STATE OF DELAWARE
Child Protection Accountability Commission
900 King Street
Wilmington, DE19801-3341

CAPTA REPORT

In the Matters of

11-000375: Y.B.G.
12-000414: R.H.
14-000015: N.H.
14-000146: Z. D.
14-000147: H.D.
14-000208: J.V.
14-000307: A.T.F.
15-000050: M.F.

October 14, 2015

Background and Acknowledgements

Under federal law, the Child Protection Accountability Commission, as Delaware's Citizen Review Panel, is required to evaluate the extent to which the State is effectively discharging its child protection responsibilities.[1] One evaluation method sanctioned under federal law is the review of child deaths and near deaths due to abuse or neglect.[2] While CPAC previously relied upon Delaware's Child Death Review Commission ("CDRC") to conduct the actual reviews and then share the findings with CPAC so that it could evaluate the State child protection system, in September of 2015, responsibility for the actual reviews was transferred to CPAC. During the transition, reviews will be a mixture of work done by CDRC and CPAC.

In accordance with 16 Del. C. § 912(b)(7), CPAC reviewed and approved findings from 8 child death and near death cases due to abuse or neglect. Below is a summary of the findings and information for each case.

Cases Reviewed

1. Case 11-000375: Y.B.G. – Near Death

Date of Birth: April 2011; Date of Incident: May 2011

In May of 2011, a one-month-old female infant was brought in to the emergency department ("ED") by her parents for excessive crying. Victim was discharged on the same date, and it was recommended that she follow up with the primary care physician ("PCP") the next day. The following day, she was seen by her PCP and referred to the ED because she was noted to be fussy, inconsolable, and febrile. Due to an unknown etiology, she was transferred to the children's hospital for further examination and evaluation. A computerized tomography ("CT") scan of the head revealed three linear, non-depressed skull fractures. The skeletal survey was negative, and the ophthalmology exam demonstrated no retinal hemorrhages. Victim also received a Child At Risk Evaluation ("CARE") team consult and was admitted.

The Division of Family Services ("DFS") and law enforcement agency responded to the children's hospital, and DFS interviewed the parents with the help of an interpreter. On the same date, another case worker from DFS responded to the home to interview other household occupants, including several siblings. Forensic interviews also occurred at a later date. No safety plan was implemented by DFS. Victim was discharged to the care of her parents four days later with approval from

[1]. 42 U.S.C § 5106 a(c)(4)(A)

[2] The federal Child Abuse Prevention and Treatment Act requires the disclosure of facts and circumstances related to a child's near death or death. 42 U.S.C § 5106 a(b)(2)(A)(x). See also, 16 Del.C. § 912(b)(7).

DFS. After three days, Victim was re-admitted to the children's hospital for seizures, and a magnetic resonance imaging ("MRI") demonstrated subacute bilateral subdural hematomas.

As a result of the second admission, DFS petitioned for and was awarded custody of Victim. In August of 2013, paternal relatives were awarded permanent guardianship of Victim.

There were no criminal charges filed in this case. Mother and her husband were substantiated for Head Trauma and entered on the Child Protection Registry at Level IV. Victim's father appealed the DFS finding and the petition was dismissed.

The family has prior DFS involvement involving Mother's six other children. She and her husband had three prior investigations, which were unsubstantiated, and one treatment case. Victim's father has had no prior DFS involvement. It was learned that he was recently convicted of an incident involving a child and deported.

Findings

1. CDNDSC recommends that the hospital follow the American Academy of Pediatrics' guidelines as to appropriate care and case management for infants under six weeks of age, presenting to the emergency department with a high fever (*from initial review by the Child Death Review Commission and included in the 2015 Joint Action Plan*).

2. CDNDSC recommends that education be offered to the hospital on what a full skeletal survey consists of as per the American College of Radiology (*from initial review by the Child Death Review Commission and included in the 2015 Joint Action Plan).*

3. The law enforcement agency did not maintain ongoing collaboration or communication with DFS and Department of Justice ("DOJ") (*from final review*).

4. The law enforcement agency had the DFS investigation worker take the lead in the interview with the suspects (*from final review*).

