



STATE OF DELAWARE
Child Death, Near Death and Stillbirth Commission
900 King Street
Wilmington, DE19801-3341

CAPTA¹ REPORT

In the Matters of

9-02-10-00038: H.W.
9-03-11-00014: I.W.
9-03-12-00006: B. P.
9-03-12-00007: T.T.
9-03-13-00004: J.M.
9-03-13-00014: I.C.
9-03-13-00017: L.D.C.
9-03-13-00023: C.M.
9-03-14-00002: C.R.
9-03-14-00006: J.M.

September 9, 2015

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).

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.

The case information presented below summarizes the findings and information gathered by the Child Abuse and Neglect Panel (“Panel”) during the reviews of ten child death and near death cases. The recommendations listed below have already been considered by the Joint Commissions and have been incorporated into an action plan for system reform unless listed as a recommendation from a final review. Attached please find a copy of the action plan.

Cases Reviewed

- 1. Case 9-02-10-00038: H.W. (Date of Birth: Feb. 2009; Date of Incident: March 2009, Death) *Sibling to Case 9-03-11-00014.**

A three-week-old female infant was reportedly laid down after being breastfed by Mother. As Mother was walking away, Victim’s apnea alarm sounded. Mother checked on the infant, and she was found unresponsive and not breathing. Attempts at resuscitation occurred but were unsuccessful. Victim was pronounced deceased at the Emergency Department (“ED”). It was noted that Victim was in the hospital the day before her death and discharged with an apnea monitor. Law enforcement investigated the infant’s death and an autopsy was performed. The manner and cause of death was undetermined. No criminal charges were filed at that time, and there was no report to the Division of Family Services (“DFS”) Child Abuse and Neglect Report Line as a result of this incident.

Mother had no history with DFS, as well as no significant criminal history. Mother reported that the Victim was a product of rape. As such, no information was known about the Victim’s father.

System Recommendations/Findings

1. CDNDSC recommends that law enforcement report all child deaths to the DFS Child Abuse and Neglect Report Line. *(from initial)*
- 2. Case 9-03-11-00014: I.W. (Date of Birth: July 2010; Date of Incident: Sept. 2010, Near Death) *Sibling to Case 9-02-10-00038**

In September of 2010, the DFS Report Line received an urgent referral alleging life threatening medical neglect and failure to thrive of a seven week old female infant. Reports indicated that while Mother was driving, she turned to interact with Victim and found her to

be unresponsive. She additionally reported that she performed two rounds of CPR, but the infant was unresponsive for two to three minutes. Upon arrival of Emergency Medical Services (“EMS”), Victim was found responsive and appeared to be doing fine.

Upon admission, Mother disclosed to hospital staff that she had a history of mental illness, including depression and delusion, but then denied it later. Throughout Victim’s hospitalization, she had been gaining weight and had not had an episode of apnea as Mother described. In addition, the apnea monitor recordings were obtained and demonstrated that Mother had very poor compliance. The hospital also noted concern that Victim was reported to have many of the same symptoms as the deceased sibling prior to her death. Victim also had a brief hospital admission a few weeks prior to the near death incident for poor feeding, fatigue and low temperature. As a result, hospital staff had suspicion of Medical Child Abuse (Munchausen Syndrome by Proxy) for Mother.

During the DFS investigation, Maternal Grandmother (“MGM”) filed a petition for guardianship of Victim. MGM was also the custodian of Mother’s two daughters, a ten-year-old and thirteen-year-old. The petition was initially denied and referred to DFS. Since MGM resided in New Jersey, the caseworker contacted the out-of-state child protection services agency and requested a courtesy home visit/safety check on MGM’s home. However, on that same day, the DFS caseworker was contacted by the Court and informed that DFS should file for emergency custody of Victim. The caseworker responded and informed the Court that DFS was not seeking emergency custody of the infant, as Mother made a plan for the infant to stay with MGM. DFS was advised that MGM must have a home study conducted before the Court is willing to place Victim with MGM. The out-of-state child protective services agency declined to do a home study with MGM. As result, the DFS caseworker drove to MGM’s home to conduct the safety assessment and determined the home to be appropriate. A Guardianship Hearing was held in which Mother agreed with MGM’s petition for guardianship. DFS supported MGM’s petition as well. The Court awarded guardianship to MGM. Mother was substantiated for life threatening medical neglect and was placed on the Child Protection Registry at level IV. The incident was not referred to law enforcement for a criminal investigation.

While DFS investigated this referral, it was noted that no report had been received regarding the death of Victim’s sibling (Case 9-02-10-00038 described in report above). In fact, Mother’s first contact with DFS came in October of 2009. It was alleged that Mother’s three sons, who resided with their father and paternal grandmother, were being spanked with wooden spoons by their grandmother. Mother was living in a shelter, and the children were visiting her on weekends. The case was unsubstantiated with concern and closed.

Victim’s Father had no prior DFS involvement and resided out-of-state. However, there was a recent incident of domestic violence against Mother in August of 2010, which occurred while Victim was hospitalized. He was charged with strangulation, assault in the third degree, and offensive touching. He pled guilty to offensive touching in June of 2011 and was sentenced to 5 years Level V, after service of 30 days Level V, balance of sentence suspended to 1 year at Level II. Additionally, he was required to complete a domestic violence and substance abuse evaluation, and to have no contact with Mother unless authorized by a Family Court order.

