



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

## **CAPTA<sup>1</sup> REPORT**

In the Matters of

9-03-12-00009: A.L.  
9-03-13-00005: A.T.  
9-03-13-00007: L.L.N.  
9-03-13-00012: K.B.  
9-03-14-00013: A.M.  
9-03-14-00014: N.T.  
9-03-14-00017: J.L.  
9-03-14-00020: J.C.  
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9-03-14-00026: K.B.  
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9-03-14-00032: K.T.  
9-03-14-00034: N.P.  
9-03-14-00033: D.M.  
9-03-15-00008: G.F.  
9-03-15-00009: H.S.

September 9, 2015

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<sup>1</sup> 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 seventeen child death and near death cases.

## **Cases Reviewed**

### **1. Case 9-03-12-00009: A.L. (Date of Birth: Sept. 2011; Date of Incident: Nov. 2011, Death)**

Emergency Medical services (“EMS”) were dispatched to the Maternal Grandmother’s residence for a report of a two-month-old female infant found unresponsive in bed by a caretaker. EMS arrived on scene where law enforcement was performing cardiopulmonary resuscitation (“CPR”) on the infant who had no pulse or respiratory effort. CPR was continued by ambulance staff, and due to proximity of “advanced life support staff” at the local emergency department (“ED”)<sup>2</sup> the infant was taken to the ED without delay.

Upon physical examination, the infant had no pulse, had fixed and dilated pupils and had no outward signs of trauma. Resuscitation efforts ceased and the infant was pronounced deceased. No blood studies, blood gases or toxicology studies were completed. The medical examiner was contacted and claimed jurisdiction.

A joint investigation was conducted by Division of Family Services (“DFS”) and law enforcement. Maternal Grandmother (“MGM”) was caring for Victim at the time of her death in violation of a DFS safety plan. She fell asleep on a mattress with Victim and her own child. Another adult was also sharing the bed and awoke to find MGM partially covering the Victim. While the Victim was supposed to be hooked up to the apnea monitor, a monitor was not located at the scene. Therefore, the results could not be obtained. Mother was not present at the time of the incident nor was Maternal Great Grandmother, who was the child’s primary caregiver as agreed upon by DFS.

Prior to this incident, in September of 2011, Mother, who was seventeen-years-old, tested positive for marijuana at the birth of Victim. She left against medical advice on the same date. It was noted that Mother refused to learn the medical procedures necessary to care

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<sup>2</sup> Per ambulance staff notes.

for infant and was rarely present during the infant's hospitalization. The DFS Report Line was contacted, and the report was screened in for investigation. In October of 2011, the infant was discharged, with an apnea monitor, to the care of Maternal Great Grandmother, who agreed to supervise all contact between Mother, Maternal Grandmother and Victim. DFS found that due to Maternal Grandmother's history, Maternal Grandmother was not appropriate to provide supervision or care for the infant. The investigation was unfounded and linked to an active treatment case with the family. The family had a significant DFS history involving six investigations prior to the September and November reports regarding Victim. A significant substance abuse history was also noted for MGM and Maternal Great Grandmother.

As a result of the death investigation, DFS substantiated Maternal Great Grandmother for Severe Physical Neglect for violating the safety plan, which resulted in the death of Victim. She was entered on the Child Protection Registry at level III. Maternal Grandmother was also substantiated for the death and medical neglect of her own son. She was entered on the Child Protection Registry at level IV. The case remained open in treatment with DFS. Victim's sibling and MGM's son were adopted by the same family in July of 2014.

An autopsy was performed and Victim's manner of death was determined to be accidental; overlay due to co-sleeping. The cause of death was a history of compression asphyxia. As a result of these findings, prosecution was declined by the Department of Justice.

### **System Recommendations/Findings**

1. DFS did not contact the maternal great grandmother's substance abuse provider before entering into a safety plan for her to care for the infant in the September of 2011 investigation (*from final review*).
2. Case presented with an accumulation of risk including substance abuse, housing issues, multigenerational history (*from final review*).
3. Standard of care was not followed with documentation of the resuscitation efforts following the Pediatric Advanced Life Support ("PAL") guidelines (*from final review*).
4. DFS did not consult with the Department of Justice ("DOJ") in regards to obtaining custody of the infant. Per the action plan approved by the Joint Commissions, DFS and DOJ have agreed to establish a protocol to facilitate communication and consultation between these agencies, particularly in child near death and death cases (*from final review*).

### **2. Case 9-03-13-00005: A.T. (Date of Birth: Nov. 2009; Date of Incident: Sept. 2012, Near Death)**

A three-year-old female child was brought into the ED, wrapped in bandages, by Father. She presented as unresponsive. Victim had a skull fracture to the back of her head. She also had fresh burns behind her leg, small circular ones on her chest/inside upper arm

area, and on her buttocks. She had bruising to her frontal area, forehead, left side of face, and some older bruising and scars. Her vaginal area was also red, and there was faint bruising inside the thigh area. Father had given three stories regarding how Victim had sustained her injuries: she walked into a wall and broke her glasses, was rough housing, and has developmental delays. Victim was considered critical. As a result, she was intubated and transported to the children's hospital for further evaluation and treatment.

A joint investigation was conducted by DFS and law enforcement. Prior to transporting the Victim to the ED, Father had visited two different relatives' homes with his three children. Mother had contact with the children as well despite a criminal no contact order from a May of 2012 incident, in which she was charged with hitting her four-year-old son with a belt and leaving injuries. The one-year-old and four-year-old siblings were medically evaluated and abuse was ruled out. DFS immediately planned with paternal aunt to care for the siblings. A forensic interview was scheduled with the older sibling at a later date. Law enforcement conducted interviews with all of the parties and were concerned that the family was being protective of Father. No one confessed to causing the injuries, but the children with both parents for a 3-5 hour window on the date of the incident. Either parent could have caused the injuries.

Law enforcement did request that DFS petition for custody of the children during the investigation. However, DFS felt strongly that the paternal aunt was protective. She was awarded guardianship of all three children at a later date.

Father was charged with two counts of Endangering the Welfare of Child ("EWC") and Conspiracy. He pled guilty to felony level EWC and was sentenced to 2 years Level V, suspended for 1 year Level II. Mother was charged with felony level EWC and pled guilty. She was sentenced to 2 years, Level V. Mother and Father were substantiated for abuse – head trauma and entered on the Child Protection Registry at level IV. The case was also linked back to treatment since the family was active with DFS at the time of the incident.