5. No doll re-enactment was completed by the law enforcement agency (*from final review*).

6. No scene investigation was completed by the law enforcement agency (*from final review*).

7. There was minimal documentation in the police report by the law enforcement agency (*from final review*).

8. Limited resources and education impacted the criminal investigation (*from final review*).

9. DFS approved discharge of baby to parents when origin of skull fractures was undetermined (*from final review*).

10. Assigned dayshift worker was notified of potential discharge by hospital but took no action (*from final review*).

11. Two radiologists came up with two different conclusions after reading the scans (*from final review*).

12. Forensic interviews did not occur until a month after the incident (*from final review*).

2. Case 12-000414: R.H. – Near Death

Date of Birth: March 2000; Date of Incident: November 2012

In November of 2012, the law enforcement agency responded to a call regarding a twelve-year-old male child, who had fled his home and was at the home of an acquaintance. Victim disclosed that he had been punched in the face by his step-mother. Law enforcement returned to the home and interviewed the family. Victim remained in the patrol car during this time. Step-Mother admitted to backhanding Victim. Father reported that Victim throws fits and self inflicts injuries. He also admitted that they often lock Victim in his room. Law enforcement observed Victim's room to have only paper, pencils and a lamp with no shade. For punishment, Victim was forced to repeatedly write that he would not throw fits. Law enforcement contacted the DFS Report Line, and the case was originally assigned a priority two response (within three days). However, after Victim was admitted to the children's hospital, a DFS case worker responded to the hospital immediately. Victim had multiple bruises to his face, back, right thigh, right hip, and knuckles, as well as an ulcer on his upper lip. He was also 30 to 40 pounds underweight.

A forensic interview occurred with Victim, and he disclosed numerous incidents of being hit with a belt, a ruler, and a spoon by both his step-mother and his father. He also disclosed being locked in his room for days at a time and not being fed. At a later date, Victim's sibling and step siblings received forensic interviews.

DFS petitioned for and was awarded custody of the children. DFS was ordered to place the sibling and step siblings with relatives. Victim was placed with a foster parent upon his discharge. Sole custody was later awarded to Victim's Mother while Victim's sibling and step siblings are in the guardianship of relatives.

In September of 2013, Father pled guilty to Assault in the Second Degree and was sentenced to 8 years at Level V confinement, suspended after serving 6 years, followed by 6 months at Level IV partial confinement and 2 years at Level III

probation. He also pled guilty to Misdemeanor Endangering the Welfare of a Child, and was sentenced to one year at Level V confinement, suspended after serving one month, followed by 11 months at Level III probation. His anticipated release date is May of 2018 with good time; his maximum release date is December of 2018.

Step-Mother pled guilty to Assault in the Second Degree and was sentenced to 8 years at Level V confinement, suspended after serving 5 years, followed by 6 months at Level IV partial confinement and 2 years at Level III probation. She also pled guilty to Misdemeanor Endangering the Welfare of a Child and was sentenced to one year at Level V confinement, suspended after serving one month, followed by 11 months at Level III probation. Her anticipated release date is July of 2017 with good time; her maximum release date is December of 2017.

As ordered by Superior Court, both Father and Step-Mother will spend 10 consecutive days in solitary confinement during the Thanksgiving holiday each year until their release. They are both entered on the Child Protection Registry at Level IV as a result of their convictions involving the same incident of abuse.

The family had frequent involvement with DFS since 2003. Between 2003 and 2007, the reports involved allegations of abuse and neglect against Victim and his sibling by Father. None of these reports resulted in a DFS finding. Routine medical care for Victim also stopped between 2009 and 2012. In April of 2012, the reports of abuse began to focus solely on Victim, but no evidence of abuse was found by DFS and no disclosure was made Victim. By August of the same year, Victim was withdrawn from school and homeschooled, limiting his contact with adults outside the home. Despite this, school staff remained diligent and reported suspicions of abuse to DFS two months prior to Victim's near death incident.

