State of Delaware

Child Protection Accountability Commission (CPAC)

Children's Justice Act

Annual Progress Report and Grant Application

May 31, 2022

GRANTEE INFORMATION

Agency

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I. Annual Progress Report and Grant Application

A. Task Force Membership and Function

Name and Title	Task Force Designation	Description
Colonel Melissa Zebley, Superintendent, Delaware State Police	Law Enforcement Community	Colonel Zebley represents the Delaware State Police (DSP) on the Task Force. She joined the DSP ranks in 1992 and has served in many leadership roles during her career. She joined the Executive Staff in 2010 at the rank of Major with oversight of the Budget, Training Academy and Human Resource sections.
Colonel Joseph Bloch, New Castle County Police Department		Colonel Joseph Bloch represents the New Castle County Police Department on the Task Force. Colonel Bloch joined the County Police in 1994 as a recruit officer. He was promoted to the rank of Captain in November 2017, where he oversaw the patrol and criminal investigation units.
The Honorable Michael K. Newell, Chief Judge, Family Court	Criminal Court Judge	The Chief Judge of the Family Court has statewide administrative responsibilities, and the Family Court has extensive jurisdiction over domestic matters, including juvenile delinquency, child neglect, child abuse, adult misdemeanor crimes against juveniles, orders of protection from abuse, intra-family misdemeanor crimes, etc.
The Honorable Joelle Hitch, Judge, Family Court	Civil Court Judge	Judge Hitch hears a broad range of cases including child neglect, dependency, child abuse, custody and visitation of children, adoptions, terminations of parental rights, etc.
James Kriner, Esquire, Deputy Attorney General, Department of Justice	Prosecuting Attorney(s)	Mr. Kriner heads the Special Victims Unit, which is a specialized unit within the Department of Justice that handles all felony level, criminal child abuse cases involving the death or serious physical injury of a child, as well as all sexual abuse cases.
Abigail Rodgers, Esquire, Deputy Attorney General, Department of Justice		Ms. Rodgers is the Director of the Family Division and oversees four units: Child Support, Child Protection, Juvenile Delinquency and Truancy and Human Trafficking.
Deborah L. Carey, Esquire Assistant Public Defender, Office of Defense Services	Defense Attorney	Ms. Carey is an Assistant Public Defender at the Delaware Office of Defense Services, which is responsible for representing indigent people at every stage of the criminal process in both adult and juvenile courts.

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

Name and Title	Task Force Designation	Description
Nicole Magnusson	Young Adult[1]	Ms. Magnusson is a Financial Advisor at Ameriprise Financial Services. She is a former foster youth in Delaware.
Pam Weir, Executive Director, Governor's Advisory Council for Exceptional Citizens	Individual experienced in working with children with disabilities	As the new Executive Director for the Governor's Advisory Council for Exceptional Citizens (GACEC), GACEC serves as the review board for policies, procedures and practices related to the delivery of services for all residents with exceptionalities or disabilities in Delaware from birth to death. The GACEC also serves as the state advisory panel for agencies providing educational services and programs to children (birth through age 26) in Delaware through the Individuals with Disabilities Education Act (IDEA). Ms. Weir participates in one of the Committees under the Task Force.
John Hulse, Education Associate, 21st CCLC and Title I Programs, Department of Education	Individual experienced in working with homeless children and youths (as defined in section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a)).	Mr. Hulse is an Education Associate and he serves as the State Coordinator for Homeless Children and Youth. He also serves as the 21st Century Community Learning Centers (CCLC) State Program Officer. He participates in one of the Committees under the Task Force.

i. Purpose and Statutory Requirements

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

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

[1] Adult former victims of child abuse and or neglect

designated under Section 931(a) of Title 16 of the Delaware Code, and it includes members from other disciplines.

The 23 Task Force members are as follows (16 Del. C. § 931(a)): (1) The Secretary of the Department of Services for Children, Youth and Their Families; (2) The Director of the Division of Family Services; (3) Two representatives from the Attorney General's Office, appointed by the Attorney General; (4) Two members of the Family Court, appointed by the Chief Judge of the Family Court; (5) One member of the House of Representatives, appointed by the Speaker of the House; (6) One member of the Senate, appointed by the President Pro Tempore of the Senate; (7) The Secretary of the Department of Education; (8) The Director of the Division of Prevention and Behavioral Health Services; (9) The Chair of the Domestic Violence Coordinating Council; (10) The Superintendent of the Delaware State Police; (11) The Chair of the Child Death Review Commission; (12) The Investigation Coordinator, as defined in § 902 of this title; (13) One youth or young adult who has experienced foster care in Delaware, appointed by the Secretary of the Department; (14) One Representative from the Office of Defense Services, appointed by the Chief Defender; and (15) Seven at-large members appointed by the Governor with 1 person from the medical community, 1 person from the Interagency Committee on Adoption who works with youth engaged in the foster care system, 1 person from a law-enforcement agency other than the State Police and 4 persons from the child protection community.

ii. Structure and Staff

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

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

- Contract Training Specialists, who develop and provide a variety of trainings to the multidisciplinary team (MDT) and other child welfare professionals;
- Data Analysts, who gather, analyze and produce reports on the various measurable aspects of the child welfare system;
- Contract MDT Training & Policy Administrator, who is responsible for improving outcomes for child victims by supporting, training and coaching multidisciplinary team agencies;
- Child Abuse and Neglect Review Specialist, who prepares the reviews of deaths and near deaths of abused and neglected children;
- MDT Case Review Specialists, who monitor each reported case involving the death of, serious physical injury to, or allegations of sexual abuse of a child from inception to final criminal and civil disposition; and,
- Chief Policy Advisor/CJA Coordinator, who shepherds staff and committees to ensure accomplishment of tasks and compliance with the charge assigned by CPAC.

The Task Force accomplishes its goals through the work of its 9 committees: Grants Oversight; Child Abuse and Neglect Steering; Data Utilization; Education; Executive; Investigation, Prosecution and Treatment of Child Sexual Abuse; Legislative; Training and Youth in Transition. The Grants Oversight Committee is responsible for providing measurable oversight of the CJA grant as well as monitoring and coordinating activities, strategic plans and reporting of grants received or administered by Task Force members or their agencies, which relate to child protection. The group helps to ensure the CJA program's activities and goals align with other federal and state grants, such as the Court Improvement Program, Victims of Crime Act and CAPTA, and to identify gaps in services provided to victims of child abuse.

The remaining Task Force committees help shape how Delaware responds to cases of child abuse and neglect. The Child Abuse and Neglect Steering Committee supervises the confidential investigation and retrospective review of deaths and near deaths of abused or neglected children pursuant to 16 Del. C. §§ 932-935. The next committee, Data Utilization, assesses the voluminous child victim data presented to CPAC on a quarterly basis to inform system improvement and CPAC initiatives.

The fourth committee, Education, is charged with the following: implementing the Memorandum of Understanding between the Department of Services for Children, Youth and Their Families (DSCYF) and the Department of Education (DOE), its school districts, and

its charter schools, which focuses on child abuse reporting and school enrollment for youth in foster care; streamlining training and education on issues related to child welfare; and looking at educational outcomes for children in foster care and exploring ways to improve those outcomes. Additionally, the Task Force has an Executive Committee, and its primary function is to hire, supervise and terminate the Executive Director of the Task Force. However, the Executive Director may also call upon the Executive Committee for consultation regarding the functions of the Office of the Child Advocate. A newer committee under the Task Force, the Committee on the Investigation, Prosecution and Treatment of Child Sexual Abuse (Child Sexual Abuse Committee), is charged with improving the multidisciplinary response to child sexual abuse cases. Another committee under the Task Force, the Legislative Committee, is responsible for reviewing proposed legislation related to child protection and making recommendations to the full Task Force for action.

Another longstanding group, the Training Committee, is charged with ensuring the training needs of the child protection system are being met through ongoing, comprehensive, multidisciplinary training opportunities on child abuse or neglect. The Training Committee is mainly responsible for carrying out the activities identified under the CJA grant. The last committee under the Task Force, the Youth in Transition Committee, is responsible for administering a state scholarship fund, donations and the Chafee Educational and Training Vouchers Program for the purpose of supporting young adults who have experienced foster care with the costs associated with post-secondary education or training programs.

iii. Meeting Frequency and Minutes

The Task Force meets on a quarterly basis to oversee the work of its 9 committees. Between quarterly Task Force meetings, CPAC's various committees and workgroups engage in substantive work at the direction of the Task Force. Minutes are taken for all meetings and posted in compliance with the Freedom of Information Act (See Appendix A: CPAC Quarterly Meeting Minutes).

iv. Work Plan

The Task Force meets approximately every 1.5 years with the Child Death Review Commission (CDRC) to review the statistics, strengths and findings, and other necessary information related to the investigation and review of deaths and near deaths of abused or neglected children. As a result of this meeting, the Joint Commissions (CPAC and CDRC) establish an Action Plan with its prioritized recommendations for system improvement. CPAC uses this forum as its three-year assessment. The Grants Oversight Committee has been charged with monitoring the Action Plan on behalf of CPAC. Then annually, at its

quarterly meetings, the Task Force will receive updates on the status of the recommendations. CPAC received an update on the Action Plan at its February 16, 2022 meeting.

v. Administration of the Grant

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

vi. Fiscal Management of the Grant

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

B. Prior Year Performance Report (May 2021-May 2022)

i. Description of Activities Using CJA Funds

a. Activity: Contract with a Training Specialist

Description: The Task Force contracted with two Training Specialists, Ameshia White and Megan Bittinger, in May 2021 to provide administrative support to CPAC for all child abuse intervention training activities related to the CJA grant, including the mandatory reporting training programs and any ongoing comprehensive training to multidisciplinary team members and other child welfare professionals. During this period, the responsibilities of the Training Specialists included: identifying training needs of the Task Force; annually updating and revising the mandatory reporting training programs; organizing the train-the-trainer session; developing supplemental training programs both in-person/virtual and web-based; evaluating the effectiveness of all training programs; organizing and facilitating in-person/virtual training programs with local and national subject matter experts; maintaining the number of professionals trained; utilizing available software to develop web-based training programs; providing technical support to users on OCA's online training system; managing the online training system and surveys; collaborating with educators and the medical community to make the mandatory reporting trainings available on other agency's professional development systems; and staffing the CPAC committees and workgroups. These positions were contracted by OCA, on behalf of CPAC, and no benefits were provided. CJA funds were utilized to pay for the contractual services provided by the Training Specialists.

Task Force Recommendation(s):

1. Provide opportunities for medical professionals to consult with a child abuse medical expert, and promote and secure resources for medical child abuse expertise downstate.
2. Develop an effective collateral information request for DFS to utilize with medical providers and other professionals and provide training on same ("How to be a good Collateral").
3. Develop an abbreviated training for MDT partners on safety organized practice, safety and risk assessment and utilization of collaterals to help partner agencies understand the practice models and tools utilized by DFS.
4. Ensure medical professionals have a dedicated line at the DFS Report Line that reduces wait times.
5. Substantially and significantly improve the medical response to child abuse cases.
6. Continuously improve and reinforce Delaware's coordinated, multidisciplinary

team (MDT) response to serious child abuse and neglect cases.

7. Improve the multidisciplinary response to child sexual abuse cases in accordance with the Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect ("MOU").

Required CJA Category: This activity contributes to the investigative, administrative, and judicial handling of cases of child abuse and neglect.

Description of Evaluation Work

Evaluation Methods: The Chief Policy Advisor/CJA Coordinator submitted quarterly program reports to the Criminal Justice Council, the agency responsible for the fiscal management of the grant. The quarterly reports described the accomplishments and activities of the Training Specialists together with the other activities funded by the CJA Grant. The Chief Policy Advisor/CJA Coordinator also met quarterly with staff from the Criminal Justice Council to discuss these activities and progress towards meeting the Task Force recommendations and the extent to which it contributes to the reform of state systems (See Appendix B: Criminal Justice Council Program Reports). Lastly, the Chief Policy Advisor/CJA Coordinator had bi-weekly meetings with the Training Specialists and evaluated the contracts annually.

Output: In October 2021, OCA entered into new contracts with Training Specialists, Ameshia White and Megan Bittinger. In October 2021, Ms. Bittinger and Ms. White finalized and published three web-based 30-minute supplemental trainings on: (1) Child Abuse and Neglect in Children with Disabilities; (2) Protective versus Risk Factors; and (3) Parental Substance Use Disorders. The Children with Disabilities training provides professional reporters with an overview on how to better identify child abuse and neglect in children with disabilities along with resources on how to best serve children with disabilities. The Protective versus Risk Factors training discusses common protective factors and risk factors and identifies the factors that can place children at an increased risk to experience child abuse or neglect. Lastly, the Parental Substance Use Disorders training provides professional reporters with an overview on the types of substances and their effects on both parents and children, parental substance use and involvement with the Division of Family Services (DFS), prenatal substance exposure, Delaware's Aiden's Law and Delaware's Plans of Safe Care.

In the same month, Ms. Bittinger and Ms. White prepared a new training procedure, which would allow professional reporters the opportunity to participate in mandatory reporting training and specialized child welfare trainings based on their field of work. As such, the Training Specialists recommended adding seven additional trainings to the

growing list of supplemental trainings offered. This training process was approved by the CPAC Mandatory Reporting Workgroup in October 2021. The workgroup also approved a new domestic violence resources guide, which provides a statewide resource network for survivors of domestic violence, a mandated reporting flowchart, and revised guidance on mandatory reporting and parental substance use. The documents are available online on the Office of the Child Advocate's website and have been shared with the CPAC Mandatory Reporting Workgroup.

In December 2021, Ms. Bittinger and Ms. White presented three new supplemental trainings to the CPAC Mandatory Reporting Workgroup: (1) Intersection of Domestic Violence and Child Abuse; (2) LGBTQ+ Experiencing Abuse, Foster Care, and Homelessness; and, (3) Recognizing and Reporting Sexual Violence. The Intersection of Domestic Violence and Child Abuse training helps professionals understand the connection between domestic violence and child abuse, along with ways they can support child victims of domestic violence. The LGBTQ+ Experiencing Abuse, Foster Care, and Homelessness training highlights one of the most at-risk populations to experience child abuse and neglect. In this training, professionals are provided with a detailed overview of the LGBTQ+ community to provide them with a better understanding of the risk factors and indicators of child abuse and neglect. These trainings were approved and published on the Delaware Learning Center, OCA's online training system.

Additionally, in January 2022, Ms. Bittinger and Ms. White revised three existing supplemental trainings and presented the trainings to the workgroup. The training were as follows: (1) Minimal Facts; (2) Child Abuse and Neglect in Children with Disabilities; and (3) Neglect. One new supplemental training, Youth Caregivers, was also presented to the workgroup. The Minimal Facts training, which help reporters to obtain the information needed to make a clear and concise report of child abuse and neglect, and Children with Disabilities training were both approved and republished on the Delaware Learning Center. Additional revisions were suggested by the workgroup for the Neglect and Youth Caregivers trainings, so these trainings were not approved by the workgroup until April 2022.

During this reporting period, Ms. Bittinger and Ms. White also began to develop three new mandatory reporting trainings for the following professionals: (1) medical professionals; (2) educators; and (3) general professionals. Each training will provide specialized information and materials based upon the profession and what they would experience in their field of work. Ms. Bittinger and Ms. White are utilizing the Articulate software to develop the web-based training. All the trainings will be reviewed, approved, and published to the Delaware Learning Center in the next reporting period.

Ms. Bittinger and Ms. White prepared the intervention materials for the 2022 Child Abuse Prevention Month campaign. They created ads with intervention and reporting messaging, which included QR codes providing citizens with immediate access to Delaware's reporting resources. Additionally, the Training Specialists secured advertisement space with the local mall, outlet center, public transportation provider, social service agency and Division of Motor Vehicles.

Additionally, Ms. Bittinger and Ms. White helped organize and facilitate the Protecting Delaware's Children Webinar Series, a virtual multidisciplinary conference for child welfare professionals, for the month of April 2022. The Training Specialists were responsible for the following: creating the save-the-dates that were shared with the child welfare community; communicating and contracting with several national and local speakers; managing the online registration; managing the continuing educations credits; preparing and reviewing the conference evaluations; and providing participants with conference certificates, materials, and link to the online copy of the presentation.

Ms. Bittinger and Ms. White were also responsible for managing OCA's online training system and training evaluations through Survey Monkey, as well as providing technical support to participants taking the web-based trainings. They also maintained the number of professionals trained and reported those numbers to the CPAC Training Committee and its Mandatory Reporting Workgroup.

Ms. Bittinger staffed the Medical Response Workgroup on 10/5/21 and 1/11/2022 and the Child Sexual Abuse Committee's Mental Health, Medical, and Prevention Workgroup on 8/27/2021, 10/1/2021, and 11/5/2021. Ms. White staffed the Grants Oversight Committee on 7/28/21, 10/27/21, and 1/26/22; the Child Sexual Abuse Committee's Extra-familial, School, Institutional Abuse Response Workgroup on 10/26/21; the Child Sexual Abuse Committee's MDT Response/MOU Compliance Workgroup on 12/17/21; and the Education Committee on 12/15/21. Lastly, both Training Specialists staffed the Training Committee on 5/13/21, 8/12/21, 11/4/21, 2/3/22 and 5/5/22; the Mandatory Reporting Workgroup on 10/20/21, 12/2/21, 1/20/22 and 4/29/22; the ChildFirst-Multidisciplinary Team Workgroup on 5/18/21, 1/24/22 and 4/26/22; the Protecting Delaware's Children Conference Workgroup on 7/13/21, 10/12/21, 11/15/21, 1/12/22 and 4/13/22; and the Child Protection Accountability Commission meeting on 8/18/2021 11/17/2021, 2/16/2022 and 5/18/22.

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

Monitoring of Evaluation Results: Monitored by the CPAC Grants Oversight Committee and the CPAC Training Committee.

b. Activity: Contract with an MDT Training & Policy Administrator

Description: The Task Force contracted with an MDT Training & Policy Administrator, Adrienne Owen, in September 2020 to improve outcomes for child victims by supporting, training and coaching multidisciplinary team agencies. During this period, the responsibilities of the MDT Training & Policy Administrator included: identifying training needs as they relate to identifying, reporting, investigating, prosecuting and treating child abuse and neglect; developing, coordinating and providing training regarding topics related to identifying, reporting, investigating, prosecuting and treating child abuse and neglect; organizing and providing train-the-trainer sessions to MDT members; providing regular, ongoing training on the Memorandum of Understanding (MOU) for the MDT Response to Child Abuse & Neglect; working closely with members of the MDT to communicate findings and recommendations from the reviews of deaths and near deaths of abused or neglected children, and to provide follow up support on those system breakdowns; leading individualized meetings and coaching sessions with MDT agencies utilizing individual child victim cases, reviewing breakdowns in the MDT response and recommending activities to improve the outcomes for child victims; serving as a liaison with the law enforcement community regarding child abuse and neglect; participating in the MDT meetings convened by OCA's Office of the Investigation Coordinator for suspected trafficking cases as well as the Juvenile Trafficking Oversight Team once it is implemented; working closely with the members of the MDT to review and update the MOU and other protocols every three years; monitoring the progress of the CPAC/CDRC Joint Action Plan and overseeing the implementation of the MDT recommendations; participating on the CPAC Training Committee, which is charged with ensuring the training needs of the child protection system are being met through ongoing, comprehensive, multidisciplinary training opportunities on child abuse or neglect; and, proposing changes to state laws and policies impacting the identification, reporting, investigation, prosecution and treatment of child abuse and neglect. CJA funds were utilized to pay for the contractual services provided by the MDT Training & Policy Administrator.

Task Force Recommendation(s):

1. Continuously improve and reinforce Delaware's coordinated, multidisciplinary team (MDT) response to serious child abuse and neglect cases.
2. Update the MOU for the MDT Response to Child Abuse & Neglect regularly to incorporate best practices and to address the latest findings from the Child Abuse and Neglect Panel.

3. Revive the CPAC CAN Best Practices Workgroup to integrate the following into MOU training, or in the development of protocols to address coordination of medical services and the MDT.
4. Improve the multidisciplinary response to child sexual abuse cases in accordance with the Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect ("MOU").

Required CJA Category: This activity contributes to the experimental, model, and demonstration programs for testing innovative approaches and techniques which may improve the prompt and successful resolution of civil and criminal court proceedings or enhance the effectiveness of judicial and administrative action in child abuse and neglect cases and the reform of State laws, ordinances, regulations, protocols and procedures to provide comprehensive protection for children.

Description of Evaluation Work

Evaluation Methods: The Chief Policy Advisor/CJA Coordinator submitted quarterly program reports to the Criminal Justice Council, the agency responsible for the fiscal management of the grant. The quarterly reports described the accomplishments and activities of the MDT Training & Policy Administrator. The Chief Policy Advisor/CJA Coordinator also met quarterly with staff from the Criminal Justice Council to discuss these activities and progress towards meeting the Task Force recommendations and the extent to which it contributes to the reform of state systems (See also Appendix B: Criminal Justice Council Program Reports). Lastly, the Chief Policy Advisor/CJA Coordinator had monthly meetings with the MDT Training & Policy Administrator and plans to evaluate the contract annually.

Output: In April 2021, OCA entered into a new contract with MDT Training & Policy Administrator, Adrienne Owen. Ms. Owen is a former Corporal with the Delaware State Police. During the period, Ms. Owen continued to collaborate with MDT partners from multiple agencies, ranging from the Division of Family Services to the OCA's Office of the Investigation Coordinator, the Division of Forensic Science, the Department of Justice, Nemours Children's Hospital, local hospitals, and various law enforcement agencies, to revise and update Delaware's MOU for the MDT Response to Child Abuse and Neglect. Specifically, Ms. Owen focused on the creation of the Juvenile Trafficking Oversight Team, which will be tasked with monitoring and tracking all suspected Juvenile Trafficking/Commercial Sexual Exploitation of Children cases and will be outlined in the updated MOU. The MOU is anticipated to be implemented by agencies later this year after approval by the Task Force. Ms. Owen also continued her work on improving law enforcement participation in the monthly reviews of child death and near death cases, by

connecting with law enforcement agency representatives and providing an overview of the panel's purpose as well as the appropriate investigative information to be provided to the panel for effective review of the cases. Upon final approval of the strengths and findings identified by the panel for the individual case, Ms. Owen shared those strengths and findings with the appropriate law enforcement agency; this was done for the purpose of ultimately improving future investigations and ensuring best practice standards are followed in forthcoming investigations. As an additional means of improving the law enforcement and MDT response to child abuse and neglect investigations, Ms. Owen worked on creating an investigative checklist for MDT agencies to utilize in their response to child drug ingestion and poisoning reports; this was completed to address confusion surrounding the appropriate investigative response to these case types, especially considering the increasing number of these situations being reported in Delaware. Ms. Owen worked on organizing advanced training for criminal investigators, which will include an overview of the updates to the MOU, as well as information on Child Torture, Child Drug Ingestion/Poisoning, Doll Re-enactment and the Minimal Facts Interview Protocol. Planning for forthcoming training for all law enforcement on the updates to the MOU continued with expected implementation in May 2022. During the period, Ms. Owen provided training to the following police departments: Seaford, Selbyville, Milton, Wyoming, Dover, Harrington, Laurel, Ellendale, Camden, and Bridgeville. Additionally, Ms. Owen provided training on the updates to the MOU to the Department of Justice, Special Victims Unit Deputy Attorneys General. Training on Identifying and Reporting Child Abuse and Neglect was also provided to the Delaware Department of Probation and Parole; and training on the Response to Child Abuse in Schools was provided to Delaware School Resource Officers and Constables. Lastly, Ms. Owen staffed the CPAC Training Committee's Child Abuse and Neglect Best Practices Workgroup on 05/14/21, 09/21/21, and 11/09/21 and the Child Sexual Abuse Committee's MDT Response/MOU Compliance Workgroup on 07/15/21, 12/17/21 and 4/22/22.

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

Monitoring of Evaluation Results: Monitored by the CPAC Grants Oversight Committee and CPAC Training Committee.

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

Description: The Task Force provided regular training and demonstrative tools to investigators and prosecutors involved in the investigation and prosecution of child abuse and neglect cases. Several training opportunities were provided on the ChildFirst® Forensic Interview Protocol and the MOU for the MDT Response to Child Abuse and Neglect. The trainings were targeted to law enforcement, prosecutors, case workers from the Division of Family Services and forensic interviewers from the Children's Advocacy Center (CAC). The ChildFirst® Forensic Interview Protocol training was covered under a grant through the Zero Abuse Project, so CJA funds were not utilized this period. CJA funds were used for the contractual MDT Training & Policy Administrator to provide training on the MOU. An annual fee was also paid to AppInstitute, the company that hosts the mobile application on the MOU for the MDT Response to Child Abuse and Neglect. In place of the Protecting Delaware's Children Conference, the Task Force facilitated a webinar series, which featured several local and national subject matter experts. CJA funds were not utilized for speaker fees.

Task Force Recommendation(s):

1. Continuously improve and reinforce Delaware's coordinated, multidisciplinary team (MDT) response to serious child abuse and neglect cases.
2. Update the MOU for the MDT Response to Child Abuse & Neglect regularly to incorporate best practices and to address the latest findings from the Child Abuse and Neglect Panel.
3. Revive the CPAC CAN Best Practices Workgroup to integrate the following into MOU training, or in the development of protocols to address coordination of medical services and the MDT.
4. Improve the multidisciplinary response to child sexual abuse cases in accordance with the Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect ("MOU").
5. Develop an abbreviated training for MDT partners on safety organized practice, safety and risk assessment and utilization of collaterals to help partner agencies understand the practice models and tools utilized by DFS.

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

Description of Evaluation Work

Evaluation Methods: To evaluate the effectiveness of the multidisciplinary response to child abuse and neglect cases, the Task Force relied on the reviews of child abuse and

neglect deaths and near deaths by the CPAC Child Abuse and Neglect Panel[2] and cases monitored by OCA's Office of the Investigation Coordinator.[3] During the reporting period, the Child Abuse and Neglect (CAN) Panel, with oversight from the CAN Steering Committee, conducted retrospective reviews on 84 cases – 62 initials and 22 finals. For the 62 cases reviewed for the first time, there were 53 near deaths and 9 deaths that occurred between September 2020 and September 2021, and the children ranged in age from two weeks to almost 12 years of age. The children were victims of abusive head trauma, poisoning via drug ingestion, bone and/or skull fractures, unsafe sleep, and medical neglect. The 22 remaining cases had previously been reviewed and were awaiting the completion of prosecution. As a result of these reviews, a total of 114 strengths and 257 findings across seven system areas were identified. Of those, 75 findings (36% decrease from the prior period) and 53 strengths (89% increase from prior period) related to the MDT response (See Appendix C: Child Abuse and Neglect Panel Findings and Strengths – MDT Response). Overall, this was an improvement from the prior reporting period for the MDT response; however, the findings that were seen most often involved crime scene investigations and joint interviews between DFS and law enforcement for adults and children. There were also several strengths noted for the MDT response, and again, the collaborative work by DFS and law enforcement was noted most often. At every quarterly meeting, the Task Force reviews the work of the Panel and findings and strengths related to the MDT response, and a letter is submitted to the Governor, General Assembly and public describing how it plans to address the issues identified (See Appendix D: Child Abuse and Neglect Panel Letters to Governor). Lastly, the findings help identify the current training needs for the MDT. Training on crime scene investigations and doll re-enactments, as well as the response to drug investigation cases is planned for 2022.

Additionally, OCA's Office of the Investigation Coordinator opened 1,718 cases (27 deaths, 95 serious physical injury cases, 1 medical child abuse, 1,571 suspected sexual abuse cases, and 24 suspected sex trafficking) cases during the reporting period. For the opened cases, the office was responsible for initiating and facilitating communication between the MDT and addressing any issues with non-compliance of the MOU for the MDT Response to Child Abuse and Neglect. The Office also provided the county-based MDT members with an email notification upon receipt of child victims of serious physical injury and death to ensure a coordinated, immediate MDT response. Any system issues were immediately brought to the attention of the individual agencies, and for cases also

[2] The Child Abuse and Neglect Panel is authorized by the Task Force to conduct the confidential investigations and retrospective reviews of deaths or near deaths of abused or neglected children.
[3] The Office of the Investigation Coordinator is responsible for monitoring each reported case involving the death of, serious physical injury to, or allegations of sexual abuse of a child from inception to final criminal and civil disposition.

referred to the Child Abuse and Neglect Panel, the Office of the Investigation Coordinator presented those findings to the Panel. During the reporting period, 252 findings related to the MDT response were made by the Office of the Investigation Coordinator; 50% of the findings were made in sexual abuse cases and 44% made in serious physical injury cases. The top findings involved breakdowns in documentation, cross reporting and the criminal investigation. In February 2021, the Office implemented multidisciplinary team meetings for all serious physical injury and death cases. These virtual meetings were scheduled within 48-72 hours of the Office receiving notice of a serious physical injury to a child, child death or suspected sex trafficking case, and 76 meetings were held during the reporting period. The MDT Meetings included the Nemours Children's Hospital's Child At Risk Evaluation (CARE) Team, the assigned DFS Worker and Supervisor, the assigned Detective and Sergeant, the assigned Deputy Attorney General or Serious Victims Unit representative, the Division of Forensic Science (for deaths) and any other agency members as needed. The goal of this protocol is to ensure that all MDT members obtain accurate information about the child's medical condition/death, share information about the civil and criminal investigations and to discuss further steps and decisions on the case.

Output: In September 2021, the Task Force co-facilitated a five-day virtual training on the ChildFirst® Forensic Interview Protocol with representatives from the Zero Abuse Project. Twenty-six members of Delaware's multidisciplinary team participated in the training and were certified in the ChildFirst® Forensic Interview Protocol. The training covered topics such as effective interviewing, dynamics in child abuse, the process of disclosure, child development, questioning children, hearsay, testifying in court, working as a multi-disciplinary team, preparing children for court, as well as in-depth explanations and exercises on the Forensic Interview Protocol.

In April 2022, the Task Force facilitated the Protecting Delaware's Children Webinar Series, and a workshop was held each Wednesday during the month. The following workshops were offered: COVID's Impact on Children & Families by Dr. Angela Moreland; Internet as a Weapon: Identifying, Interrupting, and Preventing Online Solicitation of Children by Haley King, Esq. from the Department of Justice; Sentinel Injuries: A Tool for Reducing Severe Child Maltreatment by Dr. Arne Graff; and, Child Sex Trafficking: Collaboration, Investigations, and Resources by Mission Kids Children's Advocacy Center. Approximately 100 participants attended each workshop. The Task Force plans to continue the webinar series by offering a monthly workshop through the rest of the year.

During the period, the MDT Training & Policy Administrator, Ms. Owen, provided training to the following police departments: Seaford, Selbyville, Milton, Wyoming, Dover, Harrington, Laurel, Ellendale, Camden, and Bridgeville. Additionally, Ms. Owen provided training on the updates to the MOU to the Department of Justice Special Victims Unit Deputy Attorneys General.

The MDT Best Practices MOU mobile application had 378 active users during the period and 1,462 opens.

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

Monitoring of Evaluation Results: Monitored by the CPAC Training Committee.

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

Description: Partial scholarships were provided to representatives from the multidisciplinary team, who were directly responsible for the investigation and prosecution of child abuse and neglect cases or the review of such cases, to give them the opportunity to attend national conferences, to learn advanced techniques, and to enhance their relationship with other members of the MDT. CJA funds were used for registration costs during the period. This activity continued to be impacted by COVID-19.

Task Force Recommendation(s):

1. Continuously improve and reinforce Delaware's coordinated, multidisciplinary team (MDT) response to serious child abuse and neglect cases.
2. Improve the multidisciplinary response to child sexual abuse cases in accordance with the Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect ("MOU")

Required CJA Category: This activity contributes to the investigative, administrative, and judicial handling of cases of child abuse and neglect.

Description of Evaluation Work

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

Output: In May 2022, the registration costs for paid for two representatives from the Delaware State Police to attend the Eighteenth International Conference on Shaken Baby Syndrome/Abusive Head Trauma scheduled for October 23-25, 2022.

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

Monitoring of Evaluation Results: Monitored by the CPAC Grants Oversight Committee.

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

Description: The Task Force is responsible for overseeing the statewide training on the recognition and reporting of child abuse and neglect. CPAC accomplishes this through its existing mandatory reporting training programs for educators, medical professionals, and general community and professional audiences. Supplemental trainings on various child welfare topics have also been created. The training programs are revised and updated annually by the Training Specialists with oversight by the CPAC Training Committee and its Mandatory Reporting Workgroup and Medical Response Workgroup. The web-based trainings are available on OCA's online training system (Delaware Learning Center) and other agency's learning management systems, as appropriate. CJA funds were used to pay annual fees for the Articulate: E-learning software and Survey Monkey. Zoom Pro licenses and a webinar license were also purchased to allow for virtual trainings.

Task Force Recommendation(s):

1. Substantially and significantly improve the medical response to child abuse cases.
2. Ensure medical professionals have a dedicated line at the DFS Report Line that reduces wait times.
3. Provide opportunities for medical professionals to consult with a child abuse medical expert, and promote and secure resources for medical child abuse expertise downstate.
4. Develop an effective collateral information request for DFS to utilize with medical providers and other professionals and provide training on same ("How to be a good Collateral").
5. Continuously improve and reinforce Delaware's coordinated, multidisciplinary team (MDT) response to serious child abuse and neglect cases.

6. Improve the multidisciplinary response to child sexual abuse cases in accordance with the Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect ("MOU").

Required CJA Category: This activity contributes to the investigative, administrative, and judicial handling of cases of child abuse and neglect.

Description of Evaluation Work

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

Output: During the reporting period, Megan Bittinger and Ameshia White developed additional supplemental trainings that were published on OCA's online training system including: Child Abuse and Neglect in Children with Disabilities; Protective versus Risk Factors; Youth Caregivers; and Parental Substance Use Disorder. The trainings on Neglect and Minimal Facts: Guidelines for Mandated Reporters were updated. Ms. Bittinger and Ms. White also developed trainings on Recognizing and Reporting Sexual Violence; Intersections of Domestic Violence and Child Abuse; LGBTQ+ Youth Experiencing Abuse, Foster Care, and Homelessness; and Reporting Physical and Sexual Violence in Schools. Additionally, new resources were developed including an updated Mandatory Reporter Resource Guide; Age of Consent flowchart; Making a Report to the Division of Family Services Child Abuse and Neglect Report Line flowchart; and Resources for Parents, Caregivers, and Families. Ms. White and Ms. Bittinger began research and development for new and updated Mandatory Reporter Trainings for specialized populations including educators, medical Professionals, general professionals, paramedics, and stylists and salon professionals.

Between May 1, 2021 through March 31, 2022, 1,461 professionals completed the Mandatory Reporter training for general professionals, 115 providers completed the Mandatory Reporter training for medical providers, and 10,177 educators completed the Mandatory Reporter training for educators. Additionally, 4,312 professionals completed the Mandatory Reporter Refresher training during this period. 4,884 professionals completed supplemental trainings during the grant period. 100 completed the Neglect training, 2,572 completed the Minimal Facts training, 1,951 completed the Child Abuse and Neglect in Children with Disabilities training, 33 completed the Parental Substance Use Disorder training and 20 completed the Protective versus Risk Factors training. Additionally, for the older, video-based supplemental trainings: 61 completed the Child Protection Registry part 1 training, 57 completed the Child Protection Registry part 2

training, 24 completed the Family Court Called: You've Been Appointed training, 25 completed the Permanency Options training, 33 completed the Youth Engagement in Court training, and 8 completed the Representing Older Youth training.

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

Monitoring of Evaluation Results: Monitored by the CPAC Training Committee.

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

Description: OCA's online training system, the Delaware Learning Center, was utilized to provide web-based training to professionals statewide. The training programs included: Mandatory Reporting; Mandatory Reporting Refresher; Minimal Facts: Guidelines for Mandated Reporters; Child Neglect; Child Abuse and Neglect in Children with Disabilities; Parental Substance Use Disorder; and Protective versus Risk Factors. CJA funds were used to pay the annual fees for the Articulate software and Survey Monkey. Zoom Pro licenses and a webinar license were also purchased to allow for virtual trainings.

Task Force Recommendation(s):

1. Substantially and significantly improve the medical response to child abuse cases.
2. Continuously improve and reinforce Delaware's coordinated, multidisciplinary team (MDT) response to serious child abuse and neglect cases.
3. Improve the multidisciplinary response to child sexual abuse cases in accordance with the Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect ("MOU")

Required CJA Category: This activity contributes to the investigative, administrative, and judicial handling of cases of child abuse and neglect.

Description of Evaluation Work

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

Output: Since October 2019, OCA has utilized the State of Delaware's learning management system, the Delaware Learning Center, which is utilized by various state agencies to train its employees and contractors at no cost. The web-based training is available at:

https://stateofdelaware.csod.com/LMS/catalog/Welcome.aspx?tab_page_id=-67&tab_id=20000766

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

Monitoring of Evaluation Results: Monitored by the CPAC Training Committee.

g. Activity: Attend the CJA Grantee Meeting

Description: The CJA Coordinator and Task Force Chairperson attend the annual CJA Grantee Meeting and the National Citizen Review Panel Conference due to CPAC's roles as the CJA Task Force and Citizen Review Panel. No CJA funds were used during the reporting period.

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

Description of Evaluation Work

Output: The Training Specialists, Ameshia White and Megan Bittinger, attended the virtual CJA Grantee Meeting on May 4-5, 2022.

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

ii. Description of Activities Aligned with CJA and Other Children's Bureau Programming

a. CFSP/APSR Input

In SFY22, the Division of Family Services continued to share writing and editorial input for the Annual Progress and Services Report with over twenty agencies and community partners. The Chief Policy Advisor/CJA Coordinator submitted a report on behalf of OCA/CPAC and all if its program areas, including the Court Appointed Special Advocates Program, the Child Abuse and Neglect Panel, and the Office of the Investigation Coordinator. DFS distributes the APSR to stakeholders annually, and the reports are made available online: https://kids.delaware.gov/fs/cfs-review-plan.shtml

DFS convened its 2021 Stakeholder Meeting on November 3, 2021 and is planning to move to a biannual Stakeholder gathering beginning in 2022. DFS has traditionally convened this meeting annually to seek input on child welfare strengths and areas of concern. In addition, it serves as a review of agency priorities and updates, the agency's

mission and vision, guiding principles, contextual data, population statistics and performance measures. The Biannual Stakeholder meetings will provide additional opportunities to identify strengths and areas of need for the Child Welfare system with community partners. Additionally, the goals and activities of the CFSP and APSR are monitored through the quarterly Task Force meetings. The DFS Director and Cabinet Secretary for the Department of Services for Children, Youth and Their Families provide an update at every meeting.

b. Court and Legal Representation Work

Over the past few years Delaware has made improving quality legal representation for parents, children, and the State agency a priority. In 2019 the Quality Legal Representation Workgroup was established at the request of the Court Improvement Program Steering Committee. This workgroup is led by the Chief Judge of Family Court, Michael K. Newell, and participants include attorneys and other professionals from the Family Court, Division of Family Services, Department of Justice, the Task Force, and Office of the Child Advocate. The workgroup meets regularly to review IV-E funding sources and grant projects, discuss available resources and training, and plan for projects to improve the quality of legal representation. To date these projects have included the creation of a Delaware Parent Attorney Standards guide, the hiring of social workers to assist a parent attorney in both Sussex and New Castle Counties, and the creation of a position for a Peer Parent Advocate in Sussex County. The Quality Legal Representation workgroup will continue to look at how legal representation can be improved in Delaware into the foreseeable future.

c. Court Improvement Program

The Court Improvement Program (CIP) was formed in Delaware with a final report issued by the task force in 1997 that included twenty-two recommendations for improving judicial handling of child welfare cases. All of these recommendations were eventually implemented, and in 2016, Delaware established the CIP Steering Committee, which is led by Chief Judge Michael K. Newell and Judge Kenneth M. Milliman to provide overall leadership to the CIP work in Delaware. The Office of the Child Advocate has actively participated in the CIP Steering Committee as well as other subcommittees and workgroups to support the CIP. The Child Advocate and Executive Director of CPAC, Tania Culley, has been on the CIP Steering Committee since its inception in 2016. In addition, the CIP Steering Committee also has members from the Family Court, Department of Justice, Prevention and Behavioral Health Services, Department of Education, Office of Defense Services, and parent attorney representation. Quarterly Stakeholder meetings are also held in each county.

Additionally, the CIP Steering Committee has added other subcommittees to focus on its priority areas. These subcommittees are: Executive, Data, and Training and include the Quality Legal Representation Workgroup. Representatives from the Office of the Child Advocate participate in all of these subcommittees and the workgroup. Family Court has also continued to delegate a portion of its federal CIP grant to contract with a CPAC Data Analyst, housed within OCA, who works with system partners to review and analyze child welfare data, and staff the CPAC Data Utilization Committee. The Court also continues to delegate significant federal funds to support and expand OCA's data management system, and the Court transitioned to this data management system in January 2022.

d. Enhanced Response to Children and Families Impacted by Domestic Violence

To increase collaboration with the domestic violence community, a representative from the Domestic Violence Coordinating Council and a representative from the Delaware Coalition Against Domestic Violence participate on the Child Protection Accountability Commission's Training Committee and the Mandatory Reporting and Protecting Delaware's Children Conference workgroups under this committee. Additionally, in FY22, the Training Specialist, Megan Bittinger, researched and developed a training titled Intersections of Domestic Violence and Child Abuse that provides relevant information to child welfare professionals on dynamics of abusive relationships and their impact on children in the home. In FY23, the Protecting Delaware's Children Webinar Series will include a virtual workshop in October, for Domestic Violence Awareness Month, on Supporting Child Survivors of Intimate Partner Homicides. This webinar is being planned in collaboration with the Domestic Violence Coordinating Council. This workshop will cover the developmental impact on child survivors, environmental shifts and the impact to the child, and the shift in the service sector's response to child survivors.

e. Anti-Trafficking Efforts

In April 2022, the Task Force facilitated the Protecting Delaware's Children Webinar Series and included two workshops focused on exploitation and trafficking. The workshops were as follows: Internet as a Weapon: Identifying, Interrupting, and Preventing Online Solicitation of Children by Haley King, Esq. from the Department of Justice; and Child Sex Trafficking: Collaboration, Investigations, and Resources by Mission Kids Children's Advocacy Center. Approximately 100 participants attended each workshop.

Additionally, OCA's Office of the Investigation Coordinator continues to be the entity responsible for tracking and monitoring the number of suspected trafficking victims and

making the data available to the Task Force and Delaware's Human Trafficking Interagency Coordinating Council.

B. Prior Year Line Item Budget Expenditures (May 2021-May 2022)

Both the FFY19 and FFY20 funds were used during the reporting period. As such, the partial budgets for each are listed below.

FFY19 (Grant Award $89,008) **May 1, 2021 – December 17, 2021**		**FFY20 (Grant Award $89,013)** **December 17, 2021 – May 6, 2022**		
Funding Activity	**Total**	**Funding Activity**	**Total**	**Grand Total**
Training Specialists	$56,798.15	Training Specialist	$41,480.00	$98,278.15
MDT Training & Policy Administrator	$22,531.77	MDT Training & Policy Administrator	$13,066.49	$35,598.26
Comprehensive Training to MDT	$480.00	Comprehensive Training to MDT	$0.00	$480.00
MDT Scholarships	$0.00	MDT Scholarships	$700.00	$700.00
Web-based Training	$1,088.00	Web-based Training	$0.00	$1,088.00
CJA Grantee Meeting/National Citizen Review Panel Conference	$0.00	CJA Grantee Meeting/National Citizen Review Panel Conference	$0.00	$0.00
Total FFY19 Funds	**$80,897.92**	**Total FFY20 Funds**	**$55,246.49**	**$136,144.41**

C. Application for Proposed Activities (September 2022-September 2023)

i. Description of Proposed Activities Using CJA Funds

a. Activity: Contract with a Training Specialist

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

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

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

Required CJA Category: This activity contributes to the investigative, administrative, and judicial handling of cases of child abuse and neglect.

Task Force Recommendation(s):

1. Provide opportunities for medical professionals to consult with a child abuse medical expert, and promote and secure resources for medical child abuse expertise downstate.
2. Develop an effective collateral information request for DFS to utilize with medical providers and other professionals and provide training on same ("How to be a good Collateral").
3. Develop an abbreviated training for MDT partners on safety organized practice, safety and risk assessment and utilization of collaterals to help partner agencies

understand the practice models and tools utilized by DFS.

4. Ensure medical professionals have a dedicated line at the DFS Report Line that reduces wait times.
5. Substantially and significantly improve the medical response to child abuse cases.
6. Continuously improve and reinforce Delaware's coordinated, multidisciplinary team (MDT) response to serious child abuse and neglect cases.
7. Improve the multidisciplinary response to child sexual abuse cases in accordance with the Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect ("MOU").

Description of Evaluation Methods: The Chief Policy Advisor/CJA Coordinator will submit quarterly program reports to the Criminal Justice Council, the agency responsible for the fiscal management of the grant. The quarterly reports will describe the accomplishments and activities of the Training Specialist(s) together with the other activities listed in the CJA grant application. The Chief Policy Advisor/CJA Coordinator will also meet with staff from the Criminal Justice Council to discuss these activities and progress towards meeting the task force recommendations and the extent to which it contributes to the reform of state systems. Lastly, the Chief Policy Advisor/CJA Coordinator will meet monthly with the Training Specialist(s) and evaluate the contract annually.

b. Activity: Contract with an MDT Training & Policy Administrator

Description: The Task Force will contract with an MDT Training & Policy Administrator, a law enforcement or child welfare expert, to improve outcomes for child victims in civil and criminal court proceedings by supporting, training and coaching multidisciplinary team agencies. The position will be contracted by OCA, on behalf of CPAC, and no benefits will be provided. CJA funds will be utilized for the contract position.

Goal(s): 1. Develop and provide quality training to the multidisciplinary team, as defined in Title 16 of the Delaware Code, and persons responsible for identifying and reporting child abuse and neglect; 2. Oversee the MOU for the MDT Response to Child Abuse and Neglect, and statewide policies and procedures for investigating the welfare of abused and neglected children; 3. Participate in the reviews of deaths and near deaths of child victims to provide a law enforcement perspective, and communicate the system-wide findings or recommendations arising from those reviews to the MDT and help to effectuate system change to improve responses to child crime victims; and, 4. Oversee

the implementation of MDT recommendations in the Action Plan developed by CPAC and the Child Death Review Commission.

Objective(s): 1. Identify training needs as they relate to identifying, reporting, investigating, prosecuting and treating child abuse and neglect; 2. Develop, coordinate and provide training regarding topics related to identifying, reporting, investigating, prosecuting and treating child abuse and neglect; 3. Organize and provide train-the-trainer sessions to MDT members; 4. Provide regular, ongoing training on the MOU for the MDT Response to Child Abuse & Neglect; 5. Work closely with members of the MDT to communicate findings and recommendations from the reviews of deaths and near deaths of abused or neglected children, and to provide follow up support on those system breakdowns; 6. Lead individualized meetings and coaching sessions with MDT agencies utilizing individual child victim cases, reviewing breakdowns in the MDT response and recommending activities to improve the outcomes for child victims; 7. Serve as a liaison with the law enforcement community regarding child abuse and neglect; 8. Participate in the MDT meetings convened by OCA's Office of the Investigation Coordinator for suspected trafficking cases as well as the Juvenile Trafficking Oversight Team once it is implemented; 9. Work closely with the members of the MDT to review and update the MOU and other protocols every three years; 10. Monitor the progress of the CPAC/CDRC Joint Action Plan and oversee the implementation of the MDT recommendations; 11. Participate on the CPAC Training Committee, which is charged with ensuring the training needs of the child protection system are being met through ongoing, comprehensive, multidisciplinary training opportunities on child abuse or neglect; and 12. Propose changes to state laws and policies impacting the identification, reporting, investigation, prosecution and treatment of child abuse and neglect.

Required CJA Category: This activity contributes to the experimental, model, and demonstration programs for testing innovative approaches and techniques which may improve the prompt and successful resolution of civil and criminal court proceedings or enhance the effectiveness of judicial and administrative action in child abuse and neglect cases and the reform of State laws, ordinances, regulations, protocols and procedures to provide comprehensive protection for children.