System Recommendations/Findings

1. If during an investigation the Division of Family Services determines that a child is unsafe, DFS must follow policy as it pertains to a home assessment in planning for the safety of the child. *(from initial)*
2. CDNDSC recommends that all requests of a child/family be put in a Court Order. *(from initial)*
3. **Case 9-03-12-00006: B. P. (Date of Birth: Sept. 2009; Date of Incident: Dec. 2011, Death)**
**Sibling to case 9-03-12-00007*

A two-year-old female child was put to bed by Mother's paramour as Mother had left for work. Fifteen minutes later, Victim was reportedly found to be pulseless and apneic. Paramour called Mother then called EMS. EMS arrived and cardiopulmonary resuscitation ("CPR") began. The child received four minutes of CPR before her pulse returned. A breathing tube was placed in the trachea, and the child lost her pulse again as she was being moved into the ambulance. CPR was re-initiated and her pulse returned again. The child was transported to the ED.

Upon arrival at the ED, a computed tomography ("CT") scan of the head demonstrated diffuse cerebral edema but no discrete hemorrhage, and the CT scan of the abdomen showed liver and spleen laceration, retroperitoneal blood and arterial extravasation from the superior mesenteric artery resulting in intraperitoneal blood. Blood and urine cultures were sent, and the child was started on broad spectrum of antibiotics and transported to the children's hospital.

At the children's hospital, an exam revealed multiple bruises to the bilateral limbs, back, and torso. Bruises and abrasions were also noted to the face. Laboratory studies noted significant anemia, a prolonged bleeding time, low platelets, acidosis, elevated lactic acid level, elevated liver enzymes, and blood in her urine. Ophthalmology performed an exam which demonstrated multiple patches of retinal hemorrhaging in the left eye; however, a large hemorrhage was also noted in the fundus. The coagulopathy as the source of this could not be ruled out. After two brain death exams, Victim was taken off life support and death was declared.

A joint investigation was conducted by DFS and law enforcement, during which a forensic interview was done with the Victim's older sibling. She disclosed that Mother's paramour physically abused them. Paramour began watching the children in December while Mother was working. On the day of the incident, it was alleged that Mother called Paramour and asked him to check on Victim. He noticed Victim's eyes were half open and she was just staring. He picked her up and began to shake her to wake her up, and he noticed she was not breathing.

Approximately 48 hours after Victim's death, the child's siblings were examined in the ED of the children's hospital. It was determined that the four-year-old sibling was not suffering from any physical injuries. However, the nine-month-old sibling was diagnosed with

fractures in various stages of healing, a laceration of the liver, and bruising on numerous areas of the body.²

As a result of the new allegations, DFS petitioned for temporary custody of the child's siblings. Upon their discharge from the hospital, the siblings were placed with a relative, who was eventually awarded permanent guardianship.

Mother's paramour was convicted of manslaughter in September of 2013. He was sentenced to 25 years Level V (40 years for both incidents). Paramour was substantiated by DFS for abuse of Victim, and he was placed on the Child Protection Registry at level IV. Mother was substantiated for neglect due to the fact that she failed to act upon the indications that her children were being abused, and she placed on the Child Protection Registry at level III.

System Recommendations/Findings

- Family Court did not follow its policy regarding reviewing related files for families (post incident). Mother gave birth to three other children after this incident and petitioned for guardianship of non-related children (*from final review*).
- The Panel noted the following as strengths: DFS investigation and the Court directed the sentence to run consecutively instead of concurrently (*from final review*).

4. Case 9-03-12-00007: T.T. (Date of Birth: March 2011; Date of Incident: Dec. 2011, Near Death) *Sibling to Case 9-03-12-00006

An eight-month-old infant was brought to the ED of the children's hospital approximately 48 hours after the death of her sibling to rule out abuse. DFS recently placed the Victim and her older sibling in the home of a relative through a safety plan. The relative noted Victim was not using her left arm much, and she was irritable and wanted to be held more than usual. The relative agreed to have the children examined at the children's hospital.

Upon physical examination, Victim was noted to have sustained a Grade 2 liver laceration, fractures to the left shoulder, humerus, radius and ulnar, and a right radial fracture. A new referral was made to the DFS Report Line as a result of the injuries to Victim. A Children At Risk Evaluation ("CARE") consult was completed where it was determined that the differing ages of injuries and types of fractures documented were consistent with more than one episode of trauma, and that the injuries sustained by the infant were a result of non-accidental trauma. As a result, Victim was admitted. On the same date, DFS petitioned for temporary custody of Victim and her sibling, who was not injured.

Prior to this incident, in March of 2011, Victim was born drug exposed. Mother reported taking a Percocet for severe back pain before going into labor. The same aunt, who is the current relative caregiver for the infant and her sibling, signed the safety plan agreeing to care for the infant until Mother completed her substance abuse evaluation. After no treatment was recommended by the DFS substance abuse liaison, the case was unsubstantiated and closed in April of 2011.

² Refer to case # 9-03-12-00007, for further information regarding this child's injuries.

Mother's paramour was convicted of assault by abuse in September of 2013. He was sentenced to 25 years at supervision Level V suspended after serving 15 years, followed by 2 years Level III (40 years for both incidents). Paramour was substantiated by DFS for abuse of Victim, and he was placed on the Child Protection Registry at level IV. Mother was substantiated for neglect due to the fact that she failed to act upon the indications that her children were being abused, and she placed on the Child Protection Registry at level III.

