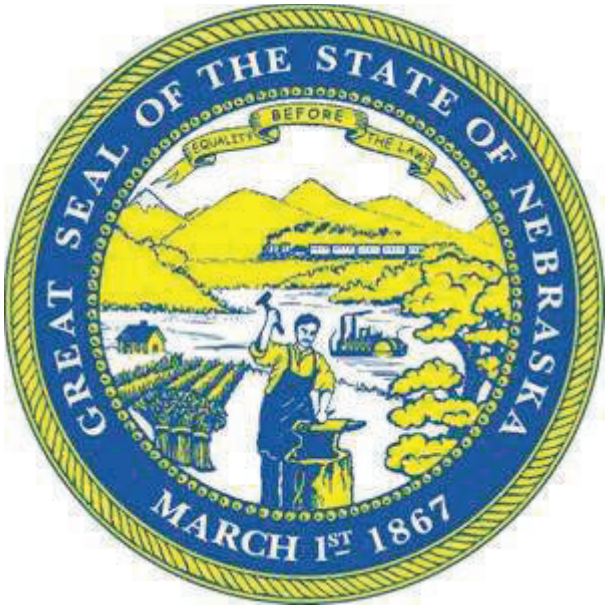

Nebraska Citizen Review Panel for Child Protective Services Annual Report

Reporting Period:
April 1, 2024, through March 31, 2025
Nebraska Commission for the Protection of Children

Submitted April 1, 2025

Nebraska Commission for the Protection of Children Membership and Representatives:

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Amanda Hoffman - Nebraska Crime Commission
Ashley D. Brown – Social Services Director, KVC
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Bill Tangeman - Office of the Nebraska Attorney General
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Corrie Kielty- Executive Director, Nebraska CASA Program
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Demi Herman - Office of the Nebraska Attorney General
Erin Konecky – High School Educator and Foster Parent
Ivy Svoboda – Executive Director, Nebraska Alliance of Child Advocacy Centers
Jake Dilsaver- Captain, Lincoln Police Department
Jarren Breeling – Parents and Representatives of Parents Group, Department of Health and Human Services
Jennifer Carter- Inspector General of Nebraska Child Welfare
Joshua Midgett- Chief Executive Officer, Integrated Life Choices
Kari Rumbaugh – Deputy Probation Administrator, Judicial Branch Juvenile Probation Services Division
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Kitty Washburn – Supervisor, Winnebago Children and Family Services
Kristin Aldridge- Pediatric Nurse Practitioner, Children's Nebraska
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Michael Jepsen – Sheriff, Sherman County
Mikayla Findlay- Budget Analyst, Nebraska's Legislative Fiscal Office
Monika Gross – Executive Director, Foster Care Review Office
Nicole Brundo – Deputy County Attorney, Douglas County Attorney's Office
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Kristi Aldridge
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The Citizen Review Panel acknowledges the support they received from the following DHHS staff:
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The Nebraska Citizen Review Panel Annual Report was prepared on behalf of the Commission by:
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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 2024. During this period, the Citizen Review Panel conducted case reviews of 56 serious injuries and near fatalities due to child abuse or neglect that occurred between July 2022-May 2023.

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 seven recommendations to improve Nebraska's child welfare system:

1. Provide additional training to DHHS case managers and law enforcement on cases of abuse and/or neglect involving medical information to include:
    - Identify cases that have medical issues that are being investigated and may take longer to be diagnosed and require collaboration with outside agencies.
    - Clarify when coordination with the local Child Advocacy Centers (CACs) is required during investigations of child abuse and neglect cases.
    - Clarify when to coordinate with hospital medical professionals during investigations, what documentation to gather, and when to defer to their medical expertise.
    - Include all relevant medical records in initial assessment documentation.
2. Provide additional training to case managers regarding the following information on coordinating with their local CAC:
    - Ensure during all child abuse and neglect cases, case managers are coordinating with their local CAC throughout the investigation process.
    - Ensure case managers understand the services that are offered at their local CAC to include: medical exams, forensic interviews, multi-disciplinary team meetings, advocacy, and coordination of therapeutic services.
    - Ensure coordination with the local CAC is thoroughly documented in assessments.
3. Work with case managers to Identify and document parental protective factors to recognize family strengths and to build upon when developing safety and case plans.
4. Clarify how to coordinate with law enforcement and what information law enforcement needs to provide during investigations. Obtain all law enforcement reports and include them in initial assessment documentation.
5. In addition to the current interview protocols, emphasize the importance of interviewing all siblings and adults that may have information about the family during the initial assessment.
6. Include detailed documentation in records when completing an assessment to include who was interviewed and what medical, law enforcement, DHHS or other records were reviewed.
7. Ensure supervisors thoroughly review all assessments conducted by their workers and identify any additional training or instruction needed.

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.

2024-2025 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. 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 thorough coordination with partner agencies, more consultations with medical experts, and more comprehensive documentation.

Serious Injury Review Results

The following section provides details on the 56 serious injury and near fatality cases that the CRP reviewed. The CRP Committee reviewed 56 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 18 different cities across the state. 21 of 56 or 37% of all injuries reviewed occurred in Omaha in Douglas County. 10 of 56 or 17% of injuries reviewed occurred in Lincoln in Lancaster County. The remaining 46% of cases reviewed occurred in 16 other cities.

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: 25 of 53 or 47% of the children seriously injured were under the age of two.
- Nine additional children who were injured were between two and four years old. In total, 64% of children injured were under the age of five.
- 26 of 55 or 47% of children seriously injured were white, and white children make up 77% of Nebraska's child population according to 2021 5-year census data.
- 12 of 55 or 22% of those seriously injured were black, and black children make up 6% of the child population.
- 6 of 55 or 11% of those seriously injured were American Indian, and American Indian children make up 1% of the child population.
- 21 of 47 cases or 45% of the children had a diagnosed condition prior to their injury. Of those with a diagnosed condition:

- Nine responses, or 19%, had medical diagnoses.
- Seven responses, or 15% had developmental disabilities.
- Four responses or 9% had mental health diagnoses.
- One response, or 2% had other conditions noted.

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:

- For primary injuries noted, fractures were determined to be the most frequent cause of injury and accounted for 14 of 47 cases or 30%. Head injuries were the second highest cause of injury and accounted for 7 of 47 cases or 15%. Bruising and Abusive Head Injury were the third most frequently reported cause of injury and both of those accounted for 6 out of 47 cases or 13% each.
- Secondary injuries noted included bruising, fractures, strangulation, and other physical trauma.
- 36 of 51 cases or 71% of serious injuries occurred in the child's household. An additional 5 of 51 or 10% of serious injuries occurred in other households. Five occurred in other community locations, four injuries occurred in an unknown location, and one occurred in the childcare center or school.
- 41 of 53 cases or 77% of the injuries were caused by the parent/guardian, or caregiver of the child.
- In 6 of 53 cases, or 11%, the party responsible for the abuse or neglect was an "other" or "other adult household member".
- In 7 of 53 cases, or 13%, no one was found responsible for the injury.
- In 1 of 53 cases or 2%, 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. As seen in previous years, reviewers noted concerns about a lack of documentation and consistent coordination between medical providers and CACs during the response to the injuries.
- Medical providers were included in 39 of 53 cases or 74% of investigations compared to 2023/2024's report of medical providers being included in 80% of investigations.
- Child advocacy centers were only used in 15 of 53 cases or 28% of investigations compared to 2023/2024's report of child advocacy centers being included in 25% of investigations.
- Criminal charges related to the injury were filed in only 20 of 53, or 38% of cases.
- 26 of 53 cases or 49% resulted in an opening of a new ongoing child welfare case.
- The concerns that were found by reviewers with the investigation included: concerns that there was a lack of investigative information (36%), the lack of medical records present in the case files (27%), concerns that conditions in the home remained unsafe (18%), medical neglect not being addressed (14%), and concerns that parents may have been the cause of the injury (9%).