Findings

1. CDNDSC recommends that DFS comply with policy as it relates to utilizing a minimum of two collateral contacts prior to case determination *(from initial review by the Child Death Review Commission and included in the 2015 Joint Action Plan).*

2. CDNDSC recommends that DFS comply with policy as it pertains to the Medical Examination Protocol for children under the age of eight years old, indicating that any infant or child who is the alleged victim of a physical abuse report must receive a medical examination by a pediatrician or family practitioner as soon as possible; and for children between the ages of nine and eighteen years old, indicating the child must be seen by a registered nurse or physician's assistant to determine if more in-depth medical care is needed, to ensure the children are evaluated to determine whether or not an injury exists as a result of said physical abuse *(from initial review by the Child Death Review Commission and included in the 2015 Joint Action Plan).*

3. CDNDSC recommends that DFS notify law enforcement in compliance with the Memorandum of Understanding ("MOU") upon receipt of any report that would constitute criminal violations against a child by a person responsible for the care, custody and control of the child *(from initial review by the Child Death Review Commission and included in the 2015 Joint Action Plan).*

4. CDNDSC recommends that in making the determination to screen out reports of physical abuse, DFS should utilize previously reported allegations and give greater credibility to professionals reporting the concerns of child abuse and neglect *(from initial review by the Child Death Review Commission and included in the 2015 Joint Action Plan).*

5. CDNDSC recommends that DFS follow the MOU with the Department of Education ("DOE") that DFS address employee performance as it relates to collateral contacts, providing caseworkers with a higher level of supervisory oversight and further guidance on how to proceed when negative concerns are presented from such collateral contacts *(from initial review by the Child Death Review Commission and included in the 2015 Joint Action Plan).*

6. CDNDSC recommends that CPAC develop a tool to educate professionals of the warning signs and indicators of physical abuse and neglect by torture. This tool shall be focused on all professionals to include school administration and staff, law enforcement, social workers, caseworkers and other professionals that may be involved with such cases. This tool shall also reflect that the child denying allegations of physical abuse and/or neglect should be an expectation *(from initial review by the Child Death Review Commission and included in the 2015 Joint Action Plan).*

7. CDNDSC recommends that judicial officers and other child welfare professionals receive training on the emotional trauma that children experience as a result of witnessing a parent or caregiver abuse and/or neglect a targeted sibling, particularly when the abuse is severe or results in death or near death (*from initial review by the Child Death Review Commission and included in the 2015 Joint Action Plan).*

8. CDNDSC applauds the efforts of the law enforcement agency in identifying a child that presented as a victim of physical abuse and neglect, and ensuring the safety of said child by responding to the children's hospital rather than returning the child home as instructed to do so by DFS *(from initial review by the Child Death Review Commission and included in the 2015 Joint Action Plan).*

9. The only oversight with the current DOE Home Schooling regulations is an application and yearly attendance (*from final review*).

10. An application for home schooling was approved despite suspicions of abuse and neglect and truancy issues. Without oversight, it may leave children vulnerable to abuse or neglect (*from final review*).

11. The inpatient psychiatric hospital shredded the child's initial assessment (*from final review*).

12. PCP did not follow up with family after 2009 visit and child was not seen again until 2012 (*from final review*).

13. PCP did not recognize signs of potential abuse and neglect during May of 2012 visit, which included swelling, bruising, delayed shots, poor weight gain, mechanism of injury, and long absence of medical care (*from final review*).

14. ***Strengths***: reporting person was willing to get involved; assigned detective built a rapport and obtained significant detail from suspects that corroborated Victim's statements; the lengthy sentence recommended by the Judge; visiting teacher and school nurse advocated for Victim; and a CARE team consult and forensic evaluation were done (*from final review*).

3. Case 14-000015: N.H. – Near Death

Date of Birth: June 2008; Date of Incident: October 2013

In October of 2013, a five-year-old female child was admitted to the children's hospital. Her blood cultures were positive for at least six types of bacterial infection for which doctors have been unable to find a medical cause. Victim's medical history was concerning as she had numerous hospital admissions to the children's hospital and an out-of-state children's hospital from 2009 to present. During her admission, Victim was moved to a hospital room with three hidden cameras. Mother was seen covering up one camera on several occasions, and later seen taking a syringe from her pants pocket, injecting the syringe into Victim's IV and placing the syringe back into her pocket.

The children's hospital contacted DFS and the law enforcement agency. Authorities in Pennsylvania were also alerted since Victim resided in Pennsylvania with her mother, father and two siblings.

Law enforcement obtained a confession from Mother, who admitted to using the syringe filled with saline or tap water on 3-4 occasions to flush out Victim's IV. In November of 2014, she pled guilty to Child Abuse in the Second Degree and Felony Endangering the Welfare of a Child. She was sentenced to 2 years at Level V, suspended for 18 months at Level II for each offense, and probation to run concurrent. She was ordered to have no contact with Victim or with any minor under the age of 18. She was entered on the Child Protection Registry at Level IV as a result of a conviction involving the same incident.