DFS first had contact with the family in 2011. The case was referred to treatment in January of 2012 due to the following concerns: medical needs of children which Mother has been slow to address, substance abuse issues for both parents, financial issues due to unemployment, domestic violence and a no contact order between the parents. Two of the children have genetic heart conditions. Victim also has a cleft palate and has had a gastrointestinal tube. They are seen by an in-home nurse and are active with Child Development Watch. The parents have had difficulty maintaining the children's medical appointments and are not always compliant with in-home services.

### **System Recommendations/Findings**

1. CDNDSC recommends that the Division of Family Services reconsider its decision making process when participants fail to complete substance abuse evaluations and/or recommended treatment. This non-compliance should be a basis for referral for services, not case closure. *(from initial review)*
2. CDNDSC recommends that the Division of Family Services' substance abuse policy be changed to include referrals for services. *(from initial review)*

3. CDNDSC recommends that a consultation occur with the Department of Justice Family Division prior to case closure in cases of parental non-compliance with recommended evaluations/services. *(from initial review)*
  4. CDNDSC recommends that Team Decision Making (“TDM”) meetings occur in all serious non-accidental injury and death cases stemming from Delaware’s Emergency Departments. *(from initial review)*
  5. CDNDSC recommends that the use of the Division of Family Services' Domestic Violence Liaisons be utilized in cases where domestic violence is suspected and that appropriate referrals for services are offered to the victim by said liaison. *(from initial review)*
  6. CDNDSC recommends that in instances where the caregiver is expressing concerns of mental health issues that appropriate referrals be made for an immediate mental health evaluation and that DFS implement a safety plan in order to ensure that the caregiver has the ability to properly care for the child(ren). *(from initial review)*
  7. CDNDSC recommends that when a participant violates a no contact order that criminal and/or civil penalties be incurred by said participant. Moreover, the violation of the contact order should be reported to law enforcement and properly documented. *(from initial review)*
  8. CDNDSC recommends that within the Division of Family Services' Risk Assessment Tool a drop down box be added in which the caseworker must articulate why the child is considered safe at case closure. *(from initial review)*
  9. CDNDSC recommends that when a child is considered medically fragile, as defined by the High Risk Medical Discharge Protocol, that the Division of Family Services assists the caregiver in receiving appropriate referrals for service and/or petition for guardianship. *(from initial review)*
  10. CDNDSC recommends that Family Court be privy to the facts and circumstances of cases where the Division of Family Services is currently active, so that appropriate oversight can be given through the exchange of information and data. Moreover, it is recommended that such information exchange occur through the use of the DFS Family Court Liaison. *(from initial review)*
- 3. Case 9-03-13-00007: L.L.N. (Date of Birth: July 2012; Date of Incident: Nov. 2012, Near Death)**

A sixteen-week-old female infant presented to the ED with 1<sup>st</sup> and 2<sup>nd</sup> degree splash scalds to her face, ears, and back. Mother indicated that she was holding the infant in her left arm while she attempted to balance a bowl of soup on her chest. She was attempting to take a bite when she accidentally hit the bowl with her right hand, spilling the soup onto the baby. She stated she was also hit with the soup but was not burned. She alleged that she placed the soup in the microwave for one minute and allowed it to cool before eating.

DFS and law enforcement responded to the hospital and interviewed Mother. They suspected Mother's paramour as the perpetrator. No safety plan was put into place at that time, because Victim was being transferred to a burn center for treatment of her injuries.

Upon further interviews, Mother admitted that she had lied about what happened because she was afraid and protected her paramour because she did not want him to be arrested. She revealed that the paramour woke her with the baby screaming, stating that he had spilled the soup on the baby, and asked her to take the blame so that he would not be arrested. Mother's paramour was taken into custody for EWC and Assault 2<sup>nd</sup> and ordered to have no contact with Victim. He was also arrested for Violation of Probation (refused to submit to an ordered drug screening). Family members of Victim also contacted Probation and Parole, because they were worried about his interaction with the infant due to his drug use.

Mother's paramour initially denied the allegations and blamed the incident on the Mother. In a second interview, he admitted that he had the bowl of soup in his hands and the container was so hot that he had to have a holder underneath it. He put some of the soup in his mouth, and spit it out because it was hot; he dropped the soup and it fell onto the infant. It is noted that he had no visible burns to his mouth; he stated he had no pain and was not scalded from the soup.

Following the arrest of Mother's paramour, Mother was asked to leave his home and had no place to stay. She temporarily stayed with an ex-paramour. DFS felt that it was in Victim's best interest to be removed from Mother's care. She was given the opportunity to make alternative arrangements. Maternal Great Aunt agreed to care for the infant and filed for guardianship of both the infant and the three-year-old sibling currently being taken care of by the maternal grandmother.

Mother's paramour was convicted of felony EWC and Child Abuse 3<sup>rd</sup> in May of 2013. He was substantiated for abuse, and entered on the Child Protection Registry at level IV for burns and scalding of Victim. Mother was not substantiated; however, DFS was concerned because she was not protective of Victim, lied about the incident, and covered up the abuse for her paramour. Concern was also noted that she was unstable, unemployed and had housing/financial issues. The case was transferred to treatment for further services. Maternal Great Aunt was awarded guardianship and she filed to terminate parental rights for both children. Mother consented and her rights were terminated. Mother later appealed, claiming she did not do so willingly. The Judge upheld the termination of parental rights. Both children remain with the maternal aunt.

### **System Recommendations/Findings**

1. 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*).
2. The DFS investigation caseworker did not report allegations of sexual abuse to the Report Line after reported allegations to her during the October of 2012 investigation. As a result, CDNDSC agreed to make a report (*from final review*).

**4. Case 9-03-13-00012: K.B. (Date of Birth: Oct. 2011; Date of Incident: May 2013, Near Death)**

A one-year-old male child was brought to the ED by his mother at approximately 4:30 p.m. due to concerns that he had ingested Mother's prescription seizure medication. Mother had reportedly spilled the bottle of prescription pills on the kitchen counter two days prior to the incident. Mother explained this morning she found the child holding one 100 mg Tegretol pill. She took the pill away from the child, swept his mouth using her finger and found no other pills. She pushed the remaining pills into the trash can and continued on with her day although Victim presented as lethargic, his eyes were rolling into his head and his limbs were limp.

