Nebraska Citizen Review Panel for Child Protective Services Annual Report

Reporting Period:
April 1, 2023, through March 31, 2024
Nebraska Commission for the Protection of Children

Submitted April 1, 2024

Nebraska Commission for the Protection of Children Membership:

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Gene Klein, Co-Chair – Executive Director, Project Harmony Child Advocacy Center
Alfred E. Corey III – Juvenile Court Judge, 9th District
Amy Hoffman - Nebraska Crime Commission
Ashley D. Brown – Social Services Director, KVC
B. Gail Steen - Steen Law Office, Attorney working with children
Bill Tangeman - Office of the Nebraska Attorney General
Bobbi Taylor – Youth Engagement Consultant
Brian Welch - - Office of Early Childhood, Nebraska Department of Education
Corrie Kielty - Nebraska CASA Association
Demi Herman - Office of the Nebraska Attorney General
Erin Konecky – Parent Representative
Ivy Svoboda – Nebraska Alliance of Child Advocacy Centers
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Julia R Keown – Health Professional
Kari Rumbaugh – Deputy Probation Administrator of Juvenile Probation
Katie A. Reichert – Juvenile Case Attorney
Kitty Washburn – Supervisor, Winnebago Children and Family Services
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Michael Jepsen – Sherman County Sheriff
Monika Gross - Director, Foster Care Review Office
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The report that follows serves as the State of Nebraska's Citizen Review Panel for Child Protective Services Annual Report covering activities of the work completed starting in April 2022. During this period, the Citizen Review Panel conducted case reviews of 58 serious injuries and near fatalities due to child abuse or neglect that occurred between May 2021-March 2022.

This report was prepared on behalf of the Citizen Review Panel subcommittee Governor's Commission for the Protection of Children (Commission), which serves as one of Nebraska's three Citizen Review Panels.

Based on its reviews, the Citizen Review Panel offers the following three recommendations to improve Nebraska's child welfare system:

- Continue efforts to address the presence of racial disparities among seriously injured children.
- Develop strategies to strengthen early development education programs, parenting instruction, and identifying resources in communities.
- Continue efforts to strengthen coordination across disciplines on child abuse and neglect investigations.
- Ensure ICWA identification is completed at the onset of a case opening.

Overview of the Citizen Review Panel

Established in 1993 by Executive Order 93-7, The Nebraska Commission for the Protection of Children (Commission) has since functioned as Nebraska's CJA State Task Force. The Nebraska CJA State Task Force is one of three Citizen Review Panels in the state. The Commission is supported and administered through a contract between the Nebraska Department of Health and Human Services, Division of Children and Family Services (DHHS) and the Nebraska Children and Families Foundation (Nebraska Children). Nebraska Children began subcontracting with the Nebraska Alliance of Child Advocacy Centers (Nebraska Alliance) to assist with some of those duties in 2019. Nebraska Alliance also began to assist with the Citizen Review Panel (CRP) in 2020. CRP functions as a subcommittee of the Commission.

The review of serious injury and near fatality cases due to child abuse has been the focused effort of CRP since 2017 under the Commission. It includes both Commission and non-Commission members from the larger community.

Preliminary identification of cases happens through the statewide Child Abuse and Neglect Hotline and additional screening is done by staff with the Nebraska Department of Health and Human Services (DHHS) to see if they meet the criteria for review. DHHS then prepares case files for CRP review.

2023-2024 Citizen Review Panel Activities

Reviews of serious injuries and near fatalities remained the focus of CRP this year. DHHS prepared case records and brought paper files to the review meetings for conducting of reviews. The paper files were used to fill out review forms by paper or electronic formats.

Over the course of the year the CRP discussed issues found in the review process that were impacting the review process. This included a need for better coordination, more medical expertise, and missing records.

The CRP's activities were conducted in an in-person format where reviewers collaborated to review cases together. Each two-person review team submitted one form per case reviewed. A final virtual meeting took place in February 2023 to finalize recommendations based on reviews completed in 2022.

Serious Injury Review Results

The following section provides details on the 58 serious injuries and near fatalities that the CRP reviewed. The CRP Committee reviewed 58 cases, however at times questions were skipped if it was not applicable to a case; the data in this report is reflective of that. The children lived in 22 different locations across the state. 22 of 56 or 39% of all injuries reviewed occurred in Omaha in Douglas County. 6 of 56 or 11% of injuries reviewed occurred in Lincoln in Lancaster County. The remaining 50% of cases reviewed occurred in 20 other counties. Two cases reviewed did not identify counties.

Child Characteristics

The reviews gathered basic demographic information about the children who were injured in addition to asking about any diagnosed conditions and additional vulnerabilities.

- Of the children injured: 32 of 56 or 57% of the children seriously injured were under the age of 2.
- Six additional children who were injured were between 2 and 4 years old. In total, 81% of children injured were under the age of 5.

Racial disparities were prevalent. Black and American Indian children were disproportionately represented in the injuries relative to their percentage of the population.

- 37 of 58 or 64% of children seriously injured were white, although white children make up 77% of Nebraska's child population according to 2021 5-year census data.
- While Black children were only 6% of the child population, however accounted for 12 of 58 or 21% of those injured. American Indian children make up 1% of the child population but 2 of 58 or 3.4% of those seriously injured.
- 20 of 50 cases or 40% of the children had a diagnosed condition prior to their injury. Of those with a diagnosed condition:
    - Four responses, or 8%, had medical diagnoses.
    - Two responses, or 4% had developmental disabilities.

- Six responses or 12% had mental health diagnoses.
- Eight responses, or 16% had other conditions.

Injury Characteristics

The reviews gathered information on the cause of injury, where the injury occurred, and the party determined responsible for the injury. The reviews revealed:

- Fractures accounted for 14 of 56 cases or 25%, and abusive head injuries accounted for 10 of 56 or 18%.
  Physical abuse was determined to be the cause of the injury most frequently – in 26 of 56 or 46% of cases. 11 of 56 or 20% of cases were determined to have an accidental cause. Neglect was the cause of injury in 9 of 56, or 16% of cases.
- Secondary injuries noted included fractures, bruising, abusive head injuries, other physical trauma, burn(s), and other skin findings.
- 34 of 55 or 62% of serious injuries occurred in the child's household. An additional 7 of 55 or 13% of serious injuries occurred in other households. Four injuries or 7% occurred in an unknown location. Two or 4% of serious injuries occurred in a childcare or school setting.
- 37 of 56 responses or 66% of the injuries were caused by the parent/guardian, or caregiver of the child.
- In 7 of 56 responses, or 13%, the party responsible for the abuse or neglect was an "other" adult household member.
- In 4 of 56 responses, or 7%, no one was found responsible for the injury.
- In 3 of 56 cases or 5%, the party responsible for the abuse or neglect was not able to be determined.

Investigation of and Response to Serious Injury

The reviews gathered information on how the injury was investigated as well as what services were provided to the family to ensure continued safety. This year's reviews showed:

- In most cases DHHS, law enforcement and medical providers were frequently involved in investigations. Reviewers noted concerns about a lack of documentation and coordination between these agencies during the response to the injury.
- Medical providers were included in 45 of 56 cases or 80% of investigations compared to 2022's report of medical providers being included in 91% of investigations.
- Child advocacy centers were only used in 14 of 56 cases or 25% of investigations compared to 2022's report of child advocacy centers being included in 14% of investigations.
- Criminal charges related to the injury were filed in only 14 of 56, or 25% of cases.
- Only 20 of 56 cases or 36% resulted in an ongoing child welfare case.
- Issues with investigation found by reviewers included insufficient documentation (25%), better coordination needed (16%), additional medical expertise needed (16%), identification of further interviews that could have been done (11%), and information that needed further verification in the cases (28%).

Household Characteristics and Child Welfare System Involvement

The reviews gathered information on the child's family and household circumstances and the child and family's involvement with the child welfare system before and after the injury for those cases where a parent or caregiver was found to be responsible for the abuse or neglect.

- 28 of 54, or 52% had no child welfare involvement at the time of their injury.
- 15 of 54 cases or 28% had contact with the child welfare system at the time of injury in the past 12 months, involvement with Alternative Response in the past 12 months, and/or a screened-out report to the Hotline.
- 2 of 54 responses or 4% had open non-Court cases.
- In 36 of 54 cases or 82%, at least one risk factor was noted. Of the 36 cases with risk factors, the following reasons were present:
    - In 13 of 51 responses or 25% of cases an "other" reason was specified. The "other" risk factors noted included prior criminal disposition or activity of a parent, foster care system involvement of the parents when they were a child, external family stressors, stressful family dynamics, or prior DHHS involvement.
    - In 22 of 51 cases or 43% a family history related to abuse and neglect.
    - In 22 of 51 cases or 43% a caregiver with diagnosed severe persistent mental illness and/or substance use disorder.
    - In 17 of 51 cases or 33% there were prior incidents of domestic violence.
    - In 18 of 51 cases or 35% the caregiver was under the age of 25.
- 72% had at least one protective factor. 62% noted Concrete supports as a protective factor; this was the most frequently reported category.

