risk of maltreatment, and such information shall be used only for the purpose for which the information is released."

MDT members are **authorized and encouraged** to communicate information with one another pertaining to families and children in a legal, ethical, professional, and timely manner throughout the course of an investigation in accordance with agency policies and existing agreements (e.g. MOUs). As noted above, applicable state and federal confidentiality laws apply.

To obtain records, the requesting MDT agency must contact the MDT agency from which the records originated. **Information may be shared between MDT agencies; however, records shall only be disseminated by the agency owning those records.** Mental health and substance abuse records are afforded a stricter level of protection under state and federal statutes requiring consent of the parent or pursuant to a subpoena issued by DOJ.

If a criminal or civil proceeding is pending, DOJ may also issue a subpoena for records or for court testimony.

Documentation should be specific to case facts and should not include information related to the opinions of the MDT members (i.e., the initial concerns of the investigator as to the strength, strategy, or course of the criminal investigation).

5. CONFLICT RESOLUTION

The MDT shall make every effort to resolve disputes through discussion and negotiation at the lowest levels of agency management. If the dispute cannot be resolved at this level, then the MDT members involved in the dispute shall contact their individual supervisors for assistance. Once the chain of command is exhausted or at the request of one of the supervisors, a team meeting may be scheduled.

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[108] Retrieved on February 6, 2017, from Child Welfare Information Gateway's Factsheet Disclosure of Confidential Child Abuse and Neglect Records: https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/confide/

[109] *See* 16 Del. C. § 906(e)

VII. JUVENILE TRAFFICKING PROTOCOL

A. DEFINITION: Juvenile trafficking includes both sex trafficking and labor trafficking, which is defined as follows:

Sex trafficking is the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purposes of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age.[110]

Labor trafficking is the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purposes of subjection to involuntary servitude, peonage, debt bondage, or slavery.[111]

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

1. CIVIL OFFENSES

- **Children who are suspected or identified to be victims of juvenile trafficking**;
- **Exploitation:** occurs when [any individual] behaves unethically toward a child, using the parent's/caregiver's position of power to solicit sexual acts in an attempt to obtain some type of sexual gratification. This category includes situations in which [any individual] prostitutes a child or knowingly permits a child to be "used" by another party, regardless of whether [any individual] receives sexual gratification or other compensation (money, drugs) or no compensation at all;[112]
- **Pornography:** means production or possession of visual material (e.g., pictures, films, video) by [any individual] depicting a child engaged in a sexual act or a simulation of such an act. The visual material involves sexualized content, as opposed to "naked baby" pictures;[113]
- **Runaway:** in-state or out-of-state runaways whose caregiver/parent refuses to resume responsibility for the child's care;
- **Sexual Abuse:** means any sexual contact, sexual intercourse, or sexual penetration, as those terms are defined in the Delaware Criminal Code, between [any individual] and a child;[114]
- **Torture** (10 Del. C. § 901(1)b.3.); and,

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[110] *See* 22 USC § 7102
[111] *See* 22 USC § 7102
[112] *See* 10.1.8. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.
[113] *See* 10.1.16. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.
[114] *See* 10.1.18. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.

- **Verbal Innuendo:** means inappropriate sexualized statements to a child by [any individual] intended to entice or alarm.[115]

2. CRIMINAL OFFENSES

- § 767 Unlawful sexual contact in the third degree; class A misdemeanor;
- § 768 Unlawful sexual contact in the second degree; class F felony;
- § 769 Unlawful sexual contact in the first degree; class D felony;
- § 770 Rape in the fourth degree; class C felony;
- § 771 Rape in the third degree; class B felony;
- § 772 Rape in the second degree; class B felony;
- § 773 Rape in the first degree; class A felony;
- § 774 Sexual extortion; class E felony;
- § 776 Continuous sexual abuse of a child; class B felony;
- § 777A Sex offender unlawful sexual conduct against a child;
- § 778 Sexual abuse of a child by a person in a position of trust, authority or supervision in the first degree; penalties;
- § 778A Sexual abuse of a child by a person in a position of trust, authority or supervision in the second degree; penalties;
- § 787 Trafficking of an individual, forced labor and sexual servitude; class D felony; class C felony; class B felony; class A felony;
- § 1100A Dealing in children; class E felony;
- § 1106 Unlawfully dealing with a child; class B misdemeanor;
- § 1108 Sexual exploitation of a child; class B felony;
- § 1109 Dealing in child pornography; class B felony;
- § 1111 Possession of child pornography; class F felony;
- § 1112A Sexual solicitation of a child; class C felony;
- § 1112B Promoting sexual solicitation of a child; class C felony; class B felony; and,
- § 1343 Patronizing a prostitute prohibited.

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[115] *See* 9.1.12. DFS CPR Regulations. http://kids.delaware.gov/fs/fs_cpr.shtml.

C. MULTIDISCIPLINARY RESPONSE

1. SCREENING & IDENTIFICATION

Juvenile trafficking is not immediately identified, because it is not defined as a single act but rather a constellation of behaviors and circumstances, which are intentionally concealed by the perpetrator through coercion, manipulation, fraud and/or force. In addition, the children may not view themselves as victims or may be fearful of reporting. Therefore, MDT members should screen children at high risk of being trafficked. Once identified as a victim of sex trafficking, the Federal Justice for Victims of Trafficking Act of 2015 requires that the child also be considered a victim of child abuse, neglect and sexual abuse – regardless of whether the perpetrator is a parent or other caregiver. In addition, the arrest of juvenile sex trafficking victims for prostitution, drug related offenses and theft shifts the accountability from the offender to the child, thereby criminalizing the child victim.

DFS may encounter victims of juvenile trafficking in any active case; however, the children at most risk for trafficking are children in foster care and/or children who are runaways or missing juveniles. Children involved in the juvenile justice system may also be at risk due to their increased vulnerability.

Similarly, these same children will have encounters with LE. The complaints may involve runaways and missing juveniles, calls for delinquent behavior, and domestic situations involving older dating partners.

These children may present to medical providers for various health issues, including sexually transmitted infections, early pregnancy, untreated injuries or medical conditions, substance abuse problems or addictions, and depression or stress-related disorders.

The Juvenile Trafficking Pre-Assessment Checklist was created to help MDT members identify potential victims of juvenile trafficking. This confidential Pre-Assessment Checklist is intended to document *indicators* only and should be followed up with a comprehensive investigation and assessment of the child's needs, where appropriate. Multiple sources of information can be used to determine if indicators of juvenile trafficking may be present, such as the location where the child is found, the context of the initial contact, current allegations, and/or medical, criminal and DFS history known about the child. If indicators are identified and juvenile trafficking is suspected, an immediate report to the Division of Family Services (DFS) Report Line and the appropriate law enforcement jurisdiction should be made. These notifications should prompt a comprehensive assessment of the child's safety, placement, mental health, medical, and substance abuse treatment needs.

In the following situations, MDT members shall consider utilizing the below screening tool: recovery of a runaways from foster care; children on run for 30 days or more or 3 or more times in the last 6 months; direct allegation or suspicion of trafficking; or victims seeking medical treatment for injuries suspicious of trafficking. The screening tool may also be used at various points throughout a case.

GENERAL YOUTH INDICATORS – SEX & LABOR TRAFFICKING
❑ **Recent and/or ongoing history of homelessness**
❑ **Multiple runaway attempts**
❑ **Not in control of their identification**
❑ **Not in control of money earned, owes a debt or has intense sense of financial responsibility toward family or intimate partner**
❑ **Lack of support system or supportive relationships**
❑ **Unexplained travel, purchases or access to money**
❑ **Inconsistencies in story**
❑ **Appears to be monitored, fearful, anxious**
❑ **Atypical appearance; clothing, hair, nails, jewelry**
HEALTH INDICATORS – SEX TRAFFICKING
❑ **High number of intimate partners reported for age**
❑ **Multiple terminated pregnancies**
❑ **Sexually transmitted infections/diseases**
❑ **Substance abuse**
❑ **Exhaustion and/or malnourishment**
❑ **Physical or sexual abuse**
❑ **Branding – tattoo (name, symbol) & reluctance to explain tattoo**
❑ **History of abuse or neglect**
❑ **Mental health issues such as depression, PTSD, withdraw, suicidal or self-harming tendencies, memory loss**
❑ **Physical signs of unhealthy living conditions (skin rash, poor hygiene including dental)**
RELATIONSHIP INDICATORS – SEX TRAFFICKING
❑ **Controlling intimate partner, friend or relative**
❑ **Older intimate partner**
❑ **Resides with non-relative**
❑ **Has relative or friend involved in commercial sex**
❑ **Females may struggle to maintain relationships with other females**
BEHAVIORAL INDICATORS – SEX TRAFFICKING
❑ **Multiple, prolonged runaway attempts (3+ or gone for more than 20 days)**
❑ **High levels of or increased truancy and/or curfew violations**
❑ **Poor school performance or behavior**
❑ **School performance is significantly under grade level**
❑ **Frequents websites known for sale of commercial sex (Backpage, Craigslist, Mocospace, Eros, Myscarletbook, etc.)**
❑ **Uses language of the commercial sex industry ("the life"):** • **Daddy (to describe partner)** • **Bottom (to describe female who has more control over others)** • **Family/Folks (to describe others in the life)** • **Renegade (selling sex without a controller)** • **Choosing up (going to another controller)** ***For full list of terms, please see:*** http://sharedhope.org/the-problem/trafficking-terms/
❑ **History of criminal charges related to prostitution or other charges that may occur while being trafficked (thefts, drugs, assault)**
ENVIRONMENTAL INDICATORS – SEX TRAFFICKING
❑ **Found in an area known for illegal commercial sex**
❑ **Found with men (often older males)**
❑ **Found with large amount of cash on their person**
❑ **Resides in or is found near hotels**
❑ **Sexually explicit social networking profiles**

❑ **Stays with individuals who require payment for housing them (could be sexual favors, drugs or money)**
LABOR TRAFFICKING INDICATORS
❑ **Recruited with false promises of work conditions**
❑ **Works long hours with few or no breaks**
❑ **Pay is inconsistent**
❑ **Some or all of pay goes towards debt or housing, food, etc.**
❑ **Some or all of pay is given to someone else**
❑ **Unexplained signs of injury or illness, possibly untreated**
❑ **Shows anxiety in maintaining job for duty to family, intimate partner or to pay a debt to employer**
❑ **Desperation to make a sale (magazines, beauty products, etc.) or for money while begging**

Please also refer to Appendix "J" for the Juvenile Trafficking Pre-Assessment Checklist.

2. CROSS-REPORTING

For the aforementioned civil and criminal offenses, the MDT agencies agree to cross-report and share information regarding the report of juvenile trafficking.

REPORTS TO DIVISION OF FAMILY SERVICES (DFS)

All suspected child abuse and neglect of any child, from birth to age 18, in the State of Delaware must be reported to the Division of Family Services Child Abuse Report Line (Report Line) at 1-800-292-9582.

DELAWARE CODE

Mandatory Reporting Law[116]

16 Del. C. § 903 states: "Any person, agency, organization or entity who knows or in good faith suspects child abuse or neglect shall make a report in accordance with § 904 of this title…"

In addition, 16 Del. C. § 904 states: "Any report of child abuse or neglect required to be made under this chapter shall be made by contacting the Child Abuse and Neglect Report Line for the Department of Services for Children, Youth and Their Families. An immediate oral report shall be made by telephone or otherwise. Reports and the contents thereof including a written report, if requested, shall be made in accordance with the rules and regulations of the Division, or in accordance with the rules and regulations adopted by the Division. No individual with knowledge of child abuse or neglect or knowledge that leads to a good faith suspicion of child abuse or neglect shall rely on another individual who has less direct knowledge to call the aforementioned Report Line."

[116] *See* 16 Del. C. § 903 and 904

Special Provisions Regarding a Minor[117]

11 Del. C. § 787(g)(1) states: "A minor who has engaged in commercial sexual activity is presumed to be a neglected or abused child under 10 *Del. C.* §§ 901 et seq. Whenever a police officer has probable cause to believe that a minor has engaged in commercial sexual activity, the police officer shall make an immediate report to the Department of Services for Children, Youth and Their Families pursuant to 16 *Del. C.*§§ 901 et seq."

Penalty for Violation[118]

16 Del. C. § 914 states: "Whoever violates § 903 of this title shall be liable for a civil penalty not to exceed $10,000 for the first violation, and not to exceed $50,000 for any subsequent violation."

Any person who has **direct knowledge** of suspected abuse must make an immediate report to the Report Line. **Direct knowledge** is obtained through disclosure (child discloses to you), discovery (you witness an act of abuse), or reason to suspect (you have observed behavioral and/or physical signs of child abuse). This report may include situations where multiple disciplines are involved, such as:

- During a forensic interview for allegations of juvenile trafficking, a child makes a disclosure of other child victims being sex trafficked. MDT members must make a joint report to the Report Line.
- A child is brought to the hospital emergency department by emergency medical services (EMS) for a suspected drug overdose. The law enforcement agency was first on the scene. LE, EMS, and emergency department staff must make the call to the Report Line.

The relationship between the child and perpetrator ***does not*** influence whether a report must be made to DFS. All reports, including domestic or intra-familial, institutional, and non-domestic or extra-familial, cases must also be reported to DFS.

Additionally, a separate report must be made to the Report Line for the following reasons:

- Additional suspects have been identified;
- Additional child victims have been identified; or,
- Secondary allegations have been disclosed (i.e. initial report alleged juvenile trafficking and child later disclosed physical abuse).

If a **secondary allegation is disclosed to the CAC** during the forensic interview process, then the MDT members present shall make a joint report to the DFS Report Line prior to conclusion of the post interview meeting. However, if circumstances prevent the joint report from being made, the MDT shall

[117] *See* 11 Del. C. § 787(g)(1)
[118] *See* 16 Del. C. § 914,

select a member to make the report on behalf of the team. The designee will make the report immediately and inform the Report Line worker that he/she is making the call on behalf of the applicable MDT agencies.

If known, the following should be provided to the DFS Report Line:

- Demographic information;

- Known information about the following:
    - Child, parents, siblings and alleged perpetrator;
    - The alleged child victim's physical health, mental health, educational status;
    - Medical attention that may be needed for injuries;
    - The way the caregiver and alleged perpetrator's behavior is impacting the care of the child; and,
    - Any circumstances that may jeopardize the child's or DFS worker's safety.

- Facts regarding the alleged abuse and any previous involvement with the family.

- What you are worried about, what is working well, and what needs to happen next to keep the child safe.

Reports received by DFS will either be screened in for investigation as an intra-familial case and/or institutional abuse (IA) case or will be screened out, documented, and maintained in the DFS reporting system.

Reports screened in for investigation by DFS are assigned a priority response time as follows:
- Priority 1 (P1) – Within 24 hours
- Priority 2 (P2) – Within 3 days
- Priority 3 (P3) – Within 10 days

REPORTS TO LAW ENFORCEMENT (LE)

DFS must make an immediate report to the appropriate law enforcement jurisdiction for all civil offenses identified in the Juvenile Trafficking Protocol, including cases that screen out (e.g. extra-familial cases). The only **exception** is a dependent child that is not a runaway, not suspected of being a victim of juvenile trafficking and not considered abandoned. DFS will also document its contact with the appropriate law enforcement agency in the DFS reporting system.

LE may report to the Federal Bureau of Investigation (FBI) situations which involve multiple states or which require specialized services and support.

LE may also contact the Immigration and Customs Enforcement (ICE) and the United States Citizens and Immigration Service (USCIS), which are part of the Department of Homeland Security (DHS). ICE should be contacted to report trafficking violations involving undocumented offenders. USCIS should

be contacted regarding services for undocumented victims of juvenile trafficking. The Department of Homeland Security reports allegations of juvenile trafficking to the appropriate local and state law enforcement agencies.

DELAWARE CODE[119]

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

16 Del. C. § 906(e)(3) states: "The Division staff shall also contact…the appropriate law-enforcement agency upon receipt of any report under this section and shall provide such agency with a detailed description of the report received."

24 Del. C. § 1762(a) states: "Every person certified to practice medicine who attends to or treats a stab wound; poisoning by other than accidental means; or a bullet wound, gunshot wound, powder burn, or other injury or condition arising from or caused by the discharge of a gun, pistol, or other firearm, or when such injury or condition is treated in a hospital, sanitarium, or other institution, the person, manager, superintendent, or other individual in charge shall report the injury or condition as soon as possible to the appropriate police authority where the attending or treating person was located at the time of treatment or where the hospital, sanitarium, or institution is located."

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

REPORTS TO THE NATIONAL CENTER FOR MISSING AND EXPLOITED CHILDREN

DFS must make a report to the National Center for Missing and Exploited Children (NCMEC) within 24 hours when a child in DFS custody is reported missing or runaway. This does not preclude DFS's responsibility to file an immediate report with the local law enforcement agency. DFS will verify that the child is entered into the National Crime Information Center (NCIC) and document these activities in the DFS reporting system.

REPORTS TO DEPARTMENT OF JUSTICE (DOJ)

DFS is required to report all civil offenses identified in the Juvenile Trafficking Protocol to the appropriate division at the Department of Justice. Additionally, DFS is required to report all persons, agencies, organizations and entities to DOJ for investigation if they fail to make mandatory reports of child abuse or neglect under 16 Del. C. § 903.

[119] *See* 16 Del. C. § 903 and 906(e)(3) and 24 Del. C. § 1762(a)

LE shall call DOJ's Child Predator Unit upon receipt of allegations of juvenile trafficking to a child.

If the matter is referred to the Children's Advocacy Center for a forensic interview, the CAC will notify the DOJ, DFS, and LE of the scheduled interview as soon as possible.

DELAWARE CODE[120]

16 Del. C. § 906(e)(3) states: "The Division staff shall also contact the Delaware Department of Justice… upon receipt of any report under this section and shall provide such agency with a detailed description of the report received."

REPORTS TO THE OFFICE OF THE INVESTIGATION COORDINATOR (IC)

The Office of the Investigation Coordinator receives reports of juvenile trafficking through data exchanges with DFS and the Delaware Criminal Justice Information System (DELJIS). Additionally, all MDT members shall provide case specific information as requested by the IC. For the purposes of conflict resolution, the Office of the Investigation Coordinator may be contacted to initiate or facilitate communication with other members of the MDT.

DELAWARE CODE[121]

16 Del. C. § 906(c)(1)a. and b. state: "The Investigation Coordinator, or the Investigation Coordinator's staff, shall…have electronic access and the authority to track within the Department's internal information system and Delaware's criminal justice information system each reported case of alleged child abuse or neglect. Monitor each case involving the death of, serious physical injury to, or allegations of sexual abuse of a child from inception to final criminal and civil disposition, and provide information as requested on the status of each case to the Division, the Department, the Delaware Department of Justice, the Children's Advocacy Center, and the Office of Child Advocate."

16 Del. C. § 905(f) states: "Upon receipt of a report of child abuse or neglect, the Division shall immediately notify the Investigation Coordinator of the report, in sufficient detail to permit the Investigation Coordinator to undertake the Investigation Coordinator's duties, as specified in § 906 of this title."

16 Del. C. § 906(d)(2) and (f)(3) state: "The law enforcement agency and Delaware Department of Justice investigating a report of child abuse shall "provide information as necessary to the Investigation Coordinator to permit case tracking, monitoring and reporting by the Investigation Coordinator."

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

REPORTS TO PROFESSIONAL REGULATORY BODIES

In keeping with the following statutory requirements, certain MDT members shall make reports to professional regulatory organizations and other agencies upon receipt of reports alleging abuse or neglect by professionals licensed in Delaware.

DELAWARE CODE[122]

16 Del. C. § 906(c)(1)c. states the Investigation Coordinator or the Investigation Coordinator's designee shall: "Within 5 business days of the receipt of a report concerning allegations of child abuse or neglect by a person known to be licensed or certified by a Delaware agency or professional regulatory organization, forward a report of such allegations to the appropriate Delaware agency or professional regulatory organization."

16 Del. C. § 906(e)(6) and (f)(4) state the Division and DOJ shall: "Ensure that all cases involving allegations of child abuse or neglect by a person known to be licensed or certified by a Delaware agency or professional regulatory organization, have been reported to the appropriate Delaware agency or professional regulatory organization and the Investigation Coordinator in accordance with the provisions of this section."

24 Del. C. § 1731A(a) states any person may report to the Board information that the reporting person reasonably believes indicates that a person certified and registered to practice medicine in this State is or may be guilty of unprofessional conduct or may be unable to practice medicine with reasonable skill or safety to patients by reason of mental illness or mental incompetence; physical illness, including deterioration through the aging process or loss of motor skill; or excessive use or abuse of drugs, including alcohol. The following have an affirmative duty to report, and must report, such information to the Board in writing within 30 days of becoming aware of the information:

(1) All persons certified to practice medicine under this chapter;

(2) All certified, registered, or licensed healthcare providers;

(3) The Medical Society of Delaware;

(4) All healthcare institutions in the State;

(5) All state agencies other than law-enforcement agencies;

(6) All law-enforcement agencies in the State, except that such agencies are required to report only new or pending investigations of alleged criminal conduct specified in § 1731(b)(2) of this title, and are further required to report within 30 days of the close of a criminal investigation or the arrest of a person licensed under this chapter.

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

3. INVESTIGATION

For the purpose of conducting an effective joint investigation, communication and coordination should occur among the MDT members as soon as possible and continue throughout the life of the case.

Upon report of suspected trafficking, DOJ, DFS, and LE will communicate and coordinate a response; however, LE will take the lead in the Joint Investigation. LE agencies needing additional resources may consult with larger jurisdictions.

For all allegations within this Protocol, the MDT will determine from the list below the appropriate investigative actions that have been identified as best practices for responding to child abuse cases.

Investigative Actions	Responsible Agency
Review Juvenile Trafficking Pre-Assessment Checklist.	MDT
Cross-report and coordinate a response between MDT members.	MDT
Contact NCMEC for missing or runaway children in DFS custody.	DFS
Establish the location(s) where the incident occurred.	LE
Identify persons involved and coordinate interviews with child, other victims, alleged perpetrator(s), and other witnesses.	LE and DFS
Exchange information regarding complaint, criminal and DFS history.	MDT
Schedule forensic interview at CAC for any child victims or child witnesses to include siblings and other children in the home.	MDT
Discuss DFS's required notification to the alleged perpetrator of the allegations. Limit the details of the allegations and the maltreatment type at the advice of the Criminal Deputy Attorney General.[123]	LE and DFS
Consider consultation with police jurisdictions with more resources.	LE
Consider utilizing federal resources, such as the FBI and DHS.	LE
Assess safety and need for out-of-home interventions of all children.	DFS
Consider Temporary Emergency Protective Custody of child and other victims.	Medical, LE and DFS
Observe and photo/video document the crime scene(s); collect evidence.	LE

[123] The federal Child Abuse Prevention and Treatment Act requires DFS to notify the alleged perpetrator of the complaints or allegations made against him or her at the initial time of contact regardless of how that contact is made (42 U.S.C. 5101 et seq).

Investigative Actions	Responsible Agency
Take photographs of child and child's injuries.	Medical
Follow Guidelines for Child Abuse Medical Response under Sexual Abuse for child and other victims in the home.	DFS, LE and Medical
Consider Hospital High Risk Medical Discharge Protocol if concerns exist about the child's safety at discharge.	Medical
Utilize victim advocates to connect children and families with appropriate mental health, substance abuse, social services and additional resources.	MDT
Complete pre-arrest intake with DOJ.	LE and DOJ
Participate in MDT meetings (i.e. case review).	MDT

INTERVIEWS

LE will conduct interviews with caregivers, alleged perpetrator(s), and other witnesses and will provide prior notice to DFS to allow for observation. Additionally, all interviews shall be audio recorded, and when practicable, video recorded by LE. DFS must receive clearance from LE before conducting follow up interviews for the purpose of gathering information relevant to the civil investigation. In the event that a LE response is delayed, DFS may obtain basic information from the family to assess the child's safety until LE arrives to conduct the interviews.

Child victims, of any age, should be interviewed at the CAC for cases that fall within the Juvenile Trafficking Protocol. Multiple interviews by multiple interviewers can be detrimental to children and can create issues for successful civil and criminal case dispositions. Use of the CAC to conduct interviews is considered best practice to minimize trauma and re-victimization of child victims and/or child witnesses.

In any investigation of criminal conduct occurring at, or related to, a facility or organization where multiple children may have been exposed to, or victimized by, a perpetrator of the conduct being investigated, the MDT must consider the potential that other children have been victimized. Thus, the MDT should schedule and conduct interviews at the CAC of all children between the age of 3 and 12 who may have been exposed to, a victim of, or a witness to the conduct being investigated. Facilities or organizations where multiple children may be exposed to criminal conduct include, but are not limited to, child care centers, schools, and youth athletic organizations. This policy is intended to both define the scope of such investigations and to provide support to children who, by mere circumstance, are, or have been, in the presence of the subject of an investigation.

If additional information is needed prior to scheduling the forensic interview with the child, the **First Responder Minimal Facts Interview Protocol** should be utilized (See Appendix A). If both LE and

DFS are present, then a lead interviewer should be identified prior to conducting the interview. This Protocol will still allow DFS to assess the child's safety through its in-house protocols while preserving the criminal investigation.

FIRST RESPONDER

Minimal Facts Interview Protocol

1. **Establish rapport**
2. **Ask limited questions to determine the following:**
   - What happened?
   - Who is/are the alleged perpetrator(s)?
   - Where did it happen?
   - When did it happen?
   - Ask about witnesses/other victims
3. **Provide respectful end**

FORENSIC INTERVIEW AT THE CAC

After making a cross-report, LE, DFS, and/or DOJ may contact the CAC in the jurisdiction where the alleged crime occurred to request a forensic interview. LE and DFS will communicate prior to contacting the CAC to determine who will make the request and the appropriate timeframe for scheduling the interview.

Forensic interviews will be scheduled on a non-urgent basis (within 5 business days) or urgent basis (within 2 business days) subject to the availability of MDT member agencies, children, and their caregivers. Please note that the CAC will accommodate after-hours interviews on an emergency basis as needed. The CAC will acquire interpreter services as needed for the child and/or family. All interviews will be video and audio recorded.

The forensic interviewer will conduct the interview utilizing a nationally recognized forensic interview protocol and forensic interview aids, as appropriate. Members of the MDT may be present for the interview based on availability. MDT members should refrain from engaging in pre-interview contact with the caregiver and child at the CAC to avoid impacting the forensic interview process.

The forensic interviewer will facilitate the CAC process. This process includes pre-interview meetings, the forensic interview, and post-interview meetings. MDT members should be prepared to discuss the following: complaint and criminal history concerning all individuals involved in the case; DFS history; prior forensic interviews at the CAC; current allegations; and strategies for the interview to include introduction of evidence to the child.

During the post-interview team meeting, the MDT may discuss interview outcomes; prosecutorial merit; next investigative steps; and medical, mental health, victim advocacy and safety needs of the child and

family. Additionally, the MDT may determine that a multi-session or subsequent interview is required based on the case circumstances and the needs of child.

If a **secondary allegation is disclosed to the CAC** during the forensic interview process, then the MDT members present shall make a joint report to the DFS Report Line prior to conclusion of the post interview meeting. However, if circumstances prevent the joint report from being made, the MDT shall select a member to make the report on behalf of the team. The designee will make the report immediately and inform the Report Line worker that he/she is making the call on behalf of the applicable MDT agencies.

When the MDT meets with the caregiver post-interview, DOJ will take the lead in sharing information related to the interview and possible criminal prosecution.

Following the post-interview meeting, the CAC Family Resource Advocate will facilitate a discussion with the caregiver about social and mental health services and other resources available for the child and/or family. Referrals will be made by the CAC as appropriate.

During the course of an investigation, a MDT meeting may be required to discuss new information obtained by any of the team members. The meeting shall be convened by the IC upon request of any team member. Otherwise, these discussions will take place at regularly scheduled MDT Case Review meetings.

If additional information is needed from the child by a MDT member, then the other team members should be contacted and a follow up forensic interview should be scheduled.

PRESERVATION OF EVIDENCE

LE will establish, examine and document the location(s) of incident as soon as practicable. The crime scene(s) and other corroborative evidence should be collected and photographed or video recorded.

Interviews by LE should be audio recorded and when practicable, video recorded. Forensic interviews with the child and siblings will be video and audio recorded at the CAC. Interviews with caregivers, alleged perpetrator(s), other witnesses, and those children not interviewed at the CAC will be audio recorded and when practicable, video recorded by LE. Any recordings created during the interview process at the CAC will be turned over to LE and LE will thereafter become the agency owning this evidence.

The sexual assault evidence collection kit will be completed by a specially trained Sexual Assault Nurse Examiner/Forensic Nurse Examiner or medical provider. Any photographs necessary to document physical injuries will be completed as part of the medical examination. Items collected by medical providers as part of the forensic evaluation (including the sexual assault evidence kits) will be turned over to LE.

TEMPORARY EMERGENCY PROTECTIVE CUSTODY

In accordance with Delaware Code, Physicians, DFS investigators, or LE may take Temporary Emergency Protective Custody of a child in imminent danger of serious physical harm or a threat to life as a result of abuse or neglect for up to 4 hours. DFS may only take Temporary Emergency Protective Custody of a child in a school, day care facility, and child care facility.
Physicians and LE must immediately notify DFS upon invoking this authority. This shall end once DFS responds.

A reasonable attempt shall also be made to advise the parents, guardians or others legally responsible for the child's care, being mindful not to compromise the investigation.

DELAWARE CODE[124]

16 Del. C. § 907(a) and (e) state: "A police officer or a physician who reasonably suspects that a child is in imminent danger of suffering serious physical harm or a threat to life as a result of abuse or neglect and who reasonably suspects the harm or threat to life may occur before the Family Court can issue a temporary protective custody order may take or retain temporary emergency protective custody of the child without the consent of the child's parents, guardian or others legally responsible for the child's care… A Division investigator conducting an investigation pursuant to § 906 of this title shall have the same authority as that granted to a police officer or physician… provided that the child in question is located at a school, day care facility or child care facility at the time that the authority is initially exercised."

TRANSPORTATION

If the alleged perpetrator is the caregiver or is unknown, an alternative means of transportation should be provided to the child for medical examinations, forensic interviews at the CAC, and out-of-home interventions. Under these circumstances, DFS or LE may transport the child to the hospital or seek medical transport for the child, and both agencies are entitled to immunity from any liability in accordance with § 4001 of Title 10.

DFS may also transport a child under the following conditions: DFS invokes Temporary Emergency Protective Custody from a school, day care facility or child care facility; DFS obtained a signed consent from the parent; or DFS is currently awarded Temporary Custody by the Family Court.

MEDICAL EXAMINATION

A medical examination will be conducted for any child, who is the alleged victim of a juvenile trafficking report, and considered for other children residing in the home. Medical examinations may be conducted

[124] *See* 16 Del. C. § 907(a) and (e)

to identify, document, diagnose, prevent, and treat medical conditions and/or trauma (resulting from abuse and unrelated to abuse), as well as to assess issues related to patient safety and well-being.

To determine the appropriate medical response for the child and other children in the home, the MDT should follow the **Delaware Multidisciplinary Team Guidelines for Child Abuse Medical Response** (Medical Response Guidelines). Please refer to Appendix "C" for the complete version of the Medical Response Guidelines.

The Medical Response Matrix for Child Sexual Abuse cases is listed below. Please note that Step 2 of the Medical Response Matrix and any medical response which involves calling the designated medical services provider will not be implemented until the resources become available.

Abuse Fact Pattern	Medical Response	Time Frame
Any type of contact between the child or abuser involving either the child's or abuser's genitals, anus or mouth having occurred **within the past 120 hours (to encompass evidentiary and medical needs).**	**Step 1. URGENT RESPONSE directly to Sexual Assault Nurse Examiner/ Forensic Nurse Examiner Program.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Any child describing sexual assault of abuse with significant genital or anal pain, genital or anal bleeding, sores in the genital or anal areas, and any pre-pubertal girl with a discharge **regardless of when the last reported contact occurred.**	**Step 1. URGENT RESPONSE directly to Sexual Assault Nurse Examiner/ Forensic Nurse Examiner Program.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Any child suggesting a significant mental health issue such as suicidal ideation or gesture, or severe depression, **regardless of when the last reported contact occurred.**	**Step 1. URGENT RESPONSE OR EMS TRANSPORT to nearest hospital for:** **A. Necessary medical services.** **B. Necessary mental health services.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Contact of abuser's mouth with child's genitals or anus. (Reported by child or witnessed by another individual.)	Call designated medical services provider. *To be implemented at later date.*	24 HR
Contact of abuser's genitals with child's genitals or anus or mouth. (Reported by child or witnessed by another individual.)	Call designated medical services provider. *To be implemented at later date.*	24 HR
Contact of abuser's hands, fingers or objects with child's genital or anus. (Reported by child or witnessed by another individual.)	Call designated medical services provider. *To be implemented at later date.*	24 HR
Pre-teen sibling of a preteen child confirmed to have STD.	Call designated medical services provider. *To be implemented at later date.*	24 HR
Any child with genital and/or anal pain or discharge; lesions/bumps/ulcers; bleeding; or painful urination, regardless of type of contact reported by child.	Call designated medical services provider. *To be implemented at later date.*	24 HR
Any pre-teen child with an abnormal examination or an STD.	Call designated medical services provider. *To be implemented at later date.*	24 HR

Prior to responding to the designated hospitals to seek a medical examination for a child, DFS or LE may call the Forensic Nurse Examiner Program to request a forensic exam and to provide case specific details.

Please remember that DFS has the authority to seek a medical examination for a child victim without the consent of the child's parents or caregiver. For siblings and other children in the home, the American Academy of Pediatrics recommends a timely medical examination for siblings and other children in the home when one child is identified as a victim of abuse.

DELAWARE CODE[125]

16 Del. C. § 906(e)(7) of the Delaware Code states: "The Division shall have authority to secure a medical examination of a child, without the consent of those responsible for the care, custody and control of the child, if the child has been reported to be a victim of abuse or neglect…"

The medical examination should include written record and photographic documentation of injuries. Preliminary medical findings will be provided immediately to LE and DFS upon completion of the examination. Subsequent findings and medical records should be obtained prior to completion of an investigation.

Potential questions that should be asked of the medical provider are listed below. Avoid asking a physician whether it is "possible" that a caregiver's explanation caused the injury, because the answer will always be yes. Instead, use the words "probable, likely or consistent with" when speaking with medical providers and note that medical providers only speak in terms of probability and not absolutes.

COLLECTING THE MEDICAL EVIDENCE[126]

Questions for the Medical Provider

- What is the nature and extent of the child's injury or illness?
- What is the mechanism of injury? What type and amount of force are required to produce the injury?
- Does the history the caregiver provided explain (in whole or in part) the child's injury?
- Have other diagnoses been explored and ruled out, whether by information gathering, examination, or medical tests?
- Could the injury be consistent with an accident?
- Can the timing of the injury be estimated? To what degree of certainty?
- Have all injuries been assessed in light of any exculpatory statements?
- What treatments were necessary to treat the injury or illness?

[125] *See* 16 Del. C. § 906(e)(7)
[126] Retrieved on February 6, 2017, from Office of Juvenile Justice and Delinquency Prevention's Portable Guide to Investigating Child Abuse: http://www.ojjdp.gov/pubs/243908.pdf

- What are the child's potential risks from the abusive event?
- What are the long-term medical consequences and residual effects of the abuse?

MDT members should consider the possibility of injuries that were not reported by the child or not readily visible (i.e. internal injuries or age progression of injuries). Be mindful that minor injuries, when paired with a history of alleged abuse or neglect, may be indicative of chronic physical abuse or torture.

Prior to discharge, if concerns regarding the child's safety exist, then the medical providers may consider requesting a meeting in accordance with Hospital High Risk Medical Discharge Protocol (See Appendix D). The Protocol ensures that children (birth to age 18) with special medical needs, who are active with DFS or have been reported to DFS by Delaware hospitals, are discharged in a planned and safe manner.

In addition to the medical examination for allegations of abuse or neglect, the American Academy of Pediatrics (AAP) recommends that children in foster care receive an initial health screening within 72 hours of placement to identify any immediate medical, mental health and dental needs, and a comprehensive health evaluation within 30 days of placement to review all available medical history, to identify medical conditions and to develop an individualized treatment plan for the child. Additionally, the AAP recommends that the child receive a screening each time the placement changes.[127] The Foster Care Health Program at the Nemours Alfred I. duPont Hospital for Children is the state's specialty clinic, and DFS is responsible for making these referrals as appropriate.

SAFETY ASSESSMENT

DFS is responsible for assessing the safety of the alleged child victim and other children in the home and/or visiting the home during the course of the investigation. If safety threats are present, DFS will consider whether an out-of-home intervention is warranted by safety agreement or custody. For children placed in out-of-home interventions through a safety agreement, DFS will conduct background checks on all individuals in that home and complete home assessments.

LE will notify DFS if removal of a child appears necessary. LE should communicate concerns and information regarding the child's safety that may impact DFS interventions. DFS, not LE, is responsible for making placement decisions when safety threats are present and the child(ren) cannot remain at the current residence. As noted above, for situations in which a child is in imminent danger, then it would be appropriate for LE to take Temporary Emergency Protective Custody.

BEHAVIORAL HEALTH AND SOCIAL SERVICES

The child and family should be connected to any needed behavioral health and social services in order to reduce trauma, promote healing and improve outcomes. Child abuse and neglect can be experienced

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

as traumatic events and can have a lifelong impact on the child and the family if appropriate resources and supportive services are not provided. The social and mental health needs of all should be considered in every case and discussed as part of the MDT meetings throughout the life of the case.

The Division of Prevention and Behavioral Health Services (DPBHS) provides a wide range of individualized, trauma-informed, and community-based behavioral health services to children and families statewide. Every child residing in Delaware can be referred to prevention/early intervention and crisis services which are provided through DPBHS. To refer or receive information about these services call the DPBHS Access Unit at 1-800-722-7710 or the Crisis Service at 1-800-969-4357.

DPBHS provides the outpatient treatment and supportive services to youth who are uninsured or insured by Medicaid through an array of specialized evidence-based practices to promote the best outcomes for children and families. In the event a child needs treatment outside of his/her community (including homes and school), the DPBHS treatment continuum may include day treatment, partial hospitalization program, residential rehabilitative treatment and inpatient hospitalization services.

Children presenting with indicators of trauma who are uninsured or insured by Medicaid should be referred to the Access Unit at DPBHS. Staff in the Access Unit will collect behavioral health and substance abuse information. If the child is in need of services beyond prevention, early intervention or outpatient, staff will complete a service intensity tool (e.g. Child and Adolescent Service Intensity Instrument (CASII) and American Society of Addiction Medicine (ASAM)) and make appropriate referrals for services. For children in need of treatment with private insurance, the families should be referred to their insurance company for information about benefits and providers.

For children entering foster care, the DFS Office of Evidence-Based Practice (OEBP) will conduct a screening to assist in identifying the needed mental health services for children and their families. In addition, if a child in foster care exhibits trauma or symptoms of trauma, the caseworker will alert the OEBP for further Trauma Screening.

MDT members may connect children and their families to these and other services with the assistance of the victim advocates identified below.

VICTIM ADVOCATES

Victim advocates are responsible for identifying the needs of the child and family and connecting them to culturally appropriate resources and services. Victim advocates are available in each of the MDT agencies as follows:

- DSCYF/Division of Family Services – Domestic Violence Liaisons & Substance Abuse Liaisons
- Law Enforcement – Victim Service Specialists
- Department of Justice – Social Workers
- Children's Advocacy Center – Family Resource Advocates
- Hospitals – Social Workers
- Federal Bureau of Investigation – Victim Service Specialist

To ensure there are no gaps in services, victim advocates will communicate with each other and coordinate with mental health and social service providers throughout the course of the investigation and beyond. The following services will be provided as needed: emergency crisis assessment and intervention, risk assessment and safety intervention for caregivers and families, information on Victims Information Notification Everyday (VINE), assistance with filing for emergency financial assistance and education regarding victim's rights, case status updates, court accompaniment, and information and referrals for appropriate social service agencies (e.g. housing, protective orders, domestic violence intervention, food, transportation, public assistance, and landlord/employer intervention).

If you suspect you have encountered a victim of trafficking, but the victim is not ready to seek help then call the National Human Trafficking Resource Center at 1-888-3737-888. For more information on human trafficking visit www.acf.hhs.gov/trafficking.

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

ARREST

LE should call DOJ's Child Predator Unit upon receipt of allegations of juvenile trafficking to a child. Communication with DOJ should be ongoing throughout the criminal investigation and prior to charging, whenever possible to ensure the best outcome for the criminal case.

When an alleged perpetrator is arrested, a no contact order with the alleged child victim and/or other children in the home may be recommended, as a specific condition of bail and/or other conditions that may be necessary to protect the child(ren) and any other members of the community. Input from DFS should be considered and offered to the issuing judicial officer. LE and/or DFS may contact DOJ to request a modification to the contact conditions of bail. Regardless of contact conditions of bail, DFS will consider an in-home intervention or an out-of-home intervention once safety threats are identified, including safety agreements, custody and placement needs.

Before clearing a case without an arrest, LE consultation with DOJ shall occur. LE will notify DFS upon case closure.

CRIMINAL PROCEEDINGS

DOJ may review the following information (both current and historical):

- All police reports and any other information obtained during the investigation concerning all individuals involved in the case;
- All non-redacted DFS records;
- All medical records pertaining to the child;
- All CAC records; and,
- Inventory and/or copies of any evidence.

The Deputy Attorney General (DAG) will evaluate the case to determine prosecutorial merits and will collaborate with LE to identify additional investigative actions as appropriate.

When two or more Divisions (typically Family & Criminal) within DOJ are involved with a particular case, the DAGs will coordinate with each other to ensure the most appropriate legal outcomes are achieved. The Civil and Criminal DAGs shall communicate regularly regarding the case status. The DAG prosecuting the criminal matter will take the lead in this process.

Before resolution of a criminal proceeding, DOJ should confer with DFS, on active cases, regarding issues impacting child safety, such as vacating the No Contact Order and potential impact to a civil substantiation proceeding prior to completion of the civil investigation. This discussion should also include recommended services and/or evaluations for the perpetrator and child. Upon a criminal conviction where the civil case was unfounded and closed, the Criminal DAG will notify the Civil DAG.

CIVIL DISPOSITION

DFS makes a determination as to whether abuse or neglect has occurred within 45 calendar days. Upon completion of the civil investigation, DFS will make a finding once it has established that a preponderance of the evidence exists; the civil finding is not dependent upon the status or outcome of the criminal case.

DFS is required to give written notice to the alleged perpetrator of its finding. Recognizing that this notice to the alleged perpetrator may impact an active criminal investigation, DFS shall contact LE/DOJ prior to case closure in order to maintain the integrity of the case.

DELAWARE CODE[128]

16 Del. C. § 924(a)(2)(b) of the Delaware Code states: "[The Division shall] advise the person that the Division intends to substantiate the allegations and enter the person on the Child Protection Registry for the incident of abuse or neglect at a designated Child Protection Level."

In addition to the DFS investigation, there may be a civil proceeding in the Family Court, such as if DFS petitions for temporary custody of a child or if the alleged perpetrator appeals a finding by DFS and a Substantiation Hearing is scheduled.

MDT members may be subpoenaed to testify in civil proceedings and/or provide case documentation or evidence subject to any relevant statutory provisions and Court rulings as to the confidentiality and admissibility of said evidence.

[128] *See* 16 Del. C. § 906(e)(7)

4. MDT CASE REVIEW

MDT Case Review is the formal process in which the team convenes regularly scheduled meetings in each county to monitor and discuss the case progress, which may include the following:

- Review interview outcomes;
- Discuss, plan and monitor the progress of the investigation;
- Review any medical examinations;
- Discuss child protection and other safety issues;
- Provide input for prosecution and sentencing decisions;
- Discuss emotional support and treatment needs of the child and family members as well as strategies for meeting those needs;
- Assess the families' reactions and response to the child's disclosure and involvement in the criminal justice and/or child protection systems;
- Review criminal and civil case updates, ongoing involvement of the child and family and disposition;
- Make provisions for court education and court support;
- Discuss ongoing cultural and special needs issues relevant to the case; and,
- Ensure that all children and families are afforded the legal rights and comprehensive services to which they are entitled.

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

Please see Appendix "F" for an example of a MDT Case Review Protocol utilized in Delaware.

5. CONFIDENTIALITY, INFORMATION SHARING & DOCUMENTATION

The Child Abuse Prevention and Treatment Act (CAPTA) requires that states preserve the confidentiality of all reports and records pertaining to cases that fall within this MOU to protect the privacy rights of the child and family.[129] However, exceptions are permitted in certain limited circumstances, and the Delaware Code provides guidance on who may access the information.

DELAWARE CODE[130]

16 Del. C. § 906(e) states: "The Division shall only release information to persons who have a legitimate public safety need for such information or a need based on the health and safety of a child subject to abuse, neglect or the risk of maltreatment, and such information shall be used only for the purpose for which the information is released."

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

MDT members are **authorized and encouraged** to communicate information with one another pertaining to families and children in a legal, ethical, professional, and timely manner throughout the course of an investigation in accordance with agency policies and existing agreements (e.g. MOUs). As noted above, applicable state and federal confidentiality laws apply.

To obtain records, the requesting MDT agency must contact the MDT agency from which the records originated. **Information may be shared between MDT agencies; however, records shall only be disseminated by the agency owning those records.** Mental health and substance abuse records are afforded a stricter level of protection under state and federal statutes requiring consent of the parent or pursuant to a subpoena issued by DOJ.

If a criminal or civil proceeding is pending, DOJ may also issue a subpoena for records or for court testimony.

Documentation should be specific to case facts and should not include information related to the opinions of the MDT members (i.e., the initial concerns of the investigator as to the strength, strategy, or course of the criminal investigation).

6. CONFLICT RESOLUTION

The MDT shall make every effort to resolve disputes through discussion and negotiation at the lowest levels of the agencies. If the dispute cannot be resolved at this level, then the MDT members involved in the dispute shall contact their individual supervisors for assistance. Once the chain of command is exhausted or at the request of one of the supervisors, a team meeting may be scheduled. Additionally, the Investigation Coordinator's Office may be contacted to initiate or facilitate communication with other members of the MDT.

MOU Signature Page(s)

The Honorable Josette Manning, Esq. **Cabinet Secretary, Department of Services for Children, Youth, and Their Families**	**Date**
The Honorable Matthew Denn, Attorney General **Department of Justice**	**Date**
Randall Williams, Chief Executive Officer **Children's Advocacy Center of Delaware, Inc.**	**Date**
John R. Evans, Director **Division of Forensic Science**	**Date**
Jennifer Donahue, Esq., Investigation Coordinator, Office of the Investigation Coordinator	**Date**
Edward Woomer, Associate Administrator **Nemours/Alfred I. duPont Hospital for Children**	**Date**
Chief Michael D. Redmon **Bethany Beach Police Department**	**Date**
Chief Paul Anthony **Blades Police Department**	**Date**
Chief H. Burke Parker **Bridgeville Police Department**	**Date**
Chief William E. Bryson **Camden Police Department**	**Date**
Chief Christopher Workman **Cheswold Police Department**	**Date**

MOU Signature Page(s)

Chief Brian Hill **Clayton Police Department**	**Date**
Chief Floyd Toomey **Dagsboro Police Department**	**Date**
Chief John Horsman **Delaware Capitol Police**	**Date**
Chief David Baylor **Delaware City Police Department**	**Date**
Colonel Richard H. Arroyo **Delaware River and Bay Authority**	**Date**
Colonel Nathaniel McQueen **Delaware State Police**	**Date**
Chief Harry Downes **Delaware State University**	**Date**
Chief Ivan E. Barkley, Sr. **Delmar Police Department**	**Date**
Chief James Faedtke **D.N.R.E.C.** **Air and Waste Management**	**Date**
Chief Drew Aydelotte **D.N.R.E.C.** **Division of Fish and Wildlife Enforcement**	**Date**
Chief Wayne Kline **D.N.R.E.C.** **Division of Parks and Recreation**	**Date**

MOU Signature Page(s)

Chief Sam Mackert **Dewey Beach Police Department**	**Date**
John Yeomans, Director **Division of Alcohol and Tobacco Enforcement**	**Date**
Acting Chief Marvin Mailey **Dover Police Department**	**Date**
Chief Bruce VonGoerres **Ellendale Police Department**	**Date**
Chief Laura Giles **Elsmere Police Department**	**Date**
Chief Levi D. Brown **Felton Police Department**	**Date**
Chief William Boyden **Fenwick Island Police Department**	**Date**
Chief Mark Hudson **Frankford Police Department**	**Date**
Chief Randall Hughes **Georgetown Police Department**	**Date**
Chief Mark Anderson **Greenwood Police Department**	**Date**
Chief Norman Barlow **Harrington Police Department**	**Date**

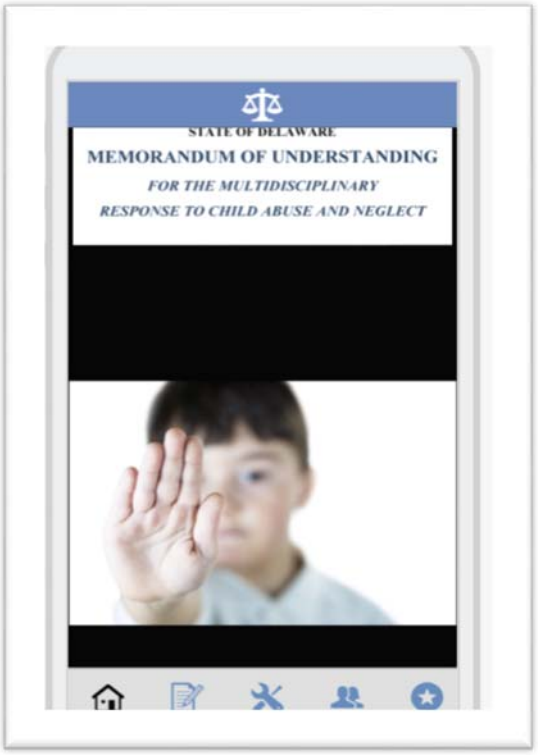
MOU Signature Page(s)

Chief Michael Hibbert **Kenton Police Department**	**Date**
Chief Danny Wright **Laurel Police Department**	**Date**
Chief Thomas Spell **Lewes Police Department**	**Date**
Chief Daniel Yeager **Middletown Police Department**	**Date**
Chief Kenneth Brown **Milford Police Department**	**Date**
Chief Brian Calloway **Millsboro Police Department**	**Date**
Chief Robert Longo **Milton Police Department**	**Date**
Chief Jamie Rogers **New Castle City Police Department**	**Date**
Lieutenant Colonel Vaughn Bond Jr. **New Castle County Police Department**	**Date**
Chief Paul Tiernan **Newark Police Department**	**Date**
Chief Michael J. Capriglione **Newport Police Department**	**Date**

MOU Signature Page(s)

Chief Kenneth McLaughlin **Ocean View Police Department**	**Date**
Grover P. Ingle, State Fire Marshal **Office of the State Fire Marshal**	**Date**
Chief Keith W. Banks **Rehoboth Beach Police Department**	**Date**
Chief Gary Flood **Seaford Police Department**	**Date**
Chief W. Scott Collins **Selbyville Police Department**	**Date**
Chief Norman Wood **Smyrna Police Department**	**Date**
Chief Troy Crowson **South Bethany Police Department**	**Date**
Chief Patrick Ogden **University of Delaware Police Department**	**Date**
Chief Bobby Cummings **Wilmington Police Department**	**Date**
Chief Martin Willey **Wyoming Police Department**	**Date**

Appendix C: Mobile Application Screen Shots



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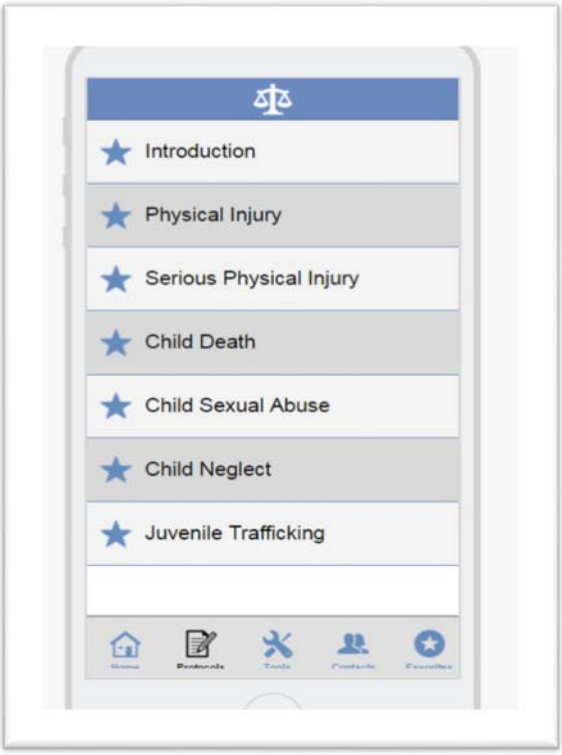
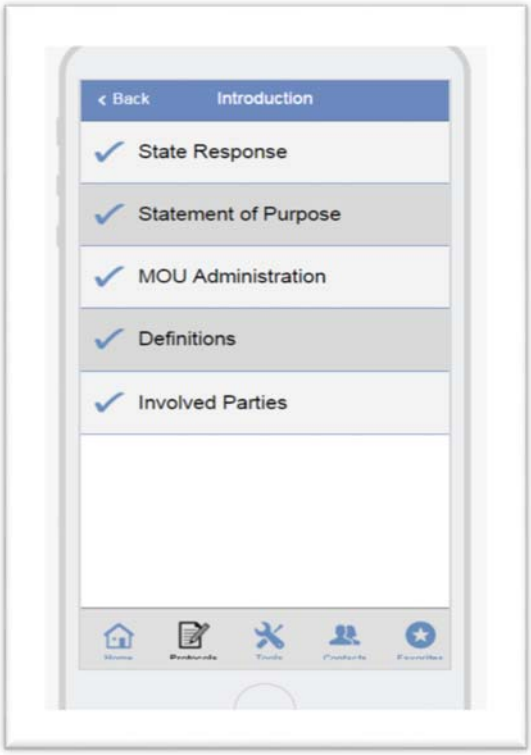
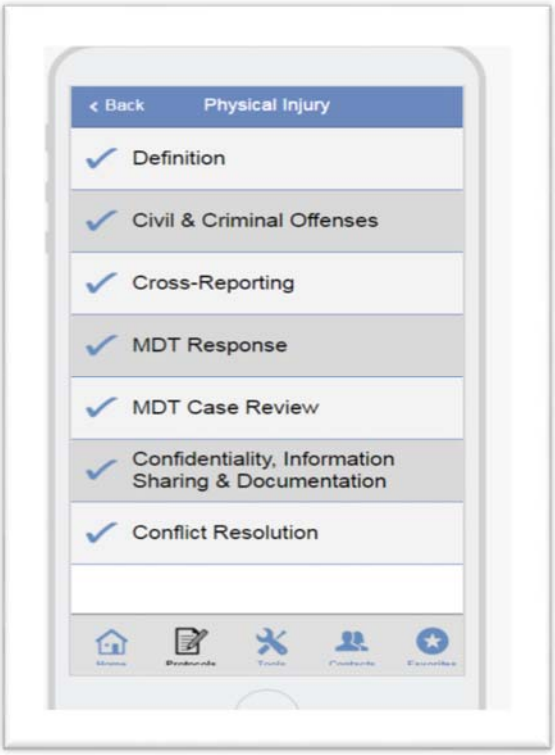