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.

- 34 of 53, or 64% had no child welfare involvement at the time of their injury.
- 6 of 53 cases or 11% had current contact with the child welfare system at the time of injury as a DHHS ward, had an open non-court case, or an open investigation/Initial Assessment.
- 18 of 53 cases or 34% had contact with the child welfare system within the past 12 months of the time of the injury with a closed on going case in the past 12 months, closed investigation/initial assessment in the past 12 month, closed alternative response case in the past 12 months, or report to the Hotline not accepted/screened out in the last 12 month.
- In 48 of 56 cases or 85%, at least one risk factor was noted and some cases had multiple risk factors noted. Of the 48 cases with risk factors, the following risk factors were present:
    - In 20 of 48 cases or 42% an "other" reason was specified as a risk factor. The "other" risk factors included parental incarceration, children mental health/behaviors health problems, lack of supervision, and caregivers were former state wards.
    - In 25 of the 48 cases or 52% included a family with a child under the age of 2.
    - In 16 of the 48 cases or 33% a caregiver was diagnosed with severe persistent mental illness and/or substance use disorder.
    - In 16 of the 48 cases or 33% included a family with a history of abuse/neglect or trauma.
    - In 15 of the 48 cases or 31% included a family that had prior incidents of family or domestic violence.
    - In 15 of the 48 cases or 31% the family had a caregiver that was under the age of 25.
- 61% had at least one protective factor. 45% noted concrete support such as access to services that address the family's needs and help minimize stress caused by challenges as a protective factor; this was the most frequently reported category.

Injury Review

In the 2024/2025 CRP review period, 38 of the 53 cases or 71% were ultimately determined by investigating parties to be caused by the parent or guardian. In 8 of the 53 cases or 15%, no one was found responsible or investigating parties were not able to determine who was responsible for the injuries.

2024-2025 Recommendations

Based on the reviews CRP conducted in 2024/2025, the CRP makes the following recommendations to improve the child welfare response in Nebraska:

1. *Provide additional training to DHHS case managers and law enforcement on cases of abuse and/or neglect involving medical information to include:*
    - *Identify cases that have medical issues that are being investigated and may take longer to be diagnosed and require collaboration with outside agencies.*
    - *Clarify when coordination with the local Child Advocacy Centers (CACs) is required during investigations of child abuse and neglect cases.*
    - *Clarify when to coordinate with hospital medical professionals during investigations, what documentation to gather, and when to defer to their medical expertise.*
    - *Include all relevant medical records in initial assessment documentation.*

The CRP wants to ensure that DHHS and law enforcement are provided with training that will allow them to recognize when child abuse and/or neglect cases involve medical information to ensure an appropriate comprehensive response. The CRP also wants to ensure that medical professionals' expertise is utilized in the investigation process. From the cases that the CRP reviewed, 26% of the cases did not involve consultation with medical providers during investigation.

2. *Provide additional training to case managers regarding the following information on coordinating with their local CAC:*

    - *Ensure during all child abuse and neglect cases, case managers are coordinating with their local CAC throughout the investigation process.*
    - *Ensure case managers understand the services that are offered at their local CAC to include: medical exams, forensic interviews, multi-disciplinary team meetings, advocacy, and coordination of therapeutic services.*
    - *Ensure coordination with the local CAC is thoroughly documented in assessments.*

The CRP evaluated the parties that were involved in the investigation of the cases that were reviewed and found that CACs were coordinated within 28% of the cases reviewed by the CRP. The CRP believes there would be a great benefit in coordinating with the local CAC in all child abuse and neglect cases. This can be accomplished by case managers gaining a better understanding of the services and benefits the local CACs can provide.

3. *Work with case managers to Identify and document parental protective factors to recognize family strengths and to build upon when developing safety and case plans.*

The CRP evaluated the protective factors present among the caregivers involved in the reviewed cases. It was found that in 39% of the cases reviewed, the CRP was not provided with enough information to determine the protective factors that were present with caregivers. The CRP believes that determining protective factors can help case managers build upon skills and resources that caregivers have, to make them more successful in accomplishing their case plan goals.

4. *Clarify how to coordinate with law enforcement and what information law enforcement needs to provide during investigations. Obtain all law enforcement reports and include them in initial assessment documentation.*

The CRP evaluated the degree to which the investigating agencies coordinated during the investigation. The CRP found that in 37% of the cases reviewed there was only a little coordination, insufficient documentation of coordination, or none at all between investigating agencies. The CRP believes that more coordination or documentation of coordination among agencies will assist case managers in the investigative process.

5. *In addition to the current interview protocols, emphasize the importance of interviewing all siblings and adults that may have information about the family during the initial assessment.*

CRP reviewers were asked if they agreed with the investigative agency assessment of what and who caused the injury. In 31% of the cases, CRP reviewers did not agree with the investigative agency assessment or were unsure if they agreed. One of the reasons that was noted by CRP reviewers was a lack of information gathered during the investigation. The CRP believes that enhancing interview training will assist DHHS case managers with interviewing a wider range of individuals in their assessment.

6. *Include detailed documentation in records when completing an assessment to include who was interviewed and what medical, law enforcement, DHHS or other records were reviewed.*

CRP reviewers were asked if there were recommendations to improve the child welfare system response and one of the most common recommendations was to have more thorough documentation of case information including medical documentation, coordination with law enforcement, and initial assessment documentation. This will assist in ensuring that all cases are thoroughly reviewed and investigated.

7. *Ensure supervisors thoroughly review all assessments conducted by their workers and identify any additional training or instruction needed.*

The CRP recommends continued participation of supervisors in the investigation process to ensure there are multiple perspectives reviewing assessments, coordination is taking place between agencies, and thorough investigations are conducted.

Update on 2023-2024 Report Recommendations

In April 2024, the CRP submitted its annual report which included four recommendations to Nebraska DHHS:

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

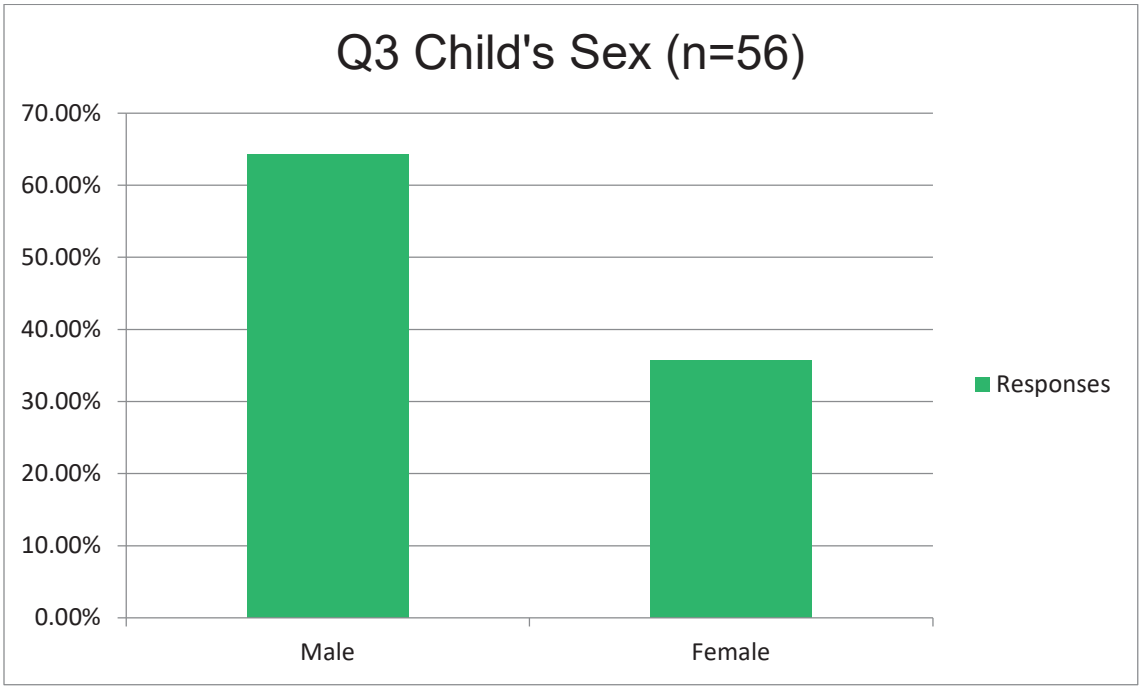
- Continue efforts to strengthen coordination across disciplines on child abuse and neglect investigations.
- Ensure ICWA identification is completed at the onset of a case opening.

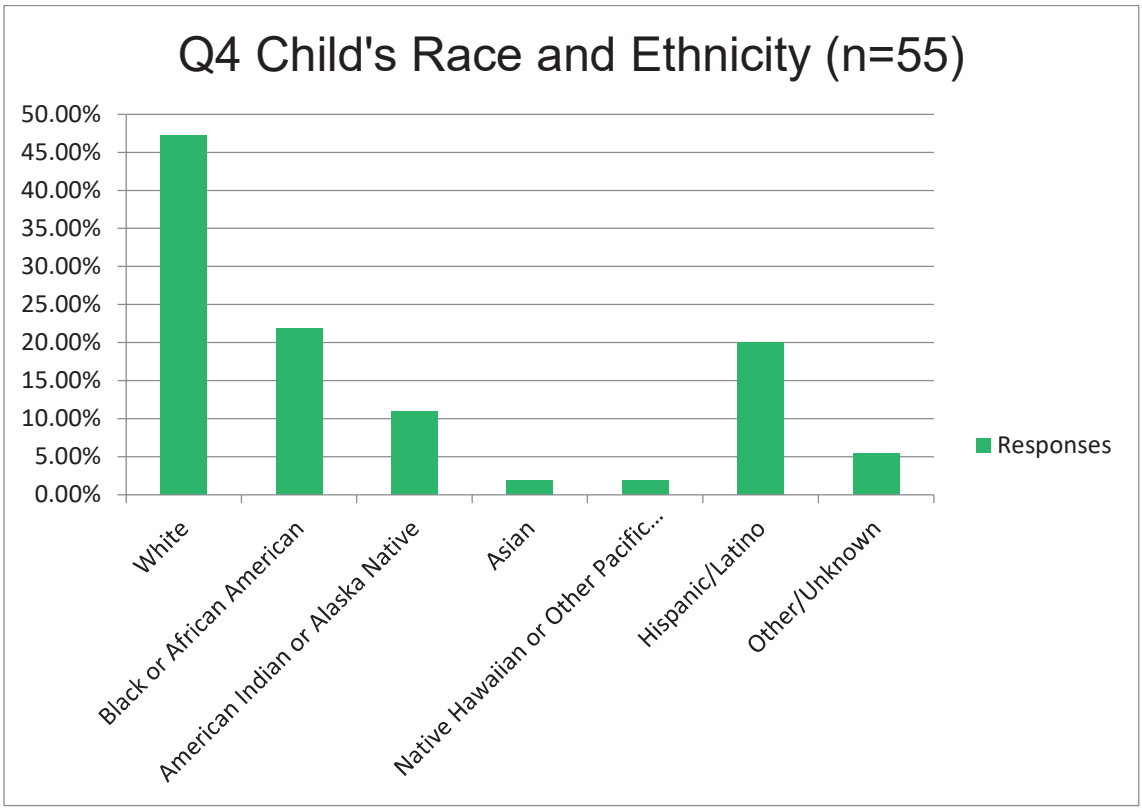
DHHS reported in response to strengthening early development education programs and parenting instructions, they actively work with community providers to address these concerns. DHHS provides community level data to 23 Bring up Nebraska Community Collaboratives to assist with where community interventions should be focused. There are several expansions of community resources such as Health Families America and Parents as Teachers occurring statewide that have a focus on providing curriculum for families that experienced adverse childhood experiences. DHHS has also collaborated with the Department for Public Health on safe sleep campaigns and are developing a new pilot program, Family Connects, to allow access to nursing home visitors.

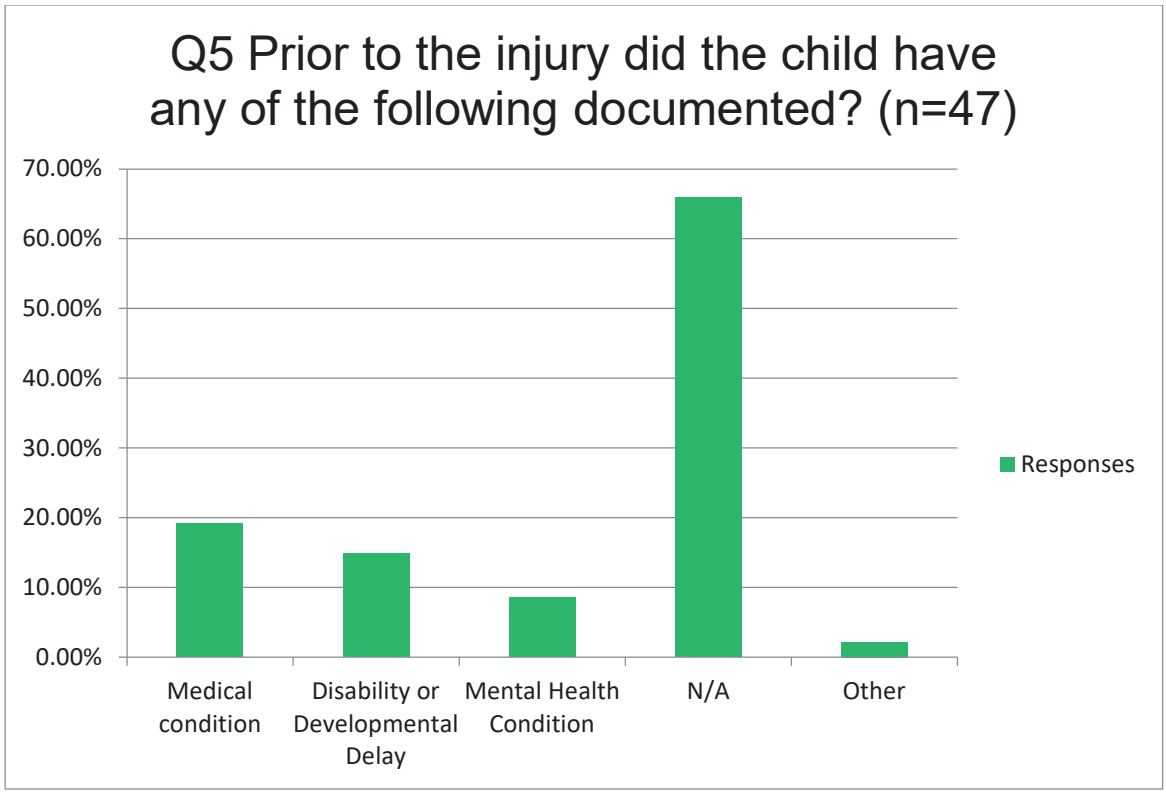
In response to strengthen coordination with local Child Advocacy Centers (CACs), DHHS noted their procedures require near fatality and severe injury cases to collaborate with CACs and be referred to Multi-Disciplinary Teams. DHHS has also developed internal procedures for reviewing critical incidents and making recommendations for changes.