A joint investigation was conducted by DFS and law enforcement. Mother reported Victim ingested the medication around 5:30 a.m. and she knew something was wrong; however, she opted to wait until 4:30 p.m. to seek medical treatment for him. Mother later admitted she had failed to seek earlier medical treatment because she felt she needed emotional support, and feared the potential actions of DFS and law enforcement. The following day, DFS was granted temporary custody, and Victim was placed into foster care.

Mother had an extensive history with DFS and law enforcement. One incident involving DFS resulted in Mother's substantiation for moderate physical neglect and dependency, placing her on the Child Protection Registry at level II. Additionally, Mother had a history of bipolar disorder and depression, as well as substance abuse. Child's father also had an extensive criminal history including traffic violations, robbery, drug related charges, assault, and criminal trespassing. He is currently serving an eight year sentence on weapons and drug charges, and is scheduled to be released in January 2020.

As a result of this incident, Mother was arrested and charged with Child Abuse 3<sup>rd</sup> and two counts of EWC. She was substantiated for Life Threatening Medical Neglect and Poisoning and placed on the Child Protection Registry at level IV. Mother pled guilty to one charge of misdemeanor EWC and was sentenced to 12 months Level V suspended to 12 months Level II. Victim was adopted in December 2014.

**System Recommendations/Findings**

1. 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*).
- 5. Case 9-03-14-00013: A.M. (Date of Birth: April 2013; Date of Incident: Oct. 2013, Death)**

A six-month-old female infant died as a result of Sudden Unexplained Death in Infancy ("SUDI"); the manner of death was undetermined. Victim was placed in a bassinet, in a back bedroom with the door closed, with blankets wrapped around her neck area to prop her bottle. Several hours later, Victim's Father found her cold and unresponsive with the blankets covering her face. Law enforcement investigated Victim's death and a report was made to DFS which was screened out at the time. Another referral was made to DFS

in November of 2013 with the original allegations as described above which was then opened for investigation, as Father was facing charges in her death. It was determined that at some point, Father checked on Victim and noticed the blanket was covering her face; however, he did not remove the blanket, instead he closed the door and walked away assuming she was asleep. Upon investigation, Victim's two-year-old sibling was placed in the care of a relative and parents were given supervised visitation. The case was transferred to treatment for ongoing services in December of 2013. The parents were compliant with their treatment case, resulting in the safety plan being lifted in February of 2014. Three months later, the case was closed as a successful plan, although the Strengthening Families program had not yet been completed.

Prior to this incident, there was no DFS history relating to Father as an adult or a child. His criminal history was minimal. There was one prior DFS investigation relating to Mother as a child in October of 1994. The report alleged lack of supervision and physical neglect by her mother, and the case was unsubstantiated and closed in January of 1995. Mother had several non-violent adjudications as a minor and no relevant adult history.

As a result of Victim's death, DFS substantiated both Mother and Father for death due to neglect. Both parents appealed the DFS substantiation and Father's criminal conviction placed him at Level III on the child protection registry. DFS dismissed Mother's petition after an appeal since there were no criminal charges filed against her. Father pled guilty to misdemeanor Endangering the Welfare of a Child and was sentenced to one year level V confinement suspended to six months level II probation, followed by six months level I probation.

### **System Recommendations/Findings**

1. CDNDSC recommends that the Division of Family Services review and comply with its policy as it relates to the closure of treatment cases. (*from initial review*)
6. **Case 9-03-14-00014: N.T. (Date of Birth: June 2000; Date of Incident: Aug. 2000, Death)**

At one month of age, a male infant was placed in foster care due to his mother's incarceration and substance abuse, and his father's inability to care for the child. Shortly after his placement, the infant was a victim of Abusive Head Trauma ("AHT") at three months of age by his foster mother. Following the incident, Victim had a complex history of static encephalopathy (brain damage) secondary to non-accidental trauma from shaken baby, laryngotracheal separation (separation of upper airway from digestive tract to avoid aspiration), trach/vent dependent with chronic restrictive lung disease, reactive airways disease, cerebral palsy, seizure disorder, cortical blindness, deafness, mutism, and osteopenia (bone weakness secondary to decreased bone density). He had a feeding tube and remained on life support measures until his death at age 13.

In January 2003, foster mother, was convicted of Assault by Abuse or Neglect, and was sentenced to 10 years Level V suspended after service of 4 years to 6 months Level III followed by 2 years Level II. She was also convicted of felony-level Endangering the Welfare of a Child, and sentenced to 2 years Level V suspended after service of 6 months to 1 year Level II. She was ordered to perform 100 hours of community service providing assistance to programs that deal with AHT, to receive substance abuse and mental health

evaluations complying with all recommendations for counseling and treatment, and to pay restitution of \$31,202 to the Victim's Compensation Board. She was prohibited from being employed in a child/foster care situation and from having contact with the victim or his foster family. She filed a motion for modification of her sentence, and in March 2006, the Level V sentence was reduced by 3 months to reflect 3 years, 9 months at Level V.

Following Victim's death, law enforcement consulted with the Child Victim's Unit of the Department of Justice. Although the manner of death was ruled a Homicide, no charges were pursued as the death was a result of the initial abuse incident, which had already been litigated, and the perpetrator was now deceased. Victim's cause of death was respiratory arrest secondary to mucus plug S/P Shaken Baby Syndrome.