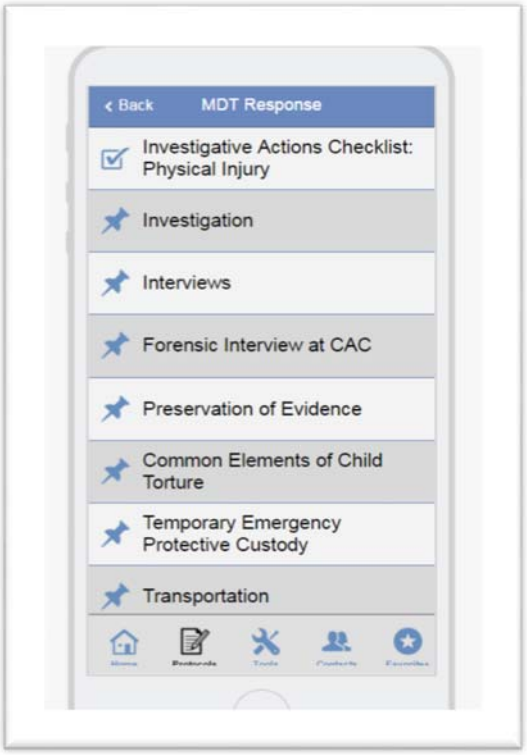
PROTOCOLS TAB



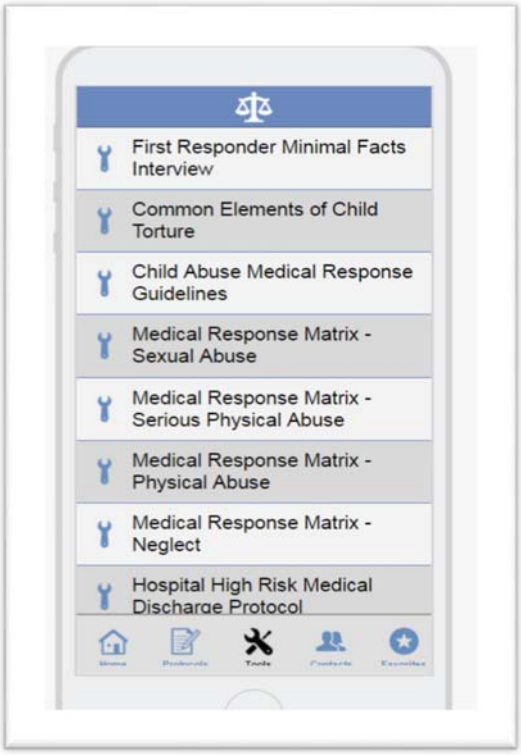
INTRODUCTION



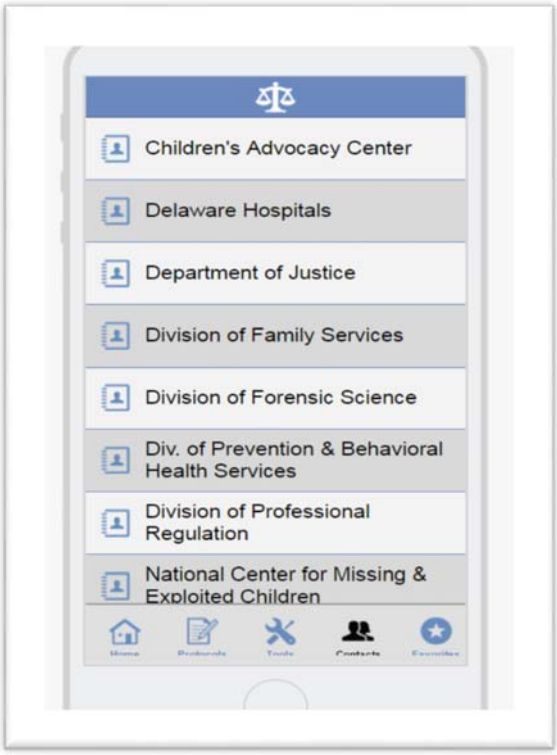
PHYSICAL INJURY (PI) PROTOCOL



MDT RESPONSE FOR PI PROTOCOL



TOOLS TAB



CONTACTS TAB

REVISED MOU:

MDT RESPONSE TO CHILD ABUSE & NEGLECT

OVERVIEW & OBJECTIVES

- ✓ Provide insight as to reason for revision of MOU
- ✓ Provide roadmap of document
- ✓ Offer generalized summary of investigative steps
- ✓ Introduce new investigative/assessment tools

MISSED OPPORTUNITIES

- Serious Physical Injury and Death cases are reviewed in depth by Delaware's Child Abuse & Neglect Panel.
- State-sanctioned panel, comprised of representatives from varied agencies touching the case. IE: DFS, LE, DOJ, CAC, CDRC, IC, Medical, Courts, DOE, Mental Health Professionals, Victim Advocates, etc.
- Findings & strengths are determined by panel and assigned to responsible agency

Child Abuse & Neglect Best Practices Workgroup

- Based upon findings & strengths from CAN Panel reviews, the CAN Best Practices Workgroup was established
- Goal to revise MOU, updating and making user-friendly
- Comprised of reps from: LE, DFS, DOJ, IC, OCA, CAC, CDRC, Hospitals (SANES/FNES), ME's Office (new DFS)

MOU SIGNATORY AGENCIES

- ❑ Department of Services for Children, Youth and Their Families (DFS)
- ❑ Children's Advocacy Center of Delaware (CAC)
- ❑ Nemours/A.I. DuPont
- ❑ Department of Justice (DOJ)
- ❑ Delaware Police Departments
- ❑ Division of Forensic Science (ME)
- ❑ Office of Investigation Coordinator (IC)

STRUCTURE

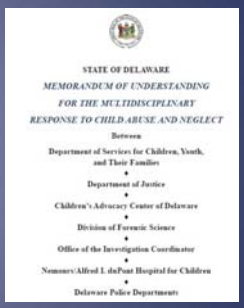
Previous MOU

- Structured by agency
- Responsibilities detailed for per agency
- Generalized duties/actions

Revised MOU

- Structured by abuse type
- Each agency's responsibilities listed for each investigative step
- More detailed duties/actions
- **Enhances collaboration & communication**

MOU: MDT RESPONSE TO CHILD ABUSE & NEGLECT



STATE OF DELAWARE

MEMORANDUM OF UNDERSTANDING
FOR THE MULTIDISCIPLINARY
RESPONSE TO CHILD ABUSE AND NEGLECT

Between

Department of Services for Children, Youth, and Their Families

+

Department of Justice

+

Children's Advocacy Center of Delaware

+

Division of Forensic Science

+

Office of the Investigation Coordinator

+

Nemours/Alfred I. duPont Hospital for Children

+

Delaware Police Departments

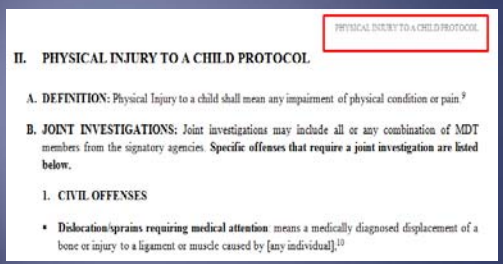
ABUSE TYPES

1. Physical Injury Protocol
2. Serious Physical Injury Protocol
3. Child Death Protocol
4. Child Sexual Abuse Protocol
5. Child Neglect Protocol
6. Juvenile Trafficking Protocol

PARTS/SECTIONS OF MOU

- PG 6-12: Intro--Purpose, Definitions, Involved Parties
- PG 13-33: Physical Injury Protocol
- PG 34-55: Serious Physical Injury (Near Death) Protocol
- PG 56-77: Death Protocol
- PG 78-100: Sexual Abuse Protocol
- PG 101-122: Neglect Protocol
- PG 123-145: Juvenile Trafficking Protocol
- Appendices

Top Right of Page: Protocol/Abuse Type



PHYSICAL INJURY TO A CHILD PROTOCOL

II. PHYSICAL INJURY TO A CHILD PROTOCOL

A. DEFINITION: Physical Injury to a child shall mean any impairment of physical condition or pain.[9]

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

1. **CIVIL OFFENSES**

- **Dislocation/sprains requiring medical attention**: means a medically diagnosed displacement of a bone or injury to a ligament or muscle caused by [any individual].[10]

LAYOUT

1. **MDT Response to Child Abuse (Intro)**
   - Statement of Purpose
   - Administration of MOU
   - Definitions
   - Involved Parties (Roles defined)

LAYOUT: ABUSE PROTOCOLS

A. Definition (of abuse type)
PI, SPI, Death, SA, Neglect, JT

B. Joint Investigation
1. List of Civil Offenses
2. List of Criminal Offenses

LAYOUT: ABUSE PROTOCOLS

C. MDT Response
1. Cross-Reporting
- When reports must be made to: DFS, LE, DOJ, Investigation Coordinator (IC), Division of Forensic Sciences (ME), Professional Regulatory Bodies

LAYOUT: ABUSE PROTOCOLS

C. MDT Response
1. Cross-Reporting **CON'T**
- Must report both intra & extra familial to DFS
- Must report additional allegations/suspects ascertained
- If multiple MDT professionals with direct knowledge involved, group can choose one of them to make the report for all. IE: at CAC
- Reports to LE as soon as possible to enhance investigation

LAYOUT: ABUSE PROTOCOLS

C. MDT Response
2. Investigation
- Interviews
  - LE & DFS coordinate interviews, allowing opportunity for attendance
  - Should be audio and/or video recorded
  - Minimal Facts Interview Protocol recommended
- Forensic Interview at CAC
  - Recommended in cases with children 3-12 yrs
  - LE, DFS,DOJ can schedule; communicate prior to call
  - Process includes: pre-interview meeting, forensic interview, post-interview MDT meeting, post-interview meeting with caregiver

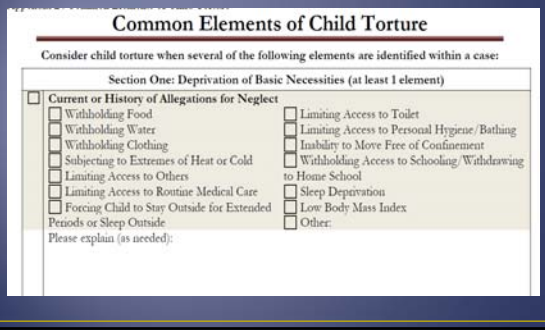
LAYOUT: ABUSE PROTOCOLS

C. MDT Response
2. Investigation
- Preservation of Evidence
  - Crime scene examined within 24-48 hrs as practicable
  - Scene & evidence photo or video documented
  - Photos of injuries should show scale
  - Doll Re-enactment in SPI & Death cases
  - SUIDI Form in Death cases
- Post-Mortem Examination (Death Protocol)
  - Post-mortem CT scan may be done prior to Exam at designated hospitals

LAYOUT: ABUSE PROTOCOLS

C. MDT Response
2. Investigation
- Common Elements of Torture (Torture Checklist)
  - Recently developed checklist—assist in ID'ing torture
  - Torture not technically a crime—constellation of factors showing extreme maltreatment of a child.
  - Historically not ID'ed until SPI or Death
- Temporary Emergency Protective Custody
  - Title 16, Section 907– LE, Physicians & DFS may take emergency custody for up to 4 hrs. LE and medical must immediately notify DFS.
  - DFS may only invoke TEPC from school, daycare/child care

TORTURE CHECKLIST



Common Elements of Child Torture

Consider child torture when several of the following elements are identified within a case:

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

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

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

Please explain (as needed):

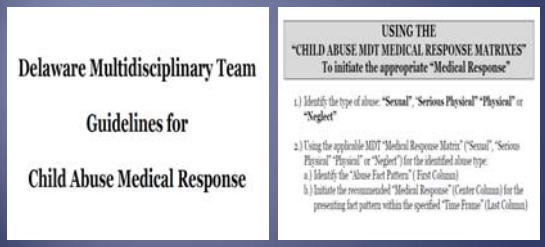
LAYOUT: ABUSE PROTOCOLS

C. MDT Response

2. Investigation

- Transportation
  - CAC and/or medical exam
  - To include other children in the home
  - Upcoming legislation address to this issue
- Medical Exam (MDT Guidelines for Child Abuse Medical Response)
  - New guidelines to assist in determining when child victims, siblings, other children in home should be medically evaluated and by whom
  - Suggested language for talking with Dr. (CAN case)
  - Current effort to increase "designated" providers

CAMR: CHILD ABUSE MEDICAL RESPONSE



Delaware Multidisciplinary Team

Guidelines for

Child Abuse Medical Response

USING THE "CHILD ABUSE MDT MEDICAL RESPONSE MATRIXES" To initiate the appropriate "Medical Response"

1.) Identify the type of abuse: **"Sexual", "Serious Physical" "Physical"** or **"Neglect"**

2.) Using the applicable MDT "Medical Response Matrix" ("Sexual", "Serious Physical" "Physical" or "Neglect") for the identified abuse type:
a.) Identify the "Abuse Fact Pattern" (First Column)
b.) Initiate the recommended "Medical Response" (Center Column) for the presenting fact pattern within the specified "Time Frame" (Last Column)

Conversation with Medical Provider

COLLECTING THE MEDICAL EVIDENCE[49]

Questions for the Medical Provider

- What is the nature and extent of the child's injury or illness?
- What is the mechanism of injury? What type and amount of force are required to produce the injury?
- Does the history the caregiver provided explain (in whole or in part) the child's injury?
- Have other diagnoses been explored and ruled out, whether by information gathering, examination, or medical tests?
- Could the injury be consistent with an accident?
- Can the timing of the injury be estimated? To what degree of certainty?
- Have all injuries been assessed in light of any exculpatory statements?
- What treatments were necessary to treat the injury or illness?
- What are the child's potential risks from the abusive event?
- What are the long-term medical consequences and residual effects of the abuse?

LAYOUT: ABUSE PROTOCOLS

C. MDT Response

2. Investigation

- Safety Assessment
  - DFS responsible for assessing safety and placement
  - LE may take TEPC in exigent circumstances, but must communicate why and turn child over to DFS
  - Background checks on all placements
- Behavioral Health & Social Services
  - Increased emphasis on social and mental health of child victim for best long-term outcomes
  - Responsibility of all MDT partners working case to communicate concerns
  - Division of Prevention & Behavioral Health can be a resource for services

LAYOUT: ABUSE PROTOCOLS

C. MDT Response

2. Investigation

- Victim Advocates
  - Advocates will assess needs of victims and families and refer to culturally appropriate services.
  - Located in: DFS, LE, DOJ, CAC, Hospitals
  - Will communicate and coordinate services to ensure no gaps
  - Crisis Intervention, link to VINES and/or VCAP, Victim's Bill of Rights, case status updates, court accompaniment, referral to social services (housing, financial assistance, etc)

LAYOUT: ABUSE PROTOCOLS

C. MDT Response

2. Investigation

- Arrest
  - LE should contact DOJ upon receipt of SPI, Death, Juvenile Trafficking, unusual/extreme SA case
  - Consultation with DOJ should happen as soon as practicable in PI, typical SA and Neglect cases.
  - Consider providing input from DFS to court issuing bond/NCO
  - LE should update DFS when case is closed with arrest

LAYOUT: ABUSE PROTOCOLS

C. MDT Response

2. Investigation

- Criminal Proceedings
  - In SPI, Death, SA, JT cases, DOJ will consult with LE : to determine further investigative measures prior to arrest & to garner case insight prior to final disposition
  - Criminal and Civil DAGs will communicate & consult to ensure best outcomes for case/child victim

LAYOUT: ABUSE PROTOCOLS

C. MDT Response

2. Investigation

- Civil Disposition
  - DFS makes Abuse or Neglect determination in 45 days
  - Civil finding not dependent upon criminal outcome
  - DFS must notify suspect of civil finding in writing; recommended DFS consult with LE/DOJ prior to same to maintain integrity of criminal case

INVESTIGATIVE ACTIONS QUICK REFERENCE TABLE

CHILD DEATH PROTOCOL

For all allegations within this Protocol, the MDT will determine from the list below the appropriate investigative actions that have been identified as best practices for responding to child abuse cases.

	Investigative Actions	Responsible Agency
☐	Contact the DOJ Special Victims Unit immediately.	LE
☐	Cross-report and coordinate an immediate response between MDT members.	MDT
☐	Establish the location(s) where the incident occurred.	LE
☐	Identify persons involved and coordinate interviews with child, siblings, caregivers, alleged perpetrator(s), and other witnesses.	DFS and LE
☐	Exchange information regarding complaint, criminal and DFS history.	MDT
☐	Consider consultation with police jurisdictions with more resources.	LE

LAYOUT: ABUSE PROTOCOLS

C. MDT Response

3. MDT Case Review
   - Monthly (or more often as needed) meetings to monitor & discuss case status: progress, needed actions/resources
   - May include: CAC, DFS, LE, DOJ, IC, medical, mental health & victim advocates
4. Confidentiality, Information Sharing & Documentation
   - Records can be shared, but must be obtained directly from the agency who possesses the records.
5. Conflict Resolution

JUVENILE TRAFFICKING PROTOCOL

- Few slight variations
- First portion of the MDT Response is "Screening & Identification" vs. investigative actions
- Trafficking often not immediately ID'd; not defined by one act, combination of behaviors/circumstances
- For this reason, Pre-Assessment Checklist provided to assist in determining possible trafficking
- Provides some common situations-- IE: Runaway Foster Youth
- Additionally, JT protocol includes cross-reporting to federal LE…FBI, ICE, USCIS… as well as NCMEC

JUVENILE TRAFFICKING CHECKLIST

JUVENILE TRAFFICKING PRE-ASSESSMENT CHECKLIST

For use by agencies only. Do not give to parent or child to complete.

The Juvenile Trafficking Pre-Assessment Checklist was created to help multidisciplinary team members identify potential victims of juvenile trafficking. This confidential Pre-Assessment Checklist is intended to document indicators only and should be followed up with a comprehensive investigation and assessment of the child's needs, where appropriate. Multiple sources of information can be used to determine if indicators of juvenile trafficking may be present, such as the location where the child is found, the context of the initial contact, current allegations, and/or medical, criminal and DFS history known about the child. If indicators are identified and juvenile trafficking is suspected, an immediate report to the Division of Family Services (DFS) Report Line and the appropriate law enforcement jurisdiction should be made. These notifications should prompt a comprehensive assessment of the child's safety, placement, mental health, medical, and substance abuse treatment needs.

Child's Name: _____ **DOB:** _____

GENERAL YOUTH INDICATORS – SEX & LABOR TRAFFICKING
❑ Recent and/or ongoing history of homelessness
❑ Multiple runaway attempts
❑ Not in control of their identification
❑ Not in control of money earned, owes a debt or has intense sense of financial responsibility toward family or intimate partner
❑ Lack of support system or supportive relationships
❑ Unexplained travel, purchases or access to money
❑ Inconsistencies in story

APPENDICES

A. First Responder Minimal Facts Interview Summary
B. Common Elements of Child Torture
C. DE MDT Guidelines for Child Abuse Medical Response
D. Hospital High Risk Medical Discharge Protocol
E. Victim Advocate Resource Numbers
F. CAC MDT Case Review Protocol
G. SUIDI (Sudden Unexplained Infant Death Invest) Form
H. Sexual Behaviors and Ages of Consent
I. PREA (Prison Rape and Elimination Act)
J. Juvenile Trafficking Pre-Assessment Checklist

LAST THOUGHTS

- Mobile APP being finalized. Make access to MOU and tools/checklists/reference materials simple and quick

LAST THOUGHTS

QUESTIONS

??????????

STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
C/O OFFICE OF THE CHILD ADVOCATE
900 KING STREET, SUITE 210
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C. MALCOLM COCHRAN, IV, ESQUIRE
CHAIR

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

May 17, 2016

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

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

Dear Governor Markell:

The Child Protection Accountability Commission ("CPAC") is now responsible for the reviews of child deaths and near deaths due to abuse or neglect. As required by law, CPAC approved findings from 14 cases at its May 11, 2016 meeting.[1] With the exception of one 2016 case, these incidents all occurred in 2015 and have resulted in 90 findings across system areas. Of these 14 cases, 9 resulted in death and 5 resulted in near death. The themes have been identified, as follows:

1. Law Enforcement/Multidisciplinary Team Response. The 12 findings continue to demonstrate struggles with best practices for criminally investigating these cases. Since the last CPAC meeting, law enforcement and the Department of Justice have discussed the required intake of cases and potential solutions. CPAC's Training Committee and Best Practices Workgroup continue to tackle proper investigative techniques with a new MOU and training expected in Spring 2017. CPAC will continue to monitor this progress in its quarterly meetings and at its September 2016 retreat. In addition, these 2015 cases indicate 6 cases where forensic interviews were not

[1] 16 Del. C. § 932

conducted of child victims and witnesses who were almost exclusively younger children. The Department of Justice and law enforcement have been tasked with reviewing the findings, focusing on the identified issues and presenting a solution.

2. Medical Response. There were 18 findings that demonstrate ongoing opportunities for improvement in the medical response to child abuse and neglect. Most prevalent were ongoing failure to report issues and the appropriate multidisciplinary response to substance exposed infants. These issues were identified in the Joint Commission Action Plan from January of 2015. The CPAC Child Abuse Medical Response Committee has been tasked with considering the findings and recommending an action plan specifically targeted at highlighting to physicians their frontline responsibilities in the diagnosing and reporting of suspected child abuse. Furthermore, the findings will be incorporated into the bi-annual medical professionals training and shared in area hospital meetings. As for the multidisciplinary response on substance exposed infants, four cases were reviewed and all infants died. CPAC and the Child Death Review Commission will continue their work in the Joint Committee on Substance Exposed and Medically Fragile Infants, and CPAC will continue to champion the passage of House Bill 319, implementing federal law for reporting substance exposed infants and developing a multidisciplinary plan of safe care.

3. DFS Safety Plans/Risk Assessments/Unresolved Risk. The most voluminous findings from these cases are applicable to DFS. Forty-three findings (47% of the total findings this quarter) were made in 14 cases that demonstrate the continual struggle by the Division of Family Services regarding the proper use and development of safety plans, appropriate use of risk assessments, and responses to cases that involve unresolved risks. The DSCYF Secretary presented to CPAC at the May 11th meeting regarding steps she has taken in the last few months. She has committed to continuous staff development around these issues and will continue to keep CPAC apprised of her efforts. However, there is little doubt that the ongoing violation of DFS statutory caseload standards and the lack of statutorily mandated resources for DFS is leading to adverse outcomes for Delaware's children. CPAC has written to the Joint

Finance Committee providing data and emphasizing the urgent need for statutory compliance with caseload standards. The Joint Finance Committee promptly and appropriately requested financial detail on resources needed to statutorily comply with 29 Del. C. §9015. DFS has indicated it needs 27 new positions to just meet statutory compliance with its volume of reports to exceed 20,000 this fiscal year. This untenable risk to children must be promptly addressed.

System responses will also be reviewed at least annually by the Child Protection Accountability Commission. We are available should further information be required. For your information we have included the findings and the details behind each.

Respectfully,

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

Enclosures
cc: CPAC Commissioners
General Assembly

LE and MDT	12
Crime Scene	1
Documentation	1
Doll Re-enactment	1
Interviews	7
Non-compliance with MOU	1
Use of History	1
Grand Total	**12**
Medical	18
Delayed Report	1
Documentation	2
Failure to Report	6
Standard of Care	1
Substance-Exposed Infant	6
Transport	1
Unresolved Risk	1
Grand Total	**18**
DFS Part 1	43
Risk Assessment	8
Safety Plan	16
Unresolved Risk	19
Grand Total	**43**
DFS Part 2	17
Best Practice	3
Collaterals	1
DFS Contact with DOJ	1
Documentation	1
Medical Exam	2
Non-compliance with MOU	3
Supervisory Oversight	3
Use of History	1
Communication	2
Grand Total	**17**
Summary Findings Total	***90***

LE and MDT			12
	Crime Scene		1
		No scene investigation was completed by the law enforcement agency.	1
	Documentation		1
		Toxicology results for the parents were not recorded in the police report.	1
	Doll Re-enactment		1
		No doll re-enactment was completed by the law enforcement agency.	1
	Interviews		7
		Forensic interview did not occur with the teen who was present in the home at the time of the death.	1
		Forensic interview did not occur with the young child during the investigation despite the disclosure of physical abuse and the appearance that the child was coached prior to the forensic interview.	1
		Forensic interview did not occur with the young child who was present in the home during the death incident.	1
		Forensic interview did not occur with the young child who witnessed the near death incident.	1
		Forensic interview did not occur with the young victim with developmental delays.	1
		Forensic interviews did not occur with the teen and young child who were present in the home at the time of the near death.	1
		Interviews did not occur with all adults in the home where the near death incident occurred.	1
	Non-compliance with MOU		1
		The law enforcement agency did not maintain ongoing collaboration or communication with DFS.	1
	Use of History		1
		History with two out of state child protective services agencies was not checked despite learning that the parents resided with the infant out of state in the last several months.	1
Grand Total			**12**

Medical			18
	Delayed Report		1
		After referring the child to the local hospital for suspected head trauma, the PCP learned that the child had a skull fracture and delayed reporting to the DFS Child Abuse and Neglect Report Line by one day.	1
	Documentation		2
		The adult accompanying the child to visits was not documented in the PCP records during mother's incarceration.	1
		The child's weight was not documented by the PCP during the first newborn visit.	1
	Failure to Report		6
		A report was not made to the DFS Report line after the parents were non-compliant with a voluntary home visiting service for a substance-exposed infant.	1
		The hospital failed to report the child's unexplained death to the DFS Child Abuse and Neglect Report Line.	1
		The substance abuse provider closed the case after non-compliance by mother, and DFS was not notified.	1
		There was no report to the DFS Child Abuse and Neglect Report Line by the birth hospital or PCP after a second child was born substance-exposed by Mother, and DFS was not able to intervene prior to the child's death. The positive test results were received post discharge, and the birth hospital alerted the PCP to the positive test results.	1
		There was no report to the DFS Child Abuse and Neglect Report Line by the PCP despite multiple no-show appointments, multiple caregivers, no dental care, self-infliction of harm, and fire play behaviors.	1
		Two months prior to the child's death, the child was in the care of a non-relative and this information was known by the PCP yet no report was made by the PCP to DFS Child Abuse and Neglect Report Line.	1
	Standard of Care		1
		At a young age, the child was reportedly engaging in fire play behaviors in the home, and the PCP made referrals to behavioral health systems but did not independently see the child.	1

Medical	Substance-Exposed Infant		6
		A Hospital High Risk Medical Discharge Protocol meeting was not requested by the birth hospital.	3
		No plan of safe care was completed by the birth hospital upon discharge of a substance-exposed infant, and the infant died two months later.	1
		The birth hospital did not document in its records that a report was made to the DFS Report Line.	1
		There was no documentation that the child was sent home with any supportive in-home services, such as a home visiting program.	1
	Transport		1
		Despite suspected head trauma with no mechanism of injury, the primary care physician allowed the mother to transport the child to the emergency department.	1
	Unresolved Risk		1
		No referral was made to a home visiting program for the young, first time mother who is low-income.	1
Grand Total			**18**
DFS Part 1			43
	Risk Assessment		8
		Despite multiple risk factors, the investigation was not substantiated against the mother.	1
		Despite the deplorable living conditions identified during the death investigation, DFS did not consider a finding of neglect at the conclusion of its investigation. The case was unsubstantiated with concern.	2
		For the near death incident, DFS did not consider making a finding of neglect against the relative for leaving the two young children unsupervised.	1
		The investigation for the near death incident was abridged by DFS despite concerns of neglect for the young victim.	1

DFS Part 1	Risk Assessment	The investigation was abridged despite the DFS history, father's absence from the home, and the child being left in the care of the non-relative who was previously substantiated for abuse against the same child.	1
		The Structured Decision Making (SDM) risk assessment for the investigation was rated high and the case was closed despite the risk level.	1
		The Structured Decision Making (SDM) risk assessment for the near death investigation was rated high and the case was closed despite the risk level.	1
	Safety Plan		16
		After the death incident, DFS history was not considered in determining the safety for the surviving siblings. A safety plan was temporarily completed with a relative, and the children returned home a few days after the incident. The conditions of the home were deplorable, prescription medication was within reach of the children, and the child's death was still unexplained.	1
		After the death, DFS addressed the repeated violations of the safety agreement by entering into a subsequent plan with the same participants, who were allowing mother unrestricted access to the child and siblings.	1
		After the death, DFS did not appropriately evaluate the placements for the surviving siblings. The three youngest children had multiple moves, and the older siblings' father's home was not evaluated and substance abuse was not assessed.	1
		After the near death incident, DFS entered into a safety agreement allowing mother only supervised contact with the child. However, only mother signed the plan, and no other participants were identified to supervise her interactions.	1
		DFS entered into safety agreements with participants who had criminal and DFS histories.	1

DFS Part 1	Safety Plan	During the death investigation, three other non-related children resided in the home with deplorable living conditions. Safety was not assessed for these children and a separate report of neglect was not made to the DFS Report Line.	1
		During the investigation, DFS learned that the safety agreement was being violated but failed to reassess safety.	1
		During the investigation, the safety agreement was lifted prior to transferring the case to treatment and the child was still at risk for abuse.	1
		Following the death, a safety agreement was completed with a participant who was present during the death and part of the original safety agreement. One of the participants was also terminally ill and had significant criminal history.	1
		Following the report of a substance-exposed infant, DFS entered into a safety agreement with the drug addicted mother. No other participants were identified in the safety agreement, and mother had no restrictions with her contact despite two substance-exposed infants.	1
		For the investigation involving a substance-exposed infant, the case worker did not complete the SDM safety assessment correctly, and there was no safety plan.	1
		For the investigation involving a substance-exposed infant, the case worker did not complete the SDM safety assessment correctly.	1
		In the investigation, the victim made a disclosure of sex abuse by her step father, but after she recanted, there was no ongoing actions taken to limit unsupervised contact between the victim and step father. The criminal charges were Nolle Prossed, and the DFS investigation was also unfounded.	1
		Neither safety agreement participant was present during the three contacts, and DFS did not address the repeated violations of the safety agreement.	1
		The safety agreement developed during the DFS investigation was not reviewed by the assigned treatment worker.	1

DFS Part 1	Safety Plan	The treatment worker was unaware the family had moved into the hotel until after the baby died, and safety agreement participants did not report the move to DFS.	1
	Unresolved Risk		19
		Despite extensive reports and investigations, there was not a heightened level of concern during the treatment case and parental risk factors were not considered.	1
		Despite multiple reports regarding drug use by mother, including a report of a substance-exposed infant, there was not a heightened level of concern during the treatment case and parental risk factors were not considered.	1
		Despite the DFS history involving substance abuse and domestic violence, there was not a heightened level of concern during the investigation and subsequent treatment case regarding the report of a substance-exposed infant.	1
		Despite the DFS history, non-relative placement, inability of the non-relative to obtain services for the child, and homelessness and substance abuse by the parent, there was no documentation that DFS considered placing the child with family members or petitioning the court for custody prior to the child's death.	1
		DFS did not evaluate substance abuse issues for father or request that he complete a substance abuse evaluation.	1
		During the investigation, there was no referral to the domestic violence liaison or substance abuse liaison.	1
		During the treatment case, it was reported to the caseworker that the child threatened suicide; however, there was no follow through with mental health services for the child.	1
		In the investigation, DFS did not contact mother's substance abuse provider to verify that she was compliant with treatment after it was reported that heroin was found in her car.	1
		In the investigation, no referral was made to the substance abuse liaison despite admission of marijuana use by the mother and allegations of cocaine use.	1

DFS Part 1	Unresolved Risk	Prior to closing the investigation, DFS did not verify services were being provided by the substance abuse provider, and the mother had a DFS history as a result of giving birth to a substance-exposed infant.	1
		Prior to the incident, the family was resistant to treatment services provided by DFS. The family was not seen for almost 2 months, and the following measures were not taken: requesting assistance from the DFS after-hours unit; adhering to the client lack of cooperation policy; filing a petition to compel cooperation; involving the special investigator; and reviewing the Division of Motor Vehicle and Medicaid records.	1
		The cases prior to the death incident did not receive a higher level of review by DFS, which may have included a consult with DOJ, a TDM meeting, or a framework. Risk factors included a family with significant DFS history, allegations involving several maltreatment types and different children, and calls by different professionals.	1
		The hotline report alleging drug use by mother was screened out, because it was labeled a prenatal case even though the then young sibling was in mother's care. The hotline worker also did not see that the case was active in treatment, so the worker was not notified of the report.	1
		The investigation was a Tier 1 (family assessment of low risk case) closure despite the extensive DFS history and recent child death.	1
		The investigation was a Tier 1 closure (family assessment of low risk case) despite the unsuitable living conditions. The family agreed to stay with the father and relative; however, no home assessment was completed and the father had restricted access to children due to his sex offender status.	1
		The near death case was not given a heightened level of concern given the risk factors: mother's incarceration, extensive criminal record, history of substance abuse, lack of providing care for the child, and an older child previously removed from the mother's care.	1
		The Panel identified that the child(ren) were currently at risk in the active treatment.	1

DFS Part 1	Unresolved Risk	There was no contact with the children for several months during the treatment case.	1
		Throughout the history of the case, the children's physical, medical, mental health and behavioral issues were not being adequately addressed. The children had chronic issues with poor hygiene, lice and an odor of urine and feces. They were frequently absent from school and ostracized by classmates. Each child also had a combination of developmental delays, speech delays, or mental health disorders. One child suffered from a chronic medical condition.	1
Grand Total			**43**
DFS Part 2			17
	Best Practice		3
		A Root Cause Analysis was not completed even though the child was active with DFS at the time of the child's death.	1
		In the investigation, group supervision and a framework were not utilized despite the active treatment case and DFS history.	1
		The DFS Child Abuse and Neglect Report Line screened out the report regarding an unexplained death to an infant, and the incident involved an impaired caregiver bed-sharing with an infant.	1
	Collaterals		1
		Collateral contacts were minimal in the 2011 and 2013 cases, which prevented DFS from obtaining additional information to verify or refute the allegations. All three cases were unsubstantiated.	1
	DFS Contact with DOJ		1
		DFS filed for temporary custody of the sibling, but did not file for custody of the victim due to the child's hospitalization.	1
	Documentation		1
		In the investigation, the PCP reported that mother no-showed for the sibling's medical appointments and sibling was due for a well visit, but there was no documentation that DFS addressed this with mother prior to closing case.	1
	Medical Exam		2

DFS Part 2	Medical Exam	During the death investigation, the two other young children were not medically evaluated despite the unexplained death of the victim. Significant concerns also existed with the conditions of the home.	1
		In the investigation, the young child was not medically evaluated despite allegations in two hotline reports that the child was punched in the back and head.	1
	Non-compliance with MOU		3
		A medical assessment was not completed for the 2013 and 2014 reports involving allegations of abuse with different victims. Bite marks, black eyes, and scratches from knives and keys were reported.	1
		Following the report of physical abuse, law enforcement was not notified of the potential criminal violation against the child, and a forensic interview was not scheduled at the Children's Advocacy Center.	1
		In the investigation, police were not notified of the potential criminal violation against the young child by the mother.	1
	Supervisory Oversight		3
		After the death, the supervisor communicated to the family that the surviving siblings should not have been placed in foster care, which contradicted the actions taken by the investigation worker.	1
		The lack of supervisory oversight negatively impacted the critical decisions made throughout the treatment case.	1
		Throughout the history of the case, the lack of supervisory oversight negatively impacted the critical decisions made, including assessing child safety.	1
	Use of History		1
		In the subsequent investigation, history was not considered from the near death investigation.	1
	Communication		2
		Lack of communication between DFS and substance abuse providers regarding this high risk family.	2
Grand Total			**17**
Summary Findings Total			***90***

STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
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C. MALCOLM COCHRAN, IV, ESQUIRE
CHAIR

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

August 10, 2016

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

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

Dear Governor Markell:

The Child Protection Accountability Commission ("CPAC") is responsible for the reviews of child deaths and near deaths due to abuse or neglect. As required by law, CPAC approved findings from 13 cases at its August 10, 2016 meeting.[1] Eight of the cases were older cases that received a final review after completion of prosecution. The five remaining cases were from late 2015 and early 2016 and resulted in 27 findings across system areas. An additional four findings were made in the older cases. The themes from the recent cases continue to be the law enforcement and MDT response for criminally investigating child abuse cases, the medical responses to these children pre and post incident, and the use of safety plans and risk assessment by the Division of Family Services. Most striking was that in each recent case, the DFS investigation worker was significantly over the statutory caseload standard.

CPAC has a retreat scheduled in September 2016. During this retreat, findings from the last year will be reviewed, trends identified and an action plan developed to

[1] 16 Del. C. § 932.

address priority areas. CPAC will share this plan in the next report on the child abuse death and near death reviews.

We are available should further information be required. For your information we have included the findings and the details behind all of the cases presented in this letter.

Respectfully,

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

Enclosures
cc: CPAC Commissioners
General Assembly

Child Abuse and Neglect Panel

Findings Summary

8-10-16

INITIALS

LE and MDT	4
Crime Scene	1
Documentation	1
Interviews	1
LE Contact with DOJ	1
Grand Total	**4**

Medical	6
Documentation	1
Failure to Report	2
Standard of Care	2
Transport	1
Grand Total	**6**

DFS Part 1	9
Safety Plan	4
Unresolved Risk	5
Grand Total	**9**

DFS Part 2	3
DFS Contact with DOJ	1
Employee Performance	1
Medical Exam	1
Grand Total	**3**

Caseloads	5
DFS Caseloads	5
Grand Total	**5**
TOTAL FINDINGS	**27**

FINALS

Legal	2
Court Hearings	2
Grand Total	**2**

DFS Part 1	1
Unresolved Risk	1
Grand Total	**1** *

DFS Part 2	1
Coordination of Care	1
Grand Total	**1** *
TOTAL FINDINGS	**4**

**These two findings relate to a case from 2014.*

Office of the Child Advocate
900 King Street, Ste 210
Wilmington, DE 19801

Prepared 08/05/2016

Child Abuse and Neglect Panel
Findings Detail and Rationale
8-10-16

INITIALS

System Area 2	Finding	PUBLIC Rationale	Count of #
LE and MDT			4
	Crime Scene		1
		No scene investigation was completed by the law enforcement agency. As a result, the water temperature was not checked.	1
	Documentation		1
		Investigative procedures followed by the law enforcement agency were not recorded in the police report.	1
	Interviews		1
		Forensic interview did not occur with the young child who was present in the home at the time of the near death despite his disclosure of being hit by the mother's paramour with a closed fist.	1
	LE Contact with DOJ		1
		The law enforcement agency did not complete an intake with the Department of Justice for the first incident involving suspicion of inflicted injury to an infant.	1
Grand Total			**4**
Medical			6
	Documentation		1
		Staff at the initial treating hospital did not document in the medical record that a call was made to the DFS Report Line for the near death incident.	1
	Failure to Report		2
		Staff at the secondary treating hospital documented that a report was made to DFS but no hotline report was identified by DFS for the near death incident.	1
		Staff at the initial treating hospital did not consider abuse as a potential mechanism for injury and no call was made to the Report Line.	1
	Standard of Care		2
		Child was high risk as a result of the injury and was not recommended by the PCP to be seen more frequently for increased medical supervision. At the follow up visit, the PCP requested to see the child in a couple months.	1
		There was no PCP contact with the child or family until almost two months of life. Child was only seen after an inpatient stay and an intervention by DFS.	1
	Transport		1
		Despite suspected abuse, it is unknown as to whether the PCP allowed the mother to transport the child to the emergency department or sought alternative transportation.	1
Grand Total			**6**
Caseloads			5
	DFS Caseloads		5
		The caseworkers were almost double the investigation caseload statutory standard the entire time the case was open.	1
		The caseworker was over the investigation caseload statutory standards the entire time the case was open.	1
		The caseworker was significantly over the investigation caseload statutory standards the entire time the case was open.	2
		The caseworker was over the investigation caseload statutory standard the entire time the case was open.	1
Grand Total			**5**

Child Abuse and Neglect Panel

Findings Detail and Rationale

8-10-16

System Area 2	Finding	PUBLIC Rationale	Count of #
DFS Part 1			9
	Safety Plan		4
		The safety agreement, implemented after the first suspected abuse incident, did not specify the adult who would supervise contact between the child and mother's paramour.	1
		For the near death incident, the DFS safety agreement was insufficient to protect the child. It did not specify the measures being taken to keep the child safe while in the hospital, including supervised contact between the victim and suspects.	1
		A DFS safety agreement was not completed by the after-hours worker since one child was hospitalized and the other was with the non-offending parent.	1
		DFS authorized the treating hospital to discharge the child to the mother despite unexplained serious physical injuries to a young child, mother being identified as a suspect, and an ongoing criminal investigation.	1
	Unresolved Risk		5
		Despite suspicions by medical staff that the infant sustained an inflicted injury, the caseworker had no contact with family in 2 months although there was one attempted home visit with the family within 30 days.	1
		A home visiting referral was not made by the caseworker after the first incident despite concerns about the mother and her paramour's parenting abilities.	1
		The caseworker did not corroborate mother's statement that she completed parenting classes after noting parenting deficiencies for mother.	1
		The DFS history search did not immediately identify that the suspect in this case was involved as a suspect in an earlier investigation. As a result, the suspect was permitted access to the child and DFS did not immediately seek custody.	1
		The DFS supervisor overrode the hotline report to screen it out. There was no investigation into the allegations of medical neglect, including follow up to make sure child was seen by PCP. No history on the father was documented.	1
Grand Total			**9**
DFS Part 2			3
	DFS Contact with DOJ		1
		DFS did not immediately file for custody upon receiving a report of serious physical injuries to a young child victim, who medical providers confirmed was a victim of child physical abuse.	1
	Employee Performance		1
		The caseworker concluded the injury may have been caused by the child even after medical experts concluded that it was improbable. This decision may have impacted the caseworker's decisions regarding the child's safety.	1
	Medical Exam		1
		The young non-victim was not medically evaluated despite the serious physical injuries to a young child victim.	1
Grand Total			**3**
TOTAL FINDINGS			**27**

FINALS

System Area 2	Finding	PUBLIC Rationale	Count of #
Legal - Finals			2
	Court Hearings		2
		The plea deal was inappropriate given the history of strangulation reported by the child and the diagnosis of neck and back pain by the children's hospital.	1
		The sentence was not appropriate for the offenses pled to by the defendant.	1
Grand Total			**2**
DFS Part 1 - Finals			1
	Unresolved Risk		1
		Mother was permitted to remove the child from a psychiatric treatment center prior to establishing a transition plan for him to move out of state.	1
Grand Total			**1**
DFS Part 2 - Finals			1
	Coordination of Care		1
		Communication did not occur between DSCYF sister divisions regarding the shared client and the seriousness of his mental health issues and the need for ongoing treatment. PBH was also not present at the hearing.	1
Grand Total			**1**

TOTAL FINDINGS **4**

STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
C/O OFFICE OF THE CHILD ADVOCATE
900 KING STREET, SUITE 210
WILMINGTON, DELAWARE 19801
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GINGER L. WARD
CHAIR

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

November 9, 2016

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

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

Dear Governor Markell:

The Child Protection Accountability Commission ("CPAC") is responsible for the reviews of child deaths and near deaths due to abuse or neglect. As required by law, CPAC approved findings from 15 cases at its November 9, 2016 meeting.[1] Seven of the cases have completed prosecution and were a final review that resulted in 15 findings primarily related to the criminal outcome. The eight remaining cases were from deaths or near deaths that occurred between March 2016 and June 2016. These resulted in 58 findings across system areas. The themes from the recent cases continue to be the law enforcement and MDT response for criminally investigating child abuse cases, the medical responses to these children pre and post incident, and the use of safety plans, unresolved risk and risk assessment by the Division of Family Services. In every recent case, the DFS investigation worker was significantly over the statutory caseload standard.

CPAC held a retreat with the Child Death Review Commission in September 2016. During this retreat, findings from January 2015 through May 2016 death and near death incidents were reviewed. An action plan was developed which is attached to

[1] 16 Del. C. § 932.

this letter. CPAC is hopeful that the steps reflected in the action plan will address the system breakdowns that are contributing to child deaths and near deaths due to abuse or neglect in Delaware.

We are available should further information be required. For your information we have included the findings and the details behind all of the cases presented in this letter.

Respectfully,

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

Enclosures
cc: CPAC Commissioners
General Assembly

Child Abuse and Neglect Panel

Findings Summary

11-9-16

INITIALS	
Legal	**5**
Court Hearings/ Process	4
DFS Contact with DOJ	1
MDT Response/ Criminal Investigations	**16**
Crime Scene	2
Doll Re-enactment	1
General - Criminal Investigation	3
Interviews - Adult	2
Interviews - Child	4
Medical Exam	4
Medical	**13**
Home Visiting Programs	4
Medical Exam/ Standard of Care - CARE	3
Medical Exam/ Standard of Care - ED	1
Medical Exam/ Standard of Care - PCP	2
Medical Exam/ Standard of Care - Urgent Care	1
Reporting	1
Transport	1
Risk Assessment/ Caseloads	**11**
Caseloads	7
Reporting	1
Risk Assessment - Abridged	1
Risk Assessment - Tools	1
Risk Assessment - Unsubstantiated	1
Safety/Use of History/Supervisory Oversight	**6**
Completed Incorrectly/Late	4
No Safety Assessment of Non-Victims	2
Unresolved Risk	**7**
Child - Medical	3
Child - Mental Health	1
Contacts	3
Grand Total	**58**

FINALS	
MDT Response/ Criminal Investigations	**13**
General - Criminal Investigation	6
Medical Exam	2
Prosecution/ Pleas/Sentence	5
Medical	**2**
Medical Exam/ Standard of Care - Forensics	1
Transport	1
Grand Total	**15** *

**6 findings relate to a case from 2012.*

TOTAL FINDINGS **73**

Office of the Child Advocate
900 King Street, Ste 210
Wilmington, DE 19801

Prepared 10/20/2016

Child Abuse and Neglect Panel

Findings Detail and Rationale

11-9-16

INITIALS

System Area	Finding	PUBLIC Rationale	Sum of #
Legal			5
	Court Hearings/ Process		4
		The Adjudicatory Hearing was not held in compliance with Family Court Rule 215(a), which requires an Adjudicatory Hearing to be held within 30 days of a Preliminary Protective Hearing.	2
		The Court denied the first emergency ex parte order, and as a result, a custody order was not in place to provide safety or protection to the mother and injured child.	1
		The Court's requirement for the completion of parent education prior to judicial scheduling was a barrier in this case. While the non-offending parent was temporarily awarded sole legal custody of the victim with primary residential placement, the case would not be assigned to a judge without completion of a parenting class by the non-offending parent.	1
	DFS Contact with DOJ		1
		DFS delayed seeking custody of the youngest sibling, who was also a victim of abuse. The child continued to reside in the home with the suspects including the child's father, who has a history of domestic violence and inappropriate discipline with the three children.	1
MDT Response/ Criminal Investigations			16
	Crime Scene		2
		No scene investigation was completed by the initial responding law enforcement agency.	1
		No scene investigation was completed by the law enforcement agency.	1
	Doll Re-enactment		1
		No doll re-enactment was completed by the law enforcement agency, despite a confession being obtained from the suspect.	1
	General - Criminal Investigation		3
		After DFS attempted to report the near death incident to the law enforcement agency, the case worker is told to call back after the weekend.	1
		The case worker called the suspects initially and asked incident based and leading questions. This contact occurred prior to the police response.	1
		The report to the law enforcement agency was delayed nearly 2 weeks for the near death incident, potentially impacting the criminal investigation.	1
	Interviews - Adult		2

		During the initial contact, DFS conducted interviews with the suspects without the law enforcement agency present, potentially impacting the criminal investigation.	1
		Multiple adult household members were known in the first investigation, and the supervisor waived the interviews without determining whether the adults had caregiving responsibilities for the children.	1
	Interviews - Child		4
		Forensic interview did not occur with the two young children who were present in the home at the time of the near death.	1
		Forensic interview did not occur with the young child who was present in the home at the time of the near death.	1
		Multiple interviews occurred before the children received forensic interviews.	1
		There was a delay in scheduling the forensic interview with the young sibling, and the child was interviewed multiple times.	1
	Medical Exam		4
		Despite the near death incident involving the young child, the siblings were not medically evaluated.	1
		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.	1
		The young sibling was not medically evaluated.	1
		The youngest sibling sustained extensive bruising and linear abrasions to the face and back, which were likely non-accidental trauma. DFS and LE did not obtain the diagnosis for this child, and as a result, the child remained in the home with a safety plan.	1
Medical			13
	Home Visiting Programs		4
		Home Visiting Services were not in place at the time of the near death incident or post incident.	3
		Home Visiting Services were not in place prior to the near death incident or post incident.	1
	Medical Exam/ Standard of Care - CARE		3
		The CARE Team was not consulted during the child's inpatient stay despite concerns of neglect.	1
		The child was discharged without a full CARE team assessment and evaluation.	1
		There was a delay in diagnosis, secondary to a three-week time gap between the need for a diagnostic exam and completion of the diagnostic exam. The skeletal survey on the first admission identified concerns with the spine, which was later confirmed as consistent with abuse.	1
	Medical Exam/ Standard of Care - ED		1

		There was no documentation to identify that the family received education on how to receive dental care hygiene and primary care management.	1
	Medical Exam/ Standard of Care - PCP		2
		During the year that the child did not attend the practice, there was no record of outreach with the family by the PCP for primary care.	1
		In the presence of vomiting without a fever and unexplained bruising to an infant, the assessment by the PCP did not lead to an explored differential diagnosis of suspected abuse. This visit to the PCP occurred 4 days prior to the near death incident.	1
	Medical Exam/ Standard of Care - Urgent Care		1
		Concern for possible inflicted injury was not documented as a consideration in the medical report by the urgent care facility. However, the child was sent for x-rays to the children's hospital.	1
	Reporting		1
		Staff at the hospital did not alert the police to the near death incident.	1
	Transport		1
		Despite suspected head trauma with no mechanism of injury, the PCP allowed the mother to transport the child to the emergency department.	1
Risk Assessment/ Caseloads			11
	Caseloads		7
		The DFS case worker was over the investigation caseload statutory standards the entire time the case was open.	4
		The DFS case workers were over the investigation and treatment caseload statutory standards while the cases were open.	3
	Reporting		1
		Caregiver reported sexualized language by the child, and the case worker did not contact the DFS Report Line regarding secondary allegations of abuse or obtain additional information.	1
	Risk Assessment - Abridged		1
		Child and sibling became dependent after the mother's sudden death, and DFS abridged the investigation without a guardianship order in place.	1
	Risk Assessment - Tools		1

		The near death incident was not assigned to the DFS Serious Injury Unit, and the case was mishandled by the assigned worker and initial supervisor.	1
	Risk Assessment - Unsubstantiated		1
		Despite the near death incident, DFS was unable to make a finding that abuse occurred at the conclusion of its investigation because the perpetrator was unknown. The case was unsubstantiated with concern.	1
Safety/Use of History/Supervisory Oversight			6
	Completed Incorrectly/Late		4
		A DFS safety agreement was not completed by the after-hours worker despite serious nonaccidental injuries to a young child. Therefore, there were no measures being taken to keep the child safe while in the hospital, including supervised contact between the victim and suspects.	1
		For the near death incident, the DFS safety agreement was insufficient to protect the child. Relatives agreed to monitor contact between the young child with serious physical injuries and the suspects through visits or phone calls.	1
		No safety agreement was implemented after the first report of abuse was received by DFS. Child presented with injuries, and children disclosed abuse of all 3 children by the youngest sibling's father.	1
		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.	1
	No Safety Assessment of Non-Victims		2
		Despite the serious physical injuries to a young child, there was a delay in assessing the safety of the young sibling. The child was seen several days after the initial contact with the victim. Reassignment to another supervisor prompted the contact.	1
		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.	1
Unresolved Risk			7
	Child - Medical		3
		Guardianship was never established for the children, and medical care and mental health services were not provided as a result. Children were dependent and exhibiting significant mental health issues; mother was deceased and father's whereabouts were unknown.	1
		Parents were not referred to Child Development Watch for services for fine motor and weight gain as per the discharge instructions.	1

		Prior to case closure, DFS did not contact the PCP to verify that the family followed up with recommended services post discharge.	1
	Child - Mental Health		1
		Despite accumulation of risk due to DFS history, allegations of abuse/dependency, and children with significant mental health issues, services were never provided to children prior to the near death incident.	1
	Contacts		3
		During a subsequent investigation, the initial contact with the family was delayed, no collaterals were completed, the youngest sibling and other household members were not seen, and the child and sibling were not referred to mental health services.	1
		The half sibling was not interviewed or observed by the case worker. The child primarily resided in another residence, but was present in the home at the time of the near death incident.	1
		The treatment worker's first contact with the family was delayed, and the near death incident was reported several days later.	1
Grand Total			**58**

FINALS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response/ Criminal Investigations			13
	General - Criminal Investigation		**6**
		No criminal investigation was completed by the law enforcement agency for the first incident of alleged abuse.	1
		Photographs of the child's injuries were not taken by the law enforcement agency.	1
		The first two investigations were classified incorrectly by the law enforcement agency. The cases were classified as either a miscellaneous investigation or an assist other agency.	1
		The law enforcement agency did not consult with the child abuse medical expert or obtain the conclusions from the doctor's medical exam.	1
		The local law enforcement agency's limited resources and training impacted the criminal investigation.	1
		The medical examiner's investigative report was not considered in determining the cause and manner of death.	1
	Medical Exam		**2**
		The law enforcement agency concluded that the injury was accidental despite the conclusions from the medical professionals.	1

		While the child abuse medical expert identified that the victim was physically abused, the case was cleared as no crime by the law enforcement agency.	1
	Prosecution/ Pleas/Sentence		**5**
		DOJ did not initially review the medical records during its intake, and as a result, DOJ was not aware of the child abuse medical expert's conclusions.	1
		Father was charged with the crime of child abuse, which is a non-violent felony, and is not punishable in the same manner as assault.	1
		The defendant was charged with Child Abuse in the first degree, but pled guilty to Assault in the second degree. The felony classification for Assault in the second degree (Class D Felony - violent) carries a higher penalty then the felony classification for Child Abuse in the second degree (Class G Felony - nonviolent). As a result, assault is used more frequently for crimes against children.	1
		The felony classification for Child Abuse in the second degree (Class G Felony - nonviolent) carries less severe penalties. As a result, the defendant was sentenced to less than 2 months at Level V. However, the presumptive sentence for this crime is up to 12 months at Level II, and the sentence was above the presumptive sentence.	1
		The plea deal was not appropriate. The defendant pled guilty to Endangering the Welfare of a Child (Class G Felony - nonviolent) for inflicting injuries to a young child that included a skull fracture and subdural hematoma and was appropriately sentenced to 1 year at Level V. The presumptive sentence is up to 12 months at Level II, and the sentence was above the presumptive sentence.	1
Medical			2
	Medical Exam/ Standard of Care - Forensics		1
		A forensic consult did not occur during the emergency department visit.	1
	Transport		1
		Despite the 3rd incident of unexplained injuries to a young child, the PCP allowed the child to return home and did not send child to the hospital emergency department with alternative transportation.	1
Grand Total			**15**

TOTAL FINDINGS **73**

STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
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GINGER L. WARD
CHAIR

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

February 8, 2017

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

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

Dear Governor Carney:

As one of its many statutory duties, the Child Protection Accountability Commission ("CPAC") is responsible for the review of child deaths and near deaths due to abuse or neglect. As required by law, CPAC approved findings from 12 cases at its February 8, 2017 meeting.[1]

Five of the cases have completed prosecution, or prosecution was declined. The final reviews resulted in 6 findings primarily related to the criminal outcome. These findings include inadequate sentences for child abuse crimes together with multidisciplinary partners not reporting cases to the child abuse hotline. Three strengths were also identified in these cases -- all related to the significant positive impact the leadership of the Department of Justice Special Victims Unit is having on criminal prosecutions in these most challenging child abuse cases.