Of the 53 cases with risk factors, the following child welfare involvement was present:

- In 19 of 53 cases or 36%, the children were part of cases involved with DHHS in which there were calls involving the child to the child abuse and neglect hotline in the prior 12 months.
- In 7 of 53 cases or 13%, the children involved with the child welfare system during or prior to their injury scored as high or very high risk for future abuse on the DHHS structured decision making (SDM) tool.

Accidental Injury Review

Last year in 2022 26% of cases flagged for CRP review were ultimately determined by investigating parties to be accidental or the ultimate cause was not able to be determined. In 2023, that percentage increased to 29% of CRP cases.

2023-2024 Recommendations

Based on the reviews it conducted in 2023, the CRP makes the following recommendations to improve the child welfare response in Nebraska:

Continue efforts to address the presence of racial disparities among seriously injured children.

The data still shows that marginalized communities are disproportionately represented in the child welfare system in Nebraska. This indicates that there is a need for further efforts to address the inequalities in the involvement of different populations in the system.

Develop strategies to strengthen early development education programs, parenting instruction, address the presence of racial disparities among seriously injured children.

During this review period, 68% of the children reviewed were under the age of 5. In some cases, there were children that had no known prior contact with the child welfare system. This suggests additional prevention and education efforts could be focused on families with young children.

Continue efforts to strengthen coordination across disciplines on child abuse and neglect investigations.

The CRP requests an update on efforts to work with local MDTs on identifying wats to improve information sharing and coordination on child abuse and neglect investigations.

Ensure ICWA identification is completed at the onset of a case opening.

The CRP reviewed some cases where ICWA was not identified until later in the case, thus denying the child access to potential resources and delaying permanency. The CRP would like to know what measures are in place for assessing for ICWA outside of asking the caregiver.

Update on 2022-2023 Report Recommendations

The CRP received an update from DHHS rerequests an update on the following recommendations contained in last year's report:

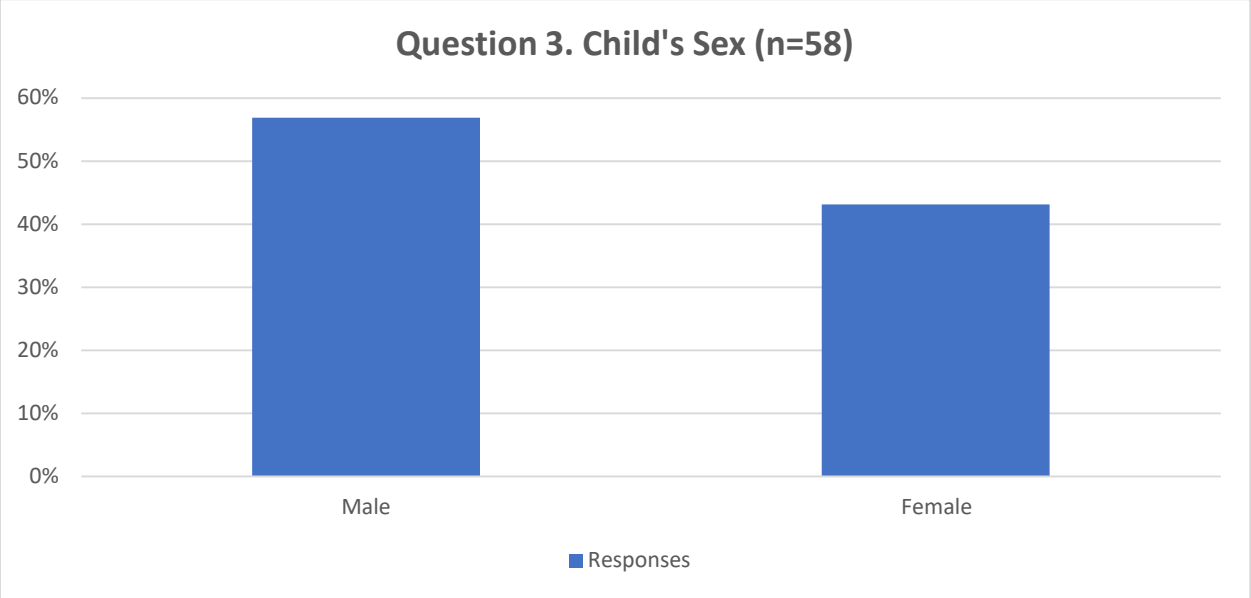
In April 2023, the CRP submitted it's annual report which included three recommendations to Nebraska DHHS:

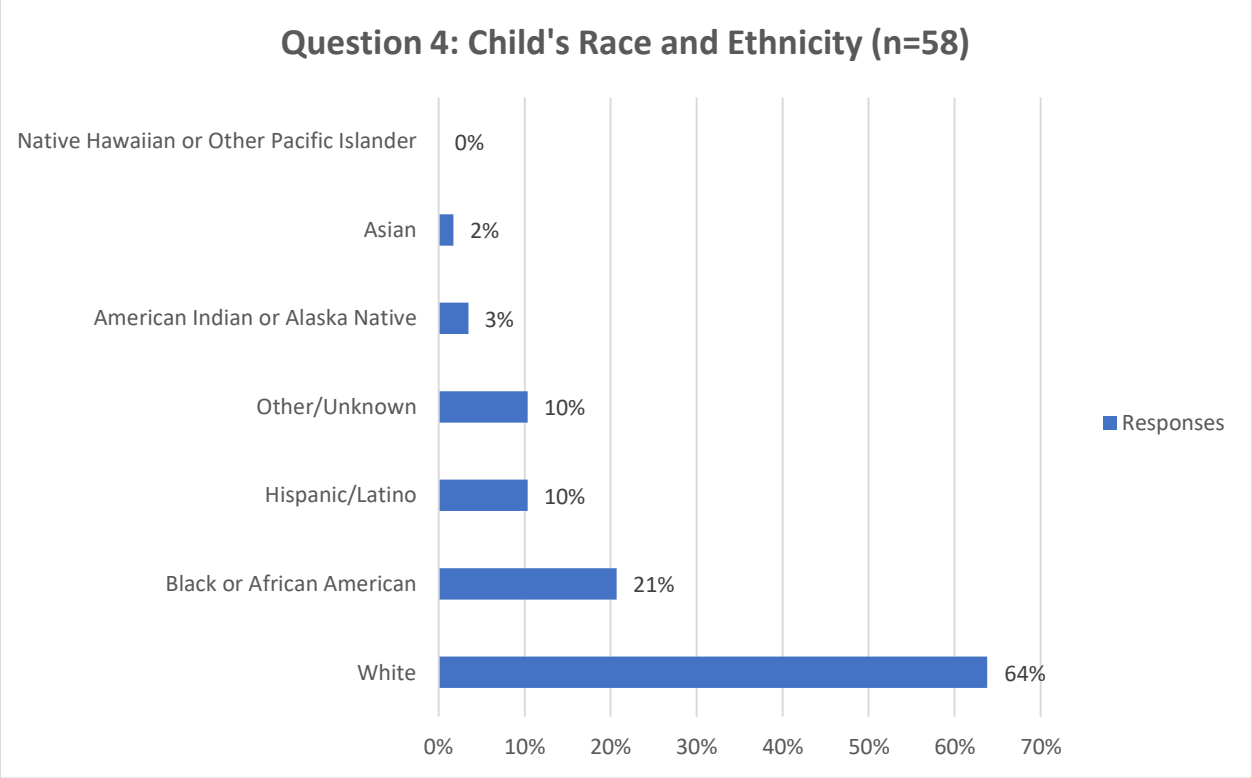
- Continue efforts to ensure law enforcement and medical reports are obtained by DHHS.
- Continue efforts to strengthen coordination across disciplines on child abuse and neglect investigations.
- Local Child Abuse and Neglect Investigation multi-disciplinary teams should conduct thorough reviews of all near fatalities and serious injuries suspected to be caused by abuse or neglect.

