



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

CAPTA¹ REPORT

In the Matter of
Alexandra Borgotti
Minor Child²

9-03-2009-00001

January 22, 2010

¹ The federal Child Abuse Prevention and Treatment Act requires the disclosure of facts and circumstances related to a child's near death or death. 42 U.S.C § 5106 a(b)(2)(A)(x). See also, 31 Del.C. § 323 (a).

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

Background and Acknowledgements

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

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

Summary of Incident

The case regarding Alexandra Borgotti was reviewed by the Child Abuse and Neglect Panel in 2009, as a near death incident. The case resulted in the near death of the child due to physical abuse, perpetrated by the father. At the time of the alleged incident the child was nine and one-half weeks of age and primarily resided with her father.

On the day of the alleged incident the child’s father called 911 stating that the child had choked while feeding and was limp and unresponsive. Emergency services arrived at the father’s residence and transported the child to the hospital. During transport, it was noted by paramedics that the child was experiencing seizures. Upon arrival at the hospital and after initial evaluations were completed, the child was found to be suffering from severe brain trauma including, subdural hematomas, subarachnoid hemorrhage, bilateral retinal and macular hemorrhages. Also noted were contusion of the eyelids and periocular area, healing right forearm burns, right femur fractures, bilateral tibial fractures, fracture of the left, first metacarpal, anemia, and dehydration. After being intubated and placed on a ventilator, the child was admitted to the Pediatric Intensive Care Unit (PICU) for further evaluation and treatment. Five days after being admitted to the PICU, the child was transferred to the General Pediatric floor. At that point, the child was breathing on her own, but she was being fed through a tube placed into her gastrointestinal tract and continuing to have seizures. Additional diagnoses resulting from the physical findings consistent with Abusive Head Trauma included diffuse axonal injury, cortical blindness, seizure disorder, swallowing dysfunction and gastroesophageal reflux, left upper extremity weakness, nutritional neglect and global developmental delays.

During the child’s stay at the hospital the child’s mother, father, and paternal grandmother were present. It was noted by hospital staff that the paternal family was extremely confrontational; however, the child’s father presented as honest and concerned for his daughter’s well-being. The child’s mother showed no affect.

Upon investigation by the police, it was found that the father and mother were in a stable relationship but living apart due to family discord and financial stressors. The child’s paternal aunt, with whom the father was living, informed the investigating officers that the father’s ability to care for the child was extremely concerning. The paternal aunt

stated that the child has presented with black eyes in the past and that she often heard muffled cries at night when the child was under the father's care. When the investigating officers questioned the child's father, he denied inflicting any bodily harm to the child and agreed to take a polygraph. The father denied being frustrated that he was the primary caretaker and stated that the relationship between him and the child's mother was in good standing. During the polygraph, father remained composed and was able to provide a great deal of information. Father presented as well spoken and knowledgeable about the care and needs of the child. The child's mother also agreed to take a polygraph, where she presented as upset and confused about the child's injuries.

Two days after the child's near death, the father admitted to the investigating police agency that he had shaken the child with great force on more than two occasions. The father also admitted to throwing the child over his shoulder and onto a hardwood floor. The father stated that his reasoning for inflicting such injuries was due to the child's continuous crying and his rising level of frustration.

The Department of Services for Children, Youth & Their Families (DSCYF) was granted custody of the child, four days after the near death incident, based upon the father's confession and the mother's inability to care for the child. The mother showed no understanding of the child's condition and prognosis, and her ability to make sound medical decisions regarding the child's safety and overall well-being were in question. In the days following the investigation, the Division concluded that placement of the child with the paternal aunt was also inappropriate due to the paternal aunt's failure to report the abuse that had occurred in her home. The child's mother agreed to DSCYF custody and the child was placed in foster care.

The father was substantiated for three different level four findings on the Child Protection Registry. Additionally, the father was charged with one count of Assault by Abuse and Neglect, a felony offense. He was sentenced to 7 years in prison. At the time of the child's placement in foster care, it was noted that the child had made only minimal developmental improvements. A Family Service Plan was established and agreed upon by the child's mother and DFS outlining what is expected of the mother and implementing supervised visitations, until otherwise determined.

System Recommendations

The following recommendations were put forth by the Commission:

- (1) CDNDSC supports the vigorous enforcement of the Department of Justice's legislation (SB 110) to increase the penalty for those who fail to report child abuse and neglect and to change it from a criminal to civil penalty.
 - a. *Rationale:* If the paternal aunt had been aware of the duty to and the increased penalty for not reporting child abuse, she may have been more likely to report the suspected abuse occurring in her own home. If she had reported the suspected abuse of the child, then the appropriate agencies would have been notified and earlier intervention would have been provided. Since the aunt failed to report the

suspected abuse, the child continued to reside in an unsafe environment and this led to the child sustaining life threatening injuries.

- b. *Anticipated Result:* To create awareness and raise the recognition of the level of their responsibility among agencies and the lay public for reporting cases of suspected child abuse and neglect.
- c. *Responsible Agency:* DOJ

(2) CDNDSC supports the legislation to amend Title 16 of the Delaware Code relating to the penalties for failing to report suspected child abuse and/or neglect. This legislation converts the criminal action for failure to comply with the mandatory reporting of suspected child abuse into a civil action with financial penalties. Whomever violates §903 of this Title shall be liable for a civil penalty not to exceed \$5,000 for the first violation, and not to exceed \$50,000 for any subsequent

- a. *Rationale:* If the paternal aunt had been aware of her duty to report the suspected abuse, then the near death incident may have been averted.
- b. *Anticipated Result:* To create awareness and raise the level of recognition of their responsibility among agencies and the lay public for reporting cases of suspected child *abuse and neglect*.
- c. *Responsible Agency:* CDNDSC and CPAC

Ancillary Factors³

The following ancillary factors were identified and will be evaluated by CDNDSC for possible action:

(1) CDNDSC supports Prevent Child Abuse Delaware's efforts to improve Shaken Baby Syndrome education in Delaware.

- a. *Rationale:* If proper education on Abusive Head Trauma/Shaken Baby Syndrome had been provided to parent(s) then the near death of this child may have been prevented.
- b. *Anticipated Result:* To create awareness among parent(s) through education in order to prevent future deaths and/or near deaths that result from Abusive Head Trauma/Shaken Baby Syndrome.
- c. *Responsible Agency:* CDNDSC

³ In some cases there may be no system practices or conditions that impacted the death or near death of the child; however, if the Panel determines that there are ancillary factors which impact the safety or mortality of children, those factors are compiled by CDNDSC staff and presented at least annually to the Commission for possible action.