The seven remaining cases were from deaths or near deaths that occurred between June 2016 and August 2016. These resulted in 41 strengths and 50 findings across system areas. The strengths demonstrate significant improvement in criminal

[1] 16 Del. C. § 932.

investigations and medical interventions. There is also some progress in the Division of Family Services' ("DFS") response. However, there is still much room for improvement. The system breakdowns and findings from the June through August 2016 cases continue to be the law enforcement and MDT response for criminally investigating child abuse cases, the medical responses to these children pre and post incident, and the use of safety plans, unresolved risk and risk assessment by DFS. In six out of the seven cases, the DFS investigation worker was significantly over the statutory caseload standard, and in every case safety agreements with the family were completed late or incorrectly.

CPAC held a retreat with the Child Death Review Commission in September 2016 which reviewed approximately 300 prior findings from child abuse death and near death reviews. An action plan was developed which is attached to this letter together with updated progress. CPAC is hopeful that the steps reflected in the action plan will address the system breakdowns that are contributing to child deaths and near deaths due to abuse or neglect in Delaware. CPAC is also hopeful that the 27 additional frontline positions at DFS will shortly begin to have a positive impact on caseloads and the ability to utilize safety agreements as well as to assess and resolve risk to children.

We are available should further information be required. For your information we have included the strengths, findings and the details behind all of the cases presented in this letter.

Respectfully,

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

Enclosures
cc: CPAC Commissioners
General Assembly

Child Abuse and Neglect Panel

Strengths Summary

2-8-17

INITIALS	
MDT Response	**17**
Crime Scene	3
Documentation	2
General Criminal Investigation	4
General DFS Investigation	5
Interviews - Child	1
Medical Exam	1
Prosecution/Pleas/Sentence	1
Medical	**13**
Home Visiting Programs	1
Medical Exam/Standard of Care - CARE	1
Medical Exam/Standard of Care - ED	6
Medical Exam/Standard of Care - EMS	1
Medical Exam/Standard of Care - Forensics	2
Medical Exam/Standard of Care - ME	1
Medical Exam/Standard of Care - PCP	1
Risk Assessment/ Caseloads	**4**
Caseloads	1
Collaterals	2
Risk Assessment - Tools	1
Safety/ Use of History/ Supervisory Oversight	**4**
Completed Correctly/On Time	2
Safety Assessment of Non-Victims	1
Supervisory Oversight	1
Unresolved Risk	**3**
Home Visiting Programs	1
Mental Health	1
Substance Abuse	1
Grand Total	**41**

FINALS	
MDT Response	**3**
Prosecution/Pleas/Sentence	3
Grand Total	**3**

TOTAL FINDINGS **44**

Office of the Child Advocate
900 King Street, Ste 210
Wilmington, DE 19801

Child Abuse and Neglect Panel

Strengths Detail and Rationale

2-8-17

INITIALS

System Area	Strength	Rationale	Count of #
MDT Response			17
	Crime Scene		3
		Thorough scene investigation was completed by the law enforcement agency.	2
		Excellent scene investigation by law enforcement to include photographs, evidence collection, measurements and weight of the chair reportedly used by the young child.	1
	Documentation		2
		The DFS caseworker thoroughly documented the case events.	2
	General Criminal Investigation		4
		Excellent MDT response and collaboration between the DFS caseworker and law enforcement.	2
		Great MDT response to the case to include medical evaluations of the siblings, forensic interview, and communication with DFS.	1
		The child's primary care physician was interviewed by the detective assigned to the case.	1
	General DFS Investigation		5
		A framework was completed during the investigation, which recommended transferring the case to treatment.	1
		DFS caseworker delayed interviews with the family until law enforcement gave clearance to do so.	1
		The DFS caseworker completed the initial response rather than requesting a response by the second-shift.	1
		The DFS caseworker made a finding against both parents at the conclusion of the investigation.	2
	Interviews - Child		1
		Forensic interview was scheduled for the young sibling and three attempts were made by law enforcement.	1
	Medical Exam		1
		The DFS caseworker ensured that a medical evaluation was completed for the young sibling.	1
	Prosecution/ Pleas/Sentence		1
		Both parents were criminally charged.	1
Medical			13
	Home Visiting Programs		1
		Home visiting services were offered to the mother at the birth of the child. Although the mother refused services, the reasoning for refusal was documented within the medical record.	1

	Medical Exam/ Standard of Care - CARE		1
		With the level of care being provided to the child, the CARE Team was consulted per protocol and a diagnosis of Child Physical Abuse given due to the degree of the child's injuries and the parents' delay in seeking medical treatment.	1
	Medical Exam/ Standard of Care - ED		6
		Life-saving efforts continued for the child until medical staff was confident that the family understood the child's condition.	1
		The child was transported from the local hospital emergency department to the children's hospital via ambulance rather than family transport.	1
		The medical staff enforced the no visitation order to protect the child and to not compromise the care of the child.	1
		The child remained hospitalized one additional night to allow for foster care placement.	1
		The initial treating hospital covered all aspects of medical treatment by not only following the clinical pathway of treatment for the child, but medically treated for differential diagnoses as well.	1
		The children's hospital ran tests to get a complete picture of the child's condition and needs.	1
	Medical Exam/ Standard of Care - EMS		1
		The emergency medical services (EMS) documented the position of the infant on the bed, to include exact positioning of the neck and airway.	1
	Medical Exam/ Standard of Care - Forensics		2
		Although a forensic evaluation was conducted at the initial treating hospital, a second forensic evaluation, to include photographic evidence, was conducted at the children's hospital.	1
		Medical evaluation of the siblings, and results thereof, were documented within the child's medical records.	1
	Medical Exam/ Standard of Care - ME		1
		The medical examiner contacted the primary care physician to inform him/her of the infant's death.	1
	Medical Exam/ Standard of Care - PCP		1

		The primary care physician maintained contact with the medical staff throughout the child's hospitalization, and discussed ongoing medical care of the child.	1
Risk Assessment/ Caseloads			4
	Caseloads		1
		Excellent work by the DFS caseworker despite being over the caseload statutory standards. Investigation included medical evaluation of the sibling, safety agreements with relatives, and thorough background checks and home assessments completed prior to sibling's placement.	1
	Collaterals		2
		DFS caseworker consulted with the child abuse medical expert to obtain the child's medical findings.	1
		DFS caseworker provided her contact information to a relative in the home and asked her to contact the caseworker if there was anything she needed to discuss outside of mother's presence.	1
	Risk Assessment - Tools		1
		Thorough investigation by the DFS caseworker, to include a Team Decision Making (TDM) meeting and referral to Child Development Watch.	1
Safety/ Use of History/ Supervisory Oversight			4
	Completed Correctly/On Time		2
		The DFS caseworker routinely re-evaluated the safety agreement, which remained in place.	2
	Safety Assessment of Non-Victims		1
		The DFS caseworker contacted the guardians of the father's older children to ensure he had no unsupervised contact.	1
	Supervisory Oversight		1
		Group supervision was utilized in treatment case, which recommended exploring permanency options with relatives and making a referral to the domestic violence liaison.	1
Unresolved Risk			3
	Home Visiting Programs		1
		A referral for Child Development Watch was made for the child.	1
	Mental Health		1
		Referrals were made for mental health evaluations for parents.	1

	Substance Abuse		1
		The DFS treatment caseworker referred the mother to the substance abuse liaison.	1
Grand Total			**41**

FINALS

System Area	Strength	Rationale	Count of #
MDT Response			3
	Prosecution/ Pleas/Sentence		3
		As a result of this case, the Special Victim's Unit within DOJ was created.	1
		Reassignment of the case to an experienced prosecutor was effective in bringing this case to trial.	1
		Review by the Director of the Special Victim's Unit allowed for criminal charges to be filed.	1
Grand Total			**3**

TOTAL FINDINGS **44**

Child Abuse and Neglect Panel

Findings Summary

2-8-17

INITIALS	
Legal	**1**
DFS Contact with DOJ	1
MDT Response	**7**
Crime Scene	1
Doll Re-enactment	1
Interviews - Adult	1
Medical Exam	3
Prosecution/ Pleas/ Sentence	1
Medical	**11**
Home Visiting Programs	4
Medical Exam/ Standard of Care - CARE	1
Medical Exam/ Standard of Care - ED	1
Medical Exam/ Standard of Care - PCP	1
Reporting	2
Substance-Exposed Infant	2
Risk Assessment/ Caseloads	**12**
Caseloads	6
Collaterals	2
Documentation	1
Risk Assessment - Closed Despite Risk Level	1
Risk Assessment - Screen Out	1
Risk Assessment - Tools	1
Safety/ Use of History/ Supervisory Oversight	**12**
Inappropriate Parent/ Relative Component	2
Oversight of Agreement	1
Supervisory Oversight	1
Use of History	1
Completed Incorrectly/ Late	7
Unresolved Risk	**7**
Contacts	1
Substance-Exposed Infant	2
Substance Abuse and Mental Health	1
Substance Abuse	2
Legal Guardian	1
Grand Total	**50**

FINALS	
Legal	**1**
Court Hearings/ Process	1
MDT Response	**4**
General - Criminal Investigation	1
Medical Exam	1
Prosecution/ Pleas/ Sentence	2
Medical	**1**
Reporting	1
Grand Total	**6**

TOTAL FINDINGS **56**

Office of the Child Advocate
900 King Street, Ste 210
Wilmington, DE 19801

Prepared 01/26/2017

Child Abuse and Neglect Panel

Findings Detail and Rationale

2-8-17

INITIALS

System Area	Finding	PUBLIC Rationale	Sum of #
Legal			1
	DFS Contact with DOJ		1
		DFS did not consult with the Civil DAG to determine whether or not custody should be sought for a young child with serious physical injuries and no history of trauma provided by the parents.	1
MDT Response			7
	Crime Scene		1
		No scene investigation was completed by the law enforcement agency.	1
	Doll Re-enactment		1
		No doll re-enactment was completed by the law enforcement agency.	1
	Interviews - Adult		1
		DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	1
	Medical Exam		3
		The young sibling was not medically evaluated.	1
		DFS did not immediately seek a medical exam for the sibling when the caseworker responded to the incident involving the burn.	1
		The Office of the Investigation Coordinator did not remind the MDT to seek a medical evaluation for the sibling.	1
	Prosecution/ Pleas/ Sentence		1
		Father's original charges were Nolle Prossed, and he was reindicted on misdemeanors. No communication occurred between DOJ and the law enforcement agency prior to this decision.	1
Medical			11
	Home Visiting Programs		4
		Home Visiting Services were not in place at the time of the near death incident or post incident.	3
		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.	1
	Medical Exam/ Standard of Care - CARE		1
		The child was not initially medically evaluated by a child abuse medical expert, because one was not available and a network of medical providers does not exist in Delaware.	1
	Medical Exam/ Standard of Care - ED		1
		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.	1

	Medical Exam/ Standard of Care - PCP		1
		During a well visit, the PCP did not consider a differential diagnosis of abuse despite the rapid increase in the child's head circumference and decrease in weight. The PCP also recommended follow up in 2 months, but the child was hospitalized for the near death incident a week after the PCP visit.	1
	Reporting		2
		PCP sent the child to the emergency department for concerns of neglect, but no report was made to the DFS Child and Neglect Report Line.	1
		A new hotline report was not made by the hospital after x-rays revealed the sibling also had multiple, healing fractures.	1
	Substance-Exposed Infant		2
		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.	1
		No plan of safe care was completed for the infant despite the positive drug screen at birth.	1
Risk Assessment/ Caseloads			12
	Caseloads		6
		The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open. However, the caseload did not negatively impact the DFS response in the near death investigation.	1
		The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open. However, the caseload did not negatively impact the DFS response in the near death investigation.	1
		The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.	1
		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. However, the caseload did not negatively impact the DFS response in the death investigation.	1
		The DFS caseworker was over the investigation caseload statutory standards for a portion of time while the case was open. However, the caseload did not negatively impact the DFS response in the death investigation.	1
		The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open. However, the caseload did not negatively impact the DFS response in the death investigation.	1
	Collaterals		2
		In the prior investigation, a collateral contact was not completed with the physician overseeing mother's pain management.	1
		In the prior investigation, a collateral contact was not completed with the PCP for the other children in the home and mother was inconsistent with their medical care.	1
	Documentation		1
		The DFS caseworker did not enter notes from the initial contact for several months. Notes were only entered after a new supervisor was assigned and noted the issue.	1

	Risk Assessment - Closed Despite Risk Level		1
		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.	1
	Risk Assessment - Screen Out		1
		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.	1
	Risk Assessment - Tools		1
		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.	1
Safety/ Use of History/ Supervisory Oversight			12
	Inappropriate Parent/ Relative Component		2
		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.	1
		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.	1
	Oversight of Agreement		1
		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.	1
	Supervisory Oversight		1
		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.	1
	Use of History		1
		In the prior investigation, history was not considered in overriding the SDM Risk Assessment to close the case and the case worker's justification did not indicate how history was factored into the decision to close. There were other prior investigations involving substance abuse concerns, a child placed outside of the home, and an unexplained burn.	1

	Completed Incorrectly/ Late		7
		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.	1
		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.	1
		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.	1
		Throughout the investigation, DFS entered into several safety agreements with multiple caregivers. The agreements were ineffective in ensuring the child(ren)'s safety.	1
		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.	1
		The DFS safety agreement did not restrict contact between the victim and potential suspects while the child was hospitalized.	1
		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.	1
Unresolved Risk			7
	Contacts		1
		Following the near death incident, the treatment worker's first contact with the family was delayed.	1
	Substance-Exposed Infant		2
		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.	1
		No plan of safe care was completed for the infant despite the positive drug screen at birth.	1
	Substance Abuse and Mental Health		1
		Although it was documented throughout the investigation that mother had substance abuse and mental health issues, there was no documentation to support such referrals were made for the mother and that the mother complied with such. No petition to compel was filed by DFS nor was a safety agreement considered.	1
	Substance Abuse		2
		In the prior investigation, DFS did not utilize the substance abuse liaison to assess mother for substance abuse when father disclosed current substance abuse and resided in the same home. It was later revealed that mother was in a substance abuse program during this investigation.	1

		In the prior investigation, DFS did not utilize the substance abuse liaison or refer the mother to complete a substance abuse and/or mental health evaluation. Mother was using drugs and had a significant mental health and trauma history.	1
	Legal Guardian		1
		A legal guardian was not established for the sibling following the death incident, and parental risk factors and safety concerns prevented the child from returning home. As a result, the child was placed with multiple caregivers.	1
Grand Total			**50**

FINALS

System Area	Finding	PUBLIC Rationale	Sum of #
Legal			1
	Court Hearings/ Process		1
		Mother filed a petition for guardianship of a relative's young child, and DFS did not include the mother's history in a court report filed. As a result, the mother was awarded visitation.	1
Medical			1
	Reporting		1
		Staff at the initial treating hospital did not make a report to the DFS Child and Neglect Report Line for the death incident.	1
MDT Response			4
	General - Criminal Investigation		1
		The Law Enforcement Agency did not make a report to DFS Child and Neglect Report Line for the death incident.	1
	Medical Exam		1
		The medical evaluations for the other children in the home at the time of the death incident were delayed.	1
	Prosecution/ Pleas/ Sentence		2
		There is not a negligent mens rea for child abuse or a statute to address those who enable child abuse, which impacted the prosecution. The defendant was charged with Murder by Abuse or Neglect and found guilty of Criminally Negligent Homicide.	1
		A sentence of 18 months probation was inadequate given that the defendant criminally negligently caused the death of this young child. The presumptive sentence is up to 2 years at Level V and the statutory maximum is 8 years. There is no enhanced penalty for Criminally Negligent Homicide when the offense is committed against a child.	1
Grand Total			**6**

TOTAL FINDINGS **56**

Child Protection Accountability Commission & Child Death Review Commission

2016-2017 Action Plan

Summary of Action Plan: These findings stem from the review of 41 child abuse and neglect death and near death cases for incidents that occurred between January 2015 and May 2016. The result was 303 findings across 6 system areas. 31 recommendations for system improvement are below. The recommendations will be explored by CPAC and its partner agencies.

System Area 1: Legal	**CAN Panel Findings:** Court Hearings/DFS Contact with DOJ	**# of Findings:** 26	**02/08/17 Status**
Recommendations: 1. Schedule regular meetings between DFS leadership, DOJ Family Division Deputies, and DOJ Special Victims Unit Deputies to foster relationships and to encourage discussion and problem solving. **Agency Responsible**: DFS/DOJ; **Timeframe**: 3-6 months 2. Schedule DOJ Family Division Deputies to be available or on-call to DFS after hours and on weekends, to provide legal advice regarding serious injury and death or emergency cases. **Agency Responsible**: DOJ/DFS; **Timeframe**: Immediately 3. Provide training to DFS by the DOJ Family Division. In addition to CORE 101 training, DOJ will regularly conduct refresher training for DFS, which will be offered statewide. The training will include the DOJ services available to DFS, circumstances under which DFS should seek legal advice and resources available to compel cooperation of families. The training will also be made available on the DSCYF online learning system. **Agency Responsible**: DOJ/DFS; **Timeframe**: 6-18 months ***Repeat recommendation from 2015 Action Plan*** 4. Add the DOJ Family Division and the Family Court to the Investigation Coordinator's contact list for notification of child abuse and neglect serious injury and death referrals. **Agency Responsible**: IC; **Timeframe**: Immediately 5. Develop a MDT protocol for removal of life support cases. **Agency Responsible**: DOJ/OCA/Family Court; **Timeframe**: 6-12 months 6. Require litigants to disclose DFS history on Family Court Form 16 (b), so that the Court may have DFS workers available at custody proceedings or mediators can refer at-risk cases to judges. **Agency Responsible**: Family Court; **Timeframe**: 6-12 months 7. Remain cognizant of Family Court hearing timeframes in complex child abuse cases. **Agency Responsible**: Family Court; **Timeframe**: Immediately		**CPAC/CDRC Approval Date(s):** 11/9/16; 11/18/16	1. **In Progress** Quarterly meetings being scheduled for 2017 2. **In Progress** Will be discussed at DOJ/DFS quarterly meetings. 3. **In Progress** Will be discussed at DOJ/DFS quarterly meetings and scheduled for 2018. 4. **DONE** 5. **In Progress** Training Committee has created a workgroup to develop protocol. 6. **In Progress** Family Court has approved; out for comment with Bar; will require a Rule change. 7. **DONE**

System Area 2: Medical	**CAN Panel Findings:** Home Visiting Services, Medical Exam/Standard of Care – CARE, Medical Exam/Standard of Care – ED, Medical Exam/Standard of Care – Films, Medical Exam/Standard of Care – Forensics, Medical Exam/Standard of Care – PCP, Medical Exam/Standard of Care – Undress, Reporting, Substance-Exposed Infant, Transport	**# of Findings:** 61	**02/08/17 Status**
Recommendations: 1. Incorporate into the mandatory reporting training, *Child Abuse Identification and Reporting Guidelines for Delaware Medical Providers*, the following: a. Transportation of abused children from PCP to hospital for forensic exam; b. Medical exam on all other children in the home under the age of six when a sibling presents with signs of abuse; and, c. Emergency department staff will consult the hospital forensic team and request forensic exams in cases of suspected child abuse. **Agency Responsible**: CPAC Training Committee; **Timeframe**: January 2017 2. Consider requiring birthing hospitals to make an evidenced based home visiting program referral for every at-risk newborn at discharge. Train home visiting staff to recognize child abuse risk factors and to report visit findings to the medical provider for the newborn, including the inability to schedule or complete a visit. Healthy Families America/Smart Start serves newborns younger than 3 months (and pregnant women). Other home visiting programs for pregnant women or children under the age of 3 include: Nurse Family Partnership, Parents as Teachers and Early Head Start. **Agency Responsible**: Delaware Home Visiting Community Advisory Board, Delaware Healthy Mother & Infant Consortium; **Timeframe**: 12 months 3. Develop a template for the required Child Abuse Prevention and Treatment Act (CAPTA) plan of safe care and identify the responsible agencies for initiating and monitoring the plan of safe care. **Agency Responsible:** CPAC/CDRC Committee on Substance Exposed Infants/Medically Fragile Children; **Timeframe:** 12 months		**CPAC/CDRC Approval Date(s):** 11/9/16; 11/18/16	1. **DONE** 2. **In Progress** Home Visiting Meeting this month. DHMIC also to consider. 3. **In Progress** SEI Policy Academy and SEI Committee are working on priorities, including legislation and development of plan.

System Area 3: MDT Response/Criminal Investigations	**CAN Panel Findings:** Crime Scene/Documentation, Doll Reenactments, General - Criminal Investigation, Intake with DOJ, Interviews w/Adult, Interviews w/Child, Medical Exam	**# of Findings:** 72	**02/08/17 Status**
Recommendations: 1. Finalize the Memorandum of Understanding (MOU), which will include best practice guidelines for the investigation of child abuse cases involving sexual abuse, serious physical injury or death, and provide training. **Agency Responsible**: CPAC Training Committee; **Timeframe**: April 2017 **Repeat recommendation from the May 2013 Final Report of the Joint Committee on the Investigation and Prosecution of Child Abuse* 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* 3. Consider sharing factual details of the CAN Panel reviews with the police departments so that the agency can explore the mistake and correct a possible breakdown in their agency. **Agency Responsible:** CPAC CAN Steering Committee; **Timeframe:** 6 months 4. 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		**CPAC/CDRC Approval Date(s):** 11/9/16; 11/18/16	1. **DONE** CPAC has approved subject to final edits of signatory agencies. Training in April 2017. 2. **In Progress** DOJ case management system piloted in several units and will soon be available agency-wide. 3. **DONE** Confidentiality prevents CAN Panel from sharing details with non-Commissioner agencies. 4. **In Progress** Presentation to Police Chiefs' Counsel on MOU will include discussion of cameras.

System Area 3: MDT Response/Criminal Investigations	**CAN Panel Findings:** Crime Scene/Documentation, Doll Reenactments, General - Criminal Investigation, Intake with DOJ, Interviews w/Adult, Interviews w/Child, Medical Exam	**# of Findings:** 72	**02/08/17 Status**
5. Create a prioritized list of CPAC funding requests to be submitted to the Joint Finance Committee each fiscal year. Each agency impacted by the requests should identify a representative to answer questions about the request. The current CPAC funding requests to be considered include: a. DOJ Special Victims Unit (SVU): The Unit with statewide jurisdiction will handle all felony level, criminal child abuse cases including those involving serious physical injury, death or sexual abuse of a child. *Prosecutors (2 NCC, 1 KC, 1 SC), a paralegal, and* criminal investigators with expertise in the investigation of child abuse should be established within the Unit. **Variation of a recommendation to staff the SVU appropriately from the May 2013 Final Report of the Joint Committee on the Investigation and Prosecution of Child Abuse* b. CPAC Guidelines for Child Abuse Medical Response: The guidelines require the MDT to seek immediate medical evaluations for children, siblings and other children in the household when specific abuse fact patterns exist. The implementation of these guidelines in April 2017 will increase the need for non-urgent medical evaluations and will require a specialized medical service provider in Kent and Sussex counties. **Agency Responsible:** CPAC; **Timeframe:** February 2017 and annually thereafter 6. 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; f. Creation of an obligation to transport an abused child for a medical exam or forensic evaluation; and, g. Modification of the list of crimes in 16 Del. C. 906 (e)(3) to align with the revised MOU. **Agency Responsible:** CPAC Legislative Committee; **Timeframe:** February 2017 **Some are repeat recommendations from the May 2013 Final Report of the Joint Committee on the Investigation and Prosecution of Child Abuse*		**CPAC/CDRC Approval Date(s):** 11/9/16; 11/18/16	5. **In Progress** Chair and Executive Director have included DOJ SVU, DFS Caseloads, SEI, and the request for no cuts to Commission services. Medical Services need to wait until next year. 6. **In Progress** DOJ child abuse package to be reviewed by Legislative Committee. (f) and (g) are drafted and circulated to CPAC Committees.

System Area 4: Risk Assessment/Caseloads	**CAN Panel Findings:** Caseloads, Collaterals, Communication, Documentation, Reporting, Risk Assessment – Abridged, Risk Assessment – Alternative Response, Risk Assessment – Closed Despite Risk, Risk Assessment – Screen Out, Risk Assessment – Tools, Risk Assessment – Unsubstantiated	**# of Findings:** 52	**02/08/17 Status**
Recommendations: 1. Consider adjusting DFS caseloads based on complexity of the cases to better utilize staff strengths and balance workload. **Agency Responsible:** DFS; **Timeframe:** 9-12 months 2. Provide ongoing training on the SDM Risk Assessment tool to reinforce the policy and ensure consistent application. **Agency Responsible:** DFS; **Timeframe:** Immediately and ongoing 3. Explore the use of differential response for domestic violence, substance exposed infants, and chronic neglect cases accepted by DFS. **Agency Responsible:** DFS; **Timeframe:** 6-12 months 4. Explore options for tiered risk assessments for DFS families. **Agency Responsible:** DFS; **Timeframe:** March 2017 5. Recommend that DFS investigate all reported cases of suspected child abuse or neglect of children less than one year old (in alignment with National standards) to decrease deaths and near deaths of children under one. **Agency Responsible:** DFS; **Timeframe:** 3 years		**CPAC/CDRC Approval Date(s):** 11/9/16; 11/18/16	1. **Deferred** DFS will reconsider after CPAC Caseloads Committee concludes its work. 2. **In Progress** DFS pursuing grant monies with Children Research Center to conduct training in Spring 2017. 3. **Deferred** DFS cannot implement without additional funds. 4. **DONE** DFS already has tiered risk assessments. 5. **In Progress** DFS has taken no action to date.

System Area 5: Safety/Use of History/Supervisory Oversight	**CAN Panel Findings:** Completed Incorrectly/Late, Inappropriate Parent/Relative Component, No Safety Assessment of Non-Victims, Oversight of Agreement, Supervisory Oversight, Use of History, Violations of Safety Agreements	**# of Findings:** 49	**02/08/17 Status**
Recommendations: 1. Use the DFS chronological history event to research information related to the child, family, and family members. **Agency Responsible**: DFS; **Timeframe**: Immediately and ongoing 2. Review CAN Panel findings related to safety assessments and agreements with DFS staff and administration to identify opportunities for ongoing training and education. **Agency Responsible**: DFS; **Timeframe**: Immediately and ongoing 3. 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 4. 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		**CPAC/CDRC Approval Date(s):** 11/9/16; 11/18/16	1. **DONE** DFS added a history event to last case management system update. 2. **DONE** DFS shares findings with various leadership teams and workgroups. 3. **In Progress** Assessment form has been modified and will be incorporated into new case management system. 4. **In Progress** Finding is also in the CFSR PIP. Completion targeted for 2018.	

System Area 6: Unresolved Risk	**CAN Panel Findings:** Child – Medical, Child – Mental Health, Contacts, Domestic Violence, Home Visiting Services, Multigenerational History, Not Utilizing Evidence-Based Tools, Parenting, Substance Abuse, Substance Abuse/Domestic Violence	**# of Findings:** 43	**02/08/17 Status**
Recommendations: 1. Research and consider the implementation of birth match in Delaware to ensure that children at high risk of child abuse and neglect are reported to DFS at birth. **Agency Responsible:** CPAC Legislative Committee; **Timeframe:** April 2017 2. Reconvene the CPAC Caseload/Workloads Committee to review treatment caseloads and state standards. **Agency Responsible:** CPAC; **Timeframe:** 3-6 months 3. 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 4. 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 5. Develop a mechanism that reminds DFS case workers to automatically follow up after referrals or services are requested for children and caregivers. **Agency Responsible:** DFS; **Timeframe:** 12 months 6. Provide treatment services through DFS and community-based providers that is more home-based and family centered as well as provide warm hand-offs from one provider to another. **Agency Responsible:** DFS/Community Service Providers; **Timeframe:** Immediately and ongoing 7. 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		**CPAC/CDRC Approval Date(s):** 11/9/16; 11/18/16	**1. DONE** CPAC supported Legislative Committee recommendation to not pursue as prior TPR is not a strong predictor of subsequent child death in Delaware. **2. In Progress** First meeting is in February 2017. **3. In Progress** DFS will continue to pursue and include IC at the state level meetings. **4. In Progress** DFS pursuing grant monies with Children Research Center to conduct booster training. **5. No Action** DFS will need additional resources/equipment. **6. DONE** **7. In Progress** Meeting being scheduled.

Delaware Multidisciplinary Team Guidelines for Child Abuse Medical Response

Endorsed by the Delaware Child Protection Accountability Commission

August 10, 2016

Acknowledgements

The guidelines and best practices contained herein were developed by the Child Protection Accountability Commission Child Abuse Medical Response Committee to assist Delaware's Multidisciplinary Teams (MDT) in determining when to refer children of alleged sexual and physical abuse and neglect for medical evaluations. This final product is a significant step toward ensuring timely, consistent and comprehensive medical treatment for all child victims of suspected abuse.

Committee Members

A.I. duPont Hospital for Children	Dr. Allan DeJong (Co-Chair)
Children's Advocacy Center	Randy Williams (Co-Chair)
Office of The Child Advocate	Tania Culley/Rosalie Morales
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The Committee wishes to thank and recognize the following individuals for their advice and support as we worked to develop these guidelines:

Ms. Anita Symonds, Christiana Health Care System
Ms. Kathryn Hudson, Nanticoke Health Services
Ms. Dawn Culp, Bayhealth Medical Center
Ms. Cheri Will, Beebe Medical Center
Ms. Eileen Carlin, A.I.duPont Hospital for Children
Dr. Donna Shaffer, CAC Board of Directors
Dr. Karen Farst, MD, MPH University of Arkansas for Medical Sciences
Ms. Kori Stephens, Project Director, Midwest Children's Advocacy Center
Mr. Chris Newlin, Executive Director, National Children's Advocacy Center
Ms. Cym Doggett, Project Director, Southern Regional Children's Advocacy Center

The Committee also wishes to thank the Children's Advocacy Centers of Texas for allowing us to freely adapt their Medical Evaluation Referral Guidelines for use in Delaware.

PURPOSE AND OVERVIEW

Child medical services are a critical piece of the multidisciplinary response to child sexual abuse, physical injury, neglect, torture, and juvenile trafficking. A comprehensive child abuse medical response assesses not only the child's acute medical needs, but also the child's emotional and physical health—enabling a child victim to begin to heal physically and emotionally from his or her trauma. It also provides forensic findings that aid in the civil and criminal investigations of child abuse. Prompt responses to the medical needs are warranted and expected.

The "Child Abuse MDT Medical Response Matrixes", attached hereto, provide "guidelines" for MDT Members in order to ensure that medical services for child abuse victims are provided in a deliberate, timely and holistic manner. Certain "Abuse Fact Patterns" will indicate an "Urgent" or "Immediate" Medical Response where the child should be referred/transported to the nearest hospital for necessary emergency medical services. Other "Abuse Fact Patterns" will indicate that a call to the "designated MDT Medical Services Provider" should be initiated. However, every medical response to every "Abuse Fact Pattern" includes a recommendation that the "designated MDT Medical Services Provider" be contacted, whether as a first step or as a second step as a follow-up to emergency medical services, in order to ensure that the medical needs of all suspected victims of child abuse are evaluated by medical professionals with expertise in child abuse and maltreatment.

IMPORTANT FACTORS FOR CONSIDERATION

- ***A child's denial of sexual abuse when circumstances suggest it may have occurred is much more likely when the child:***
  - *Is a relative or close associate of the suspected perpetrator – someone the child (or family) may wish to protect.*
  - *Bonds with the alleged perpetrator (e.g., child may have low self-esteem/self-confidence, be overly trusting or naïve, or be affection- or approval-seeking).*
  - *Has cause for fear and anxiety due to a history of physical abuse, spousal violence, or significant family dysfunction.*
  - *Has a parent who is non-believing or not supportive of the child's disclosure or other evidence that abuse has occurred (STDs, genital injury). In these cases, the child may give a partial disclosure or recant.*
- ***There is increased risk for partial or incomplete disclosure independent of the type of contact reported by the child when:***
  - *Caregiver does not believe child*
  - *Child is protecting the alleged abuser*
  - *Child is reluctant to talk based upon the forensic interview*

USING THE
"CHILD ABUSE MDT MEDICAL RESPONSE MATRIXES"
To initiate the appropriate "Medical Response"

1.) Identify the type of abuse: **"Sexual"**, "**Serious Physical" "Physical"** or **"Neglect"**

2.) Using the applicable MDT "Medical Response Matrix" ("Sexual", "Serious Physical" "Physical" or "Neglect") for the identified abuse type:
   a.) Identify the "Abuse Fact Pattern" (First Column)
   b.) Initiate the recommended "Medical Response" (Center Column) for the presenting fact pattern within the specified "Time Frame" (Last Column)

MEDICAL PROVIDERS

- **Emergency Services**
  - Bayhealth Medical Center
    - Bayhealth Emergency Center – Smyrna
    - Kent General Hospital – Dover
    - Milford Memorial Hospital – Milford
  - Beebe Healthcare
    - Beebe Medical Center – Lewes
    - Millville Emergency Room – Millville; operated as a summer emergency room due to the influx of tourists
  - Catholic Health East
    - St. Francis Hospital – Wilmington
  - Christiana Care Health System
    - Christiana Hospital – Newark
    - Middletown Emergency Department – Middletown
    - Wilmington Hospital – Wilmington
  - Nanticoke Health Services
    - Nanticoke Memorial Hospital – Seaford
  - Nemours Foundation
    - Alfred I. duPont Hospital for Children – Wilmington
- **SANE Programs (Sexual Assault Nurse Examiner)**
  - Beebe Medical Center
  - Christiana Care Health Systems
  - Bayhealth Medical Center
  - Nanticoke Memorial Hospital
  - Nemours/Alfred I. duPont Hospital for Children
- **Designated MDT Medical Services Provider**
  - A.I. duPont Hospital for Children
    - Dr. Allan DeJong
    - Dr. Stephanie Deutsch

CHILD ABUSE

MDT

MEDICAL RESPONSE MATRIXES

Child Abuse MDT Medical Response Matrix

SEXUAL ABUSE

Abuse Fact Pattern	Medical Response	Time Frame
Any type of contact between the child or abuser involving either the child's or abuser's genitals, anus or mouth having occurred **within the past 120 hours (to encompass evidentiary and medical needs).**	**Step 1. URGENT RESPONSE directly to Sexual Assault Nurse Examiner/ Forensic Nurse Examiner Program.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Any child describing sexual assault of abuse with significant genital or anal pain, genital or anal bleeding, sores in the genital or anal areas, and any pre-pubertal girl with a discharge **regardless of when the last reported contact occurred.**	**Step 1. URGENT RESPONSE directly to Sexual Assault Nurse Examiner/ Forensic Nurse Examiner Program.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Any child suggesting a significant mental health issue such as suicidal ideation or gesture, or severe depression, **regardless of when the last reported contact occurred.**	**Step 1. URGENT RESPONSE OR EMS TRANSPORT to nearest hospital for:** **A. Necessary medical services.** **B. Necessary mental health services.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Contact of abuser's mouth with child's genitals or anus. (Reported by child or witnessed by another individual.)	Call designated medical services provider. *To be implemented at later date.*	24 HR
Contact of abuser's genitals with child's genitals or anus or mouth. (Reported by child or witnessed by another individual.)	Call designated medical services provider. *To be implemented at later date.*	24 HR
Contact of abuser's hands, fingers or objects with child's genital or anus. (Reported by child or witnessed by another individual.)	Call designated medical services provider. *To be implemented at later date.*	24 HR
Pre-teen sibling of a preteen child confirmed to have STD.	Call designated medical services provider. *To be implemented at later date.*	24 HR
Any child with genital and/or anal pain or discharge; lesions/bumps/ulcers; bleeding; or painful urination, regardless of type of contact reported by child.	Call designated medical services provider. *To be implemented at later date.*	24 HR
Any pre-teen child with an abnormal examination or an STD.	Call designated medical services provider. *To be implemented at later date.*	24 HR

Child Abuse MDT Medical Response Matrix

SERIOUS PHYSICAL ABUSE

Abuse Fact Pattern	Medical Response	Time Frame
Child is 0-6 months of age for any injury.	**Step 1. IMMEDIATE EMS TRANSPORT to nearest hospital.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Severe or extensive injuries at any age, including but not limited to: head trauma, burns, fractures, chest or abdominal injuries.	**Step 1. IMMEDIATE EMS TRANSPORT to nearest hospital.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Child appears to be intoxicated, drugged, or otherwise non-responsive or abnormally responsive.	**Step 1. IMMEDIATE EMS TRANSPORT to nearest hospital.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Any child suggesting a significant mental health issue such as suicidal ideation or gesture, or severe depression, **regardless of when the last reported contact occurred**.	**Step 1. URGENT RESPONSE OR EMS TRANSPORT to nearest hospital for:** **A) Necessary medical services.** **B) Necessary mental health services.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Physical injury or condition that required medical attention or hospitalization and initiated a report to Division of Family Services or law enforcement.	Call designated medical services provider. *To be implemented at later date.*	24 HR
Siblings or juvenile housemates of child(ren) with injuries or conditions that are being evaluated for abuse or neglect.	Call designated medical services provider. *To be implemented at later date.*	24 HR

Child Abuse MDT Medical Response Matrix

PHYSICAL ABUSE

Abuse Fact Pattern	Medical Response	Time Frame
Patterned bruises, lacerations or burns. (Examples: belt loop, cigarette burn, curling iron, etc.)	**Step 1. IMMEDIATE MEDICAL RESPONSE at discretion of first responder.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Child states he/she has been hit with an object, whipped, punched, slapped, kicked or beaten.	**Step 1. IMMEDIATE MEDICAL RESPONSE at discretion of first responder.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Child appears malnourished or starved and/or demonstrates deprivational behaviors.	**Step 1. IMMEDIATE MEDICAL RESPONSE at discretion of first responder.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Any child suggesting a significant mental health issue such as suicidal ideation or gesture, or severe depression, **regardless of when the last reported contact occurred**.	**Step 1. URGENT RESPONSE OR EMS TRANSPORT to nearest hospital for:** **A) Necessary medical services.** **B) Necessary mental health services.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Siblings or juvenile housemates of child(ren) with injuries or conditions that are being evaluated for abuse or neglect.	Call designated medical services provider. *To be implemented at later date.*	24 HR

Child Abuse MDT Medical Response Matrix

NEGLECT

Neglect Fact Pattern	Medical Response	Time Frame
Drug-endangered children. ▪ **Concerns for heavy parental drug use and/or drug manufacturing or distributing in the home.** ▪ **Child was in the care of intoxicated caregivers (abuse of drugs or alcohol in the home).**	**Step 1. IMMEDIATE MEDICAL RESPONSE at discretion of first responder.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Child was left unsupervised in environments that are potentially dangerous or lethal.	**Step 1. IMMEDIATE MEDICAL RESPONSE at discretion of first responder.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Persistent failure to comply with prescribed medical treatment; or suspected harmful overuse of medical services/treatment.	**Step 1. IMMEDIATE MEDICAL RESPONSE at discretion of first responder.** **Step 2. Call designated medical services provider.** *Step 2 to be implemented at later date.*	**Step 1. IMMEDIATE** **Step 2. 24 HR**
Caregiver or investigator expressed a request for examination or a serious concern not included in other criteria.	Call designated medical services provider. *To be implemented at later date.*	5 Days

Appendix H: Child Abuse and Neglect Investigative Tools

Child Abuse & Neglect Investigative Tools

Protecting Delaware's Children Conference

April 26, 2017

Learning Objectives

- Review the 3 new tools included in the revised MOU for the Multidisciplinary Response to Child Abuse and Neglect.
- Understand the new guidelines for connecting child victims, siblings and other children in the home with appropriate medical evaluations.
- Learn potential signs of child torture and of juvenile trafficking, which may present during child abuse and neglect investigations.

MOU

- Approved by Child Protection Accountability Commission (CPAC) in February 2017
- Signatory Agencies: DSCYF, DOJ, CAC, Division of Forensic Science, Office of the Investigation Coordinator, Nemours/Alfred I. duPont Hospital for Children, and Delaware Police Departments
- Structured by protocols: Physical Injury, Serious Physical Injury, Child Death, Child Sexual Abuse, Child Neglect and Juvenile Trafficking
- More in-depth training will be provided once signed – signatures are currently being obtained

Guidelines for Child Abuse Medical Response

Dr. Allan R. De Jong, Nemours- Alfred I. duPont Hospital for Children

Purpose

- CPAC identified the following concerns:
  - the number of medical evaluations in non-acute child abuse cases had significantly declined, and
  - the need to increase the number of child abuse medical experts in the state

Guidelines

- Developed guidelines to determine the need for and type of medical response
- Guidelines have been approved but **not all components** will be implemented until resources are in place

Important Factors to Consider

- A child's denial of sexual abuse when circumstances suggest it may have occurred is much more likely when the child:
  - Is a relative or close associate of the suspected perpetrator – someone the child (or family) may wish to protect.
  - Bonds with the alleged perpetrator (e.g., child may have low self-esteem/self-confidence, be overly trusting or naïve, or be affection- or approval-seeking).

Important Factors to Consider (cont.)

- There is increased risk for partial or incomplete disclosure independent of the type of contact reported by the child when:
  - Caregiver does not believe child
  - Child is protecting the alleged abuser
  - Child is reluctant to talk based upon the forensic interview

Important Factors to Consider (cont.)

  - Has cause for fear and anxiety due to a history of physical abuse, spousal violence or significant family dysfunction.
  - Has a parent who is non-believing or not supportive of the child's disclosure or other evidence that abuse has occurred (STDs, genital injury). In these cases, the child may give a partial disclosure or recant.

Important Factors to Consider (cont.)

- Infants with suspected abuse are at risk of occult (hidden) injuries
- Young children living in the home of a suspected abuse victim are also at risk of abuse
- Children with obvious injury on exposed surfaces may also have injuries on unexposed surfaces
- Children exposed to drug industry or in care of intoxicated individuals are at risk of drug exposure and injury

Using the Guidelines

1. Identify the type of abuse: Sexual Abuse, Serious Physical Abuse, Physical Abuse and Neglect
2. Follow the Medical Response Matrix for abuse type
3. Initiate the recommended Medical Response within the specified Time Frame

**Protocols in the MDT provide guidance as to the appropriate Medical Response Matrix*

Medical Response Matrix – Sexual Abuse

- Identify the Fact Pattern

Abuse Fact Pattern	Medical Response	Time Frame
Any type of contact between the child or abuser involving either the child's or abuser's genitals, anus or mouth having occurred **within the past 120 hours (to encompass evidentiary and medical needs).**	**Step 1.** URGENT RESPONSE **directly to Sexual Assault Nurse Examiner/Forensic Nurse Examiner Program.**	**Step 1.** IMMEDIATE
	Step 2. Call designated medical services provider. *Step 2 to be delayed/implemented at later date.*	**Step 2. 24 HR**

Case Example / Rationale

- 15 y.o. evaluated 4 days after reported vaginal sexual assault by a teenage male
- She reports some urinary burning and vaginal discharge
- She is provided antibiotics for potential sexually transmitted infection and subsequently she tests positive for gonorrhea
- She is provided emergency contraception

Medical Response Matrix – Serious Physical Abuse

- Identify the Fact Pattern

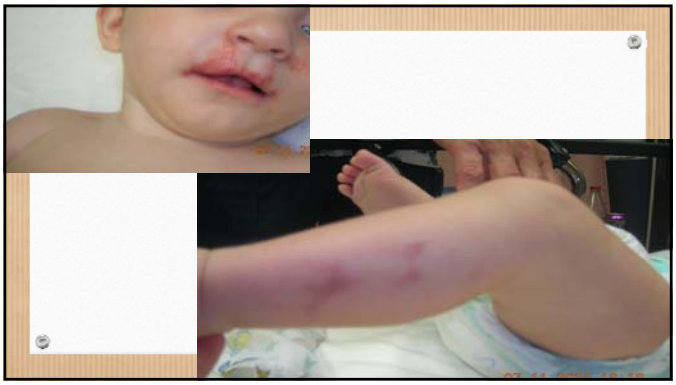
Abuse Fact Pattern	Medical Response	Time Frame
Child is 0-6 months of age for any injury.	Step 1. IMMEDIATE EMS TRANSPORT to nearest hospital.	Step 1. IMMEDIATE
	Step 2. Call designated medical services provider.	Step 2. 24 HR

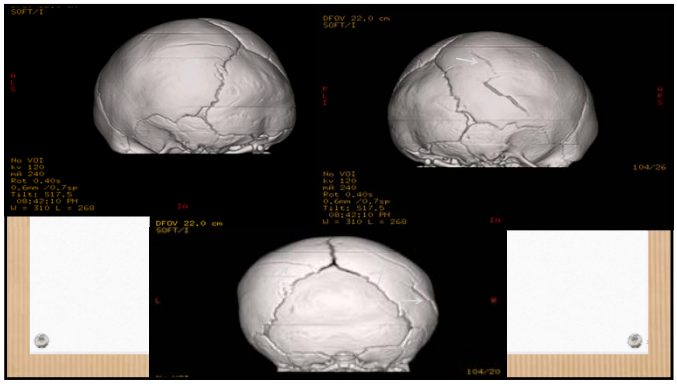
Step 2 to be implemented at later date.

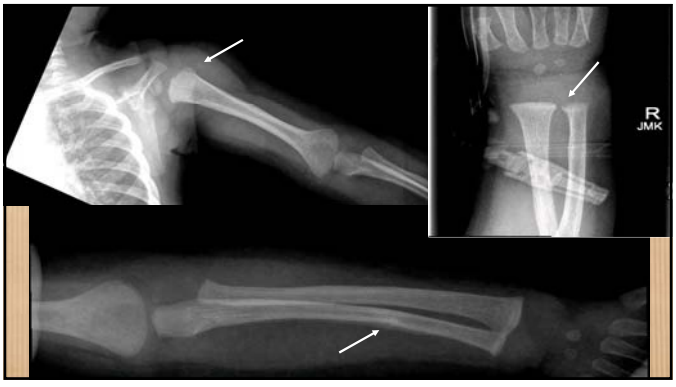
Case Example

- A MGM made report of suspected abuse because her 5 month old grandson had multiple bruises

  - Parents said rash around lips caused by blanket tied around head to keep pacifier in place, bruises from kicking legs in bouncy seat







Rationale

- **Sentinel injuries are common.**
  - **- up to 25% of all abused infants and 30% of AHT cases have sentinel injuries**
  - **- 8% of suspicious injuries, 0% of non-abuse injuries had sentinel injuries**

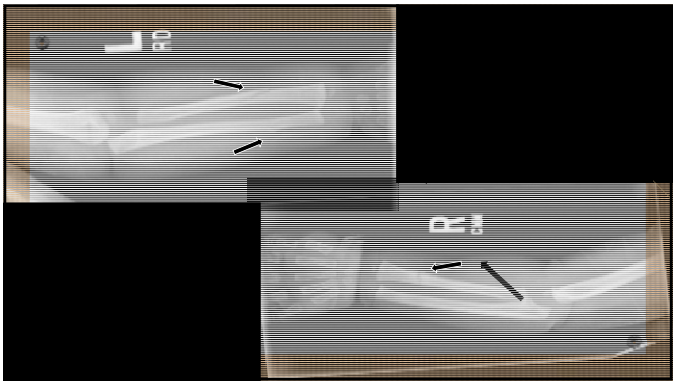
Medical Response Matrix – Siblings and Other Children in Household

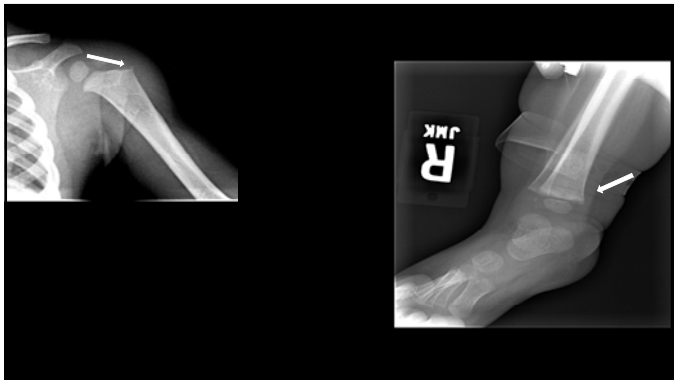
- Identify the Fact Pattern

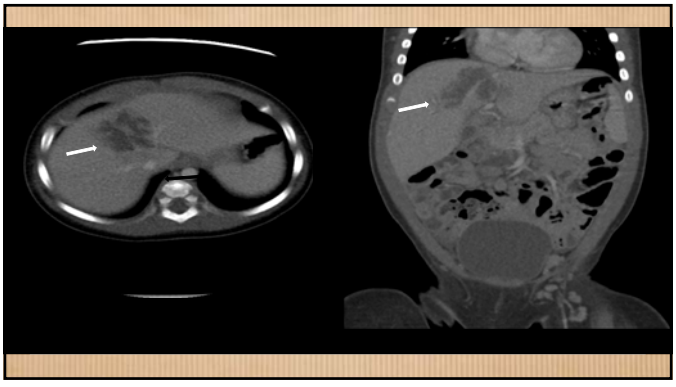
Abuse Fact Pattern	Medical Response	Time Frame
Siblings or juvenile housemates of child(ren) with injuries or conditions that are being evaluated for abuse or neglect.	Call designated medical service provider. *Step 2 to be implemented later date.*	**24 HR**

Case Example

- **9 m.o. evaluated 4 days after her 2 y.o. sister was admitted and died from irreversible abusive head injury and internal bleeding from severe blunt abdominal trauma**
- **on examination, 9 m.o. had bruising of chin, forehead and ears, and tenderness of left arm**







Rationale

- **Children in the household of abuse victim are also at risk of abuse.**
  - **about 10% will also have injuries**
  - **up to 50% will have experienced some type of abuse/neglect**

Medical Response Matrix – Physical Abuse

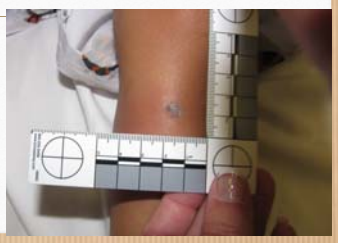
- Identify the Fact Pattern

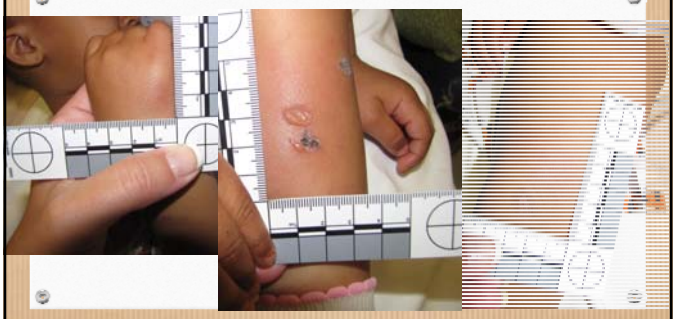
Abuse Fact Pattern	Medical Response	Time Frame
Patterned bruises, lacerations or burns. (Examples: belt loop, cigarette burn, curling iron, etc.)	**Step 1.** **IMMEDIATE MEDICAL RESPONSE** at discretion of first responder.	**Step 1.** **IMMEDIATE**
	Step 2. Call designated medical services provider.	**Step 2. 24 HR**

Step 2 to be implemented at later date.

Case Example

- **15 m.o. brought to daycare and reported because of suspected cigarette burns**
- **Both parents smoke**





Rationale

- **Skin lesions change over time and sometimes this change occurs in less than 24 hours**
- **This allows for examination of the whole body**
- **Allows for clear photography with use of a "size standard"**
- **Aids in distinguishing abuse from non-abuse**

Medical Response Matrix – Neglect

- Identify the Fact Pattern

Abuse Fact Pattern	Medical Response	Time Frame
Drug-endangered children. ❑ Concerns for heavy parental drug use and/or drug manufacturing or distributing in the home. ❑ Child was in the care of intoxicated caregivers (abuse of drugs or alcohol in the home).	**Step 1.** **IMMEDIATE MEDICAL RESPONSE** at discretion of first responder.	**Step 1.** **IMMEDIATE**
	Step 2. Call designated medical services provider.	**Step 2. 24 HR**

Step 2 to be implemented at later date.

Case Example

- **23 m.o. admitted 4 days after her 4 y.o. brother died due to a drug overdose**
- **Parents admitted to intentionally administering their own medications to both children to "control" behaviors**
- **She had a no external signs of injury and a negative drug screen at the time of admission**

Rationale

- **Children may be exposed to or ingest drugs, toxic chemicals used in drug manufacture or distribution**
- **Drug toxicity may require specific treatment and ability to document exposure is time dependent**
- **Child is at risk of accidental and inflicted injuries and at risk of sexual abuse in this setting**

Medical Providers

- Emergency Services
- SANE Programs
- Designated Medical Services Provider
- Child Abuse Medical Expert

Common Elements of Child Torture

Sgt. Reginald Later, New Castle County Police Department

Purpose

- Emerged as a recurring theme in findings from the reviews of 4 child deaths and near deaths due to abuse and neglect
- Issues identified included a lack of cross-reporting and medical assessments

Checklist

- May not immediately be identified until the abuse and/or neglect results in serious physical injury or death - often after multiple interventions for less serious offenses
- Developed checklist to help professionals recognize and appropriately respond to cases of child torture

Using the Checklist

1. Select the potential elements of child torture in each section: Deprivation of Basic Needs, Physical Abuse, Psychological Maltreatment and Supplemental Items
2. Mark the elements when the allegations are **current or based on known history**
3. Consider child torture when you have identified the following:
   - At least 1 element – Deprivation of Basic Needs, and
   - At least 2 physical assaults or 1 severe assault - Physical Abuse, and
   - 2 or more elements – Psychological Maltreatment

**Consider using the checklist in every case*

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

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

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

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

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

Current or History of Allegations for Psychological Maltreatment	
❑ Rejection by Caregiver	❑ Exploiting/Corrupting
❑ Terrorizing	❑ Unresponsive to Child's Emotional Needs
❑ Isolating	❑ Shaming/Humiliation
❑ Threats of Harm or Death to Child, Sibling(s) or Pets	❑ Other:

Section Four: Supplemental Items

Current or History of Allegations for Sexual Abuse	
❑ Penile, Digital or Object Penetration of the Anus	❑ Forcing to Remain Naked or Dance
❑ Assault to the Genitals	❑ Forcing to Witness or Participate in Sexual Violence against another person
❑ Forcing Sexual Intercourse	❑ Other

Section Four: Supplemental Items (cont.)

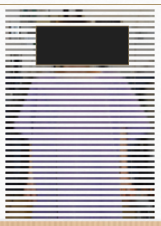
Current or History of Allegations for the following:	
❑ Forcing Excessive Exercise for Punishment	❑ Family System is Blended and Both Caregivers Participate in the Alleged Abuse and/or Neglect
❑ History of Prior Referrals and /or Investigations by the Division of Family Services (DFS)	❑ One Caregiver Fails to Protect
❑ One Child is Targeted	❑ No Disclosure is Made by Targeted Child or Siblings
❑ Sibling(s) Abused	❑ Caregivers Provide Reasonable Explanations in Response to Allegations
❑ Siblings Join in Blaming Victim and May Lack Empathy	❑ Caregivers Allege Mental Health Issues for Targeted Child (e.g. self-injury) and Report Repeated Attempts to Seek Help

Potential Next Steps

- Make an immediate report to the DFS Report Line and the appropriate law enforcement jurisdiction
- Active cases: communicate any identified elements to other members of the MDT: DOJ, DFS, Law Enforcement, Medical, CAC and Office of the Investigation Coordinator
- Schedule a forensic interview at CAC
- Comprehensive assessment of the child's safety, placement, mental health, and medical needs.