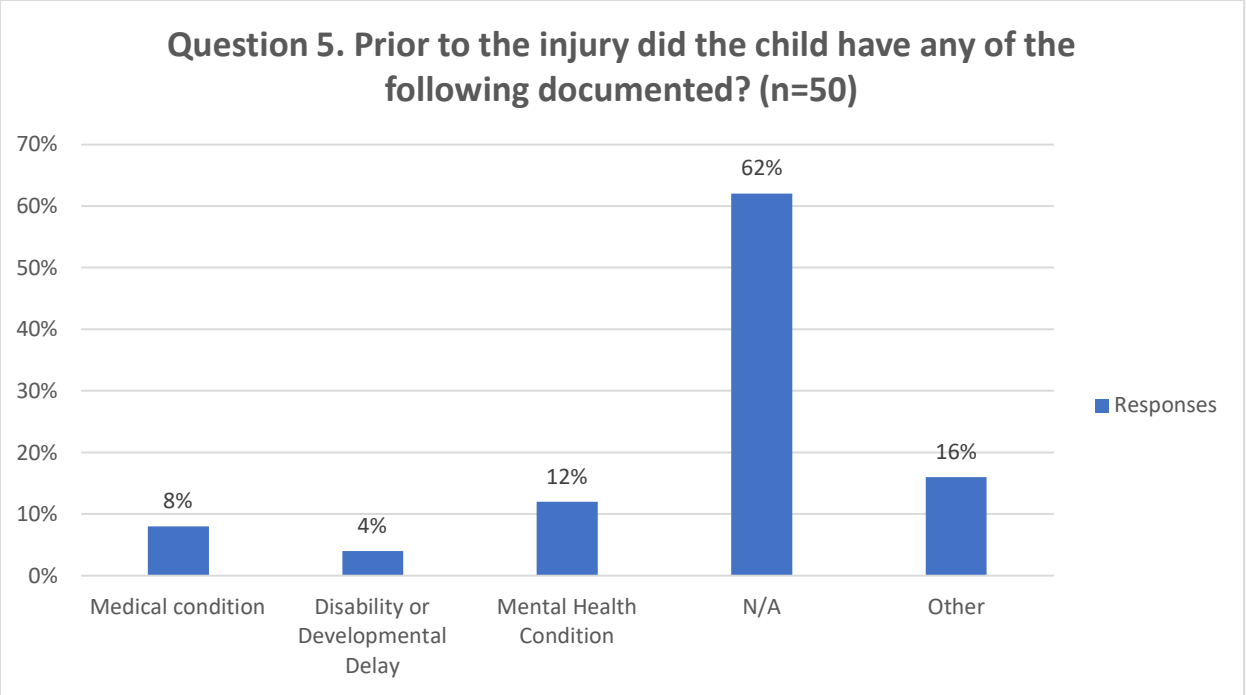
The CRP continues to monitor these issues. DHHS reported they have guidance for works to ensure law enforcement and medical reports are obtained, as well as internal documents that will be reviewed as part of an ongoing policy project. For strengthening disciplines across MDTs,

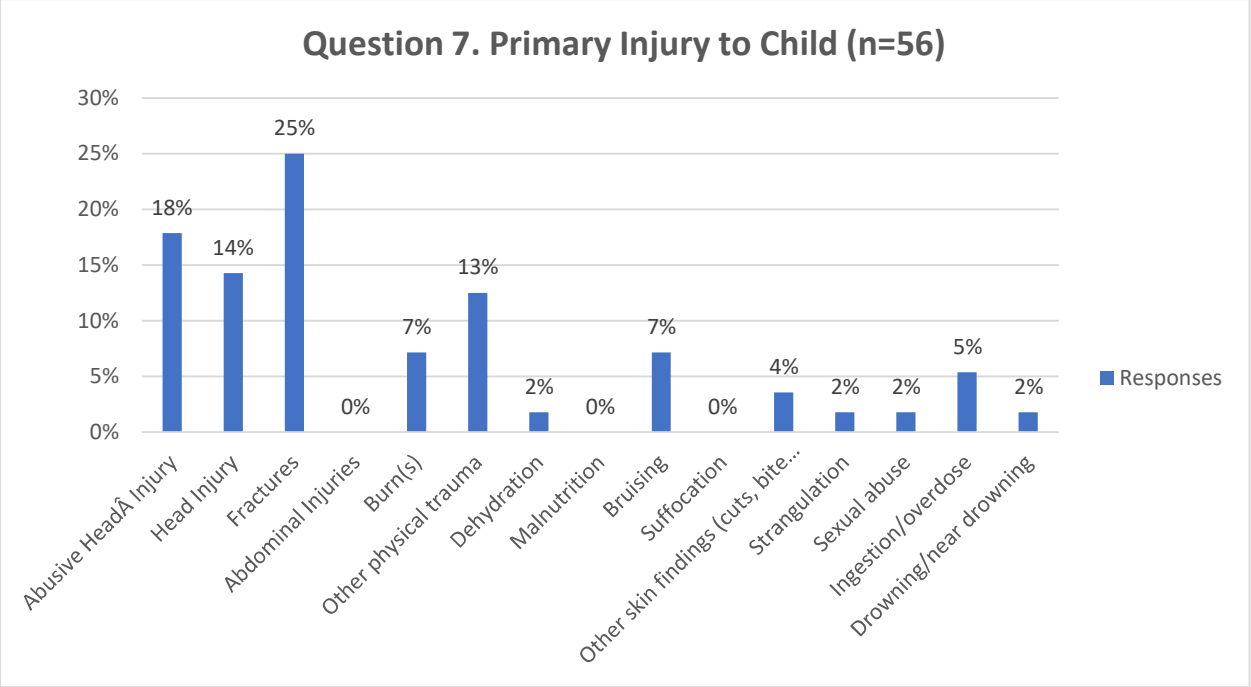
DHHS reported the MDT Subcommittee under the Commission for the Protection of Children is in the process of reviewing statewide MDT protocols that may help strengthen consistency and coordination of MDTs. In response to the recommendation around conducting thorough reviews of near fatality and serious injury cases, DHHS cited their procedure, requiring collaboration with the Child Advocacy Centers and a referral to the MDT. In addition, the statewide MDT protocols could include criteria for referral and review of cases.