System Recommendations/Findings

1. CDNDSC recommends that the Division of Family Services follow policy as it pertains to interviewing or observing, within 24 hours, all other children not identified as victims, when the reported victim is determined to not be safe. (*from initial*)
2. CDNDSC recommends that the medical profession educate the Division of Family Services, the Department of Justice and law enforcement on all substance abuse screenings within Delaware Hospitals. It is further recommended that cross training occur among these professions as to the treatment received for such substances and the impact that such substance have on the abuser's ability to care for their children. (*from initial*)

5. Case 9-03-13-00004: (Date of Birth: July 2011; Date of Incident: Sept. 2012, Near Death)

A fourteen-month-old male child presented to the ED via ambulance with the chief complaint of seizing, lethargy and facial bruising. Medical personnel were informed that prior to dispatch of EMS, Victim was fed, began to have trouble breathing and then became unresponsive. A CT scan of the head was completed and demonstrated a right frontal subdural hematoma. This injury was determined to be non-accidental. As a result of Victim's injuries, he was transferred to the children's hospital for further evaluation and treatment. It was noted that the family was Spanish speaking and therefore an interpreter was needed. Once Victim arrived at the ED, the language line was used in order to help assist with translation. During the use of the language line, it was noted that Mother provided multiple variations of how Victim sustained his injuries.

The child abuse expert advised that the hematoma resulted from blunt impact rather than Abusive Head Trauma. Furthermore, Victim had multiple bruises to his chest, sides and back. Further, the bruising to Victim's face was in a specific pattern as if he had been slapped. Additionally, over the center of his chest there were three distinct oval bruises in a triangular pattern with a fourth bruise directly below. The above described bruising patterns were most likely an inflicted injury resulting from a frontal impact from a loose fist punch. Due to the pattern and location of the bruising, coupled with Victim's age, it was concluded that his injuries were indicative of abuse. Since Mother had previously established that she was the sole caretaker of child, it was likely that Mother would have noticed the bruising on Victim's body. It was also noted that Mother had made no previous attempt to obtain medical attention or contact law enforcement relating to these unusual marks. It was also advised that Victim could have stopped breathing due to the direct force inflicted to his head. Likewise, he could have also experienced seizure-like activity due to the subdural hematoma or impact to the chest.

A joint investigation was conducted by DFS and law enforcement. Interviews were conducted with Mother and all individuals residing in the home. A search warrant was also executed at

the home, where physical and photographic evidence was collected. DFS was awarded temporary custody of Victim and his sister. It was decided that Victim's sister would need to be medically evaluated in order to rule out abuse. At that time, both children were placed in foster care.

No prior history was noted with Victim and/or family, as they had recently moved from Virginia to Delaware. Moreover, contact was made by the DFS caseworker with Virginia Child Protective Services ("CPS") and Nebraska CPS, where child's biological father resides, in order to ensure that no previous history existed in either state.

DFS substantiated Mother for physical abuse, and she was entered on the Child Protection Registry at level IV. In February 2013, Mother gave birth to another child, and DFS was awarded custody of that child as well. Criminally, Mother was charged with one count of Assault by Abuse in the Second Degree and one count of Endangering the Welfare of a Child ("EWC"), both felony level offenses. In March of 2013, Mother pled guilty to felony level EWC. As a result, Mother was detained by Immigration and Customs Enforcement ("ICE") and was deported. All three children have been adopted by the same family and are residing together.

System Recommendations/Findings

1. CDNDSC recommends that the language line be utilized within hospitals by law enforcement instead of the use of minors as interpreters. *(from initial)*
 2. CDNDSC recommends that Delaware hospitals comply with the American Academy of Pediatrics as it pertains to the standard of care when performing full body skeletal surveys. Medical staff declined to perform skeletal survey on the sibling as requested by OCA and DFS due to increased exposure of radiation to the child *(from final review)*.
6. **Case 9-03-13-00014: I.C. (Date of Birth: Oct. 2012; Date of Incident: March 2013, Near Death)**

A five-month-old female infant was brought to the ED due to Mother noticing swelling on her head. A CT scan of the head revealed a skull fracture below the swelling. Victim was then transferred to the children's hospital for further treatment. Neither parent could provide an explanation as to how the injury occurred. There were two other children residing in the home, a four-year-old and a one-year-old who share a different biological father than Victim.

A CARE consult was done that same day. No additional fractures were seen and the bones appear normal otherwise. There were no retinal hemorrhages. The child abuse expert had concerns since there was no explanation for the injury from the parents. However, the type of fracture sustained by Victim was often seen in accidental injuries. The appearance of the swelling was consistent with the injury occurring within the last several days and therefore, including while the child was reportedly in the care of her mother, her father and both the maternal and paternal grandmothers.

Law enforcement and DFS conducted a joint investigation. Victim was discharged to the care of the parents with a safety agreement in place. The agreement stated that the MGM would supervise all contact between the parents and children. After hearing from law enforcement that there would be no criminal charges, DFS closed the case, unsubstantiated with concern

for unexplained injury with lack of supervision by Father. Neither parent had a criminal history or Family Court history.

System Recommendations/Findings

1. CDNDSC recommends that in serious injury cases, the Division of Family Services' caseworker contact the Child Protection Unit of the Department of Justice Family Division, so that a determination can be made as to whether or not custody should be sought, a safety plan should be implemented OR the case be referred to treatment. *(from initial)*
2. Unsafe bedsharing with infant was suspected *(from final review)*.
3. Law enforcement did not interview the paternal grandmother during the investigation, even though she was determined to be caring for infant at the possible time of injury *(from final review)*.