### **System Recommendations/Findings**

1. The Panel identified the following strength: Excellent medical care provided by the child's therapist, whom eventually adopted the child (*from Initial/Final*).
- 7. Case 9-03-14-00017: J.L. (Date of Birth: February 2011; Date of Incident: May 2014, Near Death)**

A three-year-old male child arrived at the ED of the children's hospital with his Mother, following an injury that reportedly occurred the previous night. Mother reported that Victim had fallen down thirteen steps of uncarpeted stairs. Per Mother, she and her boyfriend were smoking outside while Victim was asleep in bed. Mother alleged Victim woke up looking for her in the dark and fell down the steps. It was identified during Victim's medical evaluation that he resided in Delaware with his maternal great-aunt, who was also his legal guardian. He was visiting his Mother in Pennsylvania at the time of the reported fall. Upon medical exam, child had swelling of his left scalp, tenderness and swelling of his left shoulder, and multiple bruises on his face, trunk and extremities. X-rays of his left shoulder showed an acute fracture of his left clavicle. A report of suspected abuse was made to Child Protective Services ("CPS") in Pennsylvania. CPS responded and restricted visitation by Mother and her boyfriend pending investigation. DFS completed a courtesy review to assist CPS with their investigation. A consult with the Children at Risk Evaluation ("CARE") consult occurred and concluded Victim's injuries were inconsistent with said history of a stairway fall. The cause of injury was identified as child physical abuse. A safety plan was put into place by DFS whereas the children would reside with the maternal great-aunt in Delaware, and she would allow no contact or visitation between the mother and children. CPS and law enforcement investigated the incident in Pennsylvania; however, Mother was not cooperative.

Prior to this incident, between September of 2011 and April of 2014, the DFS Report Line received multiple referrals alleging neglect of Mother's four children. Two of the cases were abridged, and the remaining cases were screened out. Mother had a history of drug use with multiple relapses, depression and anxiety, and homelessness. Mother also admitted to a history of domestic violence involving the father of one of her children, who was incarcerated. As a result of unresolved caregiver risk, the children were shuffled back and forth between Mother and other relatives. One month before Victim presented to the ED with physical injuries, DFS received a referral alleging that maternal great-aunt was caring for three of Mother's children, and she was overwhelmed and wanted to turn the children over to the state. However, maternal great-aunt was also their guardian, and

the reporter was not concerned that she would return the children to Mother. As a result, the report was screened out.

As a result of the near-death incident, other family members were considered as placement options to assist the maternal great-aunt. In June 2014, the oldest child's paternal grandparents petitioned for and were granted guardianship of that child. Victim and another sibling remained in the care of maternal great-aunt. Later that month, the DFS case was closed, unsubstantiated with concern since maternal great-aunt allowed the children to visit with Mother for long periods of time knowing her history with drug use and mental health issues. Pennsylvania law enforcement and CPS continued to investigate the abuse allegations, but no criminal charges were filed in Delaware.

### **System Recommendations/Findings**

1. CDNDSC recommends that in cases where a family has an accumulation of risks, the Division of Family Services should consider providing further assistance to the family by transferring the investigation case to treatment rather than case closure (*from Final*).

### **8. Case 9-03-14-00020: J.C. (Date of Birth: Jan. 2014; Date of Incident: June 2014, Near Death)**

The DFS Report Line received a referral alleging physical abuse of a five-month-old male infant. Mother changed the infant's diaper around midnight, and noticed blood on the infant's penis. Mother was concerned and took the infant to the ED. Upon medical examination, Victim had a small laceration to his penis just below the head, and a small abrasion to the right side of his testicle with no swelling; there was no injury to the anal area. Due to medical staff's concern, a full head to toe examination was completed. The infant's left arm was swollen and hard, compared to the right arm, and bruising was noted to the infant's forehead and right temple. Concerns were reported to the doctor, and a full skeletal x-ray was completed, which revealed a spiral fracture to the infant's left humerus and evidence of an old fracture to the right humerus.

It should be noted that the infant was seen at the same ED in January of 2014 for his left arm; the Father was burping infant and heard a pop. X-rays were completed but revealed no injury. A small laceration was also noted on the infant's neck to which the mother explained was caused by the car seat. Medical staff denied this could happen due to positioning of the infant in the car seat. Mother noted the bruise on the infant's forehead was from the infant hitting himself with a toy; medical staff also denied this could happen as an infant this age would not have enough strength to cause such a bruise. Victim was seen by his primary care physician ("PCP") three days prior for a well-visit and immunizations, and he was noted to be fine.

Victim was transferred to the children's hospital and admitted for further medical treatment and observation. A second referral was made to the DFS Report Line alleging the same injuries but was screened out due to the first referral being assigned as an investigation. Law enforcement was contacted by the initial reporter.

At the children's hospital, a computed tomography ("CT") scan was ordered as well as full body skeletal x-rays and labwork. The medical staff revealed that the initial x-rays

from the ED also showed two rib fractures on the right side and two rib fractures on the left side of the infant's body.

DFS and law enforcement responded to the children's hospital. Mother was noted to be the primary caretaker of the infant. When the issue concerning Victim's arm was brought up to the family, Father advised that he noticed it about one week ago. Mother advised that she brought the concern up with the infant's PCP during his earlier visit. The doctor checked it and reported the infant's arm to be fine. The maternal grandmother advised that she noticed the infant to seem to be in pain whenever she picked him up. No perpetrator was identified.

A team decision making ("TDM") meeting was held. The parents, maternal and paternal grandparents, and two paternal aunts were present. DFS was prepared to place the infant with one of the paternal aunts; however, Mother and Maternal Grandmother noted that they would prefer the infant be placed in foster care rather than with the paternal side of the family. The mother stated she had concerns with the paternal aunt but would not state what those concerns were. The DFS caseworker noted continued conflict between the family members. As a result, DFS petitioned for temporary custody of Victim, and the infant was discharged into foster care.

Mother and Father's parental rights were terminated in August 2015. Victim is currently placed with pre-adoptive parents and doing well. Both parents were substantiated for Physical Abuse – Bone fracture. Mother appealed the finding. Her hearing is scheduled for September of 2015. Father was entered on the Child Protection Registry at level IV since he never appealed. No criminal charges were filed.

### **System Recommendations/Findings**

1. The Panel noted the following as strengths: DFS substantiated both parents since no perpetrator could be identified; DFS filed for custody due to concerns with the family members; and medical professionals in the Emergency Department (ED) conducted a full evaluation. *(from initial review)*
  2. The child's Family Court case file should be flagged with an indicator of history, so that such information can be properly assessed for any subsequent filings related to the child and a decision made whether such filings should be scheduled for mediation or be referred to a Judicial Officer. *(from initial review)*
  3. There is no mechanism in place for hospitals and DFS to communicate in cases where a child is born to parents who have had parental rights terminated, been found guilty of abuse, etc. No recourse for DFS involvement until an incident of abuse or neglect occurs *(from Initial/Final)*.
- 9. Case 9-03-14-00024: A.R. (Date of Birth: March 2012; Date of Incident: July 2014, Near Death)**

A two-year-old female child fell from a three story window in her home onto a mattress on the sidewalk. Emergency Medical Services ("EMS") were dispatched to child's residence and reported that she had fallen approximately 30 feet. Victim's Mother denied any loss of consciousness. Child was transported to the ED of the children's hospital. She

was admitted to the pediatric intensive care unit (“PICU”) for further evaluation. DFS and law enforcement were contacted.