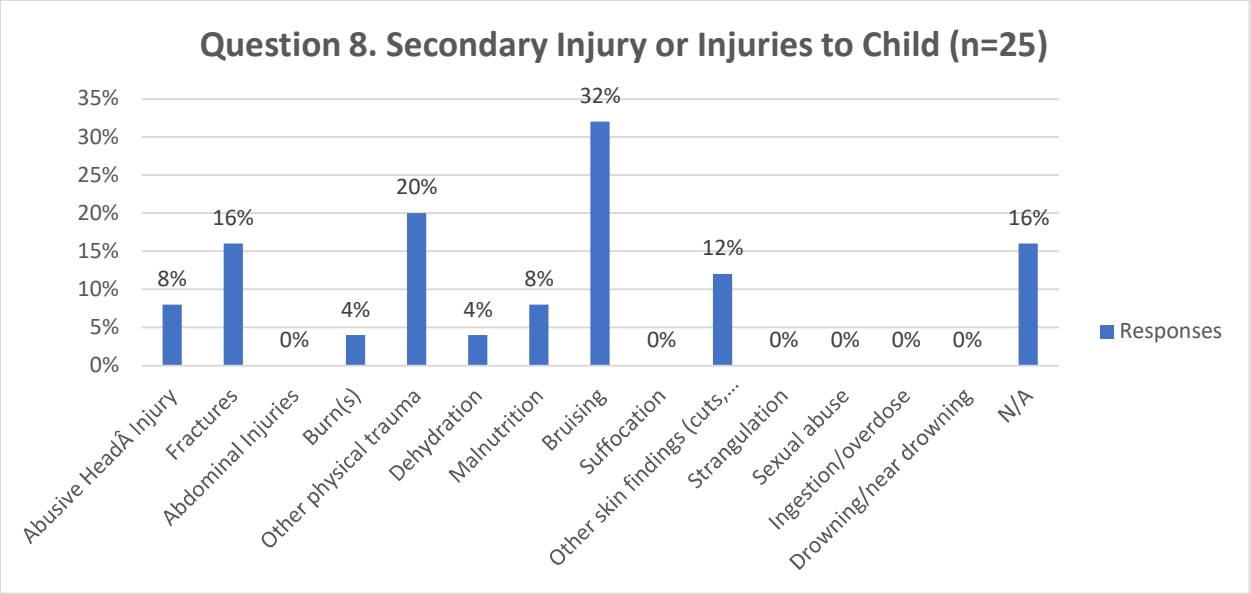
Appendix A. Full Data from Case Reviews

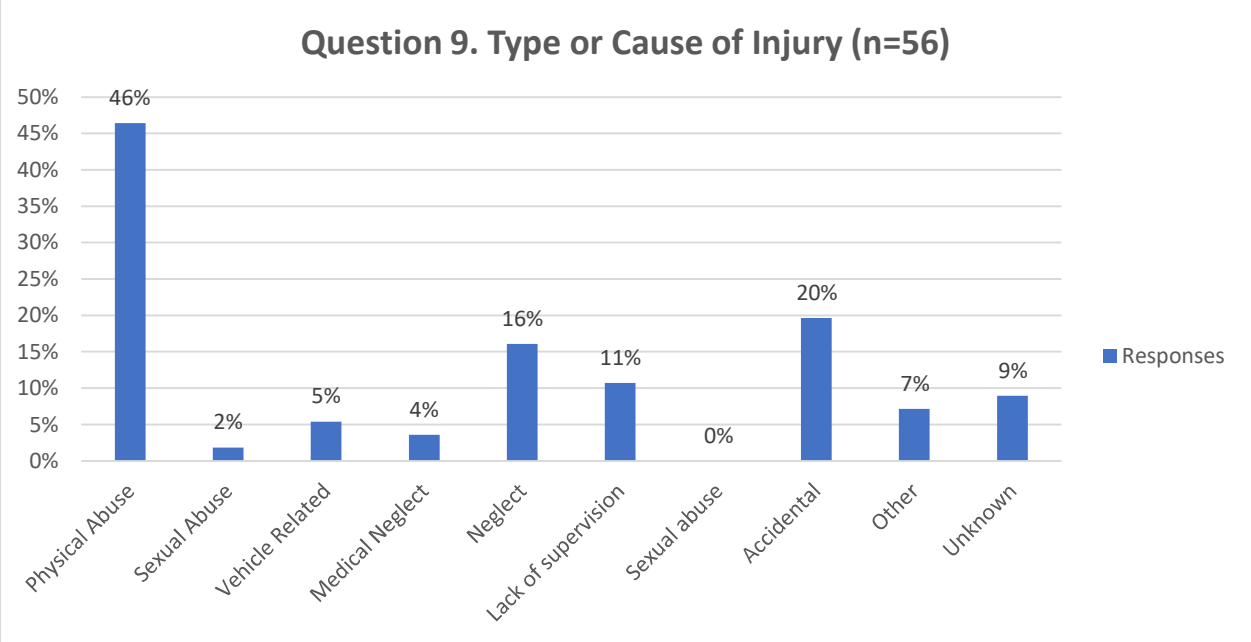


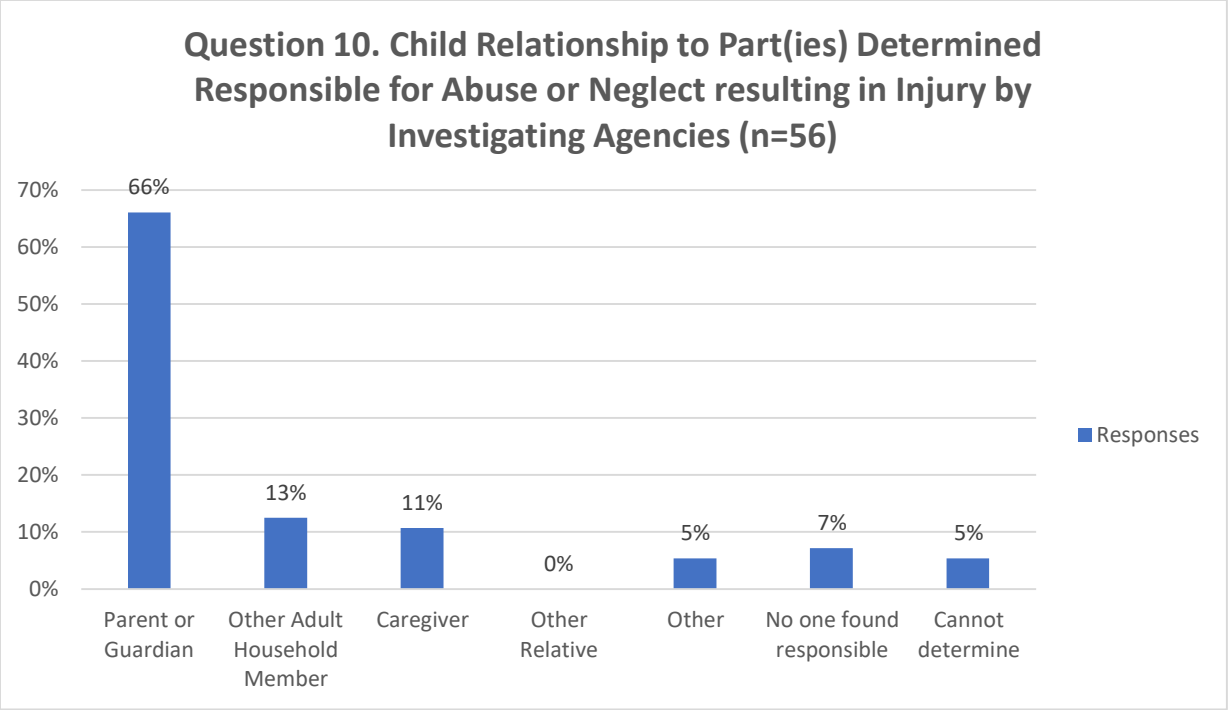


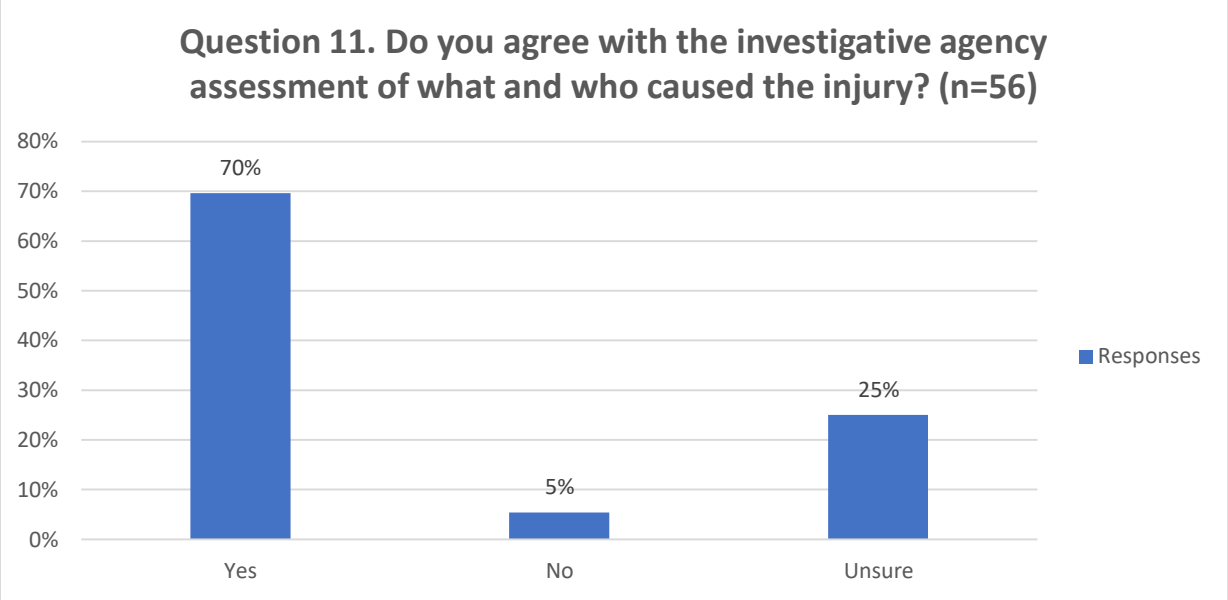

Question 5. Prior to the injury did the child have any of the following documented? (n=50)
70%
60%
50%
40%
30%
20%
10%
0%
8%
4%
12%
62%
16%
Medical condition
Disability or Developmental Delay
Mental Health Condition
N/A
Other
Responses

