



Nebraska Citizen Review Panel for Child Protective Services Annual Report

Reporting Period:
April 1, 2025, through March 31, 2026
Nebraska Commission for the Protection of Children

Submitted April 1, 2026

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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 2025. During this period, the Citizen Review Panel conducted case reviews of 61 serious injuries and near fatalities due to child abuse or neglect that occurred between May 2023-July 2024. Due to the longevity and commitment of the CRP members, the CRP was able to increase their case review by 9% from the previous reporting period.

This report was prepared on behalf of the Citizen Review Panel, a subcommittee of the Governor's Commission for the Protection of Children (Commission). This subcommittee 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. Per Nebraska Revised Statute 28-728, children who are alleged to be victims of serious physical abuse or neglect should be brought to a Child Advocacy Center for a forensic interview and assessed for medical evaluations. DHHS should coordinate with the Nebraska Alliance to develop a plan to ensure training is provided to all case managers regarding when children should be brought to Child Advocacy Centers.
2. Identify DHHS case managers who should have specialized training and experience in handling investigations involving children with medical concerns. DHHS should ensure this training includes:
 - Clarify who the experts on child abuse and neglect medical issues are in their local area to include CAC medical professionals and hospital personnel.
 - Ensure during all child abuse and neglect investigations; case managers coordinate with their local CAC throughout the investigation process.
 - Clarify when to coordinate with hospital medical professionals during investigations, what documentation to gather, and when to defer to their medical expertise.
 - Identify resources and contact information in the region that assist children and families with medical issues.
3. Ensure case managers review all historical information for every child abuse and neglect intake, even if prior reports were deemed unfounded.
4. Include detailed documentation and justification in safety assessments on how children are determined to be safe.
5. Provide clear guidance for case managers on documenting protective factors for each family and ensure these documented strengths are used to inform and guide case plan creation.
6. Develop a process for using strong collaborative cases as training examples for case managers and create a method to recognize the workers who demonstrated exemplary performance.
7. Include detailed documentation in DHHS records regarding referrals and resources offered to families, the family's response to the resources, and if any actions were taken on the resources or referrals, particularly at case closure.

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.

2025-2026 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, more CAC coordination, and more comprehensive documentation.

Serious Injury Review Results

The following section provides details on the 61 serious injury and near fatality cases that the CRP reviewed. The CRP Committee reviewed 61 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 23 different cities across the state with 1 child being reported homeless. 20 of 61 or 33% of all injuries reviewed occurred in Omaha in Douglas County. 13 of 61 or 21% of injuries reviewed occurred in Lincoln in Lancaster County. The remaining 46% of cases reviewed occurred in 21 different 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. There were no significant changes in the child characteristics from the previous reporting period except there was a decrease in the percentage of children that had a diagnosed condition prior to the injury from 45% to 33%.

- Of the children injured: 30 of 59 or 51% of the children seriously injured were under the age of two.
- 11 additional children who were injured were between two and four years old. In total, 69% of children injured were under the age of five.
- 27 of 61 or 44% of children seriously injured were white.

- 9 of 61 or 15% of those seriously injured were black.
- 9 of 61 or 15% of those seriously injured were American Indian.
- 18 of 54 cases or 33% of the children had a diagnosed condition prior to their injury as opposed to the 2024/2025 report where 45% of children had a diagnosed condition. Some of the cases reviewed included children with multiple diagnosed conditions. Of those with a diagnosed condition:
 - Seven responses, or 13%, had medical diagnoses.
 - Five responses, or 9%, had developmental disabilities.
 - Four responses, or 7%, had mental health diagnoses.
 - Six responses, or 11%, 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, head injuries were determined to be the most frequent cause of injury and accounted for 16 of 57 cases or 28%. Abusive head injuries were the second highest cause of injury and accounted for 14 of 57 cases or 25%. Fractures were the third most frequently reported cause of injury, and both of those accounted for 10 out of 57 cases or 18% each.
- Secondary injuries noted included bruising, other physical trauma, and other skin findings (all skin findings other than burns and bruising).
- 44 of 58 cases or 76% of serious injuries occurred in the child's household. An additional 5 of 58 or 9% of serious injuries occurred in other community locations, or the location was unknown. Three occurred in other households, and one occurred in a childcare center or school.
- 47 of 59 cases or 80% of the injuries were caused by the parent/guardian, or caregiver of the child.
- In 5 of 59 cases, or 8%, the party responsible for the abuse or neglect was an adult household member who was not a caregiver or parent, and someone who would be classified as "other" neither a caregiver, parent, relative, or someone who lived in the household.
- In 5 of 59 cases, or 8%, no one was found responsible for the injury.
- In 3 of 59 cases or 5%, the party responsible for the abuse or neglect could not 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 continued to mention concerns about the lack of documentation and consistent coordination between medical providers and CACs during the response to the injuries.
- Medical providers were included in 45 of 59 cases or 76% of investigations compared to 2024/2025's report of medical providers being included in 74% of investigations.
- Child Advocacy Centers were only used in 18 of 59 cases or 31% of investigations compared to 2024/2025's report of Child Advocacy Centers being included in 28% of investigations.
- Criminal charges related to the injury were filed in only 19 of 57, or 33% of cases.

- 22 of 57 cases or 39% resulted in a new ongoing child welfare case to include court involved and non-court cases.
- Recommendations from the reviewers for improvements to the investigation included: more documentation from law enforcement and medical providers (46%), more follow through in the investigation (17%), more communication across collaborating agencies (17%), more CAC collaboration (11%), and more coordination with medical providers (11%).

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.

- 38 of 46 or 68% had no child welfare involvement at the time of their injury.
- 3 of 56 cases or 5% had current contact with the child welfare system at the time of injury with an open non-court case or an open investigation/Initial Assessment.
- 14 of 56 cases or 25% 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 54 of 61 cases or 89%, at least one risk factor was noted, and some cases had multiple risk factors noted. Of the 54 cases with risk factors, the following risk factors were present:
 - In 32 of the 54 cases or 59%, the family had a child under the age of 2.
 - In 24 of the 54 cases or 44% there were prior incidents of family or domestic violence.
 - In 21 of the 54 cases or 39% there was a family history of abuse/neglect or trauma.
 - In 14 of the 54 cases or 26% a caregiver was diagnosed with a severe persistent mental illness and/or substance use disorder.
 - In 13 of the 54 cases or 24% there was a caregiver who was under the age of 25 or parents were prior state wards.
 - In 15 of the 54 cases or 28% there were other risk factors noted such as undiagnosed mental health and substance abuse concerns, prior incarceration, and prior CPS intakes and investigations.
- 56% had at least one protective factor. One of the highest recorded protective factors was found in 40% of the cases, 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 2025/2026 CRP review period, 45 of the 59 cases or 76% were determined by investigating parties to be caused by the parent or guardian. In 8 of the 59 cases or 14%, no one was found responsible, or investigating parties could not determine who was responsible for the injuries.