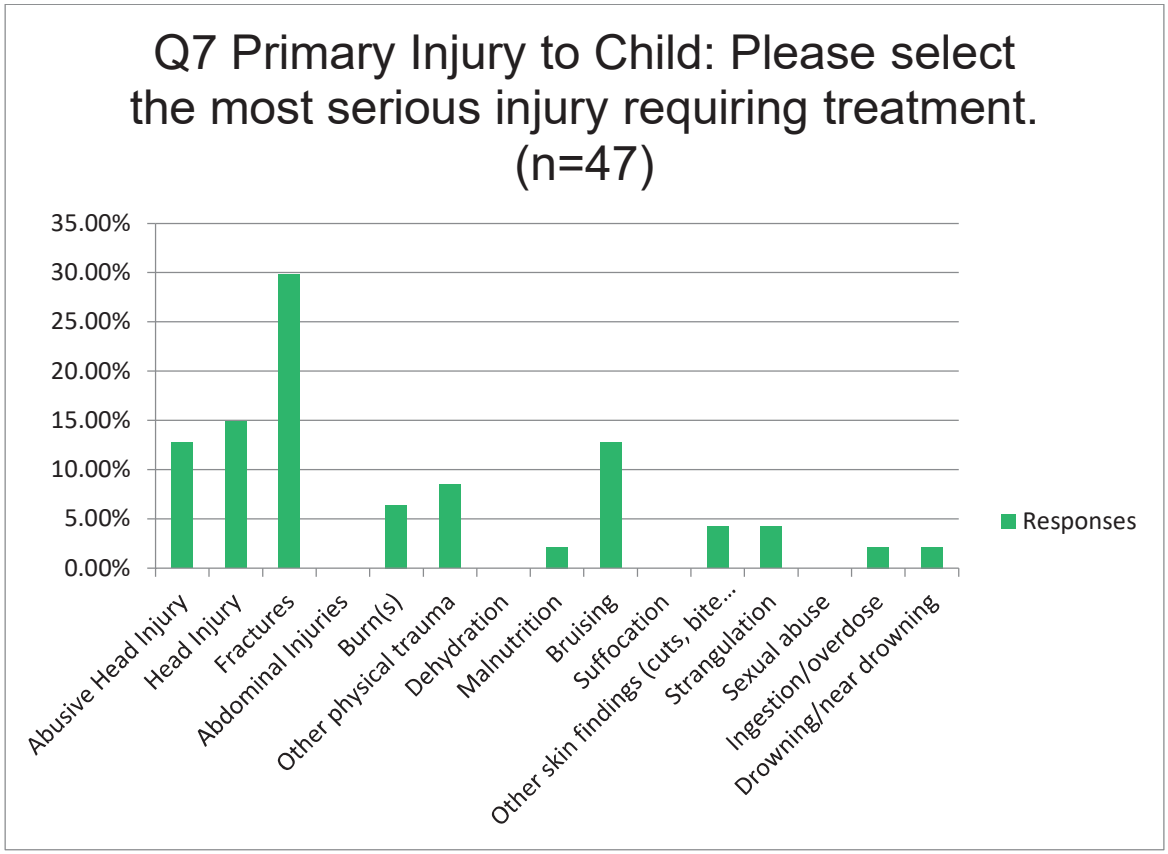
Finally, in response to ensuring ICWA is identified on cases, DHHS noted they provide guidance on identifying Native Americans on all their cases. DHHS reported on the procedures they take to ensure that ICWA notifications are made and that DHHS workers are receiving adequate ICWA training.