**Protocols in the MDT provide additional guidance*

Case Example



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First Responders

- The Call
- Preliminary Investigation
- Evidence Collection
- Cross-Reporting
- Joint Investigation
- Interviews

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Scene Photos

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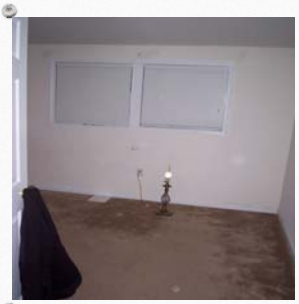

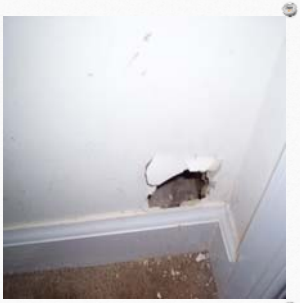

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First Responders

- The Call
- Preliminary Investigation
- Evidence Collection
- Cross-Reporting
- Joint Investigation
- Interviews

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Juvenile Trafficking Pre-Assessment Checklist

Commissioner Loretta Young, Family Court

Purpose

- Federal response to human trafficking - Federal Victims of Trafficking and Violence Protection Act (2000)
- Human Trafficking Coordinating Council created in 2014
- Established the Juvenile Committee
- Charged with improving multi-agency policies, response, communication and collaboration with stakeholders regarding juvenile trafficking

Juvenile Trafficking Pre-Assessment Checklist

- Like child torture, it's not easily identified
- Developed to assist in the identification of potential victims and youth at high risk of juvenile trafficking
  - Includes Sex and Labor Trafficking
  - Confidential
  - Intended to document *indicators* only and should be followed up with a comprehensive investigation and assessment of the child's needs

Important Factors to Consider

- Not defined as a single act but rather a constellation of behaviors and circumstances
- Intentionally concealed by the perpetrator through coercion, manipulation, fraud and/or force
- Children may not view themselves as victims or may be fearful of reporting

Important Factors to Consider (cont.)

- Children in foster care and/or children who are runaways or missing juveniles are at highest risk
- Children involved in the juvenile justice system may also be at risk
- Law enforcement may encounter complaints of runaways and missing juveniles, calls for delinquent behavior, and domestic situations involving older dating partners
- Children may present to medical providers for various health issues, including sexually transmitted infections, early pregnancy, untreated injuries or medical conditions, substance abuse problems or addictions, and depression or stress-related disorders

Important Factors to Consider (cont.)

- The screening tool should always be considered in the following scenarios:
  - Recovery of a runaways from foster care;
  - Children on run for 30 days or more or 3 or more times in the last 6 months;
  - Direct allegation or suspicion of trafficking; or victims seeking medical treatment for injuries suspicious of trafficking.

**The screening tool may also be used at various points throughout a case.*

Using the JTAC Pre-Assessment Checklist

1. List the child's name and date of birth
2. Select the potential indicators in each section: General Youth, Health, Relationship, Behavioral, Environmental and Labor.
3. Mark the indicators when the allegations are **current or based on known history**
4. Multiple sources of information can be used: location where the child is found, the context of the initial contact, current allegations, and/or medical, criminal and DFS history known about the child
5. List the name and agency of the person who completed the tool and date of completion

GENERAL YOUTH INDICATORS – SEX & LABOR TRAFFICKING

- ❑ Recent and/or ongoing history of homelessness
- ❑ Multiple runaway attempts
- ❑ Not in control of their identification
- ❑ Not in control of money earned, owes a debt or has intense sense of financial responsibility toward family or intimate partner
- ❑ Lack of support system or supportive relationships
- ❑ Unexplained travel, purchases or access to money
- ❑ Inconsistencies in story
- ❑ Appears to be monitored, fearful, anxious
- ❑ Atypical appearance; clothing, hair, nails, jewelry

HEALTH INDICATORS – SEX TRAFFICKING

- ❑ High number of intimate partners reported for age
- ❑ Multiple terminated pregnancies
- ❑ Sexually transmitted infections/diseases
- ❑ Substance abuse
- ❑ Exhaustion and/or malnourishment
- ❑ Physical or sexual abuse
- ❑ Branding – tattoo (name, symbol) & reluctance to explain tattoo
- ❑ History of abuse or neglect
- ❑ Mental health issues such as depression, PTSD, withdraw, suicidal or self-harming tendencies, memory loss
- ❑ Physical signs of unhealthy living conditions (skin rash, poor hygiene including dental)

RELATIONSHIP INDICATORS – SEX TRAFFICKING

- ❑ Controlling intimate partner, friend or relative
- ❑ Older intimate partner
- ❑ Resides with non-relative
- ❑ Has relative or friend involved in commercial sex
- ❑ Females may struggle to maintain relationships with other females

BEHAVIORAL INDICATORS – SEX TRAFFICKING

- ❑ Multiple, prolonged runaway attempts (3+ or gone for more than 20 days)
- ❑ High levels of or increased truancy and/or curfew violations
- ❑ Poor school performance or behavior
- ❑ School performance is significantly under grade level
- ❑ Frequents websites known for sale of commercial sex (Backpage, Craigslist, Mocospace, Eros, Myscarletbook, etc.)
- ❑ Uses language of the commercial sex industry ("the life")
- ❑ History of criminal charges related to prostitution or other charges that may occur while being trafficked (thefts, drugs, assault)

ENVIRONMENTAL INDICATORS – SEX TRAFFICKING

- ❑ Found in an area known for illegal commercial sex
- ❑ Found with men (often older males)
- ❑ Found with large amount of cash on their person
- ❑ Resides in or is found near hotels
- ❑ Sexually explicit social networking profiles
- ❑ Stays with individuals who require payment for housing them (could be sexual favors, drugs or money)

LABOR TRAFFICKING INDICATORS

- ❑ Recruited with false promises of work conditions
- ❑ Works long hours with few or no breaks
- ❑ Pay is inconsistent
- ❑ Some or all of pay goes towards debt or housing, food, etc.
- ❑ Some or all of pay is given to someone else
- ❑ Unexplained signs of injury or illness, possibly untreated
- ❑ Shows anxiety in maintaining job for duty to family, intimate partner or to pay a debt to employer
- ❑ Desperation to make a sale (magazines, beauty products, etc.) or for money while begging

Potential Next Steps

- Multiple indicators and suspicion of juvenile trafficking – make an immediate report to the DFS Report Line and the appropriate law enforcement jurisdiction
- Active cases: communicate any identified elements to other members of the MDT: DOJ, DFS, Law Enforcement, Medical, CAC and Office of the Investigation Coordinator
- Schedule a forensic interview at CAC
- Comprehensive assessment of the child's safety, placement, mental health, medical, and substance abuse treatment needs.

**Juvenile Trafficking Protocol in the MDT provides further guidance*

Questions?

The Tools are available at the following link:

http://courts.delaware.gov/childadvocate/cpac/cpac_reports.aspx

SPONSOR: Rep. M. Smith & Rep. Briggs King & Rep. Longhurst & Sen. Henry & Sen. Lopez & Sen. Townsend
Reps. Baumbach, Heffernan, Q. Johnson, Miro, Osienski, Ramone, Viola, Wilson; Sens. Hocker, Lavelle, Marshall, Sokola

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

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.

POLICY ACADEMY STATE TEAM ACTION PLAN

State: Delaware

State Team Project Liaison / Title: Jennifer Donahue Esq., Child Abuse Investigation Coordinator
Emily Knearl, Section Chief, Office of Health and Risk Communication

Policy Academy Team Members:
Greg Valentine, DSAMH and Women's Services Network Coordinator
Aleks Casper, March of Dimes
Cathy McKay, Connections Community Support Programs
Trenee Parker, Delaware Division of Family Services
Crystal Sherman, Division of Public Health, Maternal and Child Health Bureau
Dr. David Paul, Dept. Of Pediatrics, Christiana Care/DE Healthy Mother and Infant Consortium/Neonatalogist

Change Leader: Jill Gresham JGresham@Cffutures.org 714-505-3525

I. STATE GOALS

Goal 1: Recommend universal screening of pregnant women for early identification of substance use so that women and their families may be linked to appropriate services, including treatment, prenatal care, home visiting and other supports as needed.

Goal 2: Build a system of care and provide educational resources so that medical providers, including obstetricians/gynecologists, birth hospitals, treatment providers and social services agencies have the tools they need to help pregnant women in the prevention, recognition, and treatment of substance use disorders and related services for affected children and families.

Goal 3: Implement a universal statewide protocol for the preparation and monitoring of Plans of Safe Care for infants with prenatal exposure and their affected families.

Goal 4: Maintain an awareness of the effects of stigma in discouraging pregnant women from treatment or prenatal care, as well as the importance of non-judgmental medical provider support so that women feel safe in discussing substance use or abuse.

Major Action Steps	Completion Date	Lead Staff	TA Needed
Phase I: Setting the Stage for State Action Planning (February – September 2017)			
Goal 1: Recommend universal screening of pregnant women for early identification of substance use so that women and their families may be linked to appropriate services, including treatment, prenatal care, home visiting and other supports as needed.			
Necessary Partners: Medical providers, DHSS, DFS, substance use treatment providers			
1. Ob/Gyn Survey roll out	3/31/17	Emily Knearl, Jen Donahue	Survey Monkey assistance
2. Labor/Delivery Survey incorporated with the Hospital Data chart roll out	3/31/17	Emily Knearl, Jen Donahue, David Paul, Aleks Casper	Survey Monkey assistance
3. Review of survey results	04/15/17	All	Analysis of results
4. Create materials and information campaign for ob/gyns on substance use screening and service links – update helpishere.org; consider public awareness campaign for marijuana	05/01/2017	All, but DPH to lead	Discussion

Major Action Steps	Completion Date	Lead Staff	TA Needed
Goal 2: Build a system of care and provide educational resources so that medical providers, including obstetricians/gynecologists, birth hospitals, treatment providers and social services agencies have the tools they need to help pregnant women in the prevention, recognition, and treatment of substance use disorders and related services for affected children and families.			
Necessary Partners: ALL			
1. Expand the "Project Engage" model to Kent and Sussex Counties. a) Confer with Terri Horton and discuss an informational meeting with Beebe, Nanticoke, Milford Memorial and Kent General representatives. b) DSAMH to determine what grants are available and have been applied for pertaining to the SEI population.	04/01/2017	David Paul, Cathy McKay, Greg Valentine	TBD
2. Discuss peer support/recovery coaches to reach those women not yet in recovery.	TBD	TBD	TBD
3. Ensure pregnant women have linkages to services including substance use treatment, LARC, home visiting, CDW, family supports and medical care. a) Plan of Safe Care to incorporate linkages; b) Help is Here information sheet; c) Obtain copies of treatment plan templates from Connections, Brandywine Counseling, and Kent/Sussex Counseling and consider adding home visiting, LARC and other supports	TBD	ALL	TBD

Major Action Steps	Completion Date	Lead Staff	TA Needed
Goal 3: Implement a universal statewide protocol for the preparation and monitoring of Plans of Safe Care for infants with prenatal exposure and their affected families.			
Necessary Partners: ALL			
1. Develop draft PSC template	4/1/2017	Jen Donahue, Trenee Parker	Yes
2. Discuss PSC development prenatally by MAT or substance use treatment providers	03/24/2017 (SEI Committee meeting)	Jen Donahue, Cathy McKay	TBD
3. Discuss a pilot program for initiating PSCs at Kent General and Beebe by June 1	03/24/2017 (SEI Committee meeting)	Trenee Parker, Jen Donahue,	TBD
4. MOU vs "Coordination of Care" document – begin drafting	5/1/2017	Jen Donahue	TBD
5. SEI Bill finalization	03/30/17	Jen Donahue	TBD
6. SEI data reporting under CARA – include in MOU	TBD	TBD	TBD

Major Action Steps	Completion Date	Lead Staff	TA Needed
Goal 4: Maintain an awareness of the effects of stigma in discouraging pregnant women from treatment or prenatal care, as well as the importance of non-judgmental medical provider support so that women feel safe in discussing substance use or abuse.			
Necessary Partners: ALL			
1. Cross Systems Survey	04/01/2017	Jen Donahue, Emily Knearl	Yes

Major Action Steps	Completion Date	Lead Staff	TA Needed

Major Action Steps	Completion Date	Lead Staff	TA Needed
Phase II: Longer-Term State Team Action Planning (Begins September 2017)			
Goal 1:			
Goal 2:			

Major Action Steps	Completion Date	Lead Staff	TA Needed
Goal 3:			
Goal4:			

II. DATA NEEDS

Data Needed:	Source:	Responsible Agency:	Supports Goal(s):

III. COLLABORATIVE STRUCTURE/MEETING SCHEDULE

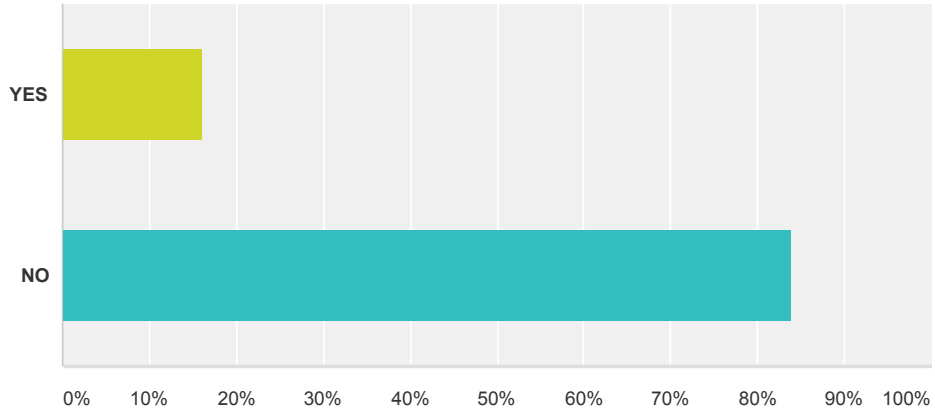
ENTITY	MEMBERS	MEETING SCHEDULE
Oversight/Steering Committee		

Core Team		
Workgroup 1: **_____**		
Workgroup 2: **_____**		
Workgroup 3: **_____**		
Local Teams		
Key Community Partners		

IV. PARKING LOT ISSUES AND NEXT STEPS

Q1 Did you participate in the MDT - Advanced Training on Tuesday, April 25th?

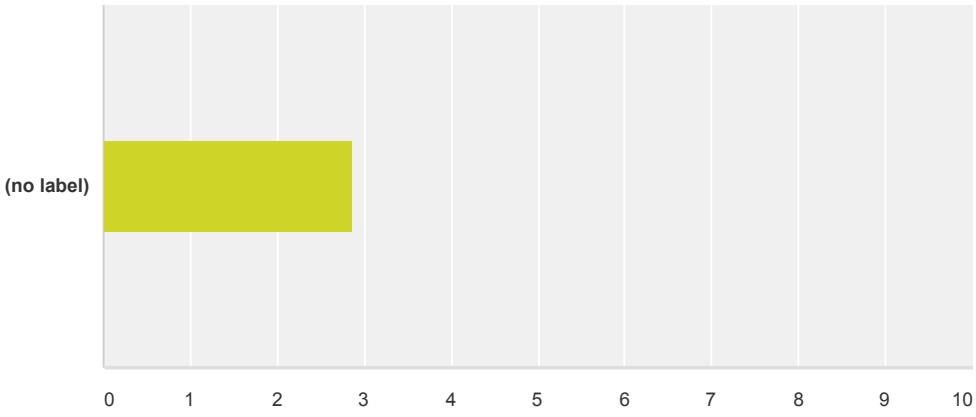
Answered: 112 Skipped: 0



Answer Choices	Responses	
YES	**16.07%**	18
NO	**83.93%**	94
Total		**112**

Q2 As a result of this training, I have a basic understanding of the revised MOU for the Multidisciplinary Response to Child Abuse and Neglect.

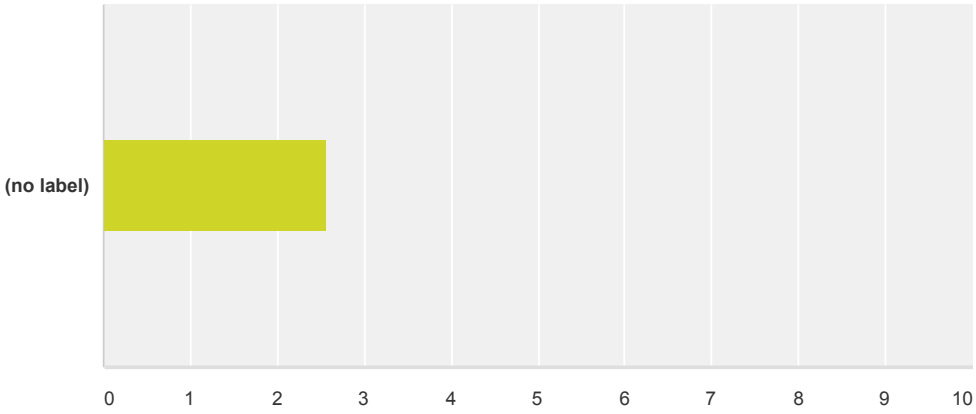
Answered: 14 Skipped: 98



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**28.57%** 4	**57.14%** 8	**14.29%** 2	**0.00%** 0	**0.00%** 0	14	2.86

Q3 As a result of this training, my knowledge of Sudden Unexpected Infant Death Investigations has increased.

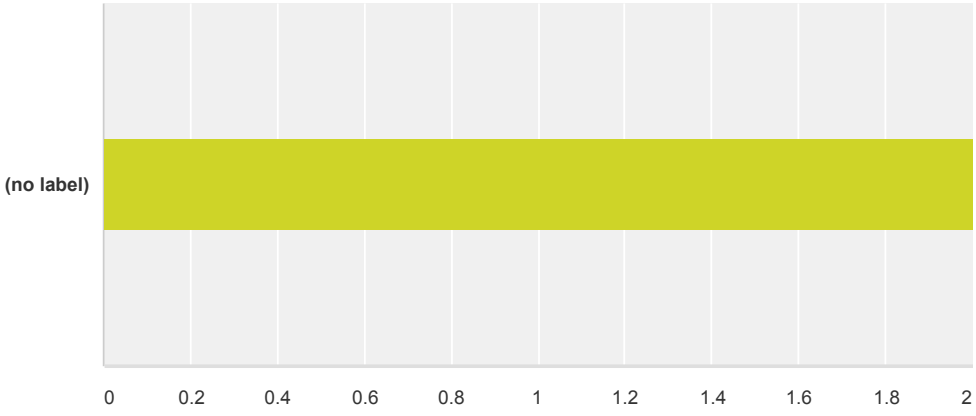
Answered: 14 Skipped: 98



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**28.57%** 4	**42.86%** 6	**21.43%** 3	**7.14%** 1	**0.00%** 0	14	2.57

Q4 The facilitators of the Sudden Unexpected Infant Death Investigation presentation demonstrated a thorough knowledge of the subject matter.

Answered: 14 Skipped: 98

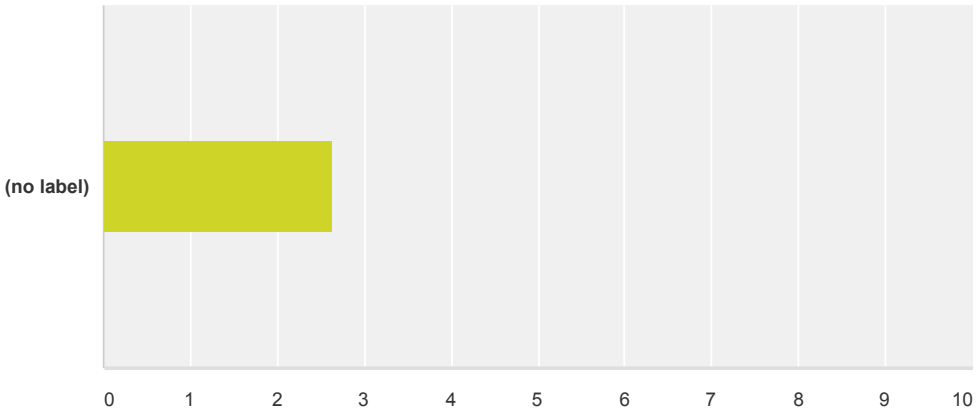


	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**28.57%** 4	**28.57%** 4	**42.86%** 6	**0.00%** 0	**0.00%** 0	14	2.00

Q5 The facilitators were well organized in

the presentation of the course material.

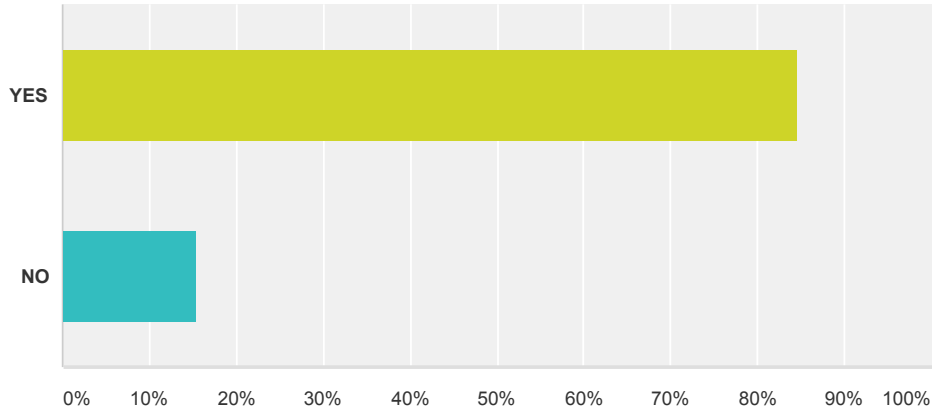
Answered: 14 Skipped: 98



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**28.57%** 4	**50.00%** 7	**21.43%** 3	**0.00%** 0	**0.00%** 0	14	2.64

Q6 Are you interested in attending a one-day session in October entitled, Sex Offenders - Responding to Crimes Against Children?

Answered: 13 Skipped: 99



Answer Choices	Responses	
YES	**84.62%**	11
NO	**15.38%**	2
Total		**13**

Q7 Are there any specific topics/subjects that you recommend we include in

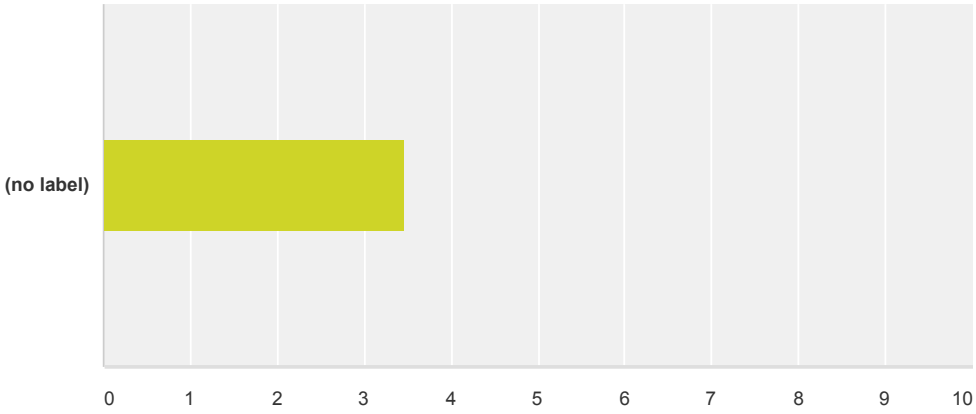
upcoming trainings?

Answered: 2 Skipped: 110

#	Responses	Date
1	none	5/11/2017 3:54 AM
2	I would like a prosecutor to review a difficult case and explain how all the member of the MDT helped put the case together	5/9/2017 11:53 PM

Q8 What is your overall evaluation of the MDT- Advanced Training Course?

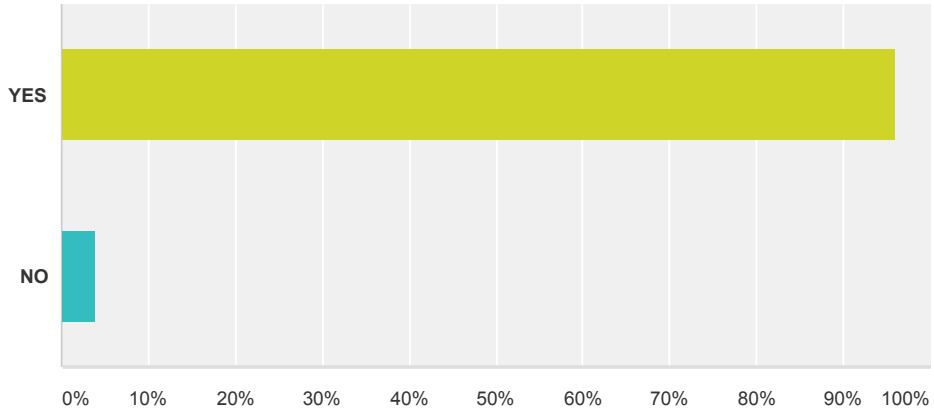
Answered: 13 Skipped: 99



	Excellent	Good	Fair	Poor	Total	Weighted Average
(no label)	**46.15%** 6	**53.85%** 7	**0.00%** 0	**0.00%** 0	13	3.46

Q9 Did you attend the conference on Wednesday, April 26th?

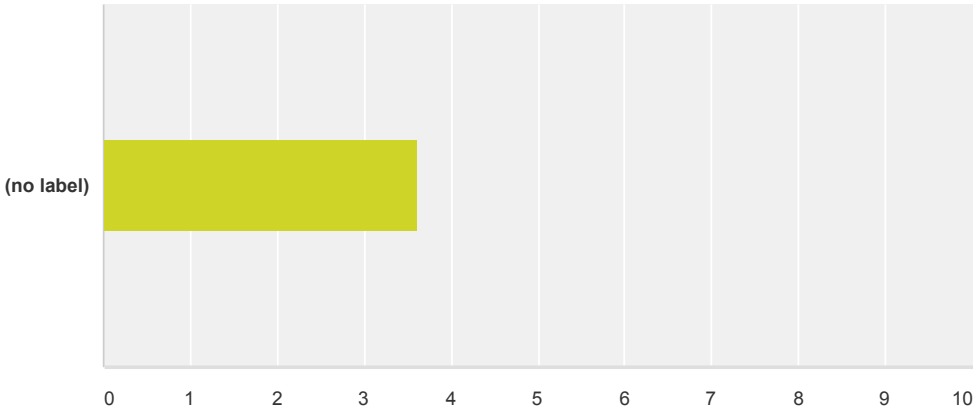
Answered: 102 Skipped: 10



Answer Choices	Responses	
YES	**96.08%**	98
NO	**3.92%**	4
Total		**102**

Q10 The conference was well organized.

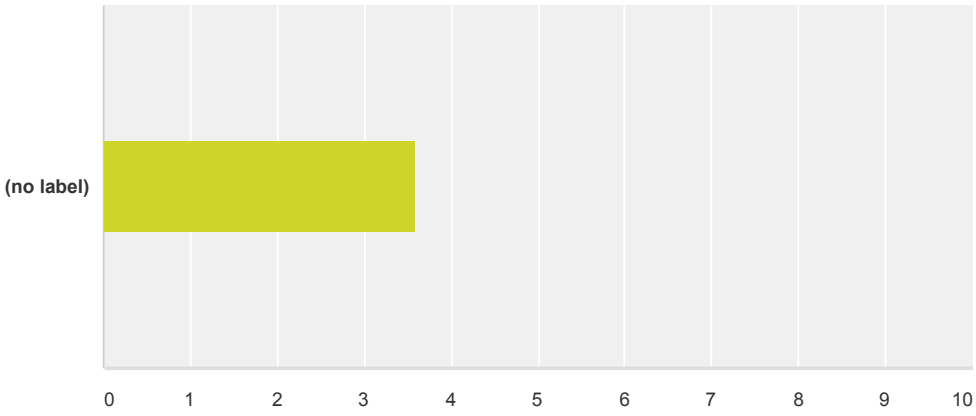
Answered: 98 Skipped: 14



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**65.31%** 64	**33.67%** 33	**1.02%** 1	**0.00%** 0	**0.00%** 0	98	3.62

Q11 The content of the conference sessions was appropriate and informative.

Answered: 98 Skipped: 14

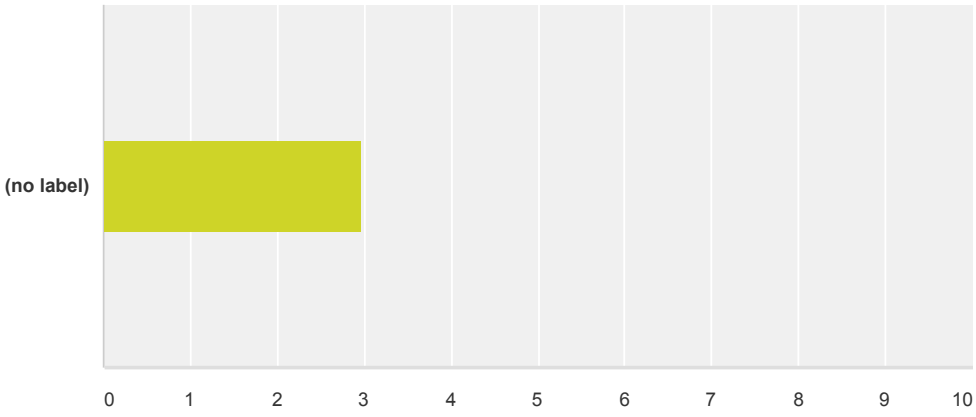


	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**63.27%** 62	**35.71%** 35	**1.02%** 1	**0.00%** 0	**0.00%** 0	98	3.60

Q12 Plenary Session - A National and Local

Perspective: Responding to infants/toddlers and parents impacted by substance abuse, Judge Lynn Tepper, Florida's 6th JudicialCircuit, Pamela Jimenez RN, MSN, FNP-BC/PNP-BC, Christiana Care Health System, and Wendy M. Felts APRN, MSN/NNP-BC; MSM/HCA, St. Francis Healthcare

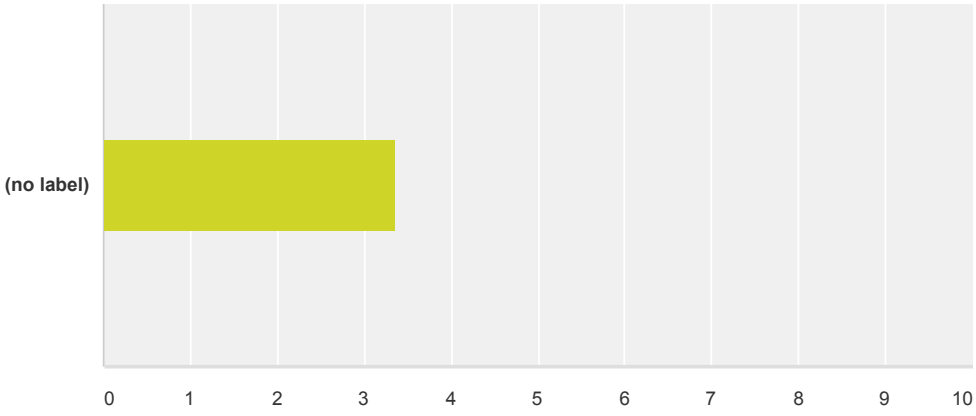
Answered: 98 Skipped: 14



	Excellent	Good	Fair	Poor	Did not attend	Total	Weighted Average
(no label)	**28.57%** 28	**39.80%** 39	**10.20%** 10	**0.00%** 0	**21.43%** 21	98	2.97

Q13 The facilitators were well organized in the presentation of the course material.

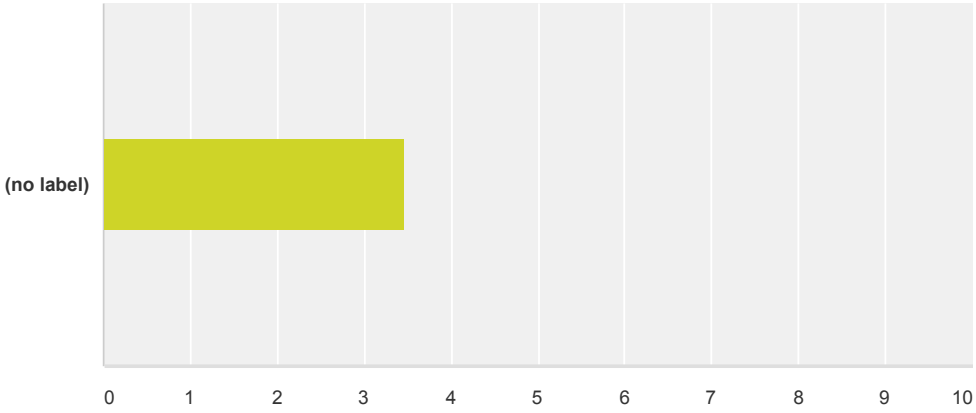
Answered: 76 Skipped: 36



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**48.68%** 37	**46.05%** 35	**3.95%** 3	**1.32%** 1	**0.00%** 0	76	3.36

Q14 The facilitators demonstrated a thorough knowledge of the subject matter.

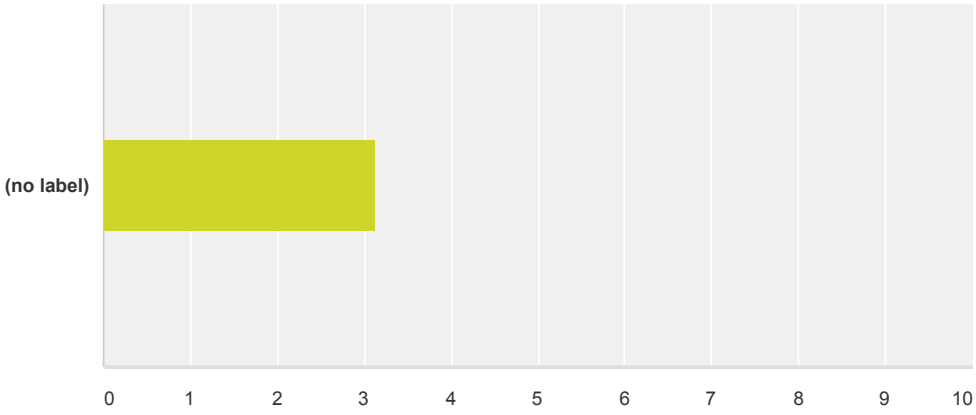
Answered: 76 Skipped: 36



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**55.26%** 42	**42.11%** 32	**2.63%** 2	**0.00%** 0	**0.00%** 0	76	3.47

Q15 My knowledge and understanding of the subject matter increased as a result of this session.

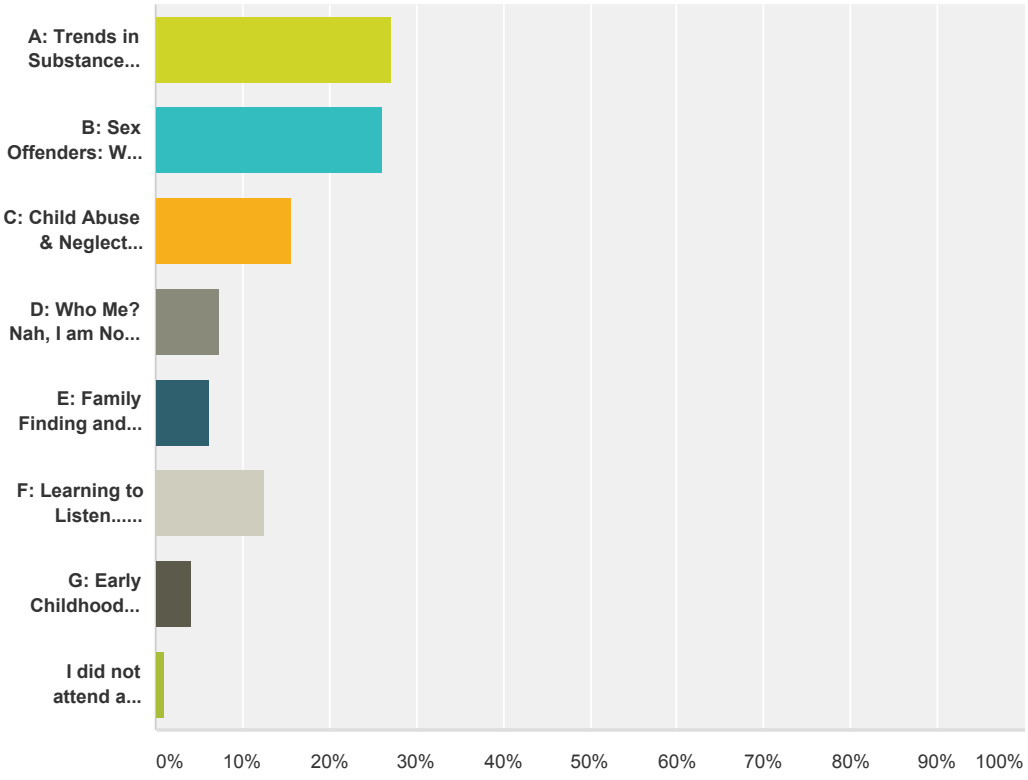
Answered: 76 Skipped: 36



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**44.74%** 34	**43.42%** 33	**9.21%** 7	**2.63%** 2	**0.00%** 0	76	3.14

Q16 Which workshop did you attend?

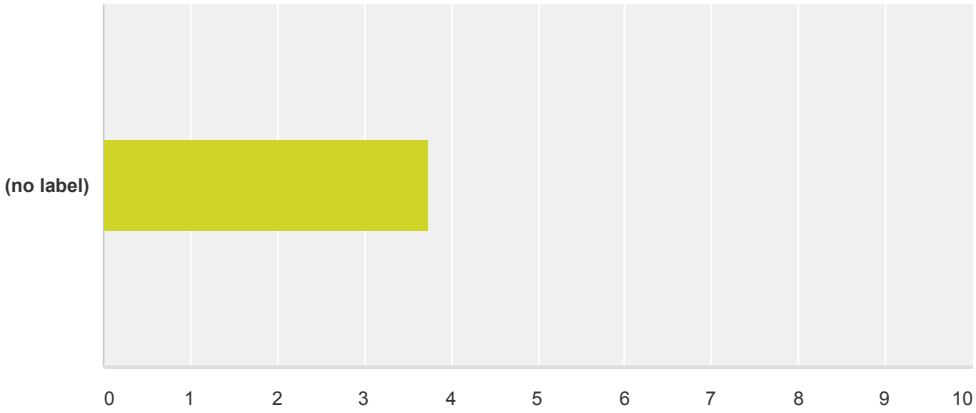
Answered: 96 Skipped: 16



Answer Choices	Responses	
A: Trends in Substance Abuse: Opiate Abuse, Lynn Riemer, ACT on Drugs, Inc.	**27.08%**	26
B: Sex Offenders: What Judges, Lawyers, Investigators and Child Advocates ShouldKnow, Cory Jewell Jensen, MS, CBI Consulting	**26.04%**	25
C: Child Abuse & Neglect Investigative Tools, Dr. Allan R. De Jong, Alfred I. duPontHospital for Children, Sgt. Reginald Laster, New Castle County Police Department,and Commissioner Loretta Young, Family Court	**15.63%**	15
D: Who Me? Nah, I am Not Toasty! Vicarious Trauma and How to Take Care of Yourself,Elena M. Giacci, Independent Contractor	**7.29%**	7
E: Family Finding and Engagement – The Key to Unlocking Permanency for Youth,Amy Edwards and Ada Lopez, Casey Family Programs	**6.25%**	6
F: Learning to Listen... “Defusing a Hostile Situation,” Jim Holler Jr, Consultant,Retired Chief of Police	**12.50%**	12
G: Early Childhood Courts: A step beyond Community Collaboration & a trauma informed approach, Judge Lynn Tepper, Florida’s 6th Judicial Circuit	**4.17%**	4
I did not attend a workshop.	**1.04%**	1
Total		**96**

Q17 Trends in Substance Abuse: Opiate Abuse, Lynn Riemer, ACT on Drugs, Inc.

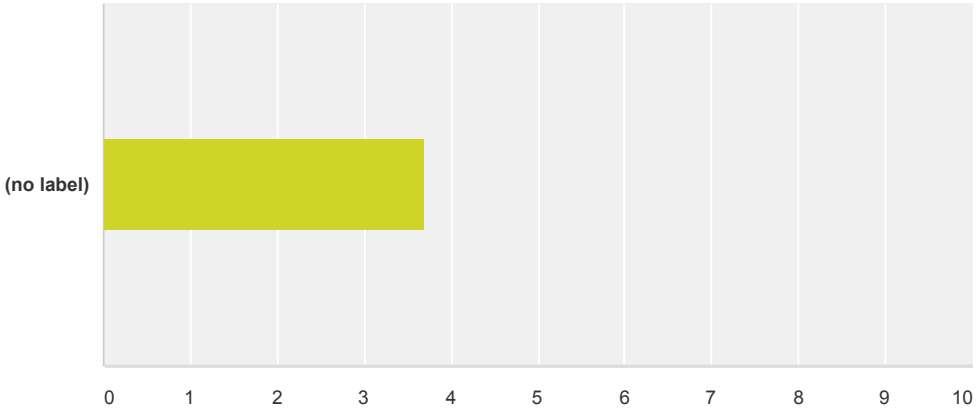
Answered: 26 Skipped: 86



	Excellent	Good	Fair	Poor	Total	Weighted Average
(no label)	**73.08%** 19	**26.92%** 7	**0.00%** 0	**0.00%** 0	26	3.73

Q18 The facilitator was organized in the presentation of course materials.

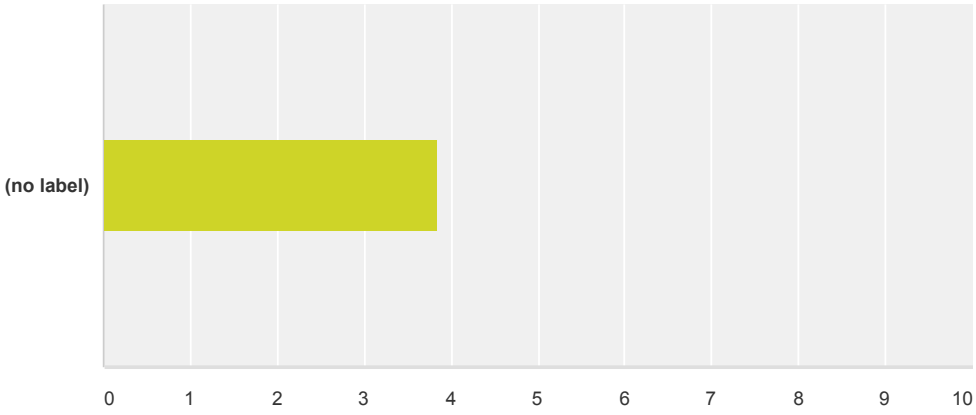
Answered: 26 Skipped: 86



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**69.23%** 18	**30.77%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	26	3.69

Q19 The facilitator demonstrated a thorough knowledge of the subject matter.

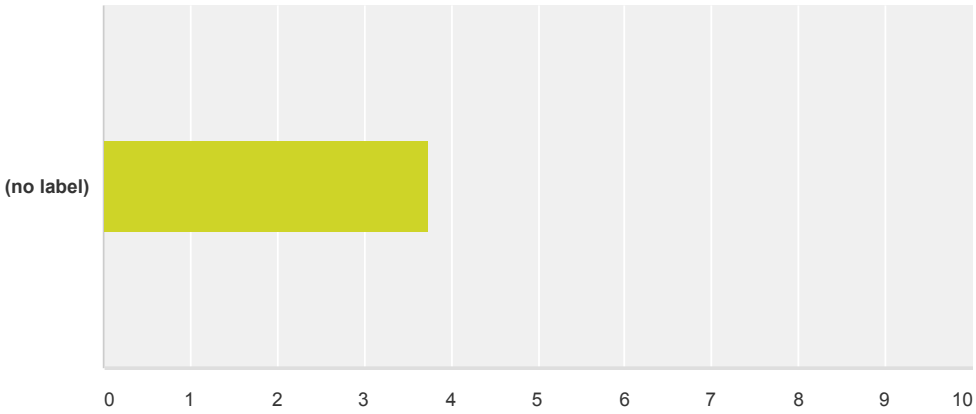
Answered: 26 Skipped: 86



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**84.62%** 22	**15.38%** 4	**0.00%** 0	**0.00%** 0	**0.00%** 0	26	3.85

Q20 My knowledge and understanding of the subject matter increased as a result of this session.

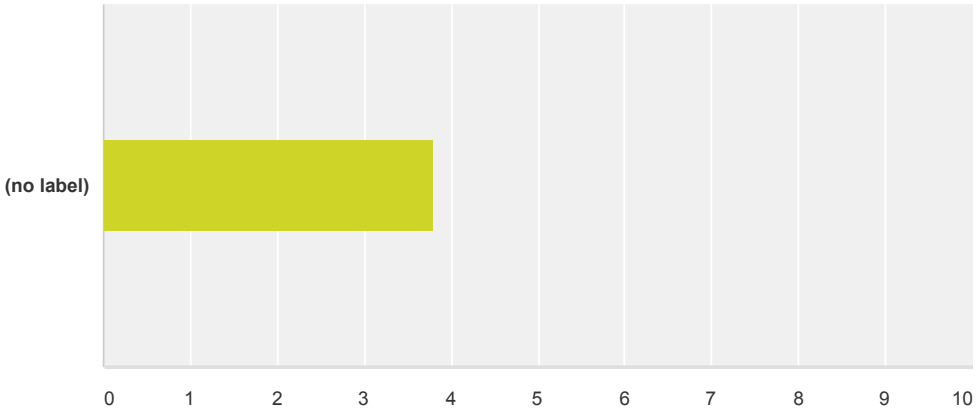
Answered: 26 Skipped: 86



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**73.08%** 19	**26.92%** 7	**0.00%** 0	**0.00%** 0	**0.00%** 0	26	3.73

Q21 Sex Offenders: What Judges, Lawyers, Investigators and Child Advocates ShouldKnow, Cory Jewell Jensen, MS, CBI Consulting

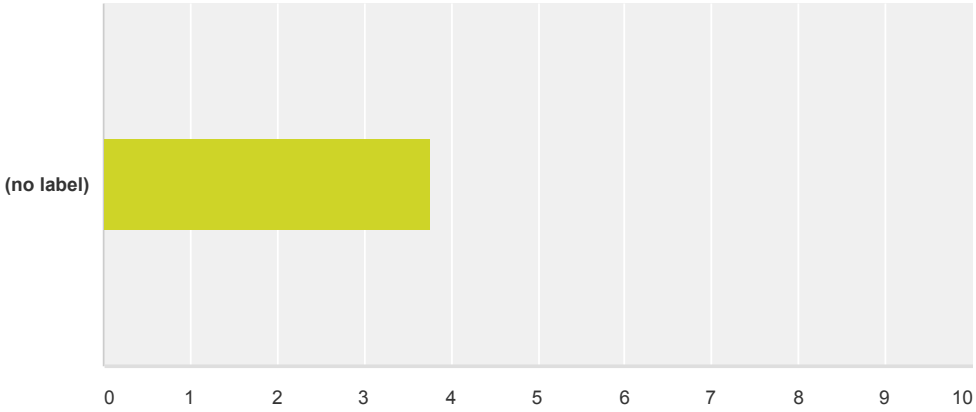
Answered: 25 Skipped: 87



	Excellent	Good	Fair	Poor	Total	Weighted Average
(no label)	**80.00%** 20	**20.00%** 5	**0.00%** 0	**0.00%** 0	25	3.80

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

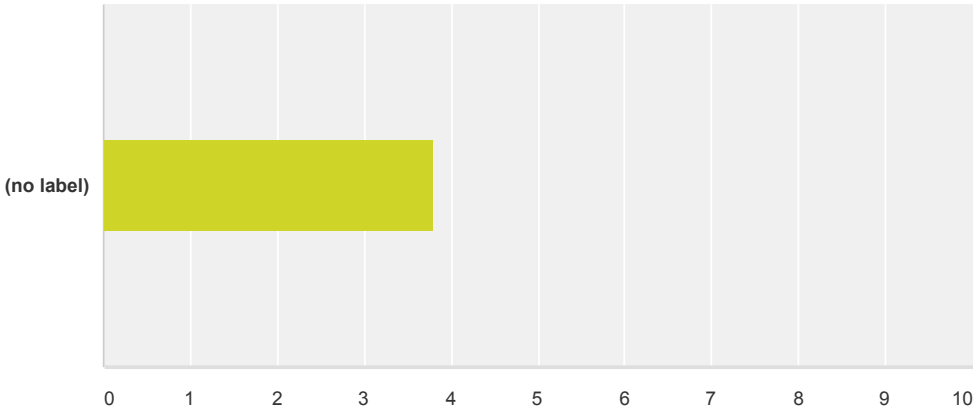
Answered: 25 Skipped: 87



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**76.00%** 19	**24.00%** 6	**0.00%** 0	**0.00%** 0	**0.00%** 0	25	3.76

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

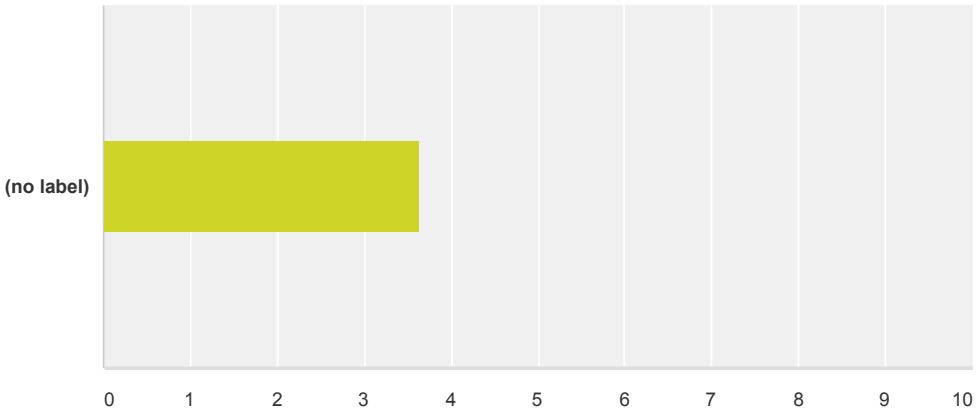
Answered: 25 Skipped: 87



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**80.00%** 20	**20.00%** 5	**0.00%** 0	**0.00%** 0	**0.00%** 0	25	3.80

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

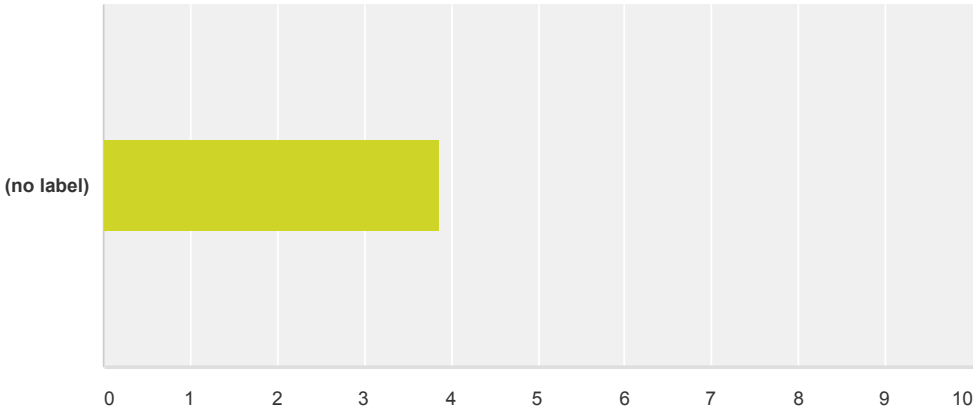
Answered: 25 Skipped: 87



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**64.00%** 16	**36.00%** 9	**0.00%** 0	**0.00%** 0	**0.00%** 0	25	3.64

Q25 Child Abuse & Neglect Investigative Tools, Dr. Allan R. De Jong, Alfred I. duPont Hospital for Children, Sgt. Reginald Laster, New Castle County Police Department, and Commissioner Loretta Young, Family Court

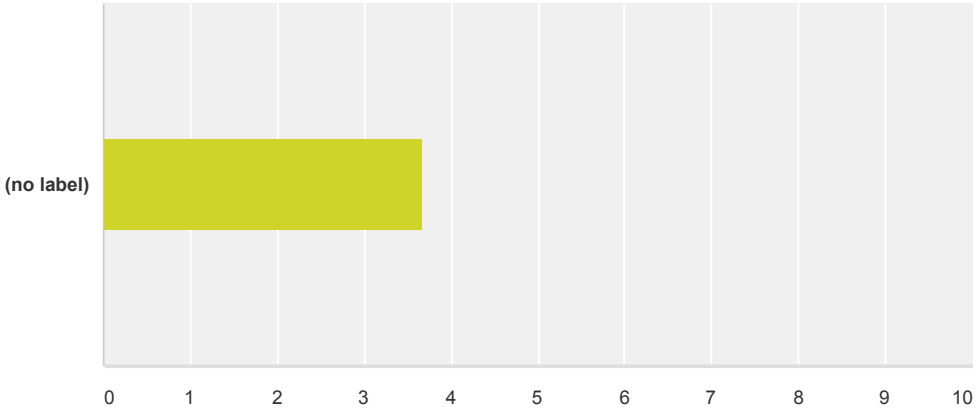
Answered: 15 Skipped: 97



	Excellent	Good	Fair	Poor	Total	Weighted Average
(no label)	**86.67%** 13	**13.33%** 2	**0.00%** 0	**0.00%** 0	15	3.87

Q26 The facilitators were well organized in the presentation of the course material.

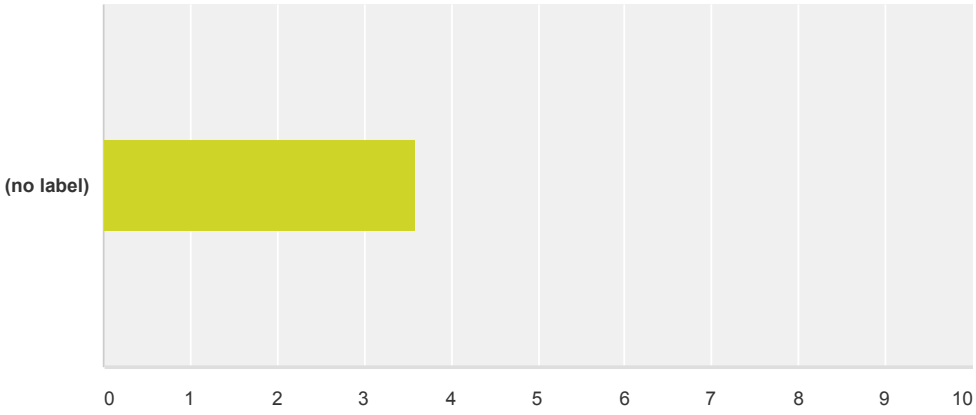
Answered: 15 Skipped: 97



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**66.67%** 10	**33.33%** 5	**0.00%** 0	**0.00%** 0	**0.00%** 0	15	3.67

Q27 The facilitators demonstrated a thorough knowledge of the subject matter.