Further medical evaluation revealed that the Victim presented with a skull fracture, bruising, depressed injury, small hematoma, and minor dislocation of neck/spine. Neurosurgery and CARE consults were completed. Victim was not a candidate for neurosurgery, and the CARE consult determined the injuries were consistent with the fall. Mother reported to medical staff that there was no ledge or other means for the child to step up to the window. She also stated the window was closed and secured with child-safety locks, which was inconsistent with the information obtained during the forensic interviews of two non-victims. One child disclosed the victim fell on her own as she was looking out the window while the other child said the first child pushed the victim. It could not be determined if the child was pushed by another child or accidentally fell from the window. Victim was referred to the concussion clinic for follow-up. Those appointments were missed.

A TDM meeting was held by DFS one month later, due to concern that Mother had missed several medical appointments for child, including her first appointment following the incident, the rescheduled appointment and the next follow-up appointment. As a result of the TDM, it was determined that Victim would remain in the care of her Mother. The case was transferred to treatment. Mother was noncompliant with the treatment case and continued with her destructive behavior, i.e. allowing a registered sex offender to reside in the home, arrests for shoplifting and other charges, substance abuse and unstable housing. In March of 2015, the family’s whereabouts were unknown. DFS was able to make contact with Mother in April of 2015; Mother had not yet completed the substance abuse evaluation. The family was again unable to be contacted; the last attempt was made by DFS in May of 2015. The case remains listed as active in treatment.

No criminal charges were filed. DFS substantiated Mother for lack of supervision and medical neglect, and she was placed on the Child Protection Registry at level III.

### **System Recommendations/Findings**

1. The Panel identified the following strength: a comprehensive medical assessment was conducted following the incident (*from Initial/Final*).
2. Mother failed to complete a substance abuse evaluation, was noncompliant with medical follow-up, has an active warrant, current homelessness and appeared to be evading the DFS caseworker. However, DFS did not consider group supervision, a framework or consultation with the Department of Justice regarding the incident and risk to the child (*from Initial/Final*).
3. No documentation of consult with the Department of Justice by law enforcement; however, a DOJ representative was present during the forensic interviews with the children (*from Initial/Final*).

**10. Case 9-03-14-00026: K.B. (Date of Birth: Sept. 2014; Date of Incident: Oct. 2014, Near Death)**

A one-month-old female infant was taken to the ED with crepitus in the chest, rash on neck and around left eye, bleeding in the right eye, lack of movement in left arm, possible bite mark on lower left leg, and vomiting without fever. Victim's father reported that infant had fallen onto the floor from a couch inside the home. Father further explained that he was feeding the newborn at 4:00 a.m., and he had fallen asleep. When he woke up, he saw the infant on the ground crying.

Law enforcement and DFS began a joint investigation. Victim was referred to the CARE team for further evaluation. She had a skull fracture, broken clavicle, left retinal hemorrhage, and right subconjunctival hemorrhage. It was further noted that the specific bruising of the chest, both arms, and left leg would not be produced by a fall or associated with coughing or vomiting. Victim's injuries were consistent with non-accidental trauma. The infant and her older sibling were placed with the paternal grandparents through a safety agreement and parents were permitted no unsupervised contact.

Prior to this incident, both parents had only been involved with DFS as children. Neither parent had Family Court history or criminal history.

As a result of the DFS investigation, both parents were substantiated for neglect due to the deplorable home environment. Father was also substantiated for abuse (shaken baby) and entered on the Child Protection Registry at level IV. The case was transferred to treatment; however, neither parent was compliant with treatment recommendations. Relatives filed for guardianship of Victim's sibling, but parents retained legal custody of Victim. Father pled guilty to felony level EWC; he was sentenced to 2 years Level V suspended to 18 months Level III. He also pled guilty to Assault 2nd and was sentenced to 8 years Level V suspended to 1 year Level IV followed by 2 years Level III (to be hot-bedded for 15 consecutive weekends at Level IV VOP Center from 6:00 PM Friday to 6:00 PM Sunday).

**System Recommendations/Findings**

1. The Panel identified the following strength: A doll re-enactment was completed by law enforcement with father (*from Initial/Final*).
2. The DFS Risk Assessment Tool was not accurately followed, which resulted in Moderate Risk. Although the case remained open and was transferred to treatment, the Panel felt that the case should have been overridden by the supervisor and placed at High Risk (*from Initial/Final*).
3. No forensic interview was conducted with the four-year-old sibling (*from Initial/Final*).
4. Medical assessment of the four-year-old sibling was delayed four days although child was present at the initial hospital response with infant. Law enforcement requested child to be assessed at the children's hospital rather than with primary care physician;

however, the child was eventually assessed at the primary care physician's office (*from Initial/Final*).

5. A permanency plan was not established for the Victim. Although the child was placed in the care of her paternal grandparents, there was no file with Family Court requesting legal guardianship of the child; therefore, the parents retained legal custody. The guardians should be encouraged to file for legal guardianship (*from Initial/Final*).
6. SENTAC guidelines need to reflect equal penalties for Child Abuse 2<sup>nd</sup> (class G felony) and Assault 2<sup>nd</sup> (class C felony). Law enforcement had to add the charge of Assault 2<sup>nd</sup> to obtain the harsher sentence since Assault 2<sup>nd</sup> is a violent felony (*from Initial/Final*).

**11. Case 9-03-14-00027: A.C. (Date of Birth: Jan. 2014; Date of Incident: Oct. 2014, Near Death)**

A nine-month-old female infant was left unsupervised in a plastic tub with 6-8 inches of water, which was placed inside a regular-sized bathtub. Victim's father placed the infant in the tub for a bath, left the room to run a bath for the older sibling, and returned to find the infant face-down and unresponsive. Father contacted 911 immediately, emergency personnel arrived on scene and transported the infant to the local hospital, where she was assessed and transferred to the children's hospital. The mother was not home at the time of the incident.