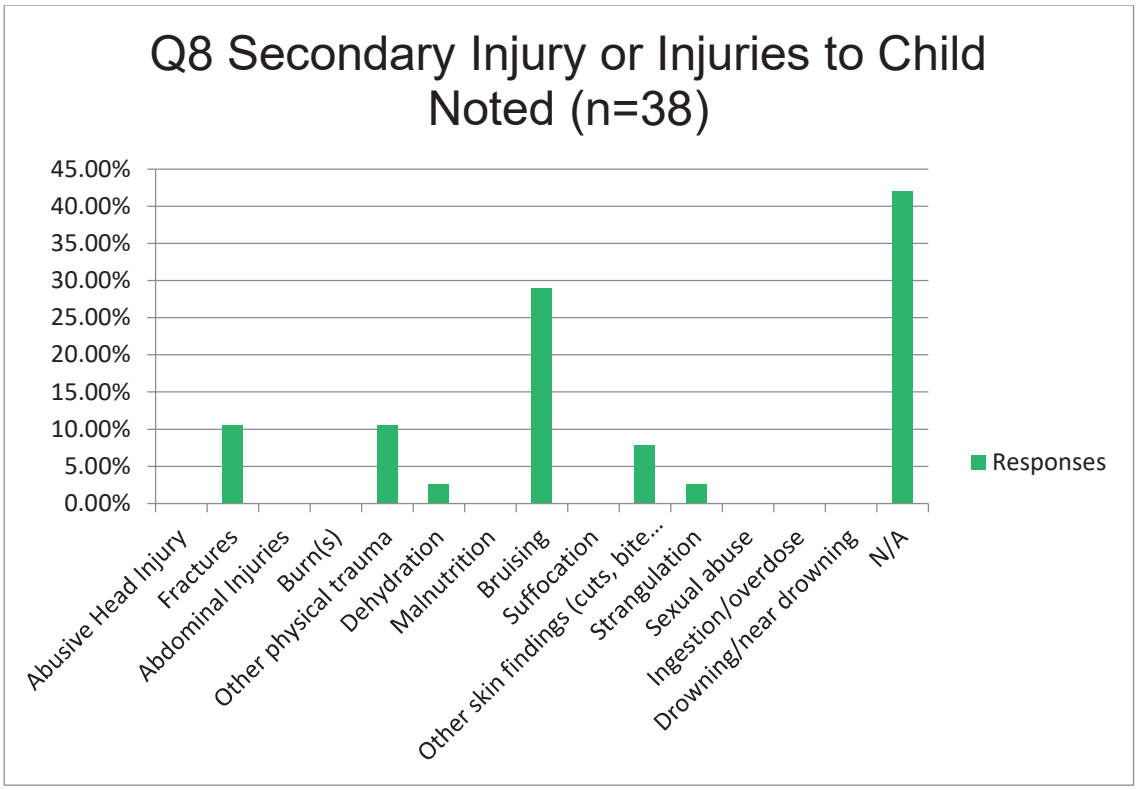
Appendix A. Full Data from Case Reviews

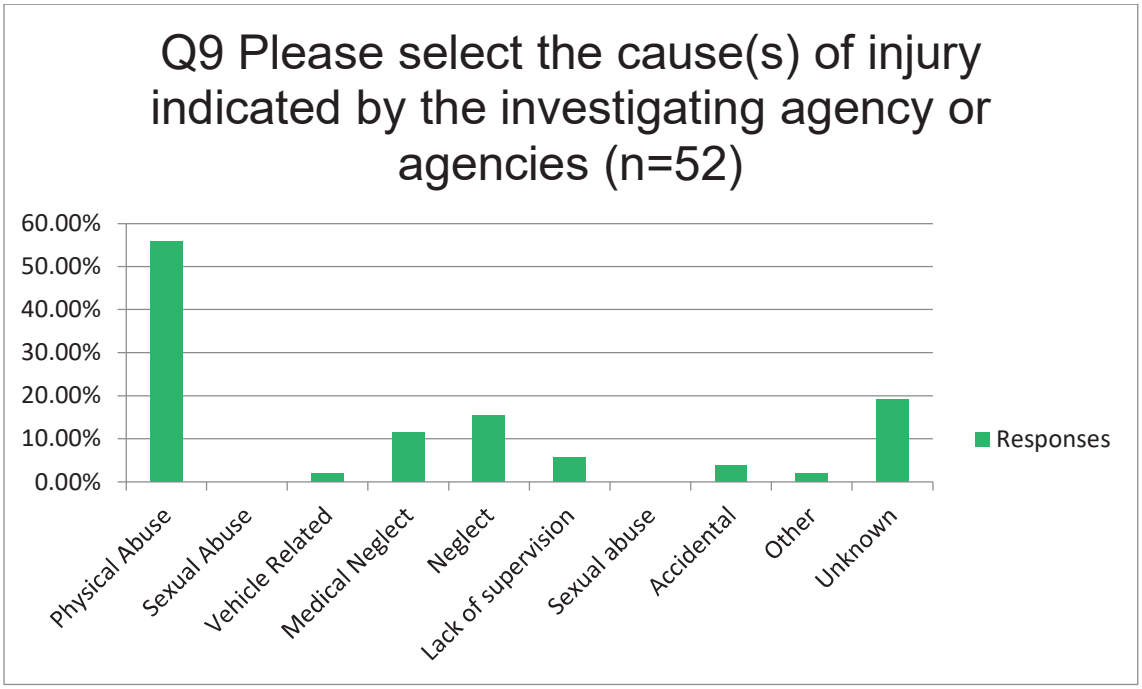


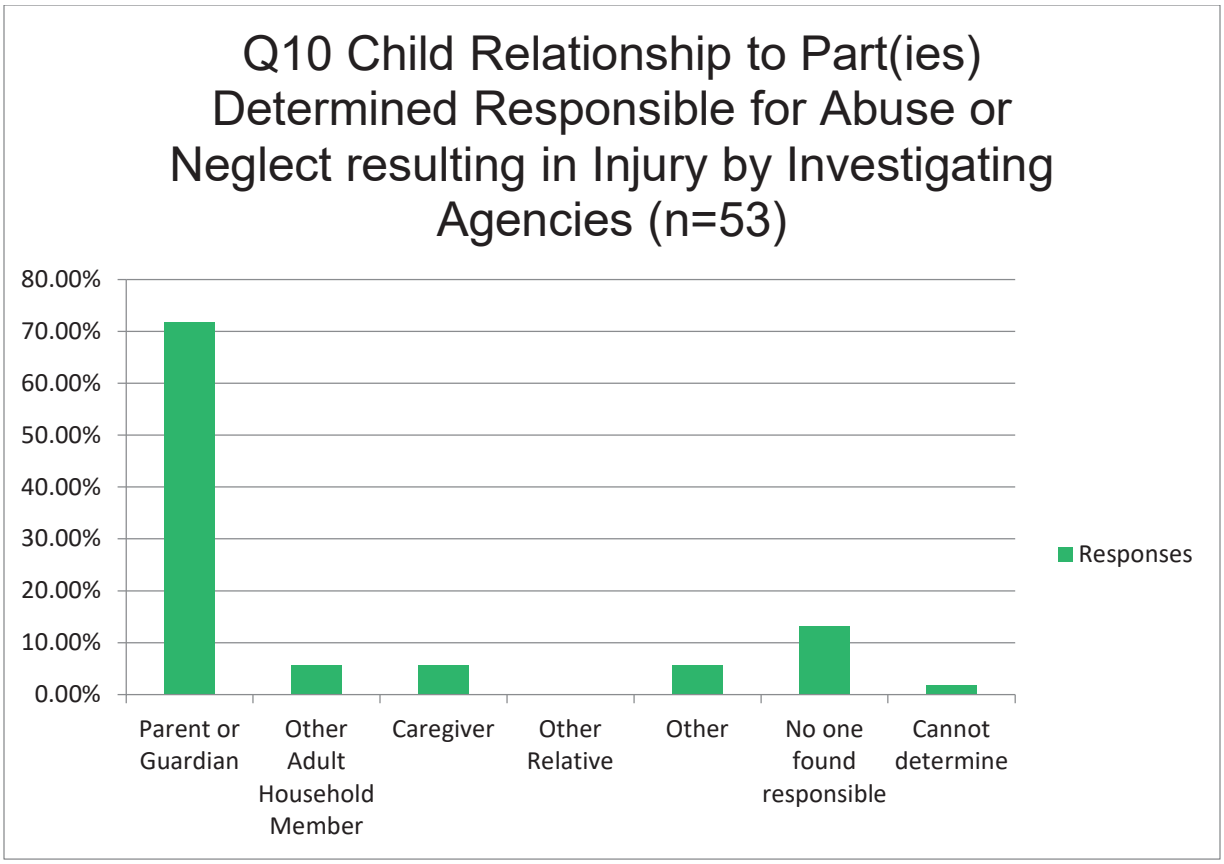


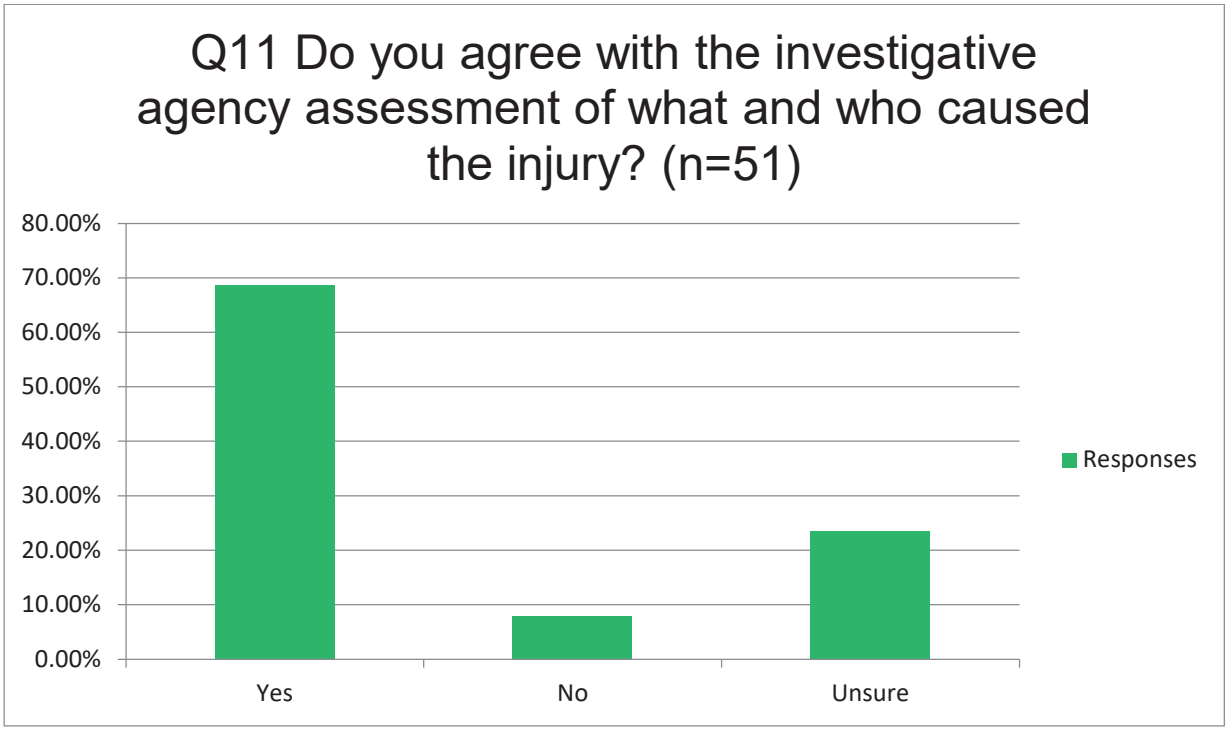

Q5 Prior to the injury did the child have any of the following documented? (n=47)
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Medical condition
Disability or Developmental Delay
Mental Health Condition
N/A
Other
Responses

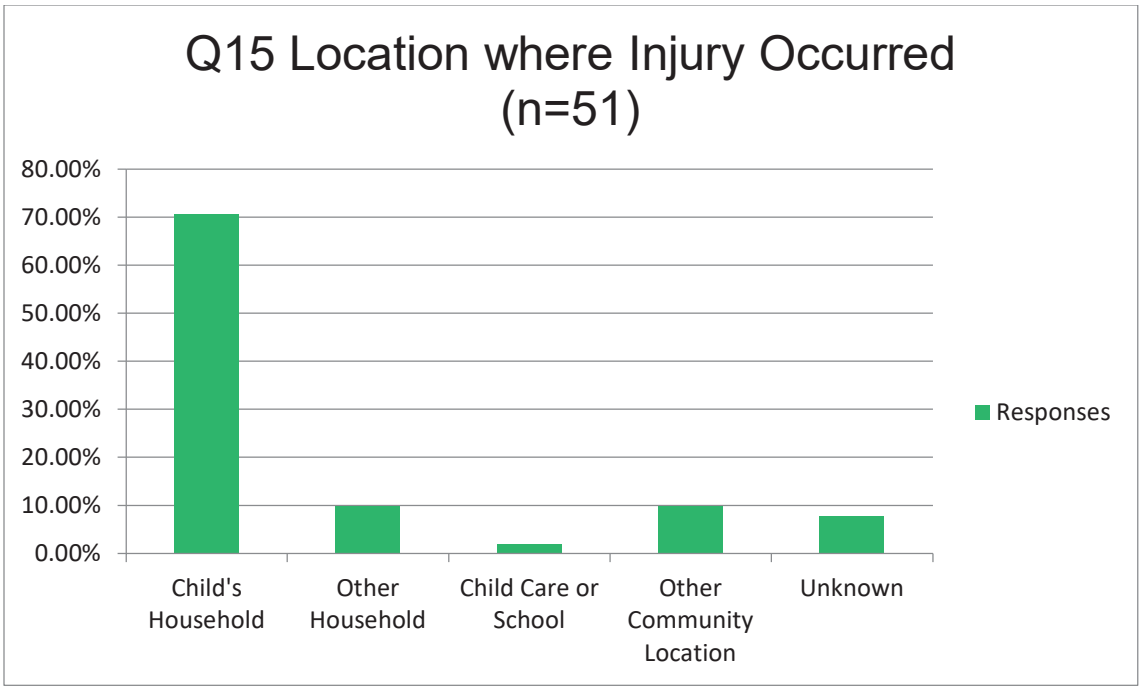

Q7 Primary Injury to Child: Please select the most serious injury requiring treatment. (n=47)
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Abusive Head Injury