2025-2026 Recommendations

Based on the reviews CRP conducted in 2025/2026, the CRP makes the following recommendations to improve the child welfare response in Nebraska:

1. Per Nebraska Revised Statute 28-728, children who are alleged to be victims of serious physical abuse or neglect should be brought to a Child Advocacy Center for a forensic interview and assessed for medical evaluations. DHHS should coordinate with the Nebraska Alliance to develop a plan to ensure training is provided to all case managers regarding when children should be brought to Child Advocacy Centers.

The CRP evaluated the parties involved in the investigation of the reviewed cases and found coordination with CACs occurred within 31% of the cases. The CRP believes CACs provide vital services to children and families and aid in the investigation process by providing child-center trauma informed interventions. CACs provide forensic interviews that allow trained professionals to provide child-friendly trauma informed interviews to children. CACs also provide connections to medical professionals with specialized training to work with victims of child abuse and neglect.

2. Identify DHHS case managers who should have specialized training and experience in handling investigations involving children with medical concerns. DHHS should ensure this training includes:
 - Clarify who the experts on child abuse and neglect medical issues are in their local area to include CAC medical professionals and hospital personnel.
 - Ensure during all child abuse and neglect investigations; case managers coordinate with their local CAC throughout the investigation process.
 - Clarify when to coordinate with hospital medical professionals during investigations, what documentation to gather, and when to defer to their medical expertise.
 - Identify resources and contact information in the region that assist children and families with medical issues.

The CRP recommends specialized training for case managers that work cases involving children with medical concerns due to the complexity of these cases. These cases require a significant amount of coordination and follow up that can be more time-consuming than other cases. When asked for improvements to the investigation process, the reviewers found 43% of cases needed more documentation in the file, including obtaining medical documentation and law enforcement reports. Several reviewers noted the need for follow up interviews, forensic interviews at CACs of alleged victims and siblings, and interviews of all those that had access to the injured child. Having a dedicated group of case managers that have familiarity with the policies and procedures regarding these cases would streamline investigations.

3. Ensure case managers review all historical information for every child abuse and neglect intake, even if prior reports were deemed unfounded.

Due to the complexity of these cases, serious injuries, and the risk of harm, the CRP finds it important to thoroughly investigate through gathering more historical information. The reviewers noted 21% of the cases should have involved reviewing and following up on historical concerns noted through prior reports. The CRP believes that reviewing historical concerns can impact the investigation process for current intakes.

4. Include detailed documentation and justification in safety assessments on how children are determined to be safe.

The CRP expressed concerns for some of the safety determinations in the cases reviewed to include noting 21% of the cases had safety concerns that were not addressed before the closure of the case. In these cases, more communication, clearer documentation, additional investigation into alleged allegations, and further exploration of individuals with access to the children were recommended. The CRP believes that clear documentation of how safety was determined would assist with discovering additional steps that should be taken to ensure child safety in all cases of alleged child abuse and neglect.

5. [Provide clear guidance for case managers on documenting protective factors for each family and ensure these documented strengths are used to inform and guide case plan creation.](#)

The CRP annotates the protective factors that can be found in the reviewed cases. In 44% of the cases, there was not enough information to determine protective factors. The reviewers recommend a designated place is developed for case managers to document protective factors to ensure those factors are used in the development of case plans.

6. [Develop a process for using strong collaborative cases as training examples for case managers and create a method to recognize the workers who demonstrated exemplary performance.](#)

The CRP has the opportunity to provide positive feedback to all the reviewed cases. Reviewers noted that some of the cases had good coordination, good communication between case professionals and families, and thorough interviews and investigations. These cases would be good case examples to provide other case managers to ensure all cases involving children with medical concerns are handled appropriately.

7. [Include detailed documentation in DHHS records regarding referrals and resources offered to families, the family's response to the resources, and if any actions were taken on the resources or referrals, particularly at case closure.](#)

The CRP believes thorough reviews of previous intakes and cases during investigation will provide beneficial historical information to assist with current case investigations. Case managers would benefit from knowing what resources have been offered to families during previous DHHS involvement to make more applicable case plans. A clear place for documenting resources offered at time of case closer should be incorporated into DHHS records.

[Update on 2024-2025 Report Recommendations](#)

In April 2025, the CRP submitted its annual report which included seven recommendations to Nebraska DHHS:

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.

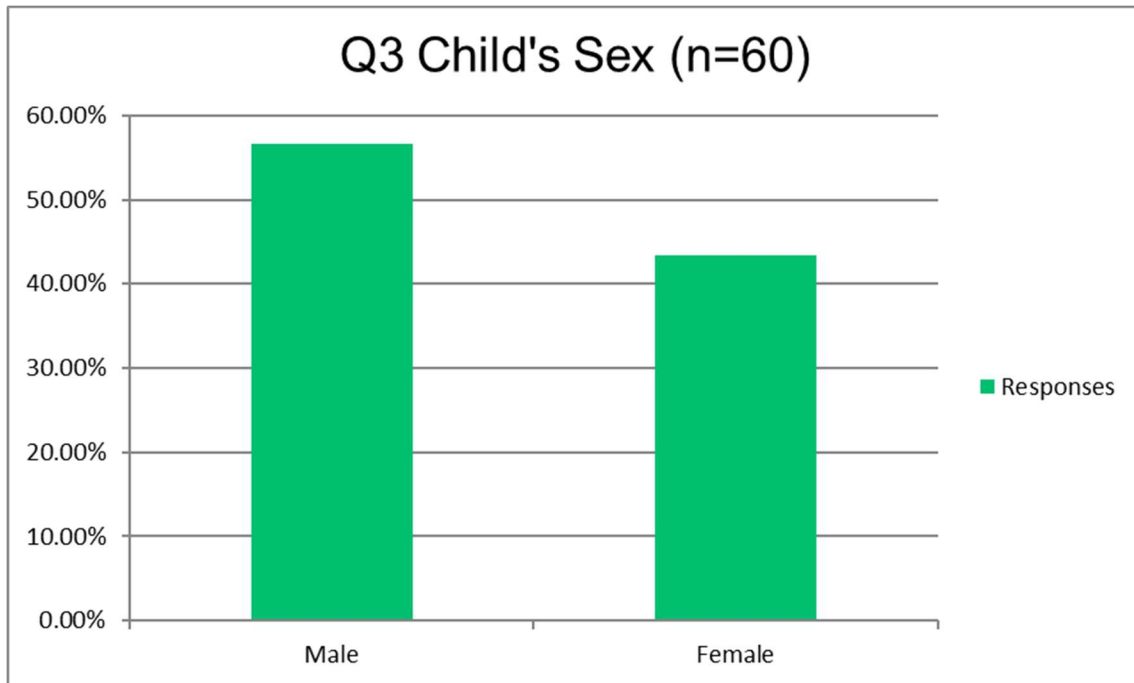
- Clarify when to coordinate with hospital medical professionals during investigations, what documentation to gather, and when to defer to their medical expertise.
 - Include all relevant medical records in initial assessment documentation.
2. Provide additional training to case managers regarding the 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.