A joint investigation was conducted by DFS and law enforcement. A safety plan was implemented whereas the father would have no unsupervised contact with the children, which was later voided. Both Mother and Father had no prior Family Court, DFS or criminal history.

Law enforcement completed their investigation of the case and consulted with the DOJ; however, prosecution was declined as the incident was deemed to be an accident. Father was substantiated for lack of supervision of a child less than six years old and was placed on the Child Abuse Registry at level III.

**System Recommendations/Findings**

1. The Panel identified the following strength: An excellent investigation was conducted by law enforcement. The law enforcement agency secured the scene first prior to responding to the hospital, and photographic evidence was taken (*from Initial/Final*).
2. No doll re-enactment was done by law enforcement due to the nature of the incident. Law enforcement requested that CDNDSC research the availability/purchase of plastic dolls to utilize in re-enactments involving water as the current dolls utilized are not water resistant (*from Initial/Final*).

**12. Case 9-03-14-00032: K.T. (Date of Birth: Aug. 2011; Date of Incident: Sept. 2014, Death)**

A three-year-old female child was playing in her paternal aunt's bedroom. She fell asleep on the bed about 7 p.m., earlier than usual as Father works night shift and she is typically on her Father's schedule. Child was later carried to her Mother by her fifteen-year-old cousin. Mother laid child down on their bed but did not notice anything out of the ordinary with her. Mother went to bed later in the night, with child and her one-year-old sibling (normal sleep environment, no Cribs for Kids referral made). Father returned home for his lunch break at approximately 1 a.m. He witnessed all three sleeping in the bed; he ate lunch and returned to work. At approximately 2:15 a.m., Mother awoke. She checked Victim's one-year-old sibling and changed her diaper. She decided to change Victim's diaper as well. Mother then noticed child still had her shoes on. Mother removed Victim's shoes and noticed her feet to be very cold. She then noticed child was not breathing. She woke up the paternal aunt and uncle. Mother began CPR on child and 911 was called. Child vomited a small amount during CPR but remained otherwise unresponsive.

During the law enforcement investigation, it was noted that the paternal aunt, kept prescription medication in her room, allegedly secured in their original containers. The medications included Lisinopril (for blood pressure), Clonidine (blood pressure patch), Lantus (for diabetes), NovoLog (for diabetes), Zofran (for nausea), Phenergan (for nausea), Protonix (for acid reflux), Reglan (for acid reflux), Tramadol (opioid for pain, schedule IV), and Tylenol w/Codeine (prescribed to her 15-yr-old son). Paternal aunt stated that she sometimes would awaken during the night shaking, due to her digestive issues. When that happens, she would spill the pills on the floor but would try to retrieve all of the pills.

An autopsy was performed. The cause of death was determined to be methadone toxicity. The manner of death was determined to be accidental. Toxicology reports found no trace of Tramadol in the child's system. The child had 250 mg/ml of methadone in her system, and it was noted by the Deputy Medical Examiner that it is impossible to know exactly how many pills were ingested.

A search of the Division of Professional Regulation's Prescription Management Program revealed that paternal aunt was prescribed 5 mg methadone HCL pills in January and February of 2014. She also had them prescribed to her on nine occasions during 2013. The residence was searched for methadone, with a focus on aunt's bedroom; no methadone was located. The criminal case was discussed with DOJ and it was determined that there was no evidence of criminal activity; therefore, there would be no criminal prosecution. It was discussed that the DOJ pushed for the manner of death to be changed to undetermined rather than accident as there was some level of neglect or lack of supervision with the drugs being in the home. However, no such modification has occurred.

Upon the child's death in September of 2014, a referral was made to the DFS Report Line; however, it was screened out as the cause of death was unclear. Law enforcement reported the case to DFS again in November of 2014 following the medical examiner's ruling on cause and manner of death. The case was accepted for investigation. Home visits and collateral contacts were completed, and a safety plan was put into place. The

case was closed in January 2015 as unsubstantiated with concern. There was no prior DFS history with the family.

### **System Recommendations/Findings**

1. The Panel identified the following strength: excellent investigation by law enforcement (*from Initial/Final*).
2. There was a seven week period from the time of the child's death until the case was accepted for investigation by DFS. When reporting the death to the DFS Report Line, law enforcement did not indicate that the death was drug related or suspicious, as this would have prompted the case to be accepted for investigation (*from Initial/Final*).
3. The hospital did not report the child's death to the DFS Report Line (*from Initial/Final*).
4. 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.

### **13. Case 9-03-14-00034: N.P. (Date of Birth: July 2014; Date of Incident: Nov. 2014, Near Death)**

A three-month-old male infant was taken to the ED for swelling to his head and eye. He was diagnosed with two linear skull fractures and mild brain bleed. Victim was transferred to the children's hospital. DFS and law enforcement investigated the case.

Maternal grandmother resided in same residence as infant; paternal grandparents visited from out of state. All three grandparents babysat the infant while parents went out and returned home at 11:00 p.m. The injury was noted on Victim at 3:30 a.m. upon feeding.

There were discrepancies noted in the explanation of how Victim was injured. During the forensic interview of the older sibling, he revealed in the waiting room that Mother had dropped the infant down the stairs. Mother denied ever dropping the child down the stairs; however, this was the most plausible explanation of how the injuries occurred as noted in the CARE consult. The parents continued to blame the grandfather and stated that he had been diagnosed with dementia and is senile. Medically, the suspicion of abuse/neglect was solely based on the lack of plausible explanation by the parents. Otherwise, the infant had appropriate medical care and treatment.

The five-year-old sibling was placed into foster care and eventually into the custody of his biological father who resided in Texas. Upon discharge from the hospital, Victim was placed in the care of relatives. Both Mother and Father were substantiated for Abuse due to Head Trauma and entered on the Child Protection Registry at level IV. The case was transferred to treatment. Parents followed all treatment recommendations; custody of the infant was rescinded to the parents and the treatment case was closed as successful. Law enforcement was unable to determine how injury occurred or who caused injury, thus no criminal charges were filed.