Task Force Recommendation(s):

1. Continuously improve and reinforce Delaware's coordinated, multidisciplinary team (MDT) response to serious child abuse and neglect cases.
2. Update the MOU for the MDT Response to Child Abuse & Neglect regularly to incorporate best practices and to address the latest findings from the Child Abuse and Neglect Panel.

3. Revive the CPAC CAN Best Practices Workgroup to integrate the following into MOU training, or in the development of protocols to address coordination of medical services and the MDT.
4. Improve the multidisciplinary response to child sexual abuse cases in accordance with the Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect ("MOU").

Description of Evaluation Methods: The Chief Policy Advisor/CJA Coordinator will submit quarterly program reports to the Criminal Justice Council, the agency responsible for the fiscal management of the grant. The quarterly reports will describe the accomplishments and activities of the MDT Training & Policy Administrator together with the other activities listed in the CJA grant application. The Chief Policy Advisor/CJA Coordinator will also meet with staff from the Criminal Justice Council to discuss these activities and progress towards meeting the task force recommendations and the extent to which it contributes to the reform of state systems. Lastly, the Chief Policy Advisor/CJA Coordinator will meet monthly with the MDT Training & Policy Administrator and evaluate the contract annually.

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

Description: The Task Force will provide regular training and demonstrative tools to investigators and prosecutors involved in the investigation and prosecution of child abuse and neglect cases. The training will be targeted to the Division of Family Services, OCA's Office of the Investigation Coordinator, statewide law enforcement agencies, criminal/civil Deputy Attorneys General from Department of Justice, Children's Advocacy Center forensic interviewers and clinicians, and related child welfare partners such as hospital based Sexual Assault Nurse Examiners. Training will also be made available to professionals involved in the judicial and administrative handling of child abuse cases. The Task Force will contract with local and national subject matter experts when necessary and CJA funds may be needed for the speaker fees and the cost of the venue(s). CJA funds will also be used to pay the annual fees associated with the mobile application for the MOU for the MDT Response to Child Abuse and Neglect.

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

Objective(s): 1. Provide ongoing training on the MOU for the MDT Response to Child Abuse and Neglect; 2. Facilitate ongoing county-based trainings for law enforcement

agencies on integrating best practices into the investigation of complex child abuse and neglect cases; 3. Promote use of the mobile application on the MDT Best Practices MOU; 4. Facilitate and sponsor the ChildFirst® Forensic Interview Training for professionals involved in the investigative handling of child abuse cases; and, 5. Sponsor a one-day conference or webinar series with the Court Improvement Program, Division of Family Services and other child welfare agencies on topics relevant to professionals involved in the investigative, administrative, and civil and criminal judicial handling of child abuse and neglect cases.

Required CJA Category: This activity contributes to the investigative, administrative, and judicial handling of cases of child abuse and neglect as well as reform of State laws, ordinances, regulations, protocols and procedures to provide comprehensive protection for children.

Task Force Recommendation(s):

1. Continuously improve and reinforce Delaware's coordinated, multidisciplinary team (MDT) response to serious child abuse and neglect cases.
2. Update the MOU for the MDT Response to Child Abuse & Neglect regularly to incorporate best practices and to address the latest findings from the Child Abuse and Neglect Panel.
3. Revive the CPAC CAN Best Practices Workgroup to integrate the following into MOU training, or in the development of protocols to address coordination of medical services and the MDT.
4. Improve the multidisciplinary response to child sexual abuse cases in accordance with the Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect ("MOU").
5. Develop an abbreviated training for MDT partners on safety organized practice, safety and risk assessment and utilization of collaterals to help partner agencies understand the practice models and tools utilized by DFS.

Description of Evaluation Methods: The Task Force will use the reviews of child abuse and neglect deaths and near deaths by the CPAC Child Abuse and Neglect Panel and cases monitored by the OCA's Office of the Investigation Coordinator to evaluate the effectiveness of the multidisciplinary response to child abuse cases and neglect cases. Tableau will continue to be used to evaluate the effectiveness of the multidisciplinary response to child abuse and neglect cases using data visualizations, and oversight will be provided by the CPAC Data Utilization Committee. In addition, Survey Monkey will be used to evaluate the training programs.

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

Description: Partial scholarships will be provided to representatives from the multidisciplinary team, who are directly responsible for the investigation and prosecution of child abuse and neglect cases or the review of such cases, to give them the opportunity to attend national conferences in-person or virtually, to learn advanced techniques, and to enhance their relationship with other members of the MDT. Priority will be given to representatives from the Division of Family Services, OCA's Office of the Investigation Coordinator, statewide law enforcement agencies, criminal/civil Deputy Attorneys General from the DOJ, and OCA/CPAC staff. 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. CJA funds may be needed for the registration, travel or hotel costs.

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

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

Required CJA Category: This activity contributes to the investigative, administrative, and judicial handling of cases of child abuse and neglect.

Task Force Recommendation(s):

1. Continuously improve and reinforce Delaware's coordinated, multidisciplinary team (MDT) response to serious child abuse and neglect cases.
2. Improve the multidisciplinary response to child sexual abuse cases in accordance with the Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect ("MOU").

Evaluation Methods: The Task Force will use the reviews of child abuse and neglect deaths and near deaths by the CPAC Child Abuse and Neglect Panel and cases monitored by OCA's Office of the Investigation Coordinator to evaluate the effectiveness of the MOU. Tableau will continue to be used to evaluate the effectiveness of the multidisciplinary response to child abuse and neglect cases using data visualizations.

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

Description: The Task Force is responsible for overseeing the statewide training on the recognition and reporting of child abuse and neglect. CPAC accomplishes this through its existing mandatory reporting training programs for educators, medical professionals, and general community and professional audiences. Supplemental trainings on various child welfare topics are also regularly being created. The training programs are revised and updated annually by CPAC staff, and the web-based trainings are available on OCA's online training system. CJA funds may be used for the annual fees associated with the Articulate software, Zoom Pro license and webinar license and Survey Monkey.

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

Objective(s): Provide in-person/virtual and web-based training on mandatory reporting and other child welfare topics to educators, medical professionals and general professional audiences.

Required CJA Category: This activity contributes to the investigative, administrative, and judicial handling of cases of child abuse and neglect.

Task Force Recommendation(s):

1. Substantially and significantly improve the medical response to child abuse cases.
2. Ensure medical professionals have a dedicated line at the DFS Report Line that reduces wait times.
3. Provide opportunities for medical professionals to consult with a child abuse medical expert, and promote and secure resources for medical child abuse expertise downstate.
4. Develop an effective collateral information request for DFS to utilize with medical providers and other professionals and provide training on same ("How to be a good Collateral").
5. Continuously improve and reinforce Delaware's coordinated, multidisciplinary team (MDT) response to serious child abuse and neglect cases.
6. Improve the multidisciplinary response to child sexual abuse cases in accordance with the Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect ("MOU")

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

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

Description: OCA's online training system will be utilized to provide web-based training to professionals statewide. The current training programs include: Mandatory Reporting; Mandatory Reporting Refresher; Minimal Facts: Guidelines for Mandated Reporters; Child Neglect; Child Abuse and Neglect in Children with Disabilities; Parental Substance Use Disorder; and Protective versus Risk Factors. CJA funds may be used for the annual fees associated with the Articulate software, Zoom Pro license and webinar license and Survey Monkey.

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

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

Required CJA Category: This activity contributes to the investigative, administrative, and judicial handling of cases of child abuse and neglect.

Task Force Recommendation(s):

1. Substantially and significantly improve the medical response to child abuse cases.
2. Continuously improve and reinforce Delaware's coordinated, multidisciplinary team (MDT) response to serious child abuse and neglect cases.
3. Improve the multidisciplinary response to child sexual abuse cases in accordance with the Memorandum of Understanding for the Multidisciplinary Response to Child Abuse and Neglect ("MOU")

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

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

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

E. **Proposed Line Item Budget** (September 2022-September 2023)

FFY21 (Grant Award $89,206.00)	
Funding Activity	**Total**
Training Specialist	$62,256.00
MDT Training & Policy Administrator	$20,000.00
Comprehensive Training to MDT (includes mobile app)	$2,400.00
MDT Scholarships	$2,050.00
Web-based Training (includes Articulate, Zoom & Survey Monkey)	$1,500.00
CJA Grantee Meeting/National Citizen Review Panel Conference	$1,000.00
Total FFY20 Funds	**$89,206.00**

F. Governor's Assurance Letter

STATE OF DELAWARE
OFFICE OF THE GOVERNOR
TATNALL BUILDING, SECOND FLOOR
JOHN CARNEY MARTIN LUTHER KING, JR. BOULEVARD SOUTH PHONE: 302-744-4101
GOVERNOR DOVER, DELAWARE 19901 FAX: 302-739-2775

May 31, 2022

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

Dear Acting Commissioner Hoffman:

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 2021 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 when held in person.

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

Sincerely,

John C. Carney
Governor, State of Delaware

G. Certification Regarding Lobbying

CERTIFICATION REGARDING LOBBYING

Listen

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

Tania Culley/Child Advocate

Organization

Office of the Child Advocate

III. Appendices

State of Delaware Child Protection Accountability Commission
Quarterly Meeting Minutes

WEDNESDAY, MAY 19, 2021
9:00 AM – 11:30 AM – Zoom Webinar

Those in Attendance:

Members of the Commission:	Statutory Role:
Mary Dugan, Esq., Chair	Child Protection Community 16 Del. C. § 931(a)(15)
The Hon. Josette Manning	Secretary of Services for Children, Youth & Their Families 16 Del. C. § 931(a)(1)
Trenee Parker	Director, Division of Family Services 16 Del. C. § 931(a)(2)
James Kriner, Esq.	Two Representatives from the Attorney General's Office 16 Del. C. § 931(a)(3)
Abigail Rodgers, 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)
The Honorable Kyle Evans Gay	One member of the Senate 16 Del. C. § 931(a)(6)
Susan Haberstroh	Designee for Secretary of the Department of Education 16 Del. C. § 931(a)(7)
Maureen Monagle	Chair of the Domestic Violence Coordinating Council 16 Del. C. § 931(a)(9)
Colonel Melissa Zebley	Superintendent of the Delaware State Police 16 Del. C. § 931(a)(10)
Dr. Garrett Colmorgen	Chair of the Child Death Review Commission 16 Del. C. § 931(a)(11)
Jen Donahue, Esq.	Investigation Coordinator 16 Del. C. § 931(a)(12)
Ellen Levin	At-large Member - Child Protection Community 16 Del. C. § 931(a)(15)
Dr. Elizabeth Higley	At-large Member - Child Protection Community 16 Del. C. § 931(a)(15)
Meg Garey	At-large Member – Interagency Committee on Adoption 16 Del. C. § 931(a)(15)
Dr. Allan De Jong	At-large Member - Medical Community 16 Del. C. § 931(a)(15)

Staff:
Tania Culley, Esq.
Rosalie Morales

Members of the Public:

Megan Bittinger	Eliza Hirst, Esq.	Erin Ridout	Lori Sitler
Antonisha Busby	Caroline Jones	JoAnn Santangelo	Eleanor Torres, Esq.
Ava Carcirieri	Ariel McHone	Meredith Seitz	Ameshia White
Kelly Ensslin, Esq.	Sue Murray	Jennifer Sieminski	Brittany Willard
Islanda Finamore, Esq.	Melissa Palokas	Brenda Smith	
Amy Gallagher	Anne Pedrick	Molly Shaw, Esq.	

I. WELCOME/INTRODUCTIONS/APPROVAL OF MINUTES

Mary Dugan, Esq. opened the meeting and welcomed the attendees.

A motion was made by Dr. Garrett Colmorgen to approve the minutes from February 17, 2021 and Judge Hitch seconded the motion. There were no abstentions. All other members voted in favor, and the motion carried.

II. EXECUTIVE DIRECTOR'S REPORT

Tania Culley, Esq. provided the Executive Director's report. She shared that the new OCA office manager is Ariel McHone, and she will be providing regular support to CPAC. Ms. Culley added that OCA has had some turnover with its contractors and casual/seasonal positions. As a result, a posting will be forthcoming for a management analyst position, and OCA recently hired Ameshia White and Megan Bittinger to fill the contractual training specialist vacancy. In addition, Jen Falkowski was hired to fill a full-time Court Appointed Special Advocate (CASA) coordinator position, and Jessica Hazzard accepted the casual/seasonal CASA coordinator position vacated by Ms. Falkowski. OCA staff will be returning to the office at least two days a week as of June 7.

Ms. Culley provided an update on training and recruitment by the CASA Program. OCA has started to recruit and train volunteer attorneys to take on CASA volunteers. OCA also continues to hold training for new CASA volunteers as well as advanced training opportunities. Ten new CASA volunteers were sworn in yesterday. Lastly, OCA is partnering with the Nemours Children's Hospital and Black Nurses Rock to recruit new volunteers.

She discussed the representation of clients in the custody of the Department of Services for Children, Youth and Their Families (DSCYF). She shared the number of entries so far in 2021. She also discussed the number of youth with a permanency plan of Another Planned Permanent Living Arrangement (APPLA).

Ms. Culley shared a brief update on the scholarship program. Young adults who have experienced foster care are in the process of being interviewed for the Chafee Education and Training Vouchers (ETV) Program and the Ivyane D.F Davis Memorial Scholarship Fund. Additionally, to support youth who are graduating, OCA is in the process of ordering various items through its donation fund.

III. COMMITTEE REPORTS

A. CHILD ABUSE AND NEGLECT STEERING COMMITTEE

i. CAN CASELOADS REPORT/ADMINISTRATIVE UPDATE

Ms. Morales reported the CPAC Child Abuse and Neglect (CAN) Steering Committee met on May 11, 2021 to provide oversight for the CAN Panel. The Committee discussed the CAN caseload, the CAN report which includes the facts and circumstances of the cases the Panel reviewed in the last quarter, and the letter to the Governor.

The CAN Panel has 80 open cases with 17 cases before the Commission today for approval. As noted at the prior meeting, the Panel continues to see an increase in the number of referrals received. From January to April 2021, 21 cases were screened in and assigned a review date. During the same period, the Panel reviewed 24 cases. In addition, there are another 33 cases scheduled for review between May and October 2021. In May, the Panel will be moving to 5 reviews a month to keep up with the workload. Lastly, Bernadette Clagg, one of the Panel's

medical abstractors, resigned. Jennifer Cooper and Andrea Repine, both from Nemours Children's Hospital, agreed to assist with the medical abstractions. As a result, three medical abstractors are providing support to the CAN Panel.

ii. CAN FINDINGS/DETAILS/LETTER TO GOVERNOR

Ellen Levin reported on the 17 cases reviewed by the CAN Panel in the last quarter. One of the near death cases approved had been previously reviewed and was awaiting the completion of the criminal investigation. Charges against both parents were nolle prossed. One additional finding against the medical community was made for failure to report suspected abuse or neglect to the Division of Family Services (DFS) Report Line and allowing the parents to transport the child to the emergency department for evaluation.

The sixteen remaining cases were from deaths or near deaths that occurred between July and September of 2020. Of these cases, four will have no further review as there are no criminal charges. Nine of the twelve remaining cases have pending charges and will be reviewed again once prosecution is completed. The remaining three cases are still being investigated. The children in these 2020 cases range in age from one month to three years of age with three deaths and thirteen near deaths. The children were victims of abusive head trauma, poisoning via drug ingestion, bone and skull fractures, and unsafe sleep. These twelve cases resulted in 18 strengths and 78 current findings across system areas.

Dr. Garrett Colmorgen made a motion to approve the letter to the Governor and findings and strengths, and Susan Haberstroh seconded the motion. There were no abstentions. All other members voted in favor, and the motion carried.

B. TRAINING

Ms. Morales reported the CPAC Training Committee met on May 13, 2021 and provided oversight for the Protecting Delaware's Children Fund and the Committee's workgroups.

The ChildFirst/Multidisciplinary Team (MDT) Workgroup will be hosting another ChildFirst® Forensic Interview training from September 13-17, 2021. The training will be facilitated by Delaware team members, and Delaware will officially be reaccredited to deliver this training on its own. A Save-the-Date will be sent out by next month.

During the quarter, the CAN Best Practices Workgroup approved several resources that will be included as appendices in the Memorandum of Understanding (MOU) for the Multidisciplinary Team Response to Child Abuse or Neglect. These resources are as follows: the Delaware Multidisciplinary Team Guidelines for Child Abuse Medical Response, Common Indicators of Medical Child Abuse, Multidisciplinary Team Protocol for Scheduling Forensic Interviews for Child Victims and the Commercial Sexual Exploitation Identification Tool (CSE-IT). CPAC previously approved the Guidelines for Child Abuse Medical Response. Ms. Morales provided a description of each and shared the CSE-IT was also approved by DSCYF. The Protocol for Scheduling Forensic

Interviews will be reviewed within six months to determine if there is an impact on the scheduling of forensic interviews.

A motion was made by Dr. Colmorgen to approve the resources, and the motion was seconded by Abigail Rodgers, Esq. There were no abstentions. All other members voted in favor, and the motion carried.

C. SEI/MEDICALLY FRAGILE – 2019/2020 SEI CASES

Jen Donahue, Esq. provided the final report of the Joint Committee on Substance-Exposed Infants (SEI)/Medically Fragile Children. First, she acknowledged the Joint Committee's co-chair, Dr. Allan De Jong, and the DFS Director, Trenee Parker, for her leadership. Ms. Donahue also recognized the first two SEI workers, Mary Baker and Kathleen Truitt. Additionally, she acknowledged the following staff at DFS: Valerie Thomas, Amie Jacquet, Bridget Holden, Wendy Stewart, Ashley Pollard, Anitra Cooper, Jackie VanNortwick-Vass, Amanda Gorr, Marsha Glover, Christian Craig, Kanina Rowe, Danielle Kromka, Taylor Robinette, Cathy Zakrewski, Tiffany Kelley, Shannon John, Sarah Azevedo and Alana Moffa.

Next, Ms. Donahue gave a presentation on the Delaware Infants with Prenatal Substance Exposure: 2020 Year in Review. This included a discussion of Aiden's Law, the Plan of Safe Care Pathways, the number of notifications to DFS in 2020, the type of substance exposure, significant findings from the 2020 data and a summary of the accomplishments by the Committee. Several commissioners offered comments acknowledging the Committee's work.

A motion was made by Dr. Colmorgen to disband the committee with understanding that work will continue to move forward, and the motion was seconded by Ms. Levin. There were no abstentions. All other members voted in favor, and the motion carried. Commissioners thanked Ms. Donahue, Ms. Parker and Dr. DeJong for their hard work.

D. LEGISLATIVE

Molly Shaw, Esq. provided the report for the CPAC Legislative Committee. Ms. Shaw reported the revisions to the Termination of Parental Rights (TPR) statute has been introduced as Senate Bill 141, and she acknowledged Senator Gay for sponsoring the bill. At the prior meeting, CPAC voted to champion the bill.

Ms. Shaw also discussed the DFS Caseload Reduction bill. It was brought to the Legislative Committee this week, and the Committee voted to support the legislation. The legislation remained the same; however, the timeframe for implementation was moved back to FY23 and FY24. Dr. Colmorgen made a motion for CPAC to champion the bill, and the motion was seconded by Ms. Donahue. There were no abstentions. All other members voted in favor, and the motion carried.

While DOE has agreed to champion the Ivyane Davis Memorial Scholarship draft bill, it will not be introduced this year. Instead, it will be included as part of the DOE legislative packet for next year.

Additionally, Ms. Shaw discussed the other legislation reviewed by the Committee that was related to child protection issues and asked for input regarding the bills supported or deferred by the Committee. Secretary Manning made a motion that any bills supported by the Committee are supported by CPAC, and the motion was seconded by Ms. Rodgers. There were no abstentions. All other members voted in favor, and the motion carried.

After some discussion about whether the pending juvenile justice legislation was under CPAC's purview, Secretary Manning made a motion that CPAC not consider the bills since serving delinquent children was outside of CPAC's mandate. The motion was seconded by Trenee Parker. There were no abstentions. All other members voted in favor, and the motion carried.

There were also several bills that dealt with services for children with disabilities. Similarly, there was discussion about whether the legislation falls under CPAC's purview. Ultimately, it was determined that no letter of support would be provided and the bills would remain on the legislative chart.

Lastly, Ms. Shaw discussed the legislation that was introduced yesterday and not considered by the Committee. Ms. Shaw explained the legislation relates to domestic violence and adds several offenses to the First Offenders Domestic Violence Diversion Program. The Commission discussed that the CPAC bylaws allow the Committee to take a position on the legislation between now and June 30 on behalf of CPAC. However, the legislation would have to be presented to the Committee if it convenes. Secretary Manning shared that this legislation would fall under CPAC's purview as domestic violence does result in children being abused, neglected or dependent. Depending on how many CPAC related bills are introduced in the next few weeks, the Legislative Committee may or may not meet again before June 30th.

E. INVESTIGATION, PROSECUTION & TREATMENT OF CHILD SEXUAL ABUSE

Ms. Donahue provided a brief report for the Committee on the Investigation, Prosecution and Treatment of Child Sexual Abuse (Committee on Child Sexual Abuse). She stated the Committee has met four times, and its next meeting is on June 17. The Committee's three workgroups are having discussions about goals and continue to meet in between the larger committee meetings. Since the Committee is in the initial stages of information gathering, more specifics will be provided at the next meeting.

F. DATA UTILIZATION

Brittany Willard gave a presentation on the quarterly child welfare trends identified by the CPAC Data Utilization Committee. This included a discussion of the DFS caseloads, cases reviewed by the Child Death Review Commission, profiles of children in DSCYF custody, and the CPAC scholarship awards for the 2020-2021 school year. Ms. Willard noted that the DFS Region 5 caseload data was visualized this quarter. In the prior quarter, it was not visualized, but it was included in the statewide calculation presented to CPAC.

G. EDUCATION

Susan Haberstroh, MPA, Ed.D., provided the CPAC Education Committee's report. First, she stated that it has been helpful for members of the Committee to participate on the Training Committee's Mandatory Reporting Workgroup and to provide feedback on the training for educators. Dr. Haberstroh also discussed the Education Committee's MOU Workgroup. She stated the current MOU between the Department of Education and DSCYF has been in place since 2018, and it discusses both child abuse reporting and investigation, and children in foster care. The workgroup is drafting two MOUs to address these areas separately. The child abuse reporting MOU will have updated timelines for making reports and will discuss minimal facts or information needed to make the reports to DFS. The children in foster care MOU will align with best interest regulations, address Interstate Compact for the Placement of Children (ICPC) and add another layer for dispute resolution. Dr. Haberstroh said the Committee is also being educated on the resources provided by DSCYF. Recent presentations have been provided by Sophia Elliott, Steve Yeatman and Casey Graney on topics including, independent living services to promoting safe and stable families. Lastly, Dr. Haberstroh mentioned that Jennifer Davis has increased her contact with foster care liaisons to focus on meeting the needs of children and youth in care as a result of COVID.

IV. COMMISSIONER REPORTS

A. OFFICE OF THE INVESTIGATION COORDINATOR

Ms. Donahue discussed the Office of the Investigation Coordinator (IC) and the unmanageable volume of cases for her staff. She thanked CPAC for support and encouragement over last 8 years, but stated that ongoing support is needed. When COVID hit, IC had 1,500 open cases. During quarantine, reports dropped and it allowed her office to resolve and close cases. However, IC is seeing a major uptick in serious injury, unsafe sleep and drug ingestions. Currently, there are 875 open cases, which are primarily child sexual abuse cases. In every case, the three IC case review specialists are responsible for extensively reviewing the case, collecting data and ensuring compliance with the MOU.

More recently, IC implemented MDT meetings within 48 to 72 hours. She said the meetings are critical in that every MDT member has the same information, criminally and civilly, to ensure victim and siblings are safe and to make sure the case is set up for the best prosecutorial outcome. However, the meetings have had an additional impact on IC workloads. To further convey the workload issues, Ms. Donahue discussed a day in the life of a case review specialist. Once again, she asked for the Commission's support and recommendations for addressing the workload issues. She added that two of the case review specialists have been grant funded since 2018, and she is hopeful that the positions will receive ongoing state funding. For long-term sustainability, IC is in need of a Deputy position, and at least one more case review specialist. These positions have been requested for the last three budget years, and Ms. Donahue is hopeful they will be funded next fiscal year. Ms. Donahue is also hopeful a plan can be made to manage the workload over the next year.

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

Secretary Manning deferred to Division Director, Trenee Parker, for comments.

i. DIVISION OF FAMILY SERVICES

Ms. Parker reported that the Department is in the process of returning to the workplace, but staff will be given more flexibility over the summer. In addition, Ms. Parker discussed the report line volume and caseloads. She stated the report line volume has increased, and DFS has returned to pre-pandemic levels. She also discussed the program areas where caseloads are high. In fact, Region 5, which handles the serious child abuse cases, did not see a reduction in cases over the pandemic. Ms. Parker also added that DFS is seeing an increase in youth entering foster care.

To deal with staffing challenges, DFS has developed a five-year recruitment and retention plan, and part of the plan is to add a standalone Sex Abuse/Serious Injury Unit in Kent County. Another investigation unit is being added to the Region 1 office on Churchman's Road, and an additional Assistant Regional Administrator position will be added to support the supervisors.

Ms. Parker discussed the new vendor, Dialpad, for the Report Line. DFS hopes the new vendor will improve the dropped calls, recording, and other issues at the Report Line. DFS is also working to develop a strong kinship navigator for the state and is working with Children's Choice and an organization in Florida called KIN-Tech. DFS hopes to prevent youth from entering foster care or to reduce the time spent in care.

Ms. Parker also discussed Division X (Supporting Foster Youth and Families through the Pandemic Act) and the additional Chafee funding that is available. It has given DFS the short-term opportunity to extend independent living services to youth up to age 23 and provided additional funding to the Education and Training Vouchers (ETV) Program and for transportation costs.

Lastly, Ms. Parker acknowledged that May is Foster Care Appreciation Month. She also mentioned the Destined for Greatness event and the Youth Advisory Council conference.

ii. PREVENTION & BEHAVIORAL HEALTH SERVICES

No report provided.

C. DEPARTMENT OF JUSTICE

Ms. Rodgers stated the Family Division staff is back in the office a few days a week, and the staff will return full time in September. Ms. Rodgers also discussed the staff turnover and onboarding of new staff during the pandemic. Lastly, Ms. Rodgers is hopeful that the DOJ case management system will be up and running for the Family Division in the fall. The pandemic had an impact on its implementation last year.

Jim Kriner, Esq. stated the Special Victims Unit (SVU) has been up and running for some time. The Unit has been intaking cases, attending forensic interviews remotely and deputies have been on call for child abuse cases, sexual assaults of adults and children, and child death cases. The SVU has also seen some turnover. Two Deputies in New Castle County transferred to other units. More recently, the Unit has been preparing for trials in Superior Court for the backlog of cases from the last year.

D. LAW ENFORCEMENT

Colonel Melissa Zebley shared that the Delaware State Police have had an opportunity to reengage in in-service training. Cpl. Andrea Warfel is in the process of providing training on the MOU for the Multidisciplinary Team Response to Child Abuse or Neglect, and she is receiving great feedback on the protocols, mobile applications and checklists.

E. MEDICAL

Dr. De Jong provided an update from the Nemours Children's Hospital of Delaware, which was recently renamed. He discussed an increase in visits to the emergency department (ED) and evaluations conducted by the Child At Risk Evaluation (CARE) Program for children in Delaware. In 2020, 759 children were seen in the ED, which is almost double the average (480). In the past, 1% of total ED visits were due to abuse. Last year, it was 2%. In 2020, the CARE Program saw an uptick in torture, ingestion, abusive head trauma and serious physical injury cases.

Dr. De Jong also shared that Nemours is in the final year of its Victims of Crime Act (VOCA) grant, which funds Nurse Practitioner, Andrea Repine.

As Ms. Donahue mentioned, the 48 to 72 hour MDT meetings are critical, but are also another workload for not only IC staff but for the CARE Program. Dr. De Jong added that the CARE Program will have reduced summer coverage while Dr. Deutsch is out on leave.

V. NEW BUSINESS

There was no new business.

VI. PUBLIC COMMENT AND ADJOURNMENT

Amy Solomon Gallagher provided public comment as an education advocate. She discussed the racial disparities in education and mentioned her observations at a public school in Delaware. Specifically, she discussed the length of time it took one child to be assessed for special education services. She recommended that CPAC partner with the Governor's Advisory Council for Exceptional Children.

Caroline Jones also provided public comment on the Kind to Kids UGrad Program, which is an education program for children and youth in foster care. She talked about the number of youth that are served by the program, as well as the various professionals that her staff interacts with on behalf of the youth. Ms. Jones said that this year there are 10 students in their senior year and all will graduate. She also discussed the impact of COVID, and how the program provided tutoring to youth.

Erin Ridout from the Delaware Coalition Against Domestic Violence provided public comment on the Domestic Violence - Community Health Worker Program. She said the Coalition partnered with Child Inc. to offer the program, which provides coordinated assistance to survivors of domestic violence. She also shared that an evaluation was completed by the University of Delaware and found the program has some prevention efforts associated with child abuse.

The meeting was adjourned at 11:43 a.m.

State of Delaware Child Protection Accountability Commission
Quarterly Meeting Minutes

WEDNESDAY, AUGUST 19, 2021
9:00 AM – 11:30 AM – Zoom Webinar and In-Person site

Those in Attendance:

Members of the Commission:	Statutory Role:
Mary Dugan, Esq., Chair	Child Protection Community 16 Del. C. § 931(a)(15)
The Hon. Josette Manning	Secretary of Services for Children, Youth & Their Families 16 Del. C. § 931(a)(1)
Trenee Parker	Director, Division of Family Services 16 Del. C. § 931(a)(2)
James Kriner, Esq.	Two Representatives from the Attorney General's Office 16 Del. C. § 931(a)(3)
Abigail Rodgers, 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)
The Honorable Kyle Evans Gay	One member of the Senate 16 Del. C. § 931(a)(6)
Maureen Monagle	Chair of the Domestic Violence Coordinating Council 16 Del. C. § 931(a)(9)
Colonel Melissa Zebley	Superintendent of the Delaware State Police 16 Del. C. § 931(a)(10)
Dr. Garrett Colmorgen	Chair of the Child Death Review Commission 16 Del. C. § 931(a)(11)
Ellen Levin	At-large Member - Child Protection Community 16 Del. C. § 931(a)(15)
Dr. Elizabeth Higley	At-large Member - Child Protection Community 16 Del. C. § 931(a)(15)
Meg Garey	At-large Member – Interagency Committee on Adoption 16 Del. C. § 931(a)(15)
Dr. Allan De Jong	At-large Member - Medical Community 16 Del. C. § 931(a)(15)
Dr. Aileen Fink	Director, Division of Prevention and Behavioral Health 16 Del.C. §931(a)(8)
Colonel Joseph Bloch	At-large Member- Law Enforcement Agency 16 Del.C. §931(a)(15)
Cpl. Andrea Warfel	Designee for Superintendent of the Delaware State Police 16 Del.C. §931(a)(10)

Staff:
Tania Culley, Esq.
Lauren Brueckner

Members of the Public:

Megan Bittinger	Mollie Marine	Cindy Sze	Lori Sitler
Ava Carcirieri	Caroline Jones	JoAnn Santangelo	Eleanor Torres, Esq.
Kelly Ensslin, Esq.	Sue Murray	Meredith Seitz	Brittany Willard
Molly Shaw, Esq.	Anne Pedrick	Mark Hudson, Esq.	Adrienne Owen
Ameshia White	Mariann Kenville-Moore	Kirsten Olson	

I. WELCOME/INTRODUCTIONS/APPROVAL OF MINUTES

Mary Dugan, Esq. opened the meeting and welcomed the attendees.

A motion was made by Dr. Garrett Colmorgen to approve the minutes from May 19, 2021 and Maureen Monagle seconded the motion. There were no abstentions. All other members voted in favor, and the

motion carried.

II. EXECUTIVE DIRECTOR'S REPORT

Tania Culley, Esq. provided the Executive Director's report. She shared that OCA has sent its budget requests, and the annual Judicial Budget retreat is being held later today. Ms. Culley stated that the priority for OCA is proper staffing for the Office of the Investigation Coordinator.

Currently, OCA has no administrative support and a new Office Manager is actively being sought. In addition to that position being open, other staff are out on parental leave until mid-September. OCA recently hired two Management Analysts; one is a contract position and one is a casual/seasonal position. Brittany Willard will share more about that during her presentation.

III. COMMITTEE REPORTS

A. CHILD ABUSE AND NEGLECT STEERING COMMITTEE

i. CAN CASELOADS REPORT/ADMINISTRATIVE UPDATE

Ms. Levin reported the CPAC Child Abuse and Neglect (CAN) Steering Committee met on July 27, 2021 to provide oversight for the CAN Panel. The Committee discussed the CAN caseload, the CAN report which includes the facts and circumstances of the cases the Panel reviewed in the last quarter, and the letter to the Governor.

The CAN Panel has 20 cases before the Commission today for approval. Two of the near death cases approved had been previously reviewed and were awaiting the completion of criminal prosecution. Both cases resolved – one as an Assault 2nd with community supervision and one as a misdemeanor Endangering the Welfare with probation. There were no additional findings made for either case; however, two additional strengths were made relating to the civil case.

The eighteen remaining cases were from deaths or near deaths that occurred between September of 2020 and January of 2021. Of these cases, nine will have no further review as there are no criminal charges in eight of the cases and the criminal charge for the ninth case has been resolved. Six of the nine remaining cases have pending charges and will be reviewed again once prosecution is completed. The remaining three cases are still being investigated.

The children in these 2020/2021 cases range in age from twelve days to eleven years of age with four deaths and fourteen near deaths. The children were victims of abusive head trauma, poisoning via drug ingestion, bone and skull fractures, medical neglect and unsafe sleep. These eighteen cases resulted in 34 strengths and 68 current findings across system areas.

As noted at the prior two meetings, the Panel continues to see an increase in the number of referrals received which is creating a heavy burden on the panel members. Ms. Levin stated that there could be as many as 14 initial reviews in December, 13 initial reviews scheduled for January 2022, and 10 initial reviews scheduled for February 2022. Ms. Levin is requesting a

"good cause" waiver as allowed by statute to increase the time frame to review CAN cases from 6 months to 9 months.

Dr. Allan De Jong commented that he has previously helped to review the criteria for CAN cases and suggested that maybe those should be looked at again. Dr. De Jong commented that federal standards for review of near death cases sets the bar much lower than Delaware. He does not believe that this should be Delaware's standard, but is suggesting a tiered approach with the ability to do an "abbreviated review" for some cases. Ms. Culley suggested that CAN Steering Committee add modification of CAN criteria to its agenda when Rosalie Morales is back from parental leave.

A Motion was then made by Ms. Levin to approve a "good cause" waiver and that was seconded by Dr. De Jong. There were no abstentions. All other members voted in favor and the motion carried.

ii. CAN LETTER TO GOVERNOR

Ms. Levin made a motion to approve the letter to the Governor and findings and strengths, and Dr. De Jong seconded the motion. There were no abstentions. All other members voted in favor, and the motion carried.

B. LEGLISLATIVE

Mark Hudson reported out on the Legislative Committee. Mr. Hudson stated that the Termination of Parental Rights ("TPR") bill passed the House and Senate and is awaiting the Governor's signature. Mr. Hudson publicly thanked Senator Kyle Gay for her sponsorship of this bill and assistance throughout the process. Sen. Gay indicated that she communicated with the Governor's Office to indicate that a ceremony was not needed and requested that the bill be signed.

Mr. Hudson stated that the DFS Treatment Caseloads bill was introduced in late June with the assistance of Senator Gay. This bill be will addressed again in the new legislative session.

Mr. Hudson reported that the Committee would like to create a Guardianship statute workgroup to examine possible revisions regarding consent to guardianship, non-relative assessments, family/ relative definitions and any other areas identified by the workgroup. A motion was made by Judge Joelle Hitch to create this workgroup, and the motion was seconded by Ellen Levin. There were no abstentions. All other members voted in favor, and the motion carried.

C. INVESTIGATION, PROSECUTION & TREATMENT OF CHILD SEXUAL ABUSE

Adrienne Owen reported out for Jennifer Donahue. The last meeting of the larger committee was held in June of 2021. Each workgroup provided an update on their prioritization of issues and development of an initial action plan. It was decided that a small focus group meeting would be scheduled with the workgroup chairs to help with the development of the action plans. The next large committee meeting is September 16, 2021.

Ms. Owen reported that the MDT Response/ MOU Compliance Workgroup met on July 15, 2021 and the small focus group meeting to prioritize the action plan items was held on August 11, 2021. It was decided that the action plan would include: create subgroup to address jurisdiction and how DFS refers cases to law enforcement; differential response for cases with flowcharts; training issues; DOJ charging decisions and outcomes; length of criminal investigations; and victim services.

Ms. Owen stated that the Extra-Familial, School and Institutional Abuse Workgroup last met on April 20, 2021 and the small focus group meeting is scheduled for August 25, 2021. The group will review the "Student Sexual Abuse Guidelines for Schools and law enforcement" from San Mateo County, CA as a starting point for Delaware's protocol. Delaware guidelines and MOUs will also be reviewed and incorporated. Action plan priorities will be finalized during the small focus group meeting. The next workgroup meeting is in September 2021.

The Mental Health, Medical and Prevention Workgroup met on May 21 and June 11, 2021 and a small focus group met on July 27, 2021. Ms. Owen stated that this workgroup is in the process of identifying mental health services available through Delaware Victim Services and Police Based Advocates. Dr. Allison Dovi from Nemours will present at the next meeting on August 20, 2021 to discuss what type of mental health treatment is appropriate for child victims of sexual abuse.

D. GRANTS OVERSIGHT

Abigail Rodgers, Esq. reported that the Grants Oversight Committee met in both April and August 2021. The Committee has recently been charged with monitoring the CPAC/CDRC Joint Action Plan as well as identifying unmet funding needs and updating the action plan to reflect that. The next meeting is scheduled for October 2021. Updates to the Joint Action Plan will be provided by the group at the February 2022 CPAC meeting.

E. DATA UTILIZATION

Brittany Willard announced that she is leaving her position as the CIP Data Manager for a full-time position in the private sector. Ms. Willard reported that two new Management Analysts were already hired and started this week. Their names are Mollie Marine and Cindy Sze. Ms. Willard intends to train them over the next six weeks.

Ms. Willard presented the quarterly child welfare trends identified by the CPAC Data Utilization Committee. This included a discussion of the DFS caseloads, profiles of children in DSCYF custody, Office of Investigation Coordinator cases, CAC age breakdowns, and education outcomes as it relates to chronic absenteeism. Ms. Willard noted that the data regarding absenteeism is challenging. If a child experiences foster care at any point during the school year, then the data indicates they are in foster care even if that was only for a short period. This makes it difficult to determine the effect that foster care has on attendance.

Secretary Manning stated that she wants to know how the children are performing in school. For instance, are they increasing proficiency in reading and math? Sec. Manning also discussed that the

UGrad program as well as Independent Living Services are there to help youth with educational needs. Trenee Parker also commented that it may be helpful to look at other data points rather than absences (i.e. increase in scores, graduation rates). Caroline Jones (public commenter) stated that UGrad program currently has 65 youth in their program and many of those youth came into the program with excessive absenteeism. However, 97% of the youth in program have regular school attendance since working with UGrad. Ms. Willard stated that she had planned to look closer at education outcomes in the 2019-20 school year but Covid disrupted that project. She would be interested in connecting the new Management Analysts with Ms. Jones to get more information on this data.

Ms. Dugan thanked Ms. Willard for her hard work over the past six years and wished her well.

IV. COMMISSIONER REPORTS

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

Secretary Manning reported that the Department will be implementing their strategic plan in the near future and will be sharing that with stakeholders. Sec. Manning deferred to Division Directors, Trenee Parker and Dr. Aileen Fink for further comments.

i. DIVISION OF FAMILY SERVICES

Ms. Parker reported that the Division has recently been the recipient of funds to increase treatment foster homes for youth. Ms. Parker states that their plan is to expand availability while also returning to more of a IRT model for those youth with more challenging behaviors. The request for proposal (RFP) for that contract is due to go out in the next couple weeks.

In addition, Ms. Parker reported that additional funds were received to be used to better support foster parents dealing with challenging behaviors of the youth in their care. That RFP is also due to go out soon.

Ms. Parker announced that Amanda Pedicone was hired as the Supervisor for the new Kent County Sex Abuse and Serious Injury Unit (Region 5). They are currently hiring staff for that unit.

ii. PREVENTION & BEHAVIORAL HEALTH SERVICES

Dr. Aileen Fink reported that the Division is continuing to focus on expanding the continuum of care and allow for better access to services. She wants to ensure that children and families are continuing to get evidence-based treatment and care aligned with best practices. Dr. Fink stated that they are in the process of finalizing the contract for their after-school programming, which will include a curriculum on suicide prevention. Dr. Fink states that there is a trauma response team for children in Wilmington that she would like to expand statewide eventually. Finally, the Division has received funds to expand the crisis bed program. There are currently 6

beds in New Castle County but the Division is looking to add 4 beds in Kent and Sussex in the near future. The RFP for that contract will be released soon.

B. CHILD DEATH REVIEW COMMISSION

Dr. Garrett Colmorgen reported that the 2020 Annual Report was released in May 2021 and is available on the website. CDRC has experienced some staff turnover in contractual staff which has caused a delay on work in the Home Visiting committees. However, Pam Jimenez started on July 1st and has jumped into assisting the work of those committees. In addition, Pam will be staffing the Delaware Safe Baby Committee which had its first meeting on July 14, 2021. The Committee will focus on prevention efforts for infant safe sleeping, abusive head trauma and accidental substance ingestion. Dr. Colmorgen commented that the statistics for safe sleep deaths has not gone down over the years.

Dr. Colmorgen also stated that Delaware CDRC has been recognized as one of three states whose data quality and timelines in the CDC National Data tool has improved significantly from 2014 to 2018. Finally, Dr. Colmorgen wanted to recognize Anne Pedrick for being the 2021 recipient of the Theresa M. Covington Award for Excellence in Fatality Review awarded by the National Center for Fatality Review and Prevention.

C. FAMILY COURT

Chief Judge Michael Newell reported that Family Court continues work on the Quality Legal Representation Workgroup. The CAP plan amendments were finally approved by the federal agency allowing attorney reimbursements to be submitted. Ms. Culley submitted Child Attorney hours, but no monies have been received yet. Chief Judge Newell stated that reimbursement for parent attorney work has been more challenging, and they continue to work to gather that historical information for reimbursement.

Chief Judge Newell reported that a full-time social worker to assist parent attorneys was added in Sussex County with the plan to add social workers in Kent and New Castle County in the near future. In addition, Family Court is working with Casey Family Programs to hire a parent peer advocate in the fall. This person would be someone who successfully regained custody of their children that can now pass on their knowledge and support to parents with children currently in DSCYF custody.

The Chief Judge stated that he presented at the NCJFCJ Conference in July 2021 regarding the work that Delaware is doing to provide quality legal representation. He reports that this presentation was very well received by other jurisdictions and he left with feeling that we are doing good work here in Delaware. Chief Judge Newell said that one thing that needs to be resolved is moving the parent attorney contracts to an institutional home other than Family Court. He is currently exploring options as to where that may be but feels that Family Court should not be managing contracts of attorneys who practice before them. Chief Judge Newell reported that Stephanie Reid and Mark Hudson helped to develop the parent attorney standards and that was presented to the parent attorneys on July 29, 2021 and was well received. Mimi Laver, from the American Bar Association

Center on Children and the Law, will present the parent attorney standards to the judges in October of 2021.

Family Court judges participated in two trainings recently. One on the child welfare response to COVID-19 and a two-part training on "Interrupting Racism" which was very interactive. Most of the judges were in attendance for those trainings.

Family Court will celebrate its Golden Anniversary on September 7, 2021 on the Legislative Mall in Dover. A history book of Family Court was published to commemorate the occasion and the Chief Judge will begin distribution of those books.

V. NEW BUSINESS

There was no new business.

VI. PUBLIC COMMENT AND ADJOURNMENT

The meeting was adjourned at 10:34 a.m by a motion from Dr. Colmorgen and a second from Sec. Manning. All members were in favor.

State of Delaware Child Protection Accountability Commission
Quarterly Meeting Minutes

WEDNESDAY, NOVEMBER 17, 2021
9:00 AM – 11:30 AM – Zoom Webinar and In-Person Site

Those in Attendance:

Members of the Commission:	Statutory Role:
Mary Dugan, Esq., Chair	Child Protection Community 16 Del. C. § 931(a)(15)
The Hon. Josette Manning	Secretary of Services for Children, Youth & Their Families 16 Del. C. § 931(a)(1)
Trenee Parker	Director, Division of Family Services 16 Del. C. § 931(a)(2)
James Kriner, Esq.	Two Representatives from the Attorney General's Office 16 Del. C. § 931(a)(3)
Abigail Rodgers, 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)
The Honorable Kyle Evans Gay	One member of the Senate 16 Del. C. § 931(a)(6)
Susan Haberstroh	Designee for Secretary of the Department of Education 16 Del. C. § 931(a)(7)
Dr. Aileen Fink	Director, Division of Prevention and Behavioral Health 16 Del.C. § 931(a)(8)
Maureen Monagle	Executive Director, Domestic Violence Coordinating Council 16 Del. C. § 931(a)(9)
Colonel Melissa Zebley	Superintendent of the Delaware State Police 16 Del. C. § 931(a)(10)
Cpl. Andrea Warfel	Designee for Superintendent of the Delaware State Police 16 Del. C. § 931(a)(10)
Dr. Garrett Colmorgen	Chair of the Child Death Review Commission 16 Del. C. § 931(a)(11)
Jen Donahue, Esq.	Investigation Coordinator 16 Del. C. § 931(a)(12)
Ellen Levin	At-large Member - Child Protection Community 16 Del. C. § 931(a)(15)
Randall Williams	At-large Member - Child Protection Community 16 Del. C. § 931(a)(15)
Meg Garey	At-large Member – Interagency Committee on Adoption 16 Del. C. § 931(a)(15)
Dr. Allan De Jong	At-large Member - Medical Community 16 Del. C. § 931(a)(15)

Staff:
Tania Culley, Esq.
Rosalie Morales

Members of the Public:

Megan Bittinger	Mariann Kenville-Moore	Adrienne Owen	JoAnn Santangelo
Ava Carcirieri	Kim Liprie	Melissa Palokas	Jennifer Sieminski
Hannah Edelman	Mollie Marine	Anne Pedrick	Lori Sitler
Kelly Ensslin, Esq.	Sue Murray	Jennifer Perry	Eleanor Torres, Esq.
Islanda Finamore, Esq.	Kirsten Olson	Cindy Sze	Ameshia White

I. WELCOME/INTRODUCTIONS/APPROVAL OF MINUTES

Mary Dugan, Esq. opened the meeting and welcomed the attendees.

A motion was made by Dr. Garrett Colmorgen to approve the minutes from August 18, 2021 and Ellen

Levin seconded the motion. Dr. Susan Haberstroh, Randall Williams and Jen Donahue, Esq. abstained. All other members voted in favor, and the motion carried.

II. EXECUTIVE DIRECTOR'S REPORT

Tania Culley, Esq. began by acknowledging Commissioner Joseph Bloch's promotion to Chief of Police and his longstanding commitment to child welfare. Ms. Culley then provided the Executive Director's report. She shared that the Office of the Child Advocate (OCA) is fully staffed, and all but one of the staff have returned from parental leave.

Ms. Culley discussed OCA's budget requests for two full time positions for the Office of the Investigation Coordinator. She is hopeful the positions will be put into the Governor's Recommended Budget, and she is grateful to the Chief Justice for his support.

OCA held its Strategic Planning Retreat, which was facilitated by Susan Decker. Ms. Decker helped OCA develop its overall mission and vision. Once finalized, Ms. Culley will share it with the Commission.

Ms. Culley provided an update on the number of Court Appointed Special Advocate (CASA) Volunteers and volunteer attorneys. She discussed how OCA annually recognizes its volunteers. Ms. Culley also reported on the representation of clients in the custody of the Department of Services for Children, Youth and Their Families (DSCYF). She shared the number of children in care and on Extended Jurisdiction (EJ). Youth with a permanency plan of APPLA were also mentioned.