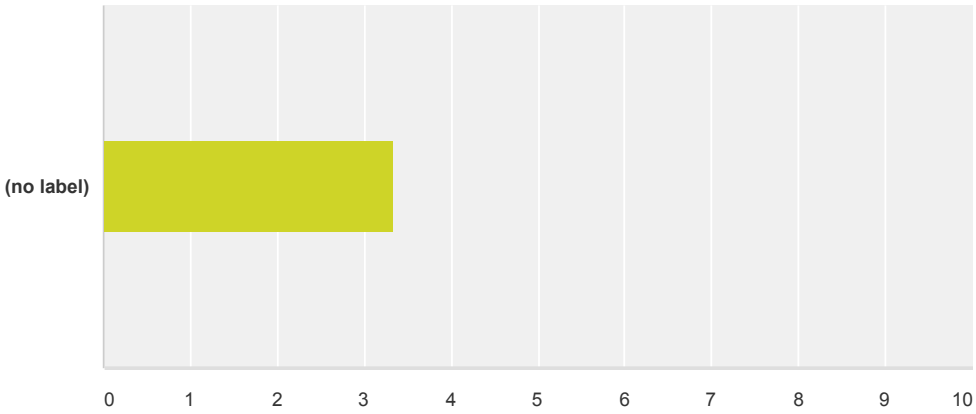
Answered: 15 Skipped: 97



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**60.00%** 9	**40.00%** 6	**0.00%** 0	**0.00%** 0	**0.00%** 0	15	3.60

Q28 My knowledge and understanding of the subject matter increased as a result of this session.

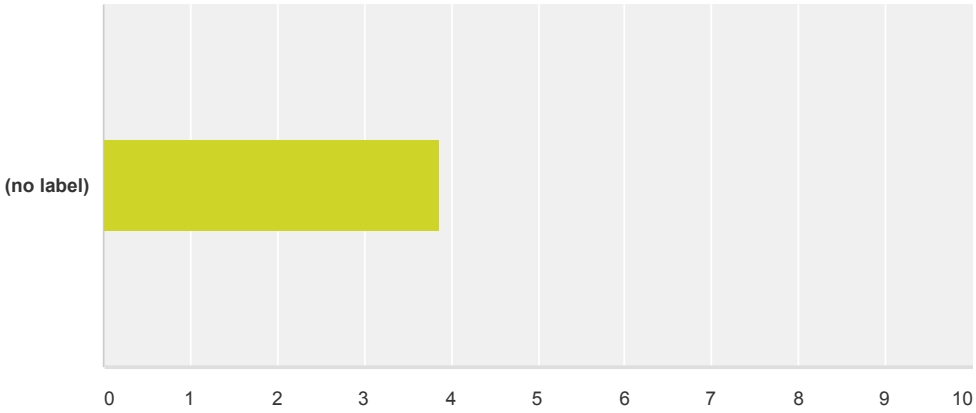
Answered: 15 Skipped: 97



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**53.33%** 8	**40.00%** 6	**6.67%** 1	**0.00%** 0	**0.00%** 0	15	3.33

Q29 Who Me? Nah, I am Not Toasty! Vicarious Trauma and How to Take Care of Yourself,Elena M. Giacci, Independent Contractor

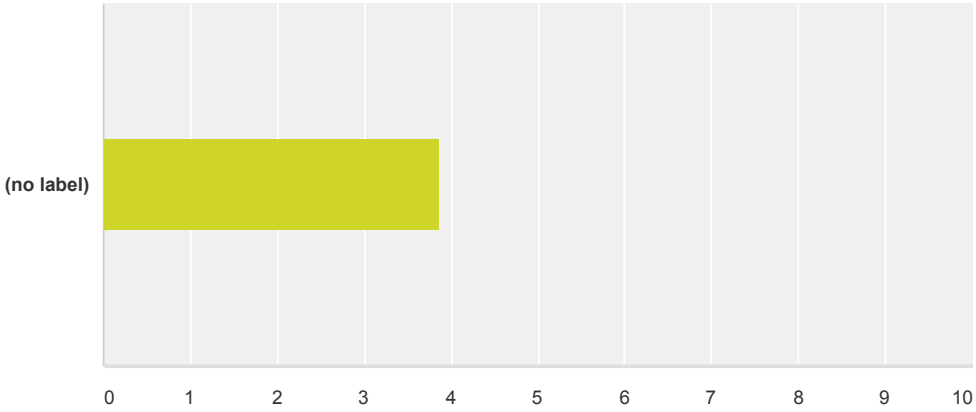
Answered: 7 Skipped: 105



	Excellent	Good	Fair	Poor	Total	Weighted Average
(no label)	**85.71%** 6	**14.29%** 1	**0.00%** 0	**0.00%** 0	7	3.86

Q30 The facilitator was well organized in the presentation of the course material.

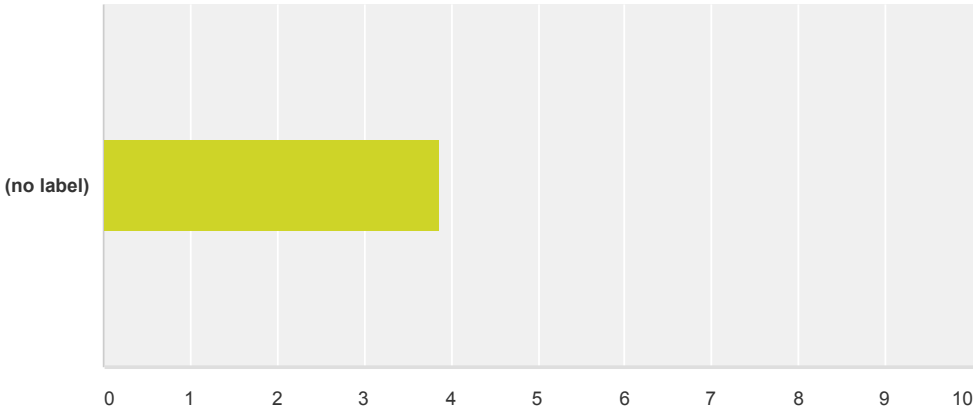
Answered: 7 Skipped: 105



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**85.71%** 6	**14.29%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	7	3.86

Q31 The facilitator demonstrated a thorough knowledge of the subject matter.

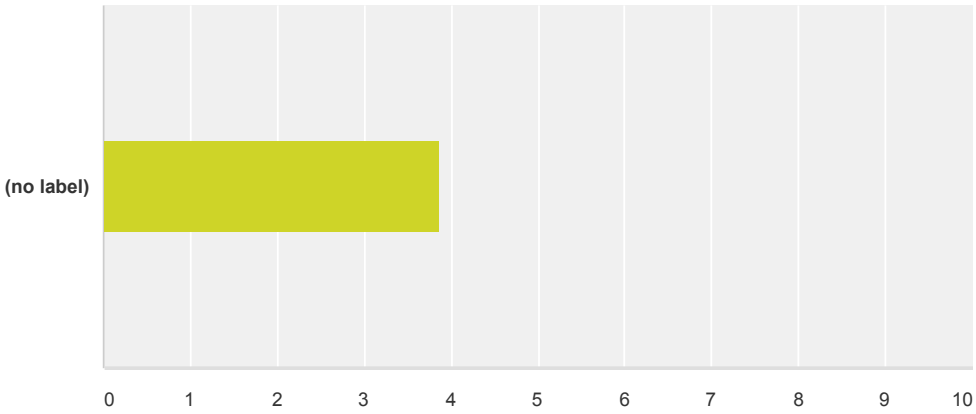
Answered: 7 Skipped: 105



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**85.71%** 6	**14.29%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	7	3.86

Q32 My knowledge and understanding of the subject matter increased as a result of this session.

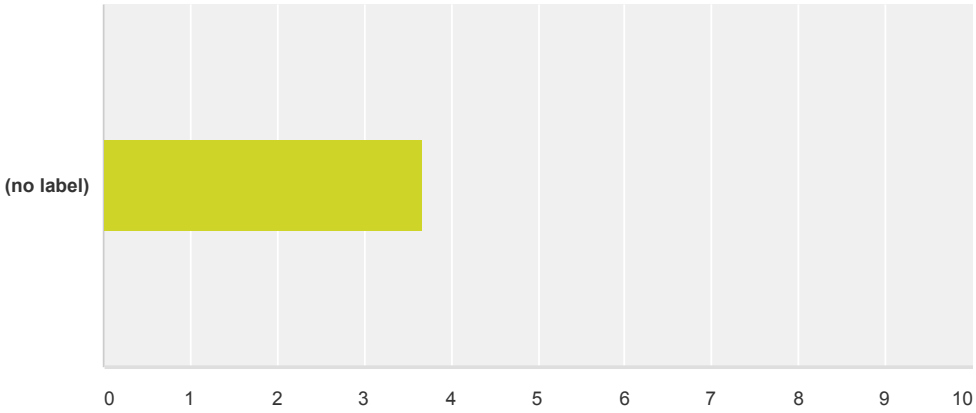
Answered: 7 Skipped: 105



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**85.71%** 6	**14.29%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	7	3.86

Q33 Family Finding and Engagement – The Key to Unlocking Permanency for Youth, Amy Edwards and Ada Lopez, Casey Family Programs

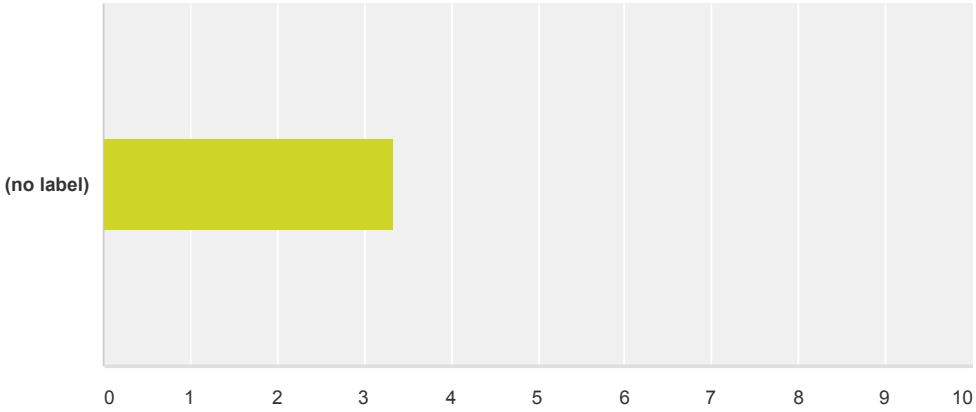
Answered: 6 Skipped: 106



	Excellent	Good	Fair	Poor	Total	Weighted Average
(no label)	**66.67%** 4	**33.33%** 2	**0.00%** 0	**0.00%** 0	6	3.67

Q34 The facilitators were well organized in the presentation of the course material.

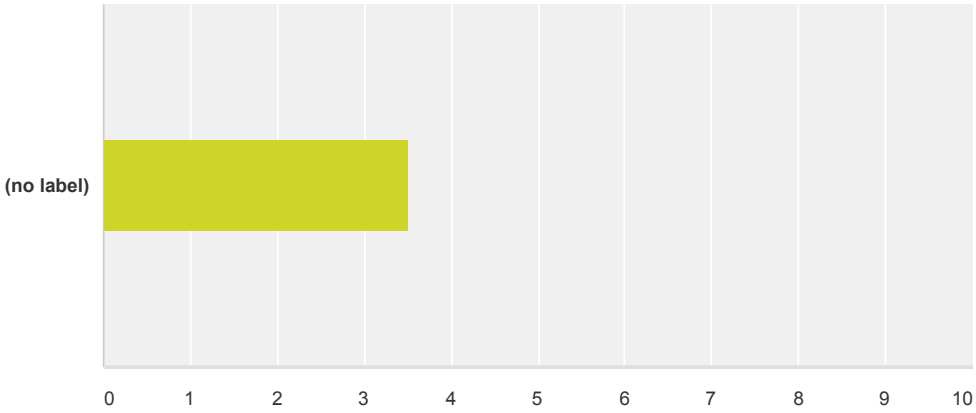
Answered: 6 Skipped: 106



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**33.33%** 2	**66.67%** 4	**0.00%** 0	**0.00%** 0	**0.00%** 0	6	3.33

Q35 The facilitators demonstrated a thorough knowledge of the subject matter.

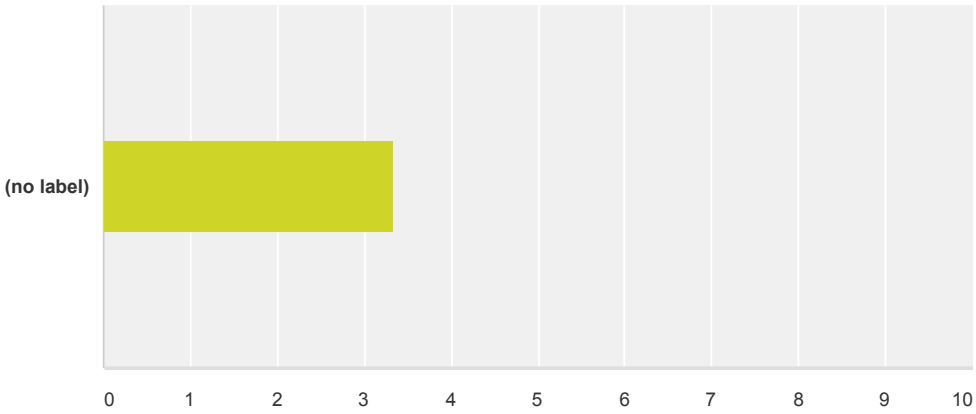
Answered: 6 Skipped: 106



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**50.00%** 3	**50.00%** 3	**0.00%** 0	**0.00%** 0	**0.00%** 0	6	3.50

Q36 My knowledge and understanding of the subject matter increased as a result of this session.

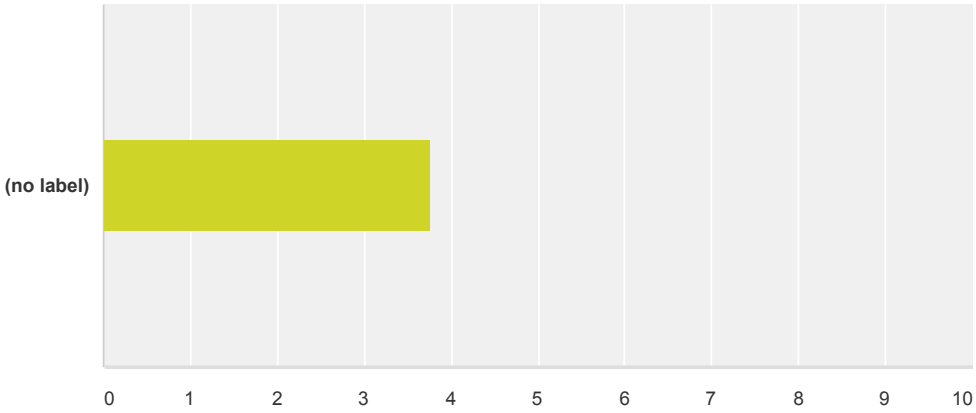
Answered: 6 Skipped: 106



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**33.33%** 2	**66.67%** 4	**0.00%** 0	**0.00%** 0	**0.00%** 0	6	3.33

Q37 Learning to Listen... “Defusing a Hostile Situation,” Jim Holler Jr, Consultant, Retired Chief of Police

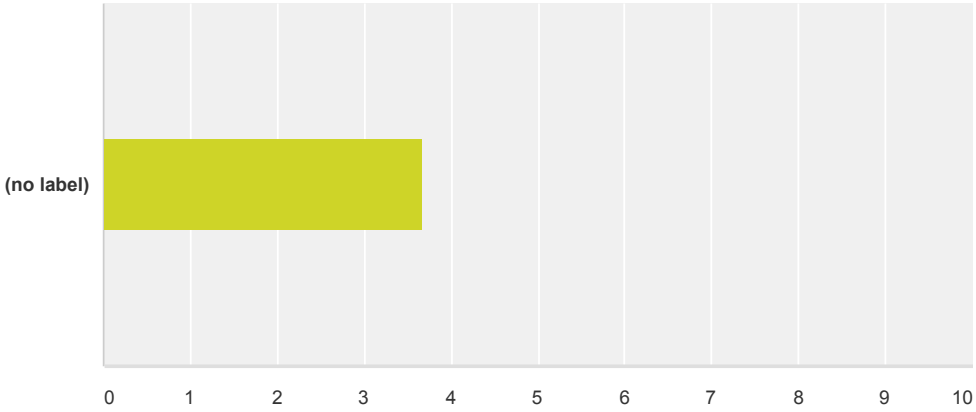
Answered: 12 Skipped: 100



	Excellent	Good	Fair	Poor	Total	Weighted Average
(no label)	**75.00%** 9	**25.00%** 3	**0.00%** 0	**0.00%** 0	12	3.75

Q38 The facilitator was well organized in the presentation of the course material.

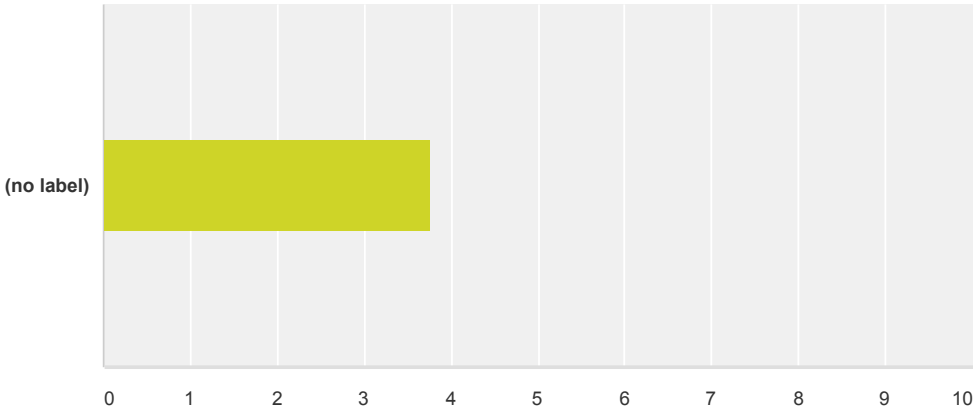
Answered: 12 Skipped: 100



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**66.67%** 8	**33.33%** 4	**0.00%** 0	**0.00%** 0	**0.00%** 0	12	3.67

Q39 The facilitator demonstrated a thorough knowledge of the subject matter.

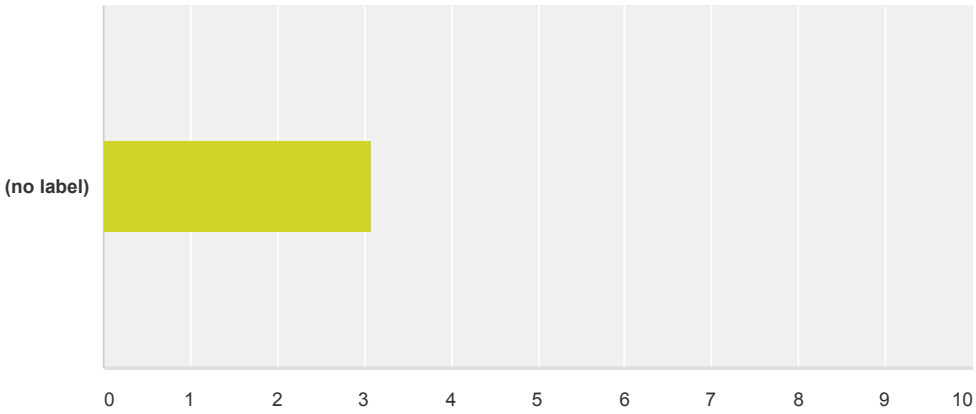
Answered: 12 Skipped: 100



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**75.00%** 9	**25.00%** 3	**0.00%** 0	**0.00%** 0	**0.00%** 0	12	3.75

Q40 My knowledge and understanding of the subject matter increased as a result of this session.

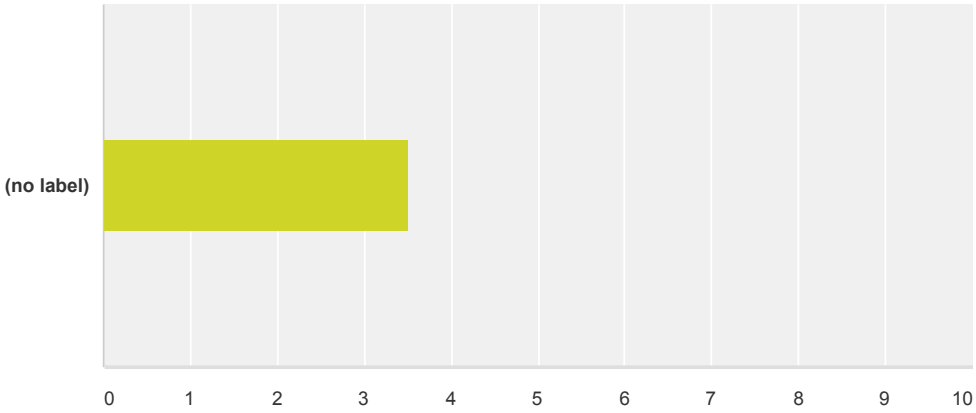
Answered: 12 Skipped: 100



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**58.33%** 7	**25.00%** 3	**16.67%** 2	**0.00%** 0	**0.00%** 0	12	3.08

Q41 Early Childhood Courts: A step beyond Community Collaboration & a trauma informed approach, Judge Lynn Tepper, Florida's 6th Judicial Circuit

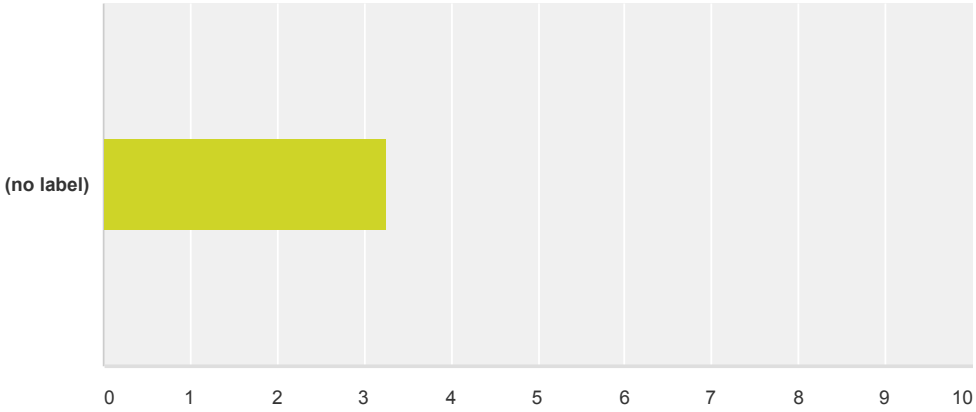
Answered: 4 Skipped: 108



	Excellent	Good	Fair	Poor	Total	Weighted Average
(no label)	**50.00%** 2	**50.00%** 2	**0.00%** 0	**0.00%** 0	4	3.50

Q42 The facilitator was well organized in the presentation of the course material.

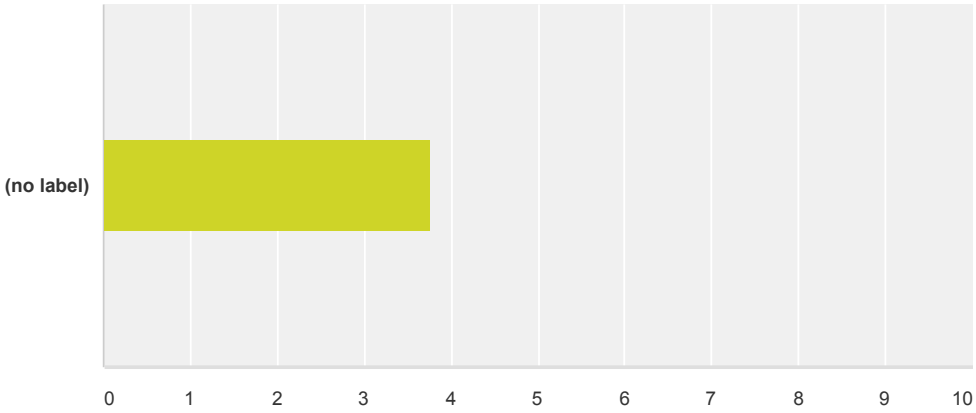
Answered: 4 Skipped: 108



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**25.00%** 1	**75.00%** 3	**0.00%** 0	**0.00%** 0	**0.00%** 0	4	3.25

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

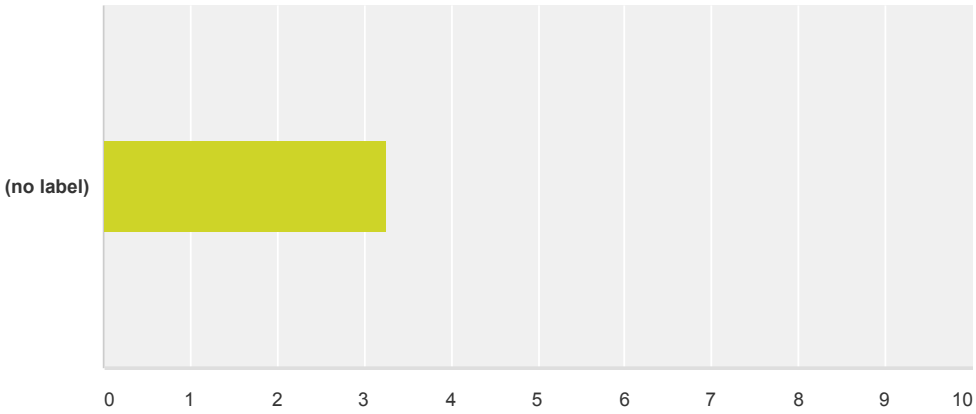
Answered: 4 Skipped: 108



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**75.00%** 3	**25.00%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	4	3.75

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

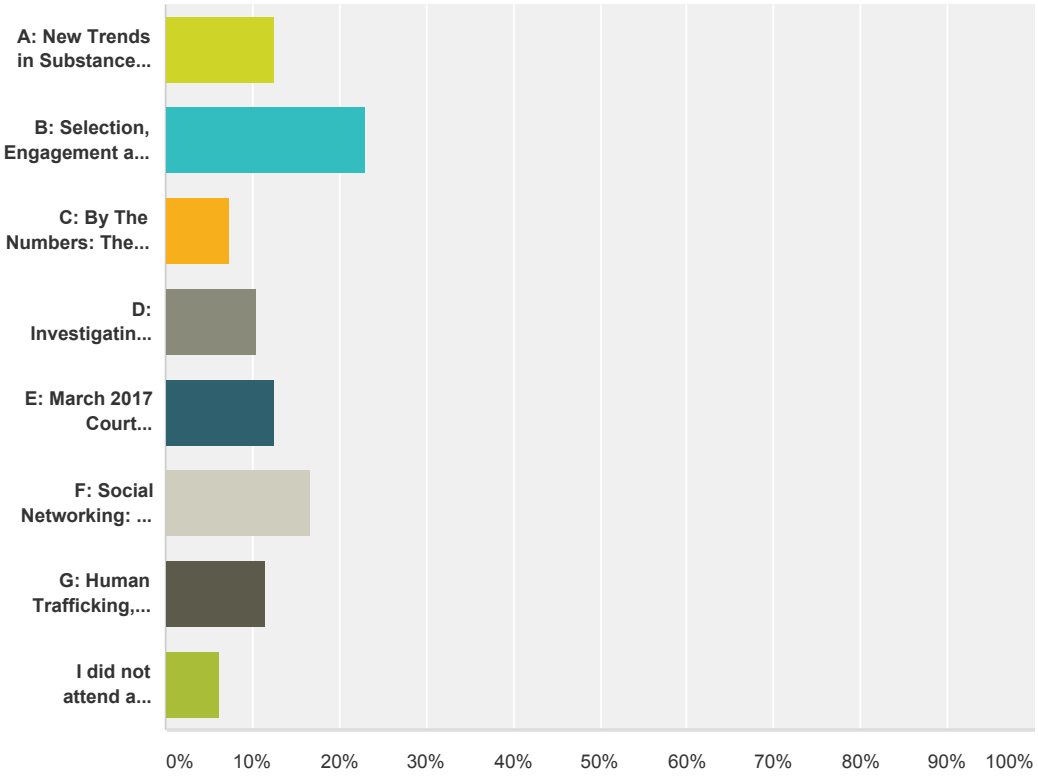
Answered: 4 Skipped: 108



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**25.00%** 1	**75.00%** 3	**0.00%** 0	**0.00%** 0	**0.00%** 0	4	3.25

Q45 Which workshop did you attend?

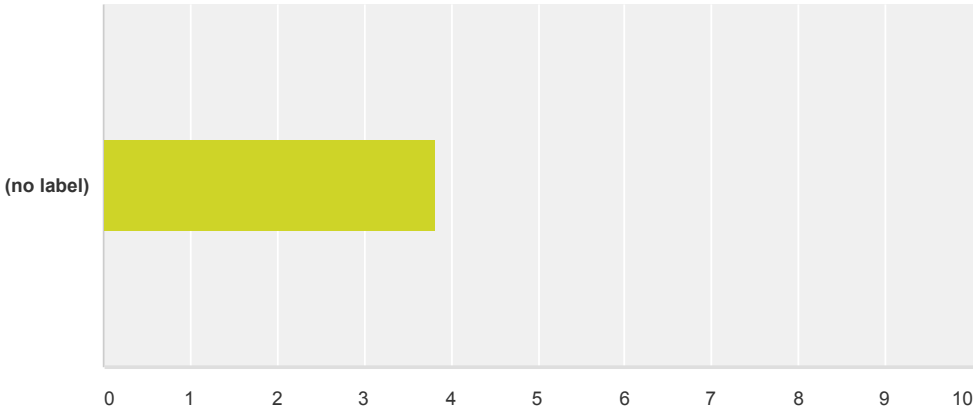
Answered: 96 Skipped: 16



Answer Choices	Responses
A: New Trends in Substance Abuse: Cocaine, Alcohol, and other "legal" substances,Lynn Riemer, ACT on Drugs, Inc.	**12.50%** 12
B: Selection, Engagement and Seduction of Children and Adults by Child Molesters,Cory Jewell Jensen, MS, CBI Consulting	**22.92%** 22
C: By The Numbers: The State of Children in Delaware, Janice Barlow, KIDS COUNT inDelaware	**7.29%** 7
D: Investigating Infant/Child Deaths: the Responsibilities of the First Responder,Detective Robert Daddio, Delaware State Police	**10.42%** 10
E: March 2017 Court Improvement Program Leading Practices Final Report, JudgeJoelle Hitch, Family Court, Judge Peter Jones, Family Court, Kelly Ensslin, Esq., OCA,Julie Yeager, Esq., Parent Attorney, and Islanda Finamore, Esq., DOJ	**12.50%** 12
F: Social Networking: the Good, the Bad, the Ugly!, Jim Holler Jr, Consultant, RetiredChief of Police	**16.67%** 16
G: Human Trafficking, Sextortion, and Social Media, Patricia Dailey Lewis, Executive Director of the Beau Biden Foundation	**11.46%** 11
I did not attend a workshop.	**6.25%** 6
Total	**96**

Q46 New Trends in Substance Abuse: Cocaine, Alcohol, and other "legal" substances,Lynn Riemer, ACT on Drugs, Inc.

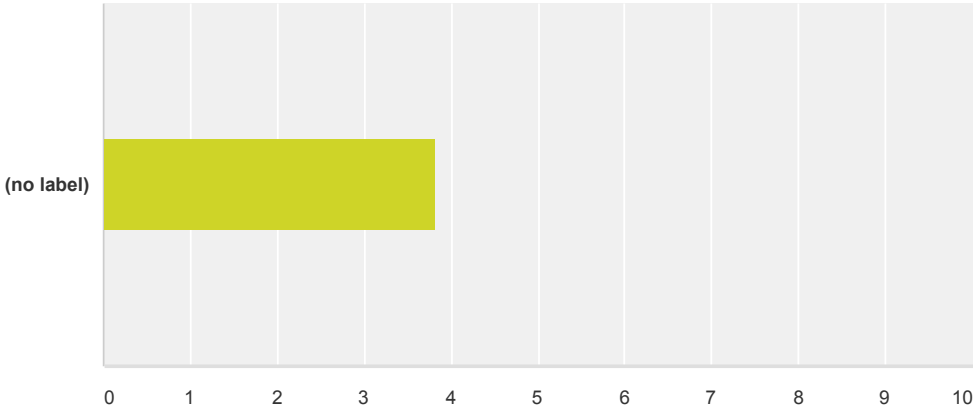
Answered: 12 Skipped: 100



	Excellent	Good	Fair	Poor	Total	Weighted Average
(no label)	**83.33%** 10	**16.67%** 2	**0.00%** 0	**0.00%** 0	12	3.83

Q47 The facilitator was well organized in the presentation of the course material.

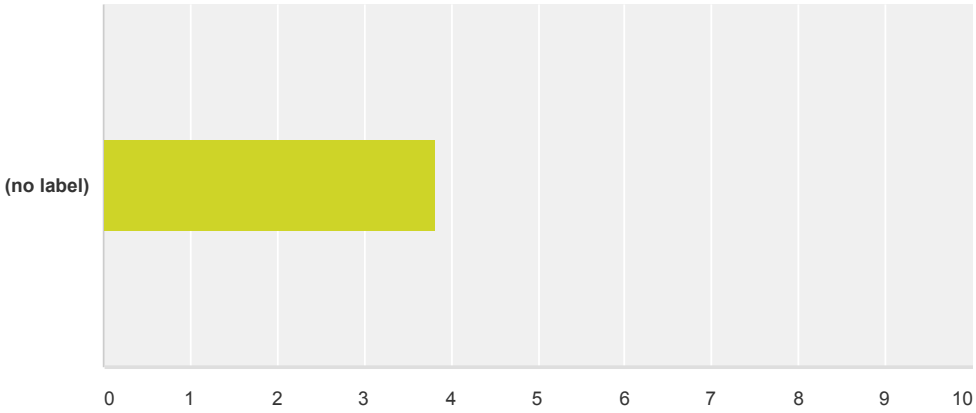
Answered: 12 Skipped: 100



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**83.33%** 10	**16.67%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	12	3.83

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

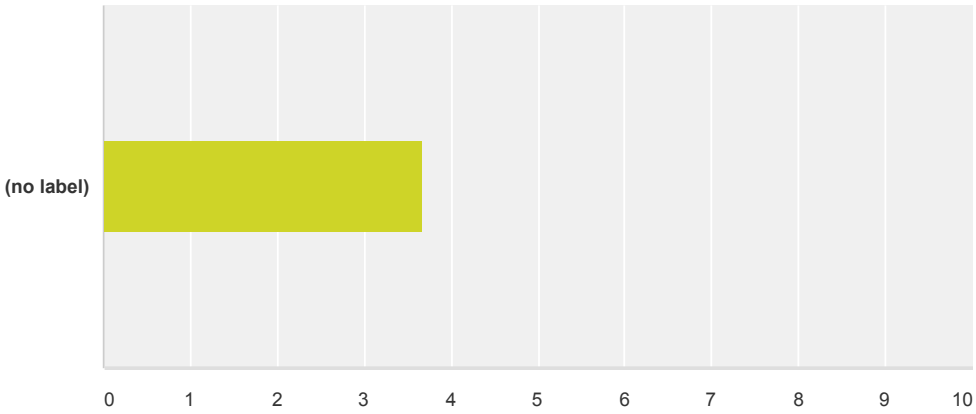
Answered: 12 Skipped: 100



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**83.33%** 10	**16.67%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	12	3.83

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

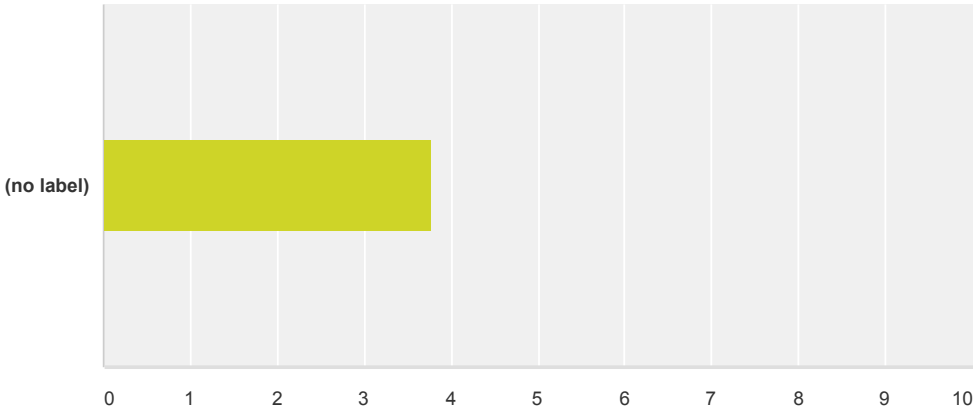
Answered: 12 Skipped: 100



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**66.67%** 8	**33.33%** 4	**0.00%** 0	**0.00%** 0	**0.00%** 0	12	3.67

Q50 Selection, Engagement and Seduction of Children and Adults by Child Molesters,Cory Jewell Jensen, MS, CBI Consulting

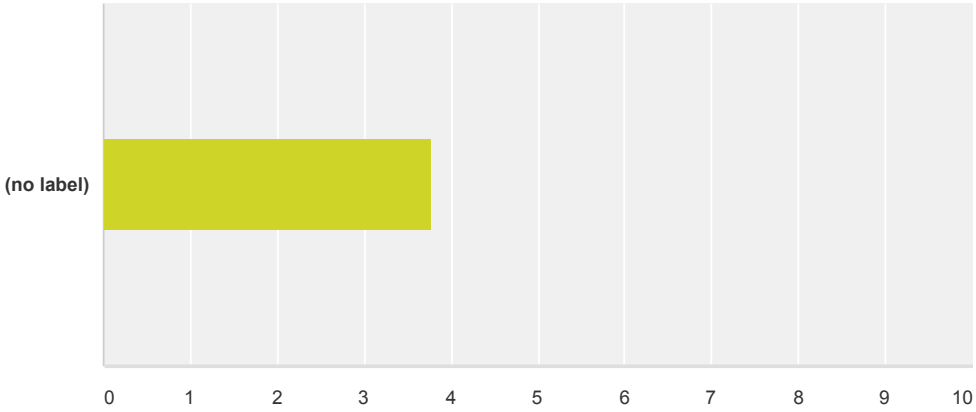
Answered: 22 Skipped: 90



	Excellent	Good	Fair	Poor	Total	Weighted Average
(no label)	**77.27%** 17	**22.73%** 5	**0.00%** 0	**0.00%** 0	22	3.77

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

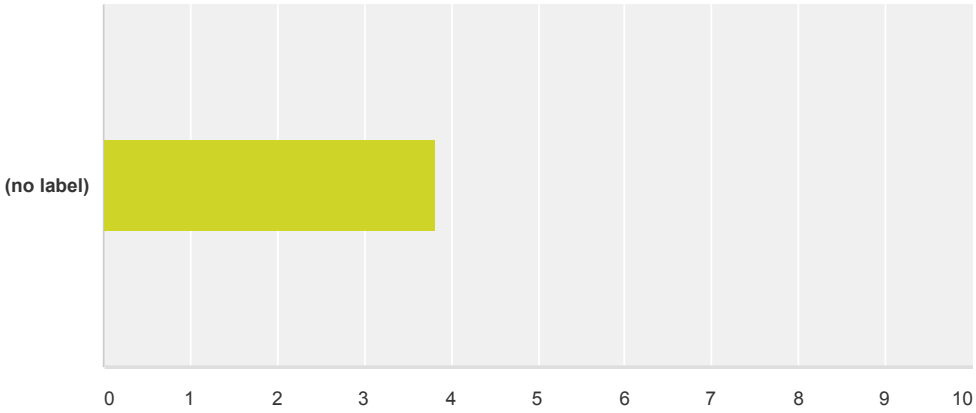
Answered: 22 Skipped: 90



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**77.27%** 17	**22.73%** 5	**0.00%** 0	**0.00%** 0	**0.00%** 0	22	3.77

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

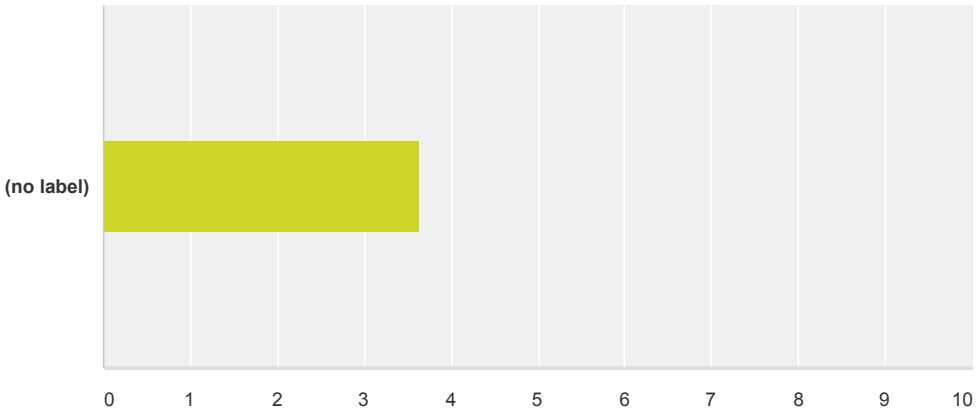
Answered: 22 Skipped: 90



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**81.82%** 18	**18.18%** 4	**0.00%** 0	**0.00%** 0	**0.00%** 0	22	3.82

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

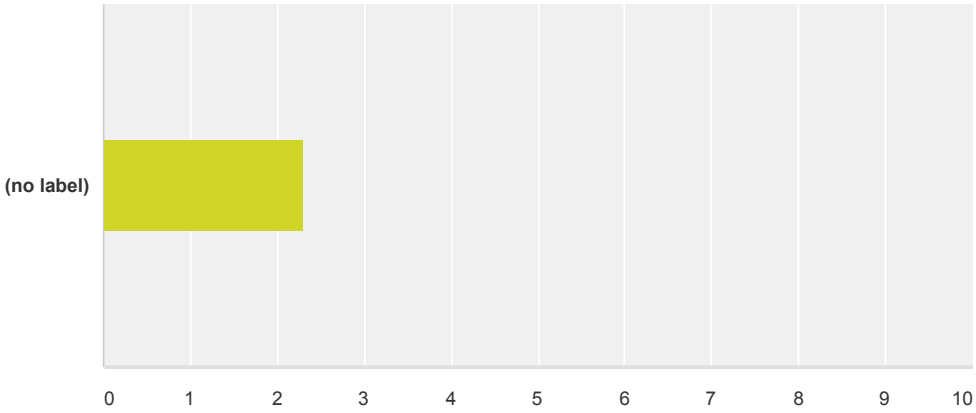
Answered: 22 Skipped: 90



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**63.64%** 14	**36.36%** 8	**0.00%** 0	**0.00%** 0	**0.00%** 0	22	3.64

Q54 By The Numbers: The State of Children in Delaware, Janice Barlow, KIDS COUNT in Delaware

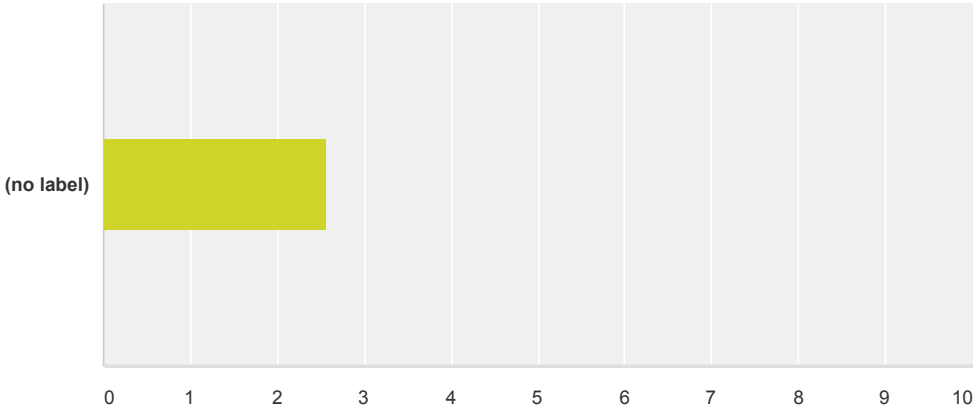
Answered: 7 Skipped: 105



	Excellent	Good	Fair	Poor	Total	Weighted Average
(no label)	**14.29%** 1	**14.29%** 1	**57.14%** 4	**14.29%** 1	7	2.29

Q55 The facilitator was well organized in the presentation of the course material.

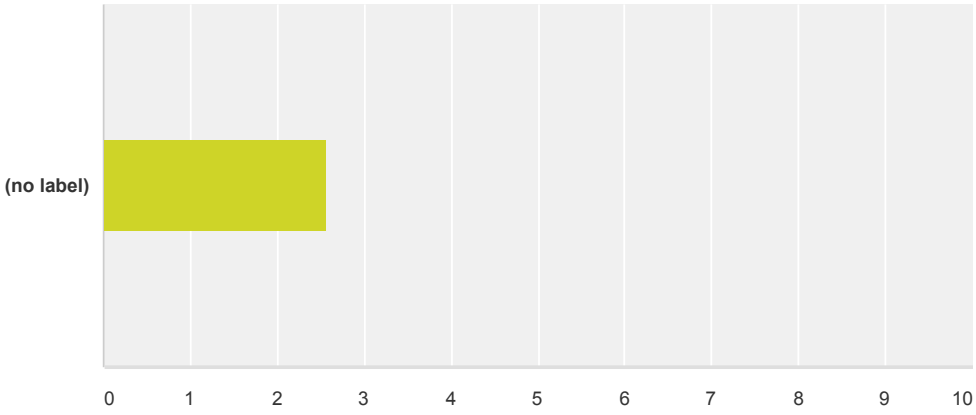
Answered: 7 Skipped: 105



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**28.57%** 2	**42.86%** 3	**14.29%** 1	**0.00%** 0	**14.29%** 1	7	2.57

Q56 The facilitator demonstrated a thorough knowledge of the subject matter.

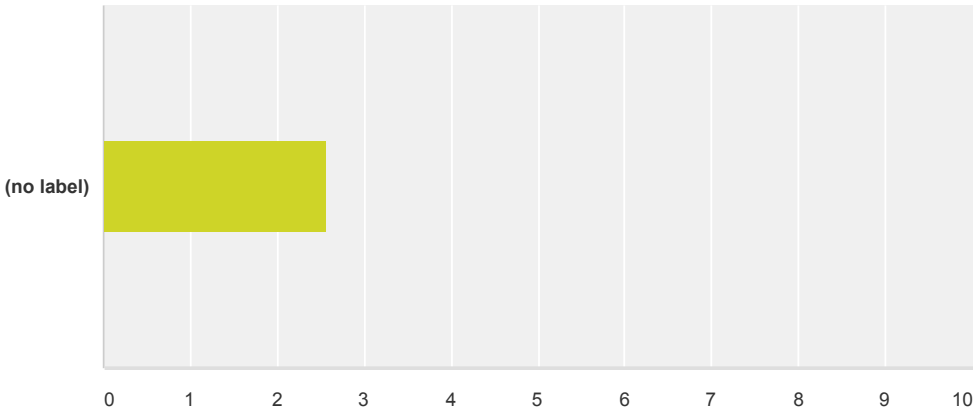
Answered: 7 Skipped: 105



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**28.57%** 2	**42.86%** 3	**14.29%** 1	**0.00%** 0	**14.29%** 1	7	2.57

Q57 My knowledge and understanding of the subject matter increased as a result of this session.

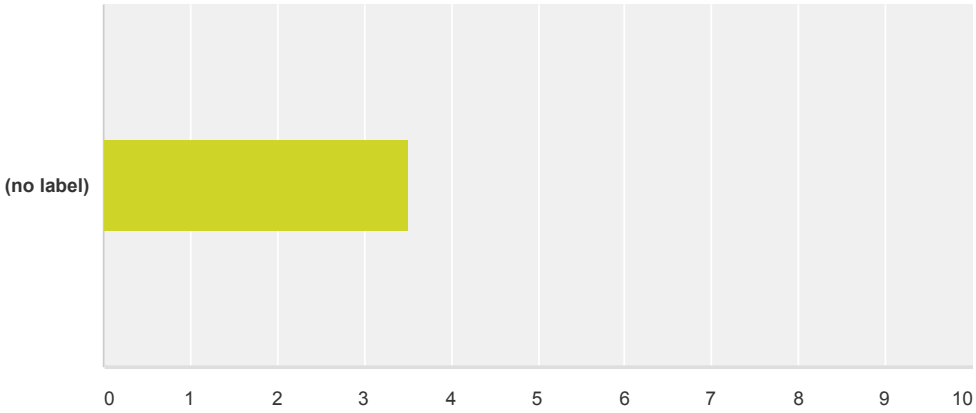
Answered: 7 Skipped: 105



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**0.00%** 0	**71.43%** 5	**0.00%** 0	**14.29%** 1	**14.29%** 1	7	2.57

Q58 Investigating Infant/Child Deaths: the Responsibilities of the First Responder, Detective Robert Daddio, Delaware State Police

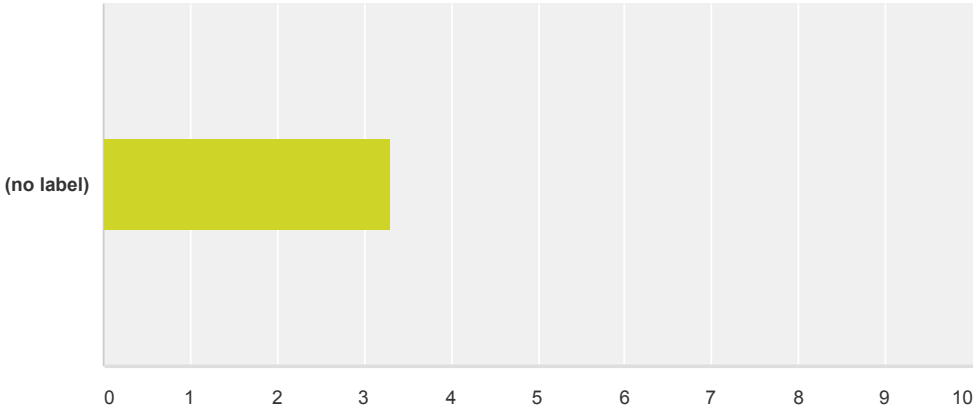
Answered: 10 Skipped: 102



	Excellent	Good	Fair	Poor	Total	Weighted Average
(no label)	**50.00%** 5	**50.00%** 5	**0.00%** 0	**0.00%** 0	10	3.50

Q59 The facilitator was well organized in the presentation of the course material.

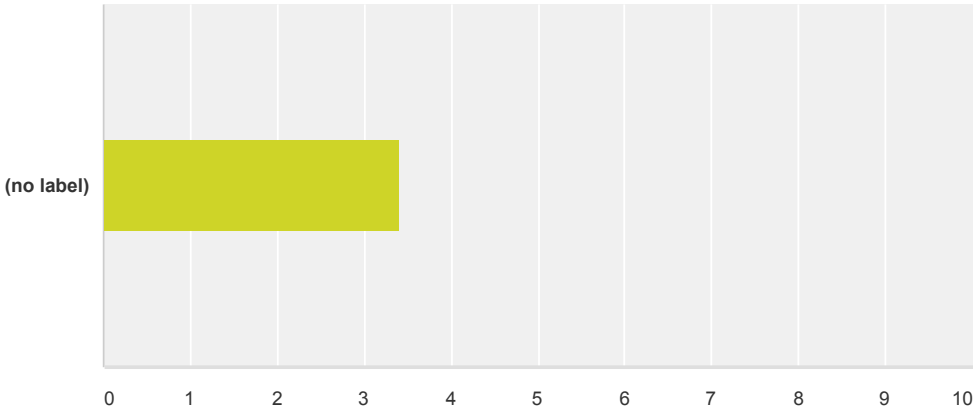
Answered: 10 Skipped: 102



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**30.00%** 3	**70.00%** 7	**0.00%** 0	**0.00%** 0	**0.00%** 0	10	3.30

Q60 The facilitator demonstrated a thorough knowledge of the subject matter.

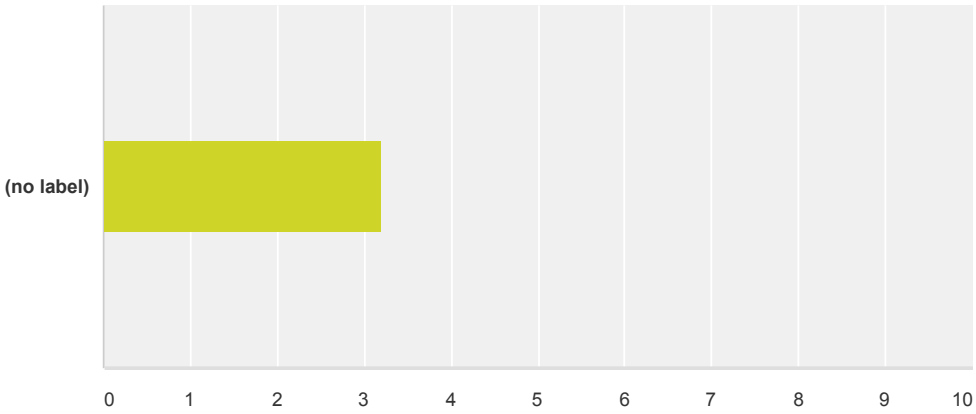
Answered: 10 Skipped: 102



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	40.00% 4	60.00% 6	0.00% 0	0.00% 0	0.00% 0	10	3.40

Q61 My knowledge and understanding of the subject matter increased as a result of this session.

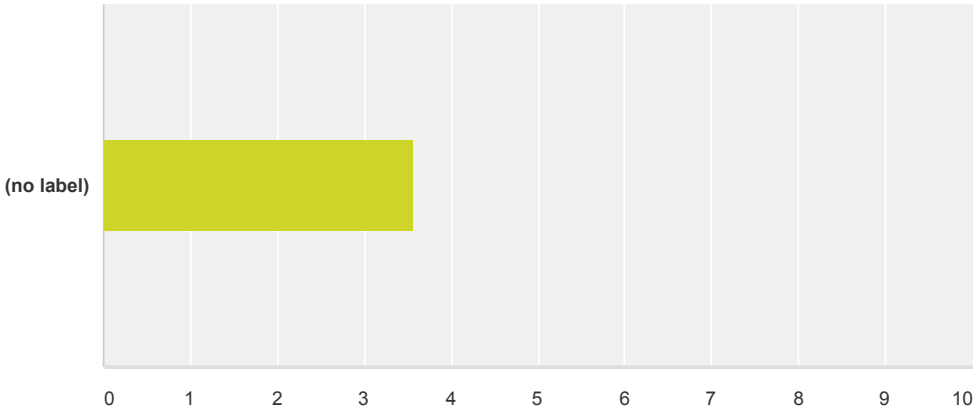
Answered: 10 Skipped: 102



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	50.00% 5	40.00% 4	10.00% 1	0.00% 0	0.00% 0	10	3.20

Q62 March 2017 Court Improvement Program Leading Practices Final Report, Judge Joelle Hitch, Family Court, Judge Peter Jones, Family Court, Kelly Ensslin, Esq.,OCA, Julie Yeager, Esq., Parent Attorney, and Islanda Finamore, Esq., DOJ

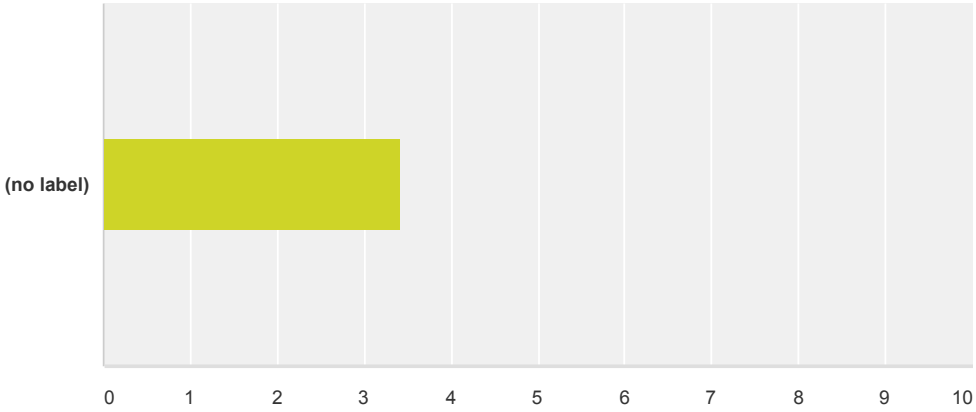
Answered: 12 Skipped: 100



	Excellent	Good	Fair	Poor	Total	Weighted Average
(no label)	**58.33%** 7	**41.67%** 5	**0.00%** 0	**0.00%** 0	12	3.58

Q63 The facilitators were well organized in the presentation of the course material.

