# State of Delaware Child Protection Accountability Commission
# Child Abuse Medical Response Committee

FRIDAY, SEPTEMBER 18, 2015 -- 10:00 AM – 12:00 PM

**In Attendance:**

Dr. Allan De Jong, Nemours-AIDHC (Co-Chair)
Col. Nathaniel McQueen, DSP
Chief Laura Giles, Police Chiefs Counsel
Tania Culley, Esq., OCA
Erin Carroll, Nemours-AIDHC
Cym Doggett, SRCAC (by t/c)
Dr. Karen Farst, Arkansas Children's Hosp (by v/c)
Randy Williams, CAC (Co-Chair)
Josette Manning, Esq., DAG
Jennifer Donahue, Esq., IC
The Hon. Joelle Hitch, Family Court
Chris Newlin, NCAC (by t/c)
Kori Stephens, MRCAC (by t/c)

**WELCOME AND INTRODUCTIONS**

Randy Williams, Co-Chair, welcomed everyone and attendees introduced themselves.

**THE IMPORTANCE OF THE MEDICAL RESPONSE TO CHILD ABUSE**

Dr. Karen Farst from the Arkansas Children's Hospital presented. Dr. Farst reviewed national data on child abuse reports and response. She indicated Arkansas is similar in numbers to Delaware in terms of population. They have 14 CAC centers and 10 have daytime medical coverage on site. Eight have ability to do onsite medical 24/7. Providers are RN-SANE nurses with a local medical director.

Dr. Farst said most of their medical coverage statewide is for sexual abuse child victims. Dr. Farst briefly reviewed the different types of child abuse including Munchausen Syndrome by Proxy. She then looked at the medical options. In order to become a child abuse pediatrician, one has to train first in pediatrics (specialty), then choose a subspecialty (child abuse). There are several levels of nursing as well – RN is bedside care and APN is advanced training on diagnosis and treatment. The SANE can be an APN or RN but this requires an additional training course. They can concentrate just on pediatrics, SANE-P, or on adult/adolescents only, SANE-A. It is critical for Arkansas to use nurses as part of the child abuse medical response as there are not enough physicians who want to do this type of work.

Dr. Farst then discussed the medial response which is the history plus the findings that lead to conclusions. No match equals a report. Dr. Farst described the multidisciplinary response, which includes not only the medical history and findings, but also criminal and child welfare history, forensic and investigative interviews, and scene investigation. She provided some coordinated response examples which are beyond critical in solving these cases. She referenced how a silo response resulted in a child returning in two months with more injuries.

Dr. Farst covered national standards for mandatory reporting as well as standards for sexual abuse, medical guidelines, and guidelines for non-medical personnel. She reviewed

the accreditation guidelines for the Children's Advocacy Center of which the medical response is a part.

Dr. Farst shared that the US Dept of Justice released in April of 2013 a national protocol for sexual assault medical forensic examinations for adults and adolescents. OJJDP also published a guide for non-medical personnel for identifying and reporting. National Children's Alliance has over 750 member centers. Over 315,000 children served in 2014. She reviewed statistics on what type of medical staff typically provide acute and non-acute medical evaluations.

Most state funding systems are set up to support sexual assaults and not physical assaults. She shared a spreadsheet of medical responses and sources of funding. One example is Oregon's "Karly' Law." Texas' response system was also reviewed. Utah has a model similar to DE and AR with one primary hospital for the state. Best practice is to have the medical providers employed by the hospital for control of the quality of the providers. NJ has a comprehensive legislative response to a medical program.

Dr. Farst indicated the pace of child abuse pediatricians retiring may outpace new fellowship graduates for the next several years. Even if you cannot revamp an entire system, she encouraged making changes where we can as it will have a domino effect. There are struggles as child abuse is not a good business plan. Much of the medical work is not reimbursable. AR spends about 20% of time in court related matters. How is that time compensated? Patient care is the only reimbursable part. Chris Newlin indicated that with three counties in Delaware we should be able to come up with a plan to serve all children who need to be served medically.

**COMMITTEE CHARGE AND NEXT STEPS**

Randy Williams then began discussion on our path forward. First is to develop a statewide protocol for medical evaluation of children who are victims of abuse or neglect. He suggests we undertake this first, then once a plan is in place, design a statewide provider response. Dr. De Jong is Delaware's only medical resource right now. What are the other resources available? Once the committee identifies the type of case and the corresponding type of care, then it can figure out the network of providers. In Delaware, we have seen a trend moving from physician only review to SANE programs at adult hospitals with pediatric training. This may or may not be the appropriate system.

Chief Giles suggests looking at the Violent Crimes Assistance Program to help fund medical services. For years, CAC had a contract with Nemours-AIDHC for nurses and Dr. De Jong. That funding was cut during the State budget crisis. Nemours-AIDHC picked up the full cost of Dr. De Jong. Delaware still does not have providers for Kent and Sussex counties.

Tania Culley suggested a two prong approach since it takes three years for certification for the fellowship programs. Delaware needs an additional Dr. De Jong and needs to start

cultivating that specialist now. Dr. De Jong says Nemours-AIDHC is recruiting and searching for an additional specialist. Delaware should have two child abuse pediatricians. Dr. De Jong and Erin Carroll will provide the committee with an update at the next meeting.

Judge Hitch suggested that legislators be invited to join the committee to figure out the medical protocol structure, staffing and funding. There will be a new RFP request from VOCA funds from the Criminal Justice Council (CJC). Consideration should be given to a multidisciplinary application to CJC for at least funding for the downstate medical providers.

Randy indicated his vision of a medical protocol that would cover every child victim of abuse or neglect and the same protocol would be used by every member of the team. Randy will be sharing information before the next meeting. There are three protocols in the binder which can be reviewed. None are comprehensive and all are different from each other.

**UPCOMING MEETING DATES**

- October 16, 2015, November 20, 2015, December 18, 2015, January 22, 2016
- Meeting times of 10-12 Noon. Meeting locations to be determined.

**PUBLIC COMMENT AND ADJOURNMENT**

There being no public comment, the meeting was adjourned at Noon.