



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

CAPTA¹ REPORT

In the Matter of
Mallory Peterson
Minor Child²

9-03-2008-00021

September 14, 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 of Incident

The case regarding Mallory Peterson is a case of physical abuse resulting in the death of Mallory by means of drowning, perpetrated by Mallory’s mother. At the time of Mallory’s death, Mallory was approximately seven months old and residing in the home of her mother and father.

Mother’s OB/GYN records revealed a history of possible bipolar disorder as well as a history of post partum depression. Following Mallory’s birth the hospital post partum and depression team met with mother. Mother was discharged with Percocet for comfort as Mallory was delivered via cesarean section.

Mallory was seen by her primary care physician (PCP) at one month of age and again at two months of age. No concerns were noted at either visit. Records maintained by the PCP do not contain any notations regarding mother’s mental health or concern for mother’s interaction with Mallory.

Approximately five months before Mallory’s death, in April of 2007, a domestic incident report concerning mother and father was forwarded to the Division of Family Services’ Child Abuse Reportline. The report indicated that mother wanted to leave with the children and go to her brother’s residence located in Maryland. Mother reported that father was addicted to prescription pain killers, which were prescribed for Osteomyelitis (acute or chronic bone infection). Officers were informed, per DELJIS, that there had been multiple reports of domestic violence between the couple and that earlier in the year mother had filed a Protection from Abuse (PFA) Order against father, but the Order was never granted as mother did not follow through with it. Father was admitted to a treatment facility where he was prescribed suboxin in order to overcome his addiction.

Mother was last hospitalized eight weeks after the birth of Mallory in April of 2007. Over the course of two days, mother had a manic episode which led to her voluntarily commitment for approximately one week. During this commitment mother’s Global Assessment of Functioning (GAF) was assessed at 20, meaning that mother was

experiencing hallucinations/delusion which influenced her behavior or serious impairment in her ability to communicate with others or serious impairment in judgment or inability to function in almost all areas. The treating facility documented that mother's suicidal and/or homicidal ideations were negative. Mother was observed to be very combative with her husband but was discharged into his care. Upon discharge, mother was prescribed Risperdal and Depakote and given an appointment for outpatient counseling.

One week before Mallory's death, mother was receiving out-patient treatment at a mental health facility. Mother had informed her counselor that she was having homicidal ideations with the intent to cause harm to the children, as well as, suicidal ideations and hallucinations. Further inquiry as to mother's mental health records revealed that on more than one occasion, mother had stated that she was going to "clean" her children with bleach. The Division of Family Services' Child Abuse Reportline was never contacted regarding these statements nor were safety precautions taken to ensure the wellbeing of Mallory and her older sibling. Discharge records indicate that Mother agreed to aftercare requirements but the records note questionable insight into her mental illness.

After discharge mother informed father that she was having unusual thoughts, such as, wanting to suffocate Mallory and kill him. Father became concerned about mother's statements and attempted to contact the doctor that mother had seen at the inpatient facility, however, the doctor was unavailable. Father contacted a pastor from a nearby church to come speak with mother. The pastor reportedly spoke to mother and after their session the pastor felt that mother was sufficiently stable.

On the day of the incident, in September of 2007, father and mother had a verbal argument that resulted in father leaving the home with Mallory's four year old sibling. Father dropped the sibling off at the paternal grandmother's home and then proceeded to drive to the video store to exchange some of his video games. Later that day, the Division of Family Services' Child Abuse Reportline received a routine referral alleging the death of Mallory. Mallory's mother had called Emergency Medical Services and informed dispatch that she had drowned her daughter in the bathtub. When law enforcement arrived on scene, they found Mallory in her car seat, in the bathroom facing the tub. Mallory was taken to the hospital where resuscitation was attempted but unsuccessful. Mallory was pronounced deceased at 1814 hours.

Immediately following Mallory's death, mother received a psychiatric evaluation at the hospital where mother had informed the nurse that her shirt was wet because she held her baby under water. Mother also reported that the voices in her head told her that Mallory would be happier in heaven.