7. Case 9-03-13-00017: L.D.C. (Date of Birth: Jan. 2010; Date of Incident: May 2011, Death)

A sixteen-month-old male child was found in his pack-n-play, by his older sibling, with rigor mortis throughout. The child's manner of death was determined to be natural and the cause of death was dehydration associated with a non-specific febrile illness. That same day, law enforcement went to Mother's residence where physical and photographic evidence was collected. The criminal investigation revealed that the room in which the children shared was excessively hot with no working air conditioner, nor was a window open that would provide proper circulation. It was determined that Victim's sleep environment was not conducive for a child of his age.

Father was not involved, his criminal history was unknown, and he had no history with DFS. Prior to this incident, Mother had no significant criminal history; however, she was involved in four investigations with DFS. The first investigation occurred in August of 2007. The DFS Report Line received a routine referral alleging the neglect of Victim's siblings. DFS conducted an initial interview, in which Mother admitted to being overwhelmed and reported she had been diagnosed with manic depression and could be suffering from post-partum depression as well. A Hospital High Risk Medical Discharge Protocol meeting was held and as a result a home visiting nurse was referred, twice a week, for two weeks. The investigation case was closed as unfounded with concern and transferred to treatment. While in treatment with DFS, documentation revealed that an intern had conducted unannounced home visits three times until the case was closed in June of 2008, due to risk reduction, even though living conditions did not improve. Mother received a mental health evaluation; however, her diagnoses were not confirmed and no follow up was noted by the caseworker with the evaluator.

Four months later, the Report Line received a second routine referral alleging the neglect of Victim's siblings. Child Development Watch and the Division of Public Health were involved with the family at that time and voiced their concerns of inadequate weight gain by the twins and inappropriate living conditions. The case was closed as unfounded with

concerns. Five months later, in March of 2009, the Report Line received the third routine referral alleging the neglect of Victim's siblings. The case was closed as unfounded with concerns. The concerns noted were Mother's financial instability and lack of housing. In February of 2010, two reports were made to the Report Line alleging physical neglect by Mother. Mother had recently given birth to Victim, and the reporters were concerned with inappropriate living conditions. An announced home visit was conducted by DFS and concerns were noted regarding the living conditions. The family agreed to make improvements prior the next visit, but no safety plan was implemented. The case was unfounded with concern and transferred to treatment for additional services. While in treatment, in March of 2010, the home was noted to be deplorable by DFS. As a result, DFS implemented weekly home visits and the family was given multiple opportunities to make improvements. In December of 2010, the caseworker observed Mother's new residence which was noted to be a converted shed. The caseworker determined that the children were safe. One month after that visit, the treatment case was closed as successful. Housekeeping standards and poverty were noted as concerns at case closure.

Although the Medical Examiner was privy to the family's DFS history, it did not change the Medical Examiner's ruling on the manner and cause of death as the Division of Forensic Science must comply with the set of codes established in the International Classification of Diseases ("ICD-9"). As a result of the Medical Examiner's findings, prosecution was declined. Mother was founded for severe physical neglect and entered on the Child Protection Registry at level IV. Maternal grandmother was granted guardianship of Victim's siblings, and the case was transferred to treatment for ongoing services. In May of 2012, the treatment case was closed as successful.

System Recommendations/Findings

1. CDNDSC recommends that the Division of Family Services comply with policy as it pertains to the following areas (*from initial*):
 - Monthly contact with children when there is an active investigation.
 - Enforcement of agreed upon case plans. During the investigation, it was noted that there was over a ten month period where there were repeated concerns by caseworker, intern, and supervisor regarding the deplorable conditions of the home and threats of consequences if such conditions did not improve.
 - Consultation with the Department of Justice. Mother repeatedly showed an inability to comply with case plans and provide suitable housing for her children.
 - Proper advisement as to what constitutes inappropriate discipline.
 - Proper evaluation of a participant's mental health during an investigation.
 - Recognition of the difference between poverty and poor living conditions as a major concern for a family's well-being. It is documented that caseworker identified poor living conditions as a result of poverty.
 - Identification of safety issues that may result in the removal of a child from the home.
 - Poor supervision of caseworker by supervisor. It was noted that supervision of caseworker was lacking, and it was permitted for an intern to perform unannounced home visits.
 - Education of staff on what is considered child well-being. Caseworker failed to address mother's lack of recognition for the well-being of her children which resulted in a lack of bonding/attachment, truancy, and hygiene issues.