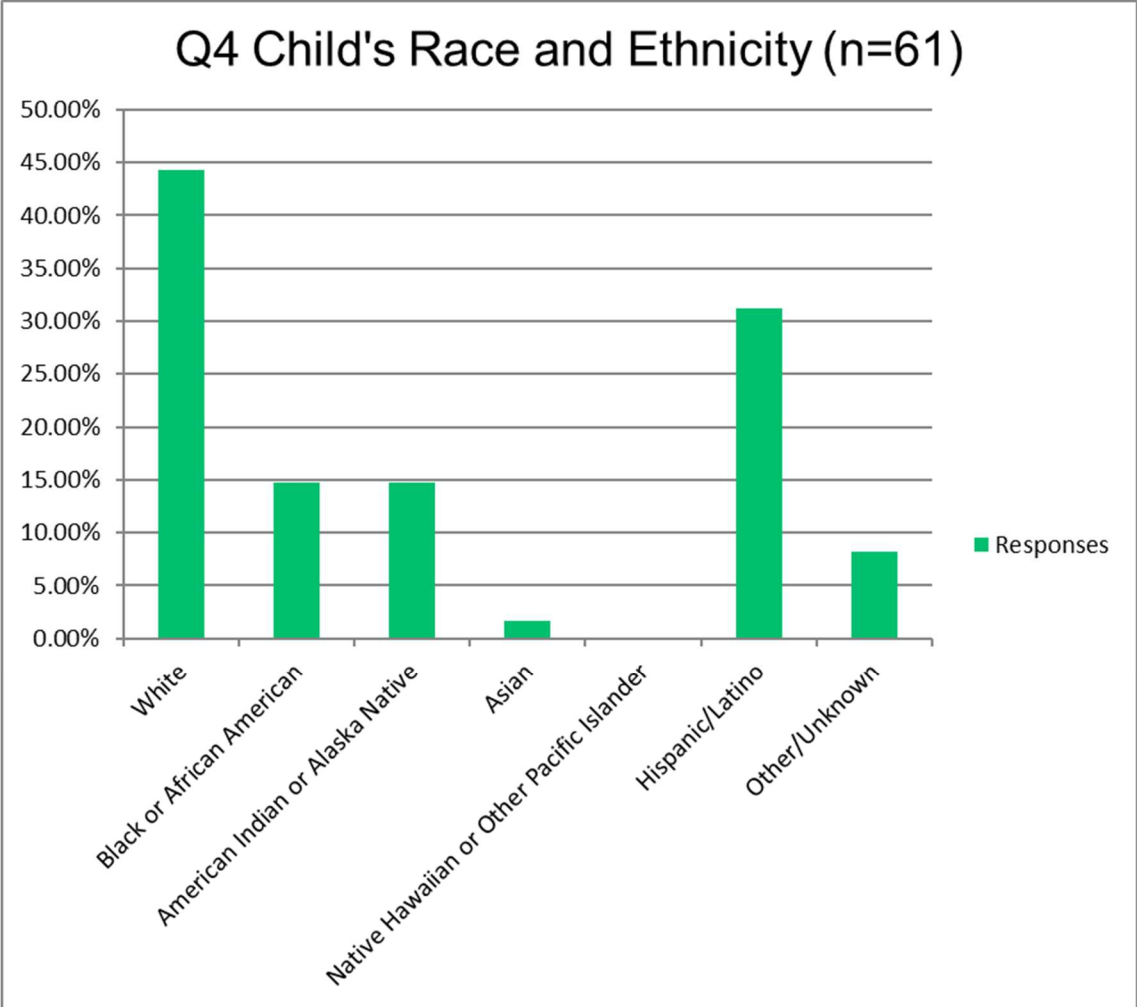
In response to the recommendations that the CRP submitted, DHHS reported they are required by state statute to conduct joint investigations with law enforcement, where they utilize an evidence-informed and validated tool to assess child risk of future abuse and the services that are needed for the family. Their standard operating procedures require DHHS workers to consult with law enforcement and CACs when there are cases that meet statutory requirements for CAC coordination.

DHHS reported they rely on collateral information to identify and document protective factors. Those protective factors are used as foundations for safety and case plans. DHHS also reported looking at prior DHHS history and pending investigations in the initial assessment process. They use this to assist with determining who will take the lead on the investigation. In response to making sure that siblings are interviewed, DHHS noted case managers must make a good-faith effort to compile all interviews on the same day when feasible. Case managers seek to interview every individual during the initial contact.