## **System Recommendations/Findings**

1. The Panel identified the following strengths: DFS requested a non-negotiable mental health evaluation for parents as they displayed a flat affect at the hospital; and law enforcement investigated the scene by taking photographs, and completing a doll re-enactment with the grandfather (*from Initial/Final*).
2. Safety of the older sibling was assessed a day after the incident. However, a safety plan was not put into place until five days later upon completion of the forensic interview; at which time, custody of the child was petitioned for and granted (*from Initial/Final*).
3. Due to the infant's unexplained injuries, medical assessment of the older sibling should have been completed immediately (*from Initial/Final*).
4. The Child Victim's Unit of the Department of Justice was not immediately notified by law enforcement (*from Initial/Final*).
5. Train ED staff in how to manage and communicate abuse/neglect cases with law enforcement. It was noted that ED nurses are not "allowed" to give their opinion on injuries to law enforcement or parents. (*from Initial/Final*)

### **14. Case 9-03-14-00033: D.M. (Date of Birth: Dec. 2012; Date of Incident: Oct. 2014, Near Death)**

A twenty-two-month-old male child was taken to his primary care physician by Mother with the chief complaint of unstable gait and being disoriented. It was noted that Victim had awoken at approximately 3:00 a.m. and had not fallen back to sleep. Mother was working and Father was home with Victim and his fifteen-year-old sibling. The sibling noted that at approximately 6:00 a.m., Victim walked down the hallway towards her and stumbled, hitting his head on the wall twice. When Mother returned home from work, she noticed Victim had poor eye contact and was fussy. Mother denied drainage from the child's ears or vomiting. Mother requested a CT scan as the child hit his head on the wall; she denied any further trauma. Upon examination, Victim was also found to have low blood sugar. He was treated for such and remained in the primary care physician's office for one hour for observation. While waiting, his sibling advised that she witnessed Father shaking the child. Victim was on the sofa with Father over him with his hands on the child's body shaking him up and down. Victim's body would rise off the sofa and slam back down onto it, while the child was flailing. The sibling reported this was going on when she entered the room and lasted about two minutes. She noted Father's demeanor changed when he noticed her.

Once Victim's demeanor and gait improved, he was transferred to the children's hospital for further evaluation and treatment. Mother transported the child in her personal vehicle to the children's hospital. Mother, Father and sibling were present at the children's hospital. Father advised that Victim awoke around 3:00 a.m. and seemed to trip over himself hitting his head on the wall as he walked with an unsteady gait. Father also advised that he struggled slightly as he tried to change and dress him due to his unsteadiness, reportedly what the sibling witnessed. Emergency medical staff at the children's hospital notified DFS, law enforcement and the hospital's social worker. A CT scan was completed yielding negative results for an obvious bleed or skull fracture; the

radiology team agreed but stated the study was limited by the motion of the child during testing. A consult with the CARE Program was completed, recommending a skeletal survey and ophthalmology examination, both of which yielded negative results.

Law enforcement and DFS investigations ensued. A safety plan was initiated with the family whereas the father would have no contact with the child or residence until the investigation was complete. A forensic interview was later conducted with the sibling, and no additional disclosure was made. Following consultation with the Department of Justice, the Deputy Attorney General (“DAG”) advised there was not enough evidence to prove without a reasonable doubt that Father caused the injuries; therefore, prosecution was declined. Father was substantiated for Bizarre Treatment by Shaking and entered on the Child Protection Registry at level III. The case was transferred to treatment for ongoing services. Parent Aide services were provided. There was no prior DFS history with the family and neither parent had significant criminal history.

### **System Recommendations/Findings**

1. The Panel identified the following strengths: clear documentation was found in the medical record that both parents received the Abusive Head Trauma education; a forensic interview was conducted with the fifteen year-old sibling that witnessed the incident; and DFS accepted the investigation and transferred the case to treatment. *(from Initial/Final Review)*
2. CDNDSC shall send a letter to the child's Primary Care Physician and Practice relaying concerns regarding transportation difficulties of child(ren) by parent(s) when there is a suspicion of child abuse and/or neglect and it is believed that the abuse and/or neglect was inflicted by the parent(s) and/or caretaker(s). *(from Initial/Final Review)*

### **15. Case 9-03-15-00008: G.F. (Date of Birth: Sept. 2012; Date of Incident: Feb. 2013, Near Death) \*Sibling to Case 9-03-2015-00009**

In October of 2012, a referral was made to the DFS Report Line regarding a one-month-old male infant. Mother had recently given birth, and the reporter was concerned that the Victim remained in the home with the parents after they were charged and convicted of abusing their older children (case 9-03-2015-00009). The DFS case regarding this prior incident was closed since the children were in the care of their paternal grandfather. Although there was no substantial evidence of abuse or neglect, the case was accepted for investigation by DFS. A collateral contact with the primary care physician revealed that the infant had webbed feet and was not up to date on immunizations. The investigation revealed no safety concerns for the infant. In January of 2013, the case was unsubstantiated and closed.

A second referral regarding the now five-month-old infant was received by DFS in February of 2013. The reporter expressed concern of the infant being underweight and failing to thrive. It was alleged that Mother oversleeps and forgets to feed Victim. A collateral contact with the primary care physician revealed that Victim dropped from the 45<sup>th</sup> to the 3<sup>rd</sup> percentile for height and weight in four months. He had not been seen since the two week visit, but on the date of the incident, Mother brought him in. Victim was noted to be lethargic and not very attentive. After having contact with Mother's probation

officer and finding additional concerns, DFS filed for custody and Victim was placed into foster care.

The next day, Victim was admitted to the children's hospital for testing after being referred to the CARE program. He was diagnosed as medically complex as a result of the following issues: deletion of chromosome 16; astigmatism, unspecified; myopia; delayed milestones; multiple congenital anomalies; webbed toes of both feet; child abuse, neglect; geographic tongue; short stature; rib deformity - right 4th rib; and congenital deformity of wall of paranasal sinus.

Law enforcement was not involved in this case. At the conclusion of the DFS investigation, Mother was substantiated for neglect, and she was entered on the Child Protection Registry at level II. Victim was adopted in February of 2015.