Victim and siblings reside in the care and custody of their father in Pennsylvania. The child protective services agency in Pennsylvania was providing ongoing services to

the family at the close of the DFS investigation. The family had no prior history with Delaware DFS.

Findings

1. ***Strengths***: DFS overrode the decision from the Structured Decision Making ("SDM") Screening Assessment to screen in the report; Delaware and Pennsylvania authorities collaborated during the investigation; a multidisciplinary team approach was utilized; and the children's hospital suspected abuse and initiated video recording *(from initial review by the Child Death Review Commission).*

2. A sentence of 18 months probation was inadequate given the finding of Medical Child Abuse (Munchausen by Proxy) (*from final review*).

4. Case 14-000146: Z. D. - Death

Date of Birth: February 2014; Date of Incident: May 2014
****Sibling to Case 14-000147***

In May of 2014, emergency medical services ("EMS") and law enforcement agencies were dispatched to a motel in reference to an unresponsive three-month-old male infant. Victim was transported to the ED in respiratory arrest. Once stabilized, a CT scan of the head was performed and showed a subdural hematoma and possibly a small amount of subarachnoid blood. Victim was transported to the children's hospital, where he received further diagnostic exams. A chest x-ray showed left rib fractures of the lateral 6th, 7th, and 8th ribs. CARE team, neurology, and ophthalmology were consulted, and it was determined that Victim presented after a prolonged cardiac arrest with evidence of significant traumatic brain injury, bilateral retinal hemorrhages, and rib fractures. The diagnosis was non-accidental trauma. Two brain death examinations occurred the next day, and the findings were consistent with brain death. He was declared deceased on the same date. Following an autopsy, the Division of Forensic Science identified the cause of death as Shaken Baby Syndrome and Blunt Force Head Trauma, and the manner of death as homicide.

DFS and the law enforcement agency responded to the children's hospital. At the same time, law enforcement secured the scene until a search warrant was obtained and a scene investigation could be completed. Law enforcement obtained a confession from Father, who admitted to shaking the infant. Father also demonstrated the mechanism of injury through a doll re-enactment. Mother denied any knowledge of the abuse and was not caring for the Victim when he was injured.

Father pled guilty to Murder by Abuse or Neglect in the Second Degree. He was sentenced to 25 years at Level V, suspended after service of 12 years to 7 years at

Level III. He was entered on the Child Protection Registry at Level IV as a result of a conviction involving the same incident.

DFS had an active investigation prior to the death incident. In March of 2014, Victim and his twin sibling were seen by the PCP at one-month of age for a well visit. The PCP noticed bruises on the children and suspected abuse. The twins were evaluated at the ED at the request of the PCP. The ED doctor indicated the red marks were not bruises, and there was no suspicion of abuse. At the request of DFS, a skeletal survey was completed showing no evidence of fractures. The infants were discharged to Mother and Father, and no safety plan was implemented by DFS. DFS continued to have contact with the family up until two days prior to the incident.

Findings

1. The hospital emergency department nurse reported the March incident to the local law enforcement agency; however, there was no action taken by the law enforcement agency.

2. PCP suspected abuse during the March incident and instructed parents to have infant seen at the hospital emergency department; however, alternate transportation was not provided.

3. The hospital emergency department doctor did not request a forensic evaluation for suspected physical abuse or a skeletal survey for the March incident.

4. For the March incident, both infants were evaluated at the hospital emergency department for "suspected abuse secondary to red marks on arms and legs"; however, an explanation for the red marks was not noted in the diagnosis.

5. It was not clear from the hospital emergency department doctor’s documentation in the medical record or diagnosis that there was no suspicion of child abuse for the March incident.

6. Despite the family's risk factors, no referral was made to a home visiting program by any of the professionals involved.

7. ***Strengths***: PCP contacted DFS with original suspicion of abuse; emergency department nurse reported March incident to law enforcement agency; the children’s hospital went above and beyond with brain death tests; DFS documentation was thorough; DFS insisted on x-rays; DFS made referrals to Parents as Teachers and Cribs for Kids; excellent law enforcement investigation, which included thorough documentation, homicide detective was assigned early, completion of SUIDI form, doll re-enactment, scene investigation, confession, and charges for abuse of sibling; excellent communication between law enforcement and DOJ; and a multidisciplinary team approach was utilized.