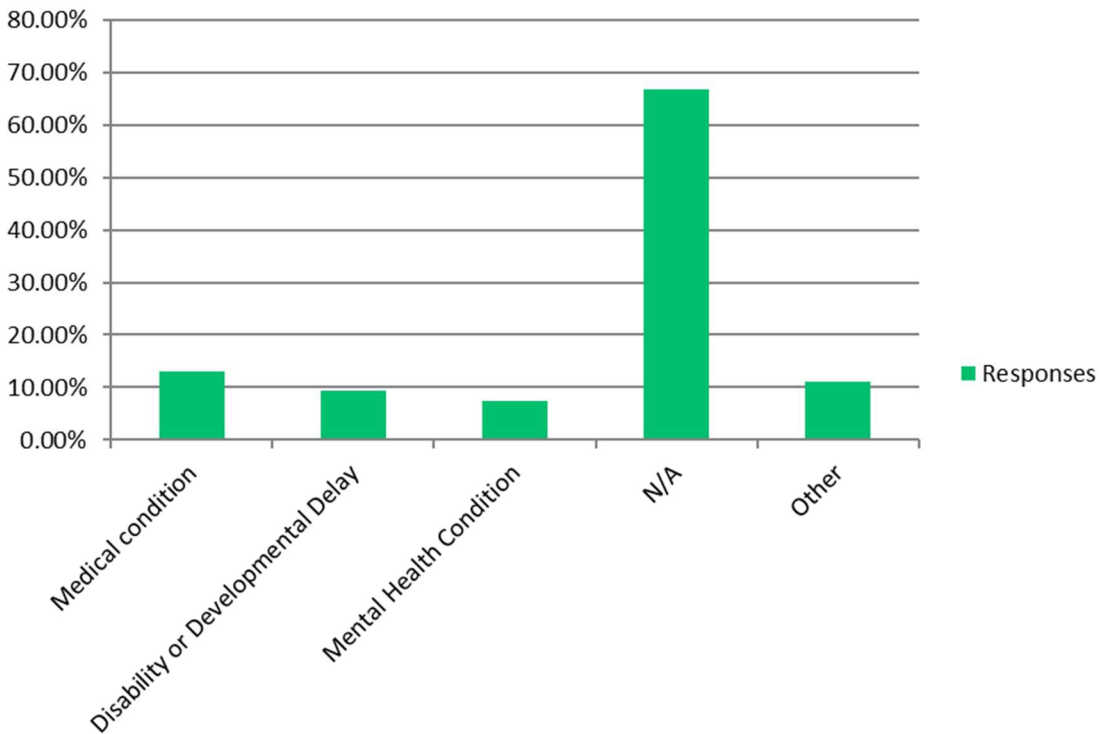
Finally, DHHS stressed the importance of communication and discussed how they are required to document all information that supports safety decisions. Those assessments are completed within 24 hours of contact. DHHS does not have a policy that requires supervisors to review all assessments, but they shared that this practice is consistently carried out as part of supervisory oversight and case consultations.