2. CDNDSC recommends that cases involving multigenerational or chronic patterns of child abuse and/or neglect should require and be given a high level of supervisory oversight. *(from initial)*
3. CDNDSC recommends that in instances where a parent and/or caregiver is expressing concerns of mental health issues that appropriate referrals be made to mental health services for an immediate evaluation and that the Division implement a safety plan in order to assure the parent/caregiver has the ability to properly care for his/her child(ren). *(from initial)*
4. CDNDSC recommends that the Division of Family Services consider revising what is considered a quality collateral contact (i.e. medical/mental health). *(from initial)*
5. CDNDSC recommends that the Division of Family Services continue in the development of Structured Decision Making (“SDM”) for treatment cases in order to aide treatment staff in making a decision to close a case. *(from initial)*
6. CDNDSC recommends that the Division of Family Services consult with the Department of Justice’s Deputy Attorney General when considering case closure during investigation for serious physical injury or death. *(from initial)*
7. CDNDSC recommends the establishment of a special victims unit with statewide jurisdiction within the Department of Justice specializing in the investigation and prosecution of felony level, criminal child abuse cases including those involving the death, near death or sexual abuse of a child.³ *(from initial)*
8. CDNDSC recommends a team of criminal investigators with expertise in the investigation of child abuse should be established within the Department of Justice. This investigation team should work directly with the special victims unit in the investigation and prosecution of felony level, criminal child abuse. Referral to the investigation teams should be mandatory in all such cases, statewide. The investigation team should have authority to seek the assistance of police agencies with appropriate expertise, when necessary to support resource constrained, local police jurisdictions in the investigation phase, although local police should be permitted to partner in the investigation.⁴ *(from initial)*
9. CDNDSC recommends that during the investigation of child deaths, where environmental conditions exist and may have impacted the child’s death, the temperature of the room be recorded by appropriate investigative agency, whether law enforcement or the forensic investigator. *(from initial)*

³ Recommendation was previously put forth in the final report from the Joint Committee on the Investigation and Prosecution of Child Abuse. May 17, 2013. Page 23.

⁴ Recommendation was previously put forth in the final report from the Joint Committee on the Investigation and Prosecution of Child Abuse. May 17, 2013. Page 23.

10. CDNDSC recommends that legislation (such as a Children's Bill of Rights) be considered and drafted in order to provide and establish further protection of children's rights. *(from initial)*
11. CDNDSC recommends that the Child Protection Accountability Commission provide best practice guidelines in regards to which agency shall complete the Sudden Unexplained Infant Death Investigation ("SUIDI") Form during investigations of an infant death. The guidelines shall entail certain situations where it would be more appropriate for the forensic investigator to complete the form; also taking into consideration that certain situations would require the two agencies to work simultaneously depending on the expertise of the law enforcement agency. *(from initial)*
12. CDNDSC recommends that the Division of Forensic Science provide training to the Child Abuse and Neglect Panel as it pertains to the forensic investigation and roles and responsibilities of the Medical Examiner. *(from initial)*
13. CDNDSC recommends that the Division of Family Services' caseworkers educate parents on the appropriate use of car seats for premature or medically fragile infants and that car seats primarily be used for transportation. Moreover, follow up must occur and documentation should be made by caseworker in the Family and Child Tracking System ("FACTS") to reflect such changes. *(from initial)*
14. CDNDSC recommends that the Division of Family Services consider adding multigenerational history to the current six supplements of the SDM Risk Assessment Tool. *(from initial)*
15. CDNDSC recommends that the Division of Family Services explore best practice as it relates to cases involving multigenerational history. Furthermore, it is recommended that a program be implemented to help address issues of multigenerational history with the family when said history is present within an active investigation. *(from initial)*
16. CDNDSC recommends that further education; such as, the development of reference book and/or guide pertaining to the psychological, developmental, and/or physical impacts of abuse and neglect on nonverbal children who sustain serious, life threatening injuries, be offered to professionals involved in the investigation and prosecution of such cases. *(from initial)*
17. CDNDSC recommends that the Division of Forensic Science review this case and provide a response to CDNDSC to help understand their protocol for reviewing records (including medical, Division of Family Services, etc) when making a determination for manner and cause of death.

8. Case 9-03-13-00023: C.M. Date of Birth: Jan. 2012; Date of Incident: May 2012, Near Death)

A three-month-old male infant presented to the ED with seizure activity, grunting respirations, and bulging fontanelles. A CT scan of the head was completed and demonstrated an acute right subdural hemorrhage, subarachnoid hemorrhage in the right occipital lobe, multiple parenchymal hemorrhages in the right temporal lobe, and a possible chronic right

frontal subdural hematoma. No external injuries were visible on Victim's body. These findings were concerning for non-accidental trauma. Victim was transferred to the children's hospital for further evaluation and care management. It was determined Victim was most likely suffering from Abusive Head Trauma/Shaken Baby Syndrome.

The DFS Report Line received a referral alleging the physical abuse of Victim and contacted law enforcement to report the situation. Upon arrival at the hospital, law enforcement obtained initial statements from Father, Mother and Paternal Grandfather ("PGF"). Father advised that he, Mother and Victim reside in the home of PGF. Father admitted to being the primary caretaker of Victim, as he was unemployed and Mother worked five days a week. Father reported that Victim had not fallen nor had anything occurred that would have caused such injuries.

Two days after Victim's admission to the children's hospital, Father confessed to inflicting the injuries. Father had initially confessed to PGF who then instructed him to contact law enforcement. A follow up interview occurred with law enforcement where a doll-reenactment was done. Father advised that Mother had left for work around 3:30 in the afternoon. Father stated that he was home alone with Victim and the baby was fussy. Father had placed Victim in his bouncy chair, because he was unable to figure out why he would not stop crying. Father then picked Victim up holding the infant in front of him as he stood. Father proceeded to shake the infant twice while saying "stop." As a result of the shaking, Victim's head was jerked fairly hard. Immediately following the shaking, Victim's eyes became droopy and he began making a grunting noise. Mother was then contacted and 9-1-1 was called.