Since the Legislative Committee was not reporting out, Ms. Culley provided a brief update on several draft bills, which included the Multidisciplinary Team (MDT) legislation, Termination of Parental Rights bill, Division of Family Services (DFS) Treatment Caseloads and the Scholarships bill. No further word has been received about the Crimes Against Children draft, but OCA is updating its criminal outcomes statistics in preparation. House Bill 123, the Tuition Waiver Program, also passed.

Senator Gay announced the Holiday Jingle, which is scheduled for December 9, 2021. Ms. Dugan said the event benefits children in DSCYF custody throughout the year.

III. CPAC Annual Report

Rosalie Morales discussed the FY21 CPAC Annual Report and highlighted CPAC's accomplishments over the last year, including the work of the committees and workgroups. Ms. Morales summarized the sections of the report. Ms. Morales acknowledged the Committee chairs and the Training Specialists for their contributions to the Annual Report.

A motion was made by Dr. Colmorgen to approve the annual report, and Ms. Levin seconded the motion. All other members voted in favor, and the motion carried.

IV. COMMITTEE REPORTS

A. CHILD ABUSE AND NEGLECT STEERING COMMITTEE

Ms. Levin reported the CPAC Child Abuse and Neglect (CAN) Steering Committee met on November 9, 2021 to provide oversight for the CAN Panel. The Committee discussed the CAN caseload, the CAN report which includes the facts and circumstances of the cases the Panel reviewed in the last quarter, and the letter to the Governor.

The Committee has 17 cases before the Commission today for approval. Three of the cases had been previously reviewed and were awaiting the completion of criminal prosecution. The death resulted in a plea to Murder by Abuse or Neglect as well as other charges with a life sentence plus 12 years. The two near death cases resulted in a plea to Assault 2nd and probation, and Misdemeanor Endangering the Welfare. One additional finding was made.

The fourteen remaining cases were from deaths or near deaths that occurred between September of 2020 and April of 2021. Of these cases, five will have no further review as there are no criminal charges – four are drug ingestions. One of the nine remaining cases has pending charges and will be reviewed again once prosecution is completed. The remaining eight cases are still being investigated.

The children in these fourteen cases range in age from six weeks to six years of age with one death and thirteen near deaths. The children were victims of abusive head trauma, poisoning via drug ingestion, bone and skull fractures, abdominal trauma and unsafe sleep. These fourteen cases resulted in 22 strengths and 46 current findings across system areas. The Joint Action Plan delineates the steps that CPAC and other agencies are taking to address the findings in these system areas.

Dr. De Jong made a motion to approve the letter to the Governor and findings and strengths, and Chief Judge Newell seconded the motion. There were no abstentions. All other members voted in favor, and the motion carried.

B. TRAINING

Ms. Morales reported the CPAC Training Committee met on November 4, 2021 and provided oversight for the Protecting Delaware's Children Fund and the Committee's workgroups.

The Committee discussed its plan for Child Abuse Prevention Month and the Protecting Delaware's Children Conference. Instead of an in-person conference in April of 2022, the Protecting Delaware’s Children Conference will feature a webinar series throughout the month of April with continuing monthly webinars throughout the rest of the year. For Child Abuse Prevention Month, the Committee plans to pursue advertising through DART and the Christiana Mall, as well as outreach events, mandatory reporting training, wear blue day and social media campaigns. To reach a broader public audience across the state, advertisements are also being pursued at the courthouses, Division of Motor Vehicles, Probation and Parole and state service centers. A calendar of events will be made available to CPAC once finalized.

During the quarter, the Mandatory Reporting Workgroup continued to provide in person or virtual and online training to over 7,200 professionals. The workgroup is also preparing several supplemental trainings on child welfare topics, which will be available on the state's Delaware Learning Center.

Lastly, 26 MDT members participated in the ChildFirst® Forensic Interview training from September 13-17, 2021. The training was facilitated by the Delaware team members with the Zero Abuse Project observing and providing feedback. Delaware is officially able to deliver this training on its own in 2022.

i. MEDICAL RESPONSE WORKGROUP

Dr. De Jong provided an update on the Medical Response Workgroup. The first meeting was held on October 5, 2021, and there was good statewide representation from medical professionals, the Division of Professional Regulation, the Medical Society of Delaware, and DFS. The workgroup discussed the current training provided for initial licensure or re-licensure. Members of the workgroup discussed their concerns and compared the training requirements for other states, in which many physicians are also licensed. The next meeting is scheduled for January 11, 2022.

ii. CAN BEST PRACTICES WORKGROUP/APPROVAL OF MOU REVISIONS

Adrienne Owen gave a presentation on the revisions to the Memorandum of Understanding (MOU) for the MDT Response to Child Abuse and Neglect. The PowerPoint slide presentation utilized at the meeting is attached to the meeting minutes. The Commissioners voiced concern that they were not given sufficient time to review the changes. Following the meeting, the revised MOU will be distributed to the Commissioners for review, and the Commission will be asked to vote on the revised MOU at the February Commission Meeting.

C. INVESTIGATION, PROSECUTION & TREATMENT OF CHILD SEXUAL ABUSE

Jen Donahue, Esq. provided a report for the Committee on the Investigation, Prosecution and Treatment of Child Sexual Abuse. She stated the Committee last met on September 16, 2021. Dr. Allison Dovi presented on the grooming behaviors of sexual predators. Currently, the Committee is working on an action plan, which includes action items for its three workgroups. The next meeting is scheduled for December 9, 2021, and a presentation will be provided by the Delaware County Child Abuse and Exploitation Task Force. The Task Force has been successful in focusing on child victims and making sure cases move swiftly through system. Ms. Donahue also provided an update for the Committee's three workgroups.

D. DATA UTILIZATION

Ms. Morales gave a presentation on the quarterly child welfare trends identified by the CPAC Data Utilization Committee. This included a discussion of the DFS caseloads, DFS hotline reports

received, cases received by the Department of Justice (DOJ) Special Victims Unit, the age breakdown of cases referred to the Children's Advocacy Center, reviews conducted by the CAN Panel, profiles of children in DSCYF custody, permanency outcomes for youth and children on EJ. Dr. De Jong noted that the trend in near death cases received by the CAN Panel is still upward despite the recent change in the definition and criteria for near deaths.

V. COMMISSIONER REPORTS

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

Secretary Manning discussed the DSCYF five-year strategic plan, which will be shared once finalized. The Department is also working on the Families First Prevention Services Act. Secretary Manning said Delaware was in a unique situation, because a lot of the work was already being done and DSCYF cannot claim the funds for existing programs. Smaller scale new prevention programs have been identified. The implementation plan will be shared after it is submitted to the Children's Bureau.

i. DIVISION OF FAMILY SERVICES

Trenee Parker recognized Sarah Azevedo and Sue Murray for their work on the revisions to the MOU for the MDT Response to Child Abuse and Neglect. Ms. Parker shared that DFS has expanded its Sex Abuse and Serious Injury Unit. The supervisor for the New Castle County Unit was recently promoted, so DFS is in the process of hiring for the position. DFS is also beginning to fill positions for the units in Kent and Sussex Counties.

Ms. Parker also provided an update on the Request for Proposals, which are out for bid. It will give DFS the ability to expand its foster care continuum with a therapeutic foster care contract. DFS is also looking to provide support to foster parents and stabilize placements. Ms. Parker added that DFS foster care entries are currently surpassing exits, and the availability of foster parents has continued to be adversely impacted by COVID. Recruitment efforts have also continued.

The Youth Advisory Council (YAC) returned to face-to-face meetings, and it led to a high turnout from youth. Ms. Parker also discussed the use of Division X funds, which provided additional support to youth during the pandemic. Ms. Parker mentioned House Bill 123 on tuition waivers, and acknowledged Meredith Seitz for her work on bill.

B. CHILDREN'S ADVOCACY CENTER

Mr. Williams provided an update on the Children's Advocacy Center (CAC). He said the CAC is back in the office and scheduling cases daily. However, the CAC is not up to full schedule due to the disinfecting and client screening processes in place. Mr. Williams said his greatest concern is scheduling for New Castle County, and he discussed the timeline for scheduling non-emergent and emergent cases. As an alternative, the CAC is offering interviews in the Dover and Georgetown offices since caseloads are not as high.

Mr. Williams also discussed the CAC's budget. The CAC saw a $49,638 increase in state funding for FY23 due to the anticipated decrease in Victims of Crime Act (VOCA) funding. Mr. Williams said he is anticipating a significant reduction in FFY21 funding, which will impact the CAC in April of 2023. As a result, he has been working with Secretary Manning and Ms. Parker to secure the state funding.

Lastly, Mr. Williams shared an update on staffing. He said the Center Coordinator/Forensic Interview Position in the Wilmington Office is vacant.

C. DEPARTMENT OF JUSTICE

Abigail Rodgers, Esq. discussed the high caseloads for the Deputies in the Family Division. She said the Deputies have about 70 cases each. After some recent hires, the Family Division is now fully staffed. Ms. Rodgers also discussed the number of open substantiation cases. Islanda Finamore, Esq. shared that the backlog has been increasing recently since the Deputies are not able to move forward on the substantiation until the criminal disposition resolves. Ms. Rodgers also discussed DOJ's holiday drive.

Jim Kriner, Esq. stated the Special Victims Unit (SVU) is busy dealing with the backlog of cases that occurred when the Courts were not hearing cases. The SVU is also down two Deputies statewide.

D. INVESTIGATION COORDINATOR

Ms. Donahue shared a report on the Office of the Investigation Coordinator (IC). She discussed the data presented in the CPAC Dashboard, which included the cases opened and closed during the quarter, the open cases at the end of the quarter and the findings made by IC.

Ms. Donahue also provided an update on the implementation of the MDT meetings within 48 to 72 hours. The IC facilitated approximately 100 meetings since March 2021. She shared that some cases require follow up meetings. The monthly case review meetings were also discussed.

Ms. Donahue discussed Jen Perry's oversight of commercial sexual exploitation of children cases (CSEC). Ms. Perry is separately scheduling meetings in those cases.

E. LAW ENFORCEMENT

Colonel Melissa Zebley acknowledged Cpl. Andrea Warfel. She discussed how Cpl. Warfel provided domestic violence training in May for the entire division, and then for recruits a week ago. Cpl. Warfel also prepares all of the Delaware State Police cases for the CAN Panel. Lastly, she thanked Adrienne Owen for her leadership on the CAN Best Practices Workgroup**.**

F. INTERAGENCY COMMITTEE ON ADOPTION

Meg Garey announced that November is National Adoption Month. This year, the focus is on teens in care, and the Adoption Day event is scheduled for November 20, 2021. Ms. Garey provided an

overview of the event, and shared that Judge Pyott and Judge Hitch will be finalizing adoptions. Jessica Sinarski was selected to win the Voice for Adoption award. Ms. Garey also provided an update on the Interagency Committee on Adoption (IACOA), which is working to decrease the number of adoption disruptions and dissolutions. IACOA is making families aware of post-adoption services and partnering with Springfield College to create an adoption competency certificate program.

VI. NEW BUSINESS

There was no new business.

VII. PUBLIC COMMENT AND ADJOURNMENT

There was no public comment.

The meeting was adjourned at 11:27 a.m. by a motion from Ms. Donahue and a second from Dr. De Jong. All other members voted in favor, and the motion carried.

State of Delaware Child Protection Accountability Commission
Quarterly Meeting Minutes

WEDNESDAY, FEBRUARY 16, 2022
9:00 AM – 11:30 AM – Zoom Webinar and In-Person Site

Those in Attendance:

Members of the Commission:	Statutory Role:
Mary Dugan, Esq., Chair	Child Protection Community 16 Del. C. § 931(a)(15)
The Hon. Josette Manning	Secretary of Services for Children, Youth & Their Families 16 Del. C. § 931(a)(1)
Trenee Parker	Director, Division of Family Services 16 Del. C. § 931(a)(2)
Abigail Rodgers, 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)
The Honorable Krista Griffith	One member of the House of Representatives 16 Del. C. § 931(a)(5)
The Honorable Kyle Evans Gay	One member of the Senate 16 Del. C. § 931(a)(6)
Dr. Susan Haberstroh	Designee for Secretary of the Department of Education 16 Del. C. § 931(a)(7)
Dr. Aileen Fink	Director, Division of Prevention and Behavioral Health 16 Del. C. § 931(a)(8)
Maureen Monagle	Executive Director, Domestic Violence Coordinating Council 16 Del. C. § 931(a)(9)
Dr. Garrett Colmorgen	Chair of the Child Death Review Commission 16 Del. C. § 931(a)(11)
Jennifer Donahue, Esq.	Investigation Coordinator 16 Del. C. § 931(a)(12)
Colonel Joseph Bloch	At-large Member – Law Enforcement Community 16 Del. C. § 931(a)(15)
Ellen Levin	At-large Member - Child Protection Community 16 Del. C. § 931(a)(15)
Randall Williams	At-large Member - Child Protection Community 16 Del. C. § 931(a)(15)
Dr. Elizabeth Higley	At-large Member - Child Protection Community 16 Del. C. § 931(a)(15)
Meg Garey	At-large Member – Interagency Committee on Adoption 16 Del. C. § 931(a)(15)
Dr. Allan De Jong	At-large Member - Medical Community 16 Del. C. § 931(a)(15)

Staff:
Tania Culley, Esq.
Rosalie Morales

Members of the Public:

Megan Bittinger	Mariann Kenville-Moore	Kirsten Olsen	JoAnn Santangelo
Ava Carcirieri	Lauren Mahler	Melissa Palokas	Meredith Seitz
Islanda Finamore, Esq.	Mollie Marine	Anne Pedrick	Jennifer Sieminski
Mark Hudson, Esq.	Shawna Milton	Jennifer Perry Ward	Lori Sitler
Caroline Jones	Sue Murray	Cindy Sze	Nona Tompkins
			Ameshia White

I. WELCOME/INTRODUCTIONS/APPROVAL OF MINUTES

Mary Dugan, Esq. opened the meeting and welcomed the attendees. Representative Krista Griffith was recognized as a newly appointed Commissioner, and Colonel Joseph Bloch was congratulated for his promotion to Chief of Police.

A motion was made by the Honorable Joelle Hitch to approve the minutes from November 17, 2021, and Ellen Levin seconded the motion. No members abstained and all voted in favor, and the motion carried.

II. EXECUTIVE DIRECTOR'S REPORT

Tania Culley, Esq. extended her congratulations to Colonel Bloch and welcomed Representative Griffith to the Commission. Ms. Culley reported that funding for the two additional positions in the Office of the Investigation Coordinator were not included in the Governor's recommended budget. Child Protection Accountability Commission (CPAC) members will be speaking at the Judiciary's Joint Finance Committee Hearing on Thursday, February 17 to advocate for these positions. Ms. Culley also reported the Office of the Child Advocate (OCA) currently has one vacancy for a casual/seasonal position. Antonisha Busby resigned as the Youth in Transition Coordinator. The position is currently posted but no applications have been received.

Ms. Culley reported OCA staff attended a strategic planning meeting in the fall and OCA leadership will attend a retreat this spring to develop a five-year plan. Ms. Culley will provide an update at the August CPAC meeting. Ms. Culley reported that OCA currently has 219 CASA volunteers. A new Court Appointed Special Advocate (CASA) class of 16 volunteers will be sworn in on March 8. CASA Program Director, Melissa Palokas, will attend the May CPAC meeting to provide the annual presentation on the CASA program. Ms. Culley also reported that OCA currently has over 200 volunteer attorneys and 9 of the attorneys celebrated their 20th anniversary with OCA in 2021.

Ms. Culley reported that there are currently 498 kids in care, 395 petitions, 61 kids on extended jurisdiction, and 18 kids who have an Another Planned Permanent Living Arrangement (APPLA) permanency plan. Lastly, Ms. Culley wanted to celebrate that the Department of Justice received a conviction on Tuesday, February 15 in a child death case that was a trial by jury. Additionally, a sexual abuse case where OCA represented the child resulted in the perpetrator being sentenced to 18 years in prison. The final case Ms. Culley highlighted was a Kent County couple charged with the murder of their child.

III. COMMITTEE REPORTS

A. CHILD ABUSE AND NEGLECT STEERING COMMITTEE

Ms. Levin reported the CPAC Child Abuse and Neglect (CAN) Steering Committee met on February 1, 2022, to provide oversight for the CAN Panel. At the meeting, the CAN Steering Committee discussed the caseload, cases reviewed in the last quarter, and the letter to the Governor. Ms. Levin reported the Committee received 14 deaths and 62 near death cases in CY21. These numbers represent a 46% increase from 2020 and an 81% increase over 2019, which has had a significant impact on the caseloads for MDT partners. For the CAN Panel, the increased caseload has impacted the timeliness of the retrospective reviews.

The Committee has 20 cases before the Commission today for approval. Of the twenty cases, three cases had been previously reviewed and were awaiting the completion of the criminal case or a

charging decision. The seventeen remaining cases were from deaths or near deaths that occurred between April of 2021 and June of 2021. Of these cases, nine will have no further review as there are no criminal charges – six are poisoning via drug ingestions. Of the remaining eight cases, five have pending charges and the other three are still under criminal investigation. Three of these cases are also poisoning via drug ingestions. The children in these seventeen cases were all near deaths and range from two weeks to five years of age. They were victims of abusive head trauma, poisoning via drug ingestion, bone and skull fractures, burns and scalding, gunshot wounds, near drowning and unsafe sleep. These seventeen cases resulted in 23 strengths and 66 current findings across system areas.

Dr. Colmorgen made a motion to approve the packet and the motion was seconded by Dr. De Jong. No members abstained and all voted in favor, and the motion carried.

B. DATA UTILIZATION

Ms. Morales reported that the Data Utilization Committee last met on February 2, 2022, to review the CPAC Child Welfare Dashboard and identify trends in data. Ms. Morales gave a presentation on the quarterly child welfare trends identified by the CPAC Data Utilization Committee. This included a discussion of the DFS caseloads, DFS hotline reports, cases received by the Department of Justice (DOJ) and profiles of children entering the custody of the Department of Services for Children, Youth and Their Families (DSCYF).

C. EDUCATION

Dr. Haberstroh reported the Education Committee met twice over the past six months. She discussed the change in membership. Dr. Haberstroh reported that the Committee has added four foster care school liaisons; one from each county and one to represent the charter schools. At the last two meetings, the Committee heard presentations on kinship services, the HeadStart program and services, and student transitions from facilities such as Rockford or Meadowood back to school. The Committee also met with the American Bar Association's Center on Children and the Law to discuss initiatives and policies that Delaware may want to explore.

D. GRANTS OVERSIGHT

i. JOINT ACTION PLAN UPDATES

Ms. Rogers reported the Grants Oversight Committee met on January 26, 2022. Ms. Rogers discussed the Joint Action Plan updates in detail and highlighted a few action items. She shared that the Child Abuse Medical Response Workgroup will be revising the medical mandatory reporting training and looking into training nurses. Ms. Rodgers also added the CAN Best Practices Workgroup has updates to introduce at this meeting. For the safety and risk recommendations, the Committee discussed providing training to judges and commissioners, as well as the idea of a virtual presentation to CPAC and the Child Death Review Commission. In addition, the Child Sexual Abuse Committee developed an action plan to accomplish its work.

E. INVESTIGATION, PROSECUTION & TREATMENT OF CHILD SEXUAL ABUSE

Jen Donahue, Esq. provided a report for the Child Sexual Abuse Committee. She stated the Committee last met on December 9, 2021. The Committee met with the Assistant District Attorney from the Delaware County Child Sexual Exploitation Task Force and discussed how Delaware's MDT is already operating as a task force. The Committee decided that rather than adopting another model, the Committee is going to review the model Delaware currently has and focus on how to make improvements. Ms. Donahue also provided an update on the Committee's Action Plan. She reported how the three workgroups on the Committee are addressing their action steps, which included updating the sexual violence guidelines for schools, creating differential response tracks for types of sexual abuse, reviewing cases of extrafamilial sexual abuse that do not have Division of Family Services (DFS) involvement, and determining availability of child mental health services. Ms. Donahue noted that this action plan will be amended and updated periodically.

F. LEGISLATIVE COMMITTEE

Mr. Hudson reported that the Legislative Committee last met on January 31, 2021, and voted to support three bills; House Bill 271, which will expand independent living services to age 23; Senate Substitute 1 for Senate Bill 151, which will establish a pilot program at OCA for driver's licenses for youth experiencing foster care; and Senate Bill 154, which will repeal the requirement for DSCYF to get approval for mixing. Mr. Hudson reviewed what each piece of legislation would do if enacted and asked the Committee to vote to support the three bills. Mr. Hudson reported that the Committee also discussed legislation regarding MDT records sharing which should be presented to the Commission in May.

A motion to support House Bill 271 was made by Dr. Colmorgen and seconded by Senator Gay. No members abstained and all voted in favor, and the motion carried. Dr. Colmorgen made a motion to support Senate Substitute 1 for Senate Bill 151 which was seconded by Sen. Gay. No members were opposed, five members abstained, and all others were in favor. The motion carried. Dr. Colmorgen made a motion to support Senate Bill 154 which was seconded by Senator Gay. One member voted in opposition and all others voted in favor, and the motion carried. In short, CPAC voted to support all three pieces of legislation, and letters of support will be sent.

G. TRAINING

Ms. Morales reported the CPAC Training Committee met on February 3, 2022, to finalize plans for Child Abuse Prevention Month and the Protecting Delaware's Children Conference webinar series. Ms. Morales reported registration is open for the conference and reviewed the specifics of the webinar series. Ms. Morales also reported that Child Abuse Prevention Month will feature advertisements, a social media campaign, and a prevention and intervention campaign. A calendar of all events will be available once finalized.

i. CAN BEST PRACTICES WORKGROUP/APPROVAL OF MOU REVISIONS

Ms. Morales reported that Adrienne Owen gave a presentation on the updated Memorandum of Understanding (MOU) for the Multidisciplinary Response to Child Abuse and Neglect at the last meeting. She also shared that a draft of the MOU revisions was distributed to Commissioners, whose agency was also an MOU signatory, for comments. Ms. Morales reviewed the suggested changes that were received, which included: DOJ attendance at multidisciplinary team (MDT) meetings; language around doll reenactments; use of the department in place of the division for DSCYF; changes to the definition of institutional abuse; and adding where the criminal offenses are found in the Delaware Code. Dr. De Jong also noted that the name of Nemours Children's Hospital needs to be updated in the MOU as the hospital's name has recently changed. Several Commissioners expressed concerned about the request from the DOJ that it be exempted from attendance at the MDT meetings. After extensive discussion, a motion was made by Dr. Colmorgen to approve moving forward with the MDT training and to approve the revisions to the MOU with the exception of the change requested by the Department of Justice. The motion was seconded by Representative Griffith. No members abstained and all voted in favor, and the motion carried. Ms. Rodgers will assist the CPAC Chair in communicating with the Attorney General regarding CPAC's concerns with DOJ's position. The MOU will again be presented to CPAC at the May meeting for a vote on DOJ's participation in MDT meetings.

IV. COMMISSIONER REPORTS

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

Secretary Manning extended her thanks to Senator Gay and Representative Griffith for their support and work on legislation to extend independent living services to children in care through age 23, to allow the DFS director to sign for voluntary admission to psychiatric hospitals for children in care, and legislation to allow law enforcement to enter private property to execute a court order. Secretary Manning also reported the Department received budget approval for improvements to surveillance in residential facilities, gang prevention, crisis bed expansion, and therapeutic foster care. Secretary Manning reported the Department is also requesting funds for staff tuition reimbursement and the Children's Advocacy Center.

i. DIVISION OF FAMILY SERVICES

Trenee Parker reported there is a 30% vacancy rate for investigation and FAIR programs. In addition, 50% of the staff is fully functioning and 67% of staff is over the caseload standard. The treatment programs have 11% of positions vacant and 70% of staff are fully functioning. The Division is seeing a trend of staff wanting to work in treatment rather than investigation. The Division has put out a request for proposals for therapeutic foster care. Ms. Parker reported the Division is preparing for the fourth round of the federal Child and Family Services Review and is hopeful Delaware will be selected as a self-administered state for the review. In the most recent review submission, Delaware was ranked number one in the nation in addressing safety concerns and performed high in all other categories. Secretary Manning added that Delaware

exceeds in every category compared to the national standard and thanked Ms. Parker for her and her team's work.

ii. PREVENTION & BEHAVIORAL HEALTH SERVICES

Dr. Aileen Fink reported there is an increase in demand for mental health and substance use services for youth, particularly crisis services. Prevention and Behavioral Health (PBH) reopened the request for proposal for the entire continuum of services and will be submitting a request for proposal for additional crisis beds. Dr. Fink also reported PBH is working with the state on the new 9-8-8 crisis line to strengthen the response of who is answering the phone and the services provided. PBH received funding for crisis services and is looking to incorporate a team-based approach and utilize peers. Dr. Fink said PBH also plans to utilize text and chat functions in addition to the crisis phone line since it is recognized as a best practice for communicating with teens.

B. DEPARTMENT OF EDUCATION

Dr. Susan Haberstroh reported the Department of Education has a new Secretary of Education, Dr. Mark Holodick. Dr. Haberstroh reported the Department is working with the Beau Biden Foundation and CPAC Mandatory Reporting Workgroup to expand the offerings for trainings for educators. Currently, there are four approved programs for students on personal body safety and over half of the students are receiving programming from Prevent Child Abuse Delaware. Dr. Haberstroh reported that sixteen out of seventeen districts provided an update on this programming and the report noted that COVID impacted the schools' ability to provide training to students. The Department received funding for emotional and wellbeing services for school staff and funding to support additional youth through the Kind to Kids UGrad program.

C. DOMESTIC VIOLENCE COORDINATORING COUNCIL

Maureen Monagle reported the DVCC has vacancies in its Trainer/Educator position and Planner IV position. The DVCC Domestic Violence and Children Committee has a workgroup to update the teen dating violence and sexual assault in schools guidelines. Ms. Monagle reported that a HB254 was introduced, and it requires the national domestic violence and suicide hotline to be printed on all student ID cards. This was a recommendation from the 2020 DVCC report on teen dating violence. Ms. Monagle also reported that February is Teen Dating Violence Awareness Month, and the Governor will be signing a proclamation today that will be livestreamed. Lastly, Ms. Monagle reported the DVCC has a Family Justice Center Steering Committee to explore revisiting the model and the feasibility of adopting this model in Delaware. The Steering Committee meetings are open to the public and the next meeting is March 4.

D. INVESTIGATION COORDINATOR

Jennifer Donahue reported the Investigation Coordinator's request for two additional positions was not included in the Governor's recommended budget. Ms. Donahue reviewed some current statistics on the Office of the Investigation Coordinator. She said there are currently 6,000 referrals received

each year for the Office's three staff members. Approximately1,286 cases are backlogged, and many of these cases are extrafamilial and have no additional oversight. In addition, Ms. Donahue said there are over 300 infants with prenatal substance exposure that have not yet been reviewed, and the Office is responsible for monitoring over 900 open cases, which are primarily child sexual abuse. Ms. Donahue shared that the MDT meetings in the death, near death and trafficking cases have been critical, and over 250 MDT meetings have been held thus far. However, the MDT Meeting and monthly case reviews have had an impact on the staff's workload. Lastly, Ms. Donahue discussed the reports to professional regulatory bodies and the Department of Justice.

E. MEDICAL

Dr. De Jong echoed Ms. Levin's CAN Panel report as the medical community is also seeing an increase in drug ingestions to infants and toddlers. Dr. De Jong reported the medical providers are also seeing an increase in torture cases, specifically complex and lengthy torture cases. He noted that torture cases go under the radar due to a lack of in-depth assessment of what is going on and cases are under investigated by police and DFS. Dr. De Jong also provided a brief report on the Child Abuse Medical Response Workgroup, which last met on January 11, 2022, and is reassessing the training given to medical providers.

V. NEW BUSINESS

Randy Williams thanked Secretary Manning and Ms. Parker for their support of the CAC's request for increased funding in DSCYF's budgetary requests to the Governor. Ms. Dugan shared the Judiciary's Budget Hearing is tomorrow. She noted the Chief Justice did include CPAC's requests in his proposal to the Governor, but the requests were not included in the Governor's recommended budget. The Chief Justice will again be including CPAC's request at Joint Finance. Representative Griffith gave an update that House Bill 317 that provides children who are undocumented with access to Medicaid and CHIP. She said the legislation may want to be considered by the CPAC Legislative Committee.

VI. PUBLIC COMMENT AND ADJOURNMENT

Lori Sitler reported that her doctoral thesis is on the value of the multidisciplinary team in responding to child abuse and neglect. The research is very clear that the Department of Justice is an instrumental leader of the MDT and without the DOJ at the table, it will disrupt the delicate balance of those interactions and could worsen the backlog of cases. Ms. Sitler opined that the suggested revision to the MOU by the Delaware Department of Justice is shortsighted and is discounting the investigatory and ongoing role DOJ plays in the MDT.

The meeting was adjourned at 11:10 a.m. by a motion from Dr. Colmorgen and a second from Senator Gay. All other members voted in favor, and the motion carried.

PROGRAM REPORT

Grant ID: 2399
Applicant Agency: Office of the Child Advocate
Project Dates: 10/1/2020 to 12/31/2021
Report Period: 4/1/2021 to 6/30/2021
Submission Date 7/20/2021

Report Due Date: 7/30/2021
Report Status: Submitted
Approval Status: Approved
Final Report: No

Is the Project On Schedule? Yes

Explanation: n/a

Activities Conducting During this Period: Services were provided by CJA Training Specialist, Kathleen McCormick until April 9, 2021. Before her departure, Ms. McCormick began revising the following supplemental trainings: Parental Substance Use Disorder, Protective versus Risk factors, and Children with Disabilities. Ms. McCormick also created a resource guide for the new training specialists and provided them with a one-day training on May 11, 2021. Services were provided by the CJA Training Specialists, Megan Bittinger and Ameshia White beginning on May 10th, 2021. In May, Ms. Bittinger updated the Mandatory Reporting for Children with Disabilities and Parental Substance Use Disorder supplemental trainings and evaluations. In June, this training was finalized and in the approval process to then be published on the Delaware Learning Center and the Department of Education's learning management system. Ms. Bittinger also began updating the evaluation and data collection process for all OCA online trainings. Ms. Bittinger created updated online resources, "Supporting Children During a Crisis," "Mandatory Reporting and Parental Substance Abuse," and "Mandated Reporting Flowchart." Lastly, Ms. Bittinger staffed the CPAC Training Committee on 5/13/2021, the ChildFirst/MDT workgroup on 5/18/2021, the CPAC meeting on 5/19/2021, the Child Abuse and Neglect Panel Review meeting on 5/27, and the Child Sexual Abuse Committee on 6/17/2021.

During the month of May, CJA Training Specialist, Miss White revised the Protective versus Risk factors supplemental training, by creating a resource guide, and updating the training evaluation to include questions to test user knowledge based on the training material. Additionally, Miss White created the save the date for the week-long ChildFirst training in September. In June, Miss White made the final revisions of the training after receiving feedback from training committee members. The Protective versus Risk factors supplemental training is in the process of being published on the Delaware Learning Center and the Department of Education's learning management system. Miss White also staffed the CPAC Training Committee on 5/13/2021, the ChildFirst/MDT workgroup on 5/18/202, the Child Abuse and Neglect Panel Review on 5/27/2021, and the Child Sexual Abuse Committee on 6/17/2021.

In the last quarter, 1,491 professionals participated in the mandatory reporting and supplemental trainings. In total, 1,385 professionals received mandatory reporting training. Of those 1,357 received mandatory reporting training through the Delaware Learning Center - 15 educators, 1,233 general professionals, and another 109 medical professionals. The trainings specialist requested information from Christiana Care Health Services and Department of Education on the number of individuals trained through their organizations, however no information was provided.

106 professionals also participated in the supplemental trainings. 8 professionals completed the Minimal Facts: Guidelines for Mandated Reporters training online. 60 professionals completed the Mandatory Reporting Refresher Training online. An additional 38 professionals completed the Child Neglect Training online.

Services were also provided by the MDT Training & Policy Administrator, Adrienne Owen. Ms. Owen spent 46 hours developing, coordinating, and providing training on the Memorandum of Understanding for the MDT Response to Child Abuse and Neglect. Specifically, she worked on developing training designed to improve response to death, serious physical injury and sexual abuse investigations. 690 law enforcement were trained. Adrienne also spent 64 hours providing communication, support and coaching to law enforcement members regarding child abuse and neglect. In effort to enhance the operation of the monthly Child Abuse and Neglect panel meetings, she spent 21 hours assisting eight law enforcement agencies to prepare for participation in the meetings.

Performance Indicators:

1. Established by DCJC
2. Established by Subgrantee

Quarterly Report Project Narrative !

Project Narrative

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

e.g.

Goal:

Progress:

Implementation Objective:

Progress:

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

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

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

During the quarter, progress was ongoing for the assessment and investigation of suspected child abuse and neglect cases because of the mandatory reporting and supplemental trainings provided to various audiences. Progress was also made for the assessment and investigation of cases of suspected child abuse-related/child neglect-related fatalities and for the investigation and prosecution of cases of child abuse/neglect due to the work of the MDT Training & Policy Administrator.

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

The implementation objectives are as follows:

- Contract with a Training Specialist –During the quarter, OCA contracted with two new Training Specialists.
- Contract with a MDT Training & Policy Administrator - OCA entered into a one-year contract with MDT Training & Policy Administrator, Adrienne Owen, on 9/21/20, and she provided services during the quarter.
- Provide Ongoing Comprehensive Training to Multidisciplinary Team Members and Others involved in the Judicial/Administrative Handling of Cases – The MDT Training & Policy Administrator provided training to law enforcement through a train the trainer program with the Delaware State Police.
- Provide Multidisciplinary Team (MDT) Scholarships to representatives involved in the investigation, prosecution and judicial handling of cases of child abuse and neglect – No progress made this quarter.
- Train Professionals on the Recognition and Reporting of Child Abuse and Neglect through in-person and web-based training – Approximately 1.491 professionals participated in the mandatory reporting and supplemental trainings through virtual training or online training through the Delaware Learning Center.
- Make web-based training available to the child welfare community through OCA's Online Training System – On October 1, 2019, OCA launched its new online training system on the State of Delaware's learning management system, Delaware Learning Center. During the quarter, the Training Specialists continued to manage the Delaware Learning Center and assist users who were completing training.
- Attend the CJA Grantee Meeting – Rosalie Morales attended the meeting on May 5-6, 2021.
- Draft and submit the CJA Annual Progress Report and Grant Application – Submitted on May 28, 2021.

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

The performance objectives are as follows:

• Annually update and revise the mandatory reporting training programs – The 2021 Mandatory Reporting Training was developed and made available to professionals on January 1, 2021.

• Organize and provide in-person and web-based mandatory reporting training for educators, medical professionals and general professional audiences – Virtual training through Zoom and WebEx was provided to professionals during the quarter by various trainers from DSCYF and OCA. Web-based training was also provided through the Delaware Learning Center and Department of Education's Professional Development Management System for public school employees.

• Partner with the Delaware Learning Center to host web-based trainings on OCA's online training system – OCA transitioned to the DLC on October 1, 2019. During the quarter, OCA continued to host trainings on the Delaware Learning Center.

• Organize and provide an annual train-the-trainer session to professionals responsible for providing training on mandatory reporting – Rosalie Morales provided a train-the-trainer session on May 12, 2021 with the Office of Childcare Licensing. Two prior train-the-trainer soccurred in 2020.

• Develop advanced training programs both in-person and web-based for MDT professionals – The Training Specialist uploaded supplemental online trainings on Parental Substance Use Disorders, Protective vs. Risk Factors and children with disabilities.

• Evaluate the effectiveness of all training programs – The Training Specialist continued to evaluate the web-based trainings utilizing Survey Monkey.

• Maintain the number of professionals trained for all training programs – The Training Specialist maintained the numbers trained and reported the numbers to the Mandatory Reporting Workgroup.

• Utilize available software to develop web-based training programs – During the quarter, the Training Specialist utilized Articulate to develop the web-based training.

• Provide ongoing training on the MDT Best Practices Memorandum of Understanding, including training on conducting doll re-enactments in child abuse and neglect death and near death cases – The MDT Training & Policy Administrator provided training on the MOU to law enforcement agencies during the quarter.

• Update the mobile application for the MDT Best Practices MOU –The mobile application will be updated once the MOU revisions are approved by CPAC in 2021.

• Facilitate and sponsor the ChildFirst® Forensic Interviewing Training for professionals involved in the investigative handling of child abuse cases – ChildFirst® training will again be provided to MDT members in September of 2021. The training will be facilitated by the local team and supported by the Zero Abuse Project.

• Offer partial scholarships to representatives from the MDT to attend national conferences – Completed in prior quarter.

• Attend the annual CJA Grantee Meeting – Completed in May of 2021.

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

The impact objectives are as follows:

• Improved coordination of training programs on the investigative, administrative and judicial handling of cases of child abuse and neglect provided by or sponsored by the Task Force – Progress was made because of the ongoing contract with the Training Specialists and MDT Training & Policy Administrator.

• Improved understanding of best practices associated with the investigation and prosecution of cases of child abuse and neglect, child death and child sexual abuse – Progress was made through the training provided by the MDT Training & Policy Administrator.

• Improved civil and criminal outcomes in child abuse and neglect deaths and near deaths investigations – Progress was made through the meetings and coaching provided by the MDT Training & Policy Administrator.

• Improved recognition and response to suspicions of child abuse and neglect by educators, medical providers and general community and professional audiences – Progress was made through the virtual and web-based trainings on mandatory reporting.

• Improved access to child welfare trainings developed by CPAC – Progress was made by making trainings available on the State of Delaware's learning management system, Delaware Learning Center, and via Zoom/Webex.

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

n/a

PROGRAM REPORT

Grant ID: 2399
Applicant Agency: Office of the Child Advocate
Project Dates: 10/1/2020 to 12/31/2021
Report Period: 7/1/2021 to 9/30/2021
Submission Date 10/29/2021

Report Due Date: 10/30/2021
Report Status: Submitted
Approval Status: Approved
Final Report: No

Is the Project On Schedule? Yes

Explanation:

Activities Conducting During this Period: Services were provided by the CJA Training Specialists, Megan Bittinger and Ameshia White. In July, the Mandatory Reporting for Children with Disabilities and Parental Substance Use Disorder supplemental trainings were published on the Delaware Learning Center and the Department of Education's learning management system. Throughout the quarter, Ms. Bittinger also researched, outlined, and drafted four new supplemental trainings, including Intersections of Domestic Violence and Child Abuse; Recognizing and Reporting Sexual Violence; Reporting Physical and Sexual Violence in Schools; and LGBTQ+ Youth Experiencing Abuse, Foster Care, and Homelessness. Additionally, during this time, Ms. Bittinger researched and developed a new outline for the Mandatory Reporter Training for Educators and General Professionals and the Mandatory Reporter Training for Medical Professionals. Ms. Bittinger developed new resources for OCA's website and trainings including, State of Delaware Age of Consent Flowchart; Resources for Parents, Caregivers, and Families; and Delaware Domestic Violence Resources. Lastly, Ms. Bittinger staffed the Training Committee's Protecting Delaware's Children Workgroup on 7/13/2021; Grants Oversight Committee on 7/28/2021; Training Committee on 8/12/2021; CPAC Quarterly Meeting on 8/18/2021; and the Child Sexual Abuse Committee's Mental Health, Medical, and Prevention Workgroup on 8/27/2021.

In the beginning of the quarter, Ms. White published trainings for the Department of Education's learning management system. Additionally, Ms. White outlined and began working on three new trainings: (1) Foster Care 101: Understanding the System, (2) Child Caregivers: When Does It Become Abuse?, and (3) Human Trafficking & Our Children. Additionally, during this time, Ms. White met with multiple stakeholders who provided excellent resources for the trainings including the American Association of Caregiving Youth, representatives from the Delaware's Department of Services for Children, Youth & Their Families, and Delaware's Department of Education. Furthermore, Ms. White created new training resources, including a training chart that provides a clear depiction on the new training process. Lastly, Ms. White staffed the Training Committee's Protecting Delaware's Children Workgroup on 7/13/2021; Grants Oversight Committee on 7/28/2021; Training Committee on 8/12/2021; and the CPAC Quarterly Meeting on 8/18/2021.
In quarter one of FY22, 7,353 professionals participated in the mandatory reporting training and 5,067 professionals participated in supplemental trainings. Of those, 460 received mandatory reporting training through the Delaware Learning Center. In addition, live-virtual trainings were also provided to 243 general professionals and 108 educators. 6 medical professionals were trained online through Christiana Care Health Services. An additional 6,480 educators were trained on the mandatory reporting training through the Department of Education.
5,067 professionals also participated in the supplemental trainings. 1,237 professionals completed the Minimal Facts: Guidelines for Mandated Reporters training online, including 1,221 educators trained through the Department of Education. 2,474 professionals completed the Mandatory Reporting Refresher Training online, and 2,414 of those were educators trained through the Department of Education. 1,238 professionals completed the Children with Disabilities training of those 1,223 were educators trained through the Department of Education. 15 professionals completed the Parental Substance Use Disorder training, 8 completed the Protective vs. Risk training, 33 completed the Child Neglect training, 43 completed the Child Protection Registry training, 8 completed the You've Been Appointed! training, 3 completed the Legal Permanency Options training, 6 completed the Youth Engagement in Court training, and 2 completed the Representing Older Youth training.
Services were also provided by the MDT Training & Policy Administrator, Adrienne Owen. Ms. Owen spent 28 hours developing, coordinating, and providing training on the Memorandum of Understanding for the MDT Response to Child Abuse and Neglect. 55 law enforcement were trained. She spent another 116 hours reviewing and making updates to the MOU. Adrienne also spent 62 hours providing communication, support and coaching to law enforcement members regarding child abuse and neglect. She also spent 9 hours in contract management, and 34 hours participating in Child Protection Accountability Commission committees and workgroups. In addition, she spent 4 hours providing oversight to CPAC's Joint Action Plan. She spent another 4 hours participating in the reviews of child deaths and near deaths and another 13 hours on policy/legal work changes.

Performance Indicators:

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2. Established by Subgrantee

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

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

During the quarter, progress was ongoing for the assessment and investigation of suspected child abuse and neglect cases because of the mandatory reporting and supplemental trainings prepared and provided to various audiences. Progress was also made for the assessment and investigation of cases of suspected child abuse-related/child neglect-related fatalities and for the investigation and prosecution of cases of child abuse/neglect due to the work of the MDT Training & Policy Administrator. The Children with Disabilities training was published on the Delaware Learning Center and the Department of Education's learning management system.

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

The implementation objectives are as follows:

- Contract with a Training Specialist –During the quarter, OCA contracted with two new Training Specialists.
- Contract with a MDT Training & Policy Administrator - OCA renewed its one-year contract with MDT Training & Policy Administrator, Adrienne Owen, and she provided services during the quarter.
- Provide Ongoing Comprehensive Training to Multidisciplinary Team Members and Others involved in the Judicial/Administrative Handling of Cases – The MDT Training & Policy Administrator provided training to 55 law enforcement members,
- Provide Multidisciplinary Team (MDT) Scholarships to representatives involved in the investigation, prosecution and judicial handling of cases of child abuse and neglect – No progress made this quarter.
- Train Professionals on the Recognition and Reporting of Child Abuse and Neglect through in-person and web-based training – Approximately 12,420 professionals participated in the mandatory reporting and supplemental trainings through virtual/in person training or online training through the Delaware Learning Center.
- Make web-based training available to the child welfare community through OCA's Online Training System – On October 1, 2019, OCA launched its new online training system on the State of Delaware's learning management system, Delaware Learning Center. During the quarter, the Training Specialists continued to manage the Delaware Learning Center and assist users who were completing training.
- Attend the CJA Grantee Meeting – Completed in May 2021.
- Draft and submit the CJA Annual Progress Report and Grant Application – Completed. Report was approved in July 2021.

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

The performance objectives are as follows:

• Annually update and revise the mandatory reporting training programs – Completed in January 2021.
• Organize and provide in-person and web-based mandatory reporting training for educators, medical professionals and general professional audiences – Virtual training through Zoom and WebEx was provided to professionals during the quarter by various trainers from DSCYF and OCA. Web-based training was also provided through the Delaware Learning Center and Department of Education's Professional Development Management System for public school employees.
• Partner with the Delaware Learning Center to host web-based trainings on OCA's online training system – OCA transitioned to the DLC on October 1, 2019. During the quarter, OCA continued to host trainings on the Delaware Learning Center.
• Organize and provide an annual train-the-trainer session to professionals responsible for providing training on mandatory reporting – Completed in May 2021. Additional train-the-trainers scheduled for October and November 2021.
• Develop advanced training programs both in-person and web-based for MDT professionals – The Training Specialists are currently developing the following trainings: Intersections of Domestic Violence and Child Abuse; Recognizing and Reporting Sexual Violence; Reporting Physical and Sexual Violence in Schools; LGBTQ+ Youth Experiencing Abuse, Foster Care, and Homelessness; Foster Care 101: Understanding the System; Child Caregivers: When Does It Become Abuse?; and Human Trafficking & Our Children.
• Evaluate the effectiveness of all training programs – The Training Specialist continued to evaluate the web-based trainings utilizing Survey Monkey.
• Maintain the number of professionals trained for all training programs – The Training Specialist maintained the numbers trained and reported the numbers to the Mandatory Reporting Workgroup.
• Utilize available software to develop web-based training programs – During the quarter, the Training Specialist utilized Articulate to develop the web-based training.
• Provide ongoing training on the MDT Best Practices Memorandum of Understanding, including training on conducting doll re-enactments in child abuse and neglect death and near death cases – The MDT Training & Policy Administrator provided training on the MOU to law enforcement agencies during the quarter.
• Update the mobile application for the MDT Best Practices MOU –The mobile application will be updated once the MOU revisions are approved by CPAC in November 2021.
• Facilitate and sponsor the ChildFirst® Forensic Interviewing Training for professionals involved in the investigative handling of child abuse cases – ChildFirst® training was facilitated in September 2021.
• Offer partial scholarships to representatives from the MDT to attend national conferences – No progress this quarter.
• Attend the annual CJA Grantee Meeting – Completed in May 2021.

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

The impact objectives are as follows:
• Improved coordination of training programs on the investigative, administrative and judicial handling of cases of child abuse and neglect provided by or sponsored by the Task Force – Progress was made because of the ongoing contract with the Training Specialist and MDT Training & Policy Administrator.
• Improved understanding of best practices associated with the investigation and prosecution of cases of child abuse and neglect, child death and child sexual abuse – Progress was made through the training provided by the MDT Training & Policy Administrator. Provided training to Seaford and Selbyville PD Criminal Investigation Unit. Provided Mandatory Reporting & MOU Recap training to statewide SRO's and Constables. Approximately 55 trained.
• Improved civil and criminal outcomes in child abuse and neglect deaths and near deaths investigations – Progress was made through the meetings and coaching provided by the MDT Training & Policy Administrator. Provided CAN panel support to DSP, NCCPD, WPD, Dover PD, Harrington PD. Provided post-CAN panel coaching to share findings with: Smyrna PD, WPD, Dover PD.
• Improved recognition and response to suspicions of child abuse and neglect by educators, medical providers and general community and professional audiences – Progress was made through the virtual and web-based trainings on mandatory reporting. Approximately 12,420 professionals were trained.
• Improved access to child welfare trainings developed by CPAC – Progress was made by making trainings available on the State of Delaware's learning management system, Delaware Learning Center, and via Zoom/Webex.