Appendix A. Full Data from Case Reviews

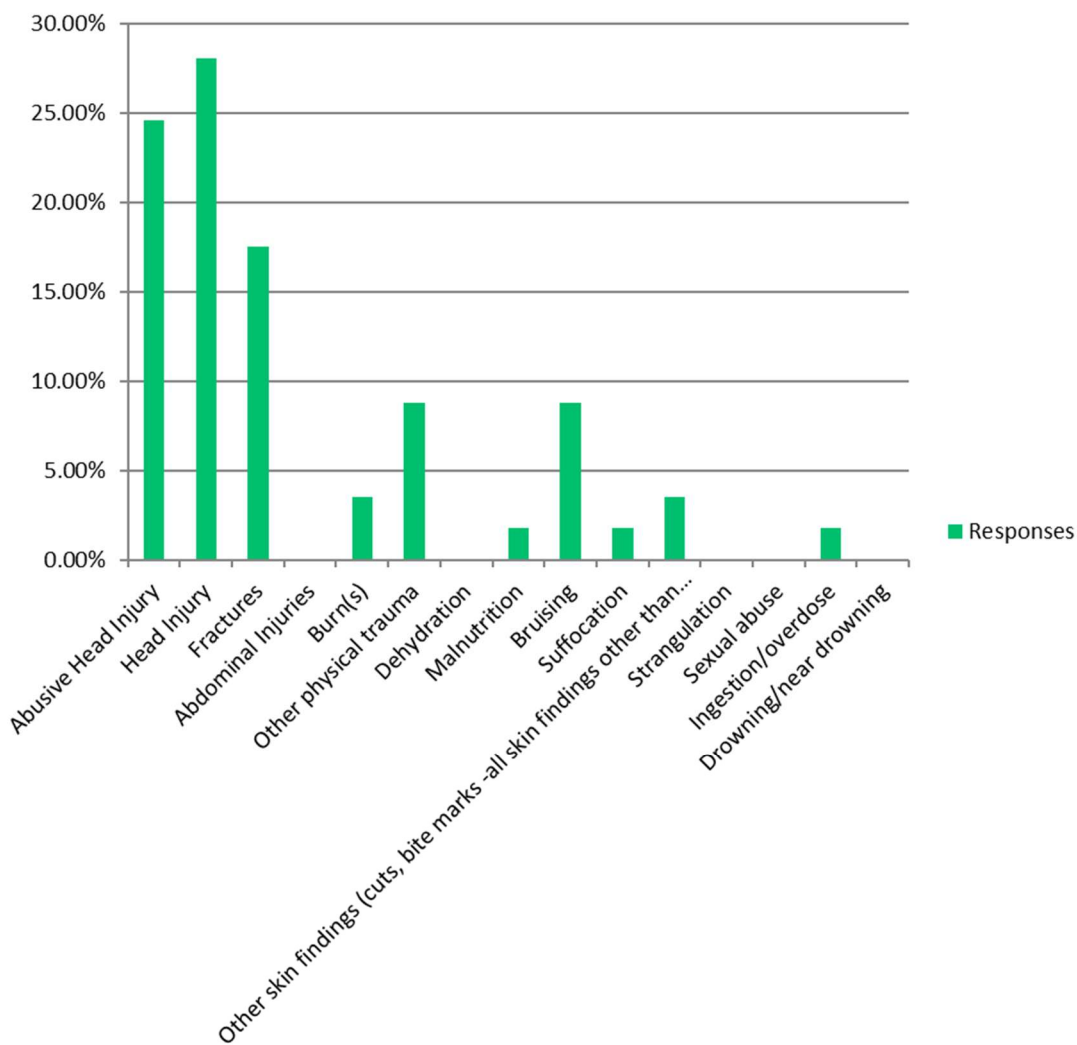




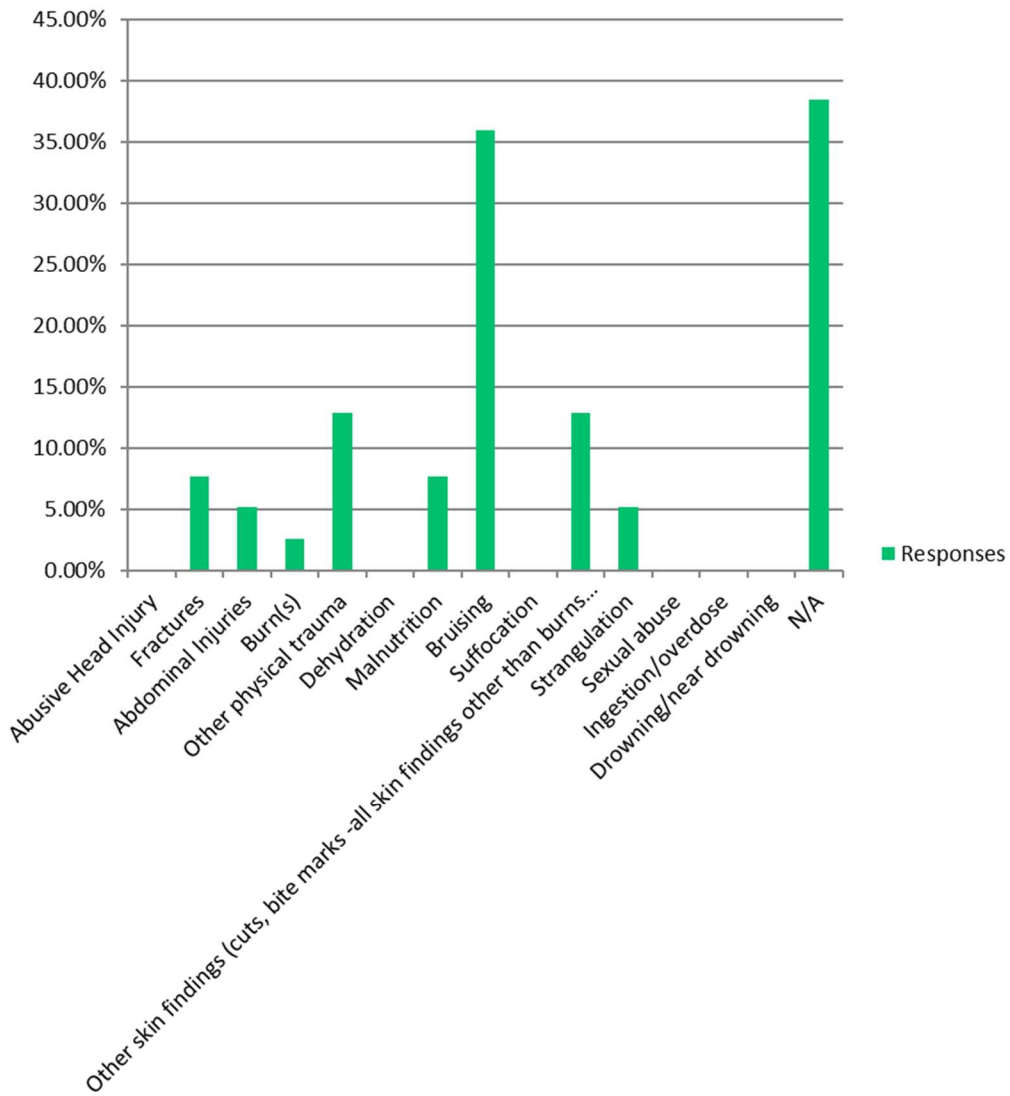
Q5 Prior to the injury did the child have any of the following documented? (n=54)



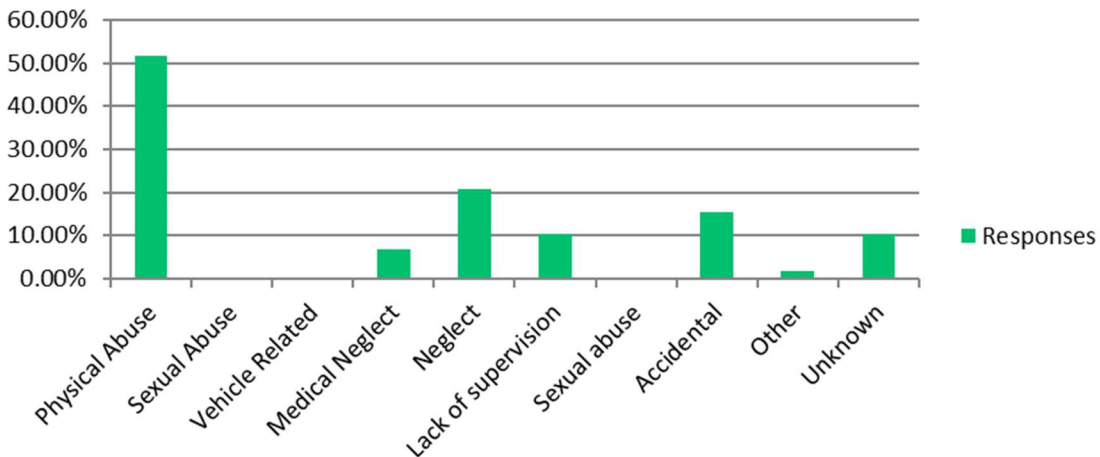
**Q7 Primary Injury to Child: Please select
the most serious injury requiring treatment.
(n=57)**



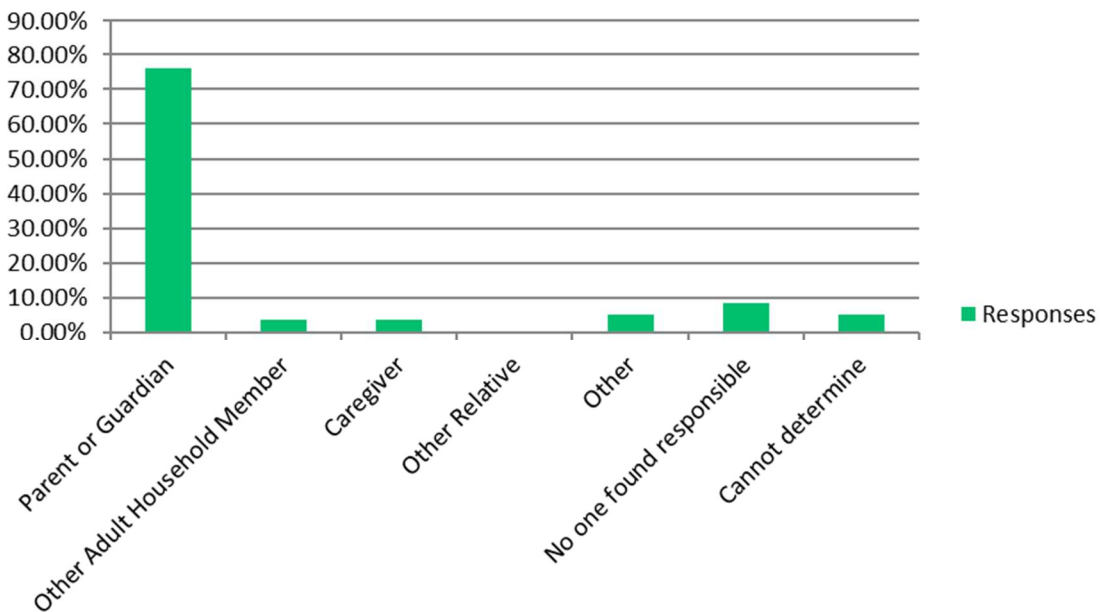
Q8 Secondary Injury or Injuries to Child Noted (n=39)