Head Injury
Fractures
Abdominal Injuries
Burn(s)
Other physical trauma
Dehydration
Malnutrition
Bruising
Suffocation
Other skin findings (cuts, bite...
Strangulation
Sexual abuse
Ingestion/overdose
Drowning/near drowning
Responses

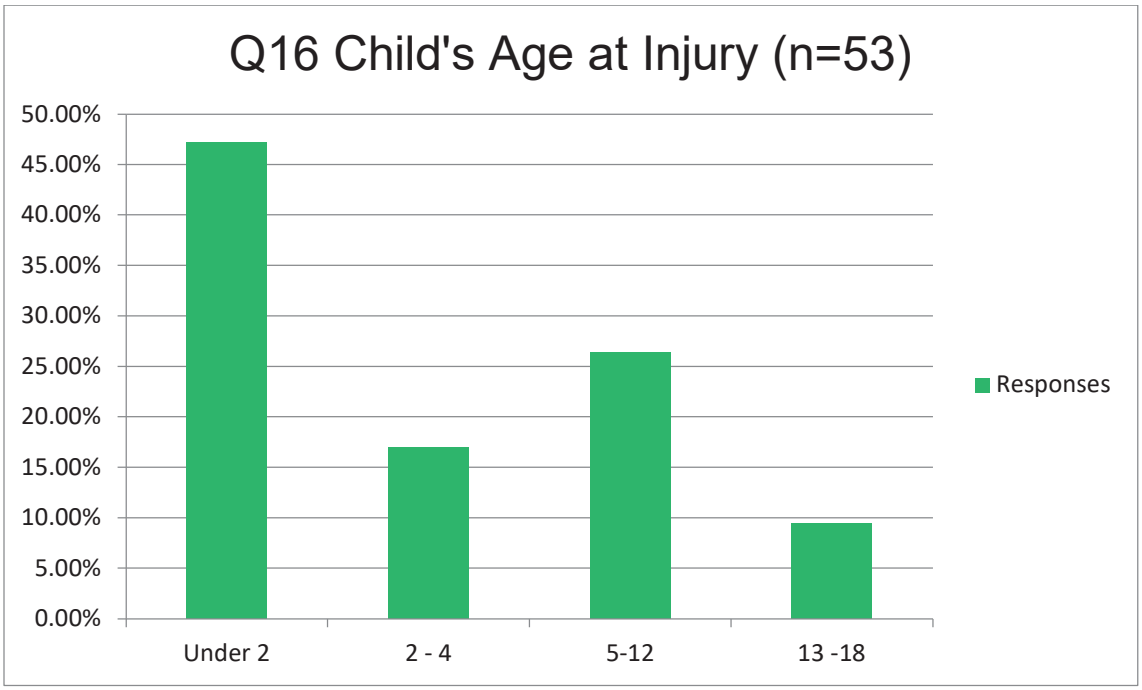

Q8 Secondary Injury or Injuries to Child Noted (n=38)
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Abusive Head Injury
Fractures
Abdominal Injuries
Burn(s)
Other physical trauma
Dehydration
Malnutrition
Bruising
Suffocation
Other skin findings (cuts, bite...
Strangulation
Sexual abuse
Ingestion/overdose
Drowning/near drowning
N/A
Responses