Based on the information obtained during the interview and after consulting the Department of Justice, Father was arrested and charged with Assault by Abuse. A No Contact Order was issued between Father and Victim. Additionally, Father, Mother, PGF and his paramour signed a Consent to Search Form, where additional evidence was seized from the residence as well as other personal belongings. Father pled Guilty to Assault by Abuse in July of 2013. In September of 2013, he was sentenced to 25 years Level V suspended after service of 18 years, balance of sentence suspended to 5 years Level IV (DOC discretion) suspended after service of 6 months, balance of sentence suspended to Level III. In December of 2013, the sentence was modified so that 25 years Level V was suspended after service of 7 years. The balance of the sentence remained the same.

Mother had no prior history with DFS. However, there was one investigation in 1999, pertaining to infant's father, as a child. The investigation was a result of a domestic violence incident, when Father was seven years of age. The investigation was closed as unfounded.

Seventeen days after Victim's near death event, he was discharged into the care of his Mother. He had more extensive brain damage than originally thought and the degree of his visual impairment was unknown. Currently, he is receiving therapy five times a week at the children's hospital and it is expected that he will continue to need therapy for the remainder of his life.

System Recommendations/Findings

1. CDNDSC supports the continued Abusive Head Trauma education within Delaware Hospitals, as well as the continued training among Delaware's first responders. *(from initial)*

2. CDNDSC applauds the efforts made by the Delaware State Police Detective in this case, and those additional officers who assisted with the criminal investigation pertaining to the assault of this child. *(from initial)*
 3. The Panel expressed concern as to why the sentence changed from 18 years to 7. Following DOJ research, it was determined that in hindsight, the Superior Court Judge felt 18 years was too harsh of a punishment than what the crime warranted. The sentence was reduced at his discretion *(from final review)*.
- 9. Case 9-03-14-00002: C.R. (Date of Birth: May 2012; Date of Incident: Aug. 2013, Near Death)**

A fifteen-month-old female child obtained a fentanyl patch belonging to her MGM, with whom she lived. After placing it on her abdomen, Victim became very lethargic and EMS was called. She was admitted to the intensive care unit (“ICU”) of the children’s hospital due to her lethargy. Medical personnel could not test for what level of the drug was in the child’s system. A larger quantity of the drug could have been fatal.

DFS and law enforcement were contacted. During the investigation, it was revealed that MGM, who was paralyzed and prescribed several medications, was the primary caregiver for the children. Law enforcement also shared that there were two recent incidents at the home as a result of Mother’s seizure disorder and noncompliance with treatment. During those incidents, her behavior was described as violent. It was also discovered that the conditions within the home were hazardous for children. DFS was granted temporary custody of the Victim and her sibling, and they were placed in foster care.

Several months prior to this incident, DFS received a referral regarding concerns of neglect for Victim and her sibling. It was alleged the home was dirty and had a stench of cat urine/feces and cigarette smoke. The case was unsubstantiated with concern for the family continuing to maintain upkeep of the home and closed. There was no documented DFS history involving the alleged biological father of the children.

As a result of the incident, MGM was substantiated for abuse - poisoning due to the fact that the fentanyl patch belonged to her, and she was entered on the Child Protection Registry at level IV. Mother was substantiated for Dependency and Severe Physical Neglect due to the conditions of the home, and she was entered on the Child Protection Registry at level III. The case was transferred to DFS treatment for ongoing services. Mother’s DFS treatment plan was to work on housing, finances and appropriate supports. She needed to follow up with her own medical appointments and take her prescribed medication. She also needed to follow up with the children’s medical appointments to ensure that their developmental growth was on target. Despite efforts at reunification, a termination of Parental Rights Hearing was scheduled in August 2015.

System Recommendations/Findings

1. CDNDSC recommends that the Division of Family Services comply with policy as it relates to utilizing a minimum of two collateral contacts prior to case determination, what is considered to be an appropriate collateral contact, and timeliness of collateral contacts. *(initial review)*

2. CDNDSC recommends that the Division of Family Services comply with policy as it pertains to the medical assessment of a child when said child is not the focus of the investigation but presents with possible medical needs. (*initial review*)
3. During the January 2013 investigation, there was an accumulation of risk factors identified that should have prompted immediate attention by the DFS caseworker; however, the cleanliness of the home was the primary focus and the case was closed, unsubstantiated (*from final review*).
4. The law enforcement officer did not report the case to the Criminal Investigative Unit. However, it was noted this was an older case, and extensive training has occurred since this incident (*from final review*).

10. Case 9-03-14-00006: J.M. (Date of Birth: Oct. 2013; Date of Incident: Dec. 2013, Near Death)

In December of 2013, a referral was made to the DFS Report Line alleging physical abuse of a two-month-old male infant by his Father. Victim's mother advised the reporter that she had left the home in the afternoon, leaving infant in the care of his Father. When she returned home, she heard screaming coming from inside the home. She found Father holding the infant. She asked why Victim was screaming and noticed a napkin/baby wipe with blood on it. She snatched the infant from Father's arms and observed the bruising and blood on the infant's face. She immediately called MGM and was advised to take Victim to the ED. Mother left the residence with the infant, on foot as they lived nearby and responded to the ED.

Upon medical examination, Victim had facial contusions and bilateral edema to the face. X-rays and additional testing, such as blood work and CT scans were completed; all yielded negative results. Victim was stabilized and breathing without intubation. He was admitted for the night for observation. Some of the marks on Victim's face looked to be fingerprints as if someone were trying to stop him from crying. The doctor planned to order an eye examination for the infant to ensure there was no damage. Medical staff was concerned since no explanation was provided by the parents.