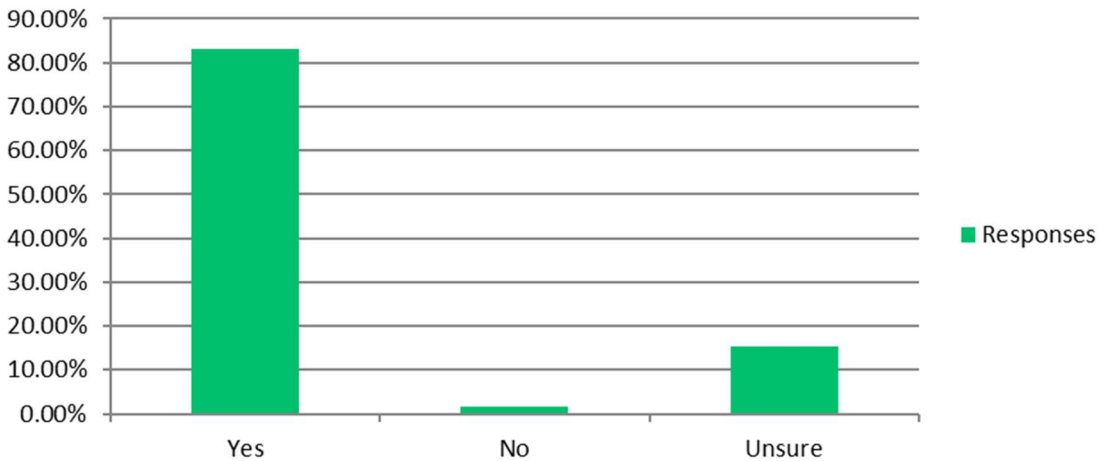
Q9 Please select the cause(s) of injury indicated by the investigating agency or agencies (n=58)



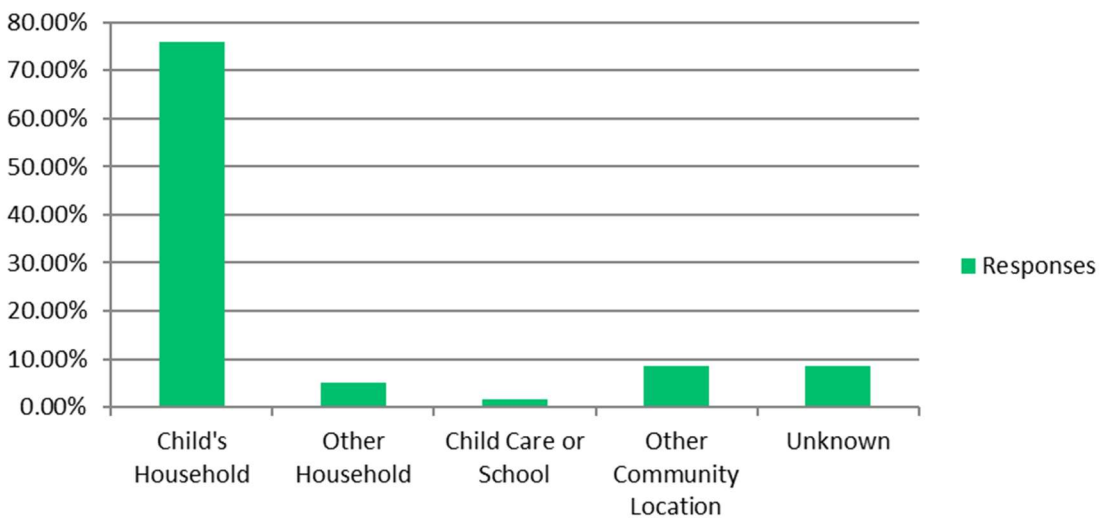
Q10 Child Relationship to Part(ies) Determined Responsible for Abuse or Neglect resulting in Injury by Investigating Agencies (n=59)