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

N/A

PROGRAM REPORT

Grant ID: 2399
Applicant Agency: Office of the Child Advocate
Project Dates: 10/1/2020 to 12/31/2021
Report Period: 10/1/2021 to 12/31/2021
Submission Date 1/17/2022

Report Due Date: 3/1/2022
Report Status: Submitted
Approval Status: Approved
Final Report: Yes

Is the Project On Schedule? Yes
Explanation:

Activities Conducting During this Period: Services were provided by the CJA Training Specialists, Megan Bittinger and Ameshia White. This quarter, Ms. Bittinger updated the Children with Disabilities, Minimal Facts, and Neglect supplemental trainings. Ms. Bittinger also developed an online component and new training slides for the existing refresher training on the MOU for the Multidisciplinary Response to Child Abuse & Neglect (CAN) for law enforcement. Additionally, Ms. Bittinger researched and developed the initial version of the new Mandatory Reporting Training for Medical Professionals. Ms. Bittinger also developed a new Mandatory Reporting Resource Guide including the updated resources she developed in the prior quarter. Ms. Bittinger additionally developed materials and website for an accidental drug ingestion campaign with the Child Death Review Commission. Lastly, Ms. Bittinger staffed the Committee on Child Sexual Abuse's Mental Health, Medical, and Prevention Workgroup on 10/1/2021 and 11/5/2021, the Training Committee's Medical Response Workgroup on 10/5/2021, the Training Committee's Protecting Delaware's Children Conference Workgroup on 10/12/2021 and 11/15/2021, the Training Committee's Mandatory Reporting Workgroup on 10/20/2021, the Training Committee on 11/4/2021, and the CPAC Quarterly Meeting on 11/17/2021.

During this quarter, Ms. White continued her work on the three supplemental trainings: (1) Foster Care 101: Understanding the System, (2) Youth Caregivers: Understanding the Role?, and (3) Human Trafficking & Our Children. Ms. White has collaborated with Claudine Wiant from the Beau Biden Foundation in completing the Human Trafficking & Our Children training, and Tracy Whitehouse from the Division of Family Services with regard to the Foster Care 101: Understanding the System training. Additionally, during this time, Ms. White continued to meet with community stakeholders and develop ways to increase participation in the online and in person trainings. Furthermore, Ms. White continued to work on the 2022 Child Abuse Prevention Month campaign. Lastly, Ms. White staffed the Training Committee's Protecting Delaware's Children Workgroup on 10/12/2021; Grants Oversight Committee on 10/27/2021; Child Sexual Abuse Committee's Extrafamilial Workgroup on 10/26/21, MDT Response Workgroup on 12/17/21; the Training Committee on 11/4/2021, the Training Committee's Protecting Delaware's Children Conference Workgroup on 10/12/2021 and 11/15/2021, the Training Committee's Mandatory Reporting Workgroup on 10/20/2021; the Education Committee on 12/15/21, and the CPAC Quarterly Meeting on 11/17/2021.

In quarter one, 3,752 professionals participated in the mandatory reporting training and 3,568 professionals participated in supplemental trainings. Of those 370 received mandatory reporting training through the Delaware Learning Center. Live, virtual trainings were also provided to 12 general professionals and 114 educators. 1 medical professional was trained online through Christiana Care Health Services. An additional 3,255 educators were trained on the mandatory reporting training through the Department of Education.

3,568 professionals also participated in the supplemental trainings. 1,229 professionals completed the Minimal Facts: Guidelines for Mandated Reporters training online, including 1,219 educators trained through the Department of Education. 1,580 professionals completed the Mandatory Reporting Refresher Training online, and 1,462 of those were educators trained through the Department of Education. 14 professionals completed the Children with Disabilities training with an additional 619 educators trained through the Department of Education, 10 completed the Parental Substance Use Disorder training, 5 completed the Protective vs. Risk training, 20 completed the Child Neglect training, 42 completed the Child Protection Registry training, 9 completed the You've Been Appointed! training, 15 completed the Legal Permanency Options training, 21 completed the Youth Engagement in Court training, and 4 completed the Representing Older Youth training.

Services were also provided by the MDT Training & Policy Administrator, Adrienne Owen. Ms. Owen spent 44 hours developing, coordinating, and providing training on the Memorandum of Understanding for the MDT Response to Child Abuse and Neglect. Training was provided to 5 law enforcement agencies, specifically to Milton, Ellendale, Camden, Dover and Wyoming police departments. Training specific to Child Abuse Medical Response, Medical Child Abuse, and the MDT Response to Serious Physical Injury Investigations was provided. Additionally, Adrienne provided training on Delaware's Mandatory Reporting Law and the MDT MOU to the Delaware Department of Justice's Special Victim's Unit. She spent another 56 hours reviewing and making updates to the MOU, which included the creation of an investigation checklist and case flow chart for Child Drug Ingestion and Poisoning Investigations. Adrienne also spent 17 hours providing communication, support and coaching to law enforcement members regarding child abuse and neglect. She also spent 9

communication, support and coaching to law enforcement members regarding child abuse and neglect. She also spent 9 hours in contract management, and 31 hours participating in Child Protection Accountability Commission committees and workgroups, serving as the chairperson for the Training Committee's Child Abuse & Neglect Best Practices Workgroup and a staff for the Child Sexual Abuse Committee's MDT/MOU Workgroup chairpersons. She spent another 27 hours participating in the reviews of child deaths and near deaths and another 52 hours on policy/legal work changes, predominately focused on Delaware's MDT response to Juvenile Trafficking and the Commercial Sexual Exploitation of Children.

Performance Indicators:

1. Established by DCJC
2. Established by Subgrantee

Final Report:

1. With the advantage of hindsight, what would you do differently in implementing this project?

N/A

2. Did you intend for this project to be sustained?

Yes

3. Choose the best response about the accomplishments of the project.

All objectives were accomplished

3.1. If less than 50% of the objectives were accomplished, please choose the best reason the objectives were not accomplished.

A response to this question is optional and no answer was provided.

4. Choose the best response related to the projected sustainability of the project 12 months **after the end of DCJC funding.**

The project will be sustained at the same level

5. Please identify all sources of continuation funding for this project.

Federal Government

6. Will the sustaining of this project result in downsizing other initiatives within your agency?

No

7. Please identify the number of agency positions that will be eliminated/furloughed as a result of this funding ending.

3.00

8. Please identify the number of agency positions that will be changed from full-time to part-time or will otherwise have their number of compensated hours reduced.

0.00

9. If this project will not be sustained, will be sustained at a greatly reduced level or sustainability will result in significant cut-backs elsewhere, please choose the best reason for lack of sustainability.

A response to this question is optional and no answer was provided.

10. Please identify, in the text box below, those variables that helped you to sustain the project, please only include those items not identified above.

N/A

11. Please identify, in the text box below, those variables that negatively affected your ability to sustain the project, please only include those items not identified above.

N/A

Quarterly Report Project Narrative !

Project Narrative

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

e.g.

Goal:

Progress:

Implementation Objective:

Progress:

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

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

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

During the quarter, progress was ongoing for the assessment and investigation of suspected child abuse and neglect cases because of the mandatory reporting and supplemental trainings provided to various audiences. Progress was also made for the assessment and investigation of cases of suspected child abuse-related/child neglect-related fatalities and for the investigation and prosecution of cases of child abuse/neglect due to the work of the MDT Training & Policy Administrator. Lastly, the Training Specialist updated the supplemental training specific to children with disabilities.

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

The implementation objectives are as follows:

- Contract with a Training Specialist – OCA continued to contract with Training Specialists, Megan Bittinger and Ameshia White.
- Contract with a MDT Training & Policy Administrator - OCA continued to contract with MDT Training & Policy Administrator, Adrienne Owen.
- Provide Ongoing Comprehensive Training to Multidisciplinary Team Members and Others involved in the Judicial/Administrative Handling of Cases – The MDT Training & Policy Administrator provided training to 5 law enforcement agencies and the Department of Justice.
- Provide Multidisciplinary Team (MDT) Scholarships to representatives involved in the investigation, prosecution and judicial handling of cases of child abuse and neglect – No progress made this quarter.
- Train Professionals on the Recognition and Reporting of Child Abuse and Neglect through in-person and web-based training – Approximately 7,320 professionals participated in the mandatory reporting and supplemental trainings through virtual training, or online training through the Delaware Learning Center.
- Make web-based training available to the child welfare community through OCA's Online Training System – During the quarter, the Training Specialist continued to manage the Delaware Learning Center and assist users who were completing training.
- Attend the CJA Grantee Meeting – Completed in May 2021.
- Draft and submit the CJA Annual Progress Report and Grant Application – Completed in May 2021.

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

The performance objectives are as follows:

• Annually update and revise the mandatory reporting training programs – Ms. Bittinger researched and developed the initial version of the new Mandatory Reporting Training for Medical Professionals. Ms. Bittinger also developed a new Mandatory Reporting Resource Guide.

• Organize and provide in-person and web-based mandatory reporting training for educators, medical professionals and general professional audiences – Virtual training through Zoom and WebEx was provided to professionals during the quarter by various trainers from DSCYF and OCA. Web-based training was also provided through the Delaware Learning Center and Department of Education's Professional Development Management System for public school employees.

• Partner with the Delaware Learning Center to host web-based trainings on OCA's online training system – During the quarter, OCA continued to host trainings on the Delaware Learning Center.

• Organize and provide an annual train-the-trainer session to professionals responsible for providing training on mandatory reporting – Completed in May, October and November 2021 by Rosalie Morales and Adrienne Owen. During this quarter, 36 professionals were trained.

• Develop advanced training programs both in-person and web-based for MDT professionals – Ms. Bittinger updated the Children with Disabilities, Minimal Facts, and Neglect supplemental trainings. Workgroup approval is pending. Ms. White continued her work on the three supplemental trainings: (1) Foster Care 101: Understanding the System, (2) Youth Caregivers: Understanding the Role?, and (3) Human Trafficking & Our Children. Trainings need to be reviewed by the Mandatory Reporting Workgroup.

• Evaluate the effectiveness of all training programs – The Training Specialist continued to evaluate the web-based trainings utilizing Survey Monkey.

• Maintain the number of professionals trained for all training programs – The Training Specialist maintained the numbers trained and reported the numbers to the Mandatory Reporting Workgroup.

• Utilize available software to develop web-based training programs – During the quarter, the Training Specialist utilized Articulate to develop the web-based training.

• Provide ongoing training on the MDT Best Practices Memorandum of Understanding, including training on conducting doll re-enactments in child abuse and neglect death and near death cases – The MDT Training & Policy Administrator provided training on the MOU to Milton, Ellendale, Camden, Dover and Wyoming police departments and the Department of Justice.

• Update the mobile application for the MDT Best Practices MOU –The mobile application will be updated once the MOU revisions are approved by CPAC in February 2022.

• Facilitate and sponsor the ChildFirst® Forensic Interviewing Training for professionals involved in the investigative handling of child abuse cases – Completed in March and September of 2021.

• Offer partial scholarships to representatives from the MDT to attend national conferences – No progress this quarter.

• Attend the annual CJA Grantee Meeting – Completed in May 2021.

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

The impact objectives are as follows:

• Improved coordination of training programs on the investigative, administrative and judicial handling of cases of child abuse and neglect provided by or sponsored by the Task Force – Progress was made because of the ongoing contract with the Training Specialists and MDT Training & Policy Administrator.

• Improved understanding of best practices associated with the investigation and prosecution of cases of child abuse and neglect, child death and child sexual abuse – Progress was made through the training provided by the MDT Training & Policy Administrator.

• Improved civil and criminal outcomes in child abuse and neglect deaths and near deaths investigations – Progress was made through the meetings and coaching provided by the MDT Training & Policy Administrator.

• Improved recognition and response to suspicions of child abuse and neglect by educators, medical providers and general community and professional audiences – Progress was made through the virtual and web-based trainings on mandatory reporting.

• Improved access to child welfare trainings developed by CPAC – Progress was made by making trainings available on the State of Delaware's learning management system, Delaware Learning Center, and via Zoom/Webex.

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

n/a

PROGRAM REPORT

Grant ID: 2657
Applicant Agency: Office of the Child Advocate
Project Dates: 10/1/2021 to 9/30/2022
Report Period: 1/1/2022 to 3/31/2022
Submission Date 4/18/2022

Report Due Date: 4/30/2022
Report Status: Submitted
Approval Status: Approved
Final Report: No

Is the Project On Schedule? Yes

Explanation: n/a

Activities Conducting During this Period: Services were provided by the CJA Training Specialists, Megan Bittinger and Ameshia White. This quarter, Ms. Bittinger updated the Neglect supplemental training and continued revisions for a new Mandatory Reporting Training for Medical Professionals. Ms. Bittinger continued to develop materials for the new Out of Reach Delaware accidental drug ingestion campaign, a joint effort with the Child Death Review Commission. Additionally, Ms. Bittinger continued researching and developing specialized population trainings for salon professionals, coaches, paramedics and advanced trainings for medical professionals. Lastly, Ms. Bittinger staffed the Medical Response Workgroup on 1/11/2022, the Protecting Delaware's Children Conference Workgroup on 1/12/2022, the Mandatory Reporting Workgroup on 1/20/2022, the ChildFirst/MDT Workgroup on 1/24/2022, the Training Committee on 2/3/2022 and the CPAC Quarterly Meeting on 2/16/2022.

During this quarter, Ms. White completed the supplemental training, Youth Caregivers: Understanding the Role, and created a new mandatory reporting training for educators. Additionally, Ms. White continued collaborating with Tracy Whitehouse from DFS with regard to the supplemental training, Foster Care 101: Understanding the System. Ms. White also created campaign ads for child abuse prevention month that will be displayed throughout the state. The ads remind all persons in Delaware to report child abuse and neglect. Likewise, Ms. White continued to meet with community stakeholders and develop ways to increase participation in the online and in person trainings. Lastly, Miss. White staffed the Protecting Delaware's Children Workgroup on 1/12/2022; Grants Oversight Committee on 1/26/2022; Child Sexual Abuse Committee's Extrafamilial Workgroup on 3/10/2022; the Training Committee on 2/3/2022, the Mandatory Reporting Workgroup on 1/20/2022, the ChildFirst/MDT Workgroup on 1/24/2022, and the CPAC Quarterly Meeting on 2/16/2022.

During the quarter, 641 professionals participated in the mandatory reporting training and 482 professionals participated in supplemental trainings. Of those 336 received mandatory reporting training through the Delaware Learning Center. Live, virtual trainings were also provided to 115 general professionals. Additionally, 305 educators were trained on the mandatory reporting training through the Department of Education.

482 professionals also participated in the supplemental trainings. 15 professionals completed the Minimal Facts training online, with an additional 83 educators trained through the Department of Education. 77 professionals completed the Mandatory Reporting Refresher Training online, and an additional 132 educators completed the training through the Department of Education. 13 professionals completed the Children with Disabilities training with an additional 67 educators trained through the Department of Education. Additionally, 8 professionals completed the Parental Substance Use Disorder training, 7 completed the Protective vs. Risk training, 25 completed the Child Neglect training, 33 completed the Child Protection Registry training, 7 completed the You've Been Appointed! training, 7 completed the Legal Permanency Options training, 6 completed the Youth Engagement in Court training, and 2 completed the Representing Older Youth training.

Ms. Owen spent 26 hours developing, coordinating, and providing training on the Memorandum of Understanding for the MDT Response to Child Abuse and Neglect. Training was provided to 3 law enforcement agencies, specifically to Bridgeville PD, Laurel PD, and Delaware Department of Probation & Parole. Additionally, training was provided to law enforcement recruits through the DSP Training Academy LEO Program. Training specific to the MDT Response to Child Near Death and Death Investigations, as well as Identifying Neglect Situations, was provided. She spent another 12 hours reviewing and making updates to the MOU, which included the updating of the Investigation Checklists utilized by frontline MDT members. Adrienne also spent 42 hours providing communication and support to law enforcement members regarding child abuse and neglect, as well as 20 hours meeting and coaching the MDT, to include participating in 3 MDT Investigative meetings for victims of juvenile trafficking. 13 hours were spent in contract management, and 6 hours participating in Child Protection Accountability Commission committees and workgroups, specifically the Committee on the Investigation, Prosecution and Treatment of Child Sexual Abuse. She spent another 87 hours engaged in policy and legal work/changes, predominately focused on Delaware's MDT response to Juvenile Trafficking and the Commercial Sexual Exploitation of Children, as well as MDT Response to Child Torture and MDT Response to Child Drug Ingestions.

Performance Indicators:

1. Established by DCJC
2. Established by Subgrantee

Quarterly Report Project Narrative !

Project Narrative

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

e.g.

Goal:

Progress:

Implementation Objective:

Progress:

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

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

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

During the quarter, progress was ongoing for the assessment and investigation of suspected child abuse and neglect cases because of the mandatory reporting and supplemental trainings provided to various audiences. The MDT Training & Policy Administrator also participates on the Committee on the Investigation, Prosecution and Treatment of Child Sexual Abuse. Progress was also made for the assessment and investigation of cases of suspected child abuse-related/child neglect-related fatalities and for the investigation and prosecution of cases of child abuse/neglect due to the work of the MDT Training & Policy Administrator. Lastly, the Training Specialist updated the supplemental training specific to Neglect, Youth Caregivers and Foster Care 101.

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

The implementation objectives are as follows:

• Contract with two Training Specialists and one MDT Policy and Training Administrator. - OCA continued to contract with Training Specialists, Megan Bittinger and Ameshia White, and MDT Training & Policy Administrator, Adrienne Owen.

• Provide 2 Trainings to Multidisciplinary Team Members and Others involved in the Judicial/Administrative Handling of Cases. - The MDT Training & Policy Administrator provided training to 3 law enforcement agencies. Additionally, training was provided to law enforcement recruits through the DSP Training Academy LEO Program.

• Train 11,000 professionals on the Recognition and Reporting of Child Abuse and Neglect through in-person and web-based training. – During the quarter, 641 professionals participated in the mandatory reporting training and 482 professionals participated in supplemental trainings.

• Make web-based training available to the child welfare community through OCA's online training system. -During the quarter, the Training Specialists continued to manage the Delaware Learning Center and assist users who were completing training.

• Two representatives will attend the annual CJA Grantee Meeting in 2022. – No progress made this quarter.

• Draft and submit the CJA Annual Progress Report and Grant Application in May 2022. – No progress made this quarter.

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

The performance objectives are as follows:

• Annually update and revise the mandatory reporting training programs by the end of the award period. - Ms. Bittinger continued to revise a new Mandatory Reporting Training for Medical Professionals. Ms. White drafted a Mandatory Reporting Training for Educators.

• Organize and provide in-person and web-based mandatory reporting training for educators, medical professionals and general professional audiences throughout the award period. - Virtual training through Zoom and WebEx was provided to professionals during the quarter by various trainers from DSCYF and OCA. Web-based training was also provided through the Delaware Learning Center and Department of Education's Professional Development Management System for public school employees.

• Partner with the Delaware Learning Center to host web-based trainings on OCA's online training system throughout the award period. - During the quarter, OCA continued to host web-based trainings on the Delaware Learning Center.

• Organize and provide an annual train-the-trainer session to professionals responsible for providing training on mandatory reporting in the fall of 2021. – Completed in prior quarter.

• Develop advanced training programs both in-person and web-based for MDT professionals throughout the award period. - Ms. Bittinger updated the Neglect supplemental trainings. Ms. White continued her work on the three supplemental trainings: (1) Foster Care 101: Understanding the System, and (2) Youth Caregivers: Understanding the Role?. Trainings need to be reviewed by the Mandatory Reporting Workgroup.

• Evaluate the effectiveness of all training programs throughout the award period using Survey Monkey. - The Training Specialists continued to evaluate the web-based trainings utilizing Survey Monkey.

• Maintain the number of professionals trained for all training programs throughout the award period. - The Training Specialists maintained the numbers trained and reported the numbers to the Mandatory Reporting Workgroup.

• Utilize available software to develop web-based training programs throughout the award period. - During the quarter, the Training Specialist utilized Articulate to develop the web-based training.

• Provide ongoing training on the MDT Best Practices Memorandum of Understanding, including training on conducting doll re-enactments in child abuse and neglect death and near death cases throughout the award period. - The MDT Training & Policy Administrator provided training on the MOU to NCC Probation & Parole, Bridgeville PD, Laurel PD and DTCC/DSP LEO Program.

• Facilitate and sponsor the ChildFirst™ Forensic Interviewing Training for 30 professionals involved in the investigative handling of child abuse cases. – The ChildFirst Workgroup is scheduled for October 17-21, 2022. The Workgroup last met on 1/24/22 to plan the session.

• Facilitate and sponsor the Protecting Delaware's Children Conference for 250 to 500 professionals. – A webinar series is being organized for the Protecting Delaware's Children Conference. A webinar will be held every Wednesday in April 2022, and then the first Monday of every month for the rest of the year.

• Attend the annual CJA Grantee Meeting as required by the federal grant award and two persons from OCA will attend. – No progress made this quarter.

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

The impact objectives are as follows:

• Improved coordination of training programs on the investigative, administrative and judicial handling of cases of child abuse and neglect provided by or sponsored by the Task Force as measured by the number of trainings coordinated by the contractors under this grant. – During the quarter, the MDT Training & Policy Administrator coordinated 3 trainings. The Training Specialists are planning and organizing the Protecting Delaware's Children Conference Webinar Series.

• Improved understanding of best practices associated with the investigation and prosecution of cases of child abuse and neglect, child death and child sexual abuse as measured by the decrease in findings from death and near reviews and the Office of the Investigation Coordinator. – In the last quarter there were 85 findings for the 26 cases reviewed. In the prior quarter, there were 68 for the 20 cases reviewed.

• Improved civil and criminal outcomes in child abuse and neglect deaths and near deaths investigations as measured by the data collected by the Child Abuse and Neglect Panel. – Of the 16 cases reviewed by the the CAN Panel for the first time, 8 had pending criminal charges.

• Improved recognition and response to suspicions of child abuse and neglect by educators, medical providers and general community and professional audiences as measured by the Survey Monkey evaluation results. – Survey Monkey responses were favorable. Feedback for the new supplemental trainings was overwhelmingly positive.

• Improved access to child welfare trainings developed by the CPAC as measured by the number of MDT members attending. – 1,123 professionals attended the CPAC trainings in the last quarter.

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

n/a

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

May 2021 - May 2022

FINDINGS

	*Current	Grand Total
MDT Response	**75**	**75**
Communication	6	6
Crime Scene	17	17
Documentation	1	1
Doll Re-enactment	1	1
General - Civil Investigation	4	4
General - Criminal Investigation	5	5
General - Criminal Investigation / Civil Investigation	7	7
Intake with DOJ	1	1
Interviews - Adult	9	9
Interviews - Child	11	11
Medical Exam	7	7
Prosecution/ Pleas/ Sentence	1	1
Reporting	5	5
Grand Total	**75**	**75**

*Current - within 1 year of incident

**Prior - 1 year or more prior to incident

Child Protection Accountability Commission
Child Abuse and Neglect Panel
Findings Detail and Rationale
May 2021 - May 2022

FINDINGS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			75
	Communication		6
		The law enforcement agency did not notify the DFS caseworker of the charges against the father. Mother disclosed the information to the caseworker.	1
		During the near death investigation, the law enforcement agency disengaged with the MDT, and stopped communicating updates on the criminal investigation.	3
		During the death investigation, the law enforcement agency disengaged with the MDT, and stopped communicating updates on the criminal investigation.	1
		During the near death investigation, the law enforcement agency did not communicate with DFS about the criminal investigation.	1
	Crime Scene		17
		No scene investigation was completed by the law enforcement agency. As a result, the scene was not photographed and no evidence was collected.	5
		The law enforcement agency did not complete an evidentiary blood draw on the child after the child ingested a controlled substance.	6
		The law enforcement agency did not complete an evidentiary blood draw on the father during the near death incident. Father disclosed that he had been drinking.	1
		The water temperature was not measured during the scene investigation by the law enforcement agency.	1
		The law enforcement agency did not complete an evidentiary blood draw on the child after the child ingested a controlled substance. The case was assigned to detectives late.	1
		The law enforcement agency did not consider an evidentiary blood draw on Mother, in addition to the relative caregiver, after the child ingested a controlled substance.	1
		The law enforcement agency did not complete an evidentiary blood draw on the child after the child ingested a controlled substance.	1
		The law enforcement agency did not complete an evidentiary blood draw on the child or adult caregivers after the child ingested a controlled substance.	1
	Documentation		1
		There was no documentation by the DFS caseworker that a lock box to store the marijuana was discussed.	1
	Doll Re-enactment		1
		No doll re-enactment was completed by the law enforcement agency.	1
	General - Civil Investigation		4
		For the prior investigation, the DFS caseworker did not initiate a multidisciplinary team response upon receipt of the physical injury report. In addition, the caseworker did not conduct a thorough investigation and made a finding of no evidence to substantiate versus unsubstantiated.	1

	For the near death investigation, the caseworker terminated the safety agreement and closed the case prior to obtaining the blood draw results from the law enforcement agency.	1
	During the near death investigation, the sibling reported that he was hit with an object and pointed to a body part; however, the DFS caseworker did not observe the child for any potential physical injuries.	1
	During the near death investigation, the father left with the child against medical advice, and it took a prolonged period of time to determine whether DFS or the out of state child protective services agency had jurisdiction in the case.	1
General - Criminal Investigation		5
	There was no documentation in the police report by the lead detective.	1
	The LE agency delayed responding to the near death incident for several days, resulting in an MDT response not being conducted.	1
	The LE agency did not initiate an MDT response to this incident resulting in the following investigative standards not being met: examination of the crime scene, response to the treating hospital(s), evidentiary blood draws completed on child or caregiver, notification to DOJ, interview with the caregiver, and forensic interview with the sibling.	1
	The law enforcement agency did not consider contacting an expert to opine on the drug metabolite levels found in the child's urine.	1
	A delay in the criminal investigation impacted the ongoing safety planning by the DFS caseworker.	1
General - Criminal Investigation / Civil Investigation		7
	There was not an initial MDT response to the near death incident in compliance with the MOU and statute. Law Enforcement responded to the initial 911 call and contacted DFS after the response.	3
	DFS and law enforcement focused solely on the mother rather than father as a suspect.	1
	There was not an initial MDT response to the near death incident in compliance with the MOU and statute. Law Enforcement contacted DFS but was initially told the case would be forwarded to the Institutional Abuse Unit.	1
	There was not an initial MDT response to the near death incident in compliance with the MOU and statute. Law enforcement was not able to respond initially, so the DFS case worker completed the interviews.	1
	There was not an initial MDT response to the near death incident in compliance with the MOU and statute. Detectives were not assigned to the case, and as a result, there was not an evidentiary blood draw for the child, scene investigation or timely report to DFS.	1
Intake with DOJ		1
	The law enforcement agency did not notify the DOJ Special Victims Unit of the near death incident. As a result, the evidentiary blood draws of the victim and the suspect were not completed.	1
Interviews - Adult		9
	DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	4

	During the near death investigation, DFS conducted interviews with the parents without the law enforcement agency present.	1
	For the near death investigation, there is no documentation that the law enforcement agency interviewed the father.	1
	For the near death investigation, there is no documentation that the caseworker interviewed an adult daughter, who resided in the home.	1
	During the prior investigation, there was no attempt by the DFS caseworker to contact the father or relative, who were the main supports for the mother.	1
	During the near death investigation, the mother reported that the child was cared for by a babysitter on the date of the incident; however, no information was obtained regarding that individual.	1
Interviews - Child		11
	Forensic interview did not occur with the sibling residing in the home where the incident occurred.	1
	Forensic interviews were not considered for the other children in the home despite the infant's serious physical injury and the concerns with the mother's involvement in trafficking.	1
	Forensic interviews did not occur with the other children residing in the home where the incident occurred. In addition, the DFS caseworker did not independently interview these children.	1
	During the prior investigation, the other children residing in the home were not interviewed by the caseworker.	1
	Forensic interviews were not considered for the other children residing in the home where the incident occurred.	1
	Forensic interview was not scheduled until approximately six months later for the sibling who resided in the home during the near death incident.	1
	Forensic interviews did not occur with the other children residing in the home where the incident occurred.	2
	There was a delay in referring the young victim to a children's advocacy center for a forensic interview.	1
	An older sibling, residing with a non-relative caregiver, was not interviewed by the DFS caseworker, and the home was not assessed.	1
	Forensic interview did not occur with the sibling residing in the home where the incident occurred.	1
Medical Exam		7
	All of the children who resided in the home during the near death incident were not medically evaluated.	1
	The sibling, who resided part-time in the residence, was not medially evaluated.	1
	During the initial response, the DFS caseworker observed the young sibling at the home, but there was no discussion about the need for a medical evaluation at that time.	1
	In the prior investigation, there was no follow up with the CARE Team to discuss the interpretation of medical findings for the fractured forearm.	1

	The young sibling who was present in the home during the near death incident was not medically evaluated until almost a month later.	1
	The half-sibling who was present in the home during the near death incident was not medically evaluated.	1
	The sibling who was present in the home was not medically evaluated during the prior investigation.	1
Prosecution/ Pleas/ Sentence		1
	The State's recommendation of 2 years and no presentence investigation for the Child Abuse 1st conviction was inappropriate. However, the recommendation may have been impacted by COVID.	1
Reporting		5
	The law enforcement agency did not make a report to the DFS Report Line for the near death incident.	1
	The law enforcement agency delayed making a report to the DFS Report Line for a prior domestic violence incident.	1
	The MDT did not make a report to the DFS Report Line for the other victims identified during the criminal investigation.	1
	In the near death investigation, the DFS caseworker delayed reporting to the law enforcement agency.	1
	In the near death investigation, the DFS caseworker delayed reporting to the law enforcement agency. As a result, there was not an initial MDT response, scene investigation or evidentiary blood draw.	1
Grand Total		**75**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

May 2021 - May 2022

STRENGTHS		
	***Current**	**Grand Total**
MDT Response	**53**	**53**
Communication	7	7
General - Civil Investigation	6	6
General - Criminal Investigation	7	7
General - Criminal Investigation	1	1
General - Criminal/Civil Investigation	27	27
Interviews - Child	1	1
Medical Exam	3	3
Reporting	1	1
Grand Total	**53**	**53**

**Current - within 1 year of incident*

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

Child Protection Accontability Commission
Child Abuse and Neglect Panel
Strengths Detail and Rationale
May 2021 - May 2022

STRENGTHS

System Area	Strength	Rationale	Count of #
MDT Response			53
	Communication		7
		There was good communication between the medical team, DFS, and the law enforcement agency.	1
		There was excellent communication and collaboration between the child abuse medical expert, the law enforcement detective, the DOJ, the civil DAG, and the Child Attorney.	1
		There was excellent communication and collaboration between the child abuse medical expert, the civil DAG, the Child Attorney, and the DFS caseworkers.	1
		There was good communication and collaboration between DFS and the law enforcement agency.	1
		There was good communication and collaboration between the medical team, DFS, the law enforcement agency, and the DOJ.	1
		There was good communication and collaboration between the law enforcement agency, the criminal DAG, the civil DAG, and the Child Attorney.	1
		There was good communication between the Child Attorney and the law enforcement agency relating to the ongoing domestic violence between the parents.	1
	General - Civil Investigation		6
		During the prior and current investigations, the DFS caseworkers thoroughly assessed the safety of both children despite concerns being for only one child. The assessments included regular visits, school and medical collaterals, and appropriate follow up to ensure the needs were being met.	1
		Despite the complexity of the case due to the child's legal status, lack of health insurance, complicated injuries, language barriers, and residency status, the DFS caseworker did an excellent job of ensuring the child received all necessary services and medical treatment, and ultimately was reunited safely with his paternal family.	1
		During the course of the multiple investigations, there was good collaboration between the investigation and treatment caseworkers, to include joint responses to the home and quality contact with the family.	1
		The DFS caseworker advocated for forensic interviews to be conducted for the other children residing in the home.	1
		Given the unusual circumstances of the case, the DFS after-hours staff went above and beyond their duties to locate the twin sibling and ensure the safety of the child.	1
		The DFS caseworker advocated for a scene investigation and evidentiary blood draws to be completed by the law enforcement agency.	1
	General - Criminal Investigation		7
		The law enforcement detective assigned to the case conducted a thorough investigation and maintained excellent communication with the DFS caseworker.	1

	The law enforcement detective conducted an excellent investigation, to include evidentiary blood draws of all household members and fingerprinting of drug evidence collected from the residence, which resulted in both parents being criminally charged.	1
	The law enforcement detective assigned to the case conducted an excellent investigation, ensuring all MOU recommendations were completed and thoroughly documented within the report, and maintained excellent communication with the DFS caseworker.	1
	The law enforcement agency conducted evidentiary blood draws of all adults residing in the home at the time of the near death incident.	1
	Despite the near death incident appearing to be accidental, the law enforcement agency conducted a thorough investigation, to include interviews with the parents, a scene investigation, collection of evidence, and forensic examination of Mother's laptop.	1
	The detective assigned to the criminal case conducted a thorough investigation, to include multiple interviews and review of video surveillance from multiple establishments along Mother's reported path of travel, which the detective documented in detail within the complaint report.	1
	Despite not having a detective assigned to the smaller jurisdiction law enforcement agency, the patrol officer conducted an excellent investigation ensuring all MOU recommendations were completed and thoroughly documented within the report.	1
General - Criminal Investigation		1
	The law enforcement detective assigned to the case conducted an excellent investigation, which included a confession and seizure of the suspect's cell phone that corroborated the confession, resulting in criminal charges being filed.	1
General - Criminal/Civil Investigation		27
	There was a good MDT response to the near death incident, which included a joint response to the hospital, joint interviews, an evidentiary blood draw of the child, medical evaluations for the siblings, and forensic interviews of the children.	1
	There was a good MDT response to the death incident, which included a joint response to the hospital, joint interviews, an evidentiary blood draw of Mother, and medical evaluations and forensic interviews of the sibling and the other children residing in the home.	1
	There was a good MDT response to the death incident, which included a joint response to the hospital, joint interviews, an evidentiary blood draw of Mother, and a medical evaluation and forensic interview of the sibling residing in the home.	1
	There was a good MDT response to the near death incident, which included a joint response to the hospital, joint interviews with the parents, and medical evaluations and forensic interviews of the child and the sibling residing in the home.	1
	There was a good MDT response to the near death incident, which included a joint response to the hospital, joint interviews, forensic interview of the child, and collaboration with outside agencies, as appropriate.	1

	There was a strong MDT response to the near death investigation, which included a joint response to the hospital, joint interviews with the parents and relative guardian, and great collaboration with DFS and DOJ.	1
	There was a good MDT response to the near death incident, which included a joint response to the hospital, joint interviews with the parents, and medical evaluation and forensic interview of the sibling residing in the home.	1
	Following assignment of a detective, there was a good MDT response to the near death incident, which included a joint response to the hospital and joint interviews with the family.	1
	There was a good MDT response to the near death investigation, which included a joint response to the hospital, a joint response to the home, joint interviews with the appropriate caregivers, medical evaluations of the siblings, which included urine drug screens, and forensic interviews of the siblings.	1
	There was a good MDT response to the near death investigation, which included responses to the hospital and the scene, interviews with all involved parties, and a forensic interview of the child.	1
	There was a good MDT response to the near death investigation, which included a joint response to the hospital, a joint response to the home, joint interviews with the appropriate caregivers, forensic interviews of the children in the home and of the paramour's nonresidential child, and coordination with the alternate biological parent of the children.	1
	There was a good MDT response to the near death investigation, which included a joint response to the home, joint interviews with all involved parties, and medical evaluation and forensic interview of the sibling.	1
	There was a good MDT response to the near death investigation, which included a joint response to the hospital, a joint response to the home, joint interviews with the appropriate caregivers, an immediate medical evaluation of the sibling residing in the home, forensic interviews of the sibling and the half-sibling, and coordination between the two local law enforcement agencies to ensure MOU recommendations were completed.	1
	There was an excellent MDT response to the near death investigation, which included a joint response to the home, joint interviews with the appropriate caregivers, all appropriate investigative steps, and consistent communication and collaboration with the medical team.	1
	There was a good MDT response to the near death investigation, which included a joint response to the hospital, a joint response to the home, joint interviews with the parents, medical evaluations of the siblings, and coordinated investigations of the child's physical abuse and the sibling's medical neglect.	1
	There was good communication and collaboration between the medical team, DFS, the law enforcement agency, and the DOJ.	1
	Following receipt of the expanded drug screen results, there was a joint response to the NRC's home by law enforcement and the DFS caseworker, and joint interviews were conducted with all involved parties.	1
	There was a good MDT response to the death investigation, which included a joint response to the hospital, joint interviews with Mother and other relatives at the hospital, and a child safety agreement restricting the parents' contact with the child.	1

	There was a good MDT response to the near death investigation, which included a joint response to the home, joint interviews with the appropriate caregivers, all appropriate investigative steps, announced and unannounced home visits to ensure the child safety agreements were being followed, and consistent communication and collaboration among the MDT members.	1
	There was excellent communication and collaboration between the MDT members, which also included joint responses to the home and joint interviews with relatives and non-relatives.	1
	There was a good MDT response to the near death, and subsequently death, investigation, which included joint responses to the hospital and the home, joint interviews with the adults in the home, a child safety agreement, forensic interview of the non-relative child, and consistent communication and collaboration among the MDT members.	1
	There was a good MDT response to the death investigation, which included a joint response to the hospital, joint interviews with the parents and other adult relatives residing in the home, a child safety agreement for the young sibling, medical evaluation and forensic interview of the sibling, and consistent communication among the MDT members.	1
	There was a good MDT response to the near death investigation, which included a joint response to the hospital, joint interviews with the parents and other adult relatives, a child safety agreement, forensic interview of the child, and consistent communication among the MDT members.	1
	There was a good MDT response to the death investigation, which included joint responses to the hospital and the home, joint interviews with the caregivers, child safety agreements for the children, medical evaluations and forensic interviews of the sibling and non-relative child, an immediate CARE Team consultation, and consistent communication among the MDT members.	2
	There was a good MDT response to the near death investigation, which included joint responses to the hospital and the home, joint interviews with Mother and the adult stepchildren residing in the home, a child safety agreement while the child was hospitalized, a medical evaluation and forensic interview of the sibling, and consistent communication among the MDT members.	1
	There was a good MDT response to the near death investigation, which included joint responses to the hospital, the neighborhood park, and the home; joint interviews with the parents; a child safety agreement; medical evaluation and forensic interview of the sibling; and consistent communication among the MDT members.	1
Interviews - Child		1
	The DFS caseworker abstained from interviewing the sibling prior to the forensic interview.	1
Medical Exam		3
	The DFS caseworker advocated for the child and the sibling to be medically evaluated by the children's hospital, to include a CARE Team consultation and blood draws of both children.	1
	The MDT members made a referral to the CARE team for the drug ingestion case.	1
	Despite the older sibling being asymptomatic and reporting not to have ingested any substances, a medical evaluation was completed for the child. The evaluation included a urine drug screen.	1

	Reporting	1
	The DFS caseworker made an immediate report to the law enforcement agency with concerns surrounding the circumstances of the children's drug ingestions.	1
Grand Total		**53**

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

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

May 19, 2021

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 17 cases at its May 19, 2021 meeting.[1]

As mentioned in our last communication, Delaware experienced 9 child abuse or neglect deaths and 43 near deaths – a 24% increase from 2019. In the first four months of 2021, there has been 1 death and 20 near deaths due to child abuse or neglect. If this trend continues, there will be a 62% increase in severe child abuse cases for 2021. As you are aware, despite the pandemic, the Child Abuse and Neglect (CAN) Panel met conscientiously to assure that child abuse deaths and near deaths were timely reviewed. The volume of deaths and near deaths to children that occurred between July 2020 and now continues to overwhelm the panel. With 21 new cases in 2021 on top of the 2020 volume, the impact on the front lines and on the CAN Panel is significant. These numbers are troubling both in terms of child safety as well as in timely caseload management and retrospective review.

With respect to the 17 cases that were approved by CPAC today, here are the strengths and system breakdowns. One of the near death cases approved had been

[1] 16 Del. C. § 932.

previously reviewed and was awaiting the completion of the criminal investigation. Charges against both parents were nolle prossed. One additional finding against the medical community was made for failure to report and allowing the parents to transport the child to the emergency department for evaluation.

The sixteen remaining cases were from deaths or near deaths that occurred between July and September of 2020. Of these cases, four will have no further review as there are no criminal charges. Nine of the twelve remaining cases have pending charges and will be reviewed again once prosecution is completed. The remaining three cases are still being investigated. The children in these 2020 cases range in age from one month to three years of age with three deaths and thirteen near deaths. The children were victims of abusive head trauma, poisoning via drug ingestion, bone and skull fractures, and unsafe sleep. These twelve cases resulted in 18 strengths and 78 current findings across system areas.

For these July through September 2020 cases, 12 strengths and 33 findings were noted for the Multidisciplinary Team Response. The Office of the Child Advocate (OCA) has now contracted with a MDT Training and Policy Administrator with significant law enforcement expertise who is working with individual law enforcement jurisdictions on best practices, resources and compliance with the MOU. The Joint Action Plan delineates the further steps this contracted position and CPAC must take to further best practices and MOU compliance by team members. The Office of the Investigation Coordinator (IC) has also instituted MDT meetings within 48-72 hours of every child abuse death, serious injury or drug ingestion. CPAC is hopeful this will have a positive impact on the post-incident investigation.

The medical response had 8 findings together with 3 strengths. The medical response to child abuse and neglect cases was a significant focus in the retreat and resulting Joint Action Plan. Significant recommendations for improvement have been delineated that focus on more tailored education, coaching and support for various aspects of the medical profession, particularly hospitals and walk in care, as well as pediatric, family medicine and obstetrics/gynecological practices. The Joint Action Plan also focuses on getting specialized child abuse expertise downstate. CPAC is creating a workgroup chaired by medical professionals to tackle these significant tasks, and will be utilizing funds from mandatory reporting training to accomplish these goals. CPAC is hopeful with this targeted focus and the additional resources, it can begin to make a substantive impact on all aspects of Delaware's medical response to

child abuse and neglect, as well as continue to empower the medical community to utilize Plans of Safe Care to assure supports for infants with prenatal substance exposure.

The Division of Family Services (DFS) had 3 strengths and 37 findings this quarter. Fourteen of those findings were regarding high caseloads. The caseloads in the DFS serious injury investigation units are at 19.7 – well above the statutory limit for the most serious of cases. The rest of the findings continue to focus on timely and appropriate completion of safety agreements, unresolved risk, and collateral and family contacts. In the Joint Action Plan, CPAC and CDRC, with full partnership by DSCYF, have recommended the following steps to improve worker and supervisory responses: develop and provide initial and ongoing training on the Structured Decision Making Safety and Risk Assessment tools; provide regular coaching and monitoring to DFS staff on child safety agreements; intensify DFS supervisory training and support on child safety agreements; develop an abbreviated DFS training for MDT partners; and utilize quarterly meetings to address findings from these cases with DFS staff.

CPAC only brings you the most horrific of Delaware's child abuse cases; however, for every one of these, there are countless more cases where DFS case workers are under the same pressures and children remain at risk of serious harm. Young children with sentinel injuries are often the victims of serious abuse just months later. Gaps in identification of these cases, and thorough investigation thereafter could decrease serious harm. For your information we have included the strengths, findings and the details behind all of the cases presented in this letter. CPAC stands ready as a partner as well as to answer any further questions you may have.