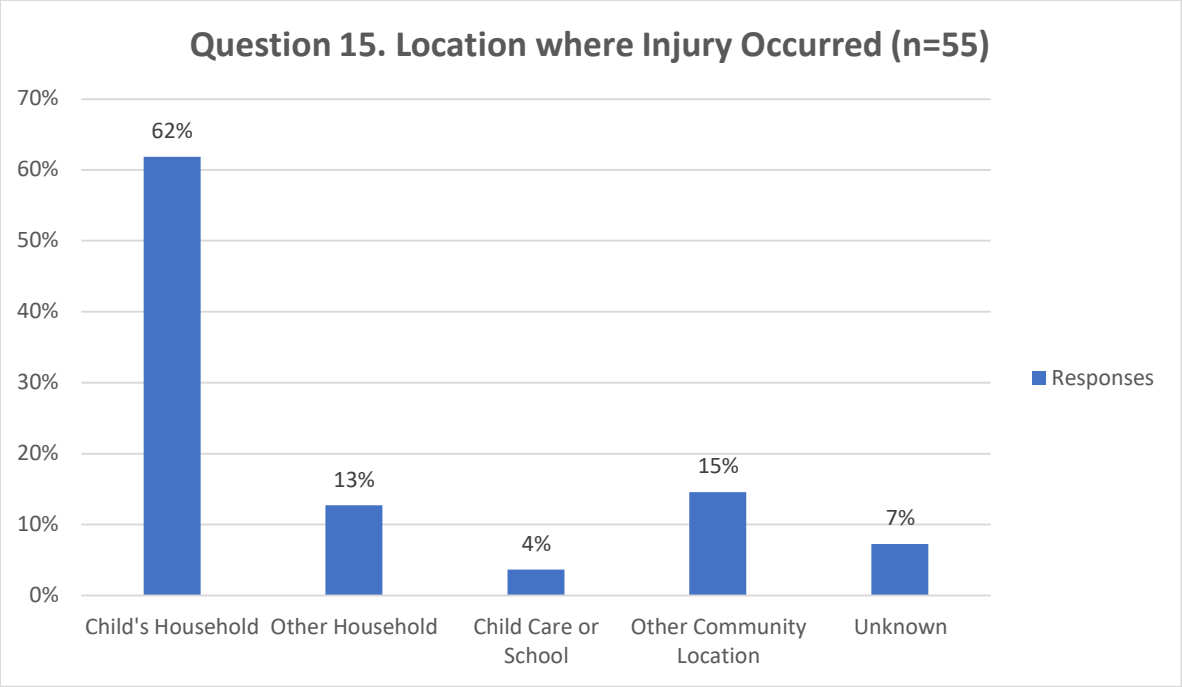

Question 7. Primary Injury to Child (n=56)
30%
25%
20%
15%
10%
5%
0%
18%
14%
25%
0%
7%
13%
2%
0%
7%
0%
4%
2%
2%
5%
2%
Abusive HeadÂ Injury
Head Injury
Fractures
Abdominal Injuries
Burn(s)
Other physical trauma
Dehydration
Malnutrition
Bruising
Suffocation
Other skin findings (cuts, bite...
Strangulation
Sexual abuse
Ingestion/overdose
Drowning/near drowning
Responses

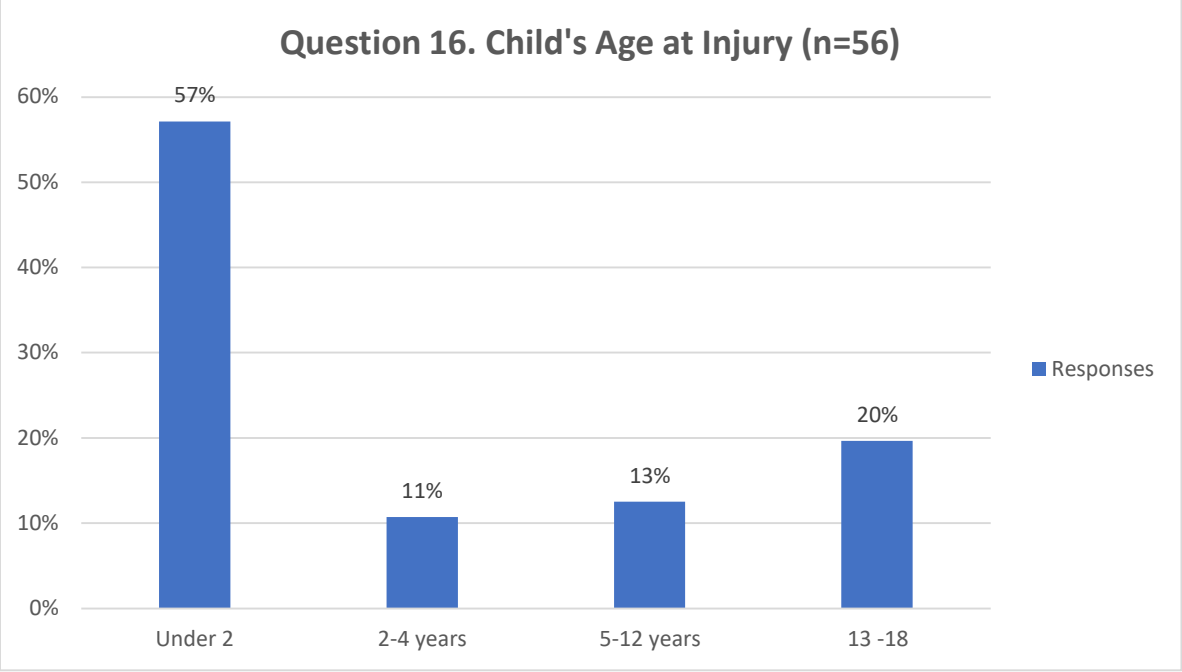

Question 8. Secondary Injury or Injuries to Child (n=25)
35%
30%
25%
20%
15%
10%
5%
0%
8%
16%
0%
4%
20%
4%
8%
32%
0%
12%
0%
0%
0%
0%
16%
Abusive HeadÂ Injury
Fractures
Abdominal Injuries
Burn(s)
Other physical trauma
Dehydration
Malnutrition
Bruising
Suffocation
Other skin findings (cuts,...
Strangulation
Sexual abuse
Ingestion/overdose
Drowning/near drowning
N/A
Responses

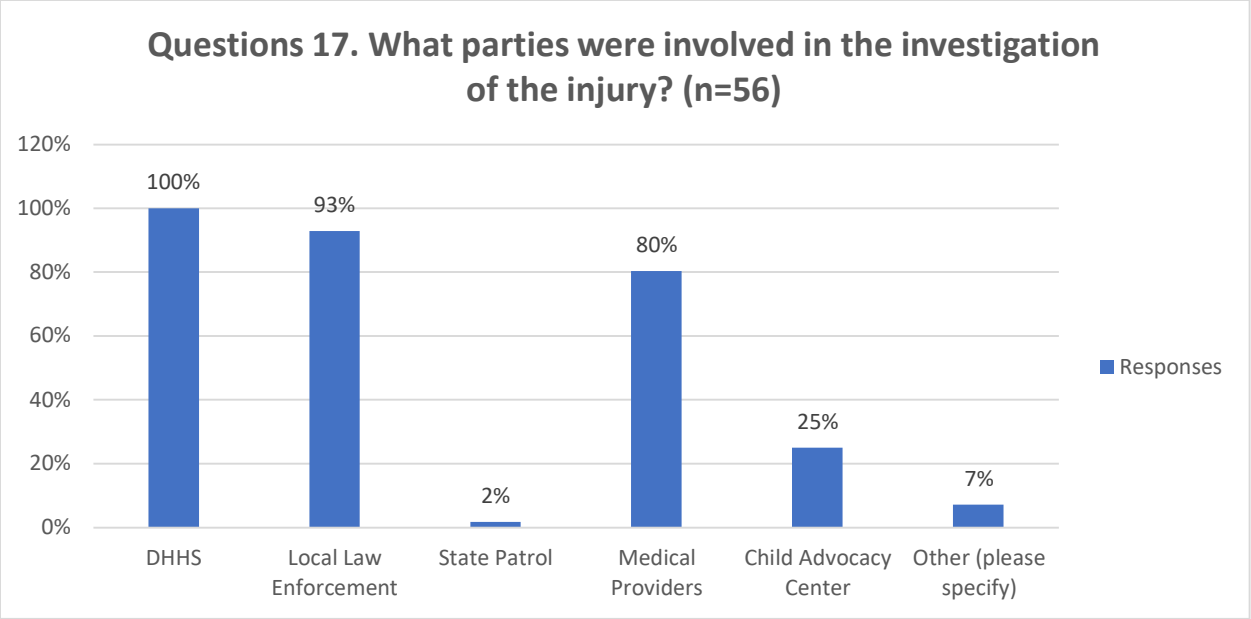

Question 9. Type or Cause of Injury (n=56)
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
46%
2%
5%
4%
16%
11%
0%
20%
7%
9%
Physical Abuse
Sexual Abuse
Vehicle Related
Medical Neglect
Neglect
Lack of supervision
Sexual abuse
Accidental
Other
Unknown
Responses