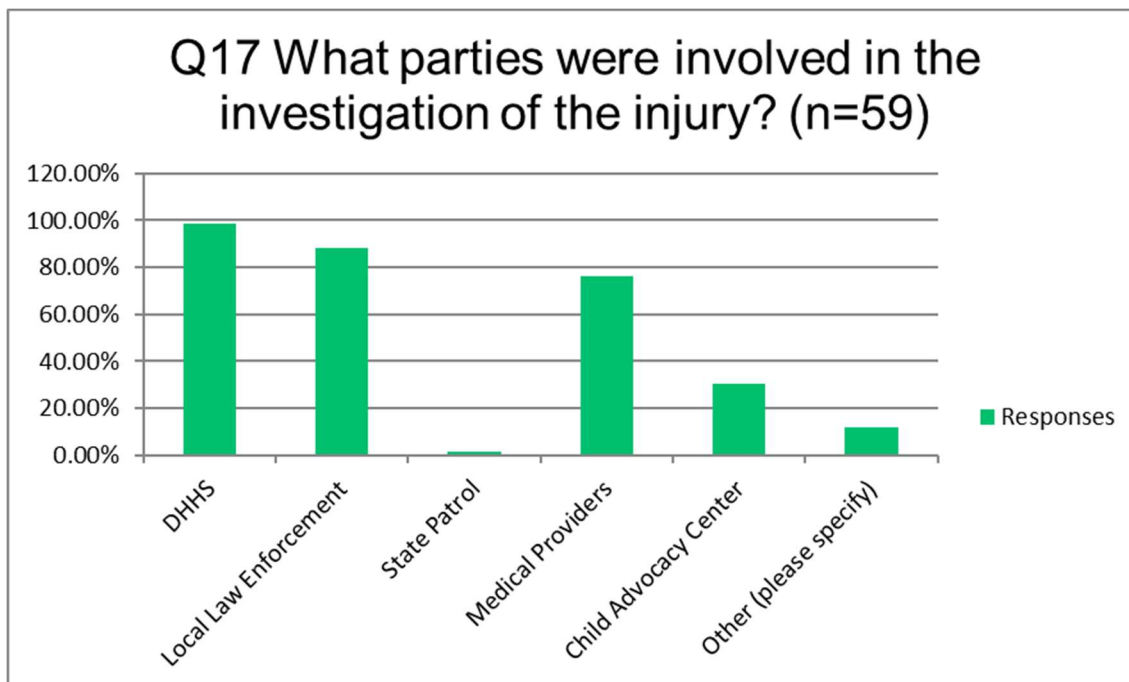
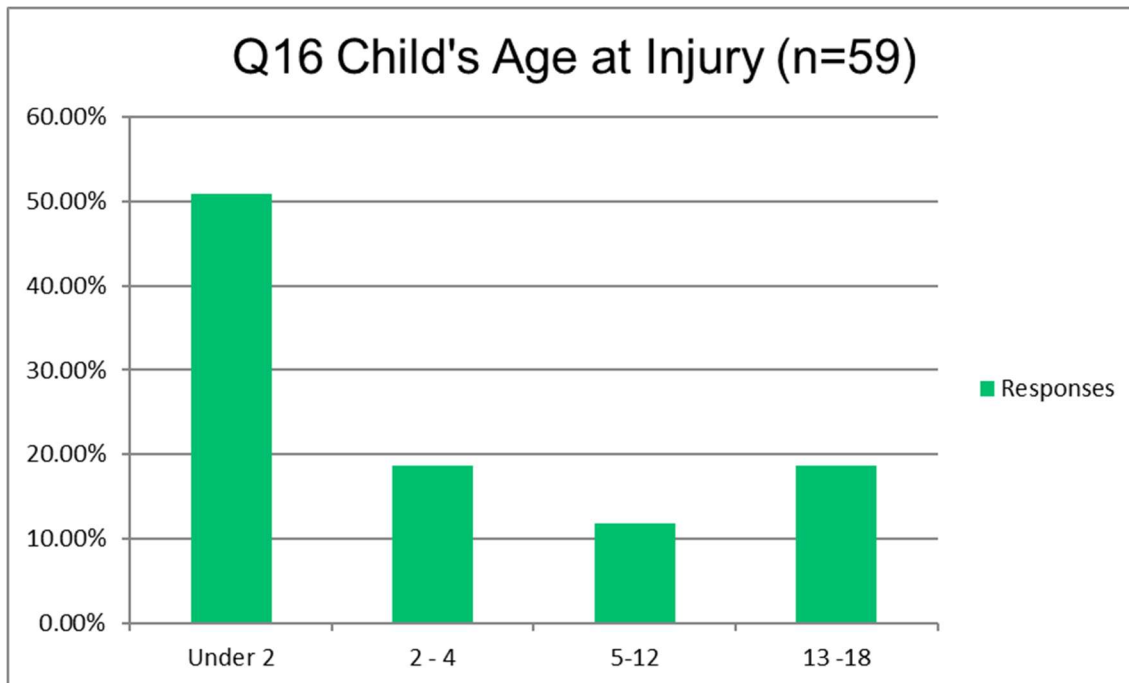


Q11 Do you agree with the investigative agency assessment of what and who caused the injury? (n=59)

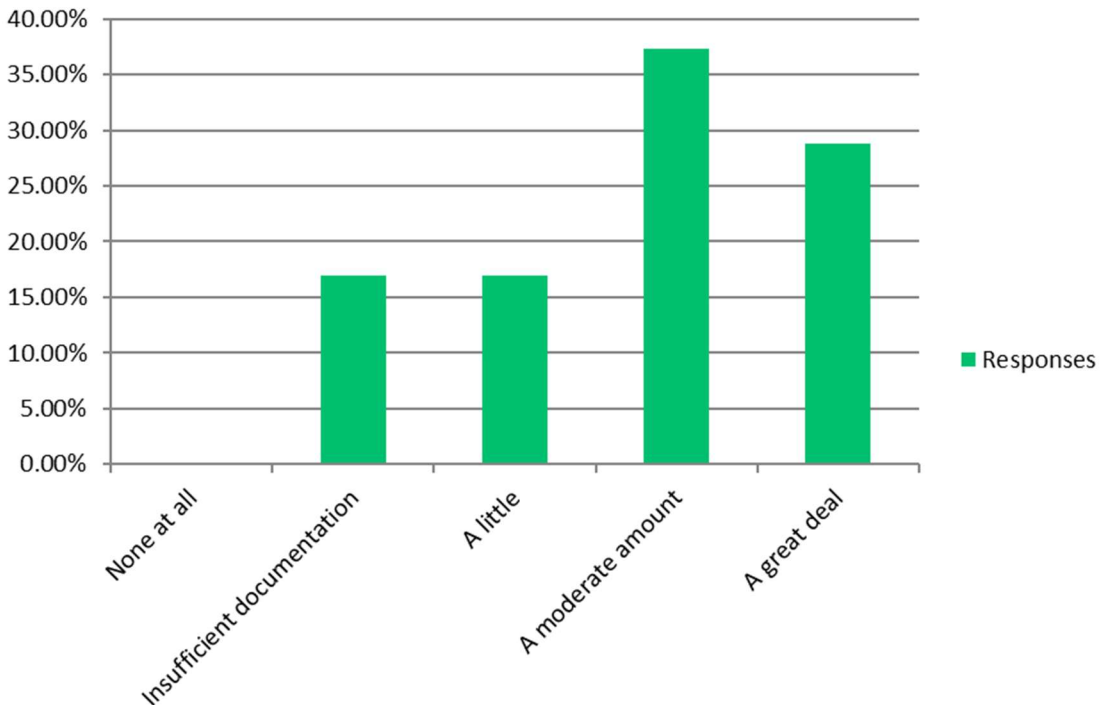


Q15 Location where Injury Occurred (n=58)

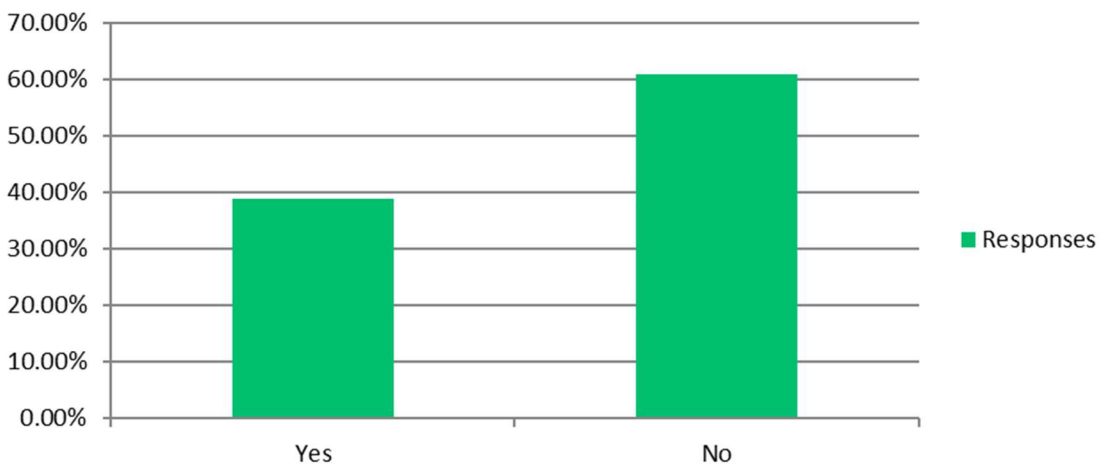




Q18 To what degree did the investigating agencies coordinate during the investigation? (n=59)



