



STATE OF DELAWARE
Child Death, Near Death and Stillbirth Commission
900 King Street
Wilmington, DE 19801-3341

CAPTA¹ REPORT

In the Matter of
Jacob Bennett
Minor Child²

9-03-2010-00002

March 2, 2012

¹ 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, 31 Del.C. § 323 (a).

² To protect the confidentiality of the family, case workers, and other child protection professionals, pseudonyms have been assigned.

Background and Acknowledgements

The Child Death, Near Death and Stillbirth Commission (“CDNDSC”) was statutorily created in 1995 after a pilot project showed the effectiveness of such a review process for preventing future child deaths. The mission of CDNDSC is to safeguard the health and safety of all Delaware children as set forth in 31 Del.C., Ch., 3.

Multi-disciplinary Review Panels meet monthly and conduct a retrospective review of the history and circumstances surrounding each child’s death or near death and determine whether system recommendations are necessary to prevent future deaths or near deaths. The process brings professionals and experts from a variety of disciplines together to conduct in-depth case reviews, create multi-faceted recommendations to improve systems and encourage interagency collaboration to end the mortality of children in Delaware.

Summary

Child was born via spontaneous vaginal delivery, full term, weighing 9 pounds 8 ounces. Upon birth no congenital anomalies or abnormal conditions were noted. Child was born out of state and therefore the prenatal history of mother and further records regarding the child’s birth were unable to be obtained.

At two months of age, child was diagnosed with a Seizure Disorder secondary to Tuberous Sclerosis.³ Upon diagnosis child was referred to and began receiving therapy, which was noted to be successful.

In February 2008, child and family moved to Delaware. A Primary Care Physician was established for the child and a *12 month Well Child visit* occurred. The child was eating stage III foods and development was noted to be normal (trying to walk). The child was noted to have tuberous sclerosis and to have some seizures. It was recommended that medicine (Topamax and Lamictal) be continued. Immunizations were not addressed and the family was counseled on needing stairway gates.

During that same month, the child also attended a neurology appointment where magnetic resonance imaging (MRI) of brain was ordered and the child’s Topamax dosage was adjusted. The neurologist noted that the child was not taking independent steps (14 months) and had been receiving therapy in his former residential state, but the child was not yet receiving such services in Delaware.

Shortly thereafter, in May 2008, the child was transported via ambulance to the Emergency Room of a children’s hospital for seizure activity. Once stabilized, the child was discharged home with medication and follow up with a neurologist.

³ Tuberous Sclerosis is a “rare genetic multisystem disorder that is typically apparent shortly after birth. The disorder may be characterized by episodes of uncontrolled electrical activity in the brain (seizures); mental retardation; distinctive skin abnormalities (lesions); and benign (noncancerous), tumor-like nodules (hamartomas) of the brain, certain regions of the eyes (e.g., retinas), the heart, the kidneys, the lungs, or other tissues or organs.” (Tuberous Sclerosis Alliance. 2011).

At the child's *15 month Well Child visit*, the child was seventeen months of age, immunization delay was diagnosed, the child was noted to have a regular diet, and the child was not yet walking but holding onto furniture. The child was also noted to have a completely normal physical exam and to have tuberous sclerosis and seizure disorder, and the child was given immunizations.

In August 2008, the MRI had yet to be completed on the child. Seizures were still occurring and Topamax level was requested. The neurologist noted that the child was not putting words together and was "not yet receiving any therapy."

At twenty-three months of age, the child attended his *18 month Well Child visit*. The child was noted to have a regular diet, allergies, take naps, no developmental delay noted, genital exam deferred, and recommended to have flu shot but not noted to be given. Lead and complete blood count (CBC) was ordered.

The MRI was completed in February 2009, approximately one year from the time the MRI was ordered. The child's Topamax level was still needed and a sleep deprived Electroencephalography (EEG) was performed. The neurologist noted that the child speaks twenty words and that the child is not using phrases or sentences.

In April 2009, the child was having increased seizures. Neurology was called and the child's Topamax level was adjusted.

At the child's *2 year Well Child Visit*, the child was noted to have a regular diet, to be toilet trained with occasional accidents, to be in pre-school, and to have "audible breath sounds."

In August 2009, Topamax level was adjusted and markedly fewer seizures were noted. An EEG was performed in May 2009 and was abnormal. The child's Topamax dosage was slightly increased. The neurologist recommended an evaluation of speech delay and also referred the child to cardiology to evaluate for cardiac complications of Tuberous Sclerosis.

According to the Department of Services for Children, Youth and Their Families, the child and family first became active with the Division of Family Services (DFS) in August 2009. The DFS Child Abuse and Neglect Report Line received a report alleging physical abuse of the child by his stepfather. The child presented to his daycare with marks along his neck and a scabbed area. The child's older sibling was asked what had occurred by daycare staff and the sibling reported that the child was choked by his stepfather. Mother had also called the daycare to check in and when asked about the marks to the child's neck, mother reported that the marks were a result of the child playing with knives as the child safety locks were not being used. At the time of this report the children had only been attending daycare for approximately two months. Prior to this event, the daycare had not noticed any other suspicious or concerning marks on the children.

The child's stepfather was questioned regarding the marks to the child's neck. Stepfather stated that when he arrived home from work (around 12 or 1AM) he saw three knives and a can opener on the floor of the kitchen. It was not until the next morning that the stepfather noticed the scratches/marks on the child's neck. He stated they looked fresh, not scabbed over.

The child was evaluated in the Emergency Room of a children's hospital where on exam "3 superficial healing linear abrasions to the left lateral neck with scattered petechiae" were noted.

During the investigation, another report was made to the hotline alleging that the child and older sibling were left alone in a car, by stepfather while he worked. This report was linked to the open investigation.