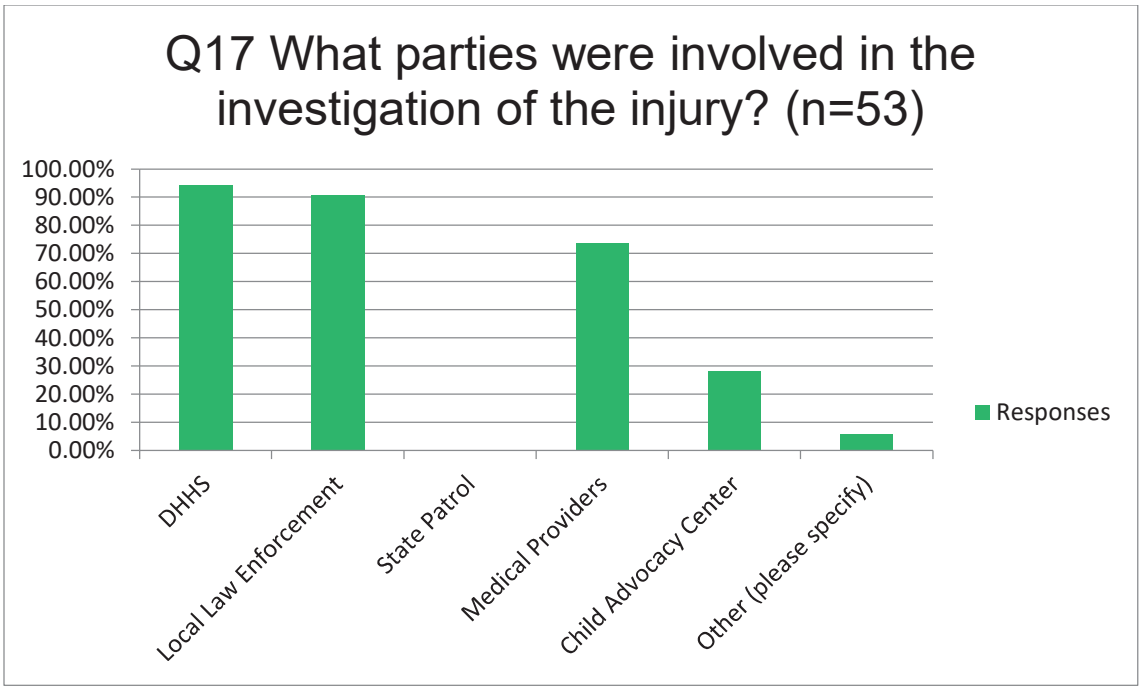

Q9 Please select the cause(s) of injury indicated by the investigating agency or agencies (n=52)
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Physical Abuse
Sexual Abuse
Vehicle Related
Medical Neglect
Neglect
Lack of supervision
Sexual abuse
Accidental
Other
Unknown
Responses

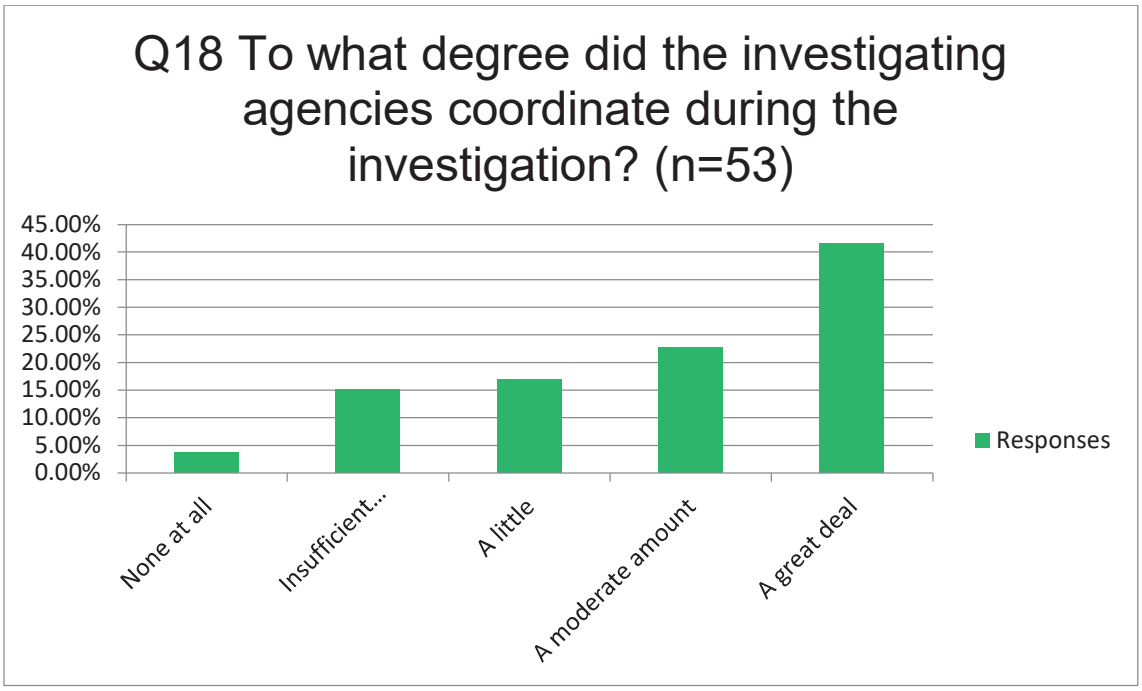

Q10 Child Relationship to Part(ies) Determined Responsible for Abuse or Neglect resulting in Injury by Investigating Agencies (n=53)
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Parent or Guardian
Other Adult Household Member
Caregiver
Other Relative
Other
No one found responsible
Cannot determine
Responses

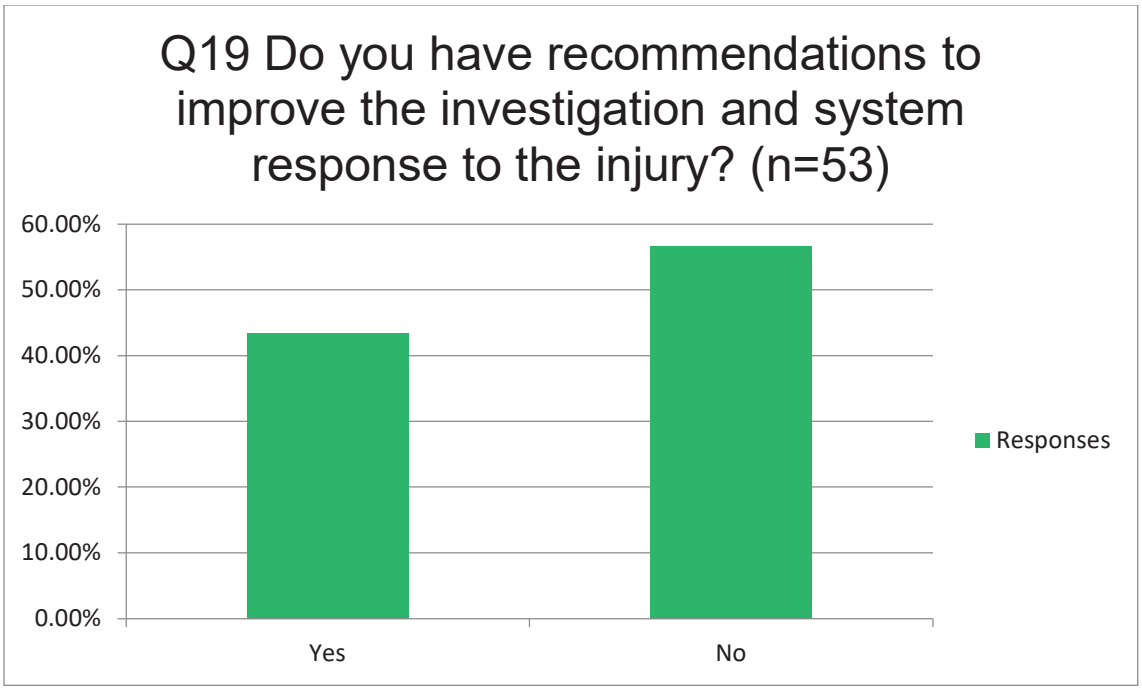

Q11 Do you agree with the investigative agency assessment of what and who caused the injury? (n=51)
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Yes
No
Unsure
Responses