Law enforcement was contacted and arrived at the hospital prior to the DFS caseworker. In speaking with Mother, law enforcement ascertained that only Mother, Father and Victim resided in the home and neither parent had other children. Mother revealed that she was prescribed five or six different psychotropic medications for her Bipolar and Schizophrenia disorders. Father also suffered from Bipolar and Schizophrenia; however, he was not taking medication. Multiple family members had arrived at the ED. All family members reported that Father was violent and had beaten Mother on a number of occasions. The medical staff reported that Mother had been treated at the ED previously as a result of this domestic violence. During his interview, Father reported he put a bottle into Victim's mouth too hard. He said Victim was screaming and when he removed the bottle, the infant's face was covered in blood. Law enforcement suspected that Mother was not at the home at the time of the incident, because she was purchasing marijuana.

Father was arrested and charged with Assault 1st, Child Abuse 1st, and felony level Endangering the Welfare of a Child. He took a plea to Assault 2nd and was sentenced to 8

years at Level IV, suspended after 12 months to 6 months work release, to 1 year Level III. Father was substantiated for Blunt Force Trauma and entered on the Child Protection Registry at level IV. DFS transferred the case to treatment for ongoing services.

During the above treatment case, a subsequent referral was made to the DFS Report Line for Other Physical Abuse alleging that Mother was using drugs in front of Victim, putting marijuana in his bottle and letting the infant sniff marijuana. Upon investigation of this referral, the caseworker concluded the referral was made out of spite after viewing text messages between Mother and another person. The home visiting nurse that saw the child regularly stated Victim was developing well and contact between Mother and Victim was appropriate. The caseworker noted no concerns during the visit. Law enforcement was not contacted regarding this referral. Discussion occurred during the Panel as to why no medical evaluation was done for Victim as a result of this referral. However, DFS determined that a medical assessment was not needed since the visiting nurse did not identify concerns. Following the incident, Victim's adult cousin filed for temporary guardianship of the child. The case was initially sent to mediation. However, since the cousin is considered a non-relative, the case will be scheduled before a judge. The matter is still pending before the Court.

Findings

1. Law enforcement did not complete a scene investigation. The initial response was made to the hospital (*from final review*).
2. Family Court does not have the ability to examine administrative findings in DFS cases prior to granting guardianship or custody unless a substantiation petition has been filed with the Court. (*from final review*).

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Prioritized CAN Panel Recommendations

System Area	Finding	# of Occurrences	Joint Commission Recommendations	Agency Responsibility	Timeframe	Joint Commission Action Plan
DFS Intake, Investigation & Treatment	Use of History	14	1. Train the CAN Panel about the use of the Structured Decision Making® (SDM) Tool as it relates to history.	1. CDNDSC & DFS	1. Feb. 26, 2015	1. Completed.
			2. Determine whether domestic violence, multi-generational history, and professional reporters should be given greater weight in SDM.	2. DSCYF, DFS & CRC	2. August 2015	2. Provide update to Joint Commission at next meeting.
			3. Meet with DFS unit supervisors to discuss how history could be made easier to review in FACTS and use specific examples from the CAN Panel. Consider technical solutions, such as: <ul style="list-style-type: none"> a. Using a master supplemental report; b. Requiring a higher level supervisory review; c. Requiring critical frame working; or d. Review by child psychologist. 	3. DFS	3. August 2015	3. Provide update to Joint Commission at next meeting.

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System Area	Finding	# of Occurrences	Joint Commission Recommendations	Agency Responsibility	Timeframe	Joint Commission Action Plan
DFS Investigation	Collaterals	16	<p>1. Expand the current DFS collateral policy and procedure to be responsive to the unique needs of the family, to be relevant to the allegations, and to inform the decision-making process. It shall include:</p> <ul style="list-style-type: none"> a. Interviewing collateral sources for all children in the family; b. Identifying collateral sources that have relevant information pertaining to the allegations; c. Contacting treatment providers when mental health and substance abuse issues are alleged/suspected for caregivers and/or child(ren); and, d. Corroborating the family's statements in response to allegations with relevant professionals. <p>2. Develop a training program and tool to assist DFS staff in obtaining collaterals from others professionals. It shall address:</p> <ul style="list-style-type: none"> a. Confidentiality; b. Non-compliance by professionals; and c. Communication. 	1. DFS	1. October 2015	1. Provide update to Joint Commission at next meeting.
				2. DOJ	2. October 2015	2. Assign to CPAC Training Committee to monitor. OCA to assist with staffing and training development. Provide updates to CPAC through Training Committee. Provide update to Joint Commission at next meeting.

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System Area	Finding	# of Occurrences	Joint Commission Recommendations	Agency Responsibility	Timeframe	Joint Commission Action Plan
DFS Investigation and Medical	Medically Fragile/ Substance-Exposed Infants	17	<p>1. Create a Joint Committee on Substance-Exposed and Medically Fragile Children to address the following recommendations:</p> <ul style="list-style-type: none"> a. Establish a definition of medically fragile child, inclusive of drug-exposed/addicted infants. b. Draft a statute to mirror the definition as needed and consider adding language to neglect statute. c. Conduct universal drug screenings for infants in all birthing facilities in the state. d. Revise the Hospital High Risk Medical Discharge Protocol to include all drug-exposed and medically fragile children. It shall include: responding to drug-exposed infants and implementing the Plan of Safe Care per CAPTA; and, involving the MDT in ongoing communication and collaboration for medically fragile children. e. Refer medically fragile children to evidence-based home visiting programs via Healthy Families America, prior to discharge. f. Include the standards developed by DHMIC's Standards of Care Committee on neonatal abstinence and guidelines for management. 	<p>1. CPAC, CDNDSC</p>	1. March 2016	1. Provide update to Joint Commission at next meeting.