Respectfully,

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

cc: CPAC Commissioners
General Assembly

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

MAY 19, 2021

INITIAL REVIEWS		
	***Current**	**Grand Total**
MDT Response	**12**	**12**
General - Civil Investigation	3	3
General - Criminal Investigation	1	1
General - Criminal/Civil Investigation	8	8
Medical	**3**	**3**
Documentation	1	1
Medical Exam/Standard of Care - CARE	1	1
Reporting	1	1
Safety/ Use of History/ Supervisory Oversight	**3**	**3**
Completed Correctly/On Time	1	1
Oversight of Agreement	1	1
Use of History	1	1
Grand Total	**18**	**18**

TOTAL CAN PANEL STRENGTHS **18**

*Current - within 1 year of incident

**Prior - 1 year or more prior to incident

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

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Detail

MAY 19, 2021

INITIAL REVIEWS

System Area	Strength Rationale	Count of #
MDT Response		12
	General - Civil Investigation	3
	During the investigation, the DFS caseworker advocated for MDT meetings and further communication with the law enforcement agency.	1
	There was great DFS response to both investigations, which included coordination with the home visiting program, advocating for the child to be transferred to the children's hospital following the near death incident, communication with the children's hospital prior to transfer, consistent contact with Mother and the relative, appropriate collaterals, and review and modification, when necessary, of the child safety agreement.	1
	Despite Mother advising the paternal family was not involved with the child, the DFS investigation and treatment caseworkers continued communication with the paternal family, which ultimately resulted in the paternal grandmother filing for guardianship.	1
	General - Criminal Investigation	1
	During response to the local hospital ED, the law enforcement detective noticed the child's clothing had been thrown into the trash; the clothing was retrieved and collected as evidence.	1
	General - Criminal/Civil Investigation	8
	There was a good MDT response to the death investigation by the law enforcement agency and DFS, to include joint responses to the hospital and the home, joint interviews, and communication between the two agencies.	1
	There was a good initial MDT response to the near death investigation by the law enforcement agency and DFS, to include a joint response to the hospital, a joint interview with Mother, forensic interviews of the siblings residing in the home, and medical evaluations of the siblings residing in the home.	1
	There was a good initial MDT response to the near death investigation by the law enforcement agency and DFS, to include joint responses to the hospital and the home, joint interviews with the parents and relative caregiver, and communication with the medical team.	1
	There was a good initial MDT response to the near death investigation by the law enforcement agency and DFS, to include joint responses to the hospital and joint interviews.	1
	There was a good initial MDT response to the near death investigation by the law enforcement agency and DFS, to include joint responses to the child's home and the NRC's home, joint interviews with the adults in both homes, child safety agreements for both families, and medical evaluations for all children in both homes.	1

	There was a good MDT response to the near death investigation by the law enforcement agency and DFS, to include joint responses to the hospital, joint interviews with the parents and the paternal uncle, a child safety agreement while the child was hospitalized, medical evaluation of the sibling, and forensic interview of the sibling.	1
	There was a good MDT response to the near death investigation by the law enforcement agency and DFS, to include joint responses to the hospital, joint interviews with the parents, and medical evaluations of the siblings.	1
	There was a good MDT response to the near death investigation by the law enforcement detective and the DFS caseworker, to include a joint response to the home, joint interviews, medical examination of the sibling, and forensic interviews of the sibling and minor relative residing in the home.	1
Medical		3
	Documentation	1
	The treating physician in the emergency department photographed the rapid changes of the child's bruising and this documentation was included as part of the medical record.	1
	Medical Exam/ Standard of Care - CARE	1
	There was great coordination by the medical team to establish a safe discharge for the child to trained caregivers, which included several meetings with different disciplines.	1
	Reporting	1
	The initial treating hospital immediately reported concerns that the mother was demonstrating signs of impairment.	1
Safety/ Use of History/ Supervisory Oversight		3
	Completed Correctly/On Time	1
	The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. There was consistent review and modification, when necessary, of the safety agreement by the DFS caseworker.	1
	Oversight of Agreement	1
	The assigned DFS caseworker immediately amended the initial child safety agreement upon being notified by medical personnel that the child had additional injuries in varying stages of healing.	1
	Use of History	1
	Despite being unsubstantiated with perpetrator unknown, Father's prior DFS investigation was considered during implementation of the child safety agreement during the death investigation.	1
Grand Total		**18**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

MAY 19, 2021

INITIAL REVIEWS

Sum of #	Column Labels	
	*Current	Grand Total
MDT Response	**33**	**33**
Communication	2	2
Crime Scene	5	5
Documentation	1	1
Doll Re-enactment	1	1
General - Civil Investigation	2	2
General - Criminal Investigation	2	2
General - Criminal Investigation / Civil Investigation	2	2
Interviews - Adult	7	7
Interviews - Child	4	4
Medical Exam	5	5
Reporting	2	2
Medical	**7**	**7**
Medical Exam/ Standard of Care - ED	1	1
Medical Exam/ Standard of Care - Forensics	2	2
Reporting	3	3
Transport	1	1
Risk Assessment/ Caseloads	**19**	**19**
Caseloads	14	14
Collaterals	2	2
Documentation	1	1
Risk Assessment - Screen Out	1	1
Risk Assessment - Tools	1	1
Safety/ Use of History/ Supervisory Oversight	**9**	**9**
Safety - Completed Incorrectly/ Late	5	5
Safety - Inappropriate Parent/ Relative Component	1	1
Safety - Oversight of Agreement	1	1
Safety - Violations of Safety Agreements	2	2
Unresolved Risk	**9**	**9**
Child Risk Factors	1	1
Contacts with Family	2	2
Parental Risk Factors	6	6
Grand Total	**77**	**77**

FINAL REVIEWS

Count of #	Column Labels	
	*Current	Grand Total
Medical	**1**	**1**
Reporting	1	1
Grand Total	**1**	**1**

TOTAL CAN PANEL FINDINGS **78**

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

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

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Detail

MAY 19, 2021

INITIALS REVIEWS

System Area	Finding PUBLIC Rationale	Sum of #
MDT Response		33
	Communication	2
	The law enforcement agency did not notify the DOJ Special Victims Unit of the near death incident.	1
	There was no communication initially between the Division of Forensic Science and the rest of the MDT regarding the findings from the post-mortem CT scan.	1
	Crime Scene	5
	No scene investigation was completed by the law enforcement agency. As a result, the scene was not photographed and no evidence was collected.	2
	The SUIDI form was not fully completed by the forensic investigator, and it is unknown whether this may have impacted the cause and manner of death.	1
	The law enforcement agency did not complete an evidentiary blood draw on the child after the child ingested a controlled substance.	1
	The law enforcement agency did not complete an evidentiary blood draw on the child after the child ingested an over the counter substance.	1
	Documentation	1
	There was no documentation in the police report by the lead detective.	1
	Doll Re-enactment	1
	No doll re-enactment was completed by the law enforcement agency.	1
	General - Civil Investigation	2
	There was a significant delay in closing the DFS investigation and no reason was documented by the caseworker or supervisor.	1
	DFS did not send out a Serious Injury report upon receipt of the near death investigation, and as a result, no referral was sent out by the Office of the Investigation Coordinator.	1
	General - Criminal Investigation	2
	There was a delayed response to the children's hospital by the law enforcement agency. However, the smaller jurisdiction may have had limited officers on duty at the time.	1
	There was no documentation in the police report until approximately six months after the incident.	1
	General - Criminal Investigation / Civil Investigation	2
	There was not an initial MDT response to the death incident in compliance with the MOU and statute. Law Enforcement delayed its report to DFS.	1

	There was not an initial MDT response to the near death incident in compliance with the MOU and statute. Law Enforcement declined to send a detective to the hospital.	1
Interviews - Adult		7
	There was no documentation that the DFS caseworker reviewed a copy of the law enforcement interview with father.	1
	The child was in the care of multiple caregivers 24 hours before the death incident, and these other caregivers were not interviewed by the caseworker since the focus was solely on the father.	1
	There was no documentation that the DFS caseworker reviewed a copy of the law enforcement interviews with father or other caregivers in the mother's home.	1
	For the near death investigation, there was no documentation that the mother's paramour was interviewed by the caseworker.	1
	For the near death investigation, the child was recently in the care of mother and father, but it was only suspected that mother inflicted the bone fracture and her explanation was the only one considered.	1
	During the near death investigation, the DFS caseworker did not attempt to contact the father, who resided out of state, but had frequent contact with the victim.	1
	During the near death investigation, there was no attempt by the caseworker to contact the sibling's father. The sibling was present during the incident but lived out of state.	1
Interviews - Child		4
	Forensic interviews did not occur with the other children residing in the home where the incident occurred.	1
	The half-sibling in the mother's home was not observed or interviewed by the DFS caseworker.	1
	A forensic interview was not considered for the other child residing in the home where the incident occurred.	1
	A forensic interview was not considered for the sibling present in the home where the incident occurred.	1
Medical Exam		5
	The young sibling who was present in the home during the near death incident was not medically evaluated.	1
	All of the children who resided in the home during the death incident were not medically evaluated.	1
	During the MDT meetings, the additional photos of the child's injuries and the video of the doll re-enactment were not presented to the child abuse medical expert.	1
	During the near death investigation, there was no follow up with the CARE Team or family to ensure the repeat skeletal exam occurred.	1
	During the death investigation, the DFS caseworker did not independently contact the child abuse medical expert to discuss the medical findings.	1
Reporting		2
	In the prior investigation, the DFS caseworker did not make a report to the law enforcement agency.	1

	DFS delayed making a screening decision on the hotline report until corroborating the medical information with the children's hospital. As a result, the report to law enforcement was delayed, and no blood draw could be obtained.	1
Medical		7
	Medical Exam/ Standard of Care - ED	1
	For the near death investigation, the children's hospital emergency department evaluated the child's lower extremities during an initial visit and noted no concerns. However, the child was later diagnosed with a bone fracture after the father returned the child to the hospital.	1
	Medical Exam/ Standard of Care - Forensics	2
	A forensic consult did not occur during the emergency department visit since the hospital does not have an FNE on staff. This may have had an impact on evidence collection.	1
	A forensic nurse was not available in the emergency department (ED) to take photographs of the victim's injuries due to resource issues. However, the injuries were photographed by the treating physician in the emergency department.	1
	Reporting	3
	The hospital made a delayed report to the DFS Report Line for the near death incident.	1
	For the near death investigation, the child was medically discharged for the burn injuries prior to the hospital emergency department's call to the DFS Report Line.	1
	There was no report to the DFS Report Line by the PCP after the PCP documented a differential diagnosis of non-accidental trauma and received the confirmed x-ray results.	1
	Transport	1
	The PCP allowed the parents to transport the child to the emergency department, and did not send the child with alternative transportation.	1
Risk Assessment/ Caseloads		19
	Caseloads	14
	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	7
	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open, and the caseload appears to have had a negative impact on the delayed final outcome and documentation.	1
	The DFS caseworker was over the investigation caseload statutory standards during the prior investigation. However, it does not appear that the caseload negatively impacted the DFS response to the case.	1

	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open, and the caseload appears to have had a negative impact on the collateral contacts and documentation.	1
	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open, and the caseload appears to have had a negative impact on the delayed final outcome.	1
	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open, and the caseload appears to have had a negative impact on the documentation and delayed final outcome.	1
	The DFS caseworker was over the investigation caseload statutory standards the entire time the prior and current investigations were open, and the caseload appears to have had a negative impact on the quality of work by the caseworker and supervisor in the prior case.	1
	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open, and the caseload appears to have had a negative impact on the DFS response to the case.	1
	Collaterals	2
	During the death incident, a collateral contact was not completed with the PCP who allegedly saw the child the day prior.	1
	During the near death incident, collateral contacts were not completed for the siblings.	1
	Documentation	1
	Documentation of the hotline reports was delayed by the DFS Intake Worker.	1
	Risk Assessment - Screen Out	1
	The DFS Report Line screened out a prior hotline report, which alleged domestic violence. However, the report should have been screened in and linked to the active investigation.	1
	Risk Assessment - Tools	1
	During the near death investigation, family team meetings were not considered with the father's support network. These meetings would have helped to formalize the supports available to the father.	1
Safety/ Use of History/ Supervisory Oversight		9
	Safety - Completed Incorrectly/ Late	5
	For the near death investigation, DFS entered into a safety agreement with the sibling's father (who was mother's paramour), but did not specify the type of contact that must occur.	1
	During the near death investigation, the initial DFS safety agreement included the mother and victim, but not the other adults and children in the home.	1
	During the near death investigation, the initial safety agreement excluded the need for supervision during the child's hospitalization. As a result, the mother could remain in the hospital without supervision.	1

	For the near death investigation, DFS entered into a safety agreement with the father, but the agreement did not document who was responsible for making sure the mother was supervised.	1
	Prior to transferring the case to treatment, a safety assessment was not repeated. As a result, the agreement was terminated and the sibling was left without a plan for safety.	1
	Safety - Inappropriate Parent/ Relative Component	1
	For the near death incident, DFS initially entered into a safety agreement allowing mother to supervise contact between the victim and her paramour, but she was not ruled out as a suspect.	1
	Safety - Oversight of Agreement	1
	During the near death incident, the safety agreement was violated, and the DFS caseworker did not reassess for safety and implement a new agreement.	1
	Safety - Violations of Safety Agreements	2
	During the near death investigation, the DFS caseworker allowed the safety agreement to lapse despite being advised by law enforcement that the agreement was violated by father. In addition, the agreement was modified to allow father, who was considered a suspect, to have supervised contact.	1
	During the near death investigation, the safety agreement was violated by mother. The caseworker addressed the violation with mother over the phone instead of conducting a home visit or reaching out to the safety participants.	1
Unresolved Risk		9
	Child Risk Factors	1
	During the death investigation, concerning behaviors involving another child in the home of the victim were reported by family members. However, there was no assessment by the DFS caseworker to determine if services were needed.	1
	Contacts with Family	2
	For the incident preceding the death, the initial contact with the family was overdue by 5 days.	1
	For the incident preceding the death, there was no follow up with family until approximately seven months after the initial response, and it occurred as a result of the death incident.	1
	Parental Risk Factors	6
	In the prior investigation, the DFS caseworker allowed the suspected perpetrator to drive the victim to the children's hospital.	1
	During the treatment case, the DFS caseworker did not follow up with the children's hospital to make sure the medical concerns were addressed nor address the concerns which resulted in the transfer to treatment.	1
	DFS did not evaluate substance abuse issues for the mother by requesting that she complete a substance abuse evaluation. Risk factors included an infant born with prenatal substance exposure and a pending DUI.	1

	For the incident preceding the death, Mother reported that she was in a new relationship and suggested that there were problems, but DFS did not explore this further or request the name of her paramour to complete a background check.	1
	A referral to the domestic violence liaison was not considered despite the prior hotline reports involving domestic violence between the mother and intimate partners.	1
	DFS did not initiate a discussion with Father regarding supervision and the need for childcare. Father violated the safety agreement to go to work, and then later requested assistance from the DFS caseworker.	1
Grand Total		**77**

FINAL REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
Medical			1
	Reporting		1
		There was no report to the DFS Report Line by the urgent care center, and the parents were permitted to transport the child to the hospital emergency department.	1
Grand Total			**1**

TOTAL FINDINGS **78**

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

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

August 18, 2021

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

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

Dear Governor Carney:

As one of its many statutory duties, the Child Protection Accountability Commission ("CPAC") is responsible for the review of child deaths and near deaths due to abuse or neglect. As required by law, CPAC approved findings from 20 cases at its August 18, 2021 meeting.[1]

Thus far in 2021, there have been 3 deaths and 35 near deaths due to child abuse or neglect. In June alone, there were 8 near deaths and 1 death. As you are aware, despite the pandemic, the Child Abuse and Neglect (CAN) Panel met conscientiously to assure that child abuse deaths and near deaths were timely reviewed. The volume of deaths and near deaths to children continues to overwhelm the panel. With 38 new cases in 2021 thus far, the impact on the front lines and on the CAN Panel is significant. These numbers are troubling both in terms of child safety as well as in timely caseload management and retrospective review.

With respect to the 20 cases that were approved by CPAC today, here are the strengths and system breakdowns. Two of the near death cases approved had been previously reviewed and was awaiting the completion of the criminal investigation. Both cases resolved – one as an Assault 2nd with community supervision and one as a

[1] 16 Del. C. § 932.

misdemeanor endangering with probation. No additional findings were made – two strengths were noted.

The eighteen remaining cases were from deaths or near deaths that occurred between September of 2020 and January of 2021. Of these cases, nine will have no further review as there are no criminal charges. Six of the nine remaining cases have pending charges and will be reviewed again once prosecution is completed. The remaining three cases are still being investigated. The children in these cases range in age from two weeks to eleven years of age with four deaths and fourteen near deaths. The children were victims of abusive head trauma, poisoning via drug ingestion, bone and skull fractures, medical neglect and unsafe sleep. These eighteen cases resulted in 34 strengths and 68 current findings across system areas.

For these September 2020 through January of 2021 cases, 16 strengths and 15 findings were noted for the Multidisciplinary Team Response. The Office of the Child Advocate (OCA) has now contracted with a MDT Training and Policy Administrator with significant law enforcement expertise who is working with individual law enforcement jurisdictions on best practices, resources and compliance with the MOU. The Joint Action Plan delineates the further steps this contracted position and CPAC must take to further best practices and MOU compliance by team members. The Office of the Investigation Coordinator (IC) has also instituted MDT meetings within 48-72 hours of every child abuse death, serious injury or drug ingestion. These steps by CPAC have shown a significant positive impact this quarter on the multidisciplinary investigations as only 15 findings were made and more strengths were noted.

The medical response had 8 findings together with 2 strengths. Five of the findings surround reporting of child abuse and neglect. The medical response to child abuse and neglect cases was a significant focus in the retreat and resulting Joint Action Plan. Significant recommendations for improvement have been delineated that focus on more tailored education, coaching and support for various aspects of the medical profession, particularly hospitals and walk in care, as well as pediatric, family medicine and obstetrics/gynecological practices. The Joint Action Plan also focuses on getting specialized medical child abuse expertise downstate. CPAC has created a workgroup chaired by medical professionals to tackle these significant tasks, and will be utilizing funds from mandatory reporting training to accomplish these goals. While this take time and resources to accomplish, CPAC is hopeful with this targeted focus and the

additional resources, it can begin to make a substantive impact on all aspects of Delaware's medical response to child abuse and neglect, as well as continue to empower the medical community to utilize Plans of Safe Care to assure supports for infants with prenatal substance exposure.

The Division of Family Services (DFS) had 16 strengths and 45 findings this quarter. Sixteen of those findings were regarding high caseloads. The rest of the findings continue to focus on timely and appropriate completion of safety agreements, inappropriate safety agreements and parental risk factors. In the Joint Action Plan, CPAC and CDRC, with full partnership by DSCYF, have recommended the following steps to improve worker and supervisory responses: develop and provide initial and ongoing training on the Structured Decision Making Safety and Risk Assessment tools; provide regular coaching and monitoring to DFS staff on child safety agreements; intensify DFS supervisory training and support on child safety agreements; develop an abbreviated DFS training for MDT partners; and utilize quarterly meetings to address findings from these cases with DFS staff. CPAC is hopeful that as these measures are implemented, improvements to these areas will be reflected in these retrospective reviews.

CPAC only brings you the most horrific of Delaware's child abuse cases; however, for every one of these cases, there are countless more cases where DFS case workers are under the same pressures with children at risk of serious harm. Young children with sentinel injuries are often the victims of serious abuse just months later. Prompt identification of these cases, and thorough investigation thereafter could decrease serious harm. For your information we have included the strengths, findings and the details behind all of the cases presented in this letter. CPAC stands ready as a partner as well as to answer any further questions you may have.

Respectfully,

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

cc: CPAC Commissioners
General Assembly

Child Protection Accountability Commission

Child Abuse and Neglect (CAN) Panel

Current Caseload

AUGUST 18, 2021

Total Open CAN Cases	**99**
Initials	*56*
Finals	*43*

INITIALS	**56**
Preparation	**47**
Within Compliance	*47*
Out of Compliance	*0*
Pending Review	**0**
Within Compliance	*0*
Out of Compliance	*0*
Reports	**9**
Initial Report Not Written	*0*
Initial Report Written	*9*

FINALS	**43**
Preparation	**0**
Pending Prosecution	**38**
Pending Review	**3**
Reports	**2**
Final Report Not Written	*0*
Final Report Written	*2*

2015-2020 Child Abuse & Neglect Case Summaries			
Year	**Near Deaths**	**Deaths**	**Total**
2015	21	11	**32**
2016	22	5	**27**
2017	31	13	**44**
2018	34	14	**48**
2019	29	13	**42**
2020	43	9	**52**

2021 Child Abuse & Neglect Case Summaries[1]		
Month	**Near Deaths**	**Deaths**
January	2	0
February	6	1
March	5	0
April	8	0
May	4	0
June	8	1
July	2	1
August	0	0
September	0	0
October	0	0
November	0	0
December	0	0
Total	**35**	**3**
	Total	**38**

[1]This summary only includes cases screened in and accepted by the CAN Panel for review. Cases that are pending a decision will not be in until a screening decision has been made.

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

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

AUGUST 18, 2021

INITIAL REVIEWS

	*Current	Grand Total
MDT Response	**16**	**16**
Communication	2	2
General - Civil Investigation	3	3
General - Criminal/Civil Investigation	9	9
Interviews - Child	1	1
Medical Exam	1	1
Medical	**2**	**2**
Documentation	1	1
Medical Exam/Standard of Care - ED	1	1
Risk Assessment/ Caseloads	**3**	**3**
Collaterals	2	2
Reporting	1	1
Safety/ Use of History/ Supervisory Oversight	**12**	**12**
Completed Correctly/On Time	10	10
Oversight of Agreement	2	2
Unresolved Risk	**1**	**1**
Parental Risk Factors	1	1
Grand Total	**34**	**34**

FINAL REVIEWS

	*Current	Grand Total
Unresolved Risk	**2**	**2**
Legal Guardian	1	1
Parental Risk Factors	1	1
Grand Total	**2**	**2**

TOTAL CAN PANEL STRENGTHS **36**

*Current - within 1 year of incident

**Prior - 1 year or more prior to incident

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Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Detail

AUGUST 18, 2021

INITIAL REVIEWS

System Area	Strength	Rationale	Count of #
MDT Response			16
	Communication		2
		There was good communication between the medical team, DFS, and the law enforcement agency.	1
		There was good communicaiton between the medical team, DFS, and the law enforcement agency.	1
	General - Civil Investigation		3
		During the prior and current investigations, the DFS caseworkers thoroughly assessed the safety of both children despite concerns being for only one child. The assessments included regular visits, school and medical collaterals, and appropriate follow up to ensure the needs were being met.	1
		Despite the complexity of the case due to the child's legal status, lack of health insurance, complicated injuries, language barriers, and residency status, the DFS caseworker did an excellent job of ensuring the child received all necessary services and medical treatment, and ultimately was reunited safely with his paternal family.	1
		During the course of the multiple investigations, there was good collaboration between the investigation and treatment caseworkers, to include joint responses to the home and quality contact with the family.	1
	General - Criminal/Civil Investigation		9
		There was a good MDT response to the near death investigation by the law enforcement agency and DFS, to include joint responses to the children's hospital and the home, joint interviews, and a child safety agreement during hospitalization despite an initial negative urine drug screen for the child.	1
		There was good MDT communication and collaboration between DFS, the law enforcement agency, the medical team, and the DAG, to include joint responses to the hospital, joint interviews, blood draws, medical evaluations and forensic interviews of the children within both households.	1
		There was a good MDT response to the near death investigation by the law enforcement agency and DFS, which appropriately assessed the needs of all children residing in the home, and included joint responses to the hospital, joint interviews with the parents and the relative, a child safety agreement, medical evaluation of the sibling, and forensic interview of the sibling.	1
		There was a good MDT response to the near death investigation by the law enforcement agency and DFS, which included joint responses to the hospital and to the home, joint interviews with Mother and the maternal relatives, a child safety agreement, medical evaluation of the siblings, and forensic interview of the older sibling.	1
		There was a good MDT response to the near death incident, which included a joint response to the hospital, joint interviews, an evidentiary blood draw of the child, medical evaluations for the siblings, and forensic interviews of the children.	1
		There was a good MDT response to the death incident, which included a joint response to the hospital, joint interviews, an evidentiary blood draw of Mother, and medical evaluations and forensic interviews of the sibling and the other children residing in the home.	1
		There was a good MDT response to the death incident, which included a joint response to the hospital, joint interviews, an evidentiary blood draw of Mother, and a medical evaluation and forensic interview of the sibling residing in the home.	1

	There was a good MDT response to the near death incident, which included a joint response to the hospital, joint interviews with the parents, and medical evaluations and forensic interviews of the child and the sibling residing in the home.	1
	There was a good MDT response to the near death incident, which included a joint response to the hospital, joint interviews, forensic interview of the child, and collaboration with outside agencies, as appropriate.	1
Interviews - Child		1
	The DFS caseworker abstained from interviewing the sibling prior to the forensic interview.	1
Medical Exam		1
	The DFS caseworker advocated for the child to be medically evaluated by the children's hospital despite the initial treating hospital determining the child was cleared for medical discharge.	1
Medical		2
Documentation		1
	There was excellent documentation within the local hospital ED medical records relating to the child's presentation and the MDT response to the near death.	1
Medical Exam/ Standard of Care - ED		1
	The initial treating hospital identified and thoroughly documented other non-presenting injuries, which were concerning for child physical abuse.	1
Risk Assessment/ Caseloads		3
Collaterals		2
	Strong collaterals were completed by the DFS caseworker. The contacts included both professional and personal resources.	2
Reporting		1
	A report was made to the Office of Professional Standards, and subsequently to the Office of Child Care Licensing, which resulted in the unlicensed in-home daycare being closed.	1
Safety/ Use of History/ Supervisory Oversight		12
Completed Correctly/On Time		10
	The DFS caseworker immediately implemented a child safety agreement restricting contact with the child while hospitalized. There was consistent review and modification, when necessary, of the safety agreement.	1
	The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. There was consistent review and modification, when necessary, of the safety agreement by the DFS caseworker.	1
	The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. There was consistent review and modification, when necessary, of the safety agreement.	2
	The DFS caseworker was diligent in implementing a child safety agreement for the daycare provider's infant, although neither the provider nor her attorney were agreeable. A medical evaluation was also completed for the infant.	1
	The DFS caseworker immediately implemented a child safety agreement restricting contact with the child while hospitalized. The agreement also included the siblings in the home. There was consistent review and modification, when necessary, of the safety agreement.	1

		The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. The agreement also included the siblings in the home. There was consistent review and modification, when necessary, of the safety agreement.	1
		During the prior investigations, the DFS caseworker thoroughly assessed the safety of both children. The assessments included regular visits, and school and medical collaterals.	1
		The DFS caseworker immediately implemented a child safety agreement for the siblings in the home. There was consistent review and modification, when necessary, of the safety agreement. Medical evaluations were also completed for the siblings expeditiously.	1
		The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. The agreement also included the children residing in the non-relative caregiver's home. There was consistent review and modification, when necessary, of the safety agreement.	1
	Oversight of Agreement		2
		Following Mother's violation of the child safety agreement, a TDM was held, and as a result, a new child safety agreement was implemented for the child and a custody petition was filed for the sibling.	2
Unresolved Risk			1
	Parental Risk Factors		1
		The DFS investigation and treatment caseworkers made timely, appropriate referrals for the family, which included an early intervention program, home visiting services, alcohol or drug (AOD) liaison, Purchase of Care, and the family interventionist.	1
Grand Total			**34**

FINAL REVIEWS

System Area	Strength	Rationale	Count of #
Unresolved Risk			2
	Parental Risk Factors		1
		The parents were offered case plans to be able to reunify with their children after DFS is no longer involved.	1
	Legal Guardian		1
		Despite the relatives filing for guardianship, the case was transferred to treatment for ongoing services.	1
Grand Total			**2**

TOTAL CAN PANEL STRENGTHS **36**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

AUGUST 18, 2021

INITIAL REVIEWS		
Sum of #	**Column Labels**	
	***Current**	**Grand Total**
MDT Response	**15**	**15**
Crime Scene	3	3
General - Civil Investigation	1	1
General - Criminal Investigation	1	1
General - Criminal Investigation / Civil Investigation	1	1
Intake with DOJ	1	1
Interviews - Adult	3	3
Interviews - Child	1	1
Medical Exam	3	3
Reporting	1	1
Medical	**8**	**8**
Medical Exam/ Standard of Care - ED	3	3
Reporting	5	5
Risk Assessment/ Caseloads	**26**	**26**
Caseloads	16	16
Collaterals	6	6
Risk Assessment - Closed Despite Risk Level	1	1
Risk Assessment - Screen Out	3	3
Safety/ Use of History/ Supervisory Oversight	**11**	**11**
Oversight of Agreement	1	1
Safety - Completed Incorrectly/ Late	5	5
Safety - Inappropriate Parent/ Relative Component	3	3
Safety - No Safety Assessment of Non-Victims	1	1
Supervisory Oversight	1	1
Unresolved Risk	**8**	**8**
Child Risk Factors	1	1
Contacts with Family	2	2
Parental Risk Factors	4	4
Substance-Exposed Infant	1	1
Grand Total	**68**	**68**

TOTAL CAN PANEL FINDINGS **68**

*Current - within 1 year of incident

**Prior - 1 year or more prior to incident

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

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Detail

AUGUST 18, 2021

INITIALS REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			15
	Crime Scene		3
		No scene investigation was completed by the law enforcement agency. As a result, the scene was not photographed and no evidence was collected.	1
		No scene investigation was completed by the law enforcement agency at the parents' home. As a result, the scene was not photographed and no evidence was collected.	1
		The scene investigation by the law enforcement agency was delayed.	1
	General - Civil Investigation		1
		For the prior investigation, the DFS caseworker did not initiate a multidisciplinary team response upon receipt of the physical injury report. In addition, the caseworker did not conduct a thorough investigation and made a finding of no evidence to substantiate versus unsubstantiated.	1
	General - Criminal Investigation		1
		The initial responding officer concluded the victim's injuries were not serious in nature, and as a result, it initially impacted the assignment to the Criminal Investigations Unit. However, the DFS caseworker provided photographs and additional information.	1
	General - Criminal Investigation / Civil Investigation		1
		There was not an initial MDT response to the near death incident in compliance with the MOU and statute. Law Enforcement declined to send a detective to the hospital.	1
	Intake with DOJ		1
		The law enforcement agency did not notify the DOJ Special Victims Unit of the near death incident. As a result, the evidentiary blood draws of the victim and the suspect were not completed.	1

	Interviews - Adult	3
	DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	2
	During the home visit, there was no attempt by the DFS caseworker to gather information or interview the unknown male in the babysitter's home.	1
	Interviews - Child	1
	During the prior investigation, the children reported having an older sister, but there was no attempt by the caseworker to identify this child or interview her.	1
	Medical Exam	3
	During the prior investigation, the sibling was medically examined for vaginal bleeding and bruising and a CT scan was recommended. However, there was no follow up by the caseworker to ensure the imaging occurred.	1
	The two half-siblings who were present in the home during the near death incident were not medically evaluated.	1
	The sibling, who resided part-time in the residence, was not medially evaluated.	1
	Reporting	1
	The law enforcement agency delayed making a report to the DFS Report Line for a prior domestic violence incident.	1
Medical		8
	Medical Exam/ Standard of Care - ED	3
	The children's hospital does not test for Fentanyl in its urine drug screen. As a result, the initial urine drug screen came back as negative, and this impacted the investigation.	1
	For the near death investigation, the emergency department physician opined that the child's fracture was more likely due to an accidental injury, and the physician had no concerns about the infant's safety.	1

	For the near death investigation, the emergency department physician had no plans to transfer the infant to the children's hospital for further assessment and evaluation despite bilateral subconjunctival hemorrhages, petechia and bruising. Rib fractures were later identified on the follow up skeletal survey.	1
Reporting		5
	There was no report to the DFS Report Line by the PCP after mother called the office reporting bruising to a 10-week-old infant and the mechanism of injury is unknown.	1
	There was no report to the DFS Report Line by the hospital emergency department for the near death incident, and the child was released prior to the x-rays being read.	1
	Prior to the near death incident, concern for bruising was noted by the PCP and bloodwork was ordered. However, there was no report to the DFS Report Line once the bloodwork came back normal.	1
	The hospital emergency department failed to make a report to the DFS Report Line for a prior injury that is highly suspicious for abuse to a child under age 4, despite lack of an adequate explanation from parents for the injury.	1
	The attending hospital nurses did not make a report to the DFS Report Line for the near death incident which occurred in the hospital. The treating hospital physician did not feel that DFS should be conducting an investigation and would not share information relevant to the case with the DFS caseworker.	1
Risk Assessment/ Caseloads		26
Caseloads		16
	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	5

	The caseworkers were over the investigation caseload statutory standards during the current and prior investigations. However, it does not appear that the caseload negatively impacted the DFS response to the cases.	1
	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	6
	The DFS caseworker was over the investigation caseload statutory standards during the prior investigation. However, it does not appear that the caseload negatively impacted the DFS response to the case.	1
	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open, and the caseload appears to have had a negative impact on the DFS response to the case.	1
	The caseworkers were over the investigation caseload statutory standards during the current and prior investigations. The caseload appears to have had a negative impact on the response in one of the prior investigations. However, it does not appear that the caseload negatively impacted the DFS response in a subsequent investigation or in the near death investigation.	1
	The DFS caseworkers were over the investigation caseload statutory standards during the prior, current, and subsequent investigations. The caseload appears to have had a negative impact on the response in the prior investigation. However, it does not appear that the caseload negatively impacted the DFS response in the near death investigation or in the subsequent investigation.	1
Collaterals		6
	During the near death incident, a collateral contact was not completed with non-professional sources close to the family.	1

	During the prior investigation, a collateral contact was not completed with the specialist who mother claimed had examined the child.	1
	During the prior investigation, the DFS caseworker did not request the child's medical records and medical neglect was suspected.	1
	During the prior investigation, a collateral contact was not completed with non-professional sources close to the family.	1
	DFS investigated multiple reports alleging medical neglect but there was not an attempt to communicate with all the medical providers and specialists for the medically complex child or to obtain an assessment by the child abuse medical experts to allow for an earlier intervention.	1
	During a prior investigation, a collateral contact was not completed with a relative caregiver, with whom the child had previously resided.	1
Risk Assessment - Closed Despite Risk Level		1
	The SDM Risk Assessment identified the risk as high in the prior investigation. Ongoing service was recommended; however, the case disposition was overridden to close the investigation after a Framework was completed. This was a medically complex child with a history of medical neglect allegations and appointments were not being kept and feeding issues were unresolved.	1
Risk Assessment - Screen Out		3
	The call by hospital emergency department to the DFS Report Line was written as a hotline progress note rather than a new report.	1
	The call by the Division of Forensic Science to the DFS Report Line was written as a hotline progress note rather than a new report.	1

The call to the DFS Report Line by the law enforcement agency was documented by DFS as a progress note rather than as a new hotline report.	1
Safety/ Use of History/ Supervisory Oversight	**11**
Oversight of Agreement	1
During the treatment case, there was no documentation to suggest the older sibling's safety or the living arrangements had been reassessed since closure of the previous investigation.	1
Safety - Completed Incorrectly/ Late	5
During the near death investigation, no safety agreement was initially completed for the hospitalized victim. Parents should have been permitted no unsupervised contact while at the hospital.	1
The DFS caseworker delayed implementing a safety agreement for the sibling, despite the sibling having been in the care of a relative for several days.	1
During the near death investigation, there was no attempt by the DFS caseworker to contact the sibling's father regarding the safety planning for the child.	1
The DFS caseworker did not consult with law enforcement to determine if the child's relatives had been cleared as suspects prior to implementing a safety agreement which allowed the child to be discharged from the hospital to the relatives' care.	1
During a prior investigation involving the neglect of an older sibling, the initial safety assessment by the DFS caseworker did not accurately reflect family history related to the siblings. The siblings were born substance-exposed and the mother did not express interest in parenting them, which should have prompted implementation of a DFS safety agreement or custody being sought for the older sibling.	1
Safety - Inappropriate Parent/ Relative Component	3

	During the near death investigation, DFS implemented safety agreements allowing relative caregivers to supervise contact between the children and parents. However, contact should have been restricted with all parties until they were ruled out as suspects.	1
	During the death investigation, DFS implemented a safety agreement with a relative caregiver for the surviving sibling, which permitted supervised contact with mother. However, mother should not have been permitted contact since she violated the prior agreement and the sibling was fearful of her, and the caregiver was inappropriate for enabling mother's conduct and not following the prior safety agreement.	1
	For the near death incident, the DFS caseworker amended the safety agreement to include a participant, who resided in the home and was not ruled out as a suspect.	1
	Safety - No Safety Assessment of Non-Victims	1
	During the near death investigation, it was noted that the mother had weekend visits with her other child, and safety was not assessed for this child.	1
	Supervisory Oversight	1
	Prior to the near death incident, a DFS safety agreement was not implemented nor was custody sought for the child despite multiple risk factors, which included the substance-exposed birth, mother's substance abuse impacting her ability to care for the child, mother's lack of bonding with the child, and the prior involuntary termination of mother's parental rights over siblings.	1
Unresolved Risk		8
	Child Risk Factors	1
	During a prior investigation, the DFS caseworker permitted a teen child to continue to reside in the home, which had no running water.	1

Contacts with Family		2
	Upon receiving a report of neglect for the sibling, which was linked to the death investigation, the DFS caseworker delayed response for six weeks.	1
	The DFS caseworker did not complete the standard 30-day contacts with the sibling for a five-month period.	1
Parental Risk Factors		4
	During the prior investigation, DFS received allegations that the parents maintain a secret stash in the home that the children are not permitted to touch, but this was not addressed by the caseworker.	1
	A referral was not made to the DFS domestic violence liaison, and the family had multiple documented incidents of interpersonal violence.	1
	A referral was not made to the DFS domestic violence liaison, and the hotline report and prior investigations noted concerns of intimate partner violence.	1
	DFS did not evaluate substance abuse issues for the parents by requesting that they complete substance abuse evaluations. Concerns of substance abuse were noted in the hotline report and during prior investigations.	1
Substance-Exposed Infant		1
	After birth and prior to the near death incident, a Plan of Safe Care was not implemented for the child who was born substance-exposed.	1
Grand Total		**68**

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

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

November 17, 2021

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 17 cases at its November 17, 2021 meeting.[1]

Thus far in 2021, there have been 11 deaths and 56 near deaths due to child abuse or neglect. In August alone, there were 9 near deaths and 4 deaths with an additional 12 near deaths and 2 deaths in September and October. With 67 new cases in 2021 thus far, the impact on the front lines and on the Child Abuse and Neglect (CAN) Panel is significant. These numbers are troubling both in terms of child safety as well as in timely caseload management and retrospective review.

With respect to the 17 cases that were approved by CPAC today, here are the strengths and system breakdowns. Three of the cases approved had been previously reviewed and were awaiting the completion of the criminal case. The death resulted in a plea to Murder by Abuse or Neglect as well as other charges with a life sentence plus 12 years. The two near death cases resulted in a plea to Assault 2nd and probation and Misdemeanor Endangering the Welfare. One additional finding was made.

[1] 16 Del. C. § 932.

The fourteen remaining cases were from deaths or near deaths that occurred between September of 2020 and April of 2021. Of these cases, five will have no further review as there are no criminal charges – four are drug ingestions. One of the nine remaining cases have pending charges and will be reviewed again once prosecution is completed. The remaining eight cases are still being investigated. The children in these fourteen cases range in age from six weeks to six years of age with one death and thirteen near deaths. The children were victims of abusive head trauma, poisoning via drug ingestion, bone and skull fractures, abdominal trauma and unsafe sleep. These fourteen cases resulted in 22 strengths and 46 current findings across system areas.

For these cases which primarily occurred in February and March of 2021, 11 strengths and 10 findings were noted for the Multidisciplinary Team Response. The Office of the Child Advocate (OCA) has contracted with a MDT Training and Policy Administrator with significant law enforcement expertise who is working with individual law enforcement jurisdictions on best practices, resources and compliance with the MOU. The Joint Action Plan delineates the further steps this contracted position and CPAC must take to further best practices and MOU compliance by team members. The Office of the Investigation Coordinator (IC) has also instituted MDT meetings within 48-72 hours of every child abuse death, serious injury or drug ingestion. CPAC is hopeful that these steps will positively impact multidisciplinary investigations.

The medical response had 6 findings together with 5 strengths. Three of the findings surround reporting of child abuse and neglect. CPAC has established a workgroup to tackle the significant recommendations for improvement outlined in the CPAC/CDRC Joint Action Plan such as more tailored education, coaching and support for various aspects of the medical profession, particularly hospitals and walk in care, as well as pediatric, family medicine and obstetrics/gynecological practices. The Joint Action Plan also focuses on getting specialized child abuse medical expertise downstate. While this will take time and resources to accomplish, CPAC is hopeful with this targeted focus and the additional resources, it can begin to make a substantive impact on all aspects of Delaware's medical response to child abuse and neglect, as well as continue to empower the medical community to utilize Plans of Safe Care to assure supports for infants with prenatal substance exposure.

The Division of Family Services (DFS) had 6 strengths and 30 findings this quarter. Thirteen of those findings were regarding high caseloads. The rest of the findings

continue to focus on timely and appropriate completion of safety agreements, inappropriate safety agreements and parental risk factors. In the Joint Action Plan, CPAC and CDRC, with full partnership by DSCYF, have recommended the following steps to improve worker and supervisory responses: develop and provide initial and ongoing training on the Structured Decision Making Safety and Risk Assessment tools; provide regular coaching and monitoring to DFS staff on child safety agreements; intensify DFS supervisory training and support on child safety agreements; develop an abbreviated DFS training for MDT partners; and utilize quarterly meetings to address findings from these cases with DFS staff. CPAC is hopeful that as these measures are implemented, improvements to these areas will be reflected in these retrospective reviews.

CPAC only brings you the most horrific of Delaware's child abuse cases; however, for every one of these cases, there are countless more cases where DFS case workers are under the same pressures with children at risk of serious harm. Young children with sentinel injuries are often the victims of serious abuse just months later. Prompt identification of these cases, and thorough investigation thereafter could decrease serious harm. For your information we have included the strengths, findings and the details behind all of the cases presented in this letter. CPAC stands ready as a partner as well as to answer any further questions you may have.

Respectfully,

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

Enclosures

cc: CPAC Commissioners
General Assembly

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

NOVEMBER 17, 2021

INITIAL REVIEWS

	*Current	Grand Total
MDT Response	**12**	**12**
Communication	3	3
General - Criminal Investigation	1	1
General - Criminal/Civil Investigation	6	6
Medical Exam	2	2
Medical	**6**	**6**
Communication / Documentation	1	1
Medical Exam/Standard of Care - CARE Team	1	1
Medical Exam/Standard of Care - ED	3	3
Reporting	1	1
Safety/ Use of History/ Supervisory Oversig	**6**	**6**
Completed Correctly/On Time	6	6
Grand Total	**24**	**24**

FINAL REVIEWS

	*Current	Grand Total
Medical	**1**	**1**
Medical Exam/Standard of Care - CARE Team	1	1
Grand Total	**1**	**1**

TOTAL CAN PANEL STRENGTHS **25**

*Current - within 1 year of incident

**Prior - 1 year or more prior to incident

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

Child Protection Accountability Commission
Child Abuse and Neglect Panel
Strengths Detail
NOVEMBER 17, 2021

INITIAL REVIEWS

System Area	Strength	Rationale	Count of #
MDT Response			12
	Communication		3
		There was good communication between the medical team, DFS, and the law enforcement agency.	1
		There was excellent communication and collaboration between the child abuse medical expert, the law enforcement detective, the DOJ, the civil DAG, and the Child Attorney.	1
		There was excellent communication and collaboration between the child abuse medical expert, the civil DAG, the Child Attorney, and the DFS caseworkers.	1
	General - Criminal Investigation		1
		The law enforcement detective assigned to the case conducted a thorough investigation and maintained excellent communication with the DFS caseworker.	1
	General - Criminal/Civil Investigation		6
		There was a strong MDT response to the near death investigation, which included a joint response to the hospital, joint interviews with the parents and relative guardian, and great collaboration with DFS and DOJ.	1
		There was a good MDT response to the near death incident, which included a joint response to the hospital, joint interviews with the parents, and medical evaluation and forensic interview of the sibling residing in the home.	1
		There was a good MDT response to the near death investigation, which included a joint response to the hospital, a joint response to the home, joint interviews with the appropriate caregivers, medical evaluations of the siblings, which included urine drug screens, and forensic interviews of the siblings.	1
		There was a good MDT response to the near death investigation, which included responses to the hospital and the scene, interviews with all involved parties, and a forensic interview of the child.	1
		There was a good MDT response to the near death investigation, which included a joint response to the hospital, a joint response to the home, joint interviews with the appropriate caregivers, forensic interviews of the children in the home and of the paramour's nonresidential child, and coordination with the alternate biological parent of the children.	1
		Following assignment of a detective, there was a good MDT response to the near death incident, which included a joint response to the hospital and joint interviews with the family.	1
	Medical Exam		2
		The DFS caseworker advocated for the child and the sibling to be medically evaluated by the children's hospital, to include a CARE Team consultation and blood draws of both children.	1
		The MDT members made a referral to the CARE team for the drug ingestion case.	1
Medical			6
	Communication / Documentation		1
		There was good communication with the out-of-state child protective services (CPS) agency and hospital resources regarding Mother's previous incidents, which was also well documented within the medical records.	1

	Medical Exam/ Standard of Care - ED		3
		The initial treating hospital emergency department provided a comprehensive medical response to the child prior to transfer to the children's hospital.	1
		A forensic nurse served as the triage nurse in the emergency department (ED), which allowed the child abuse pathway process to begin immediately. The child received a Child At Risk Evaluation (CARE) assessment in the ED and progression photos of the child's injuries were completed.	1
		Forensic nurses were available in the resuscitation room at the time of the child's transport to the children's hospital, as such, a forensic evidence collection kit and photo documentation were obtained prior to the child being moved to the operating room.	1
	Medical Exam/Standard of Care - CARE Team		1
		The child abuse medical expert requested an MDT meeting where child physical abuse was suspected for a medically complex child, and it resulted in the establishment of MDT meetings as a regular practice.	1
	Reporting		1
		The emergency medical services made an immediate report to the DFS Report Line due to the child's suspected drug ingestion.	1
Safety/ Use of History/ Supervisory Oversight			6
	Completed Correctly/On Time		6
		The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. There was consistent review and modification, when necessary, of the safety agreement.	3
		The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. The agreement also included the sibling residing in the home. There was consistent review and modification, when necessary, of the safety agreement.	1
		The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. The agreement also included the siblings residing in the home. There was consistent review and modification, when necessary, of the safety agreement.	2
Grand Total			**24**

FINAL REVIEWS

System Area	Strength	Rationale	Count of #
Medical			1
	Medical Exam/Standard of Care - CARE Team		1
		The child abuse medical expert participated in the review of hours of video footage, together with the Department of Justice, and it led to a good prosecutorial outcome in the case.	1
Grand Total			**1**

TOTAL CAN PANEL STRENGTHS **25**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

NOVEMBER 17, 2021

INITIAL REVIEWS

	*Current	Grand Total
MDT Response	**10**	**10**
Doll Re-enactment	1	1
General - Criminal Investigation	2	2
Interviews - Adult	2	2
Interviews - Child	2	2
Medical Exam	2	2
Reporting	1	1
Medical	**6**	**6**
Medical Exam/ Standard of Care - ED	2	2
Medical Exam/ Standard of Care - Radiology	1	1
Reporting	3	3
Risk Assessment/ Caseloads	**18**	**18**
Caseloads	13	13
Collaterals	4	4
Risk Assessment - Abridged	1	1
Safety/ Use of History/ Supervisory Oversight	**9**	**9**
Safety - Completed Incorrectly/ Late	6	6
Safety - Inappropriate Parent/ Relative Component	1	1
Safety - Violations of Safety Agreements	2	2
Unresolved Risk	**2**	**2**
Parental Risk Factors	2	2
Grand Total	**45**	**45**

FINAL REVIEWS

	*Current	Grand Total
MDT Response	**1**	**1**
Reporting	1	1
Grand Total	**1**	**1**

TOTAL CAN PANEL FINDINGS **46**

*Current - within 1 year of incident

**Prior - 1 year or more prior to incident

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

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Detail

NOVEMBER 17, 2021

INITIALS REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			10
	Doll Re-enactment		1
		No doll re-enactment was completed by the law enforcement agency.	1
	General - Criminal Investigation		2
		The LE agency did not initiate an MDT response to this incident resulting in the following investigative standards not being met: examination of the crime scene, response to the treating hospital(s), evidentiary blood draws completed on child or caregiver, notification to DOJ, interview with the caregiver, and forensic interview with the sibling.	1
		The LE agency delayed responding to the near death incident for several days, resulting in an MDT response not being conducted.	1
	Interviews - Adult		2
		DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	1
		During the near death investigation, DFS conducted interviews with the parents without the law enforcement agency present.	1
	Interviews - Child		2
		The sibling was not interviewed at the CAC.	1
		Forensic interviews were not considered for the other children in the home despite the infant's serious physical injury and the concerns with the mother's involvement in trafficking.	1
	Medical Exam		2
		In the prior investigation, there was no follow up with the CARE Team to discuss the interpretation of medical findings for the fractured forearm.	1
		During the initial response, the DFS caseworker observed the young sibling at the home, but there was no discussion about the need for a medical evaluation at that time.	1
	Reporting		1
		The law enforcement agency did not make a report to the DFS Report Line for the near death incident.	1
Medical			6
	Medical Exam/ Standard of Care - ED		2
		During the prior ED visit, the admitting medical team did not follow the CARE Team's recommendation to complete a skeletal survey of the child due to concern for abuse, resulting in multiple prior injuries being missed.	1
		The child was not referred to the CARE Team for an assessment.	1

	Medical Exam/ Standard of Care - Radiology		1
		During the prior ED visit, the CT scan was incorrectly read, resulting in a subdural hemorrhage not being identified.	1
	Reporting		3
		The medical professional completing the initial report to DFS utilized the online reporting portal, bypassing the prompt directing the professional to report the incident by placing a call to the Report Line, and thereby delaying the DFS response.	1
		The treating hospital delayed reporting the near death incident to DFS Report Line for 24 hours, thereby delaying the DFS response.	1
		Prior to the near death incident, concern for chronic, unexplained bruising was noted by the PCP and bloodwork was ordered. However, there was no report to the DFS Report Line and the PCP documented no suspicion for abuse.	1
Risk Assessment/ Caseloads			18
	Caseloads		13
		The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	9
		The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open, and the caseload appears to have had a negative impact on the DFS response to the case.	2
		The DFS caseworkers were over the investigation and treatment caseload statutory standards the entire time the cases were open. However, it does not appear that the caseloads negatively impacted the DFS response to the cases.	2
	Collaterals		4
		A history check with the out of state CPS agency, where two half-siblings resided in relative care, was not completed by the DFS caseworker.	1
		Collateral contacts with the child's multiple medical providers and non-professional sources close to the family were not completed by the DFS caseworker.	1
		The DFS caseworker did not complete a collateral contact with the probation officer to ensure Mother's paramour was compliant with drug treatment standards.	1
		Collateral contacts with the child's new day care and the caregiver's counselor were not completed by the DFS caseworker, despite FAIR recommendations that same be done.	1
	Risk Assessment - Abridged		1
		The prior investigation was abridged by DFS despite the infant's serious physical injury and absent a reasonable explanation provided by the parents.	1

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Detail

NOVEMBER 17, 2021

Safety/ Use of History/ Supervisory Oversight		9
	Safety - Completed Incorrectly/ Late	6
	The SDM Risk Assessment was completed incorrectly as the risk was scored based upon assessment of the relative caregiver's household rather than the parents' household, and as a result, the safety agreement was terminated without safety being reassessed.	1
	For the near death investigation, DFS entered into a safety agreement with a non-relative, despite a home assessment not being completed for that person.	1
	For the near death investigation, DFS entered into a safety agreement with a non-relative, despite a background check not being completed on that person.	1
	The DFS caseworker delayed implementing a safety agreement for the child during the current investigation.	1
	The DFS caseworker incorrectly completed the safety assessment and delayed implementing a child safety agreement for the prior investigation.	1
	During the near death investigation, no safety agreement was initially completed for the two absent siblings; however, the caseworker arranged for the children to remain in the care of their father.	1
	Safety - Inappropriate Parent/ Relative Component	1
	During the near death incident, the DFS caseworker implemented a safety agreement with an 18-year-old relative to supervise the parents' contact with the children. However, the relative should have been ruled out due to his age.	1
	Safety - Violations of Safety Agreements	2
	During the near death investigation, the safety agreement was violated by mother. She continued to have contact with the twins while they were hospitalized, and it was not addressed by the DFS caseworker.	1
	During the near death investigation, the safety agreement was violated by the relative, and it was not addressed by the DFS caseworker. It appears, from the documentation, that the young sibling was left in the care of the suspect while the mother and relative drove to the hospital.	1
Unresolved Risk		2
	Parental Risk Factors	2
	Despite DFS providing the appropriate consents and completing multiple requests for the parents' treatment records, the medication assisted treatment provider failed to provide the requested documentation to DFS.	1
	A collateral with Mother's medication assisted treatment (MAT) provider revealed that Mother continued to test positive for marijuana, and this was not addressed by the DFS caseworker.	1
Grand Total		**45**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Detail

NOVEMBER 17, 2021

FINAL REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			1
	Reporting		1
		The MDT did not make a report to the DFS Report Line for the other victims identified during the criminal investigation.	1
Grand Total			**1**

TOTAL FINDINGS **46**

STATE OF DELAWARE
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MARY F. DUGAN, ESQUIRE
CHAIR

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

February 16, 2022

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

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

Dear Governor Carney:

As one of its many statutory duties, the Child Protection Accountability Commission ("CPAC") is responsible for the review of child deaths and near deaths due to abuse or neglect. As required by law, CPAC approved findings from 20 cases at its February 16, 2022 meeting.[1]

In 2021, there were 14 deaths and 61 near deaths due to child abuse or neglect. These numbers represent a 44% increase from 2020 and an 79% increase over 2019. The impact on the Child Abuse and Neglect (CAN) Panel, the Office of the Investigation Coordinator, law enforcement, the Division of Family Services and the medical community is significant. These numbers are troubling both in terms of child safety as well as in timely caseload management and retrospective review.