5. Case 14-000147: H.D. – Near Death

Date of Birth: February 2014; Date of Incident: May 2014
Sibling to Case 14-000146

In May of 2014, a three-month-old male infant was brought to the ED for suspected abuse after Victim's sibling presented with serious non-accidental trauma. In addition to multiple bruises on several body surfaces, an abrasion or ulceration on Victim's chin was identified, and it was suspicious for a cigarette burn. Further diagnostic exams were completed at the ED, including a head CT scan and skeletal survey. The skeletal survey was suspicious for fractures of the left upper extremity.

DFS and the law enforcement agency had already begun an investigation as a result of the sibling's injuries. DFS implemented a safety plan and placed Victim with a paternal relative. However, the paternal relative violated the safety plan. As a result, DFS petitioned for and was awarded custody of Victim, and Victim was placed in foster care.

A few days after the incident, Victim received a CARE team consult at the children's hospital, which identified healing fractures of his left 6th, 7th, and 8th lateral ribs; a compression fracture of the L2 vertebrae likely to be healing; and irregularities of the left shoulder and arm consistent with fractures.

Father denied shaking or inflicting the injuries to Victim. Father was later indicted for Victim's injuries, and he pled guilty to Assault in the Second Degree. He was sentenced to 8 years at Level V, suspended after service of 30 months and 5 days to 5 years at Level III. The Level III probation will run concurrent with his sentence related to Victim's sibling. He was entered on the Child Protection Registry at Level IV as a result of a conviction involving the same incident.

Mother denied any knowledge of the abuse and was not caring for the Victim when he was injured. She completed her case plan, and custody was eventually rescinded to Mother by agreement of all the parties.

DFS had an active investigation prior to the near death incident. In March of 2014, Victim and his twin sibling were seen by the PCP at one-month of age for a well visit. The PCP noticed bruises on the children and suspected abuse. The twins were evaluated at the ED at the request of the PCP. The ED doctor indicated the red marks were not bruises, and there was no suspicion of abuse. At the request of DFS, a skeletal survey was completed showing no evidence of fractures. The infants were discharged to Mother and Father, and no safety plan was implemented by DFS. DFS continued to have contact with the family up until two days prior to the incident.

Findings

1. The hospital emergency department nurse reported the March incident to the local law enforcement agency; however, there was no action taken by the law enforcement agency.

2. PCP suspected abuse during the March incident and instructed parents to have infant seen at the hospital emergency department; however, alternate transportation was not provided.

3. The hospital emergency department doctor did not request a forensic evaluation for suspected physical abuse or a skeletal survey for the March incident.

4. For the March incident, both infants were evaluated at the hospital emergency department for "suspected abuse secondary to red marks on arms and legs"; however, an explanation for the red marks was not noted in the diagnosis.

5. It was not clear from the hospital emergency department doctor's documentation in the medical record or diagnosis that there was no suspicion of child abuse for the March incident.

6. Despite the family's risk factors, no referral was made to a home visiting program by any of the professionals involved.

7. DFS did not follow through with referrals for domestic violence services for mother despite identifying it as a concern.

8. No services were provided to help mother learn to identify appropriate caregivers/partners in the future.

9. ***Strengths***: DFS insisted on x-rays; DFS Case Plan with Mother was well written and comprehensive; law enforcement and DFS documentation was thorough; child was transported to hospital by law enforcement agency; perpetrator was charged for injuries to child even without a confession; excellent communication between law enforcement and DOJ; Family Court kept case open for 60 days after rescinding custody to Mother; and emergency department nurse reported March incident to law enforcement agency.

6.	Case 14-000208: J.V. – Near Death Date of Birth: April 2014; Date of Incident: July 2014

In July of 2014, the DFS Report Line received a report regarding a two-month-old male infant. It was alleged that Victim had been crying all night according to Mother. The four-year-old sibling disclosed that Victim was dropped by his three-year-old sibling, and Mother's paramour confirmed this story. However, Mother reported that the four-year-old fell while holding the Victim.

DFS contacted Mother and advised her to have Victim medically evaluated at the children's hospital. At the hospital, DFS conducted interviews with Mother and her paramour. Both reported that the four-year-old fell while holding the victim. Victim was examined and no marks or bruises were visible, but further diagnostic exams were scheduled. DFS determined Victim to be safe prior to completion of the diagnostic exams, and the case worker left the hospital without implementing a plan.