### **System Recommendations/Findings**

1. The Panel identified the following strengths: the Family Court ruling was very well written alleviating DFS of planning for reunification; second DFS investigation in February of 2013 was accepted with a priority response; excellent collaboration between OCA and DFS; probation officer was in communication with DFS; the DFS caseworker was given the wrong address, but was diligent about finding the correct address; Criminal DAG really pushed for and was committed to ensuring the safety and well-being of all three children; and a CARE Team consult occurred (*from Initial/Final*).
2. With obvious signs of a physical disability during the October of 2012 investigation, the child was not referred to Child Development Watch per policy by the DFS caseworker (*from Initial/Final*).
3. The entity which had firsthand knowledge of the incident, the school's Family Crisis Therapist, should have made a report to the DFS Report Line (*from Initial/Final*).
4. Non-compliance with medical care for the infant was not addressed prior to case closure following the October of 2012 report (*from Initial/Final*).
5. History was not properly utilized in assessing safety prior to closing the investigation case in January of 2013 (*from Initial/Final*).
6. PCP noted no medical concerns in the October of 2012 investigation despite not having seen the infant for two months. Given the history with the family, when the infant did not show for his two-month check-up, the primary care physician should have contacted the DFS hotline (*from Initial/Final*).
7. Collateral contact with maternal grandmother was not appropriate as the family resided with the grandmother (*from Initial/Final*).
8. DFS does not have the ability to document legal findings in FACTS to inform decision making on future cases. A significant legal finding was documented regarding the Victim in a court order for the sibling that was not a Termination of Parental Rights Order (*from Initial/Final*).

**16. Case 9-03-15-00009: H.S. (Date of Birth: Aug. 2006; Date of Incident: July 2012, Near Death) \*Sibling to Case 9-03-2015-00008**

In July of 2012, law enforcement and DFS responded to a home to check on the welfare of a five-year-old female child. This check was in response to allegations of abuse and neglect suspected by the paternal grandfather after Victim's Mother refused to allow the child to accompany him on a scheduled visitation. Victim was found in her bedroom after Mother denied she was present. Victim appeared to be malnourished and wearing filthy clothing; she presented with bruises on her arms, legs and face. She disclosed that for punishment, her parents used spanking, locking her in the bedroom, and sometimes tied her to the dresser with a pair of child's tights. Meals consisted of bologna or peanut butter & jelly sandwiches, and Mother reportedly force-fed her when she would not eat the sandwiches. Mother also bit Victim's thumb on one such incident, causing a break/crush injury to the thumb. Victim's Step-Father participated in the abuse as well. Victim's older sibling, was also present and physically abused, but to a lesser extent. Both Victim and her sibling had forensic interviews and disclosed the abuse.

Following the incident, the grandfather filed an ex parte petition for guardianship; however, it was denied as Father was living in the home thus no emergency existed. Mediation occurred and a consent order was entered granting the grandfather temporary guardianship. Mother was not permitted visitation due to her ongoing criminal investigation.

Mother was substantiated for Abuse/Bone fracture and Severe Physical Neglect, and she was entered on the Child Protection Registry at level IV. Step-Father was substantiated for Neglect/Lock-In or Out, Ages 0-6, and Severe Physical Neglect, and he was entered on the Child Protection Registry at level IV.

Criminally, in January of 2013, Mother pled guilty to Unlawful Imprisonment 2<sup>nd</sup>, two counts of misdemeanor EWC and Assault 3<sup>rd</sup>. She was sentenced to one year Level V suspended for one year Level II for each charge, to be served concurrently. In December of 2013, Mother violated her probation and was sentenced to 11 months Level V suspended for 11 months Level III TASC for the Unlawful Imprisonment charge, and one year Level V suspended for one year Level III TASC for the three remaining charges. In March of 2014, she received a subsequent violation of probation and was sentenced to 11 months Level V w/credit given for service of 22 days, the balance suspended to Level IV Residential Substance Abuse Treatment, after successful completion, balance suspended for 11 months Level III Aftercare, for the Unlawful Imprisonment charge, and one year Level V suspended for 1 year Level III TASC for the three remaining charges.

Step-Father pled guilty to Unlawful Imprisonment 2<sup>nd</sup> and two counts of misdemeanor EWC. He was sentenced to one year Level V suspended to six months Level IV followed by six months Level III for the Unlawful Imprisonment charge, and one year Level V suspended for one year Level III, to be served concurrently, for the remaining two charges.

**System Recommendations/Findings**

1. The Panel identified the following strengths: the Children's Advocacy Center did an excellent job with the children's forensic interviews, and the interviews were conducted immediately following the reported incident; thorough medical evaluation

was conducted at the emergency department following the December 2012; and the Criminal DAG really pushed for and was committed to ensuring the safety and well-being of all three children (*from Initial/Final*).

2. The child's Family Court case file should be flagged with an indicator of history, so that such information can be properly assessed for any subsequent filings related to the child and a decision made whether such filings should be scheduled for mediation or be referred to a Judicial Officer. Furthermore, it is recommended that the Family Court Judge presiding over the sibling's case take judicial notice and have the Order dated April of 2014, which finds torture committed against this child, become part of Victim's Family Court file to connect the child, sibling, and family history. Also, there was a period (July through November) in which the children did not have legal guardians because DFS did not file for custody and grandfather had not yet received guardianship. The guardianship filing was resolved at mediation. The panel was concerned that the parties could have agreed to dismiss the petition at mediation and DFS was not a party to the case (*from Initial/Final*).
3. DFS does not have the ability to document legal findings in FACTS to inform decision making on future cases. A significant legal finding was documented regarding the Victim in a court order for the sibling that was not a Termination of Parental Rights Order (*from Initial/Final*).
4. There was no home assessment completed of the grandfather's home until four days following placement of the girls (*from Initial/Final*).
5. The child was interviewed by the DFS caseworker at the hospital in the presence of her mother (*from Initial/Final*).
6. Despite the history of chronic abuse, the criminal sentencing for both parties was suspended to probation, even after multiple violations of such probation. Given the nature of the charges, the Panel felt that the parents should have received stricter penalties (*from Initial/Final*).
7. Mother was seven months pregnant at the time of this investigation and was found guilty of abusing her two children; however, no referral was made to a home visiting program for ongoing services for the mother in relation to the unborn child (*from Initial/Final*).
8. There is no mechanism in place for hospitals and DFS to communicate in cases where a child is born to parents who have had parental rights terminated, been found guilty of abuse, etc. No recourse for DFS involvement until an incident of abuse or neglect occurs (*from Initial/Final*).