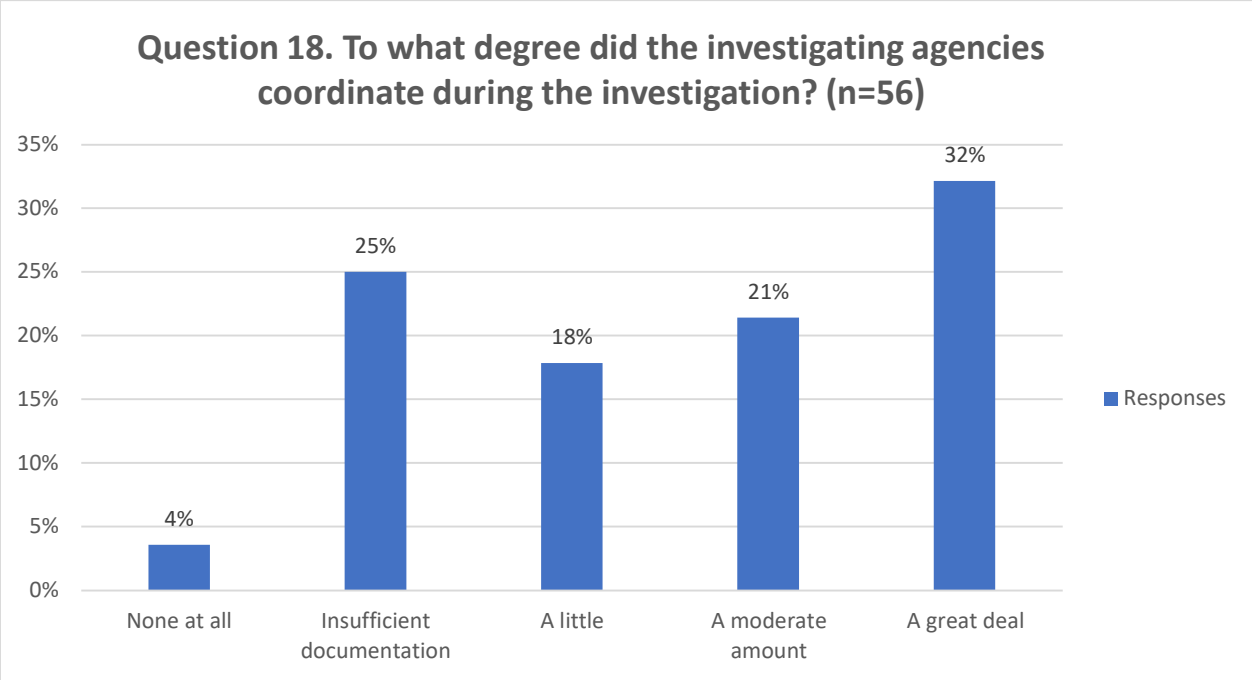

Question 10. Child Relationship to Part(ies) Determined Responsible for Abuse or Neglect resulting in Injury by Investigating Agencies (n=56)
70%
60%
50%
40%
30%
20%
10%
0%
66%
13%
11%
0%
5%
7%
5%
Parent or Guardian
Other Adult Household Member
Caregiver
Other Relative
Other
No one found responsible
Cannot determine
Responses

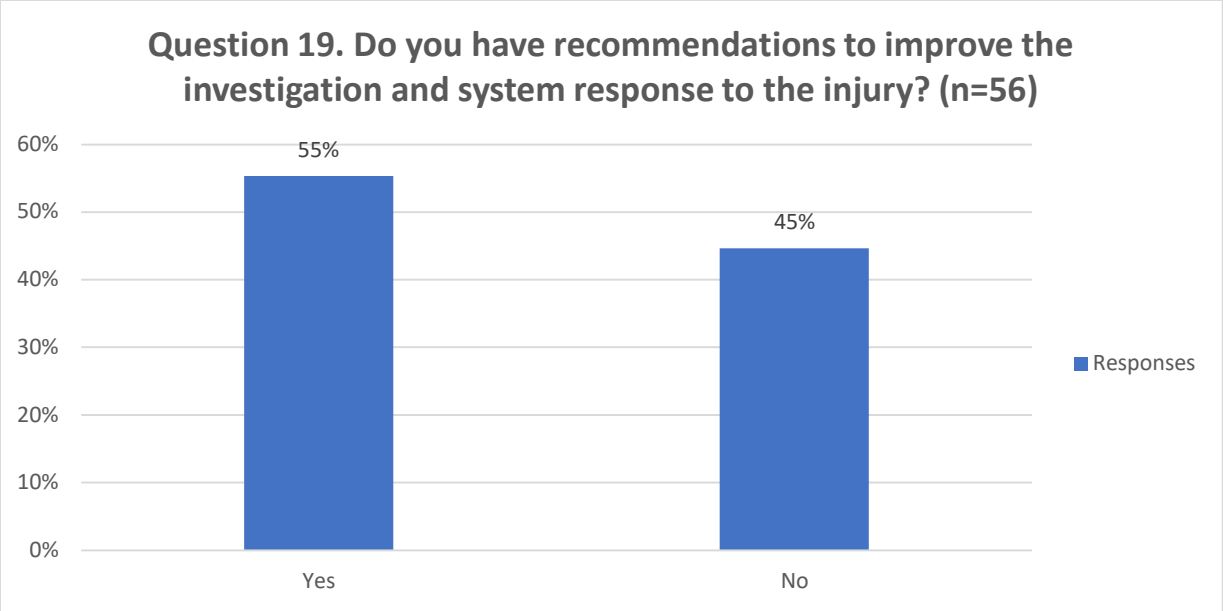

Question 11. Do you agree with the investigative agency assessment of what and who caused the injury? (n=56)
80%
70%
60%
50%
40%
30%
20%
10%
0%
70%
5%
25%
Yes
No
Unsure
Responses

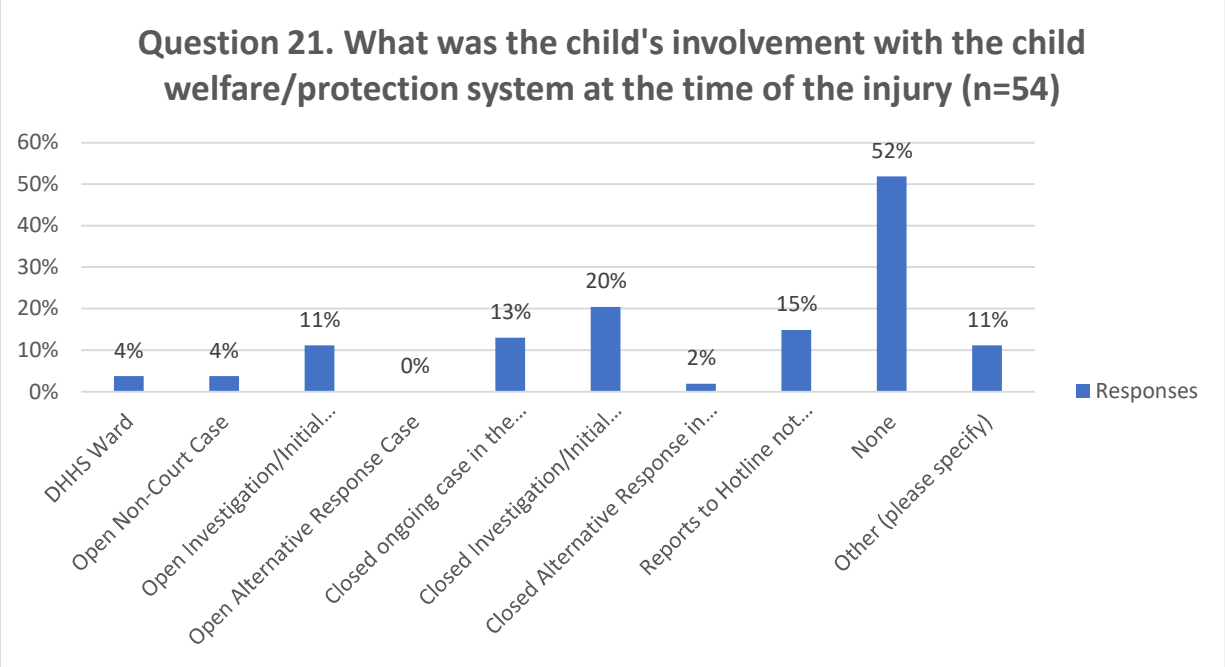

Question 15. Location where Injury Occurred (n=55)
70%
60%
50%
40%
30%
20%
10%
0%
62%
13%
4%
15%
7%
Child's Household
Other Household
Child Care or School
Other Community Location
Unknown
Responses