Parents were questioned on both accounts and denied that the children were left in the car while stepfather was working or that they inflicted the injuries to the child's neck. Children were also interviewed and no further disclosures were made. Collaterals were completed with stepfather's co-workers, the daycare, and the Primary Care Physician. No concerns were noted.

Based on the information gathered, the allegations for physical abuse and lack of supervision were not validated. No criminal charges were filed and the case was closed unfounded by DFS with concerns for lack of supervision.

On October 2009, the day of the near death incident, the child, two years and ten months of age, was brought to an Emergency Room after the DFS Child Abuse and Neglect Report Line received an allegation of abuse. It was alleged that the child presented that morning to daycare with bruising to his face and was lethargic. The near death incident resulted in a joint investigation between DFS and local law enforcement. A DFS caseworker responded to the daycare and observed what appeared to be a shoe mark to the front, right side of the child's forehead. Photographs of the injury were taken and the caseworker transported child to a children's hospital.

The child was accompanied to the Emergency Room by a DFS caseworker and law enforcement officer. Law enforcement questioned the child's stepfather about the incident. He informed the responding officer that the child was jumping off the dresser and likely landed on a shoe, located on the floor with the sole of the shoe facing up. The medical examination revealed that the stepfather's account of the child's injury was not consistent with the extent of the injuries. Stepfather was later questioned by detectives where he admitted to causing the injuries to the child by whacking the child with the shoe and then pushing the child with enough force that the child's head hit the back of a nearby rocking chair.

One day prior to the child's hospital admission, mother was called by the daycare to come pick-up the child, because the child had bitten another child. Mother picked the child up from daycare, returned home to leave the child under the supervision of his stepfather, and then mother left to pick up the child's older sibling from another daycare. When mother and sibling returned home, child was standing in the corner and stepfather stated that child was being punished for biting. Mother then left the residence, by herself, in order to go shopping for approximately one hour. Upon her return home, mother noted that child had a fresh bruise over his left eye which had a distinct pattern to it. Stepfather stated that child was in his room, jumped off the dresser and landed on a shoe, with the sole of the shoe facing upward. Child was put to bed and sent to daycare the following morning where a report to the DFS Child Abuse and Neglect Report Line was made.

While at the Emergency Room a physical examination of the child revealed a four centimeter hematoma (bruise) to the left top of the child's head, a three centimeter hematoma to the right forehead area with a "waffle" like pattern, multiple red lines to the neck and petechiae (red dot hemorrhages) to the upper back and chest. A CT of the head noted right occipital (back part of head) skull fractures near midline with overlaying soft tissue swelling. A skeletal survey was completed and yielded negative results. Blood studies were also completed but did not reveal any abnormalities. An Ophthalmologic exam demonstrated no retinal hemorrhages. The child was admitted for further observation and evaluation. The following day, the child was discharged home to the care of his mother.

The child's stepfather was founded by the Division of Family Services for abuse/fracture, level IV. The stepfather was charged with assault in the second degree and a no contact order was put in place with child. Stepfather pled to assault in the second degree. He was sentenced to two years, suspended after services with intense supervision. Stepfather is currently on probation with a maximum release date of March 2012.

System Recommendations

After review of the facts and findings of this case, the Panel determined that all systems did not meet the current standards of practice.

The following **recommendations** were put forth by the Panel:

- (1) CDNDSC recommends that the child's Primary Care Physician be referred to the Department of State, Division of Professional Regulation as the Primary Care Physician failed to appropriately refer the child and family to medical specialists, services and/or resources for the child's diagnosis of, treatment of, and understanding of Tuberous Sclerosis. Furthermore, the documentation by this Physician within the child's medical chart was conflicting and refuted medical records obtained from neurology at the children's hospital which were consistent with the child's diagnosis.

- (2) CDNDSC strongly supports the use of the standard developmental screening as consistent with the Help Me Grow Delaware program.

The following **ancillary recommendation** was put forth by the Panel:

- (1) CDNDSC recommends that health care professionals be trained and educated on how to identify, refer, and educate parents about services and/or resources that are available for children who present as medically fragile and developmentally and/or physically delayed.

The following **concern** was noted by the Panel:

- (1) The new worker training which is mandatory for DFS caseworkers focuses on brain development. This training specifically highlights the parts and functions of the brain, brain plasticity, chemical influences, types of emotions, memory, language, the four kinds of attachment, developmental milestones (primary domains), the effects of abuse and/or neglect on development (broken down by age), and services that are offered for children to help in these areas. Although this training does highlight services which cater to the needs of child development, the training does not address how to make a referral.

Moreover, *Child First*⁴ is an advanced training offered to DFS caseworkers but not mandated as part of core training. This training focuses on interviewing and preparing children for court through the use of forensic interviewing and multi-disciplinary team collaboration. A portion of this training is dedicated to the understanding of child development and specifically focuses on the 3 phases of memory, how children think (broken down by age), and use of language (child's language verse interviewer's language and the interpretation of such). This part of child first is centered solely on the developmental stages of a child and does not address services that can be rendered.

The panel noted that although the above trainings focus on child development, they do not necessarily focus on the behavior and/or development of a child who presents as non-atypical. It was further noted, that often times because a child presents as non-verbal or developmentally/physically delayed, the caseworker and/or investigating officer tend to remove their focus from the child and center that attention around the parent(s) in order to create a case. The child's safety and well being should remain the focal point of the case at all times. After review of this case, it was apparent that the child was not referred for appropriate services by DFS.

⁴ This training was developed through a relationship with the National Child Protection Training Center, Department of Justice, Division of Family Services, and the Children's Advocacy Center. It is currently one of the trainings overseen by the Child Protection Accountability Commission through the Abuse Intervention Subcommittee.