With respect to the 20 cases that were approved by CPAC today, here are the strengths and system breakdowns. Three of the cases approved had been previously reviewed and were awaiting the completion of the criminal case or a charging decision. The death resulted in a not guilty to Murder by Abuse or Neglect and the two near death cases were not prosecuted. There were two findings made at these final reviews regarding reporting by medical providers and communications between the multidisciplinary team.

[1] 16 Del. C. § 932.

The seventeen remaining cases were from deaths or near deaths that occurred between April of 2021 and June of 2021. Of these cases, nine will have no further review as there are no criminal charges – six are poisoning via drug ingestions. Of the remaining eight cases, five have pending charges and the other three are still under criminal investigation. Three of these cases are also poisoning via drug ingestions. The children in these seventeen cases were all near deaths and range from two weeks to five years of age. They were victims of abusive head trauma, poisoning via drug ingestion, bone and skull fractures, burns and scalding, gunshot wounds, near drowning and unsafe sleep. These seventeen cases resulted in 23 strengths and 66 current findings across system areas.

For these cases which all occurred between April and June of 2021, 12 strengths and 28 findings were noted for the Multidisciplinary Team Response. Findings were noted in the gathering of evidence at the crime scene, particularly in poisoning via drug ingestion cases, and in the interviewing, or lack thereof, of children and adults. The Office of the Child Advocate (OCA) has contracted with a MDT Training and Policy Administrator with significant law enforcement expertise who will continue to support and coach individual law enforcement jurisdictions on best practices, resources and compliance with the MOU. The Office of the Investigation Coordinator (IC) has also instituted MDT meetings within 48-72 hours of every child abuse death, serious injury or poisoning via drug ingestion. CPAC has also produced a webinar series of basic and advanced child abuse trainings to begin in April of 2022. CPAC has also supported OCA in its multi-year request to add additional positions to the Office of the Investigation Coordinator to begin to address the unmanageable caseloads.

The medical response had 14 findings together with 4 strengths. Half of these findings surround the failure to report or delayed reporting of child abuse and neglect by medical providers. CPAC has established a workgroup to tackle the significant recommendations for improvement outlined in the CPAC/CDRC Joint Action Plan such as more tailored education, coaching and support for various aspects of the medical profession, particularly hospitals and walk in care, as well as pediatric, family medicine and obstetrics/gynecological practices. The Joint Action Plan also focuses on getting specialized child abuse medical expertise downstate. While this will take time and resources to accomplish, CPAC is hopeful with this targeted focus and the additional resources, it can begin to make a substantive impact on all aspects of Delaware's medical response to child abuse and neglect, as well as continue to

empower the medical community to utilize Plans of Safe Care to assure supports for infants with prenatal substance exposure.

The Division of Family Services (DFS) had 7 strengths and 23 findings this quarter. Ten of those findings were regarding high caseloads. The rest of the findings continue to focus on risk assessment and the proper use and enforcement of safety agreements. In the Joint Action Plan, CPAC and CDRC, with full partnership by DSCYF, have recommended the following steps to improve worker and supervisory responses: develop and provide initial and ongoing training on the Structured Decision Making Safety and Risk Assessment tools; provide regular coaching and monitoring to DFS staff on child safety agreements; intensify DFS supervisory training and support on child safety agreements; develop an abbreviated DFS training for MDT partners; and utilize quarterly meetings to address findings from these cases with DFS staff. CPAC is hopeful that as these measures are implemented, improvements to these areas will be reflected in these retrospective reviews. CPAC has also championed Senate Bill 197, introduced by Senator Gay, to reduce DFS treatment caseloads.

In conclusion, CPAC asks that the General Assembly support its multi-year requests to fund additional positions in the Office of the Investigation Coordinator, and to support Senate Bill 197, reducing treatment caseloads for the Division of Family Services. In the future, CPAC may be requesting legislative action regarding the mandatory reporting training for the medical community. For your information we have included the strengths, findings and the details behind all of the cases presented in this letter. CPAC stands ready as a partner as well as to answer any further questions you may have.

Respectfully,

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

Enclosures

cc: CPAC Commissioners, General Assembly

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

FEBRUARY 16, 2022

INITIAL REVIEWS

	*Current	Grand Total
MDT Response	**12**	**12**
Communication	1	1
General - Civil Investigation	1	1
General - Criminal Investigation	4	4
General - Criminal/Civil Investigation	6	6
Medical	**4**	**4**
Medical Exam	1	1
Medical Exam/Standard of Care - Films	1	1
Medical Exam/Standard of Care - Forensics	1	1
Reporting	1	1
Risk Assessment/ Caseloads	**3**	**3**
Collaterals	3	3
Safety/ Use of History/ Supervisory Oversight	**4**	**4**
Completed Correctly/On Time	4	4
Grand Total	**23**	**23**

TOTAL CAN PANEL STRENGTHS **23**

*Current - within 1 year of incident

**Prior - 1 year or more prior to incident

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Detail

FEBRUARY 16, 2022

INITIAL REVIEWS

System Area	Strength	Rationale	Count of #
MDT Response			12
	Communication		1
		There was good communication and collaboration between DFS and the law enforcement agency.	1
	General - Civil Investigation		1
		The DFS caseworker advocated for forensic interviews to be conducted for the other children residing in the home.	1
	General - Criminal Investigation		4
		The law enforcement detective conducted an excellent investigation, to include evidentiary blood draws of all household members and fingerprinting of drug evidence collected from the residence, which resulted in both parents being criminally charged.	1
		The law enforcement detective assigned to the case conducted an excellent investigation, ensuring all MOU recommendations were completed and thoroughly documented within the report, and maintained excellent communication with the DFS caseworker.	1
		The law enforcement agency conducted evidentiary blood draws of all adults residing in the home at the time of the near death incident.	1
		Despite the near death incident appearing to be accidental, the law enforcement agency conducted a thorough investigation, to include interviews with the parents, a scene investigation, collection of evidence, and forensic examination of Mother's laptop.	1
	General - Criminal/Civil Investigation		6
		There was a good MDT response to the near death investigation, which included a joint response to the home, joint interviews with all involved parties, and medical evaluation and forensic interview of the sibling.	1
		There was a good MDT response to the near death investigation, which included a joint response to the hospital, a joint response to the home, joint interviews with the appropriate caregivers, an immediate medical evaluation of the sibling residing in the home, forensic interviews of the sibling and the half-sibling, and coordination between the two local law enforcement agencies to ensure MOU recommendations were completed.	1

		There was an excellent MDT response to the near death investigation, which included a joint response to the home, joint interviews with the appropriate caregivers, all appropriate investigative steps, and consistent communication and collaboration with the medical team.	1
		There was a good MDT response to the near death investigation, which included a joint response to the hospital, a joint response to the home, joint interviews with the parents, medical evaluations of the siblings, and coordinated investigations of the child's physical abuse and the sibling's medical neglect.	1
		There was good communication and collaboration between the medical team, DFS, the law enforcement agency, and the DOJ.	1
		Following receipt of the expanded drug screen results, there was a joint response to the NRC's home by law enforcement and the DFS caseworker, and joint interviews were conducted with all involved parties.	1
Medical			4
	Medical Exam		1
		The pediatric intensive care unit social worker identified the need for CARE Team involvement, which had not yet been considered.	1
	Medical Exam/ Standard of Care - Forensics		1
		The forensic nurse coordinator at the initial treating hospital identified the lack of appropriate non-accidental trauma workup following the child's medical discharge and contacted the family to return to the emergency department for completion.	1
	Medical Exam/Standard of Care - Films		1
		For the near death incident, the x-ray technician recognized the necessity for the child abuse pathway to be completed given the child's age and injuries.	1
	Reporting		1
		The children's hospital made an immediate report to the DFS Report Line with concerns surrounding the circumstances of the child's injuries.	1
Risk Assessment/ Caseloads			3
	Collaterals		3
		The DFS caseworker maintained regular, quality contact with the family, which included the half-sibling and her biological mother.	1
		The DFS caseworker maintained regular, quality contact with the family. The contact included both in person and virtual visits.	1
		In the prior investigation, comprehensive medical collaterals were completed for the children and Mother.	1

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Detail

FEBRUARY 16, 2022

Safety/ Use of History/ Supervisory Oversight		4
	Completed Correctly/On Time	4
		The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. There was consistent review and modification, when necessary, of the safety agreement. 2
		The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized and for the sibling residing in the home. There was consistent review and modification, when necessary, of the safety agreement. 1
		The DFS caseworker immediately implemented a child safety agreement while the children were hospitalized. There was consistent review and modification, when necessary, of the safety agreement. 1
Grand Total		**23**

TOTAL CAN PANEL STRENGTHS **23**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

FEBRUARY 16, 2022

INITIAL REVIEWS

	*Current	Grand Total
Legal	**1**	**1**
DFS Contact with DOJ	1	1
MDT Response	**28**	**28**
Communication	1	1
Crime Scene	6	6
General - Civil Investigation	1	1
General - Criminal Investigation	2	2
General - Criminal Investigation / Civil Investigation	4	4
Interviews - Adult	4	4
Interviews - Child	5	5
Medical Exam	3	3
Reporting	2	2
Medical	**14**	**14**
Medical Exam/ Standard of Care - ED	4	4
Medical Exam/ Standard of Care - PCP	1	1
Medical Exam/ Standard of Care - Radiology	1	1
Medical Exam/ Standard of Care - Urgent Care	1	1
Reporting	7	7
Risk Assessment/ Caseloads	**16**	**16**
Caseloads	10	10
Collaterals	2	2
Risk Assessment - Closed Despite Risk Level	2	2
Risk Assessment - Screen Out	1	1
Screen Out	1	1
Safety/ Use of History/ Supervisory Oversight	**6**	**6**
Safety - Completed Incorrectly/ Late	1	1
Safety - Inappropriate Parent/ Relative Component	1	1
Safety - No Safety Assessment of Non-Victims	1	1
Safety - Violations of Safety Agreements	2	2
Use of History	1	1
Unresolved Risk	**1**	**1**
Contacts with Family	1	1
Grand Total	**66**	**66**

FINAL REVIEWS

	*Current	Grand Total
MDT Response	**1**	**1**
Communication	1	1
Medical	**1**	**1**
Reporting	1	1
Grand Total	**2**	**2**
TOTAL CAN PANEL FINDINGS		**68**

*Current - within 1 year of incident

**Prior - 1 year or more prior to incident

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

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Detail

FEBRUARY 16, 2022

INITIALS REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
Legal			1
	DFS Contact with DOJ		1
		DFS did not consider immediately filing for custody of the young victim. In the incident preceding the near death, the infant was born drug exposed, a relative caregiver could not be identified and the parents were not compliant with the recommendations by the caseworker.	1
MDT Response			28
	Communication		1
		The law enforcement agency did not notify the DFS caseworker of the charges against the father. Mother disclosed the information to the caseworker.	1
	Crime Scene		6
		No scene investigation was completed by the law enforcement agency. As a result, the scene was not photographed and no evidence was collected.	1
		The law enforcement agency did not complete an evidentiary blood draw on the child after the child ingested a controlled substance.	3
		The law enforcement agency did not complete an evidentiary blood draw on the father during the near death incident. Father disclosed that he had been drinking.	1
		The water temperature was not measured during the scene investigation by the law enforcement agency.	1
	General - Civil Investigation		1
		For the near death investigation, the caseworker terminated the safety agreement and closed the case prior to obtaining the blood draw results from the law enforcement agency.	1
	General - Criminal Investigation		2
		There was no documentation in the police report by the lead detective.	1
		The law enforcement agency did not consider contacting an expert to opine on the drug metabolite levels found in the child's urine.	1
	General - Criminal Investigation / Civil Investigation		4
		There was not an initial MDT response to the near death incident in compliance with the MOU and statute. Law Enforcement responded to the initial 911 call and contacted DFS after the response.	3
		DFS and law enforcement focused solely on the mother rather than father as a suspect.	1
	Interviews - Adult		4
		DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	3
		For the near death investigation, there is no documentation that the law enforcement agency interviewed the father.	1
	Interviews - Child		5
		Forensic interviews did not occur with the other children residing in the home where the incident occurred. In addition, the DFS caseworker did not independently interview these children.	1
		During the prior investigation, the other children residing in the home were not interviewed by the caseworker.	1
		Forensic interviews were not considered for the other children residing in the home where the incident occurred.	1
		Forensic interview was not scheduled until approximately six months later for the sibling who resided in the home during the near death incident.	1
		Forensic interviews did not occur with the other children residing in the home where the incident occurred.	1
	Medical Exam		3
		All of the children who resided in the home during the near death incident were not medically evaluated.	1
		The young sibling who was present in the home during the near death incident was not medically evaluated until almost a month later.	1
		The half-sibling who was present in the home during the near death incident was not medically evaluated.	1

	Reporting	2
	In the near death investigation, the DFS caseworker delayed reporting to the law enforcement agency.	1
	In the near death investigation, the DFS caseworker delayed reporting to the law enforcement agency. As a result, there was not an initial MDT response, scene investigation or evidentiary blood draw.	1
Medical		14
	Medical Exam/ Standard of Care - ED	4
	The child was discharged without a full CARE team assessment and evaluation.	1
	During the near death investigation, the emergency department initially conducted an incomplete workup for the infant with unexplained bruising and discharged the child home. Multiple bone fractures were later identified.	1
	The child was discharged without a full CARE team assessment and evaluation when the child tested positive for illicit drugs.	1
	The CARE Team was not contacted by the emergency department staff until the child was close to being discharged.	1
	Medical Exam/ Standard of Care - PCP	1
	The PCP did not consider a differential diagnosis of abuse, and instead misdiagnosed the infant as having a hemangioma. As a result, the medical evaluation and treatment was significantly delayed for the infant with multiple undiagnosed fractures.	1
	Medical Exam/ Standard of Care - Radiology	1
	The radiologist misread the infant's CT scan as normal, which resulted in the child being discharged home. A CT scan completed by the children's hospital later identified bilateral subdural hematomas.	1
	Medical Exam/ Standard of Care - Urgent Care	1
	The out of state medical facility did not complete a skeletal survey despite the recommendation by the child abuse medical expert.	1
	Reporting	7
	There was no report to the DFS Report Line by the emergency department after the young child first presented with symptoms of drug ingestion/poisoning.	1
	There was no report to the DFS Report Line by the birth hospital for the past child abuse disclosed by the mother, who is now an adult.	1
	There was no report to the DFS Report Line by the PCP after the PCP documented unexplained injuries to a 6-week-old infant during two office visits.	1
	The treating hospital delayed reporting the near death incident to DFS Report Line for 72 hours, which was when the urine drug confirmation results were confirmed.	1
	The treating hospital delayed reporting the near death incident to the DFS Report Line for 72 hours.	1
	The treating hospital delayed reporting the near death incident to DFS Report Line until the CARE team was consulted.	1
	PCP failed to make a report to the DFS Report Line for an unwitnessed burn to a young child and questionable history provided by the mother.	1
Risk Assessment/ Caseloads		16
	Caseloads	10
	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	9
	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open, and the caseload appears to have had a negative impact on the DFS response to the case.	1
	Collaterals	2
	During the near death incident, collateral contacts were not completed for mother's mental health providers, and concerns raised by the children's collaterals were not addressed with the parents or providers.	1
	During the prior investigation, a collateral contact was not completed with the daycare provider to confirm whether any injuries to the child were observed and to identify who drops off and picks up the child.	1

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Detail

FEBRUARY 16, 2022

	Risk Assessment - Closed Despite Risk Level	2
	The SDM Risk Assessment identified the risk as high in the near death investigation. Ongoing service was recommended; however, the case disposition was overridden to close the investigation despite the closure factors not being met as a result of the extensive and recent DFS history.	1
	The SDM Risk Assessment identified the risk as high in the near death investigation. Ongoing service was recommended; however, the case disposition was overridden to close the investigation despite the closure factors not being met as a result of the DFS history and current substance abuse.	1
	Risk Assessment - Screen Out	1
	The call to the DFS Report Line with the positive drug screen results was initially documented by DFS as a progress note rather than a new report.	1
	Screen Out	1
	The DFS Report Line screened out the call regarding the near drowning from the treating hospital, and it resulted in a delayed response by DFS.	1
Safety/ Use of History/ Supervisory Oversight		6
	Safety - Completed Incorrectly/ Late	1
	During the near death investigation, no safety agreement was initially completed for the child and sibling. It was implemented with the father and a relative approximately 72 hours later.	1
	Safety - Inappropriate Parent/ Relative Component	1
	During the near death incident, the DFS caseworker amended the safety agreement to include the mother and to allow her to supervise contact. However, the mother should have been ruled out due to her domestic violence history with the alleged perpetrator.	1
	Safety - No Safety Assessment of Non-Victims	1
	A safety agreement was not completed for the non-victim children residing in the home.	1
	Safety - Violations of Safety Agreements	2
	During the near death investigation, the safety agreement was violated by mother during a follow up appointment to the children's hospital, and it was not addressed by the DFS caseworker.	1
	In the incident preceding the near death, the safety agreement was violated by the non-relative. The violation was not considered when the caseworker completed the new safety for the near death incident.	1
	Use of History	1
	In the first hotline report, the father's DFS history and level IV finding of abuse was not documented by the intake worker. The assigned DFS caseworker did not document the history either.	1
Unresolved Risk		1
	Contacts with Family	1
	During the prior investigation, the initial contact with the victim was delayed by the caseworker.	1
Grand Total		**66**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Detail

FEBRUARY 16, 2022

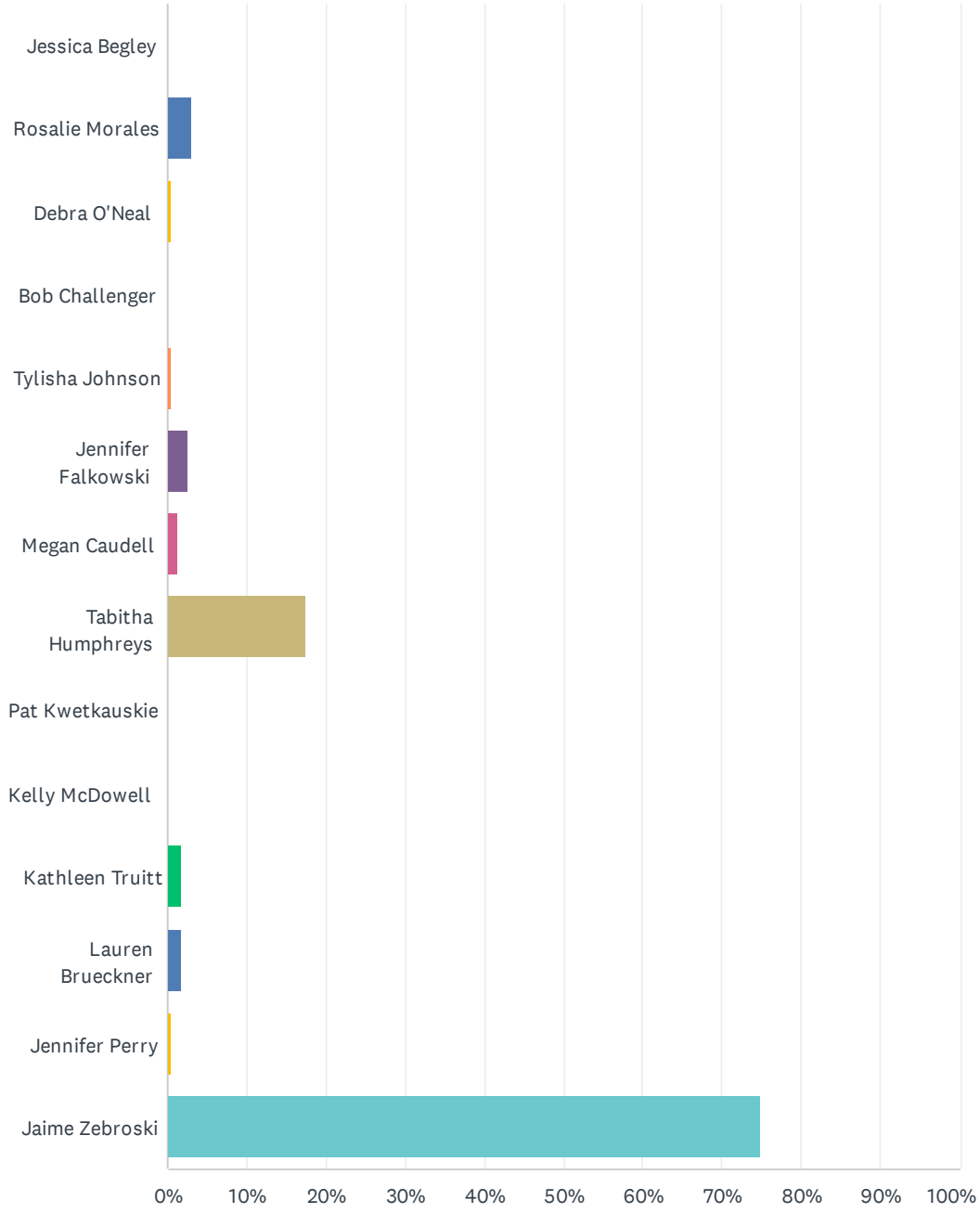
FINAL REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			1
	Communication		1
		During the near death investigation, the law enforcement agency disengaged with the MDT, and stopped communicating updates on the criminal investigation.	1
Medical			1
	Reporting		1
		There was no report to the DFS Report Line by the PCP after the PCP documented bruising of the bilateral ears and scalp swelling of the 4-month-old infant, and referred the infant to the emergency department.	1
Grand Total			**2**

TOTAL FINDINGS **68**

Q1 Enter the Trainer's name.

Answered: 234 Skipped: 203



ANSWER CHOICES	RESPONSES	
Jessica Begley	0.00%	0
Rosalie Morales	2.99%	7
Debra O'Neal	0.43%	1
Bob Challenger	0.00%	0
Tylisha Johnson	0.43%	1
Jennifer Falkowski	2.56%	6
Megan Caudell	1.28%	3
Tabitha Humphreys	17.52%	41
Pat Kwetkauskie	0.00%	0
Kelly McDowell	0.00%	0
Kathleen Truitt	1.71%	4
Lauren Brueckner	1.71%	4
Jennifer Perry	0.43%	1
Jaime Zebroski	74.79%	175
Total Respondents: 234		

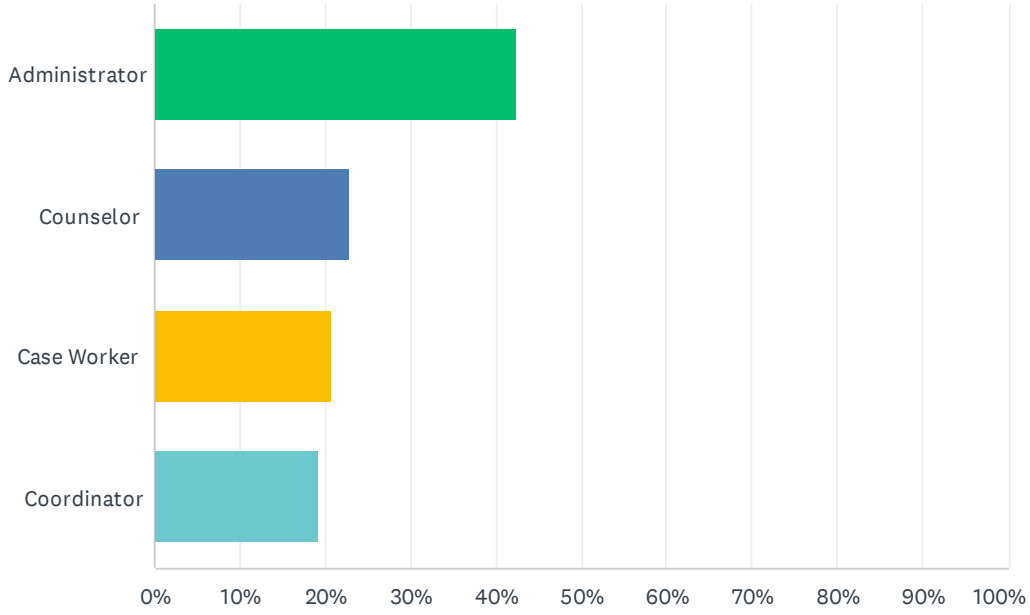
Q2 Enter the date of the training.

Answered: 437 Skipped: 0

ANSWER CHOICES	RESPONSES	
Use format listed.	100.00%	437

Q3 Enter the Respondent's Position if listed.

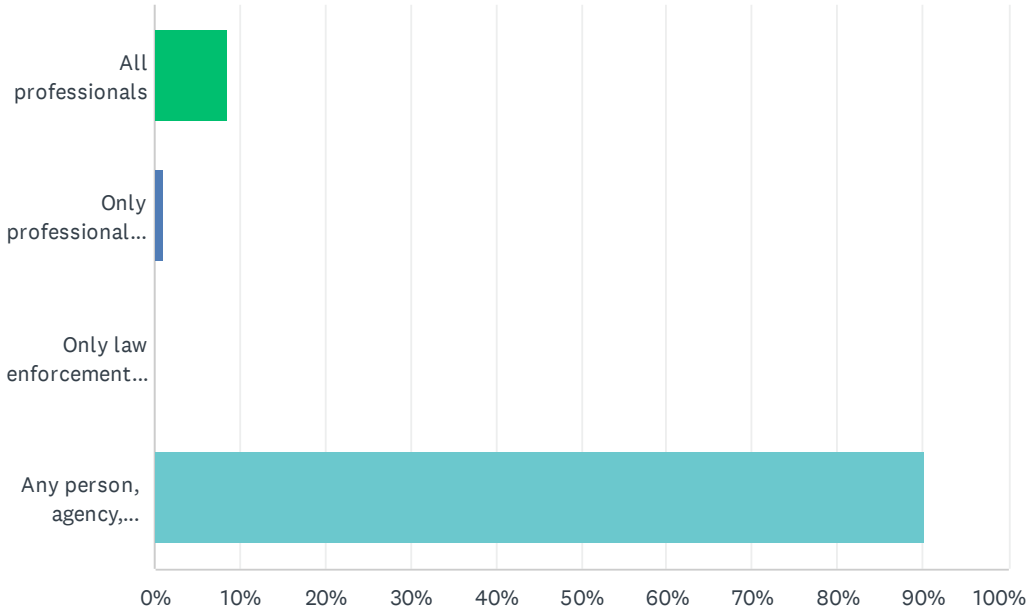
Answered: 198 Skipped: 239



ANSWER CHOICES	RESPONSES	
Administrator	42.42%	84
Counselor	22.73%	45
Case Worker	20.71%	41
Coordinator	19.19%	38
Total Respondents: 198		

Q4 In Delaware, who is mandated to report known or suspected cases of child abuse or neglect?

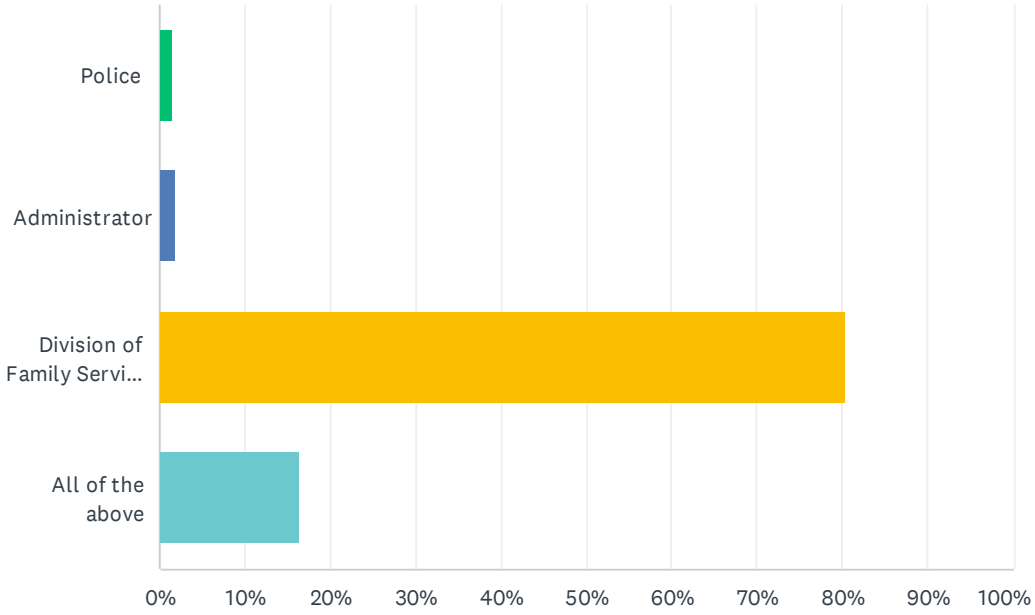
Answered: 432 Skipped: 5



ANSWER CHOICES	RESPONSES	
All professionals	8.56%	37
Only professionals that work directly with children (i.e. teachers, physicians)	1.16%	5
Only law enforcement officers	0.00%	0
Any person, agency, organization or entity	90.28%	390
TOTAL		432

Q5 I am obligated by LAW to FIRST report my suspicions of abuse and neglect to:

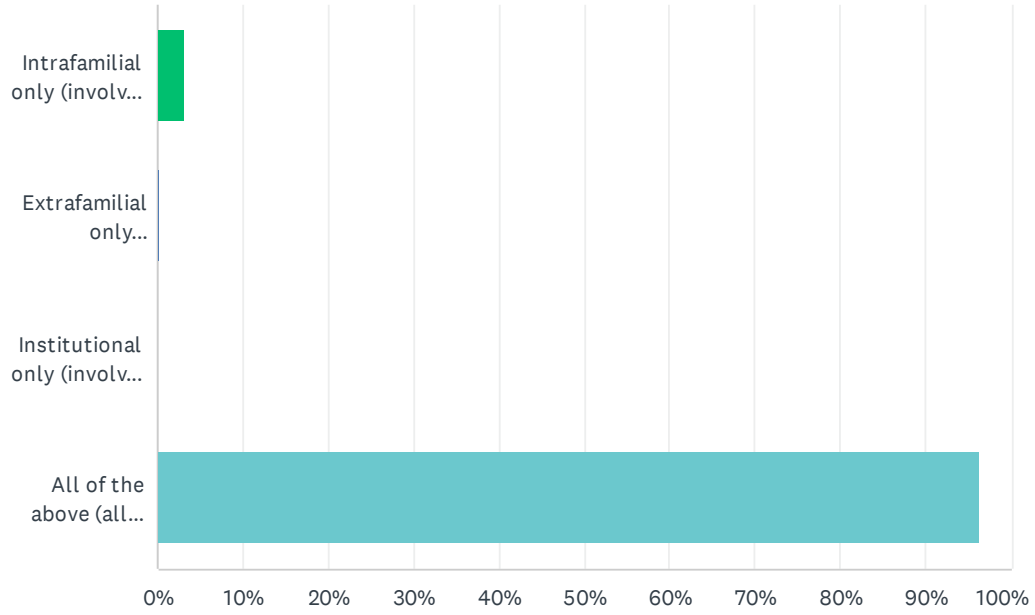
Answered: 429 Skipped: 8



ANSWER CHOICES	RESPONSES	
Police	1.40%	6
Administrator	1.86%	8
Division of Family Services Child Abuse and Neglect Report Line	80.42%	345
All of the above	16.32%	70
TOTAL		429

Q6 What types of cases must be reported to the Division of Family Services Child Abuse and Neglect Report Line?

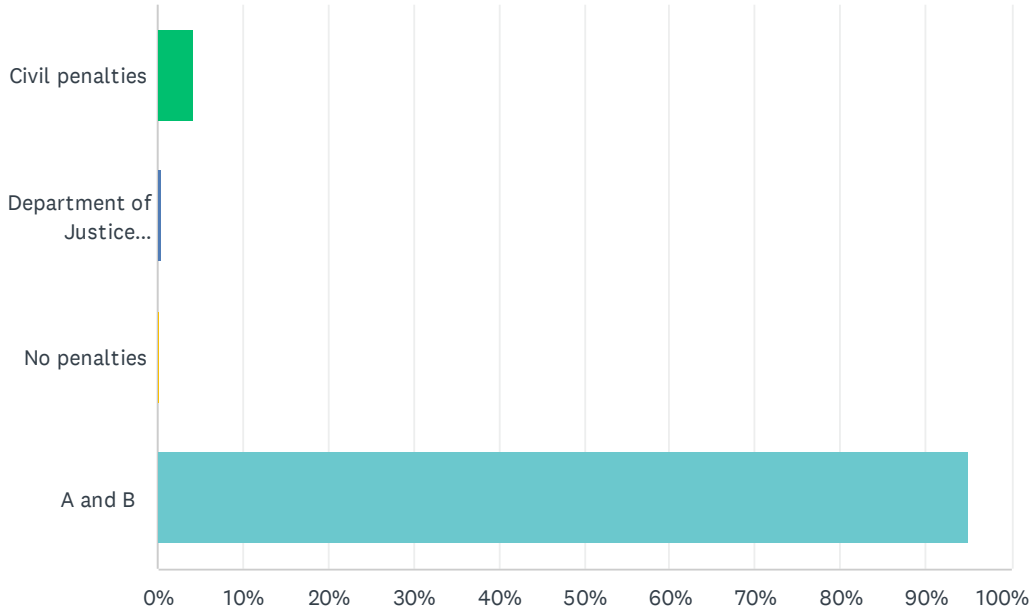
Answered: 426 Skipped: 11



ANSWER CHOICES	RESPONSES	
Intrafamilial only (involving parent, guardian, custodian, or member of the household)	3.29%	14
Extrafamilial only (perpetrator is not a member of the household or family)	0.23%	1
Institutional only (involving licensed child placement facilities)	0.00%	0
All of the above (all suspected abuse and neglect of any child, birth to age 18)	96.48%	411
TOTAL		426

Q7 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:

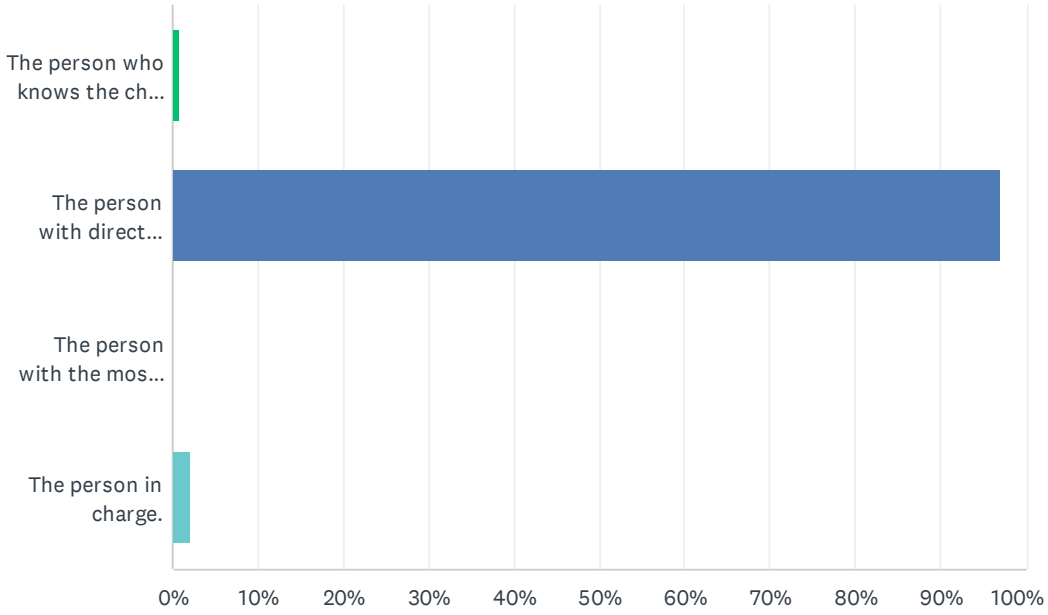
Answered: 426 Skipped: 11



ANSWER CHOICES	RESPONSES	
Civil penalties	4.23%	18
Department of Justice investigation	0.47%	2
No penalties	0.23%	1
A and B	95.07%	405
TOTAL		426

Q8 Which person must make a report to the DFS Child Abuse and Neglect Report Line?

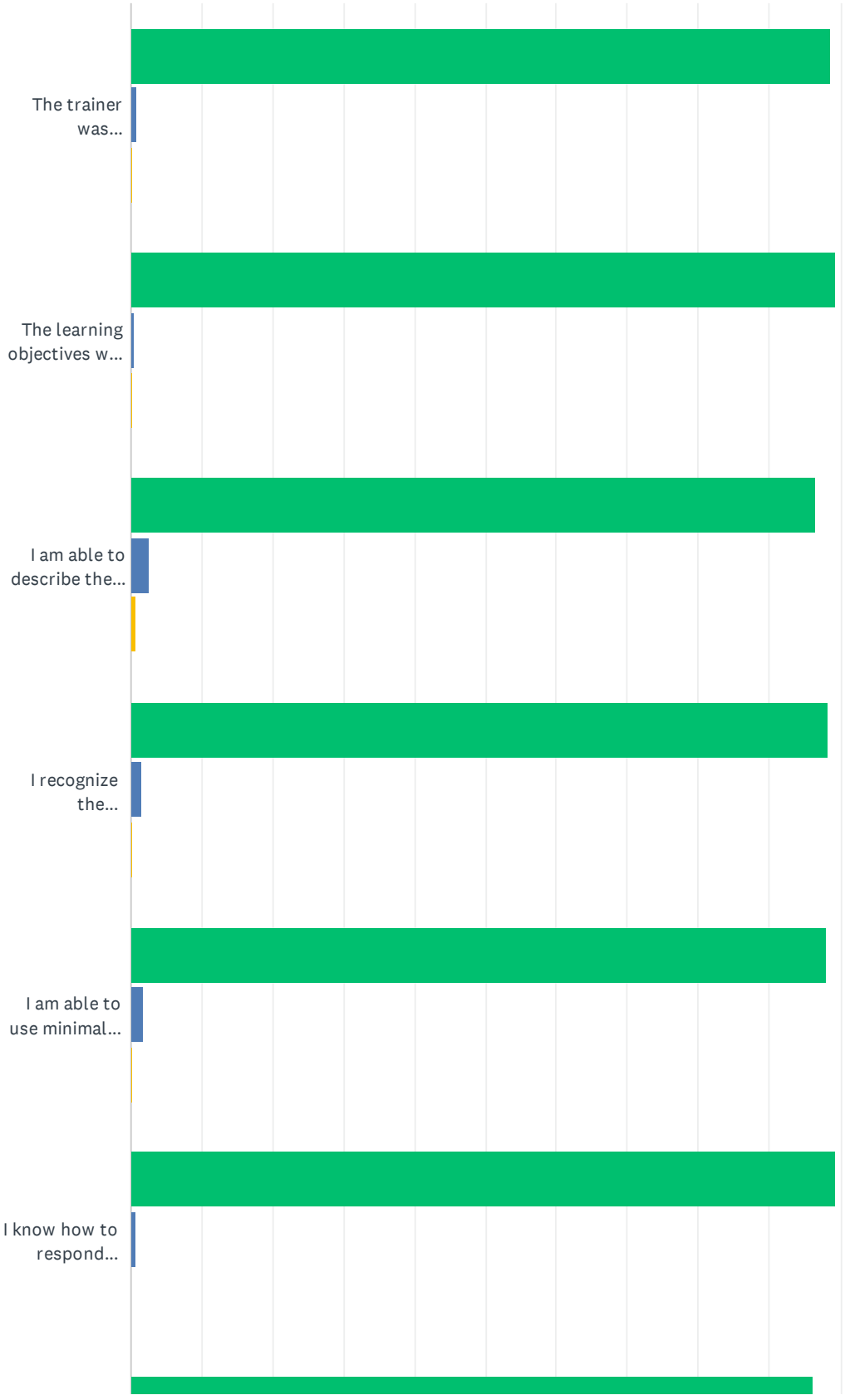
Answered: 426 Skipped: 11

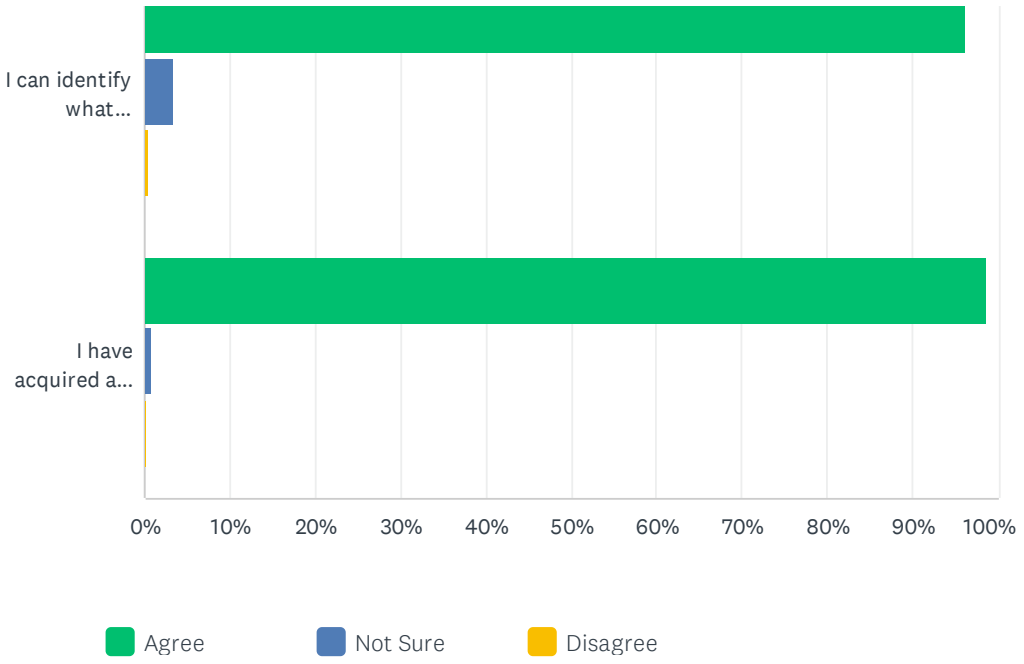


ANSWER CHOICES	RESPONSES	
The person who knows the child best.	0.94%	4
The person with direct knowledge.	96.95%	413
The person with the most time.	0.00%	0
The person in charge.	2.11%	9
TOTAL		426

Q9 Please rate each of the following statements.

Answered: 423 Skipped: 14





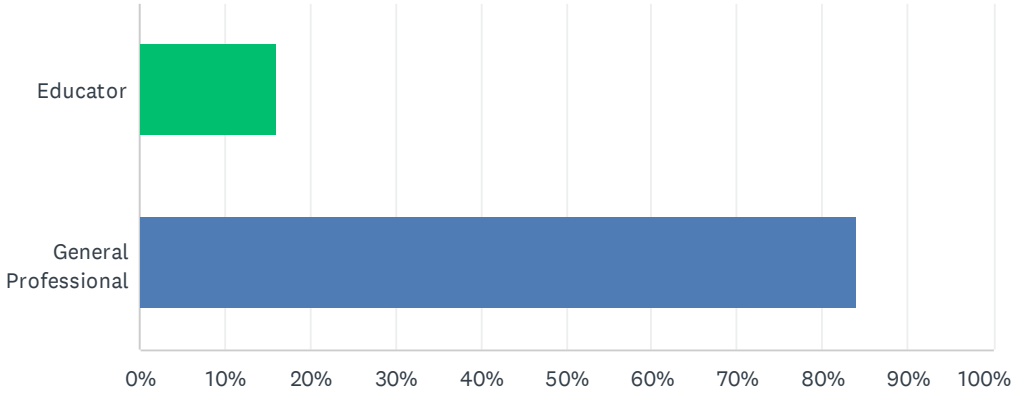
	AGREE	NOT SURE	DISAGREE	TOTAL	WEIGHTED AVERAGE
The trainer was knowledgeable and communicated effectively.	98.82% 418	0.95% 4	0.24% 1	423	1.01
The learning objectives were met.	99.29% 420	0.47% 2	0.24% 1	423	1.01
I am able to describe the reporting law and reporting procedure for the State of Delaware.	96.69% 409	2.60% 11	0.71% 3	423	1.04
I recognize the relationship between physical and behavioral indicators and suspicion of child abuse and neglect.	98.35% 416	1.42% 6	0.24% 1	423	1.02
I am able to use minimal fact questions when indicators are observed and/or a disclosure is made.	98.10% 413	1.66% 7	0.24% 1	421	1.02
I know how to respond appropriately when children disclose allegations of abuse or neglect.	99.29% 420	0.71% 3	0.00% 0	423	1.01
I can identify what information to expect from DFS following a report of child abuse or neglect.	96.22% 407	3.31% 14	0.47% 2	423	1.04
I have acquired a basic understanding of the civil and criminal definitions in statute for the various types of child maltreatment.	98.82% 418	0.95% 4	0.24% 1	423	1.01

Q10 Please list any recommendations or suggestions for future content (i.e. ways training can be improved)

Answered: 72 Skipped: 365

Q1 Please select the reporter group that best describes you.