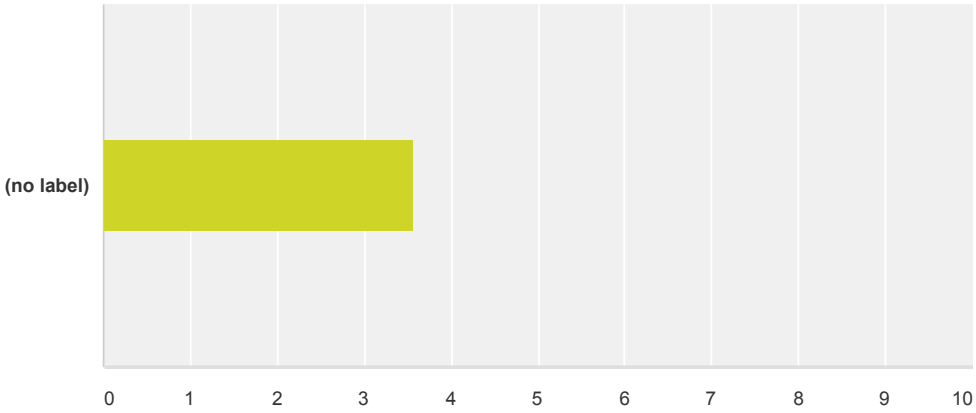
Answered: 12 Skipped: 100



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**41.67%** 5	**58.33%** 7	**0.00%** 0	**0.00%** 0	**0.00%** 0	12	3.42

Q64 The facilitators demonstrated a thorough knowledge of the subject matter.

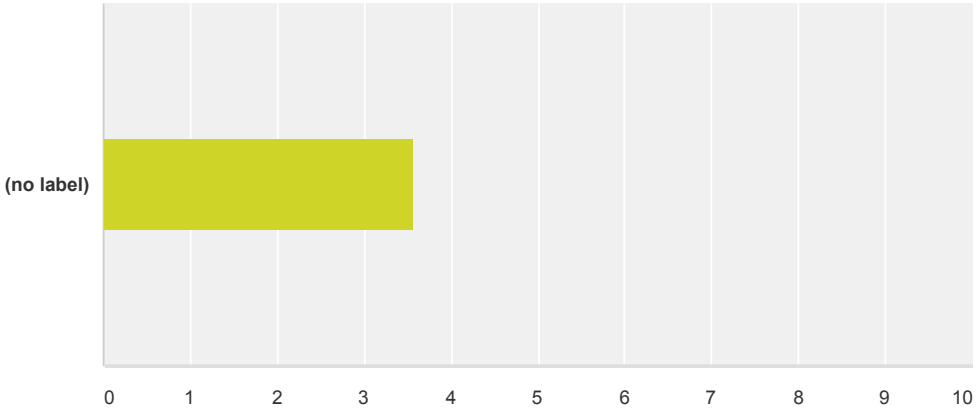
Answered: 12 Skipped: 100



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**58.33%** 7	**41.67%** 5	**0.00%** 0	**0.00%** 0	**0.00%** 0	12	3.58

Q65 My knowledge and understanding of the subject matter increased as a result of this session.

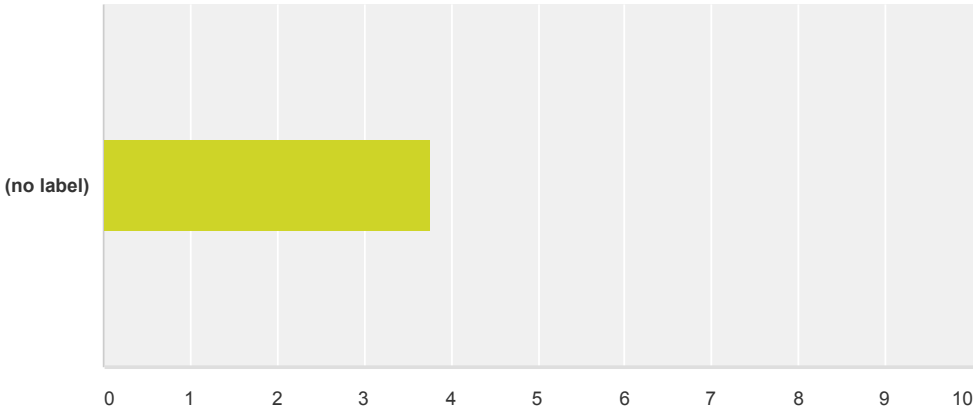
Answered: 12 Skipped: 100



	Strongly Agree	Agree	Neither Agree nor Dosagree	Disagree	Strongly Disagee	Total	Weighted Average
(no label)	**58.33%** 7	**41.67%** 5	**0.00%** 0	**0.00%** 0	**0.00%** 0	12	3.58

Q66 Social Networking: the Good, the Bad, the Ugly!, Jim Holler Jr, Consultant, Retired Chief of Police

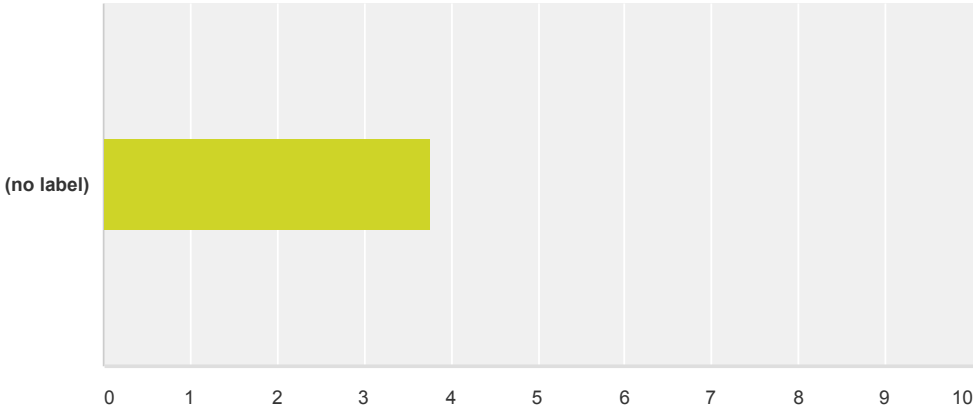
Answered: 16 Skipped: 96



	Excellent	Good	Fair	Poor	Total	Weighted Average
(no label)	**75.00%** 12	**25.00%** 4	**0.00%** 0	**0.00%** 0	16	3.75

Q67 The facilitator was well organized in the presentation of the course material.

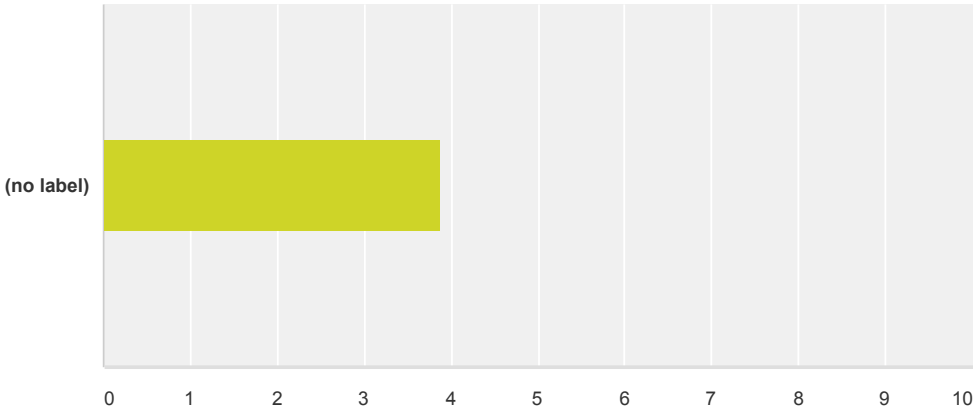
Answered: 16 Skipped: 96



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**75.00%** 12	**25.00%** 4	**0.00%** 0	**0.00%** 0	**0.00%** 0	16	3.75

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

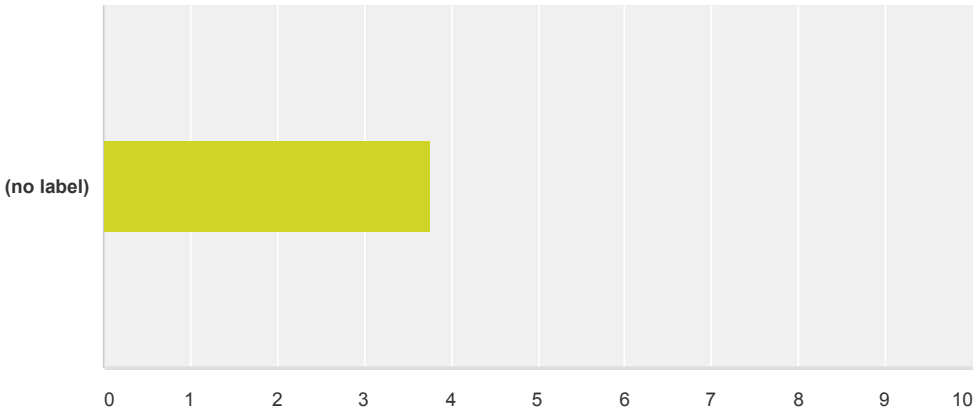
Answered: 16 Skipped: 96



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**87.50%** 14	**12.50%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	16	3.88

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

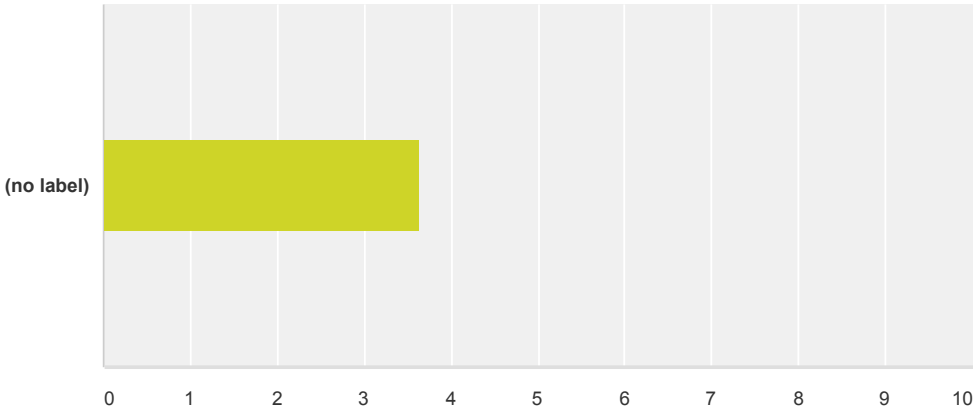
Answered: 16 Skipped: 96



	Strongly Agree	Agree	Neither Agree nor Dosagree	Disagree	Strongly Disagee	Total	Weighted Average
(no label)	**75.00%** 12	**25.00%** 4	**0.00%** 0	**0.00%** 0	**0.00%** 0	16	3.75

Q70 Human Trafficking, Sextortion, and Social Media, Patricia Dailey Lewis, Executive Director of the Beau Biden Foundation

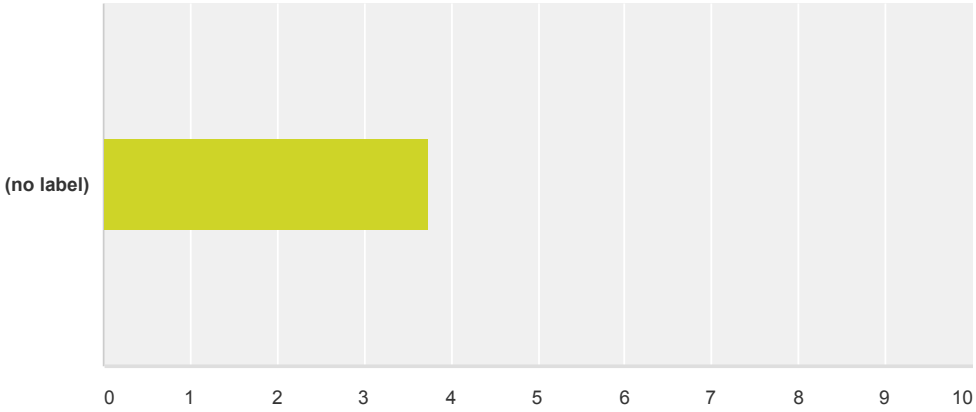
Answered: 11 Skipped: 101



	Excellent	Good	Fair	Poor	Total	Weighted Average
(no label)	**63.64%** 7	**36.36%** 4	**0.00%** 0	**0.00%** 0	11	3.64

Q71 The facilitator was well organized in the presentation of the course material.

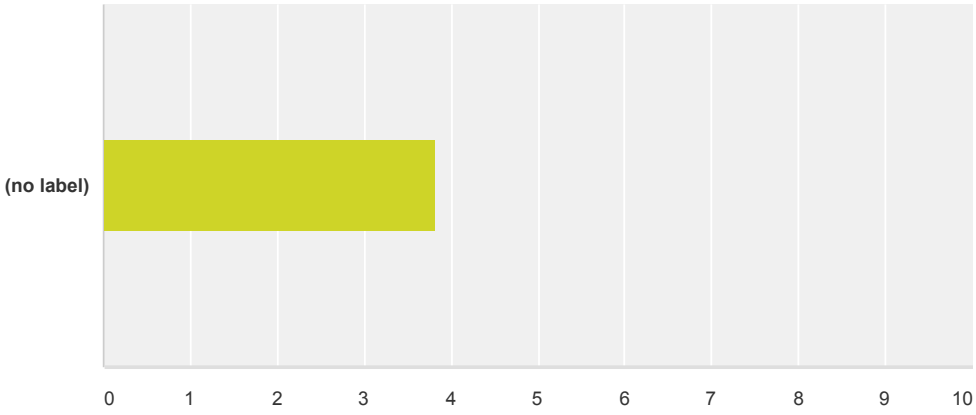
Answered: 11 Skipped: 101



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**72.73%** 8	**27.27%** 3	**0.00%** 0	**0.00%** 0	**0.00%** 0	11	3.73

Q72 The facilitator demonstrated a thorough knowledge of the subject matter.

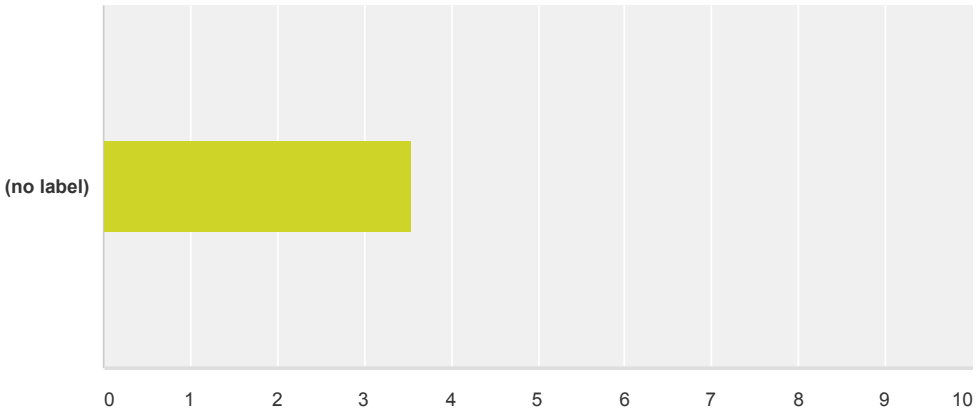
Answered: 11 Skipped: 101



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**81.82%** 9	**18.18%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	11	3.82

Q73 My knowledge and understanding of the subject matter increased as a result of this session.

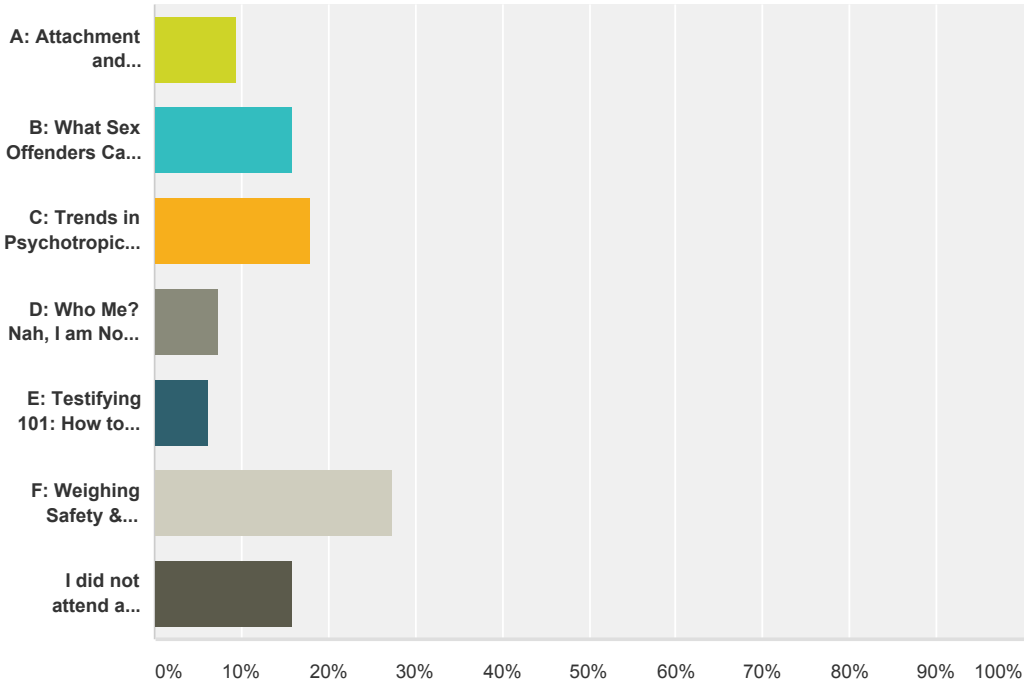
Answered: 11 Skipped: 101



	Strongly Agree	Agree	Neither Agree nor Dosagree	Disagree	Strongly Disagee	Total	Weighted Average
(no label)	**54.55%** 6	**45.45%** 5	**0.00%** 0	**0.00%** 0	**0.00%** 0	11	3.55

Q74 Which workshop did you attend?

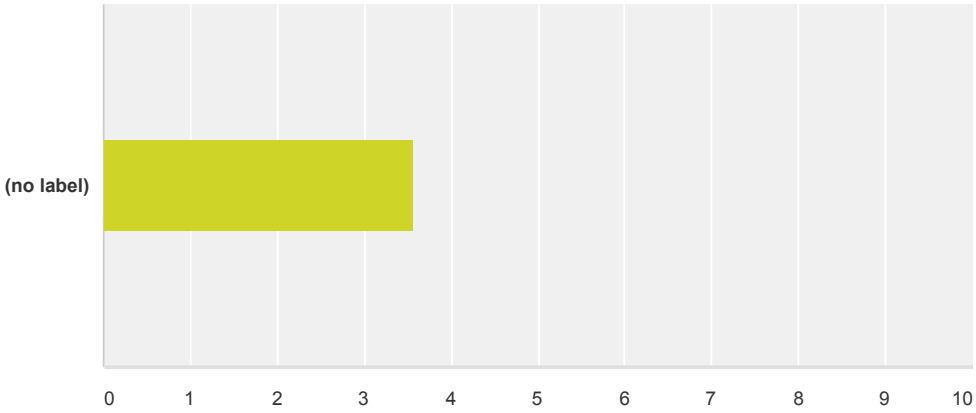
Answered: 95 Skipped: 17



Answer Choices	Responses
A: Attachment and Biobehavioral Catch-up: Intervening with Parents of Infants in theChild Welfare System, Dr. Mary Dozier, University of Delaware	**9.47%** 9
B: What Sex Offenders Can Teach Us About Interviewing, Cory Jewell Jensen, MS, CBIConsulting	**15.79%** 15
C: Trends in Psychotropic Medication Use Among Children in Foster Care, Dr. MeredithMatone and Leigh Wilson from the PolicyLab at Children's Hospital of Philadelphia,and Dr. Heather Alford and Thomas Wolters from DSCYF	**17.89%** 17
D: Who Me? Nah, I am Not Toasty! Vicarious Trauma and How to Take Care of Yourself,Elena M. Giacci, Independent Contractor	**7.37%** 7
E: Testifying 101: How to testify effectively and survive cross examination, MartinO'Connor, Esq., DOJ	**6.32%** 6
F: Weighing Safety & Connection in Families Experiencing Domestic Violence,Blanche Creech, M.A. Turning Point at People's Place, Inc. and Mariann Kenville-Moore,LCSW & DVS, Delaware Coalition Against Domestic Violence	**27.37%** 26
I did not attend a workshop.	**15.79%** 15
Total	**95**

Q75 Attachment and Biobehavioral Catch-up: Intervening with Parents of Infants in the Child Welfare System, Dr. Mary Dozier, University of Delaware

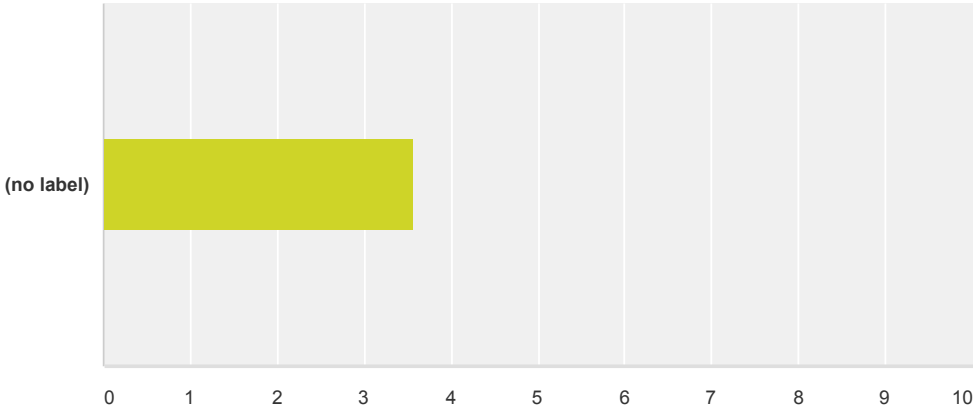
Answered: 9 Skipped: 103



	Excellent	Good	Fair	Poor	Total	Weighted Average
(no label)	**55.56%** 5	**44.44%** 4	**0.00%** 0	**0.00%** 0	9	3.56

Q76 The facilitator was well organized in the presentation of the course material.

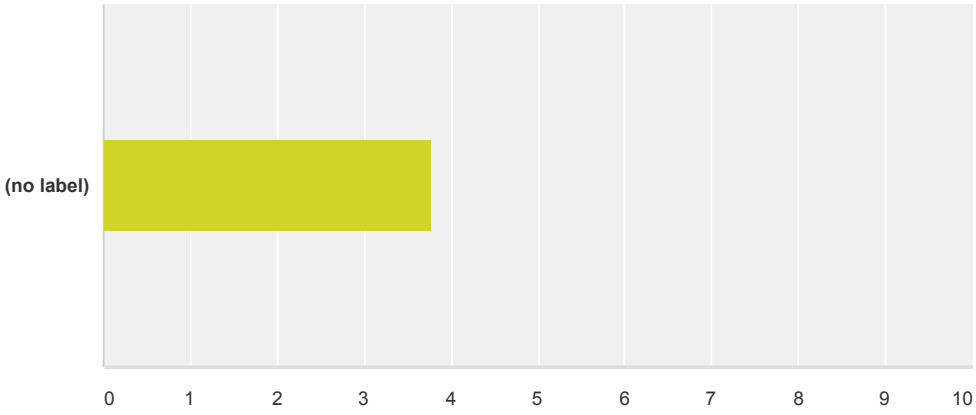
Answered: 9 Skipped: 103



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**55.56%** 5	**44.44%** 4	**0.00%** 0	**0.00%** 0	**0.00%** 0	9	3.56

Q77 The facilitator demonstrated a thorough knowledge of the subject matter.

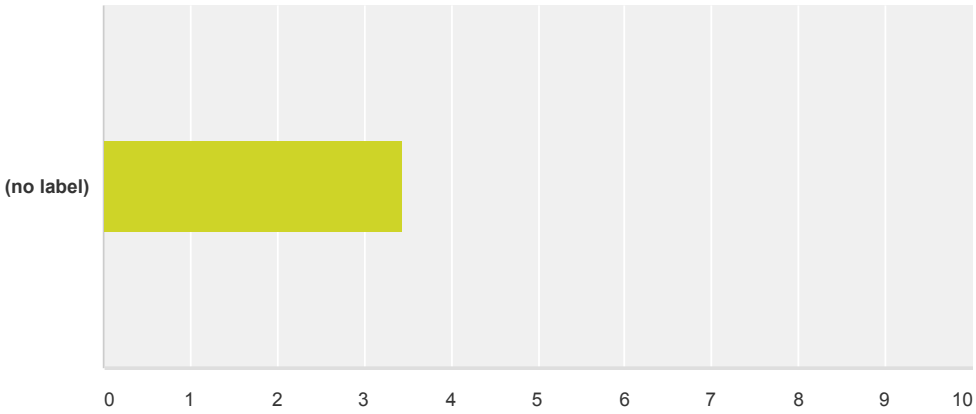
Answered: 9 Skipped: 103



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**77.78%** 7	**22.22%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	9	3.78

Q78 My knowledge and understanding of the subject matter increased as a result of this session.

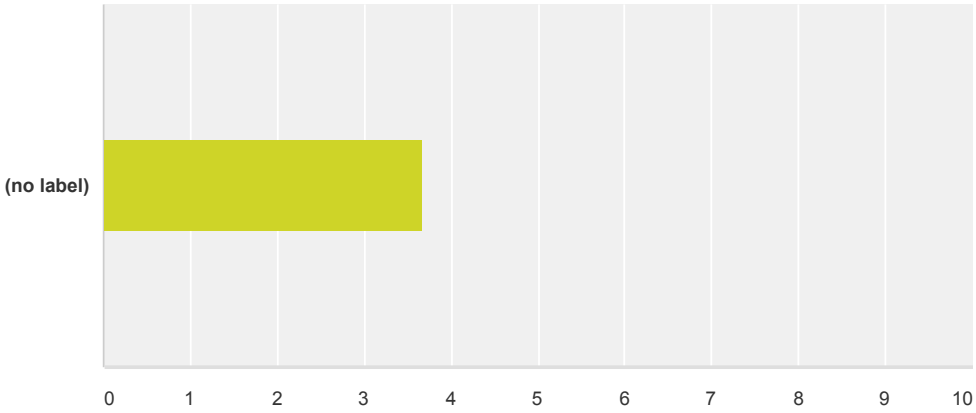
Answered: 9 Skipped: 103



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**44.44%** 4	**55.56%** 5	**0.00%** 0	**0.00%** 0	**0.00%** 0	9	3.44

Q79 What Sex Offenders Can Teach Us About Interviewing, Cory Jewell Jensen, MS, CBI Consulting

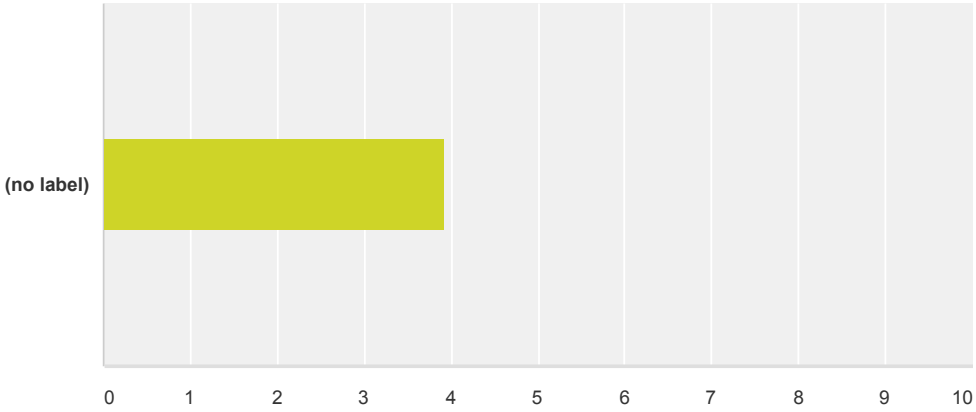
Answered: 15 Skipped: 97



	Excellent	Good	Fair	Poor	Total	Weighted Average
(no label)	**66.67%** 10	**33.33%** 5	**0.00%** 0	**0.00%** 0	15	3.67

Q80 The facilitator was well organized in the presentation of the course material.

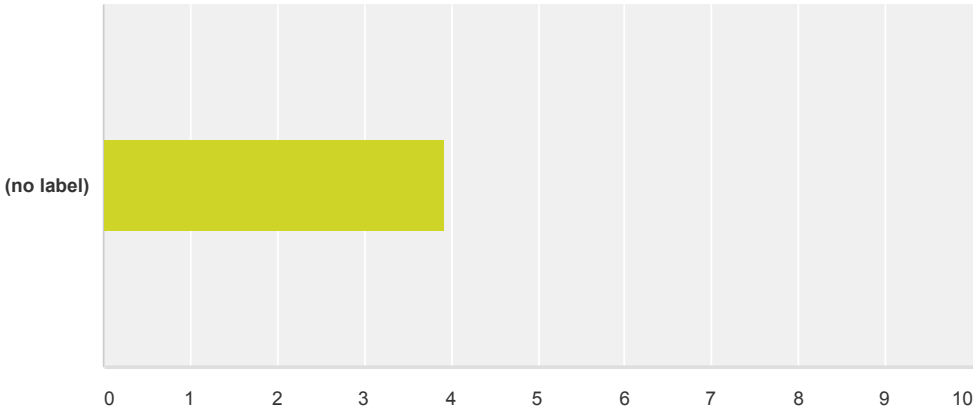
Answered: 15 Skipped: 97



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**93.33%** 14	**6.67%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	15	3.93

Q81 The facilitator demonstrated a thorough knowledge of the subject matter.

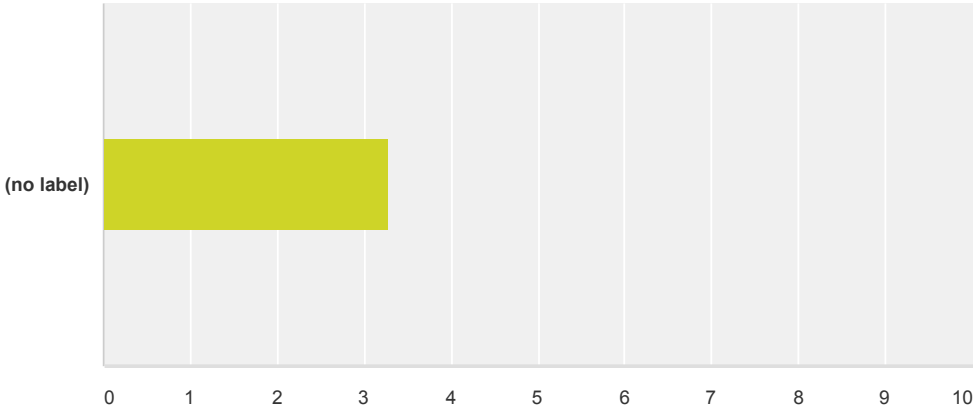
Answered: 15 Skipped: 97



	Strongly Agree	Agree	Neihter Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**93.33%** 14	**6.67%** 1	**0.00%** 0	**0.00%** 0	**0.00%** 0	15	3.93

Q82 My knowledge and understanding of the subject matter increased as a result of this session.

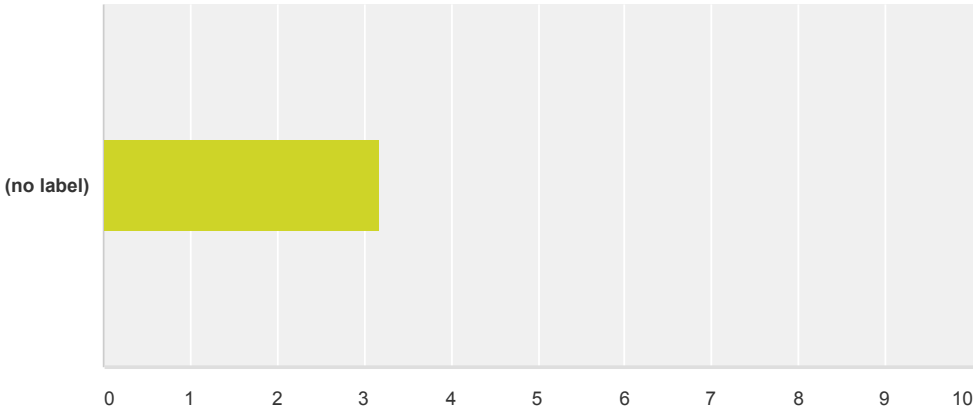
Answered: 15 Skipped: 97



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**66.67%** 10	**20.00%** 3	**13.33%** 2	**0.00%** 0	**0.00%** 0	15	3.27

Q83 Trends in Psychotropic Medication Use Among Children in Foster Care, Dr. Meredith Matone and Leigh Wilson from the Policy Lab at Children's Hospital of Philadelphia,and Dr. Heather Alford and Thomas Wolters from DSCYF

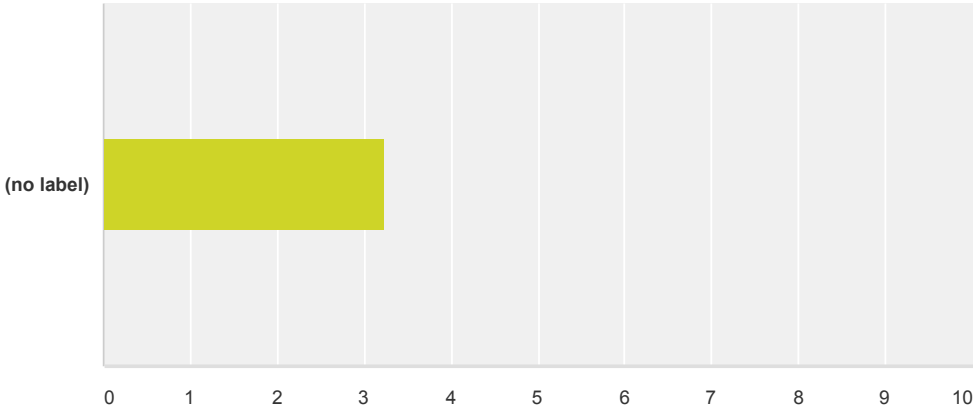
Answered: 17 Skipped: 95



	Excellent	Good	Fair	Poor	Total	Weighted Average
(no label)	**23.53%** 4	**70.59%** 12	**5.88%** 1	**0.00%** 0	17	3.18

Q84 The facilitators were well organized in the presentation of the course material.

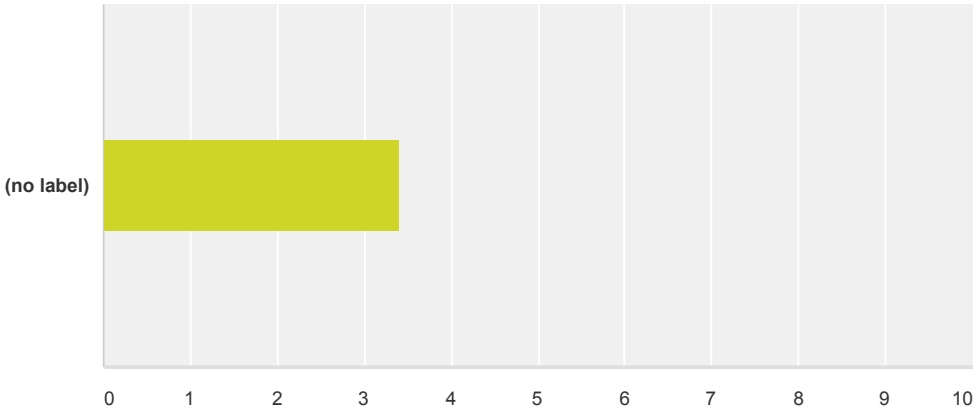
Answered: 17 Skipped: 95



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**23.53%** 4	**76.47%** 13	**0.00%** 0	**0.00%** 0	**0.00%** 0	17	3.24

Q85 The facilitators demonstrated a thorough knowledge of the subject matter.

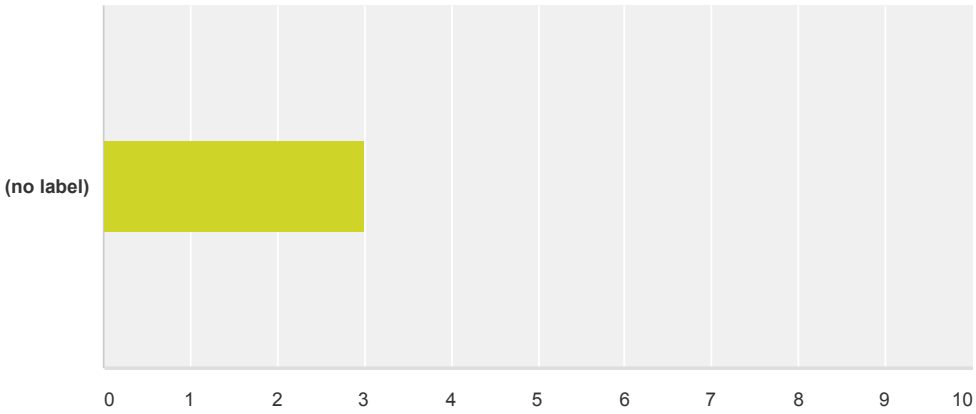
Answered: 17 Skipped: 95



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**41.18%** 7	**58.82%** 10	**0.00%** 0	**0.00%** 0	**0.00%** 0	17	3.41

Q86 My knowledge and understanding of the subject matter increased as a result of this session.

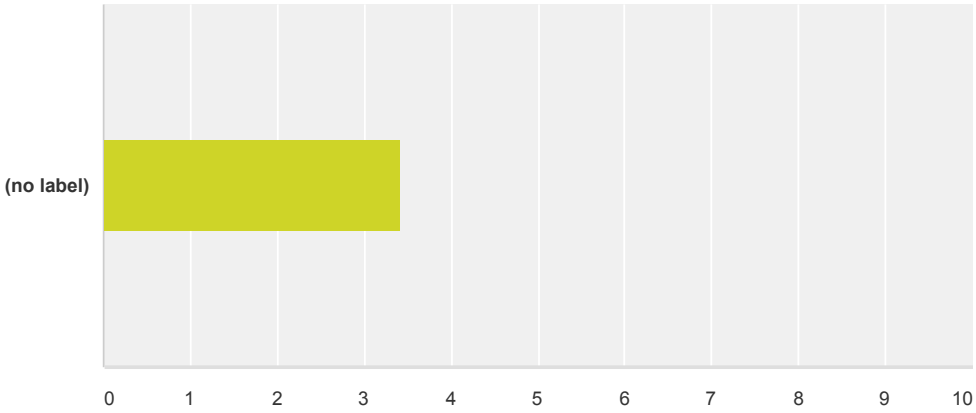
Answered: 17 Skipped: 95



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**35.29%** 6	**52.94%** 9	**11.76%** 2	**0.00%** 0	**0.00%** 0	17	3.00

Q87 Who Me? Nah, I am Not Toasty! Vicarious Trauma and How to Take Care of Yourself, Elena M. Giacci, Independent Contractor

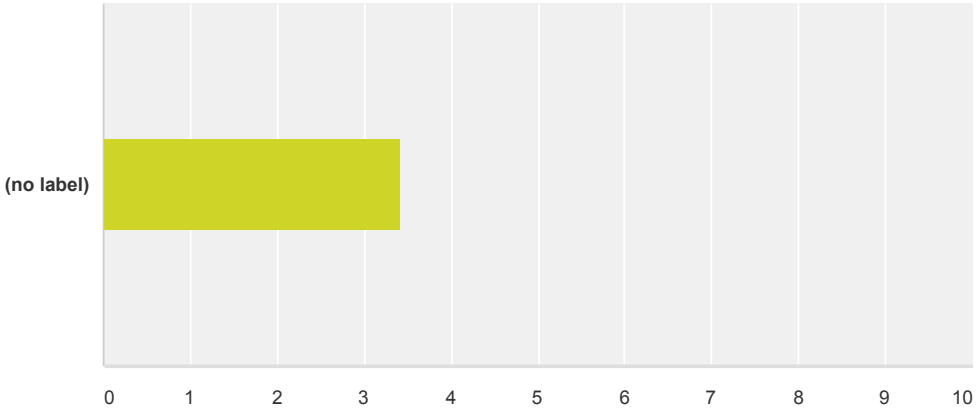
Answered: 7 Skipped: 105



	Excellent	Good	Fair	Poor	Total	Weighted Average
(no label)	**42.86%** 3	**57.14%** 4	**0.00%** 0	**0.00%** 0	7	3.43

Q88 The facilitator was well organized in the presentation of the course material.

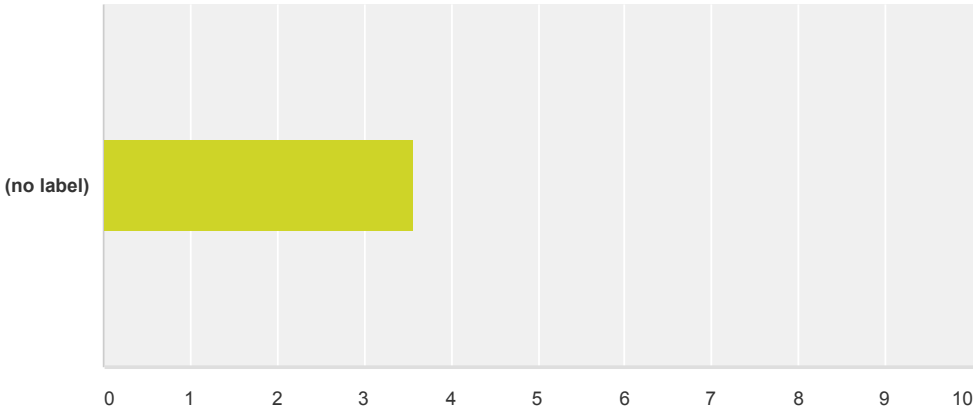
Answered: 7 Skipped: 105



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**42.86%** 3	**57.14%** 4	**0.00%** 0	**0.00%** 0	**0.00%** 0	7	3.43

Q89 The facilitator demonstrated a thorough knowledge of the subject matter.

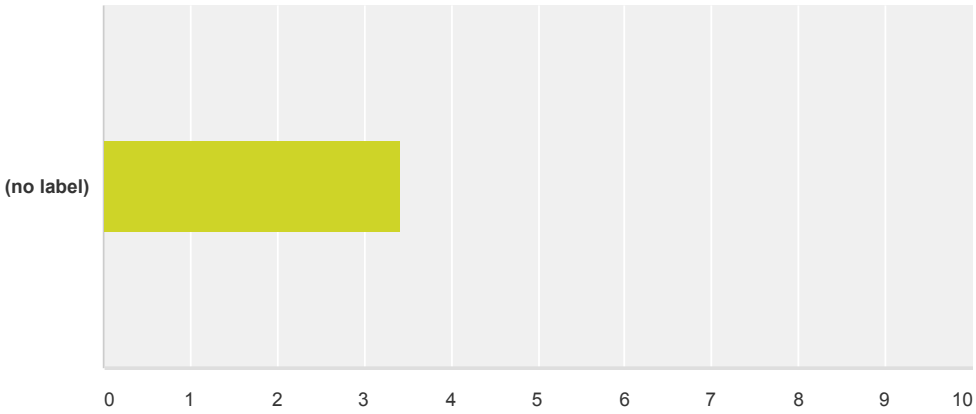
Answered: 7 Skipped: 105



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**57.14%** 4	**42.86%** 3	**0.00%** 0	**0.00%** 0	**0.00%** 0	7	3.57

Q90 My knowledge and understanding of the subject matter increased as a result of this session.

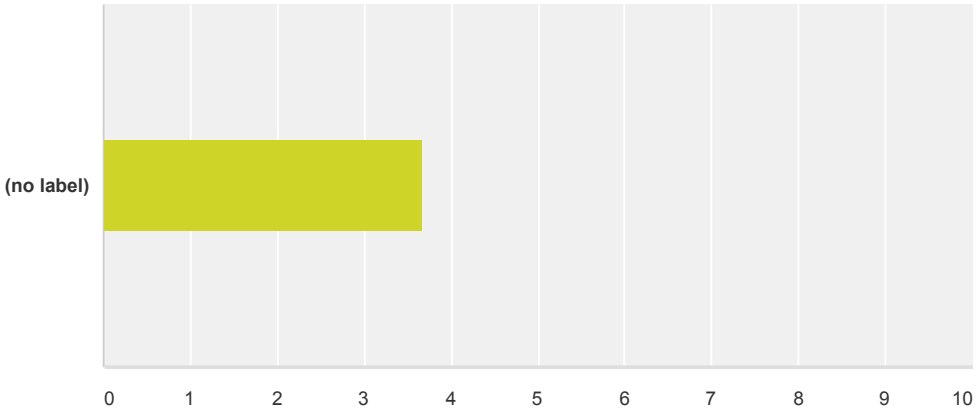
Answered: 7 Skipped: 105



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**42.86%** 3	**57.14%** 4	**0.00%** 0	**0.00%** 0	**0.00%** 0	7	3.43

Q91 Testifying 101: How to testify effectively and survive cross examination, Martin O'Connor, Esq., DOJ

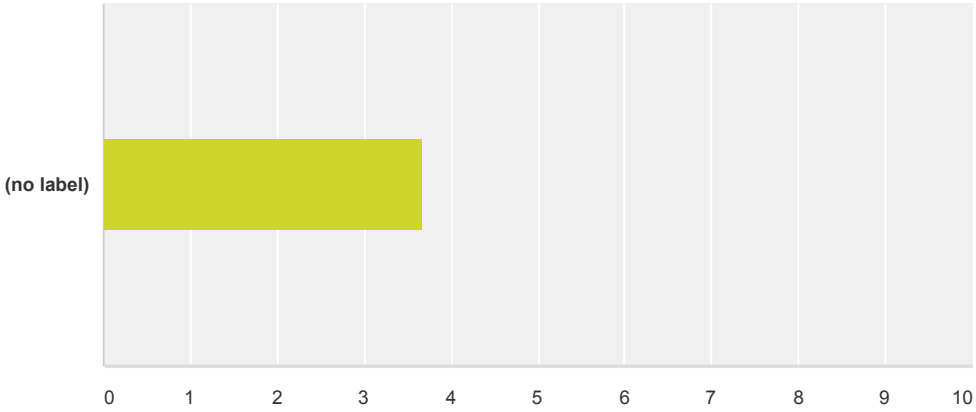
Answered: 6 Skipped: 106



	Excellent	Good	Fair	Poor	Total	Weighted Average
(no label)	**66.67%** 4	**33.33%** 2	**0.00%** 0	**0.00%** 0	6	3.67

Q92 The facilitator was well organized in the presentation of the course material.

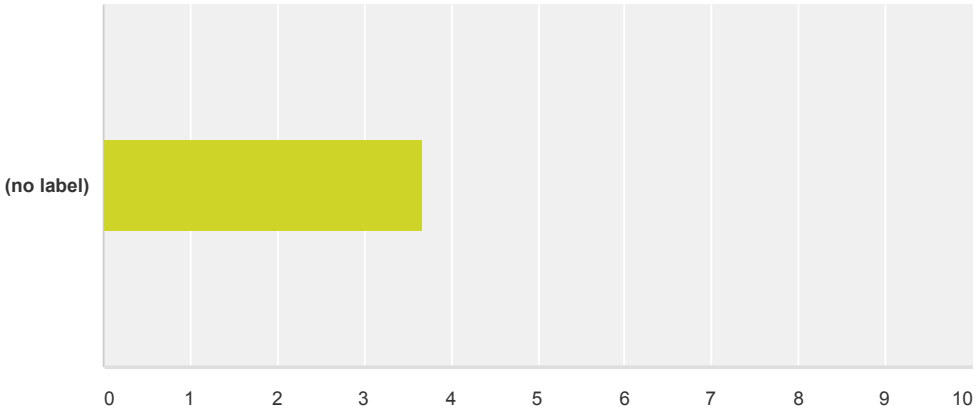
Answered: 6 Skipped: 106



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**66.67%** 4	**33.33%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	6	3.67

Q93 The facilitator demonstrated a thorough knowledge of the subject matter.

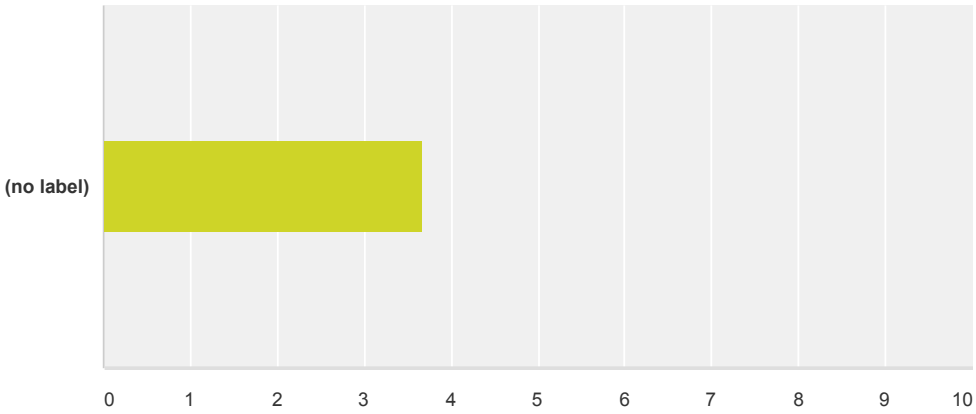
Answered: 6 Skipped: 106



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**66.67%** 4	**33.33%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	6	3.67

Q94 My knowledge and understanding of the subject matter increased as a result of this session.

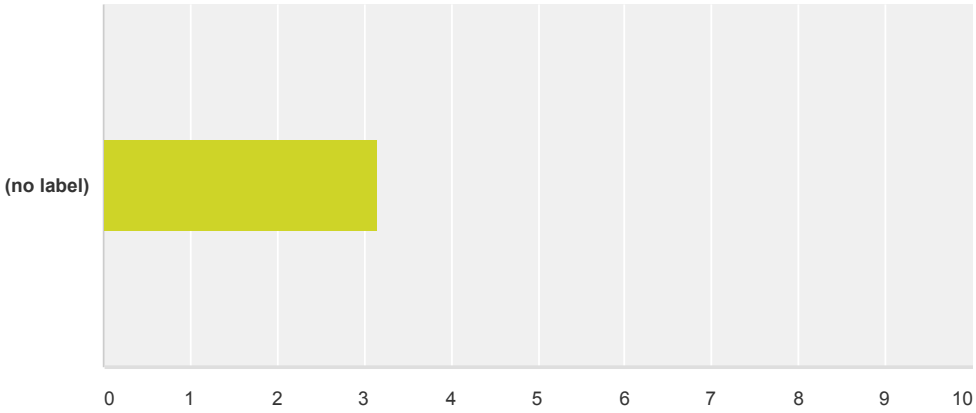
Answered: 6 Skipped: 106



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**66.67%** 4	**33.33%** 2	**0.00%** 0	**0.00%** 0	**0.00%** 0	6	3.67

Q95 Weighing Safety & Connection in Families Experiencing Domestic Violence, Blanche Creech, M.A. Turning Point at People's Place, Inc. and Mariann Kenville-Moore, LCSW & DVS, Delaware Coalition Against Domestic Violence

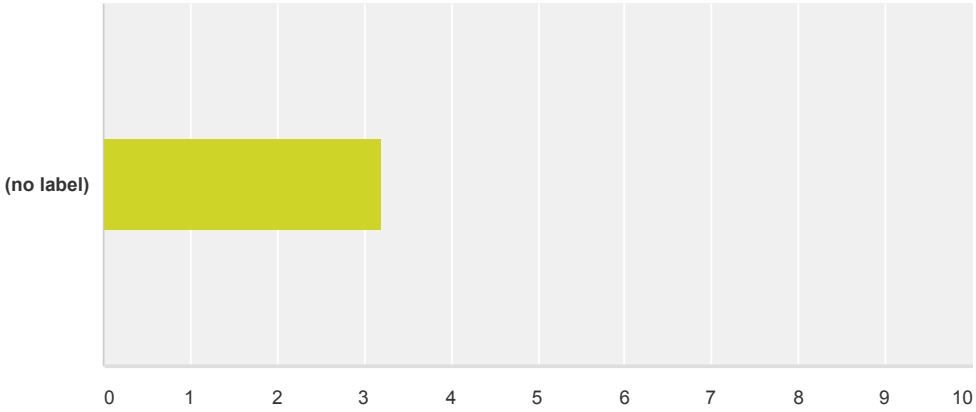
Answered: 26 Skipped: 86



	Excellent	Good	Fair	Poor	Total	Weighted Average
(no label)	**38.46%** 10	**46.15%** 12	**7.69%** 2	**7.69%** 2	26	3.15

Q96 The facilitators were well organized in the presentation of the course material.

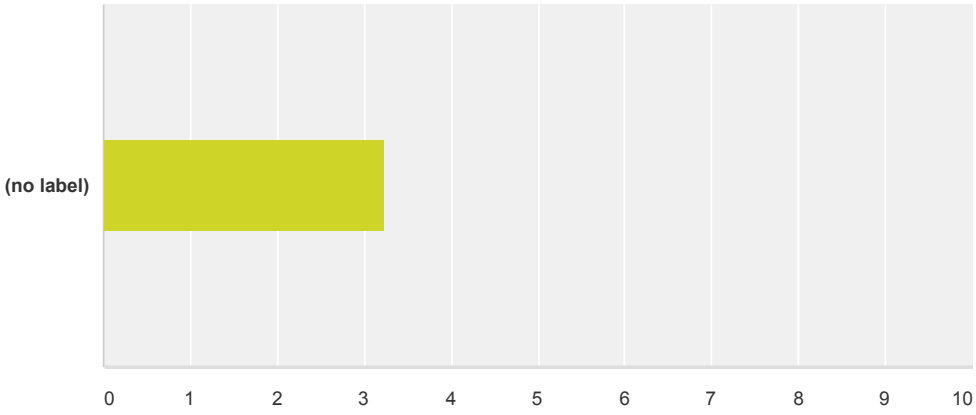
Answered: 26 Skipped: 86



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**34.62%** 9	**57.69%** 15	**3.85%** 1	**3.85%** 1	**0.00%** 0	26	3.19

Q97 The facilitators demonstrated a thorough knowledge of the subject matter.