Q19 Do you have recommendations to improve the investigation and system response to the injury? (n=59)



Q20 What was the child's involvement with the child welfare/protection system at the time of the injury? (mark all that apply) (n=56)

Answer Choices	Responses	
DHHS Ward	0.00%	0
Open Non-Court Case	1.79%	1
Open Investigation/Initial Assessment	3.57%	2
Open Alternative Response Case	0.00%	0
Closed ongoing case in the past 12 months	1.79%	1
Closed Investigation/Initial Assessment in past 12 months	14.29%	8
Closed Alternative Response in the past 12 months	3.57%	2
Reports to Hotline not accepted/screened out in past 12 months	5.36%	3
None	67.86%	38
Other (please specify)	14.29%	8

Q21 If the child and family was involved with DHHS, please respond to the following questions about safety and risk: (n=46)

	Yes		No		Unsure		N/A	Total	
Were there calls to the child abuse and neglect hotline in the prior 12 months involving the child?	21.74%	10	10.87%	5	10.87%	5	56.52%	26	46
Was there an active safety plan in place when the injury occurred?	2.22%	1	31.11%	14	8.89%	4	57.78%	26	45
Was there a safety plan in place for the child at any point in the twelve months before the injury?	6.67%	3	26.67%	12	8.89%	4	57.78%	26	45
Was the family classified as high or very high risk in the twelve months before the injury?	8.89%	4	20.00%	9	13.33%	6	57.78%	26	45
Was the child welfare case meeting the family needs and child safety?	2.27%	1	11.36%	5	11.36%	5	75.00%	33	44
Comments:									9

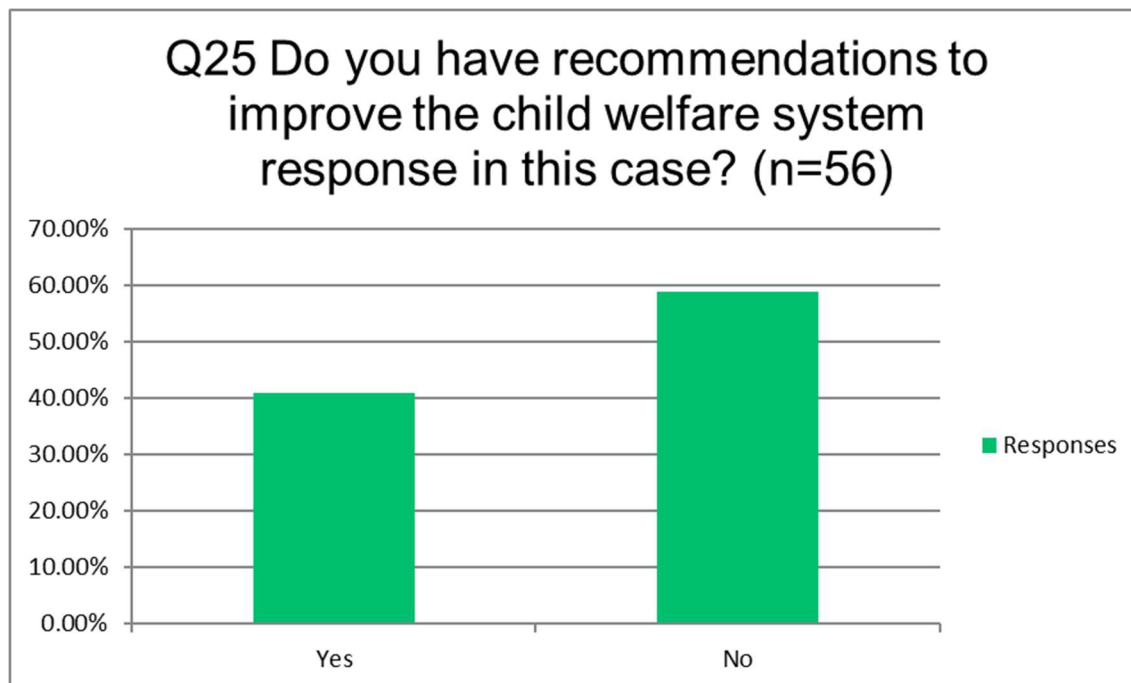
Q22 What risk factors were present? (n=54)

Answer Choices	Responses	
Family living in poverty, lack of basic needs	18.52%	10

Caregiver with diagnosed severe persistent mental illness and/or substance use disorder	25.93%	14
Prior incidents of family or domestic violence	44.44%	24
Prior open ongoing case due to abuse/neglect	16.67%	9
Family history of abuse/neglect or trauma	38.89%	21
Prior injury to any child in the home from abuse or neglect	20.37%	11
Caregiver under age 25	24.07%	13
Any children in the home under the age of 2	59.26%	32
Parent/s are prior statewards	24.07%	13
Other (please specify)	27.78%	15

Q23 What protective factors were present? (n=55)

Answer Choices	Responses	
Parental resilience: Manages stress and functions well when faced with challenges, adversity, and trauma	16.36%	9
Social connections: Builds positive relationships that provide emotional, informational, instrumental, and spiritual support	23.64%	13
Knowledge of parenting and child development: Understands child development and parenting strategies that support physical, cognitive, language, social, and emotional development	12.73%	7
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	40.00%	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	18.18%	10
Not enough information to determine.	43.64%	24
Other (please specify)	21.82%	12



Appendix B. Case Review Tool 2025/2026

1. Separate attachment

2025/2026 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.

2025/2026 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:

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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.

2025/2026 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

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Household and Caregiver Characteristics and System Involvement

20. 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)

21. 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:

22. 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
- ☐ Parent/s are prior statewards
- ☐ Other (please specify)

23. 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)

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System Response to Injury

24. 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)

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

- ☐ Yes
- ☐ No

Please provide your suggestions

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