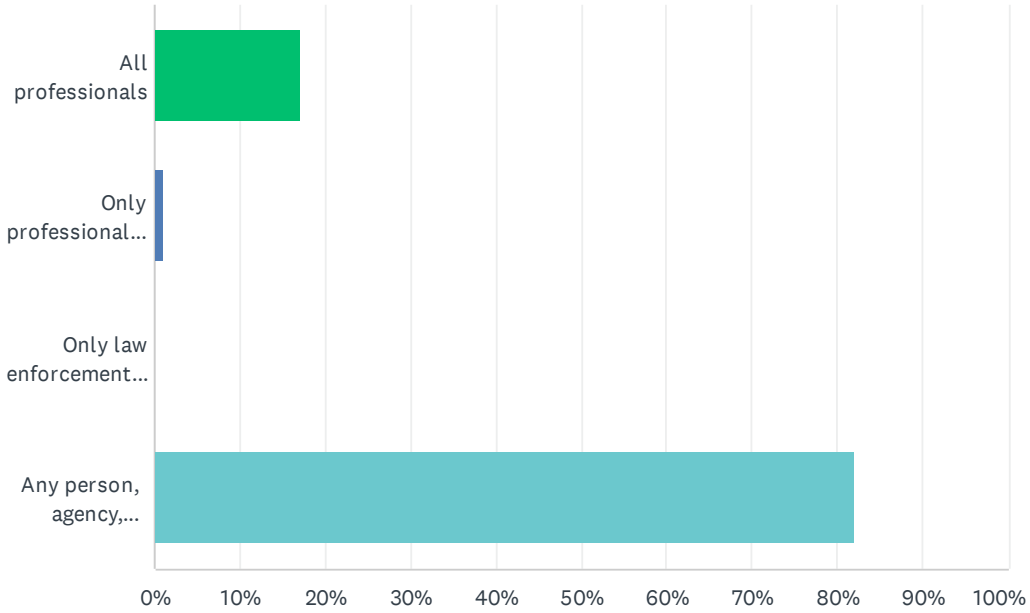
Answered: 791 Skipped: 20



ANSWER CHOICES	RESPONSES	
Educator	16.06%	127
General Professional	83.94%	664
TOTAL		791

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

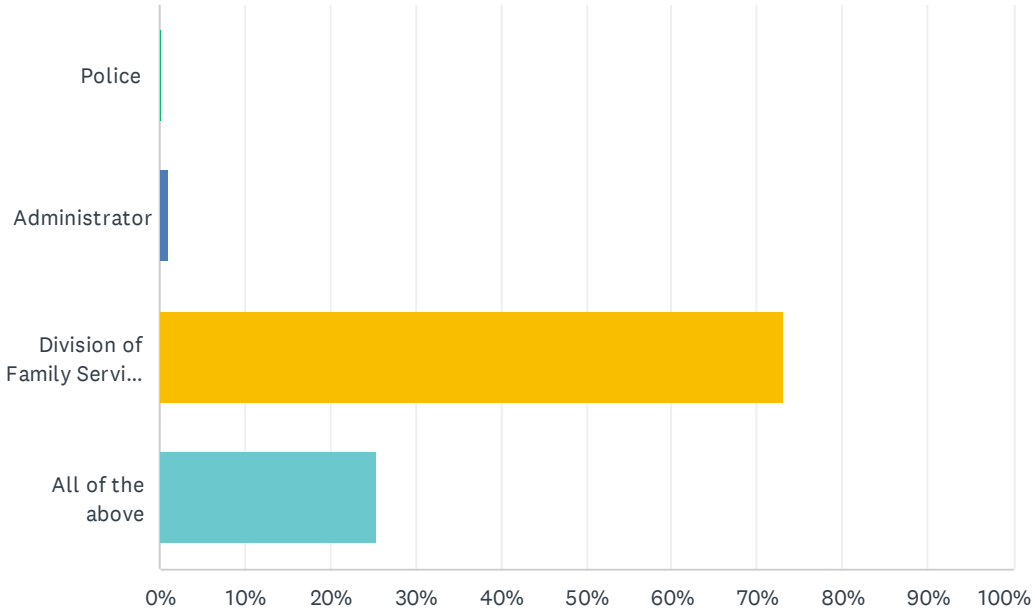
Answered: 811 Skipped: 0



ANSWER CHOICES	RESPONSES	
All professionals	17.02%	138
Only professionals that work directly with children (i.e. teachers, physicians)	0.99%	8
Only law enforcement officers	0.00%	0
Any person, agency, organization or entity	82.00%	665
TOTAL		811

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

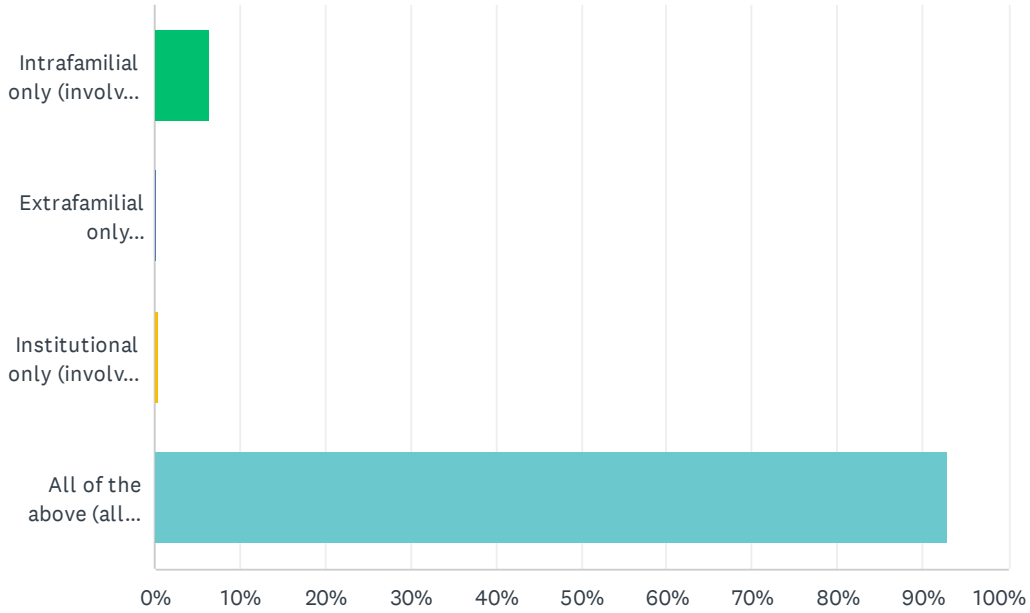
Answered: 807 Skipped: 4



ANSWER CHOICES	RESPONSES	
Police	0.25%	2
Administrator	1.12%	9
Division of Family Services Child Abuse and Neglect Report Line	73.23%	591
All of the above	25.40%	205
TOTAL		807

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

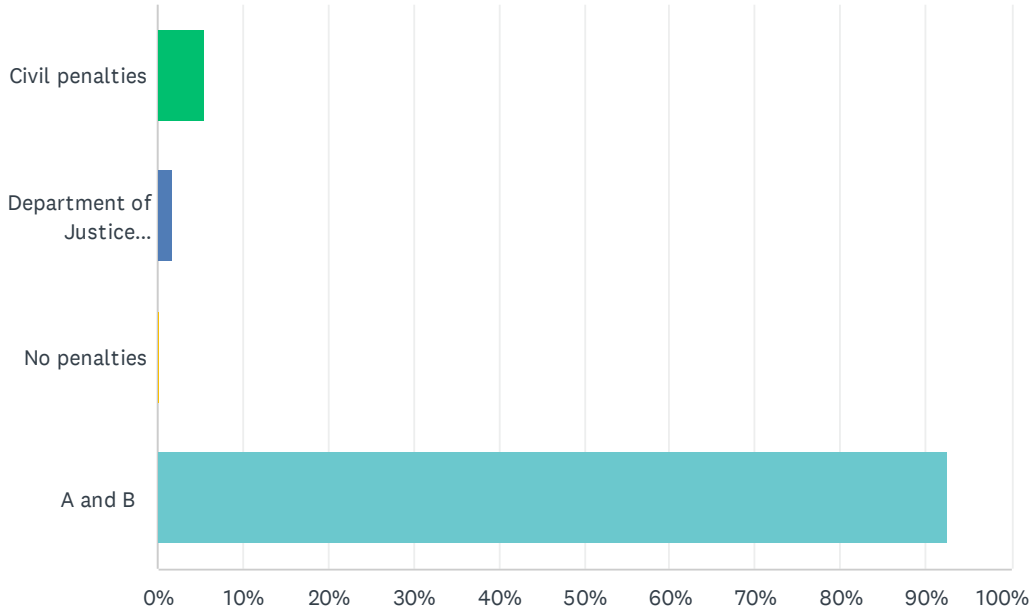
Answered: 795 Skipped: 16



ANSWER CHOICES	RESPONSES	
Intrafamilial only (involving parent, guardian, custodian, or member of the household)	6.42%	51
Extrafamilial only (perpetrator is not a member of the household or family)	0.25%	2
Institutional only (involving licensed child placement facilities)	0.38%	3
All of the above (all suspected abuse and neglect of any child, birth to age 18)	92.96%	739
TOTAL		795

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

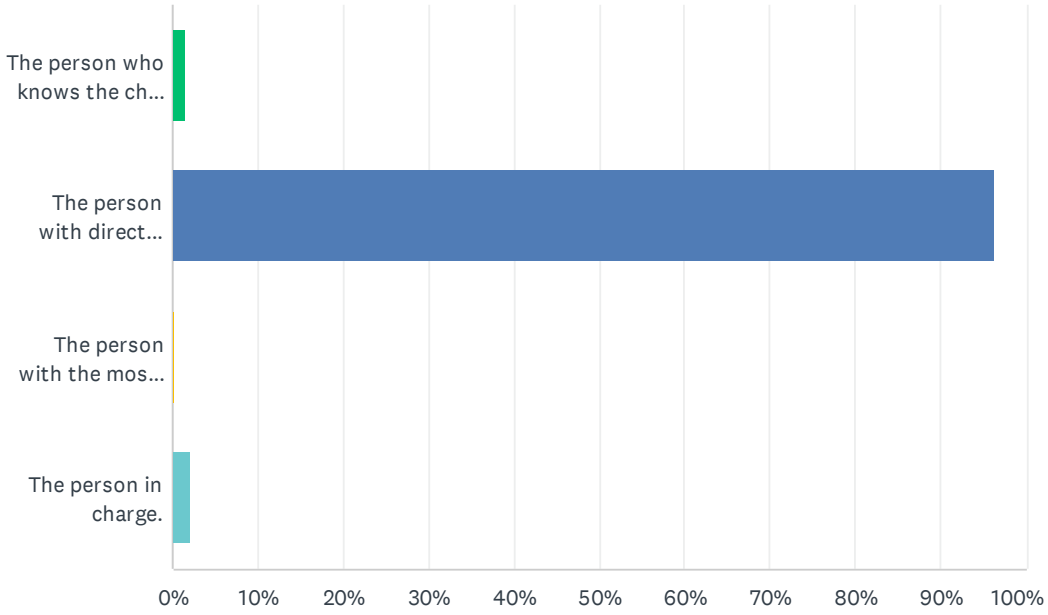
Answered: 793 Skipped: 18



ANSWER CHOICES	RESPONSES	
Civil penalties	5.55%	44
Department of Justice investigation	1.77%	14
No penalties	0.25%	2
A and B	92.43%	733
TOTAL		793

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

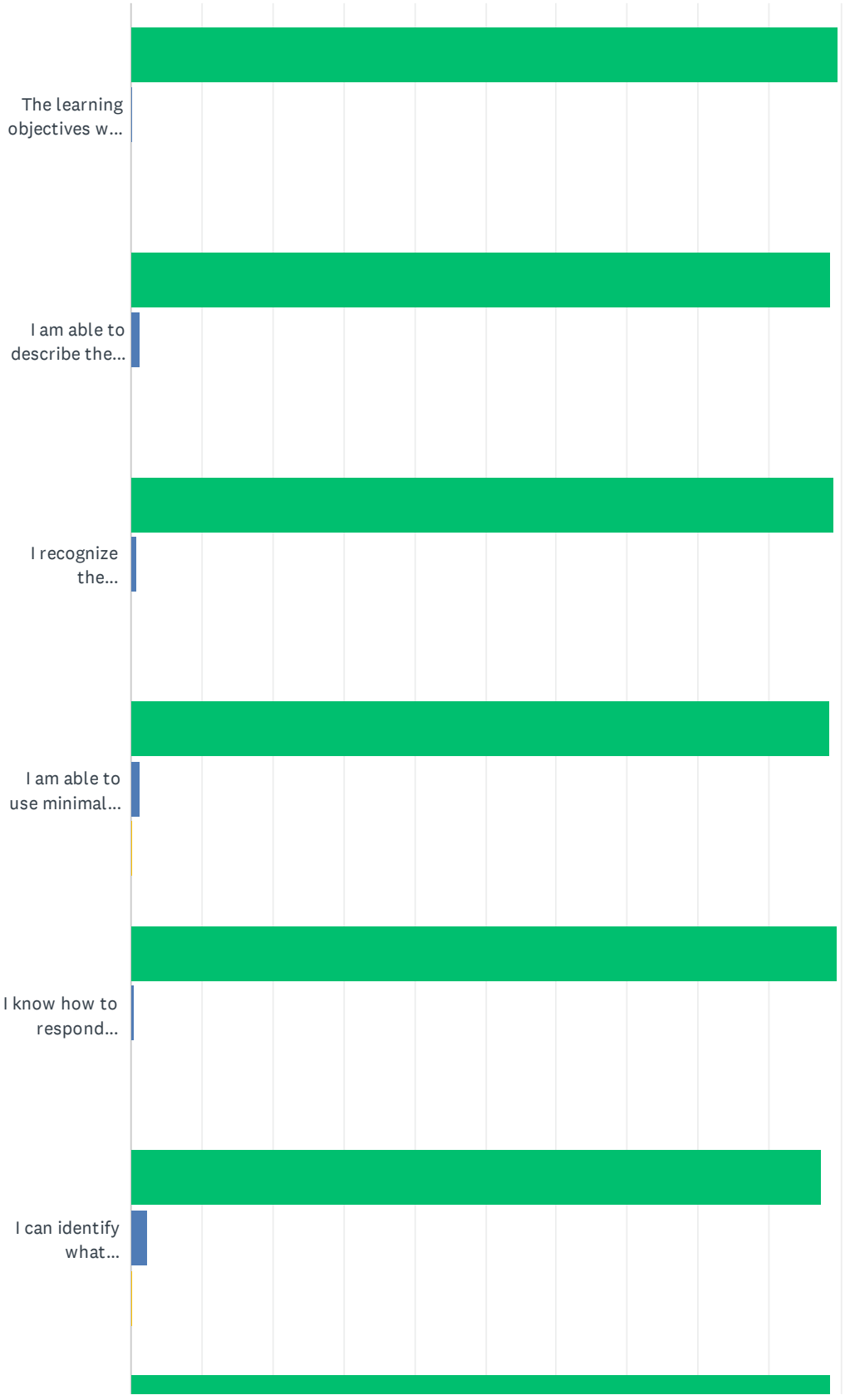
Answered: 792 Skipped: 19

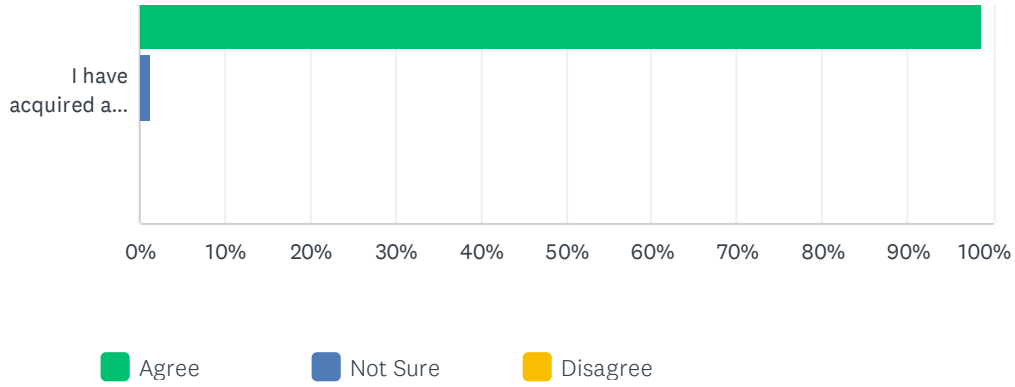


ANSWER CHOICES	RESPONSES	
The person who knows the child best.	1.39%	11
The person with direct knowledge.	96.34%	763
The person with the most time.	0.13%	1
The person in charge.	2.15%	17
TOTAL		792

Q7 Please rate each of the following statements.

Answered: 792 Skipped: 19





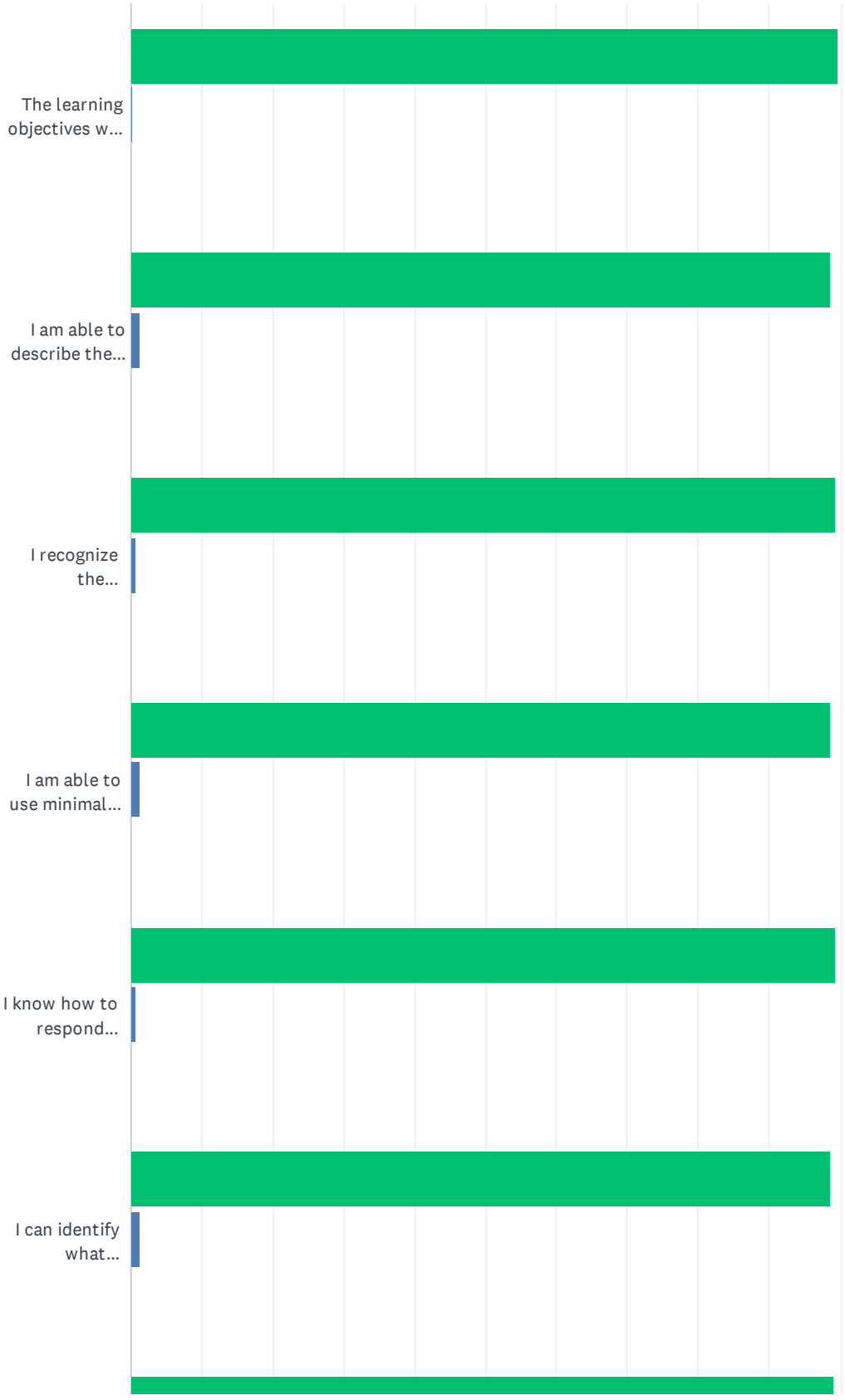
	AGREE	NOT SURE	DISAGREE	TOTAL	WEIGHTED AVERAGE
The learning objectives were met.	99.75% 790	0.25% 2	0.00% 0	792	1.00
I am able to describe the reporting law and reporting procedure for the State of Delaware.	98.74% 782	1.26% 10	0.00% 0	792	1.01
I recognize the relationship between physical and behavioral indicators and suspicion of child abuse and neglect.	99.24% 786	0.76% 6	0.00% 0	792	1.01
I am able to use minimal fact questions when indicators are observed and/or a disclosure is made.	98.48% 780	1.26% 10	0.25% 2	792	1.02
I know how to respond appropriately when children disclose allegations of abuse or neglect.	99.49% 788	0.51% 4	0.00% 0	792	1.01
I can identify what information to expect from DFS following a report of child abuse or neglect.	97.47% 772	2.40% 19	0.13% 1	792	1.03
I have acquired a basic understanding of the civil and criminal definitions in statute for the various types of child maltreatment.	98.74% 782	1.26% 10	0.00% 0	792	1.01

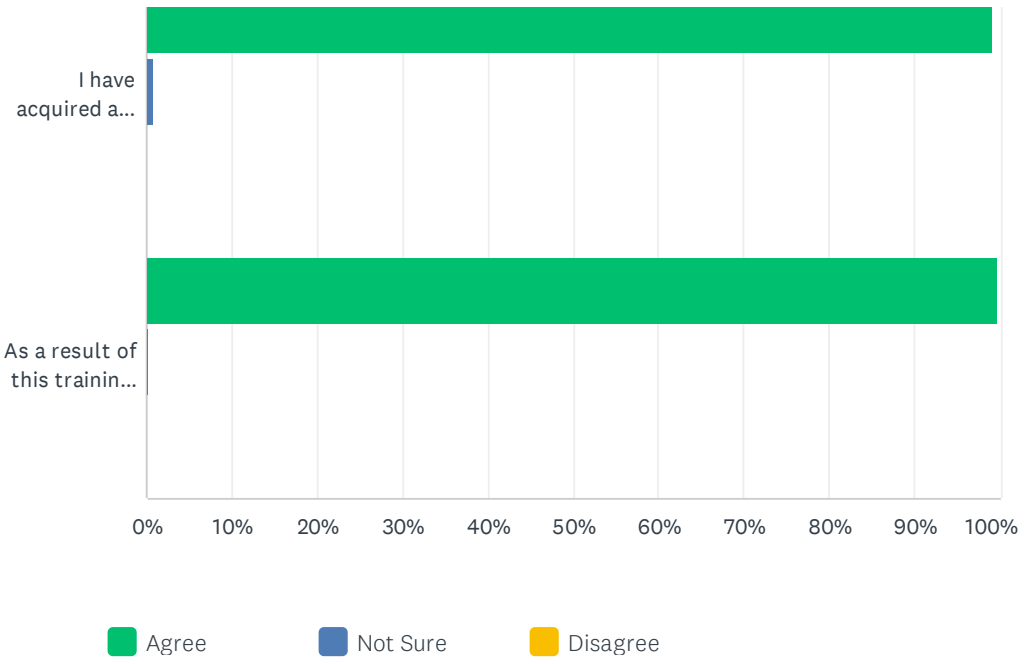
Q8 Please list any recommendations or suggestions for future content (i.e. ways training can be improved)

Answered: 143 Skipped: 668

Q1 Please rate each of the following statements.

Answered: 322 Skipped: 0





	AGREE	NOT SURE	DISAGREE	TOTAL	WEIGHTED AVERAGE
The learning objectives were met.	99.69% 319	0.31% 1	0.00% 0	320	1.00
I am able to describe the reporting law and reporting procedure for the State of Delaware.	98.76% 318	1.24% 4	0.00% 0	322	1.01
I recognize the relationship between physical and behavioral indicators and suspicion of child abuse and neglect.	99.38% 320	0.62% 2	0.00% 0	322	1.01
I am able to use minimal fact questions when indicators are observed and/or a disclosure is made.	98.76% 318	1.24% 4	0.00% 0	322	1.01
I know how to respond appropriately when children disclose allegations of abuse or neglect.	99.38% 320	0.62% 2	0.00% 0	322	1.01
I can identify what information to expect from DFS following a report of child abuse or neglect.	98.76% 318	1.24% 4	0.00% 0	322	1.01
I have acquired a basic understanding of the civil and criminal definitions in statute for the various types of child maltreatment.	99.07% 318	0.93% 3	0.00% 0	321	1.01
As a result of this training, I have a better understanding of my reporting obligations under the Medical Practice Act.	99.69% 320	0.31% 1	0.00% 0	321	1.00

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

Answered: 61 Skipped: 261

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

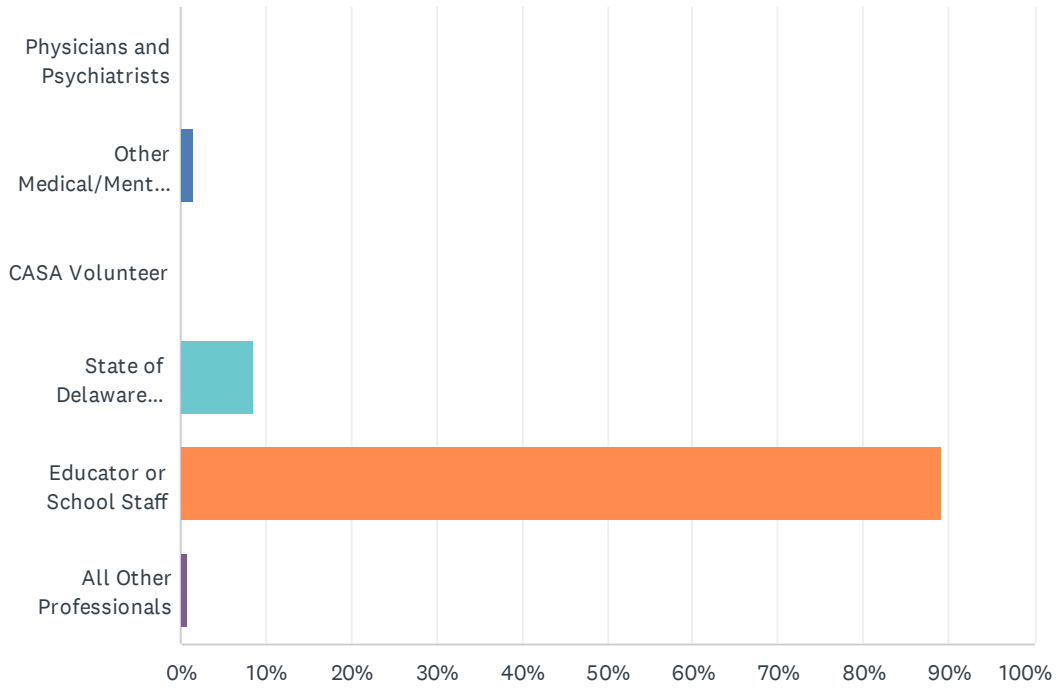
Answered: 68 Skipped: 254

Q1 Name

Answered: 1,266 Skipped: 0

Q2 Please select the category that best matches your profession

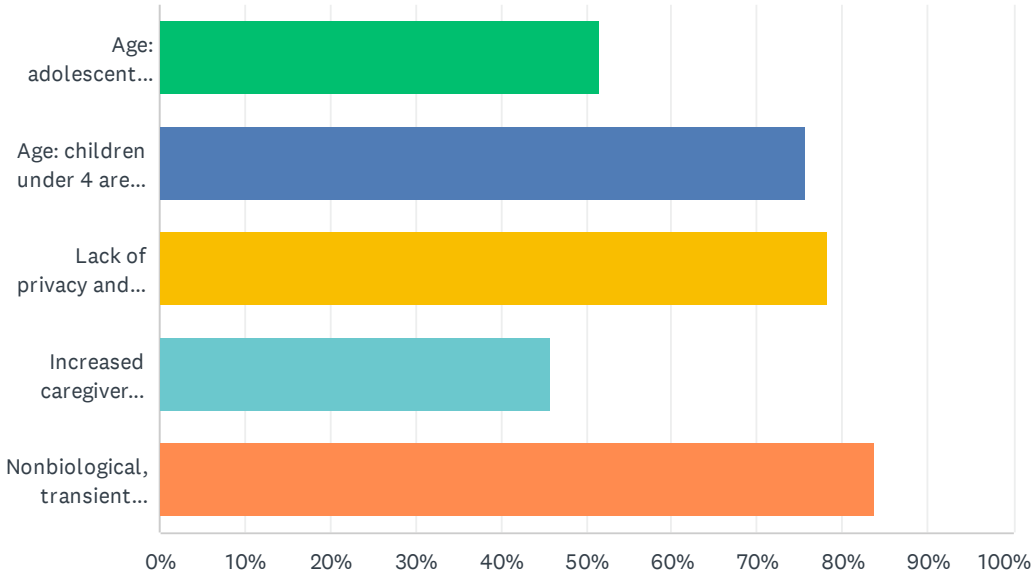
Answered: 1,266 Skipped: 0



ANSWER CHOICES	RESPONSES	
Physicians and Psychiatrists	0.00%	0
Other Medical/Mental Health Professional	1.50%	19
CASA Volunteer	0.00%	0
State of Delaware Employee	8.53%	108
Educator or School Staff	89.10%	1,128
All Other Professionals	0.87%	11
TOTAL		1,266

Q3 Select the risk factors for victimization for children with disabilities. Select all that apply.

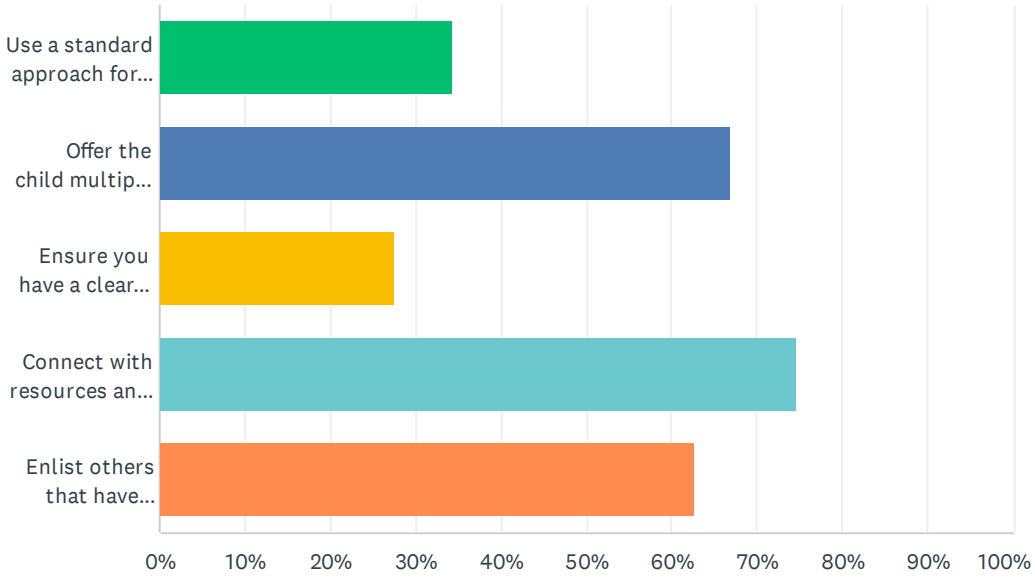
Answered: 1,266 Skipped: 0



ANSWER CHOICES	RESPONSES	
Age: adolescent children more likely to be victimized	51.66%	654
Age: children under 4 are more likely to be victimized	75.75%	959
Lack of privacy and independence	78.28%	991
Increased caregiver presence	45.89%	581
Nonbiological, transient caregivers in the home	83.73%	1,060
Total Respondents: 1,266		

Q4 When a child with disabilities discloses experiencing abuse or neglect, what are the best practices for navigating the situation? Select all that apply.

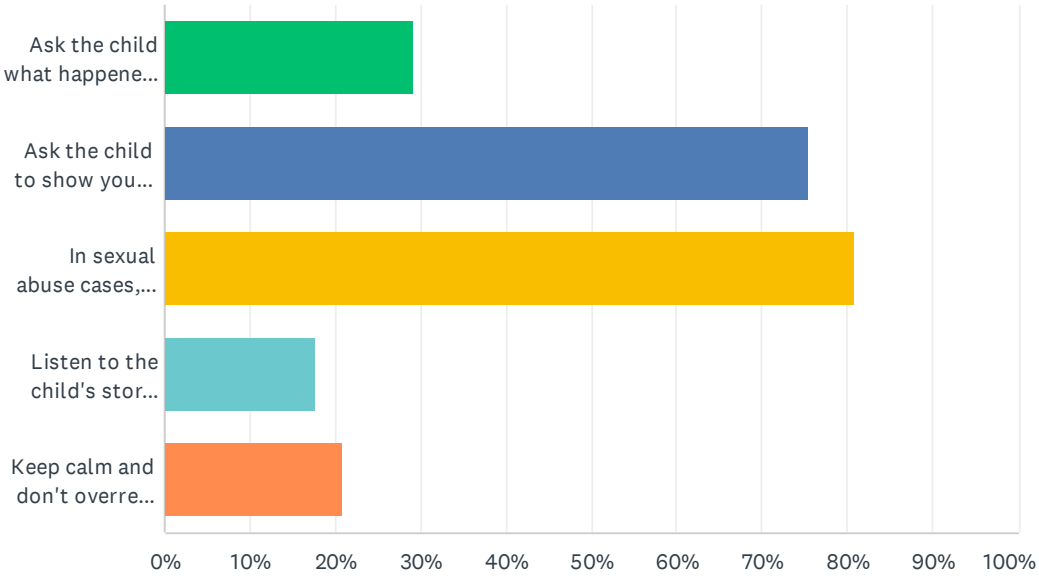
Answered: 1,256 Skipped: 10



ANSWER CHOICES	RESPONSES	
Use a standard approach for all children, regardless of ability	34.32%	431
Offer the child multiple, different opportunities to disclose	67.04%	842
Ensure you have a clear, verbal story from the child	27.55%	346
Connect with resources and help for yourself and the child	74.68%	938
Enlist others that have experience working with children with disabilities	62.66%	787
Total Respondents: 1,256		

Q5 What are the actions to AVOID when a child discloses abuse or neglect. Select all that apply.

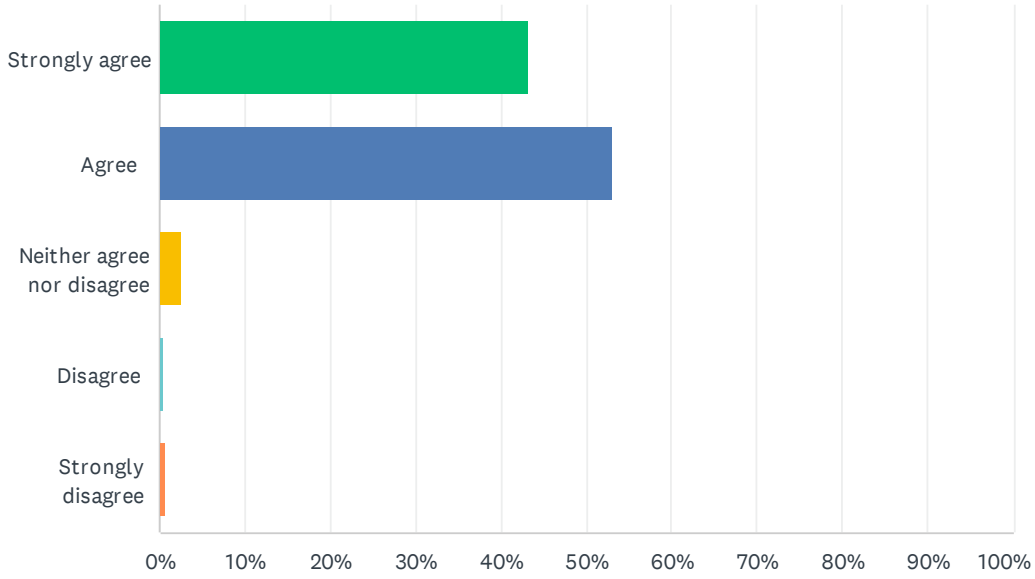
Answered: 1,249 Skipped: 17



ANSWER CHOICES	RESPONSES	
Ask the child what happened, when did it happen, where did it happen, and who did this?	29.22%	365
Ask the child to show you where they were physically hurt and take a photo of the injury for law enforcement	75.42%	942
In sexual abuse cases, have the child undress and change clothes so law enforcement may take the clothes for evidence	80.78%	1,009
Listen to the child's story, let them know it is not their fault and they did nothing wrong	17.61%	220
Keep calm and don't overreact in front of the child	20.90%	261
Total Respondents: 1,249		

Q6 After completing this training, I have a better understanding of mandated reporting and child abuse and neglect in children with disabilities.

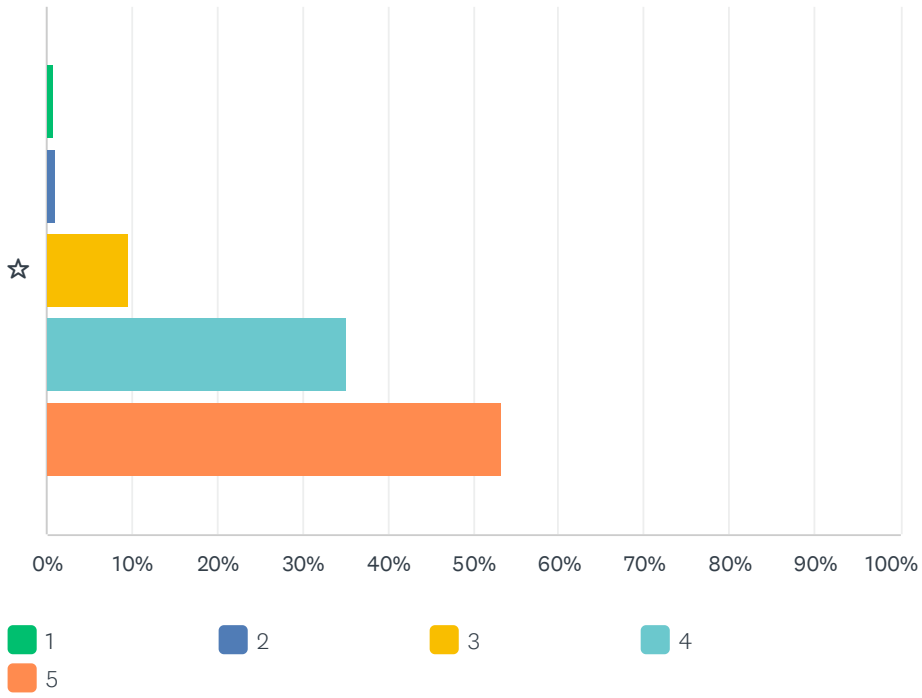
Answered: 1,243 Skipped: 23



ANSWER CHOICES	RESPONSES	
Strongly agree	43.36%	539
Agree	53.02%	659
Neither agree nor disagree	2.57%	32
Disagree	0.32%	4
Strongly disagree	0.72%	9
TOTAL		1,243

Q7 Please rate this training overall

Answered: 1,243 Skipped: 23



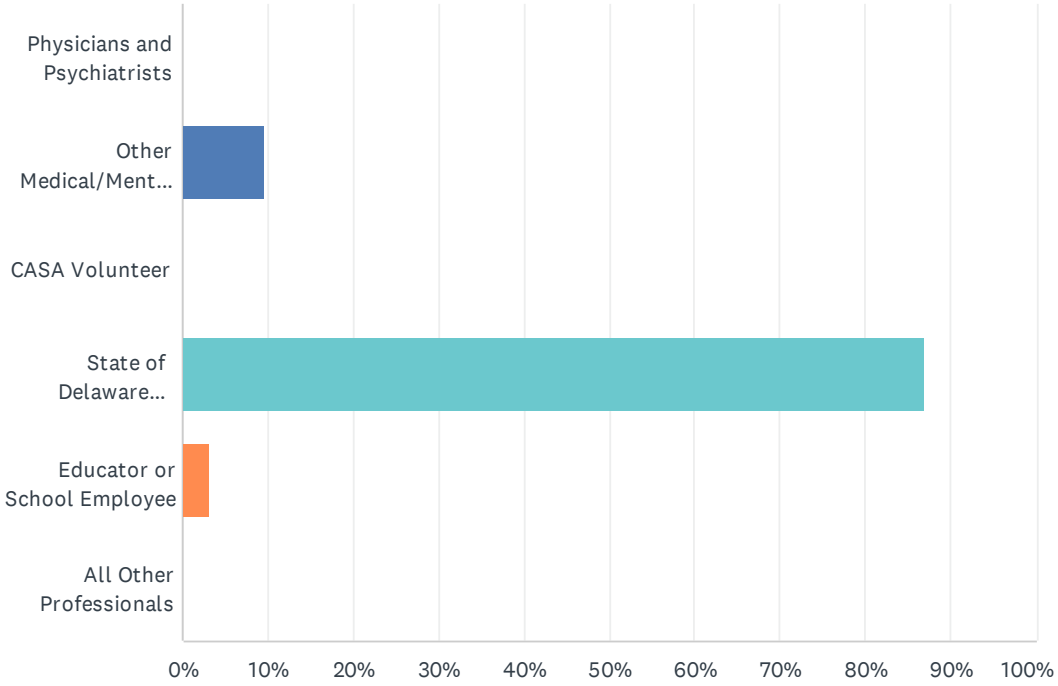
	1	2	3	4	5	TOTAL	WEIGHTED AVERAGE
☆	0.88% 11	1.05% 13	9.65% 120	35.08% 436	53.34% 663	1,243	4.39

Q1 Name

Answered: 31 Skipped: 0

Q2 Please select the category that best matches your profession

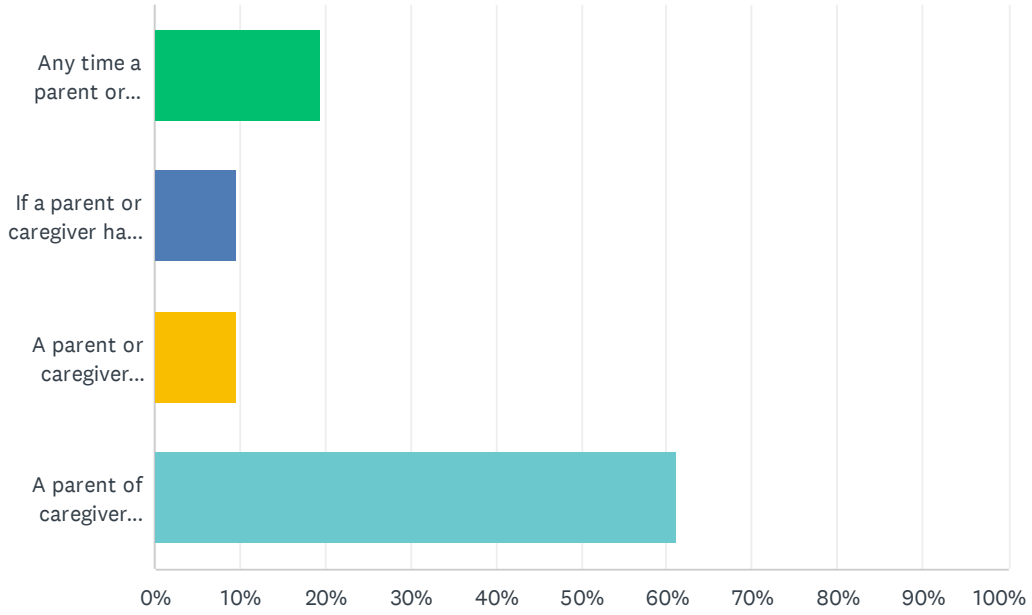
Answered: 31 Skipped: 0



ANSWER CHOICES	RESPONSES	
Physicians and Psychiatrists	0.00%	0
Other Medical/Mental Health Professional	9.68%	3
CASA Volunteer	0.00%	0
State of Delaware Employee	87.10%	27
Educator or School Employee	3.23%	1
All Other Professionals	0.00%	0
TOTAL		31

Q3 In Delaware, when does parental substance abuse constitute child neglect and require a mandated report?

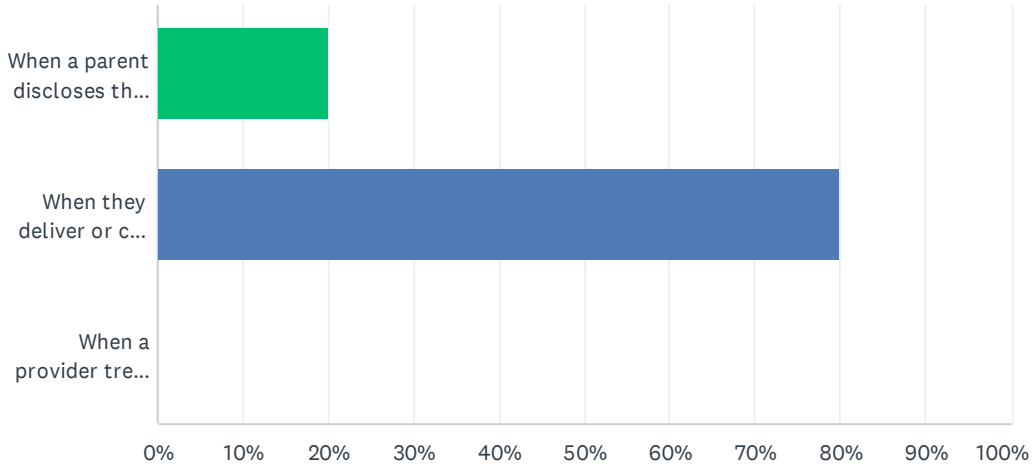
Answered: 31 Skipped: 0



ANSWER CHOICES	RESPONSES	
Any time a parent or caregiver uses substances while caring for a child it is a mandated report	19.35%	6
If a parent or caregiver has a substance use disorder, it is always a mandated report	9.68%	3
A parent or caregiver chronically engages in substance use while caring for a child	9.68%	3
A parent of caregiver chronically engages in substance use and the substance abuse negatively impacts the care of the child	61.29%	19
TOTAL		31

Q4 Aiden's Law requires healthcare providers to notify the Division of Family Services (DFS) when...

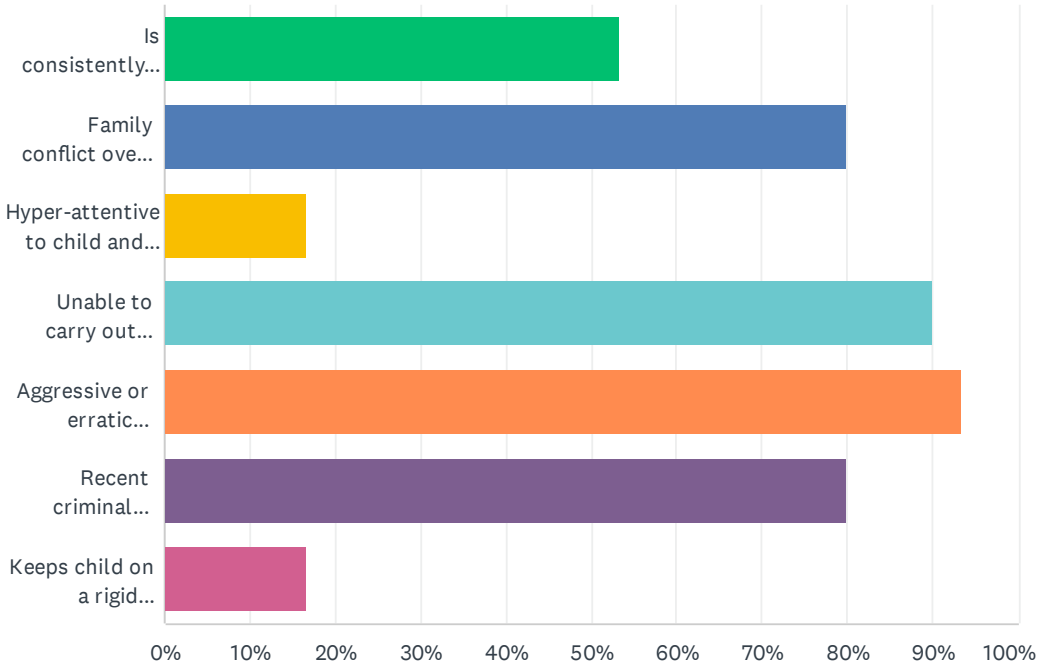
Answered: 30 Skipped: 1



ANSWER CHOICES	RESPONSES	
When a parent discloses they have used alcohol or substances while pregnant or caring for the child	20.00%	6
When they deliver or care for an infant with Fetal Alcohol Spectrum Disorder or effects of parental substance use	80.00%	24
When a provider treats a child for ingestion of alcohol or a substance(s)	0.00%	0
TOTAL		30

Q5 Select the correct indicators that a parent or caregiver may have a substance use disorder.

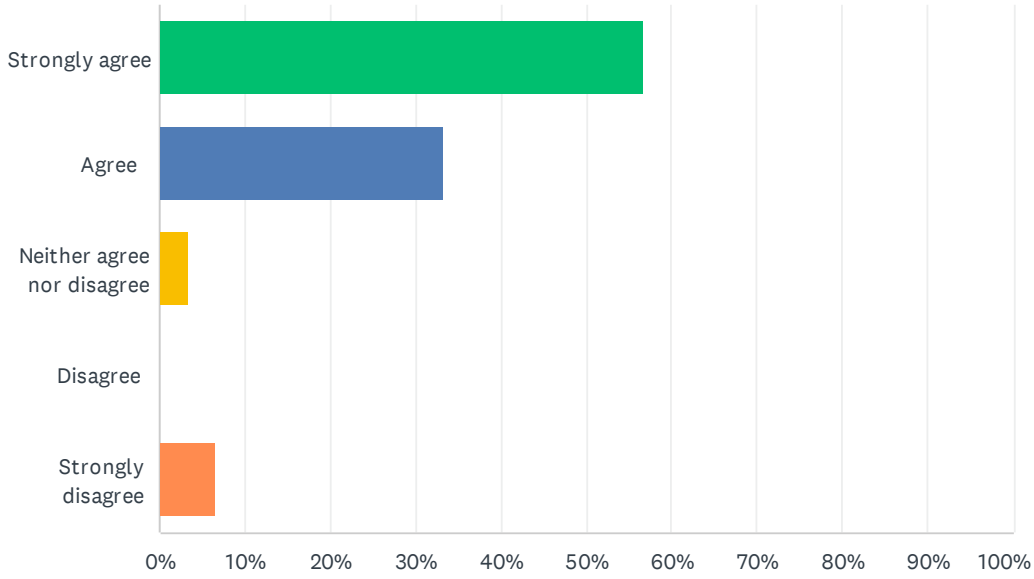
Answered: 30 Skipped: 1



ANSWER CHOICES	RESPONSES	
Is consistently late or early for picking up child from school or activities	53.33%	16
Family conflict over substance use	80.00%	24
Hyper-attentive to child and child's needs	16.67%	5
Unable to carry out parenting or caregiver responsibilities	90.00%	27
Aggressive or erratic behaviors	93.33%	28
Recent criminal behavior related to substance use	80.00%	24
Keeps child on a rigid structure and is unable to be flexible in routine	16.67%	5
Total Respondents: 30		

Q6 After completing this training, I have a better understanding of parental substance use disorder and how it can affect children.