Initial statements were gathered by mother from law enforcement. Mother had repeatedly confessed to holding Mallory underwater. Shortly thereafter, mother was transferred to a correctional facility where she was held with no bail due to being charged with Murder in the First Degree. Mother was placed in the infirmary, heavily medicated

and on suicide watch. Mother was under supervision at all times and was not placed in the general population due to the nature of her crime.

Father was also interviewed by law enforcement on the day of Mallory's death. Father informed law enforcement that mother was diagnosed as bipolar with Schizophrenic features over 14 years ago. Mother has been admitted for inpatient treatment on more than one occasion. Prior to the incident, mother was being treated by a psychiatrist at an outpatient facility. During this treatment mother also attended weekly counseling. Mother was prescribed Risperdal and Colnepam. Father was uncertain whether or not mother was taking her medications regularly. However, this concern was never reported to mother's treatment providers.

Father further stated that in the months after the birth of Mallory, mother's manic and depressive episodes became abnormal. Father believed that mother was depressed due to father's recent diagnosis of a tumor on his tailbone and the family facing economic hardships due to his unemployment. Mother and father were receiving public assistance and their family was providing money for food and fuel. Father also indicated that mother was unable to deal with the responsibility of parenting and had suggested that the children be placed for adoption.

In August 2008, Mallory's mother pled Guilty but Mentally Ill to Assault by Abuse or Neglect. In November 2008, mother was sentenced to 15 years in prison, followed by 6 months Home Confinement or Work Release, and then 30 months of intensive Probation. During her stay in prison, mother is to complete mental health treatment and take all prescribed medications. Once time is served, mother must continue her mental health treatment and comply with random drug testing.

The Division of Family services substantiated mother for physical abuse resulting in the death of Mallory Peterson, level IV.

System Recommendations

After review of the facts and findings of this case, the Panel determined that not all systems met the current standards of practice and therefore the following system recommendations was put forth:

- (1) CDNDSC shall send a letter to the outpatient facility expressing concern as to their policy regarding record keeping of patients and the length of time that must pass prior to records being destroyed.
 - a. Rationale: An effective review of this case was unable to be performed because CDNDSC was unable to obtain the appropriate records from this facility and other mental health facilities pertaining to services and treatment received by mother.
 - b. Anticipated Result: To ensure that records are properly kept and archived in order to efficiently and effectively review a patient's history.
 - c. Responsible Agency: CDNDSC

- (2) CDNDSC shall send a letter requesting that the inpatient facility complete an internal case review in order to evaluate the assessment and documentation of patient's presenting with Post Partum Depression, as well as their policy and procedure pertaining to mandatory reporting and whether it falls into compliance with Delaware's mandatory reporting statute, 16 Del. C. § 903.
 - a. Rationale: Proper assessment and documentation of mother's post partum depression was not properly documented and therefore the risk that mother posed to her child(ren) was not properly assessed.
 - b. Anticipated Result: To evaluate the risk of the child(ren) within the home.
 - c. Responsible Agency: CDNDSC

- (3) CDNDSC shall continue to support the Delaware Healthy Mother and Infant Consortium's (DHMIC) System of Care Subcommittee in their work surrounding mothers and post partum depression.
 - a. Rationale: More awareness and understanding as to the effects and symptoms of post partum depression is needed in order for mothers to be properly diagnosed.
 - b. Anticipated Result: Community Awareness
 - c. Responsible Agency: Delaware Healthy Mother and Infant Consortium (DHMIC)

- (4) CDNDSC encourages Delaware State Hospitals, under the guidance of the Delaware Healthy Mother and Infant Consortium (DHMIC), to explore and assess patients who present with post partum depression through techniques such as screening tools, referrals, and additional resources and services.
 - a. Rationale: To give medical and mental health facilities the proper resources and tools to appropriately screen for and provided services for patients who present with post partum depression.
 - b. Anticipated Result: Increased safety for Mothers and Infants
 - c. Responsible Agency: Delaware Healthy Mother and Infant Consortium (DHMIC)