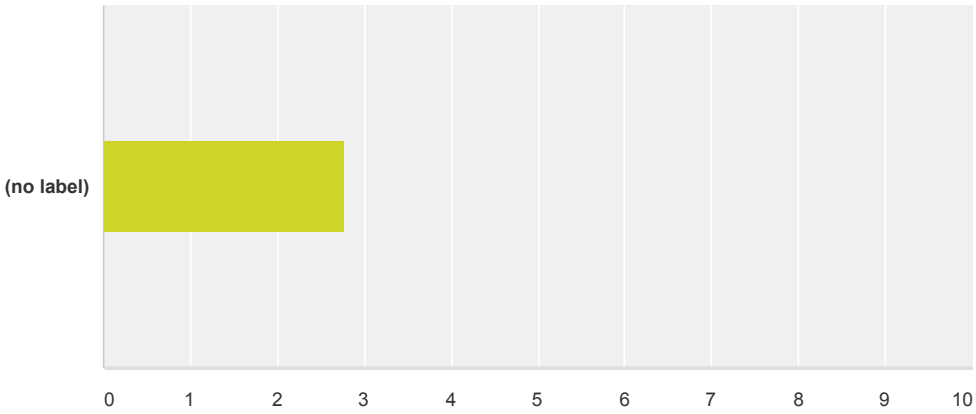
Answered: 26 Skipped: 86



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**38.46%** 10	**53.85%** 14	**3.85%** 1	**3.85%** 1	**0.00%** 0	26	3.23

Q98 My knowledge and understanding of the subject matter increased as a result of this session.

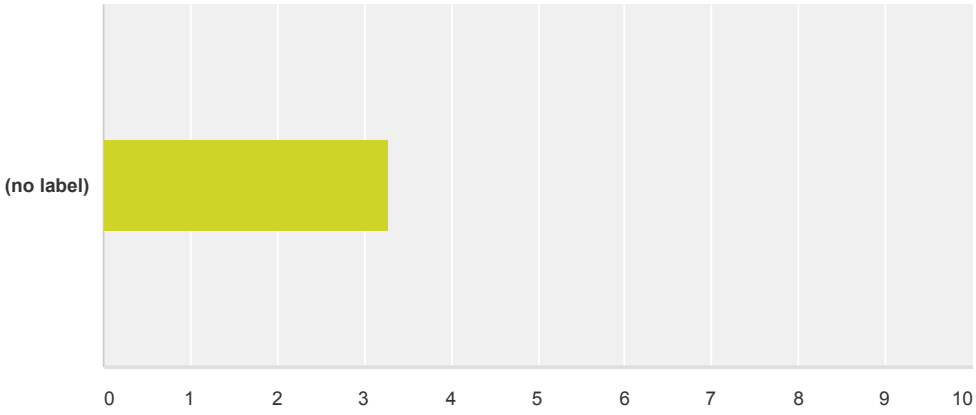
Answered: 26 Skipped: 86



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**34.62%** 9	**42.31%** 11	**15.38%** 4	**3.85%** 1	**3.85%** 1	26	2.77

Q99 Information provided in the workshops I attended will help me perform my job more effectively.

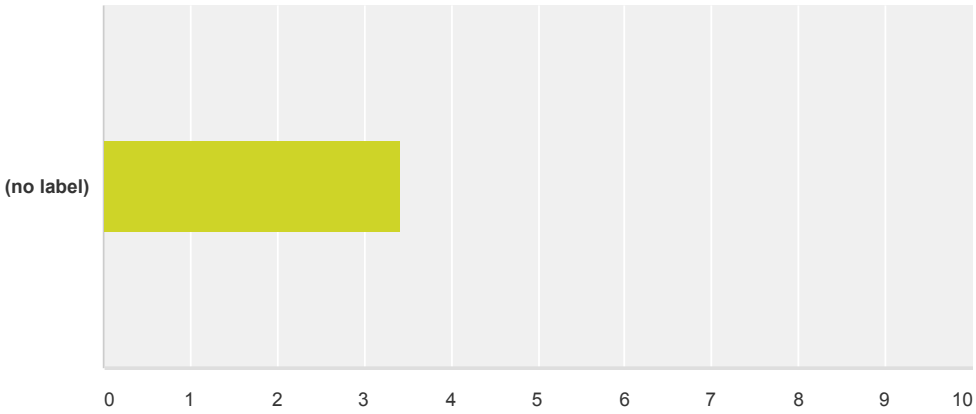
Answered: 93 Skipped: 19



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**41.94%** 39	**52.69%** 49	**4.30%** 4	**0.00%** 0	**1.08%** 1	93	3.27

Q100 In general, the workshop content was at an appropriate level for my background and experience.

Answered: 93 Skipped: 19



	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Total	Weighted Average
(no label)	**50.54%** 47	**46.24%** 43	**2.15%** 2	**1.08%** 1	**0.00%** 0	93	3.43

Q101 Thank you for completing this survey. Please use the space below to provide additional comments about specific workshops or the conference in general:

Answered: 19 Skipped: 93

#	Responses	Date

1	It would have extremely helpful to have handouts from the sessions.	5/19/2017 3:25 AM
2	Well done.	5/18/2017 8:08 AM
3	Excellent conference.	5/11/2017 12:32 AM
4	Well done as always!	5/10/2017 1:10 PM
5	Excellent conference!	5/10/2017 6:01 AM
6	The location was perfect, it was just cold initially. The range/selection of workshops was excellent. The food was excellent!	5/10/2017 5:00 AM
7	Thank you, it was a wonderful conference	5/10/2017 2:13 AM
8	Very informative workshops! I look forward to attending next year!	5/10/2017 2:08 AM
9	I think the facilitators were great and well versed in their fields. The were informative, yet gave relatable information for my particular job.	5/10/2017 2:07 AM
10	In the breakout workshops, a writing surface would be helpful. Thanks	5/10/2017 1:47 AM
11	I think the conference should be held in a central Delaware location to make it easily accessible for everyone across the state. It was inconvenient that it was held in Wilmington when you live further south in the state. I also thought the Domestic Violence workshop in Session III would have been much more better and engaging if the presenters did not read directly off the powerpoint, especially when we were already given copies of it. I thought that workshop was dry and hard to keep attention in.	5/10/2017 12:58 AM
12	I would like to see this back in central Delaware due to the long travel from Sussex.	5/10/2017 12:47 AM
13	The conference in general was a great one. I would definitely attend another conference. I would like CE credits to be included due to the conference reflects nursing field.	5/10/2017 12:45 AM
14	The sessions were interesting and helpful. I liked how diverse the subject matter was for each session.	5/10/2017 12:27 AM
15	The venue and food were excellent.	5/10/2017 12:21 AM
16	I attended the conference in an effort to get more involved in the prevention of child abuse in Del. If there are different resources where I can assist I'd love get that information. D.Brittingham 302-233-1748 (c)	5/10/2017 12:18 AM
17	I was disappointed that the speakers were not kept on time.	5/9/2017 12:35 PM
18	even though the conference was free of cost, I thought that I was getting nursing CEU for the hours I attended.	5/9/2017 8:44 AM
19	once again an excellent conference. Speakers were all knowledgeable, kept the attendee interested and really cared for the welfare of children. great job	5/9/2017 8:32 AM

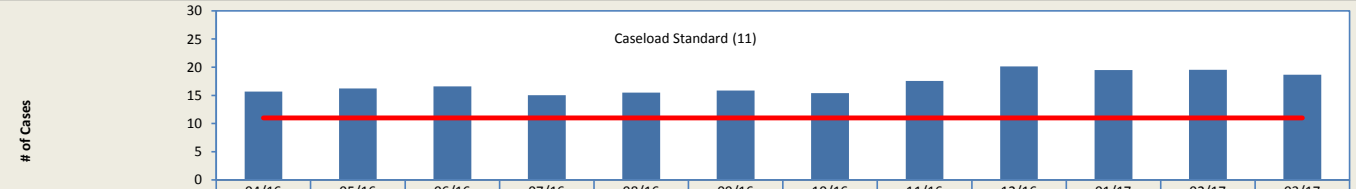
DELAWARE CHILD WELFARE DASHBOARD - STATEWIDE

REPORT DATE: MAY 17, 2017

1.0. CASELOAD

1.1 DFS INVESTIGATION CASELOADS BASED ON FULLY FUNCTIONAL WORKERS (SB 165 / SB 113)

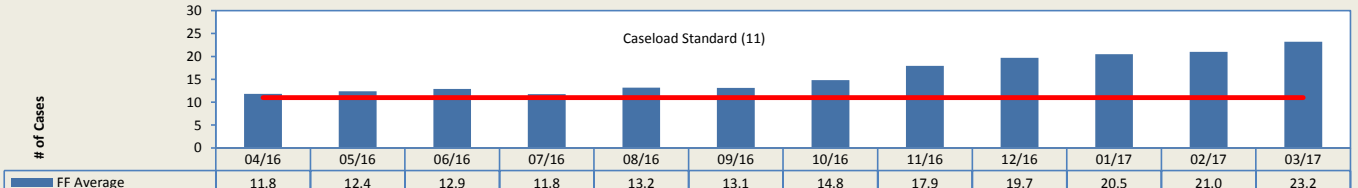
1.11 DFS INVESTIGATION - STATEWIDE



	04/16	05/16	06/16	07/16	08/16	09/16	10/16	11/16	12/16	01/17	02/17	03/17
FF Average	15.7	16.2	16.6	15.0	15.5	15.9	15.4	17.6	20.2	19.5	19.5	18.7
*# Full Function Workers	65	66	66	63	64	66	72	71	63	65	63	67
% Full Function Workers	83%	85%	85%	81%	76%	75%	75%	74%	62%	64%	62%	66%
**% FF Over Standard	68%	74%	74%	76%	72%	70%	72%	77%	95%	80%	81%	82%
FF Over Standard	44	49	49	48	46	46	52	55	60	52	51	55
Caseload Standard	11	11	11	11	11	11	11	11	11	11	11	11

*# Full Functioning Workers does not include workers on extended medical leave, new workers who have not yet received cases, workers with restricted caseloads because they have not completed mandatory training, or trainees who have not completed training
**% FF Over Standard = # of Workers Over Standard divided by # of Fully Functioning Workers

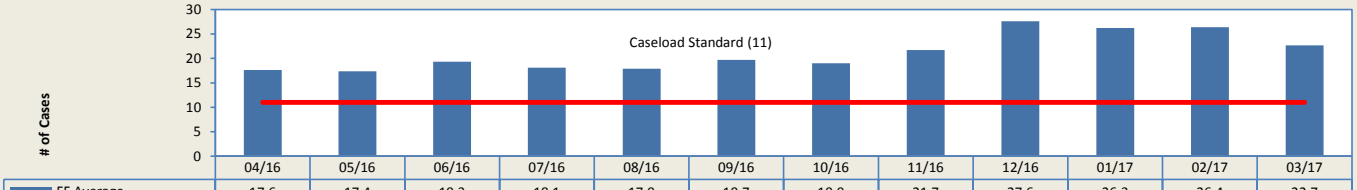
1.12 DFS INVESTIGATION - BEECH



	04/16	05/16	06/16	07/16	08/16	09/16	10/16	11/16	12/16	01/17	02/17	03/17
FF Average	11.8	12.4	12.9	11.8	13.2	13.1	14.8	17.9	19.7	20.5	21.0	23.2
*# Full Function Workers	17	17	18	16	16	16	16	16	14	15	14	15
% Full Function Workers	94%	94%	100%	89%	89%	89%	62%	62%	54%	58%	54%	58%
**% FF Over Standard	41%	59%	67%	56%	63%	63%	75%	81%	86%	73%	86%	100%
FF Over Standard	7	10	12	9	10	10	12	13	12	11	12	15
Caseload Standard	11	11	11	11	11	11	11	11	11	11	11	11

*# Full Functioning Workers does not include workers on extended medical leave, new workers who have not yet received cases, workers with restricted caseloads because they have not completed mandatory training, or trainees who have not completed training
**% FF Over Standard = # of Workers Over Standard divided by # of Fully Functioning Workers

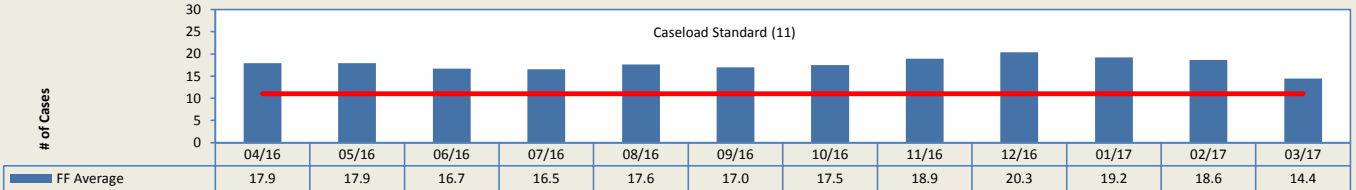
1.13 DFS INVESTIGATION - UNIVERSITY PLAZA



	04/16	05/16	06/16	07/16	08/16	09/16	10/16	11/16	12/16	01/17	02/17	03/17
FF Average	17.6	17.4	19.3	18.1	17.9	19.7	19.0	21.7	27.6	26.3	26.4	22.7
*# Full Function Workers	19	21	21	19	21	21	21	21	16	16	15	18
% Full Function Workers	79%	88%	88%	79%	88%	88%	88%	88%	55%	55%	52%	62%
**% FF Over Standard	74%	76%	76%	84%	76%	95%	100%	90%	100%	100%	100%	89%
FF Over Standard	14	16	16	16	16	20	21	19	16	16	15	16
Caseload Standard	11	11	11	11	11	11	11	11	11	11	11	11

*# Full Functioning Workers does not include workers on extended medical leave, new workers who have not yet received cases, workers with restricted caseloads because they have not completed mandatory training, or trainees who have not completed training
**% FF Over Standard = # of Workers Over Standard divided by # of Fully Functioning Workers

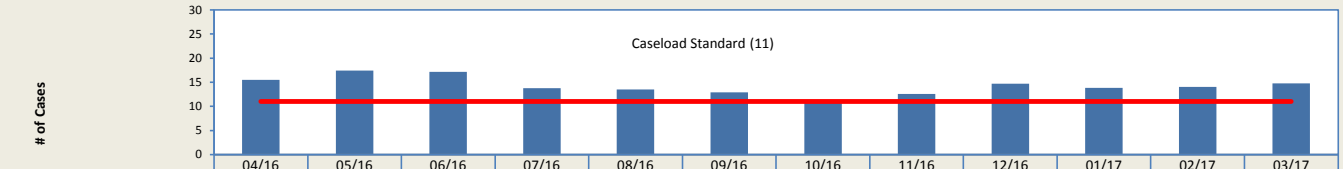
1.14 DFS INVESTIGATION - KENT



	04/16	05/16	06/16	07/16	08/16	09/16	10/16	11/16	12/16	01/17	02/17	03/17
FF Average	17.9	17.9	16.7	16.5	17.6	17.0	17.5	18.9	20.3	19.2	18.6	14.4
*# Full Function Workers	14	13	12	11	10	12	13	12	12	13	14	17
% Full Function Workers	82%	76%	71%	65%	43%	52%	57%	52%	52%	57%	61%	74%
**% FF Over Standard	86%	85%	67%	82%	80%	75%	77%	92%	92%	92%	86%	59%
FF Over Standard	12	11	8	9	8	9	10	11	11	12	12	10
Caseload Standard	11	11	11	11	11	11	11	11	11	11	11	11

*# Full Functioning Workers does not include workers on extended medical leave, new workers who have not yet received cases, workers with restricted caseloads because they have not completed mandatory training, or trainees who have not completed training
**% FF Over Standard = # of Workers Over Standard divided by # of Fully Functioning Workers

1.15 DFS INVESTIGATION - SUSSEX

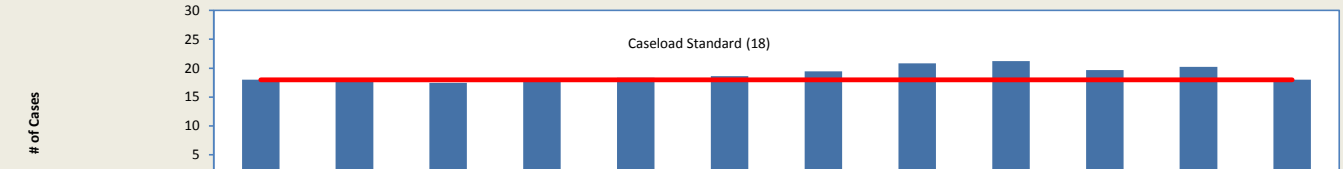


	04/16	05/16	06/16	07/16	08/16	09/16	10/16	11/16	12/16	01/17	02/17	03/17
FF Average	15.5	17.4	17.1	13.8	13.5	12.9	11.2	12.6	14.7	13.8	14.0	14.8
*# Full Function Workers	15	15	15	17	17	17	22	22	21	21	20	17
% Full Function Workers	79%	79%	79%	89%	89%	74%	96%	96%	91%	91%	87%	74%
**% FF Over Standard	73%	80%	87%	82%	71%	41%	41%	55%	100%	62%	60%	82%
FF Over Standard	11	12	13	14	12	7	9	12	21	13	12	14
Caseload Standard	11	11	11	11	11	11	11	11	11	11	11	11

*# Full Functioning Workers does not include workers on extended medical leave, new workers who have not yet received cases, workers with restricted caseloads because they have not completed mandatory training, or trainees who have not completed training
**% FF Over Standard = # of Workers Over Standard divided by # of Fully Functioning Workers

1.2 - DFS TREATMENT CASELOADS BASED ON FULLY FUNCTIONAL WORKERS (SB 165 / SB 113)

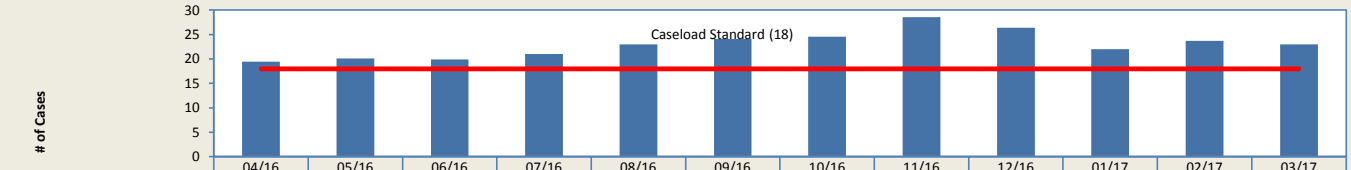
1.21 DFS TREATMENT - STATEWIDE



	04/16	05/16	06/16	07/16	08/16	09/16	10/16	11/16	12/16	01/17	02/17	03/17
FF Average	18.0	17.9	17.5	17.6	18.4	18.6	19.4	20.8	21.2	19.7	20.2	18.0
*# Full Function Workers	72	70	72	73	69	68	67	62	61	58	55	60
% Full Function Workers	94%	91%	94%	95%	90%	88%	87%	81%	79%	75%	71%	78%
**% FF Over Standard	47%	40%	42%	44%	48%	53%	52%	56%	56%	55%	49%	47%
FF Over Standard	34	28	30	32	33	36	35	35	34	32	27	28
Caseload Standard	18	18	18	18	18	18	18	18	18	18	18	18

*# Full Functioning Workers does not include workers on extended medical leave, new workers who have not yet received cases, workers with restricted caseloads because they have not completed mandatory training, or trainees who have not completed training
**% FF Over Standard = # of Workers Over Standard divided by # of Fully Functioning Workers

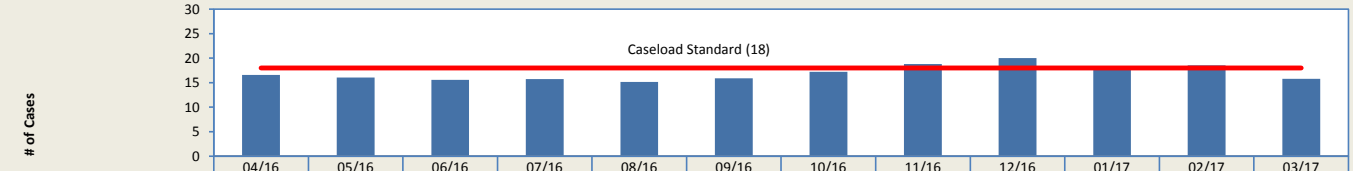
1.22 DFS TREATMENT - BEECH



	04/16	05/16	06/16	07/16	08/16	09/16	10/16	11/16	12/16	01/17	02/17	03/17
FF Average	19.4	20.1	19.9	21.0	23.0	24.1	24.6	28.5	26.4	22.0	23.7	23.0
*# Full Function Workers	23	22	23	23	21	19	19	17	18	16	15	15
% Full Function Workers	92%	88%	92%	92%	84%	76%	76%	68%	72%	64%	60%	60%
**% FF Over Standard	65%	64%	61%	70%	86%	100%	95%	88%	83%	69%	60%	73%
FF Over Standard	15	14	14	16	18	19	18	15	15	11	9	11
Caseload Standard	18	18	18	18	18	18	18	18	18	18	18	18

*# Full Functioning Workers does not include workers on extended medical leave, new workers who have not yet received cases, workers with restricted caseloads because they have not completed mandatory training, or trainees who have not completed training
**% FF Over Standard = # of Workers Over Standard divided by # of Fully Functioning Workers

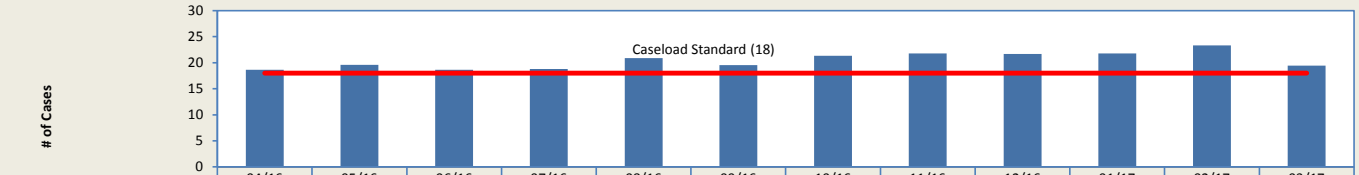
1.23 DFS TREATMENT - UNIVERSITY PLAZA



	04/16	05/16	06/16	07/16	08/16	09/16	10/16	11/16	12/16	01/17	02/17	03/17
FF Average	16.6	16.1	15.6	15.7	15.1	15.9	17.2	18.8	20.0	18.0	18.5	15.8
*# Full Function Workers	14	15	15	15	15	15	15	11	11	11	11	13
% Full Function Workers	93%	100%	100%	100%	100%	100%	100%	73%	73%	73%	73%	87%
**% FF Over Standard	36%	33%	27%	33%	20%	27%	20%	64%	36%	27%	36%	23%
FF Over Standard	5	5	4	5	3	4	3	7	4	3	4	3
Caseload Standard	18	18	18	18	18	18	18	18	18	18	18	18

*# Full Functioning Workers does not include workers on extended medical leave, new workers who have not yet received cases, workers with restricted caseloads because they have not completed mandatory training, or trainees who have not completed training
**% FF Over Standard = # of Workers Over Standard divided by # of Fully Functioning Workers

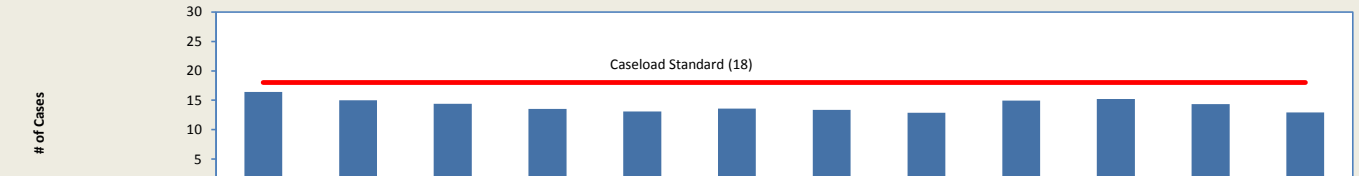
1.24 DFS TREATMENT - KENT



	04/16	05/16	06/16	07/16	08/16	09/16	10/16	11/16	12/16	01/17	02/17	03/17
FF Average	18.6	19.6	18.7	18.8	20.9	19.6	21.4	21.8	21.7	21.8	23.3	19.4
*# Full Function Workers	19	17	18	18	16	18	17	18	18	18	15	18
% Full Function Workers	95%	85%	90%	90%	80%	90%	85%	90%	90%	90%	75%	90%
**% FF Over Standard	47%	47%	61%	56%	75%	67%	76%	67%	78%	94%	80%	67%
FF Over Standard	9	8	11	10	12	12	13	12	14	17	12	12
Caseload Standard	18	18	18	18	18	18	18	18	18	18	18	18

*# Full Functioning Workers does not include workers on extended medical leave, new workers who have not yet received cases, workers with restricted caseloads because they have not completed mandatory training, or trainees who have not completed training
**% FF Over Standard = # of Workers Over Standard divided by # of Fully Functioning Workers

1.25 DFS TREATMENT - SUSSEX



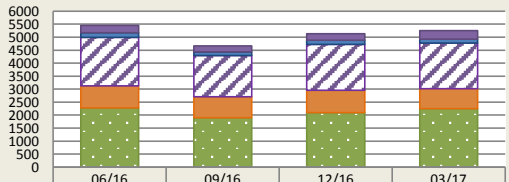
	04/16	05/16	06/16	07/16	08/16	09/16	10/16	11/16	12/16	01/17	02/17	03/17
FF Average	16.4	15.0	14.4	13.5	13.1	13.6	13.4	12.9	14.9	15.2	14.4	12.9
*# Full Function Workers	16	16	16	17	17	16	16	16	14	13	14	14
% Full Function Workers	94%	94%	94%	100%	100%	94%	94%	94%	82%	76%	82%	82%
**% FF Over Standard	31%	6%	6%	6%	0%	6%	6%	6%	7%	8%	14%	14%
FF Over Standard	5	1	1	1	0	1	1	1	1	1	2	2
Caseload Standard	18	18	18	18	18	18	18	18	18	18	18	18

*# Full Functioning Workers does not include workers on extended medical leave, new workers who have not yet received cases, workers with restricted caseloads because they have not completed mandatory training, or trainees who have not completed training
**% FF Over Standard = # of Workers Over Standard divided by # of Fully Functioning Workers

2.0 PROCESSING OF CHILD ABUSE CASES

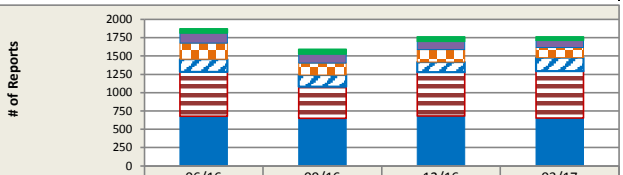
2.1 DIVISION OF FAMILY SERVICES

2.11 DFS HOTLINE REPORTS RECEIVED DURING QUARTER



	06/16	09/16	12/16	03/17
Linked to Active Inv.	282	231	258	329
Screened In (FAIR)	179	139	160	148
Screened In (Inv.)	1870	1592	1762	1762
Screened Out - Law Enforcement	843	807	863	767
Screened Out - General	2282	1898	2094	2246
Total	5456	4667	5137	5252

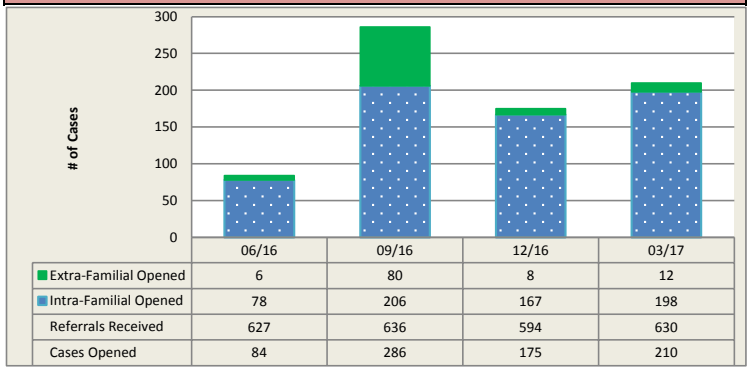
2.12 DFS HOTLINE REPORTS SCREENED IN (INVESTIGATION) DURING QUARTER SORTED BY PRIMARY MALTREATMENT TYPE



	06/16	09/16	12/16	03/17
Dependency	56	63	61	48
No Allegation	137	126	112	99
Emotional Abuse/Neglect	221	161	171	139
Sexual Abuse/Exploitation	172	161	140	184
Physical Abuse	606	433	598	638
Neglect	678	648	680	654
Total	1870	1592	1762	1762

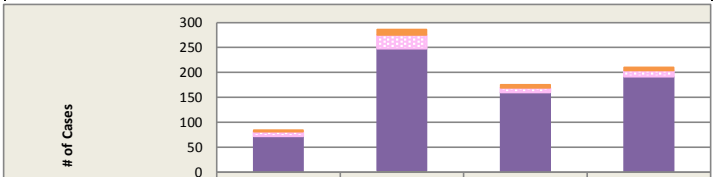
2.2 INVESTIGATION COORDINATOR

2.21 CASES OPENED DURING QUARTER



	06/16	09/16	12/16	03/17
Extra-Familial Opened	6	80	8	12
Intra-Familial Opened	78	206	167	198
Referrals Received	627	636	594	630
Cases Opened	84	286	175	210

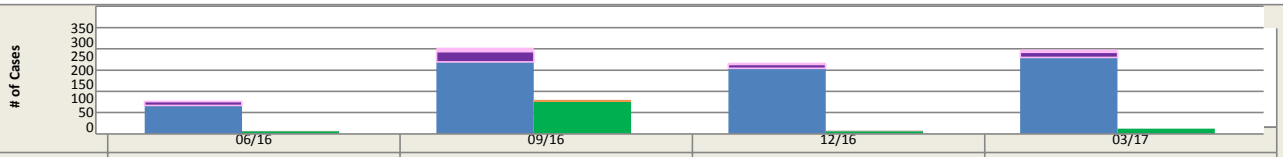
2.22 CASES OPENED BY MALTREATMENT TYPE DURING QUARTER



	06/16	09/16	12/16	03/17
Death	3	11	6	6
Serious Physical Injury	9	27	9	12
Sexual Abuse	72	245	160	192
MDT Contact*	0	3	0	0
Cases Opened	84	286	175	210

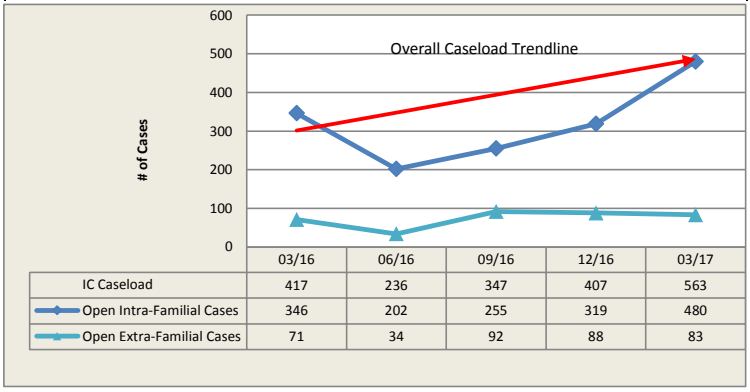
*** MDT Contact - Any communication with a multidisciplinary team member pertaining to a child**

2.23 INTRA-FAMILIAL AND EXTRA-FAMILIAL CASES OPENED DURING QUARTER



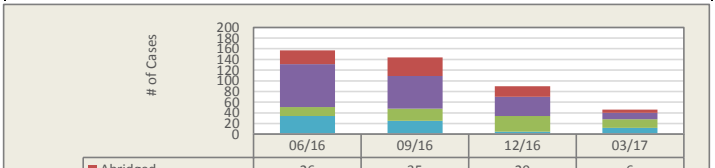
	06/16	09/16	12/16	03/17
Intra-familial Sex Abuse	67	169	154	180
Extra-familial Sex Abuse	5	76	6	12
Total Sex Abuse	72	245	160	192
Intra-familial Serious Physical Injury	9	24	9	12
Extra-Familial Serious Physical Injury	0	3	0	0
Total Serious Physical Injury	9	27	9	12
Intra-familial Death	2	10	4	6
Extra-familial Death	1	1	2	0
Total Death	3	11	6	6
Total	84	286	175	210

2.24 OPEN CASES AT END OF QUARTER (IC CASELOAD)



	03/16	06/16	09/16	12/16	03/17
IC Caseload	417	236	347	407	563
Open Intra-Familial Cases	346	202	255	319	480
Open Extra-Familial Cases	71	34	92	88	83

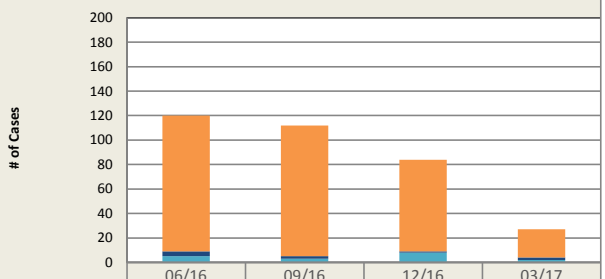
2.25 IC CASES CLOSED, CIVIL OUTCOMES - STATUS OF DFS INVOLVEMENT



	06/16	09/16	12/16	03/17
Abridged	26	35	20	6
Unfounded	80	61	36	12
Founded	17	23	29	16
No DFS Involvement	34	25	5	12
IC Admin Discontinued*	23	31	26	8
Total Cases Closed	180	178	116	54

* IC Admin Discontinued may include duplicate case entries, a case not in the jurisdiction of Delaware, insufficient information, etc.

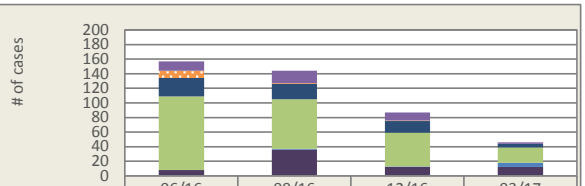
2.26 IC CASES CLOSED, CIVIL OUTCOMES - OUTCOME FOR CHILD



	06/16	09/16	12/16	03/17
No DSCYF Custody Child in Home	111	107	75	23
No DSCYF Custody Child Not in Home	4	2	1	2
DSCYF Custody	5	3	8	2
Not Applicable*	60	66	32	27
Total Cases Closed	180	178	116	54

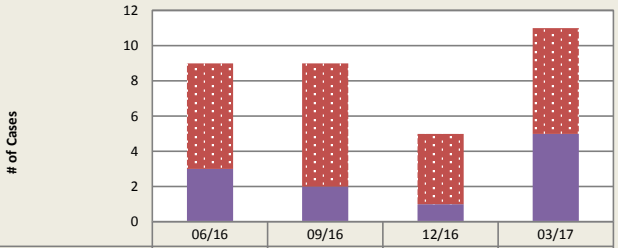
* Not Applicable includes any IC Administratively Discontinued cases, Child Deaths, and cases with No DFS Involvement

2.27 IC CASES CLOSED, CRIMINAL CASE OUTCOMES



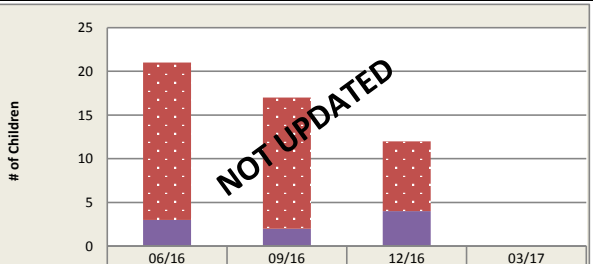
	06/16	09/16	12/16	03/17
No LE Involvement	13	17	11	2
LE Inactive	10	1	1	0
LE Unfounded	25	21	16	5
Prosecution Declined	101	68	46	21
Trial	0	1	1	6
Plea	8	36	12	12
Criminal Investigation or AG Decision > 1 Year	0	0	2	0
Criminal Investigation or AG Decision > 2 Years	0	0	0	0
IC Administratively Discontinued	23	31	27	8
MDT Contact	0	3	0	0
Total Cases Closed	180	178	116	54

2.3 CAN PANEL CASES OPENED



	06/16	09/16	12/16	03/17
Serious Physical Injury (Near Death)	6	7	4	6
Death (CAN)	3	2	1	5
Total Cases	9	9	5	11

2.4 DOJ SPECIAL VICTIM'S UNIT: CASES RECEIVED DURING QUARTER

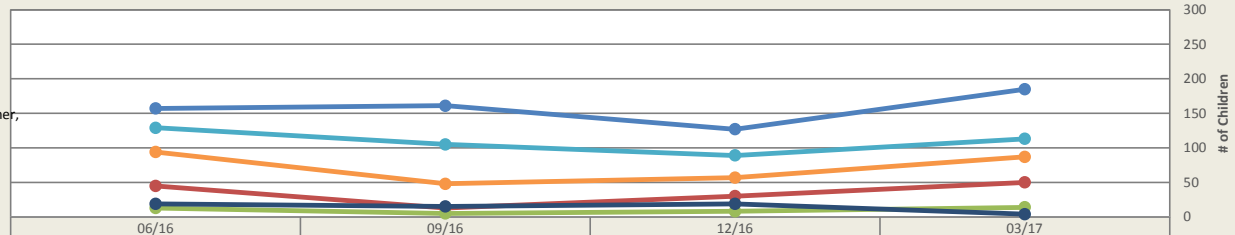


	06/16	09/16	12/16	03/17
Serious Physical Injury (Near Death)	18	15	8	
Death (CAN)	3	2	4	
Total Cases	21	17	12	

2.5 CHILDREN'S ADVOCACY CENTER

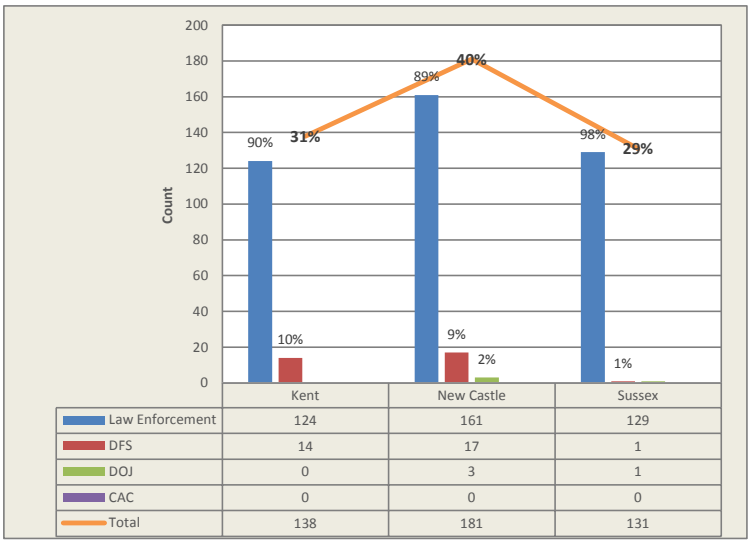
2.51 CAC CASE TYPES

*Other cases may include multiple maltreatment types such as Neglect/Emotional, Physical/Emotional, Sexual/Physical, as well as Other, Miscellaneous categories



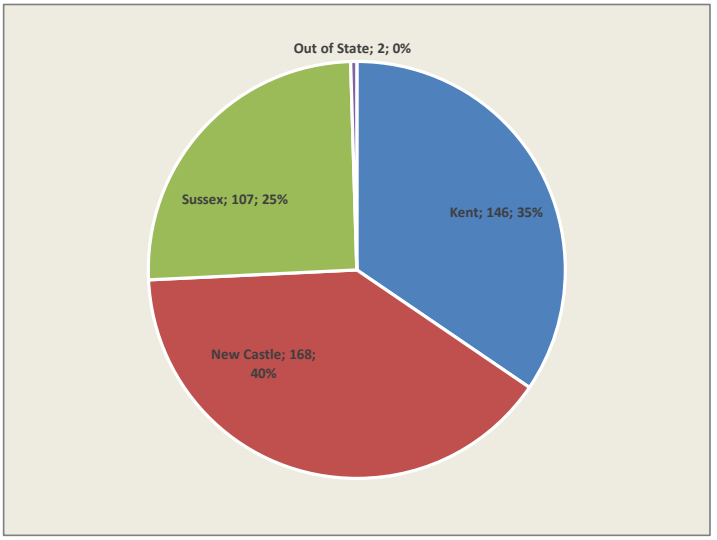
	06/16	09/16	12/16	03/17
Intra-familial Sexual	157	161	127	185
Intra-familial Physical	45	13	30	50
Intra-familial Other *	13	5	8	14
Intra-familial Total	215	179	165	249
Extra-familial Sexual	129	105	89	113
Extra-familial Physical	94	48	57	87
Extra-familial Other *	19	15	19	4
Extra-familial Total	242	168	165	204
Witness Interview	40	37	21	44

2.52 INCIDENTS RECEIVED BY REFERRAL AGENCY DURING QUARTER ENDING MARCH 31, 2017

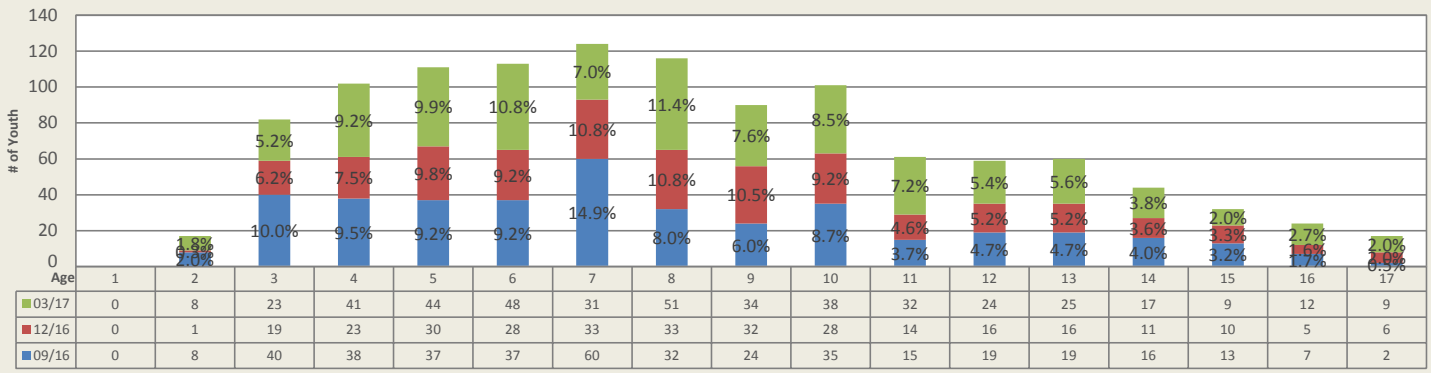


	Kent	New Castle	Sussex
Law Enforcement	124	161	129
DFS	14	17	1
DOJ	0	3	1
CAC	0	0	0
Total	138	181	131

2.53 CAC COUNTY OF ALLEGED ABUSE OF INCIDENTS RECEIVED DURING QUARTER AS OF MARCH 31, 2017



2.54 AGES OF YOUTH INTERVIEWED

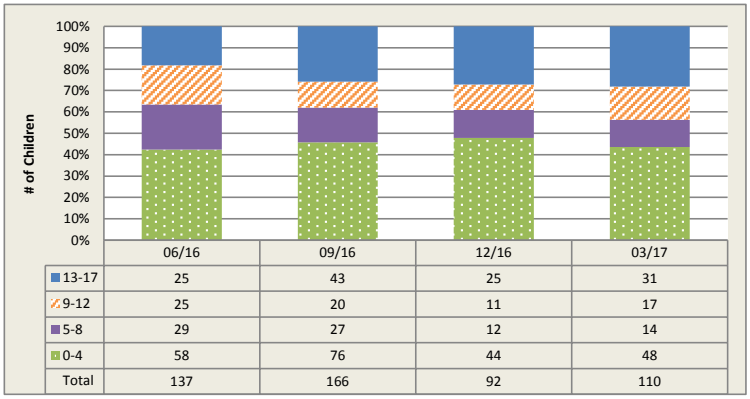


Age	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
03/17	0	8	23	41	44	48	31	51	34	38	32	24	25	17	9	12	9
12/16	0	1	19	23	30	28	33	33	32	28	14	16	16	11	10	5	6
09/16	0	8	40	38	37	37	60	32	24	35	15	19	19	16	13	7	2

3.0 CHILDREN IN DSCYF CUSTODY

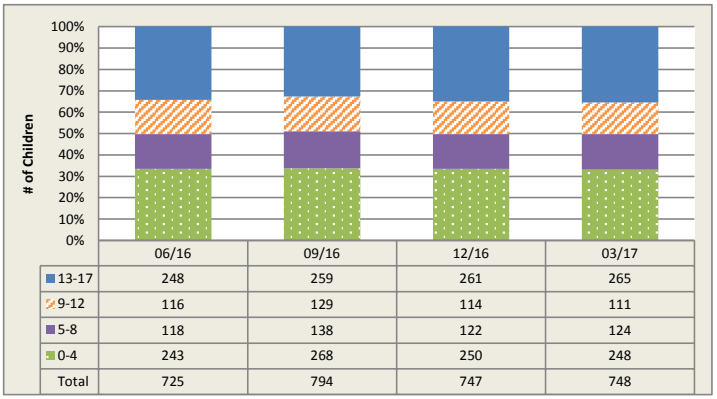
3.1 PROFILES OF DSCYF CHILDREN

3.11 AGES OF CHILDREN ENTERING DSCYF CUSTODY DURING QUARTER



	06/16	09/16	12/16	03/17
13-17	25	43	25	31
9-12	25	20	11	17
5-8	29	27	12	14
0-4	58	76	44	48
Total	137	166	92	110

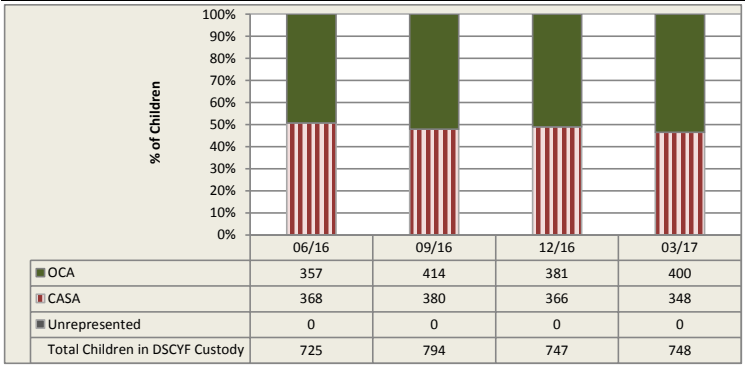
3.12 AGES OF CHILDREN IN DSCYF CUSTODY AT END OF QUARTER



	06/16	09/16	12/16	03/17
13-17	248	259	261	265
9-12	116	129	114	111
5-8	118	138	122	124
0-4	243	268	250	248
Total	725	794	747	748

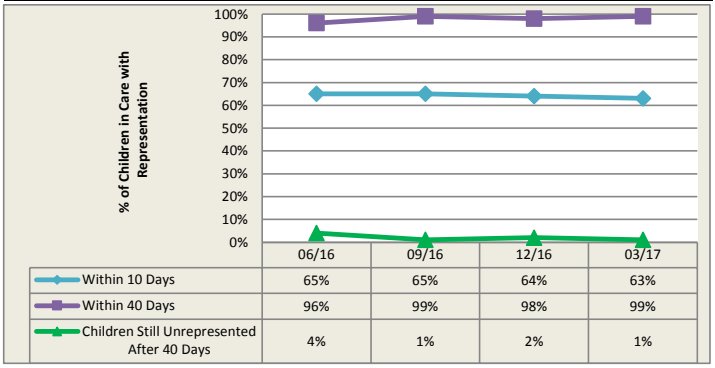
3.2 LEGAL REPRESENTATION

3.21 REPRESENTATION OF YOUTH IN DSCYF CUSTODY AT END OF QUARTER



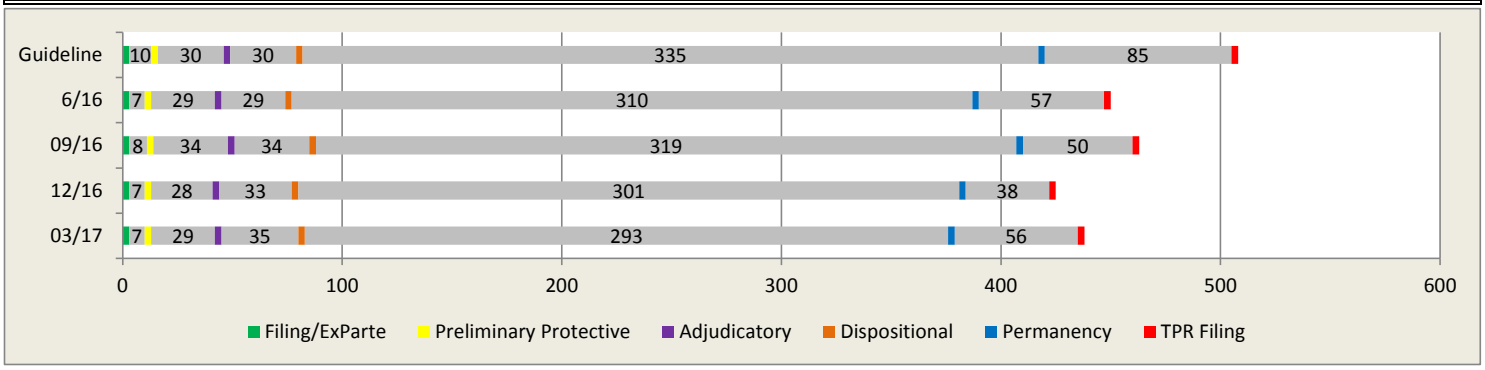
	06/16	09/16	12/16	03/17
OCA	357	414	381	400
CASA	368	380	366	348
Unrepresented	0	0	0	0
Total Children in DSCYF Custody	725	794	747	748

3.22 NUMBER OF DAYS FROM FILING OF PETITION UNTIL CHILD IS REPRESENTED



	06/16	09/16	12/16	03/17
Within 10 Days	65%	65%	64%	63%
Within 40 Days	96%	99%	98%	99%
Children Still Unrepresented After 40 Days	4%	1%	2%	1%

3.3 GUIDELINES AND ACTUAL MEDIAN TIMELINE FOR FAMILY COURT CASES CLOSED DURING PERIOD

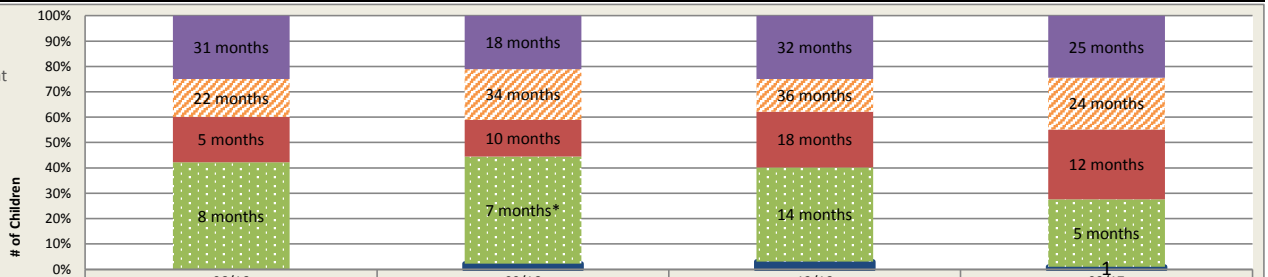


4.0 PERMANENCY OUTCOMES

4.1 OUTCOMES FOR ALL CHILDREN

4.11 PERMANENCY OUTCOMES & MEDIAN LENGTH OF STAY OF CHILDREN EXITING DSCYF CUSTODY DURING QUARTER (DFS PLACEMENT ONLY)

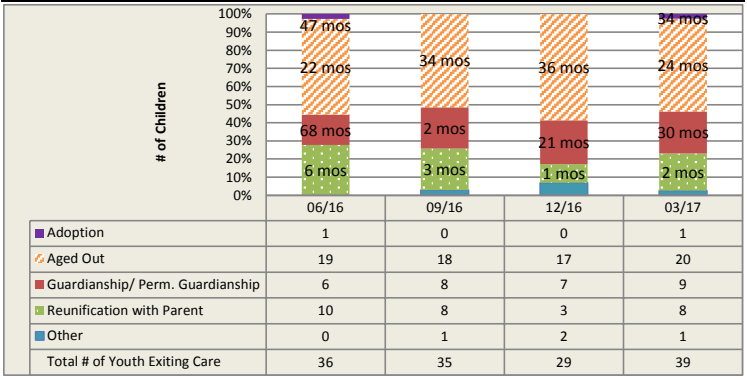
*Of the 38 youth exiting to reunification on the 09/16 quarter, 16 of those exited at the Preliminary Protective Hearing



	06/16	09/16	12/16	03/17
Adoption	32	19	33	24
Aged Out	19	18	17	20
Guardianship/ Perm. Guardianship	23	13	29	27
Reunification w/ Parent	54	38	49	26
Other	0	2	4	1
Total # of Children Exiting Care	128	90	132	98

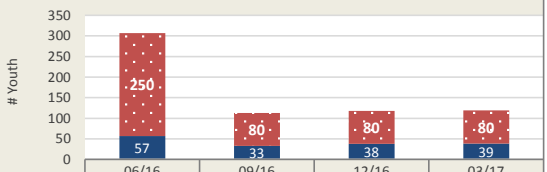
4.2 ADOLESCENT OUTCOMES

4.21 PERMANENCY OUTCOMES OF ADOLESCENTS (13 -17) EXITING DSCYF CUSTODY DURING QUARTER



	06/16	09/16	12/16	03/17
Adoption	1	0	0	1
Aged Out	19	18	17	20
Guardianship/ Perm. Guardianship	6	8	7	9
Reunification with Parent	10	8	3	8
Other	0	1	2	1
Total # of Youth Exiting Care	36	35	29	39

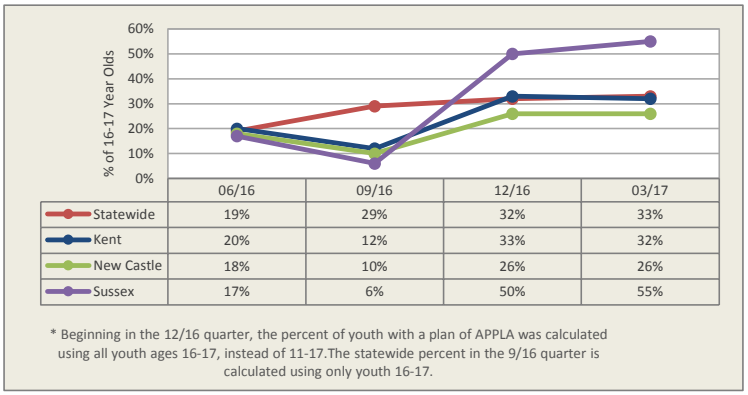
4.22 QUARTER PROFILES OF YOUTH 16-17 WITH APPLA VS. ANOTHER PERMANENCY PLAN AT THE END OF THE QUARTER



	06/16	09/16	12/16	03/17
DSCYF Youth with Other Permanency Plan	250	80	80	80
DSCYF Youth with Plan of APPLA	57	33	38	39
Total Youth Ages 16-17 in DSCYF Custody	307	113	118	119
% of Youth 16-17 with Plan of APPLA	19%	29%	32%	33%

*Beginning in the 9/16 quarter, the total number of youth with a plan of youth was calculated using all youth ages 16-17. instead of 11-17

4.23 COUNTY PROFILES OF YOUTH WITH APPLA VS. ANOTHER PERMANENCY PLAN AT THE END OF THE QUARTER

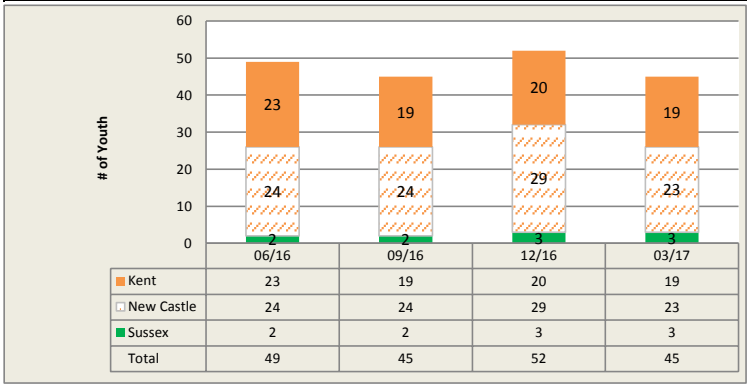


	06/16	09/16	12/16	03/17
Statewide	19%	29%	32%	33%
Kent	20%	12%	33%	32%
New Castle	18%	10%	26%	26%
Sussex	17%	6%	50%	55%

* Beginning in the 12/16 quarter, the percent of youth with a plan of APPLA was calculated using all youth ages 16-17, instead of 11-17.The statewide percent in the 9/16 quarter is calculated using only youth 16-17.