Question 16. Child's Age at Injury (n=56)
60%
50%
40%
30%
20%
10%
0%
57%
11%
13%
20%
Under 2
2-4 years
5-12 years
13 -18
Responses


Questions 17. What parties were involved in the investigation of the injury? (n=56)
120%
100%
80%
60%
40%
20%
0%
100%
93%
2%
80%
25%
7%
DHHS
Local Law Enforcement
State Patrol
Medical Providers
Child Advocacy Center
Other (please specify)
Responses

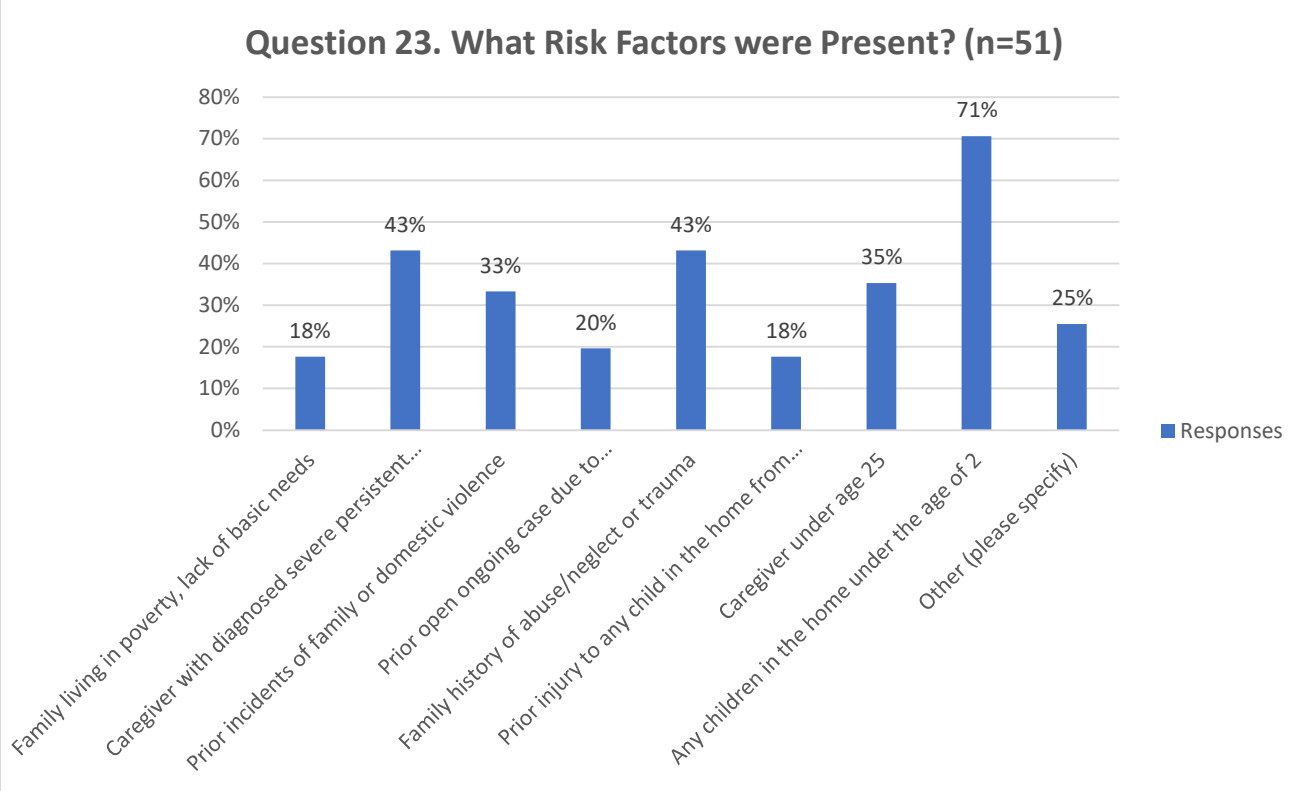

Question 18. To what degree did the investigating agencies coordinate during the investigation? (n=56)
35%
30%
25%
20%
15%
10%
5%
0%
4%
25%
18%
21%
32%
None at all
Insufficient documentation
A little
A moderate amount
A great deal
Responses


Question 19. Do you have recommendations to improve the investigation and system response to the injury? (n=56)
60%
50%
40%
30%
20%
10%
0%
55%
45%
Yes
No
Responses


Question 21. What was the child's involvement with the child welfare/protection system at the time of the injury (n=54)
60%
50%
40%
30%
20%
10%
0%
4%
4%
11%
0%
13%
20%
2%
15%
52%
11%
DHHS Ward
Open Non-Court Case
Open Investigation/Initial...
Open Alternative Response Case
Closed ongoing case in the...
Closed Investigation/Initial...
Closed Alternative Response in...
Reports to Hotline not...
None
Other (please specify)
Responses

Question 22. If the child and family was involved with DHHS, please respond to the following questions about safety and risk.

If the child and family was involved with DHHS, please respond to the following questions about safety and risk:									
	Yes		No		Unsure		N/A		Total
Were there calls to the child abuse and neglect hotline in the prior 12 months involving the child?	35.84%	19	5.66%	3	1.88%	1	56.60%	30	53
Was there an active safety plan in place when the injury occurred?	9.43%	5	30.19%	16	3.77%	2	55.78%	29	52
Was there a safety plan in place for the child at any point in the twelve months before the injury?	9.43%	5	30.19%	16	3.77%	2	55.78%	29	52
Was the family classified as high or very high risk in the twelve months before the injury?	13.46%	7	25%	13	5.77%	3	55.78%	29	52
Was the child welfare case meeting the family needs and child safety?	5.77%	3	17.31%	9	3.77%	2	55.78%	38	52
Comments:									17

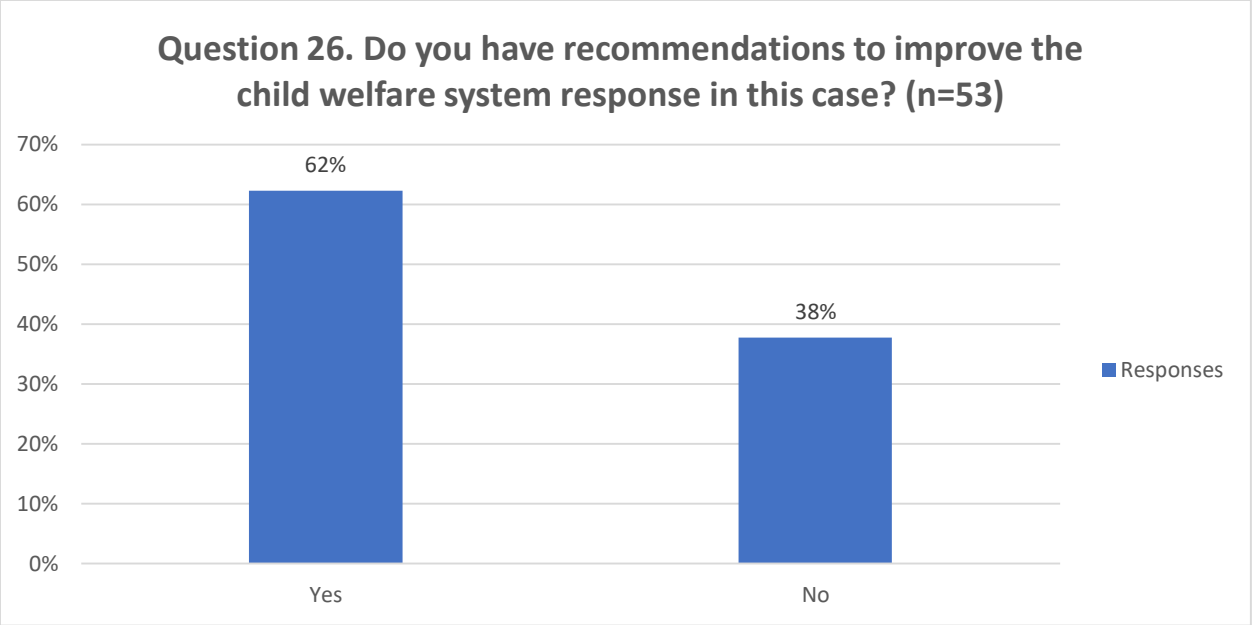


Question 24. What Protective Factors were present? (n=38)