Q15 Location where Injury Occurred (n=51)
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Child's Household
Other Household
Child Care or School
Other Community Location
Unknown
Responses


Q16 Child's Age at Injury (n=53)
50.00%
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Under 2
2 - 4
5-12
13 -18
Responses


Q17 What parties were involved in the investigation of the injury? (n=53)
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
DHHS
Local Law Enforcement
State Patrol
Medical Providers
Child Advocacy Center
Other (please specify)
Responses


Q18 To what degree did the investigating agencies coordinate during the investigation? (n=53)
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
None at all
Insufficient...
A little
A moderate amount
A great deal
Responses



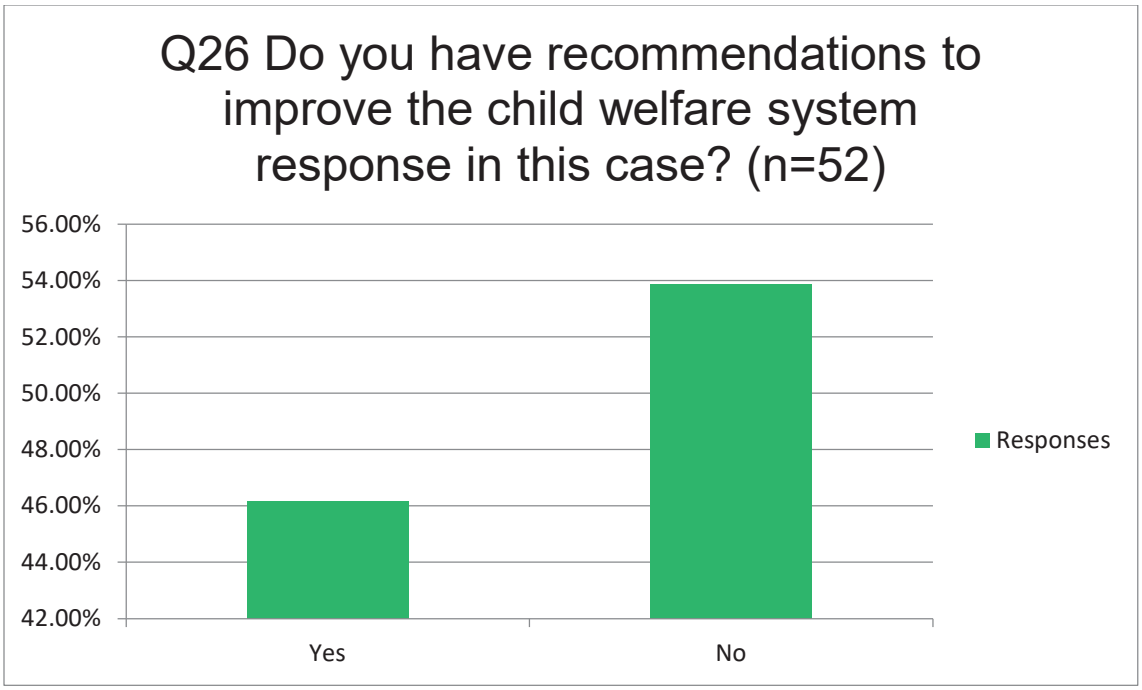
Q21 What was the child's involvement with the child welfare/protection system at the time of the injury? (mark all that apply) (n=53)		
Answer Choices	Responses	
DHHS Ward	1.89%	1
Open Non-Court Case	5.66%	3
Open Investigation/Initial Assessment	3.77%	2
Open Alternative Response Case	0.00%	0
Closed ongoing case in the past 12 months	7.55%	4
Closed Investigation/Initial Assessment in past 12 months	13.21%	7
Closed Alternative Response in the past 12 months	3.77%	2
Reports to Hotline not accepted/screened out in past 12 months	9.43%	5
None	64.15%	34
Other (please specify)	7.55%	4
	Answered	**53**
	Skipped	**3**

Q22 If the child and family was involved with DHHS, please respond to the following questions about safety and risk: (n=45)									
	Yes		No		Unsure		N/A		Total
Were there calls to the child abuse and neglect hotline in the prior 12 months involving the child?	35.56%	16	22.22%	10	0.00%	0	42.22%	19	45
Was there an active safety plan in place when the injury occurred?	2.22%	1	48.89%	22	4.44%	2	44.44%	20	45
Was there a safety plan in place for the child at any point in the twelve months before the injury?	6.67%	3	42.22%	19	6.67%	3	44.44%	20	45
Was the family classified as high or very high risk in the twelve months before the injury?	8.89%	4	37.78%	17	8.89%	4	44.44%	20	45
Was the child welfare case meeting the family needs and child safety?	4.65%	2	16.28%	7	16.28%	7	62.79%	27	43
Comments:									12
							Answered		**45**
							Skipped		**11**

Q23 What risk factors were present? (n=48)		
Answer Choices	Responses	
Family living in poverty, lack of basic needs	10.42%	5
Caregiver with diagnosed severe persistent mental illness and/or substance use disorder	33.33%	16
Prior incidents of family or domestic violence	31.25%	15
Prior open ongoing case due to abuse/neglect	16.67%	8
Family history of abuse/neglect or trauma	33.33%	16
Prior injury to any child in the home from abuse or neglect	18.75%	9
Caregiver underage 25	31.25%	15
Any children in the home under the age of 2	52.08%	25
Other (please specify)	41.67%	20
	Answered	**48**
	Skipped	**8**

Q24 What protective factors were present? (n=49)		
Answer Choices	Responses	
Parental resilience: Manages stress and functions well when faced with challenges, adversity, and trauma	20.41%	10
Social connections: Builds positive relationships that provide emotional, informational, instrumental, and spiritual support	26.53%	13
Knowledge of parenting and child development: Understands child development and parenting strategies that support physical, cognitive, language, social, and emotional development	12.24%	6
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	44.90%	22
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	20.41%	10
Not enough information to determine.	38.78%	19
Other (please specify)	30.61%	15
	Answered	**49**
	Skipped	**7**

Q25 What was the outcome of the investigation? (n=53)		
Answer Choices	Responses	
Criminal Charges Filed	37.74%	20
Juvenile Petition Filed/Court-Involved Child Welfare Case Opened	35.85%	19
Non-Court Child Welfare Case Opened	13.21%	7
Child welfare case open prior to injury continued	3.77%	2
Community Services and Supports Offered	22.64%	12
Child Removal	39.62%	21
None of the above	18.87%	10
Other (please specify)	28.30%	15
	Answered	**53**
	Skipped	**3**


Q26 Do you have recommendations to improve the child welfare system response in this case? (n=52)
56.00%
54.00%
52.00%
50.00%
48.00%
46.00%
44.00%
42.00%
Yes
No
Responses

Appendix B. Case Review Tool 2024/2025

1. Separate attachment

2024/2025 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.

2024/2025 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.

2024/2025 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

2024/2025 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)

2024/2025 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).