5.0 EXTENDED JURISDICTION

5.11 YOUTH ON EXTENDED JURISDICTION DURING QUARTER SORTED BY COUNTY

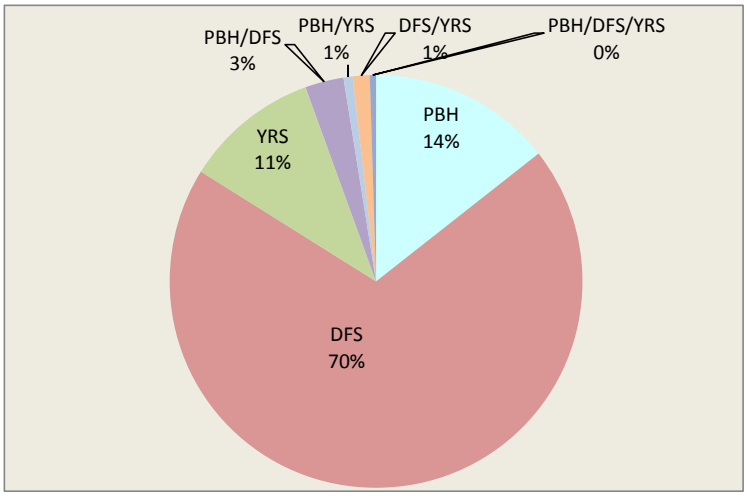


	06/16	09/16	12/16	03/17
Kent	23	19	20	19
New Castle	24	24	29	23
Sussex	2	2	3	3
Total	49	45	52	45

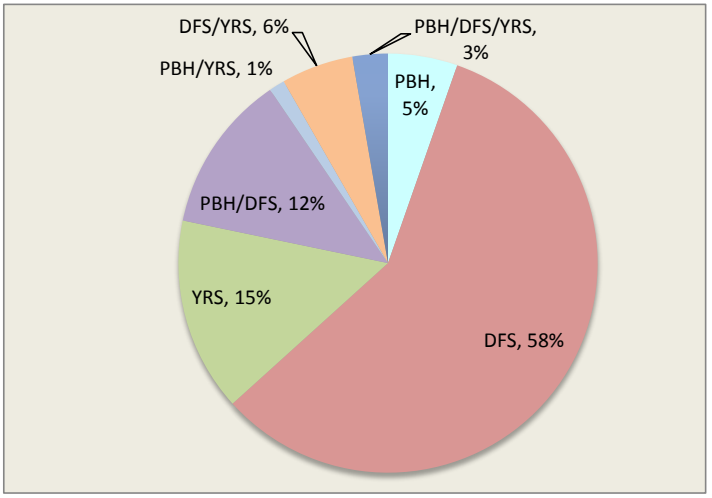
6.0 DUAL STATUS YOUTH

6.1 DUAL STATUS YOUTH

6.11 DSCYF INVOLVEMENT BY DIVISION FOR ALL CHILDREN AT END OF QUARTER

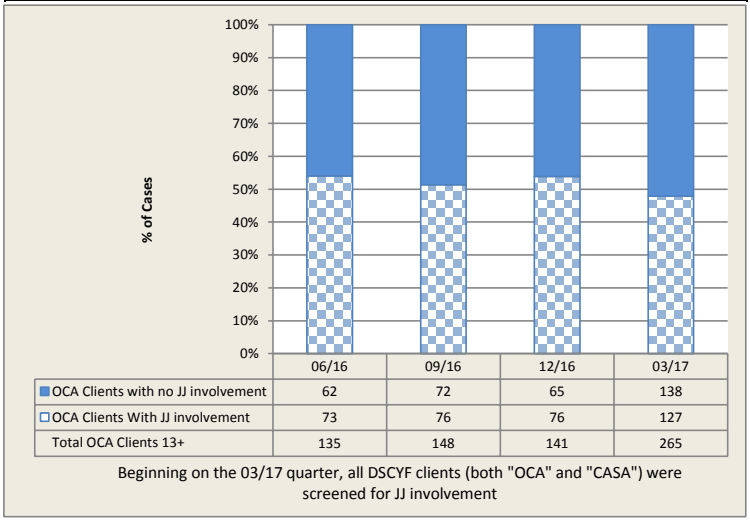


6.12 DSCYF INVOLVEMENT BY DIVISION FOR ALL CHILDREN IN OUT-OF-HOME PLACEMENT AT END OF QUARTER



6.2 OCA CLIENTS (AGES 13-17) IN DSCYF CUSTODY

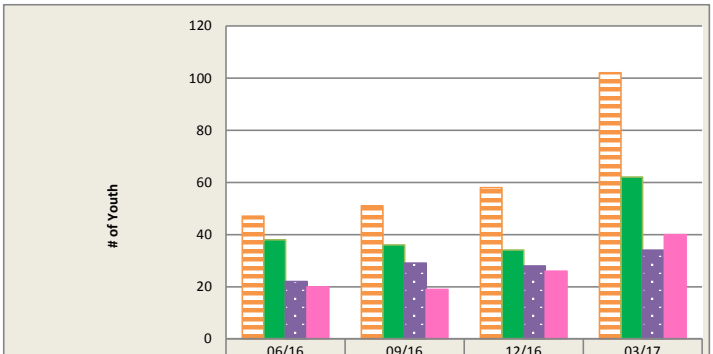
6.21 OCA CLIENTS WITH JUVENILE JUSTICE INVOLVEMENT AT END OF QUARTER



	06/16	09/16	12/16	03/17
OCA Clients with no JJ involvement	62	72	65	138
OCA Clients With JJ involvement	73	76	76	127
Total OCA Clients 13+	135	148	141	265

Beginning on the 03/17 quarter, all DSCYF clients (both "OCA" and "CASA") were screened for JJ involvement

6.22 STATUS OF CRIMINAL CHARGES FOR OCA CLIENTS IN JUVENILE JUSTICE SYSTEM AT END OF QUARTER



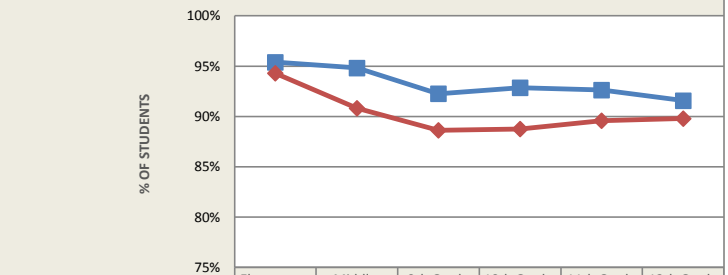
	06/16	09/16	12/16	03/17
Dropped Charges	47	51	58	102
Adjudications	38	36	34	62
Pending Charges	22	29	28	34
Expungement Elligible	20	19	26	40

Beginning on the 03/17 quarter, all DSCYF clients (both "OCA" and "CASA") were screened for JJ involvement

7.0 EDUCATION OUTCOMES FOR CHILDREN IN FOSTER CARE (UPDATED 5/11/16)

7.1 COMPARISONS BETWEEN CHILDREN IN FOSTER CARE AND ALL STUDENTS

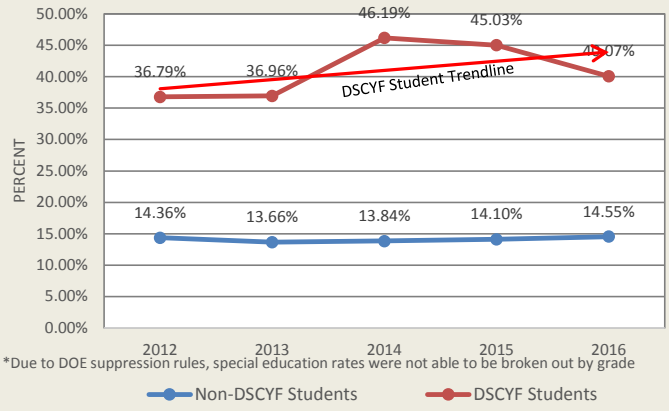
7.11 TWO YEAR COMPARISON OF ATTENDANCE RATES FOR CHILDREN IN DSCYF CUSTODY*



	Elementary	Middle	9th Grade	10th Grade	11th Grade	12th Grade
2015-2016 Non-DSCYF Students	95.39%	94.82%	92.25%	92.85%	92.63%	91.57%
2015-2016 DSCYF Students	94.30%	90.81%	88.62%	88.76%	89.59%	89.80%

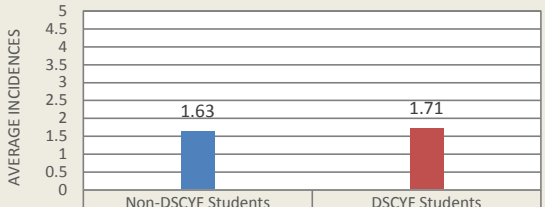
*Average Daily Attendance (Average % of Population in attendance each day)

7.12 FIVE YEAR COMPARISON OF SPECIAL EDUCATION RATES FOR CHILDREN IN DSCYF CUSTODY, FOR ALL GRADES*



*Due to DOE suppression rules, special education rates were not able to be broken out by grade

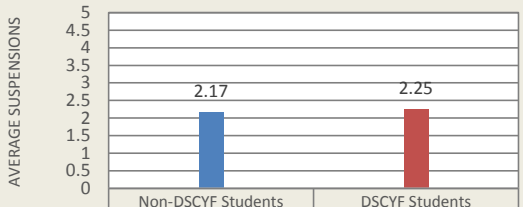
7.13 2016 AVERAGE DISCIPLINE* RATES PER DISCIPLINED CHILD, FOR ALL GRADES



	Non-DSCYF Students	DSCYF Students
# of Incidences	12597	159
# of Unduplicated Students with Discipline Incidences	7741	93
Average # of Incidences, per Disciplined Student	1.63	1.71
# of Total Students	135515	584
% Students with Discipline Incidences	5.7%	15.9%

* Discipline incidences include incidences that are reportable to DOE or Law Enforcement, including (but not limited to) violent felonies, drug offenses, sexual harassment, bullying, etc.

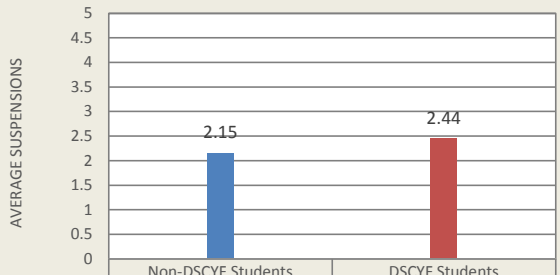
7.14 2016 AVERAGE IN-SCHOOL SUSPENSIONS* PER SUSPENDED CHILD, FOR ALL GRADES



	Non-DSCYF Students	DSCYF Students
# of Suspensions	20756	198
# of Unduplicated Suspended Students	9577	88
Average # of Suspensions, per Suspended Student	2.17	2.25
# of Total Students	135515	584
% Students with In-School Suspensions	7.1%	15.1%

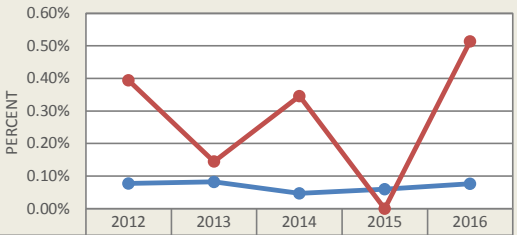
* Suspensions can occur due to a non-reportable (to DOE or Law Enforment) offense.

7.15 2016 AVERAGE OUT-OF-SCHOOL SUSPENSION PER SUSPENDED CHILD, FOR ALL GRADES



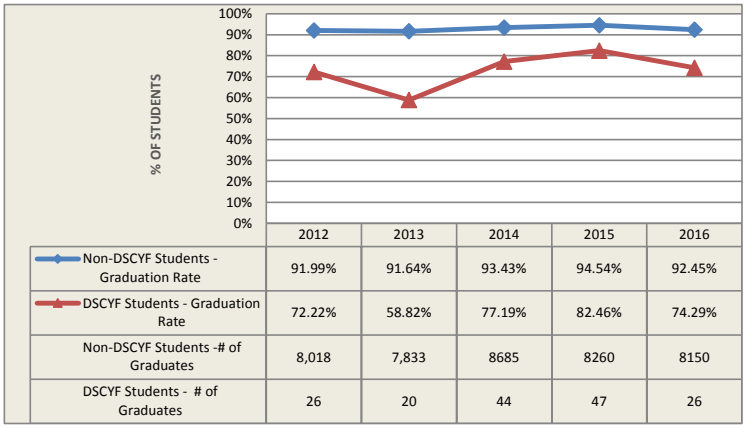
	Non-DSCYF Students	DSCYF Students
# of Suspensions	23426	320
# of Unduplicated Suspended Students	10881	131
Average # of Suspensions, per Suspended Student	2.15	2.44
# of Total Students	134662	584
% Students with Out of School Suspensions	8.1%	22.4%

7.16 FIVE YEAR COMPARISON OF EXPULSION RATES FOR CHILDREN IN DSCYF CUSTODY



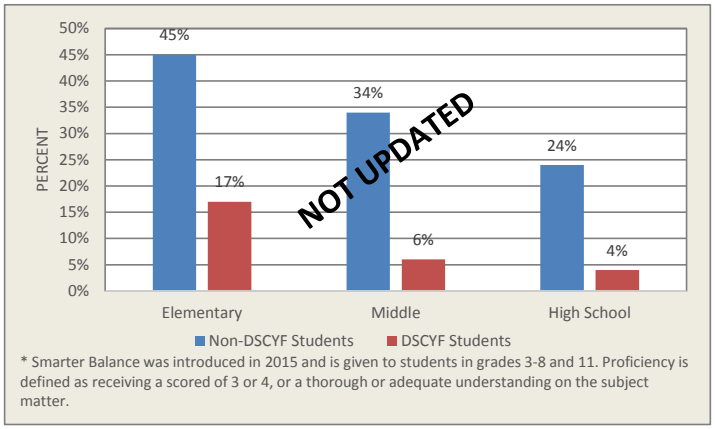
	2012	2013	2014	2015	2016
Non-DSCYF Students	101	108	63	81	104
DSCYF Students	3	1	2	0	3
Total # of Non-DSCYF Students	129983	130994	133188	134662	135515
Total # of DSCYF Students	761	690	578	584	584
% Non-DSCYF Students Expelled	0.08%	0.08%	0.05%	0.06%	0.08%
% DSCYF Students Expelled	0.39%	0.14%	0.35%	0.00%	0.51%

7.17 FIVE YEAR COMPARISON OF GRADUATION RATES FOR CHILDREN IN DSCYF CUSTODY



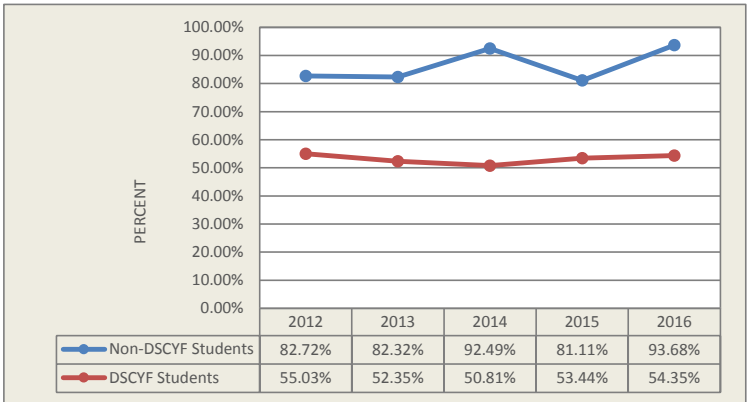
	2012	2013	2014	2015	2016
Non-DSCYF Students - Graduation Rate	91.99%	91.64%	93.43%	94.54%	92.45%
DSCYF Students - Graduation Rate	72.22%	58.82%	77.19%	82.46%	74.29%
Non-DSCYF Students -# of Graduates	8,018	7,833	8685	8260	8150
DSCYF Students - # of Graduates	26	20	44	47	26

7.18 2015 SMARTER BALANCE* MATH PROFICIENCY



* Smarter Balance was introduced in 2015 and is given to students in grades 3-8 and 11. Proficiency is defined as receiving a scored of 3 or 4, or a thorough or adequate understanding on the subject matter.

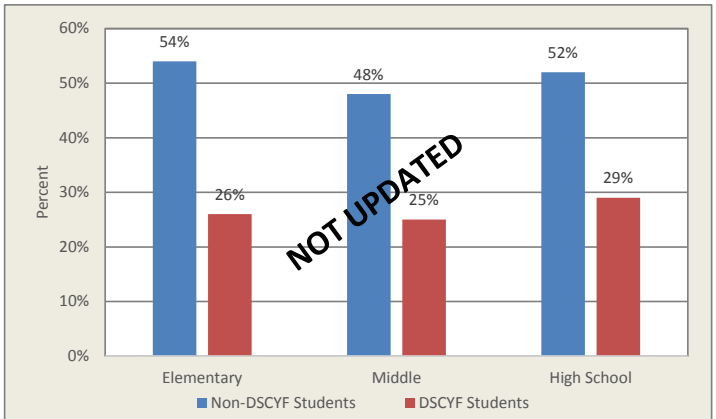
7.19 FIVE YEAR COMPARISON FOR % OF CHILDREN IN DSCYF CUSTODY PASSING ALEGEBRA I*



	2012	2013	2014	2015	2016
Non-DSCYF Students	82.72%	82.32%	92.49%	81.11%	93.68%
DSCYF Students	55.03%	52.35%	50.81%	53.44%	54.35%

*For all students entering 10th grade, those who took and passed Algebra I or higher are considered passing. Those who either failed or did not take an Algebra I or higher class are not considered passing.

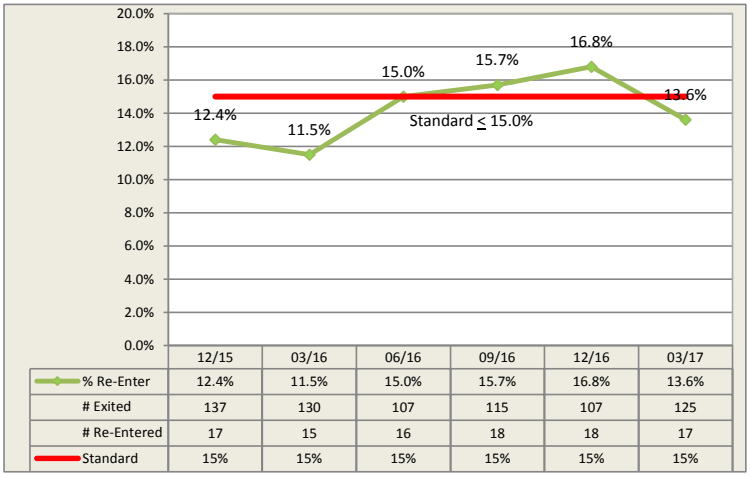
7.20 2015 SMARTER BALANCE* ENGLISH/LANGUAGE ARTS PROFICIENCY



* Smarter Balance was introduced in 2015 and is given to students in grades 3-8 and 11. Proficiency is defined as receiving a scored of 3 or 4, or a thorough or adequate understanding on the subject matter.

8.0 RE-ENTRY/RE-OCCURRENCE OF MALTREATMENT

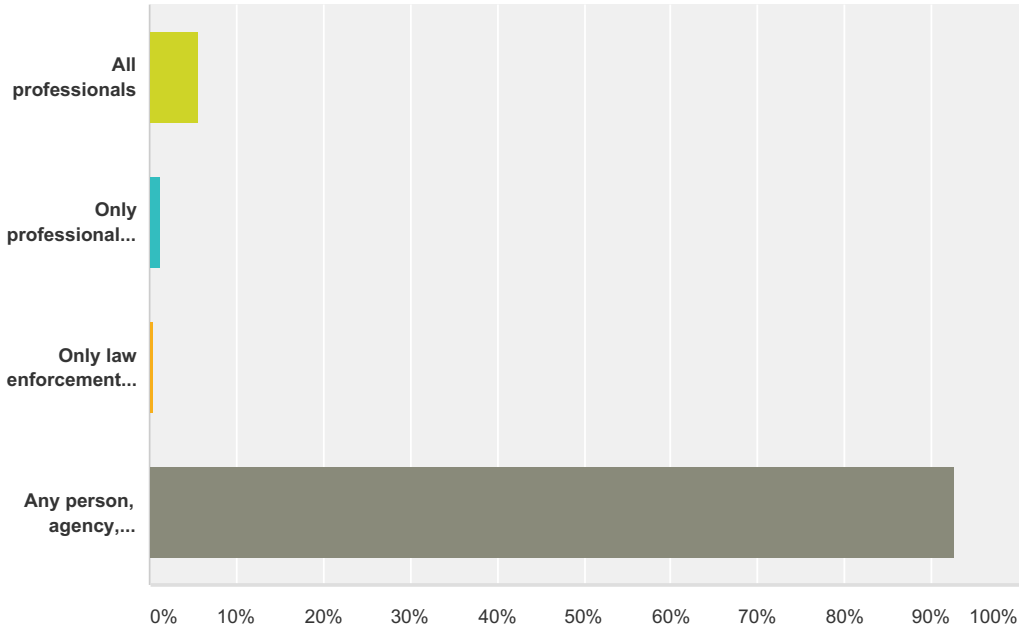
8.1 % OF CHILDREN WHO RE-ENTER CARE IN LESS THAN 12 MONTHS (STANDARD: <= 15.0%)



	12/15	03/16	06/16	09/16	12/16	03/17
% Re-Enter	12.4%	11.5%	15.0%	15.7%	16.8%	13.6%
# Exited	137	130	107	115	107	125
# Re-Entered	17	15	16	18	18	17
Standard	15%	15%	15%	15%	15%	15%

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

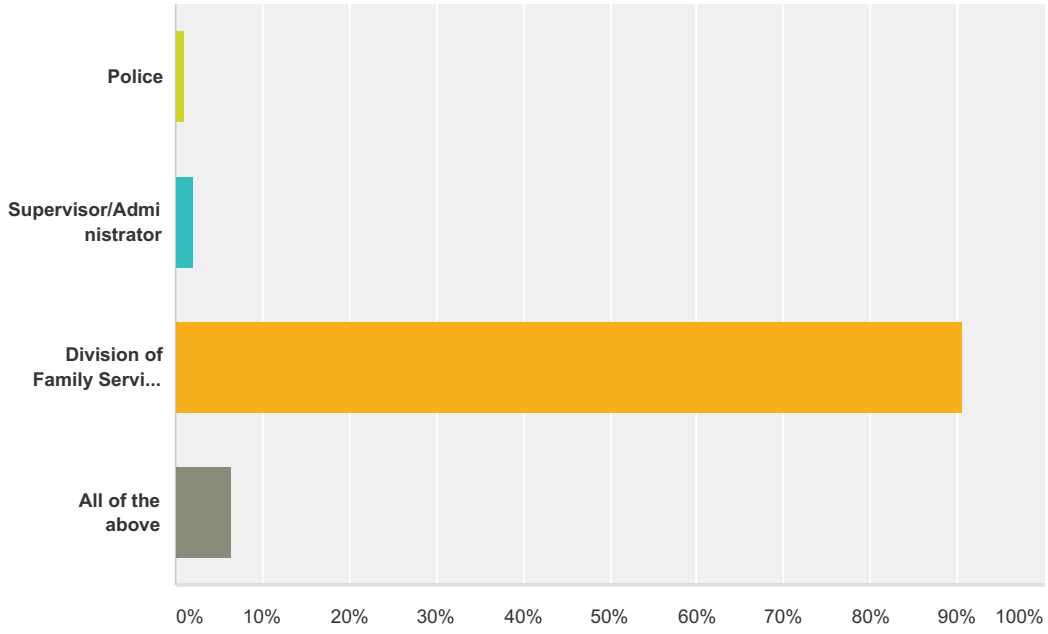
Answered: 297 Skipped: 0



Answer Choices	Responses	
All professionals	**5.72%**	17
Only professionals that work directly with children (i.e. teachers, physicians)	**1.35%**	4
Only law enforcement officers	**0.34%**	1
Any person, agency, organization or entity	**92.59%**	275
Total		**297**

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

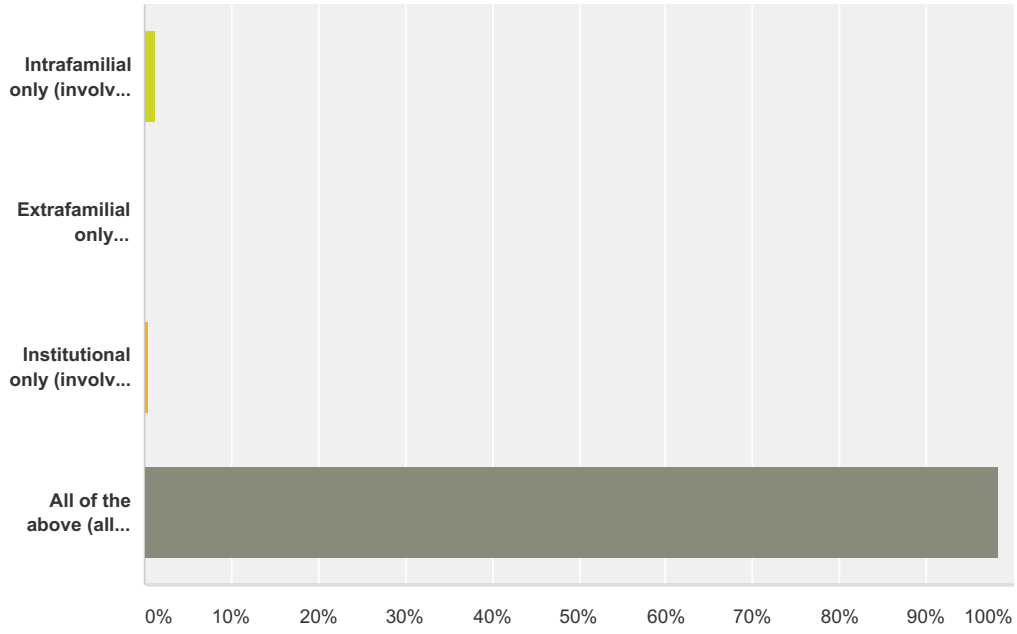
Answered: 297 Skipped: 0



Answer Choices	Responses	
Police	**1.01%**	3
Supervisor/Administrator	**2.02%**	6
Division of Family Services Child Abuse and Neglect Report Line	**90.57%**	269
All of the above	**6.40%**	19
Total		**297**

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

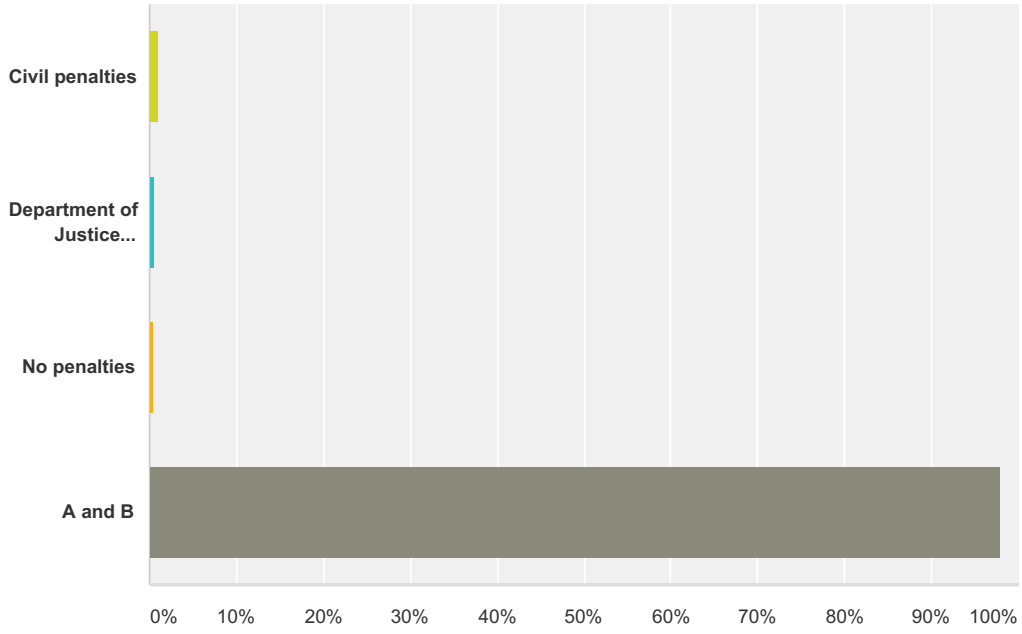
Answered: 297 Skipped: 0



Answer Choices	Responses	
Intrafamilial only (involving parent, guardian, custodian, or member of the household)	**1.35%**	4
Extrafamilial only (perpetrator is not a member of the household or family)	**0.00%**	0
Institutional only (involving licensed child placement facilities)	**0.34%**	1
All of the above (all suspected abuse and neglect of any child, birth to age 18)	**98.32%**	292
Total		**297**

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:

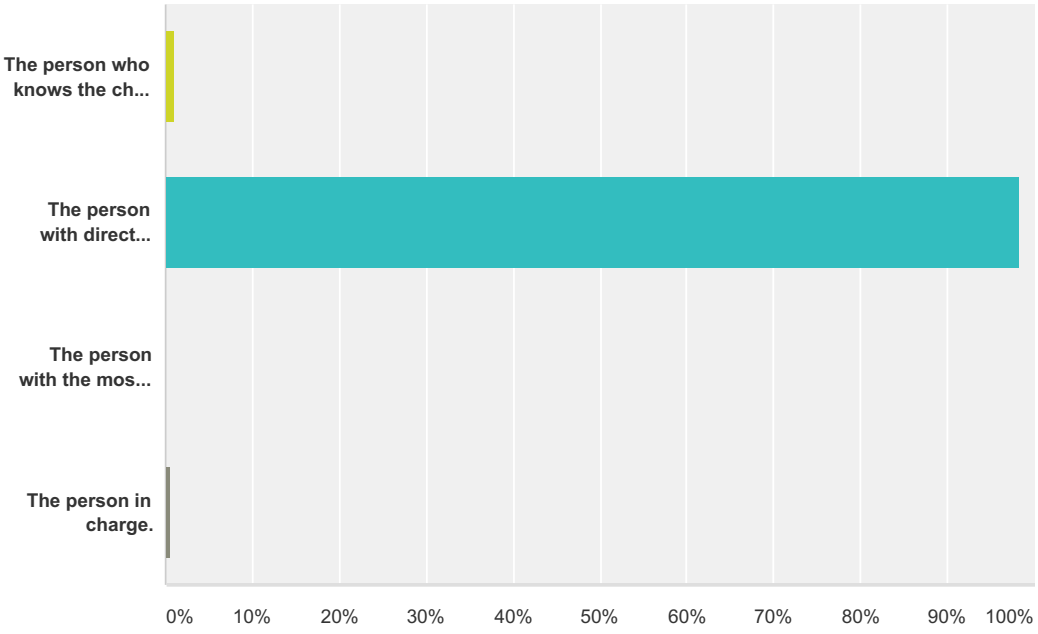
Answered: 296 Skipped: 1



Answer Choices	Responses	
Civil penalties	**1.01%**	3
Department of Justice investigation	**0.68%**	2
No penalties	**0.34%**	1
A and B	**97.97%**	290
Total		**296**

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

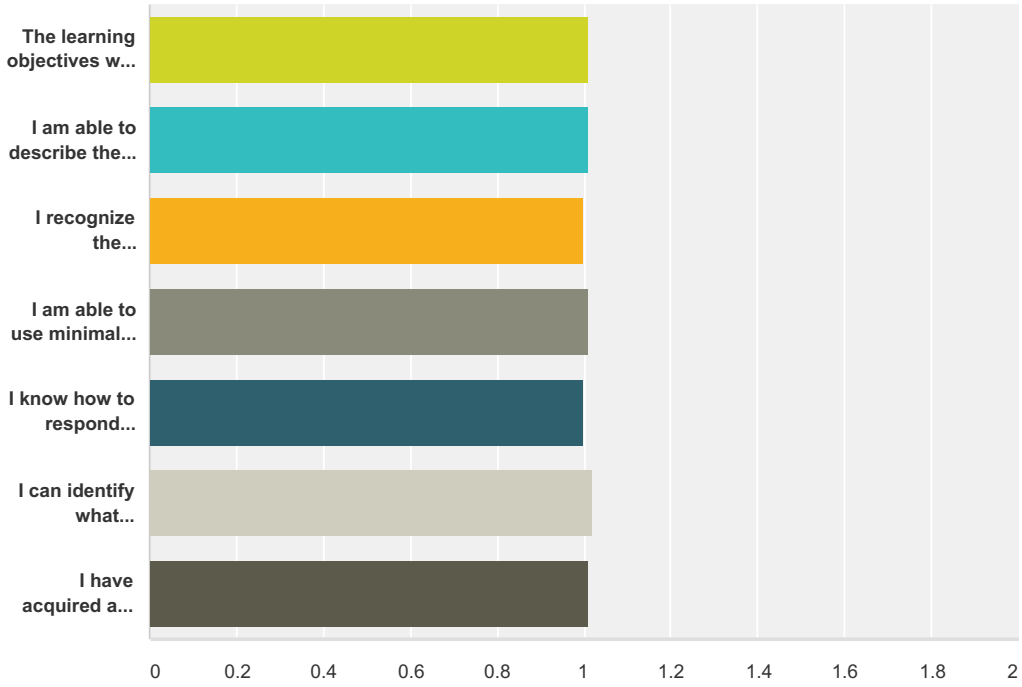
Answered: 296 Skipped: 1



Answer Choices	Responses	
The person who knows the child best.	**1.01%**	3
The person with direct knowledge.	**98.31%**	291
The person with the most time.	**0.00%**	0
The person in charge.	**0.68%**	2
Total		**296**

Q6 Please rate each of the following statements.

Answered: 295 Skipped: 2



	Agree	Not Sure	Disagree	Total	Weighted Average
The learning objectives were met.	**99.32%** 293	**0.68%** 2	**0.00%** 0	295	1.01
I am able to describe the reporting law and reporting procedure for the State of Delaware.	**98.98%** 292	**1.02%** 3	**0.00%** 0	295	1.01
I recognize the relationship between physical and behavioral indicators and suspicion of child abuse and neglect.	**99.66%** 294	**0.34%** 1	**0.00%** 0	295	1.00
I am able to use minimal fact questions when indicators are observed and/or a disclosure is made.	**99.32%** 293	**0.68%** 2	**0.00%** 0	295	1.01
I know how to respond appropriately when children disclose allegations of abuse or neglect.	**99.66%** 294	**0.34%** 1	**0.00%** 0	295	1.00
I can identify what information to expect from DFS following a report of child abuse or neglect.	**97.97%** 289	**2.03%** 6	**0.00%** 0	295	1.02
I have acquired a basic understanding of the civil and criminal definitions in statute for the various types of child maltreatment.	**99.32%** 293	**0.68%** 2	**0.00%** 0	295	1.01

Q7 Please submit any questions you have about the training content here:

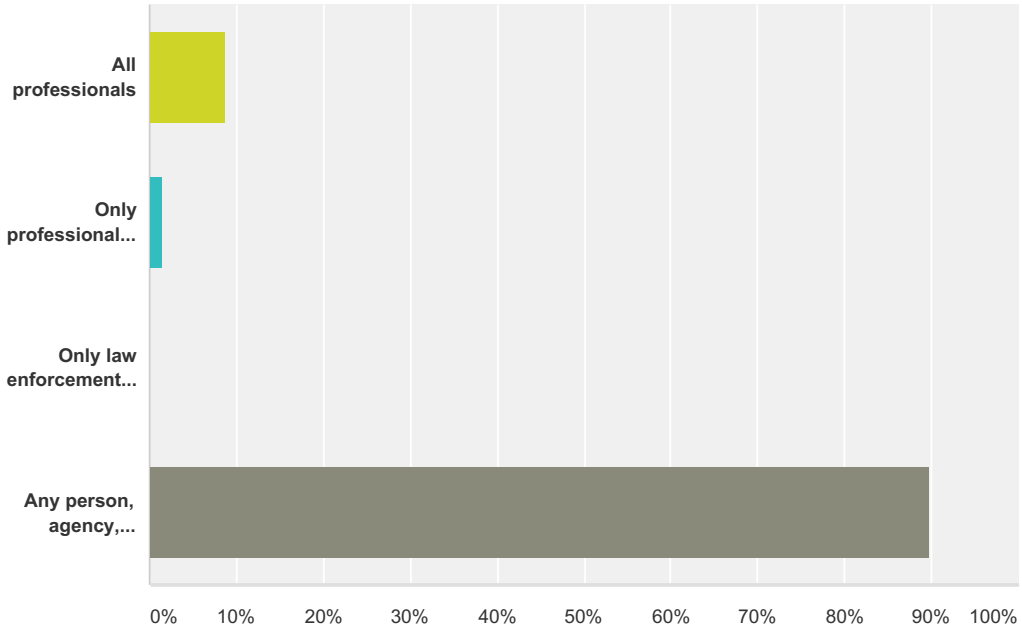
Answered: 36 Skipped: 261

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

Answered: 44 Skipped: 253

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

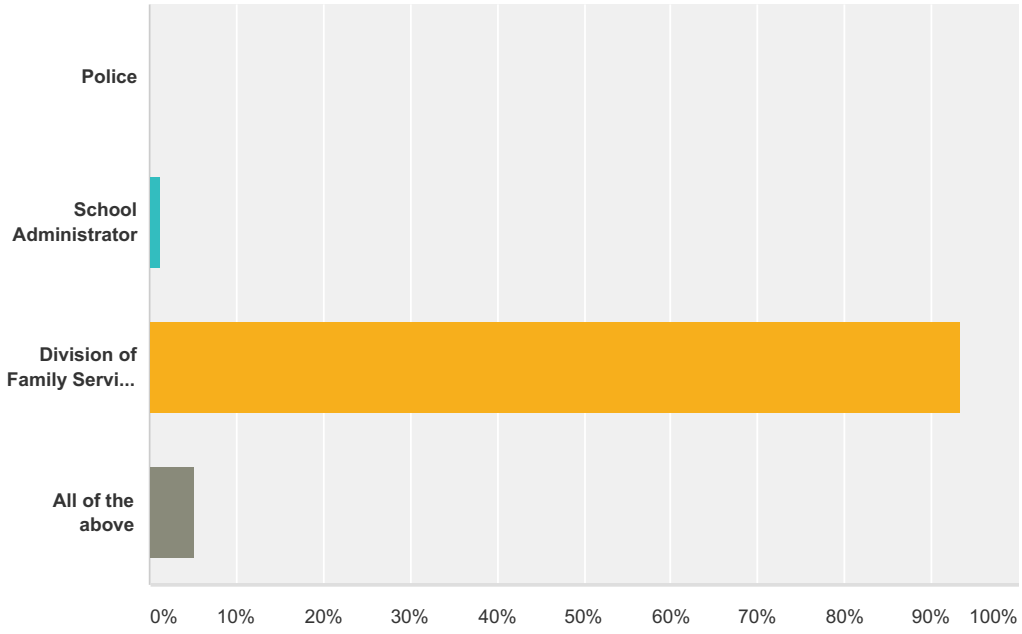
Answered: 7,607 Skipped: 0



Answer Choices	Responses	
All professionals	**8.70%**	662
Only professionals that work directly with children (i.e. teachers, physicians)	**1.46%**	111
Only law enforcement officers	**0.03%**	2
Any person, agency, organization or entity	**89.81%**	6,832
Total		**7,607**

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

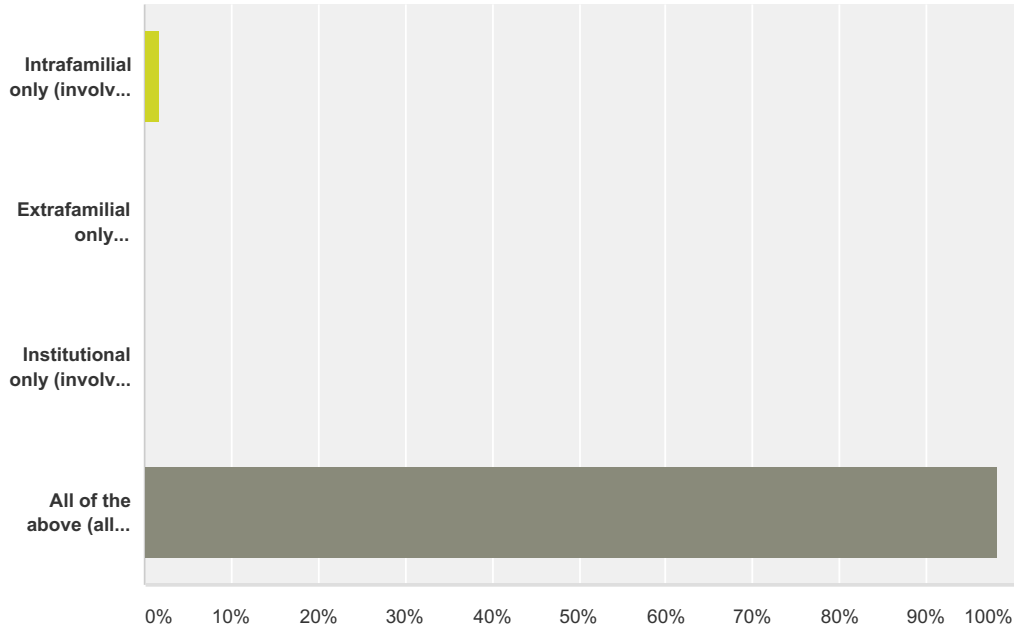
Answered: 7,597 Skipped: 10



Answer Choices	Responses	
Police	**0.09%**	7
School Administrator	**1.36%**	103
Division of Family Services Child Abuse and Neglect Report Line	**93.31%**	7,089
All of the above	**5.24%**	398
Total		**7,597**

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

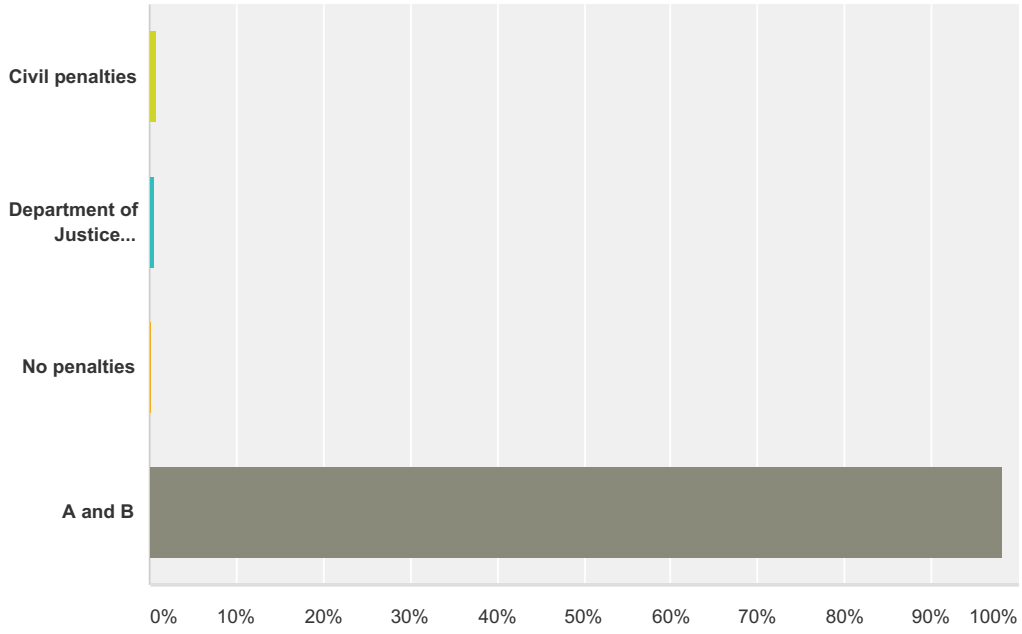
Answered: 7,589 Skipped: 18



Answer Choices	Responses	
Intrafamilial only (involving parent, guardian, custodian, or member of the household)	**1.74%**	132
Extrafamilial only (perpetrator is not a member of the household or family)	**0.05%**	4
Institutional only (involving licensed child placement facilities)	**0.08%**	6
All of the above (all suspected abuse and neglect of any child, birth to age 18)	**98.13%**	7,447
Total		**7,589**

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:

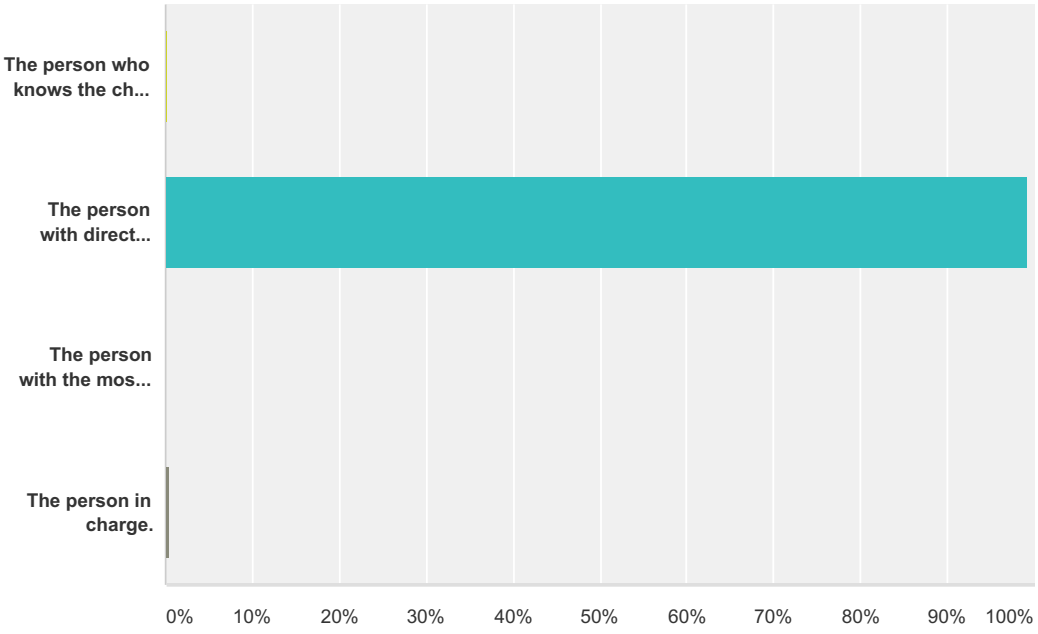
Answered: 7,586 Skipped: 21



Answer Choices	Responses	
Civil penalties	**0.88%**	67
Department of Justice investigation	**0.69%**	52
No penalties	**0.24%**	18
A and B	**98.19%**	7,449
Total		**7,586**

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

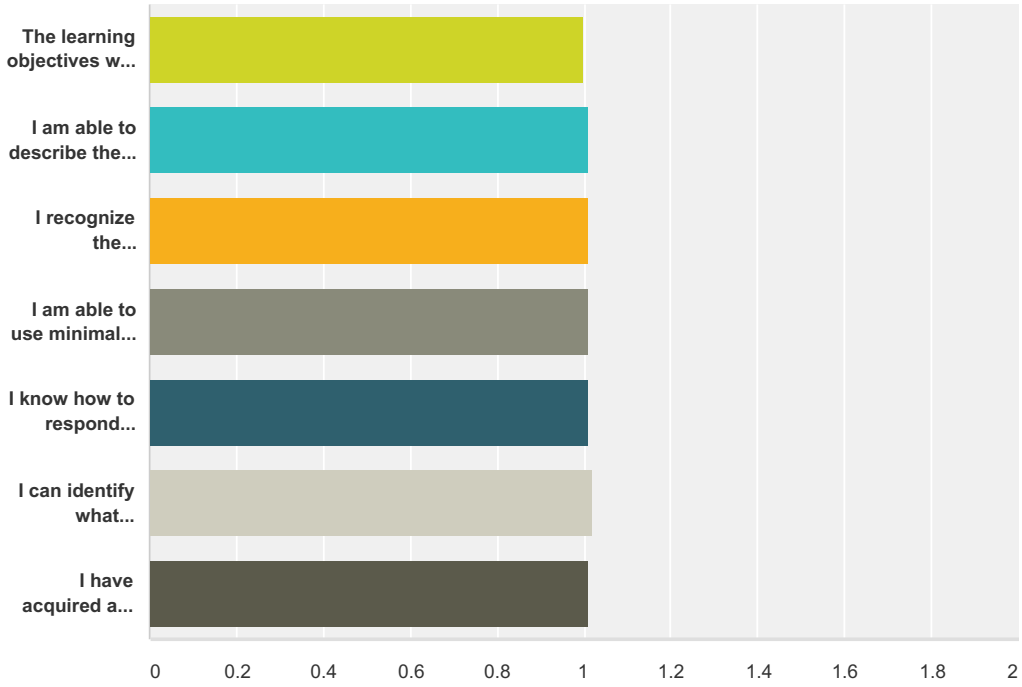
Answered: 7,577 Skipped: 30



Answer Choices	Responses	
The person who knows the child best.	**0.29%**	22
The person with direct knowledge.	**99.16%**	7,513
The person with the most time.	**0.08%**	6
The person in charge.	**0.48%**	36
Total		**7,577**

Q6 Please rate each of the following statements.

Answered: 7,560 Skipped: 47



	Agree	Not Sure	Disagree	Total	Weighted Average
The learning objectives were met.	**99.62%** 7,531	**0.36%** 27	**0.03%** 2	7,560	1.00
I am able to describe the reporting law and reporting procedure for the State of Delaware.	**99.01%** 7,485	**0.93%** 70	**0.07%** 5	7,560	1.01
I recognize the relationship between physical and behavioral indicators and suspicion of child abuse and neglect.	**99.46%** 7,519	**0.52%** 39	**0.03%** 2	7,560	1.01
I am able to use minimal fact questions when indicators are observed and/or a disclosure is made.	**99.02%** 7,486	**0.91%** 69	**0.07%** 5	7,560	1.01
I know how to respond appropriately when children disclose allegations of abuse or neglect.	**99.30%** 7,507	**0.69%** 52	**0.01%** 1	7,560	1.01
I can identify what information to expect from DFS following a report of child abuse or neglect.	**98.15%** 7,420	**1.79%** 135	**0.07%** 5	7,560	1.02
I have acquired a basic understanding of the civil and criminal definitions in statute for the various types of child maltreatment.	**99.44%** 7,518	**0.54%** 41	**0.01%** 1	7,560	1.01

Q7 Please submit any questions you have about the training content here:

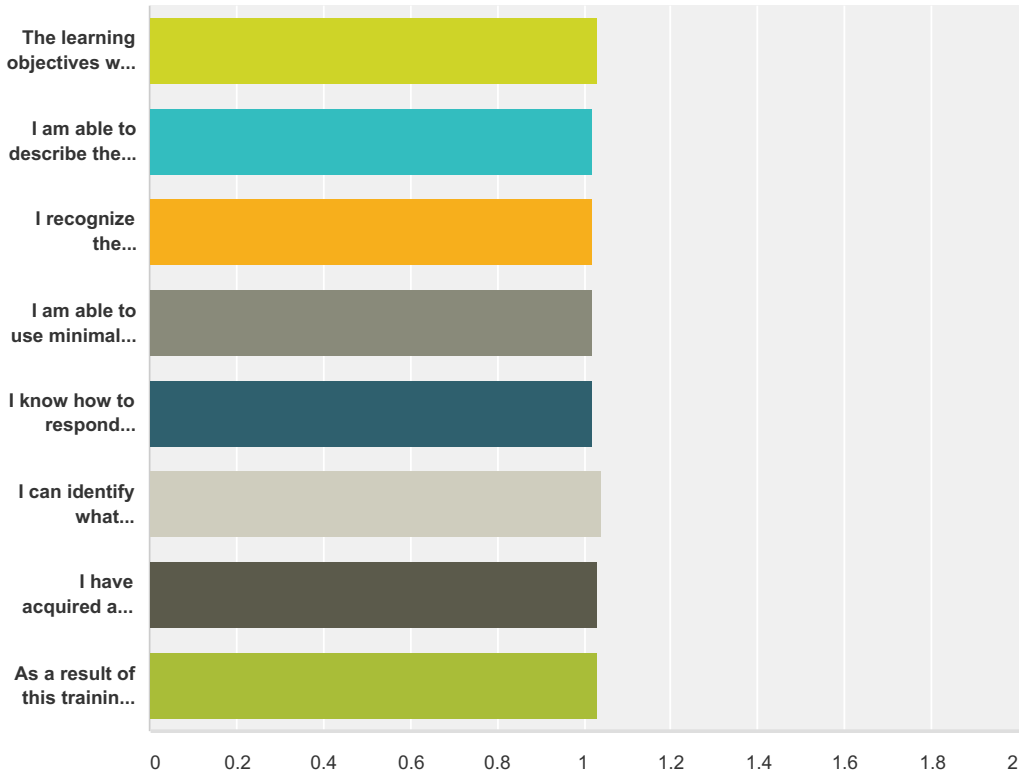
Answered: 559 Skipped: 7,048

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

Answered: 670 Skipped: 6,937

Q1 Please rate each of the following statements.

Answered: 4,613 Skipped: 0



	Agree	Not Sure	Disagree	Total	Weighted Average
The learning objectives were met.	**97.85%** 4,499	**1.76%** 81	**0.39%** 18	4,598	1.03
I am able to describe the reporting law and reporting procedure for the State of Delaware.	**98.02%** 4,514	**1.76%** 81	**0.22%** 10	4,605	1.02
I recognize the relationship between physical and behavioral indicators and suspicion of child abuse and neglect.	**98.16%** 4,523	**1.61%** 74	**0.24%** 11	4,608	1.02
I am able to use minimal fact questions when indicators are observed and/or a disclosure is made.	**97.92%** 4,509	**1.85%** 85	**0.24%** 11	4,605	1.02
I know how to respond appropriately when children disclose allegations of abuse or neglect.	**98.00%** 4,512	**1.76%** 81	**0.24%** 11	4,604	1.02
I can identify what information to expect from DFS following a report of child abuse or neglect.	**96.61%** 4,447	**3.08%** 142	**0.30%** 14	4,603	1.04
I have acquired a basic understanding of the civil and criminal definitions in statute for the various types of child maltreatment.	**97.63%** 4,492	**2.15%** 99	**0.22%** 10	4,601	1.03
As a result of this training, I have a better understanding of my reporting obligations under the Medical Practice Act.	**97.20%** 4,444	**2.10%** 96	**0.70%** 32	4,572	1.03

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

Answered: 323 Skipped: 4,290

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

Answered: 543 Skipped: 4,070