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System Area	Finding	# of Occurrences	Joint Commission Recommendations	Agency Responsibility	Timeframe	Joint Commission Action Plan
DFS Investigation & Treatment	Safety Plan & Unresolved Risk	52	1. Consider legislation to add the Secretary or Division Directors of DHSS as Commissioners to CPAC, (barriers to services provided by DPH, DSS, and DSAMH in recommendations).	1. CPAC	1. June 30, 2015	1. Provide update to Joint Commission at next meeting.
			2. Conduct an analysis of DFS system improvements over the last 2 years to determine impact on child death and near death cases.	2. DFS	2. September 2015	2. Provide update to Joint Commission at next meeting.
			3. Develop policies and procedures to ensure that information from mental health, substance abuse, and domestic violence assessments are incorporated into safety planning, and no case will be closed without a supervisory review documenting that referral services are underway, as appropriate.	3. DFS	3. September 2015	3. Provide update to Joint Commission at next meeting.
			4. Establish a Joint Committee to identify recommendations to assure high risk families are engaged in early intervention /prevention services (i.e., home visiting to decrease risk of abuse or neglect).	4. CPAC & CDNDSC	4. September 2015	4. Provide update to Joint Commission at next meeting.

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System Area	Finding	# of Occurrences	Joint Commission Recommendations	Agency Responsibility	Timeframe	Joint Commission Action Plan
Legal	Legislative & DFS Contact with DOJ	34	<ol style="list-style-type: none"> 1. Develop a statewide, annual training program for DSCYF staff. It shall address: <ol style="list-style-type: none"> a. Legal services available from DOJ; and, b. Circumstances under which DOJ should be consulted. 2. Schedule a meeting between Attorney General Matt Denn, DSCYF Cabinet Secretary Jennifer Ranji, necessary staff, and the CPAC Executive Committee, as necessary. It shall address: <ol style="list-style-type: none"> a. Communication gaps between DOJ and DFS; b. Education needs for each agency; and c. Establishment of a written protocol to facilitate communication and consultation between the agencies and to complete the annual training program. 3. Develop a training program for members of the judiciary addressing the impact of crimes of violence and other forms of abuse on non-verbal children who experience or witness such. Offer training across disciplines. 	<ol style="list-style-type: none"> 1. DFS & DOJ 2. DOJ, DSCYF, & CPAC 3. CPAC & Family Court 	<ol style="list-style-type: none"> 1. September 2015 2. September 2015 3. January 2016 	<ol style="list-style-type: none"> 1. Provide update to Joint Commission at next meeting. 2. Provide update to Joint Commission at next meeting. 3. Assign to CPAC Training Committee to monitor. OCA to assist with staffing and training development.

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MDT Response	Crime Scene, Interviews & Non-compliance with MOU	38	<ol style="list-style-type: none"> 1. Implement MOU between DSCYF, DOJ, Law Enforcement, and CAC and develop a training program on the best practice guidelines for investigating and prosecuting these cases. 2. Develop and provide advanced training programs annually for members of the MDT. This shall include: <ol style="list-style-type: none"> a. Drug and Alcohol Abuse; b. Abusive Head Trauma; c. Safety & Medical Assessments; d. Warning Signs & Indicators of Abuse and Torture; and, e. Developmental, psychological & emotional impact of abuse. 3. Identify resource constraints for DOJ and support appropriate budgetary requests for additional resources, to include the recruitment, addition and development of felony level prosecutors with expertise in the prosecution of felony level child abuse cases. 4. Research and develop best practices and/or trainings to help professionals recognize and appropriately respond to cases of child torture. Specific examples from the CAN Panel will be utilized. 	<ol style="list-style-type: none"> 1. CPAC 2. CPAC 3. DOJ & CPAC 4. CPAC & CDNDSC 	<ol style="list-style-type: none"> 1. Jan. 2017 2. Jan. 2017 3. Spring 2016 4. March 2016 	<ol style="list-style-type: none"> 1. Assigned to CPAC Training Committee - CAN Best Practices Workgroup. 2. Assign to CPAC Training Committee – Joint Conference Workgroup. 3. CPAC to monitor and pursue budget request by FY17. 4. Assigned to Joint Committee on Child Torture.

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System Area	Finding	# of Occurrences	Joint Commission Recommendations	Agency Responsibility	Timeframe	Joint Commission Action Plan
Medical	Standard of Care	22	<p>1. Consider modification to Delaware law to include an education requirement for medical professionals that incorporates the appropriate evaluation and management of a child suspected of child abuse and neglect as per the guidelines of the AAP, ACR, AAFP and ACEP. It shall emphasize:</p> <ul style="list-style-type: none"> a. Assignment of an appropriate provider; b. Comprehensive history taking; and c. Complete age appropriate exam, including disrobing, radiologic survey, and sexual assault evaluation. 	<p>1. Board of Medical Licensure and Discipline, Board of Nursing, & Medical Society of Delaware</p>	1. January 2017	<p>1. CDNDSC shall write a letter to the agencies responsible. Provide update to Joint Commission at next meeting.</p>