The children's hospital contacted the DFS Report Line a short time later with the results. Victim had a healing right tibia fracture; healing fractures of his 3rd, 4th, 5th, and 7th ribs; an acute 4th rib fracture; a possible fracture of the L2 vertebrae; and a fracture to the right 5th middle phalanx finger. Victim was admitted. Following the call, the DFS second shift case worker contacted the law enforcement agency to request a response and immediately responded to the children's hospital. The siblings were medically evaluated, and there were no concerns of abuse. A safety plan was implemented for the siblings to remain in the care of their father.

Forensic interviews were also conducted with the three-year-old and four-year-old. The four-year disclosed that she and her sibling have dropped Victim and demonstrated her interactions with the forensic interviewer. The detective later presented this information to the medical expert, and the conclusion was that the siblings may have caused the injuries.

Prosecution was denied by DOJ due to lack of evidence. Mother was substantiated for neglect and entered on the Child Protection Registry at Level III. The children remained in the care of their father at the close of the investigation.

Multi-generational history existed with DFS for Mother prior to the near death incident. Following the incident, DFS investigated allegations that Father sexually abused the three-year-old sibling. Father was substantiated and entered on the Child Protection Registry at Level IV. Children remain in the care of Mother.

Findings

1. DFS received a call from the children's hospital with a report of abuse as a result of the conclusions from the initial medical evaluation and diagnostics, and it was not written as a new report.

2. A safety determination was made before the initial medical evaluation and diagnostics were completed.

3. No scene investigation was completed by the law enforcement agency.

4. Child was not able to be immediately evaluated by a child abuse expert as there is no statewide network of medical professionals who have received specialized training in the evaluation and treatment of child abuse.

5. The CARE team was consulted; however, there was no note in the medical record.

6. ***Strengths***: DFS utilized group supervision; DFS weekend shift immediately responded after diagnostic results were received; forensic interviews occurred and were timely; the law enforcement agency assigned two detectives and presented disclosures from the forensic interviews to the medical expert; medical provider told family to call if overwhelmed or concerned; and the daycare provider was involved and appropriate.

7. Case 14-000307: A.F. – Near Death

Date of Birth: August 2014; Date of Incident: August 2014

In August of 2014, EMS, law enforcement, and the fire department were dispatched to a medical complaint of a child birth at home. Upon arrival, law enforcement observed the alleged father standing over the toilet and holding the male victim's head above the water. He reported that he was not sure if the infant was breathing. Mother was also observed in the bathroom and noted to be unclothed and disoriented. She was described as having slurred speech and glassy eyes, and law enforcement believed that she was under the influence of drugs or alcohol. EMS arrived and took over care of the Victim, who was now pink and breathing. Victim and Mother were transported to the ED.

While at the hospital, Victim was assessed by a neonatologist and noted to have gestational exposure to methadone, heroin and benzodiazepines. He was later discharged at day 49 of life after being monitored for neonatal abstinence and prescribed a medication regimen.

Law enforcement contacted the DFS Report Line and then responded to the ED. Mother disclosed to law enforcement that she had not used heroin since December of 2013, but she was prescribed several other prescription medications. She also reported that she was on Level III probation. There was no further involvement from law enforcement since it was a medical complaint only.

DFS also responded to the ED and interviewed Mother. DFS suspected she was under the influence of drugs or alcohol. She disclosed a history of mental health issues. No safety plan was implemented as the Victim was admitted. On the same date, Mother left against medical advice. DFS conducted a home visit with Mother and alleged father five days later, where Mother was again noted to have slurred speech. Mother would not confirm paternity when questioned. In addition, Hospital staff contacted DFS with concerns since Mother was not visiting regularly. During her visits, she was noted to nod off while holding Victim and repeatedly asked the same questions.

Prior to Victim's discharge, DFS convened a Team Decision Making ("TDM") meeting, and it was decided DFS would file for custody. During the meeting, the alleged father admitted to buying Mother heroin so she could be admitted into a detoxification program. It was determined that paternity testing was needed, and the alleged father agreed to complete a substance abuse evaluation.