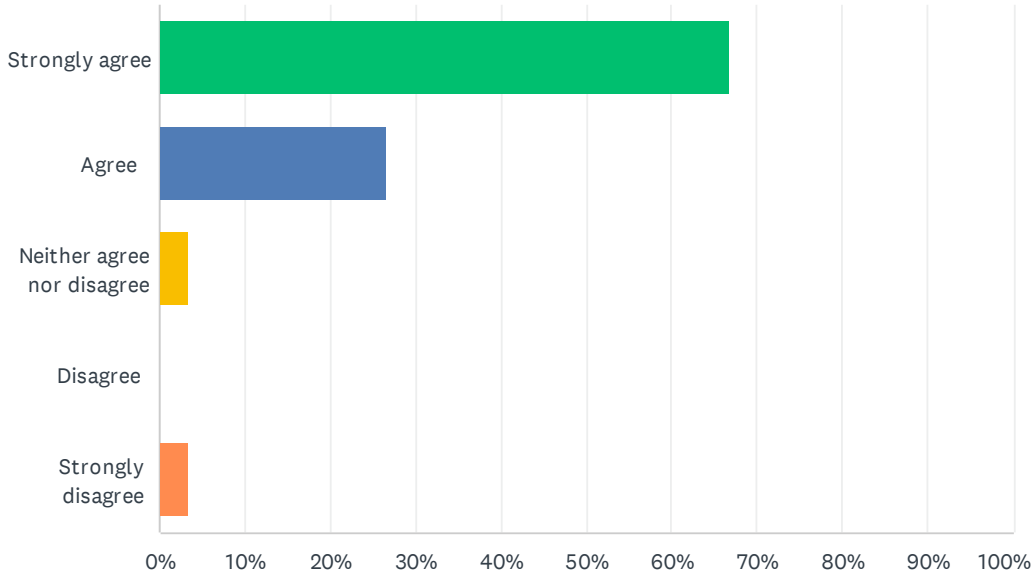
Answered: 30 Skipped: 1



ANSWER CHOICES	RESPONSES	
Strongly agree	56.67%	17
Agree	33.33%	10
Neither agree nor disagree	3.33%	1
Disagree	0.00%	0
Strongly disagree	6.67%	2
TOTAL		30

Q7 After completing this training, I feel comfortable making a mandated report.

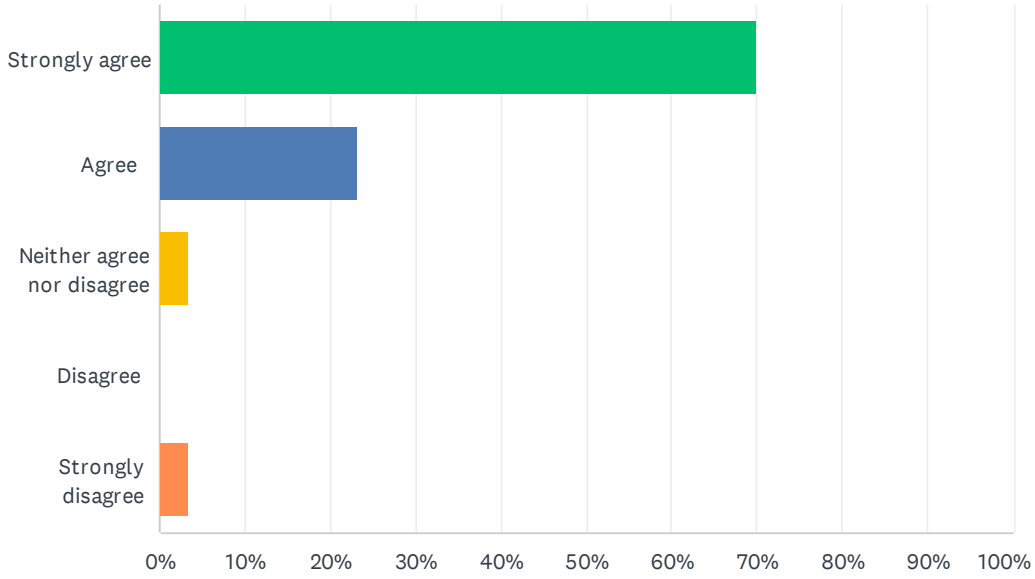
Answered: 30 Skipped: 1



ANSWER CHOICES	RESPONSES	
Strongly agree	66.67%	20
Agree	26.67%	8
Neither agree nor disagree	3.33%	1
Disagree	0.00%	0
Strongly disagree	3.33%	1
TOTAL		30

Q8 After completing this training, I have a better understanding of when a mandated report is required in situations involving parental substance use disorder or substance abuse.

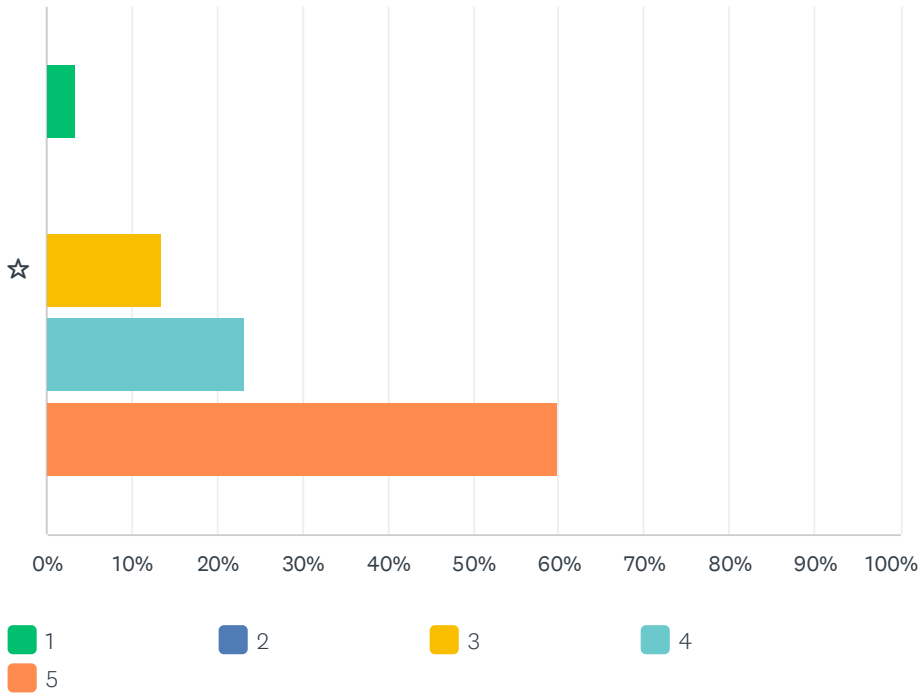
Answered: 30 Skipped: 1



ANSWER CHOICES	RESPONSES	
Strongly agree	70.00%	21
Agree	23.33%	7
Neither agree nor disagree	3.33%	1
Disagree	0.00%	0
Strongly disagree	3.33%	1
TOTAL		30

Q9 Please rate this training overall

Answered: 30 Skipped: 1

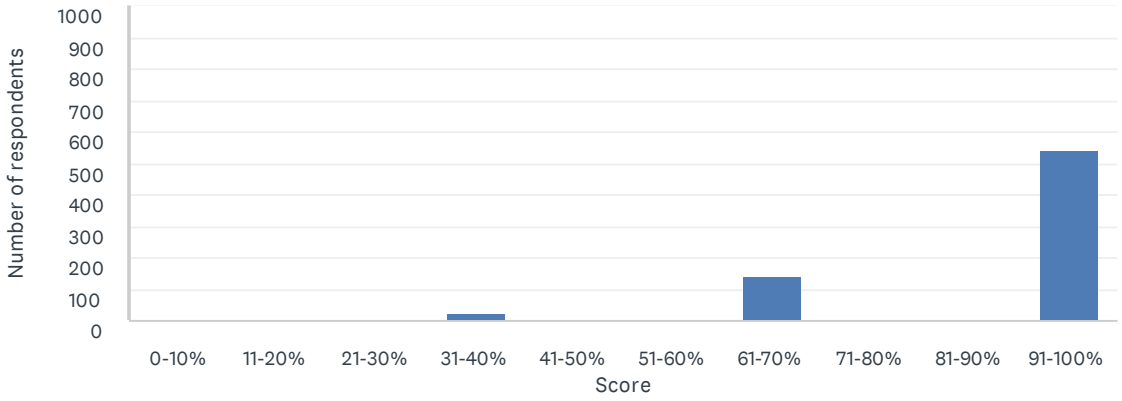


	1	2	3	4	5	TOTAL	WEIGHTED AVERAGE
☆	3.33% 1	0.00% 0	13.33% 4	23.33% 7	60.00% 18	30	4.37

Quiz Summary

AVERAGE SCORE

91% • 2.7/3 PTS



STATISTICS		
Lowest Score	Median	Highest Score
0%	100%	100%
Mean: 91%		
Standard Deviation: 18%		

Question Ranking

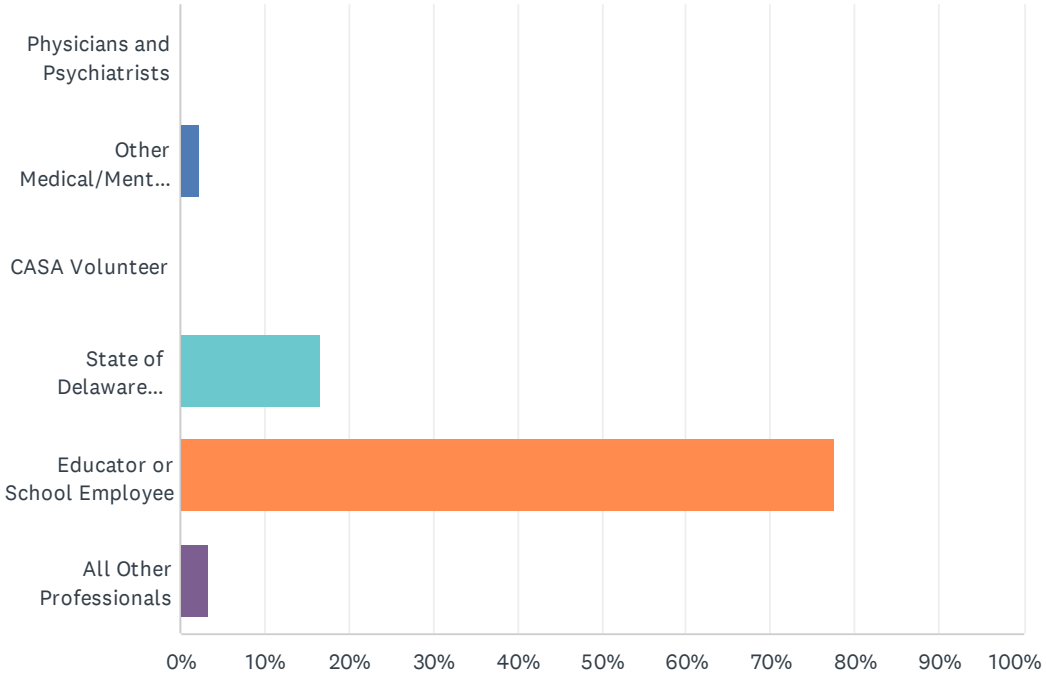
QUESTIONS (3)	DIFFICULTY	AVERAGE SCORE
Q3 Protective factors refer to....	1	81%
Q4 Examples of Risk Factors include	2	95%
Q5 Examples of Protective Factors include...	3	96%

Q1 Name

Answered: 713 Skipped: 0

Q2 Please select the category that best matches your profession

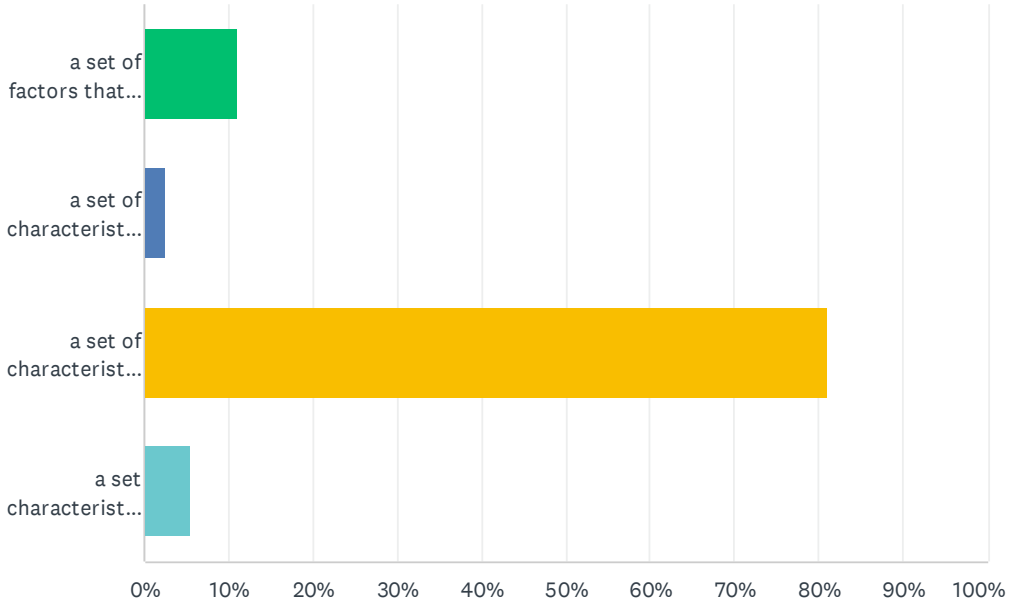
Answered: 713 Skipped: 0



ANSWER CHOICES	RESPONSES	
Physicians and Psychiatrists	0.00%	0
Other Medical/Mental Health Professional	2.38%	17
CASA Volunteer	0.00%	0
State of Delaware Employee	16.55%	118
Educator or School Employee	77.70%	554
All Other Professionals	3.37%	24
TOTAL		**713**

Q3 Protective factors refer to....

Answered: 713 Skipped: 0

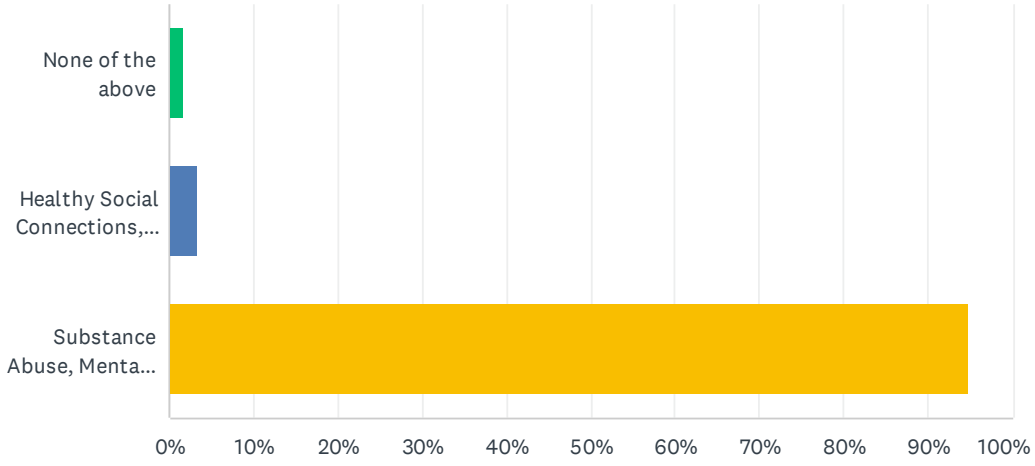


QUIZ STATISTICS			
Percent Correct 81%	Average Score 0.8/1.0 (81%)	Standard Deviation 0.39	Difficulty 1/3

ANSWER CHOICES	SCORE	RESPONSES	
a set of factors that help children protect themselves	0/1	11.08%	79
a set of characteristics that can increase the risk of child abuse and neglect	0/1	2.52%	18
✓ a set of characteristics that can help reduce the risk of child abuse and neglect and increase the well being of children and families	1/1	80.93%	577
a set characteristics that can help reduce the risk of child abuse	0/1	5.47%	39
TOTAL			**713**

Q4 Examples of Risk Factors include

Answered: 713 Skipped: 0

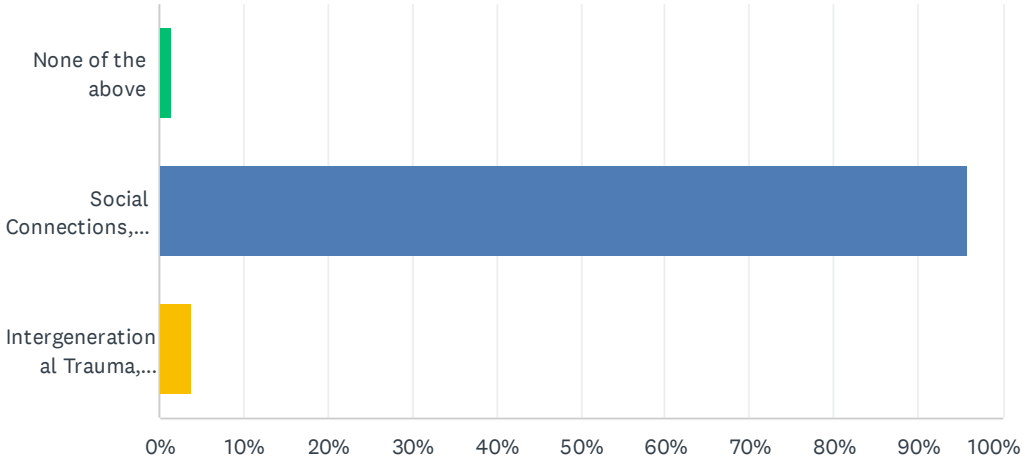


QUIZ STATISTICS			
Percent Correct 95%	Average Score 0.9/1.0 (95%)	Standard Deviation 0.22	Difficulty 2/3

ANSWER CHOICES	SCORE	RESPONSES	
None of the above	0/1	1.68%	12
Healthy Social Connections, Supportive Family, Pro-Social Behavior	0/1	3.37%	24
✓ Substance Abuse, Mental Health, History of Family Violence	1/1	94.95%	677
TOTAL			**713**

Q5 Examples of Protective Factors include...

Answered: 713 Skipped: 0

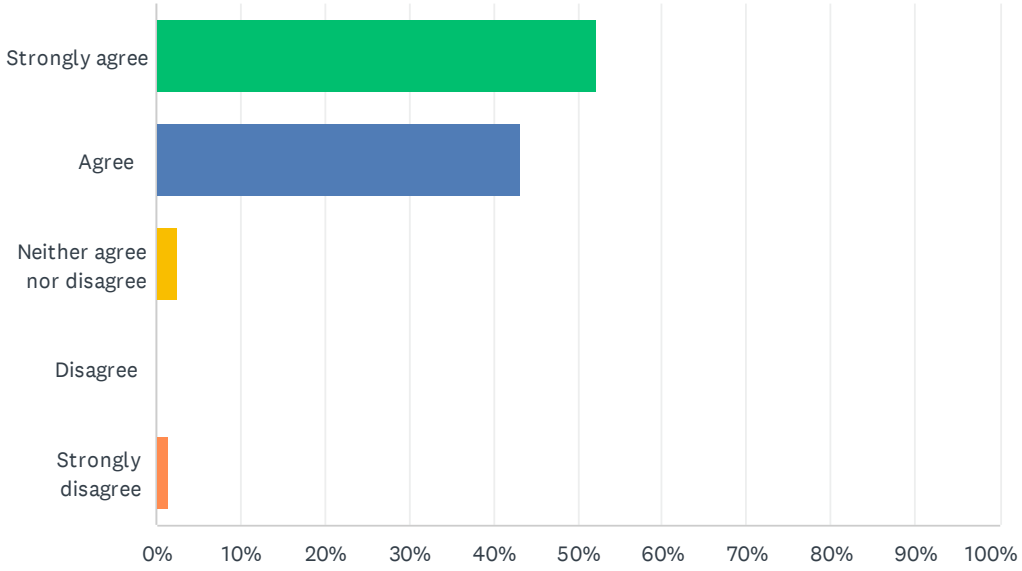


QUIZ STATISTICS			
Percent Correct 96%	Average Score 1.0/1.0 (96%)	Standard Deviation 0.20	Difficulty 3/3

ANSWER CHOICES	SCORE	RESPONSES	
None of the above	0/1	1.40%	10
✓ Social Connections, Concrete Support, Parental Resilience	1/1	95.93%	684
Intergenerational Trauma, History of Family Violence, Unstable Family Structure	0/1	3.79%	27
Total Respondents: 713			

Q6 After completing this training, I have a better understanding of risk and protective factors

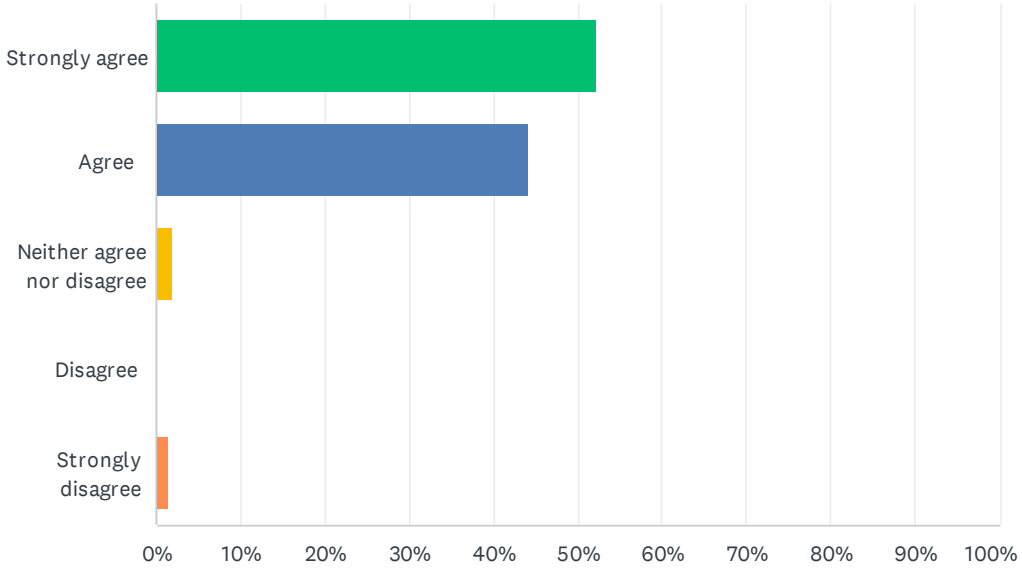
Answered: 713 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	52.31%	373
Agree	43.34%	309
Neither agree nor disagree	2.66%	19
Disagree	0.14%	1
Strongly disagree	1.54%	11
TOTAL		**713**

Q7 After completing this training, I feel comfortable to identify protective and risk factors.

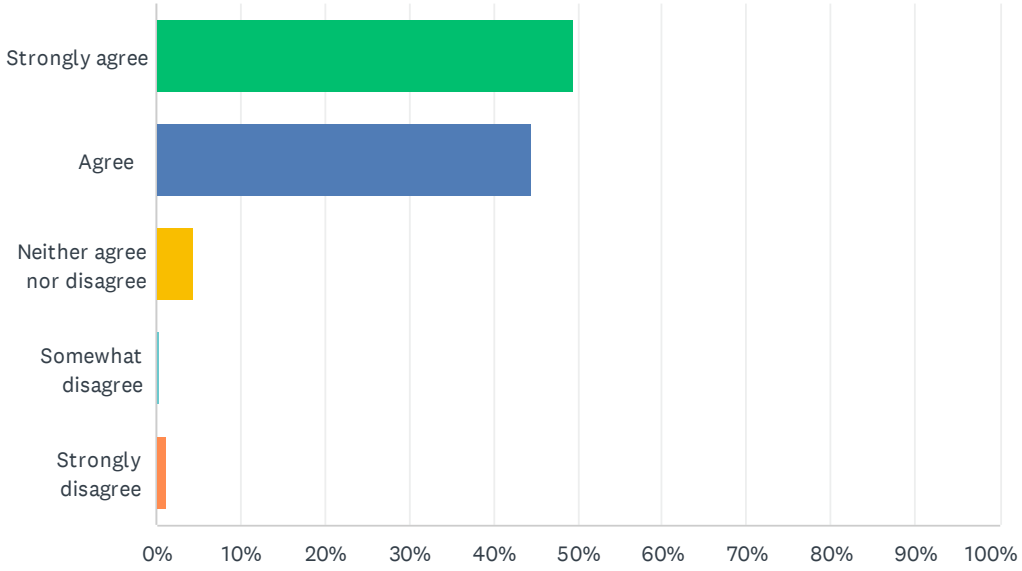
Answered: 713 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	52.31%	373
Agree	44.18%	315
Neither agree nor disagree	1.82%	13
Disagree	0.14%	1
Strongly disagree	1.54%	11
TOTAL		**713**

Q8 After completing this training, I feel comfortable making a mandated report

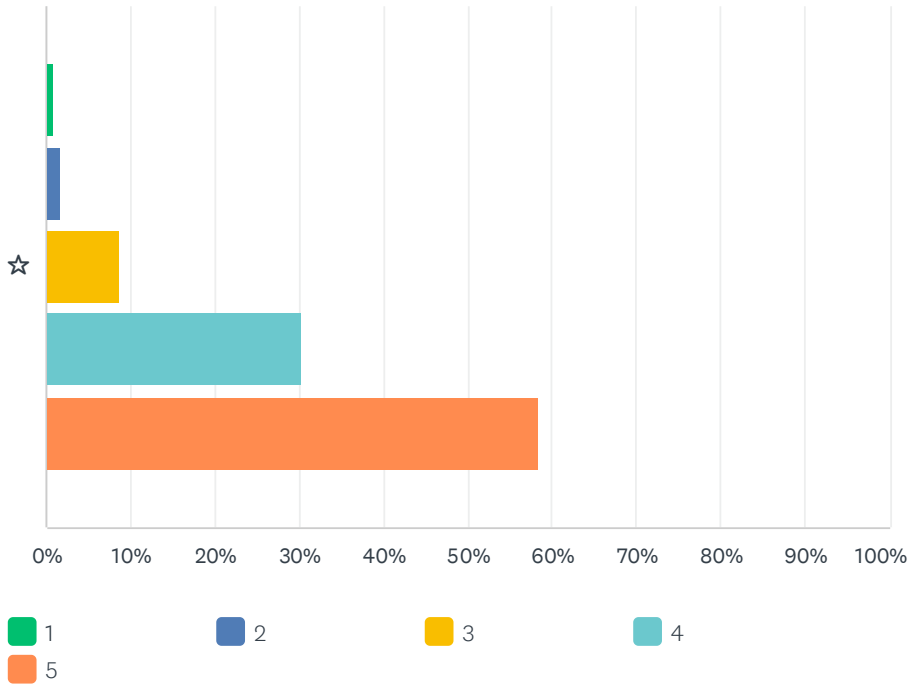
Answered: 713 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	49.37%	352
Agree	44.46%	317
Neither agree nor disagree	4.49%	32
Somewhat disagree	0.42%	3
Strongly disagree	1.26%	9
TOTAL		**713**

Q9 Please rate this training overall

Answered: 713 Skipped: 0



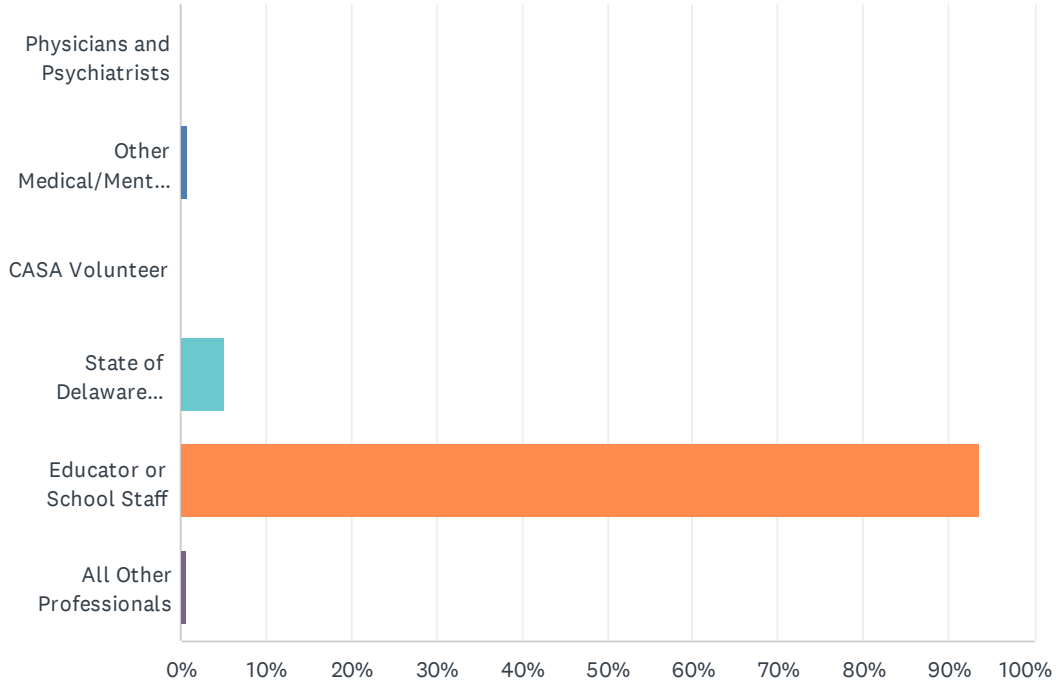
	1	2	3	4	5	TOTAL	WEIGHTED AVERAGE
☆	0.84% 6	1.68% 12	8.70% 62	30.29% 216	58.49% 417	713	4.44

Q1 Name

Answered: 4,282 Skipped: 0

Q2 Please select the category that best matches your profession

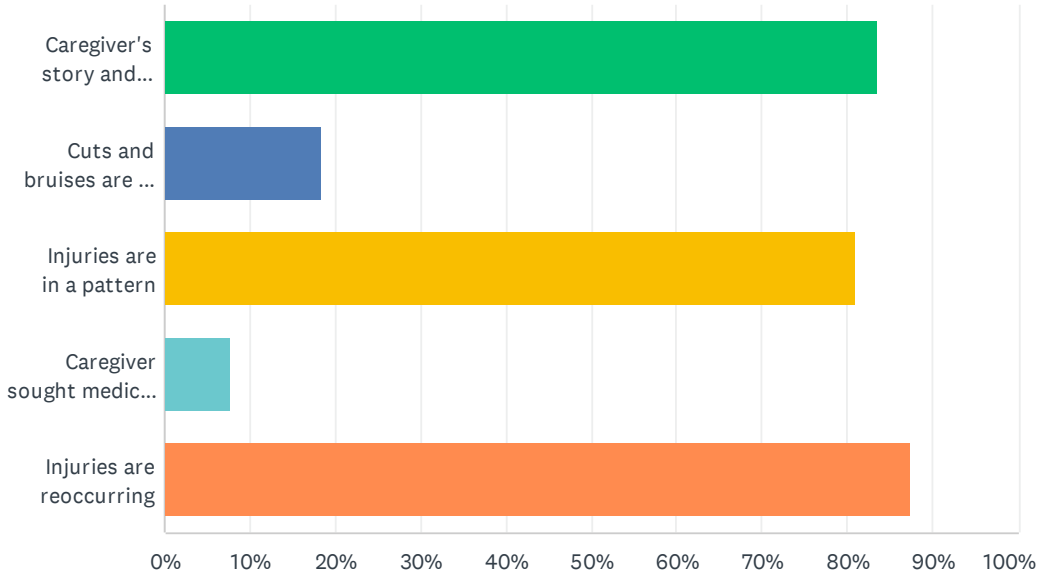
Answered: 4,282 Skipped: 0



ANSWER CHOICES	RESPONSES	
Physicians and Psychiatrists	0.02%	1
Other Medical/Mental Health Professional	0.82%	35
CASA Volunteer	0.00%	0
State of Delaware Employee	5.07%	217
Educator or School Staff	93.55%	4,006
All Other Professionals	0.54%	23
TOTAL		4,282

Q3 Select the common indicators of physical abuse that are uncommon in accidental injuries

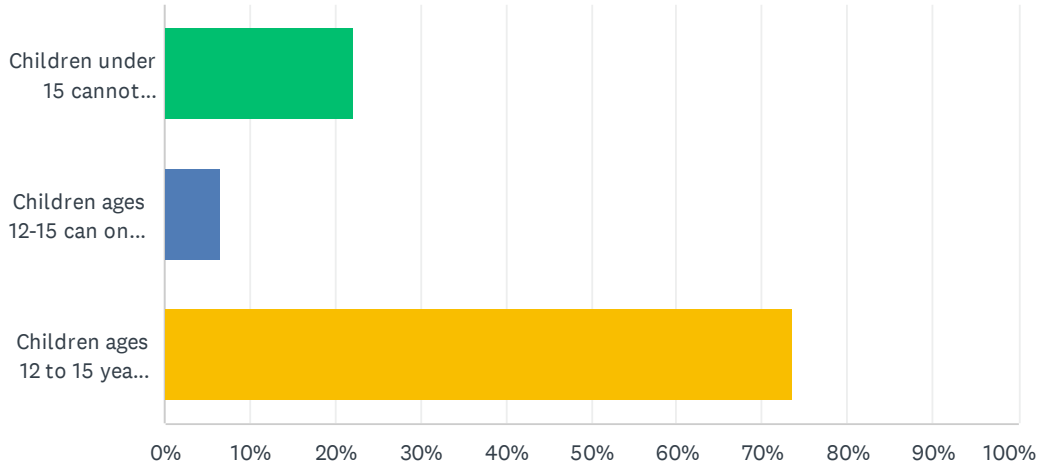
Answered: 4,282 Skipped: 0



ANSWER CHOICES	RESPONSES	
Caregiver's story and child's story are inconsistent	83.58%	3,579
Cuts and bruises are on bony areas of the body	18.43%	789
Injuries are in a pattern	81.06%	3,471
Caregiver sought medical attention right away	7.73%	331
Injuries are reoccurring	87.46%	3,745
Total Respondents: 4,282		

Q4 Select the correct legal guideline for consent regarding children ages 12-15

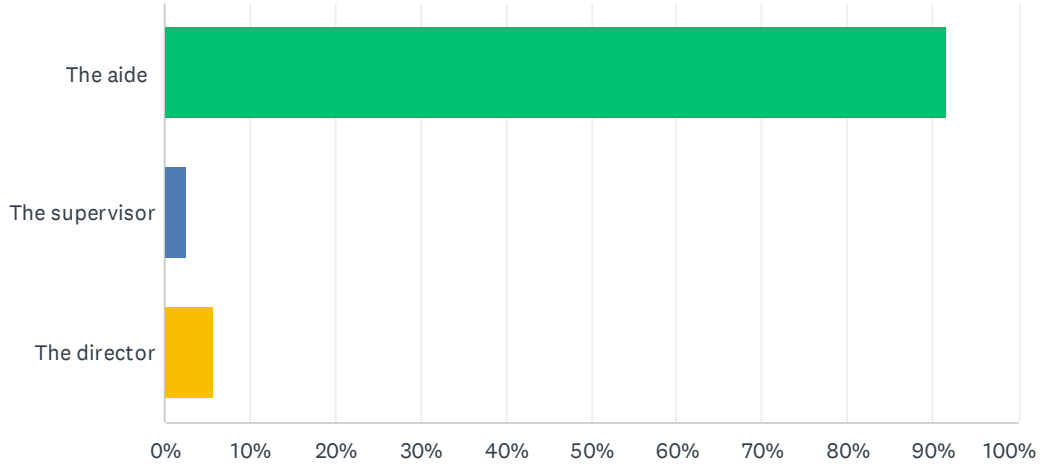
Answered: 4,282 Skipped: 0



ANSWER CHOICES	RESPONSES	
Children under 15 cannot consent to any sexual activity	22.26%	953
Children ages 12-15 can only consent to someone who is under the age of 18	6.52%	279
Children ages 12 to 15 years can only consent to sexual contact with someone who is no more than 4 years older than they are	73.49%	3,147
Total Respondents: 4,282		

Q5 In this scenario, who is required to make the mandated report to Division of Family Services (DFS)? A child tells an aide at the preschool about the physical abuse they experience. The aide tells their direct supervisor what the child said. Both the aide and supervisor tell the director of the preschool about the situation. Who is, by law, required to make the report?

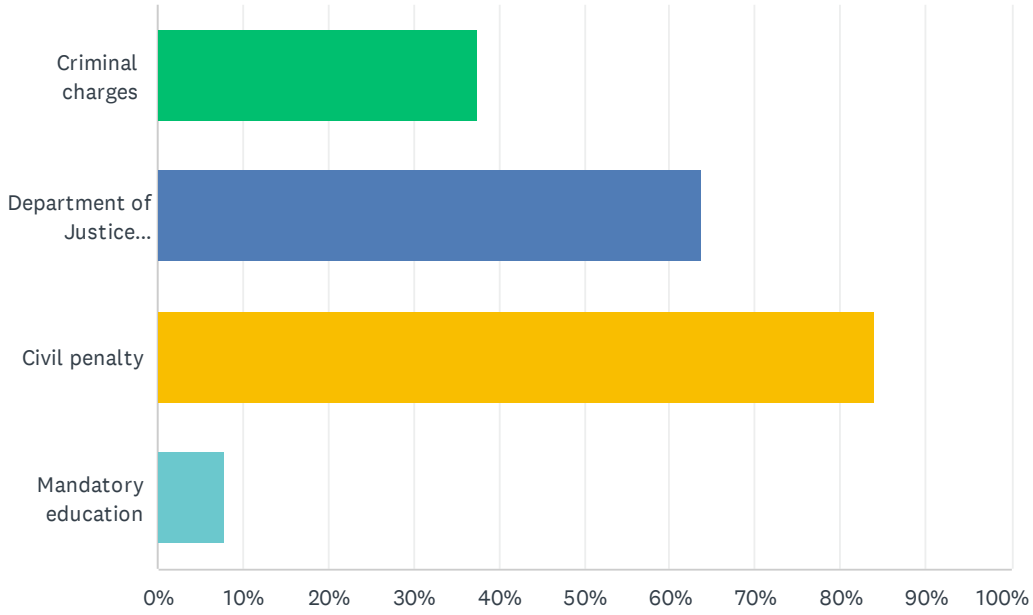
Answered: 4,282 Skipped: 0



ANSWER CHOICES	RESPONSES	
The aide	91.73%	3,928
The supervisor	2.48%	106
The director	5.79%	248
TOTAL		4,282

Q6 What are the two penalties for failure to report suspected child abuse or neglect? Select both.

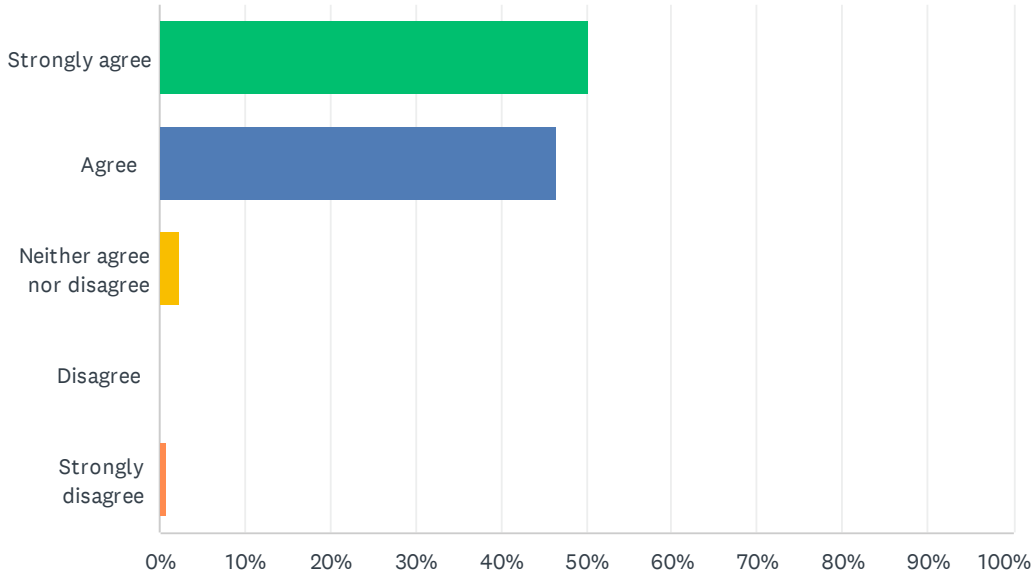
Answered: 4,282 Skipped: 0



ANSWER CHOICES	RESPONSES	
Criminal charges	37.53%	1,607
Department of Justice investigation	63.66%	2,726
Civil penalty	83.96%	3,595
Mandatory education	7.92%	339
Total Respondents: 4,282		

Q7 After completing this training, I have a better understanding of mandated reporting and child abuse and neglect.

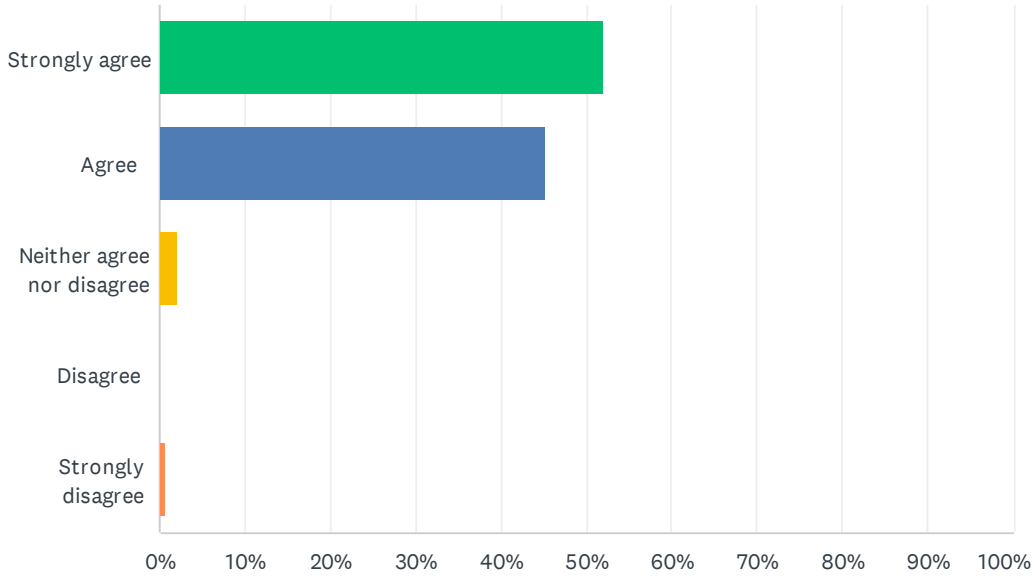
Answered: 4,282 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	50.23%	2,151
Agree	46.50%	1,991
Neither agree nor disagree	2.36%	101
Disagree	0.02%	1
Strongly disagree	0.89%	38
TOTAL		4,282

Q8 After completing this training, I have a better understanding of when a mandated report is required, who is required to make a report, and how to make a report.

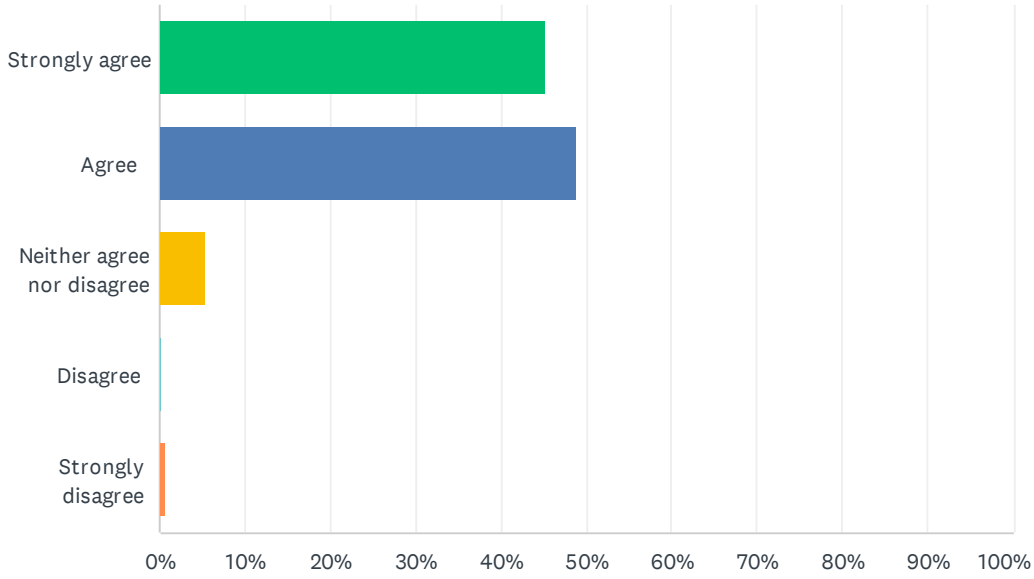
Answered: 4,282 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	52.03%	2,228
Agree	45.17%	1,934
Neither agree nor disagree	2.10%	90
Disagree	0.00%	0
Strongly disagree	0.70%	30
TOTAL		4,282

Q9 After completing this training, I feel comfortable making a mandated report.

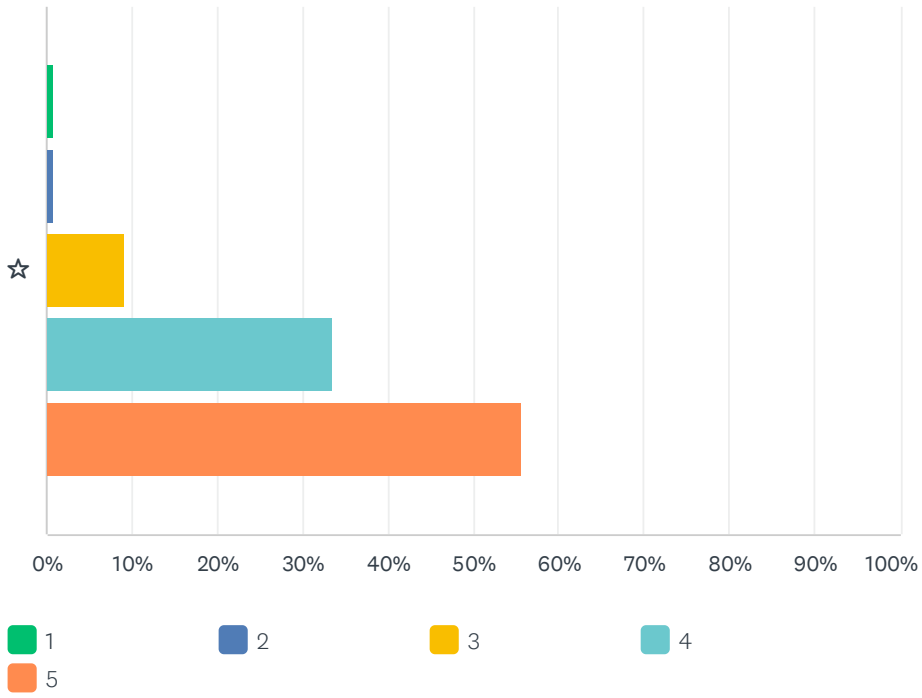
Answered: 4,282 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	45.12%	1,932
Agree	48.74%	2,087
Neither agree nor disagree	5.30%	227
Disagree	0.16%	7
Strongly disagree	0.68%	29
TOTAL		4,282

Q10 Please rate this training overall

Answered: 4,282 Skipped: 0



	1	2	3	4	5	TOTAL	WEIGHTED AVERAGE
☆	0.82% 35	0.93% 40	9.20% 394	33.42% 1,431	55.63% 2,382	4,282	4.42