Answer Choices	Responses	
Parental resilience: Manages stress and functions well when faced with challenges, adversity, and trauma	32.08%	17
Social connections: Builds positive relationships that provide emotional, informational, instrumental, and spiritual support	28.30%	15
Knowledge of parenting and child development: Understands child development and parenting strategies that support physical, cognitive, language, social, and emotional development	32.08%	17
Concrete support in times of need: Has access to support and/or services (e.g., healthy food; a safe environment; specialized medical, mental health, social, educational, and legal services, as needed) that address a family's needs and help minimize stress caused by challenges	62.26%	33
Social-emotional competence of children: Encourages family and child interactions that help children develop the ability to communicate clearly, recognize and regulate their emotions, and establish and maintain relationships	18.87%	10
Not enough information to determine	28.30%	15
Other (please specify)	13.21%	7

Question 25. What was the outcome of the investigation? (n=41)

Answer Choices	Responses	
Criminal Charges Filed	25.00%	14
Juvenile Petition Filed/Court-Involved Child Welfare Case Opened	35.71%	20
Non-Court Child Welfare Case Opened	8.93%	5
Child welfare case open prior to injury continued	8.93%	5
Community Services and Supports Offered	19.64%	11
Child Removal	41.07%	23
None of the above	25.00%	14
Other (please specify)	26.79%	15


Question 26. Do you have recommendations to improve the child welfare system response in this case? (n=53)
70%
60%
50%
40%
30%
20%
10%
0%
62%
38%
Yes
No
Responses

Appendix B. Case Review Tool 2023

1. Separate attachment

2023 CRP Serious Injury and Near Fatality Review Form

Reviewer and Child Demographic Information

1. Name of Reviewer(s)

2. Child Information

DHHS ID Number	
Date of Birth	
City/Town of Residence	
County of Residence	

3. Child's Sex

- ◯ Male
- ◯ Female

4. Child's Race and Ethnicity

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Hispanic/Latino
- ☐ Other/Unknown

5. Prior to the injury did the child have any of the following documented?

- ☐ Medical condition
- ☐ Disability or Developmental Delay
- ☐ Mental Health Condition
- ☐ N/A
- ☐ Other

Provide any relevant details.

2023 CRP Serious Injury and Near Fatality Review Form

Cause of Injury

6. Provide a brief narrative of the injury

7. Primary Injury to Child: Please select the most serious injury requiring treatment.

- ◯ Abusive Head Injury
- ◯ Head Injury
- ◯ Fractures
- ◯ Abdominal Injuries
- ◯ Burn(s)
- ◯ Other physical trauma
- ◯ Dehydration
- ◯ Malnutrition
- ◯ Bruising
- ◯ Suffocation
- ◯ Other skin findings (cuts, bite marks -all skin findings other than burns and bruising)
- ◯ Strangulation
- ◯ Sexual abuse
- ◯ Ingestion/overdose
- ◯ Drowning/near drowning

8. Secondary Injury or Injuries to Child Noted

- [ ] Abusive Head Injury
- [ ] Fractures
- [ ] Abdominal Injuries
- [ ] Burn(s)
- [ ] Other physical trauma
- [ ] Dehydration
- [ ] Malnutrition
- [ ] Bruising
- [ ] Suffocation
- [ ] Other skin findings (cuts, bite marks -all skin findings other than burns and bruising)
- [ ] Strangulation
- [ ] Sexual abuse
- [ ] Ingestion/overdose
- [ ] Drowning/near drowning
- [ ] N/A

9. Please select the cause(s) of injury indicated by the investigating agency or agencies

- [ ] Physical Abuse
- [ ] Sexual Abuse
- [ ] Vehicle Related
- [ ] Medical Neglect
- [ ] Neglect
- [ ] Lack of supervision
- [ ] Sexual abuse
- [ ] Accidental
- [ ] Other
- [ ] Unknown

Comments:

10. Child Relationship to Part(ies) Determined Responsible for Abuse or Neglect resulting in Injury by Investigating Agencies

- [ ] Parent or Guardian
- [ ] Other Adult Household Member
- [ ] Caregiver
- [ ] Other
- [ ] No one found responsible
- [ ] Cannot determine

Please use this space to provide any clarification or additional information.

11. Do you agree with the investigative agency assessment of what and who caused the injury?

- ◯ Yes
- ◯ No
- ◯ Unsure

If no or unsure, please share why and what you think caused the injury.

2023 CRP Serious Injury and Near Fatality Review Form

Investigation of Serious Injury

12. Date of Injury

Date of Injury Occurrence

Date

MM/DD/YYYY

13. Date of Report

The Date the Injury was Reported

Date

MM/DD/YYYY

14. City/Town and County where Injury Occurred

15. Location where Injury Occurred

- ◯ Child's Household
- ◯ Other Household
- ◯ Child Care or School
- ◯ Other Community Location
- ◯ Unknown

Please use this space to provide any clarification or additional information.

16. Child's Age at Injury

- ◯ Under 2
- ◯ 2 - 4
- ◯ 5-12
- ◯ 13 -18

17. What parties were involved in the investigation of the injury?

- [ ] DHHS
- [ ] Local Law Enforcement
- [ ] State Patrol
- [ ] Medical Providers
- [ ] Child Advocacy Center
- [ ] Other (please specify)

18. To what degree did the investigating agencies coordinate during the investigation?

- ◯ None at all
- ◯ Insufficient documentation
- ◯ A little
- ◯ A moderate amount
- ◯ A great deal

19. Do you have recommendations to improve the investigation and system response to the injury?

- ◯ Yes
- ◯ No

Please provide your suggestions

2023 CRP Serious Injury and Near Fatality Review Form

Household and Caregiver Characteristics and System Involvement

20. Please provide a brief description of the child and family's involvement with the child welfare system at time of injury.

21. What was the child's involvement with the child welfare/protection system at the time of the injury? (mark all that apply)

- [ ] DHHS Ward
- [ ] Open Non-Court Case
- [ ] Open Investigation/Initial Assessment
- [ ] Open Alternative Response Case
- [ ] Closed ongoing case in the past 12 months
- [ ] Closed Investigation/Initial Assessment in past 12 months
- [ ] Closed Alternative Response in the past 12 months
- [ ] Reports to Hotline not accepted/screened out in past 12 months
- [ ] None
- [ ] Other (please specify)

22. If the child and family was involved with DHHS, please respond to the following questions about safety and risk:

	Yes	No	Unsure	N/A
Were there calls to the child abuse and neglect hotline in the prior 12 months involving the child?	○	○	○	○
Was there an active safety plan in place when the injury occurred?	○	○	○	○
Was there a safety plan in place for the child at any point in the twelve months before the injury?	○	○	○	○
Was the family classified as high or very high risk in the twelve months before the injury?	○	○	○	○
Was the child welfare case meeting the family needs and child safety?	○	○	○	○

Comments:

23. What risk factors were present?

- [ ] Family living in poverty, lack of basic needs
- [ ] Caregiver with diagnosed severe persistent mental illness and/or substance use disorder
- [ ] Prior incidents of family or domestic violence
- [ ] Prior open ongoing case due to abuse/neglect
- [ ] Family history of abuse/neglect or trauma
- [ ] Prior injury to any child in the home from abuse or neglect
- [ ] Caregiver under age 25
- [ ] Any children in the home under the age of 2
- [ ] Other (please specify)

24. What protective factors were present?

- [ ] Parental resilience: Manages stress and functions well when faced with challenges, adversity, and trauma
- [ ] Social connections: Builds positive relationships that provide emotional, informational, instrumental, and spiritual support
- [ ] Knowledge of parenting and child development: Understands child development and parenting strategies that support physical, cognitive, language, social, and emotional development
- [ ] Concrete support in times of need: Has access to support and/or services (e.g., healthy food; a safe environment; specialized medical, mental health, social, educational, and legal services, as needed) that address a family's needs and help minimize stress caused by challenges
- [ ] Social-emotional competence of children: Encourages family and child interactions that help children develop the ability to communicate clearly, recognize and regulate their emotions, and establish and maintain relationships
- [ ] Not enough information to determine.
- [ ] Other (please specify)

2023 CRP Serious Injury and Near Fatality Review Form

System Response to Injury

25. What was the outcome of the investigation?

- [ ] Criminal Charges Filed
- [ ] Juvenile Petition Filed/Court-Involved Child Welfare Case Opened
- [ ] Non-Court Child Welfare Case Opened
- [ ] Child welfare case open prior to injury continued
- [ ] Community Services and Supports Offered
- [ ] Child Removal
- [ ] None of the above
- [ ] Other (please specify)

26. Do you have recommendations to improve the child welfare system response in this case?

- ◯ Yes
- ◯ No

Please provide your suggestions

27. What went well within the case? Please provide example(s).