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

# CAPTA[1] REPORT

In the Matter of
W.R.
Minor Child[2]

9-03-2008-00022

November 30, 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 W.R. is considered a near death incident due to the child's near drowning. At the time of the near death incident, the child was two years of age and residing in the home of his mother and father.

On the day of the near death incident, law enforcement responded to the residence of the child's mother where Cardio Pulmonary Resuscitation (CPR) was being performed on the child by Emergency Medical Services. Initial statements by mother report that she was giving the child and his three year old sibling a bath when her cellular phone rang and she left the bathroom to answer the call. Approximately six minutes later, upon returning to the bathroom with her cellular phone, the child was found face down in the tub and not breathing. Emergency Medical Services was called and responded to the residence where the child was immediately taken to the Emergency Room and intubated and given medication to control seizure activity. The child was admitted to the Pediatric Intensive Care unit for further treatment, evaluation, and care management. The child was later transferred to rehabilitative services and shortly thereafter discharged home into the care of his mother.

Prior to this near death incident, the child was considered medically fragile. The child was diagnosed pre-birth with hydrocephalus (increased accumulation of cerebrospinal fluid within the ventricles for the brain) and his mother was noncompliant with prenatal care. Although mother was compliant with the child's therapy, frequent notations in the medical records reflect that mother was in denial regarding the extent of the child's limitations. Due to the effects of hydrocephalus, the child was unable to sit without assistance.

The joint investigation that occurred between the Division of Family Services and law enforcement concluded that the possible neglect of the child by his mother was unable to be determined due to a lack of evidence. At the close of the investigation, the case was unfounded for possible neglect. Child had fully recovered from the near death incident with no proven physical and/or developmental effects stemming from the

incident. The Division of Family Services found mother to be very appropriate and extremely concerned for her children's well-being.

Per routine procedure, law enforcement referred the case to the Attorney General's Office. Mother was charged with Endangering the Welfare of a Child. In 2008, mother pled to probation before judgment. Mother successfully completed her probation as no violations were documented and a conviction was not entered onto her record.

The investigation by the Division of Family Services also revealed that six months prior to the near death incident, the Child Abuse and Neglect Report Line was contacted alleging the sexual abuse of the child's three year old sibling, perpetrated by father. The report was accepted and a joint investigation between the Division of Family Services and law enforcement commenced. The child in this investigation was interviewed at the Children's Advocacy Center but made no disclosure of sexual abuse and denied making such allegations. The child also received a medical examination where there was no disclosure or physical evidence. The case was closed by the Division of Family Services and law enforcement as unfounded for sexual abuse.

## **Ancillary Recommendation**[3]

(1) CDNDSC recommends that Department of Services for Children, Youth, and Their Families redefine case findings/dispositions to terminology that is logical, consistent, factual, and uniform.
   a. *Rationale:* The Child Abuse and Neglect Panel has reviewed numerous cases in which there is conflict with the findings/dispositions of a case.
   b. *Anticipated Result:* To create more clarity in the disposition of cases and allow for more uniform terminology.
   c. *Responsible Agency:* Child Protection Accountability Commission

[3] In some cases there may be no system failures; however if the panel believes there are public policy issues or prevention suggestions that need to be monitored, these issues will be monitored and tracked by CDNDSC staff. These prevention suggestions or public policy issues may have been discovered during the review but were not directly related to the near death/death