In September of 2014, DFS was awarded temporary custody of Victim. However, within days, the Family Court determined that DFS did not establish probable cause to continue custody believing the alleged Father's court testimony over the statements of DFS and law enforcement as to the events that occurred on the day of birth. The Family Court rescinded custody of Victim to Mother. Paternity was not established at the conclusion of this hearing. DFS filed a motion for re-argument, which was denied. The decision was appealed to the Supreme Court not on the facts of the case, but on a legal issue. The Supreme Court rejected the legal argument raised by DFS and affirmed the Family Court decision on that basis.

Mother was substantiated for neglect; however, her substantiation is pending appeal. The case was transferred to treatment for ongoing services, and Victim remains in the home of Mother and alleged father.

Mother had no prior DFS involvement. However, a relative was awarded guardianship of her six-year-old son when he was an infant, as a result of her drug use. She was also convicted of drug related charges in 2013. The alleged father had no DFS history, but had a criminal history of two DUIs.

Findings

1. ***Strengths***: excellent response by the DFS caseworker, which included filing for custody, good communication with hospital staff, convening a TDM meeting, and keeping the case open in treatment; and excellent medical documentation by the

nursing staff at the hospital *(from final review by the Child Death Review Commission).*

2. When DFS filed for custody of the infant in September of 2014, there was an error in the reporting of the mother's date of birth that would have flagged previous court involvement and brought such files to the Judge's attention, perhaps assisting the Court in considering mother's history *(from final review by the Child Death Review Commission).*

3. No collateral contacts were completed by the DFS caseworker during the investigation of the case *(from final review by the Child Death Review Commission).*

4. Although it was documented throughout the investigation and treatment cases that the mother had substance abuse and mental health issues, there was no documentation to support such referrals were made for the mother and that the mother complied with such *(from final review by the Child Death Review Commission).*

5. Upon law enforcement response to the incident, the investigation proceeded as a medical emergency rather than a potential criminal investigation of abuse or neglect of an infant. There was no referral to the Criminal Investigative Unit and no scene investigation *(from final review by the Child Death Review Commission).*

6. At the onset of the case, the law enforcement agency failed to utilize a multidisciplinary team approach and failed to consult with the Department of Justice following an incident involving the possible abuse/neglect of an infant *(from final review by the Child Death Review Commission).*

8. Case 15-000050: M.F. – Near Death

Date of Birth: May 2014; Date of Incident: February 2015

In February of 2015, an eight-month-old male infant was brought in to the ED by Mother for swelling to his head after a fall. Mother reported that the fall occurred approximately five hours earlier. However, she had been monitoring Victim and brought him in once the swelling started. She reported no nausea, vomiting, sleepiness, or other concerns.

DFS and the law enforcement agency responded to the ED to interview Mother and Father. Mother reported that Victim has been attempting to walk, and fell between a carpeted area in the living room and the linoleum floor in the kitchen. Father was not present during the incident. A three-year-old sibling also resided in the home.

Further diagnostic exams were completed at the ED, including a head CT scan and blood work. The head CT identified a non-displaced right parietal bone fracture with hematoma. As a result, Victim was transferred to the children's hospital and admitted. The CARE team and ophthalmology were consulted. The right parietal skull fracture was confirmed, as well as an acute epidural or subdural hemorrhage underlying the skull fracture. The skeletal survey revealed no other fractures, and no retinal hemorrhages were identified by ophthalmology. The CARE team consult revealed that mother's story did not explain the skull fracture. A fall from an elevated surface or while being carried was identified as the likely cause of the injuries, but a single inflicted blunt impact was not ruled out. There was concern that a communication barrier may be hindering Mother's explanation, but an interpreter was utilized and the explanation remained the same.

No safety plan was implemented by DFS, and the case was unsubstantiated with concern since the injury did not match the explanation given by Mother. Additionally, there were no criminal charges filed in this case.

Findings

1. There was minimal documentation in the police report by the law enforcement agency.

2. No scene investigation was completed by the law enforcement agency.

3. No doll re-enactment was completed by the law enforcement agency.

4. Limited resources and education impacted the criminal investigation.

5. DFS and the law enforcement agency misinterpreted the findings from the CARE team consult once "accidental fall" was mentioned, and the investigations immediately concluded as a result. The CARE team consult revealed that mother's history did not explain the skull fracture. A fall from an elevated surface or while being carried was identified as the likely cause of the injuries, but a single inflicted blunt impact was not ruled out.