



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

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

In the Matter of  
Caleb Galbin  
Minor Child<sup>2</sup>

9-03-2010-00006

April 18, 2013

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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).

<sup>2</sup> 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 and create multi-faceted recommendations to improve systems and encourage interagency collaboration to end the mortality of children in Delaware.

## **Case Summary**

The child who is the subject of this review, Caleb Galbin, was born in December 2008 to Joann Thomas and Carl Galbin. Caleb was born at 39 weeks gestation, weighing eight pounds and five ounces. Following his birth, Caleb was admitted to the Neonatal Intensive Care Unit (NICU) for respiratory distress. He remained in the NICU for 48 hours due to concern of sepsis and was subsequently discharged to the care of his mother on day three of life.

In August 2009, at nine months of age, Caleb presented to the Emergency Department with a soft fluid filled area noted on the left side of his skull. A computed tomography (CT) scan of his head was completed and demonstrated a left linear skull fracture with an overlying subgaleal hematoma and small subarachnoid hemorrhage. A skeletal survey was also completed and revealed a possible rib fracture with new bone formation and calcification, suggestive of a healing fracture, as well as a fracture to Caleb's lower right arm.

## **Mother's History:**

In 2003, mother, Joann Thomas, was active as a child with the Division of Family Services (DFS). A report was received by the DFS' Child Abuse Reportline alleging emotional neglect of Joann by her biological mother. It was reported that Joann had run away due to drug activity that was occurring in her home. Based upon interviews and collateral contacts, it was determined that Joann was experiencing adolescent adjustment problems. The allegations of emotional neglect were not substantiated and therefore the case with DFS was closed.

That same year, DFS received another referral stating that Joann's behaviors were becoming more problematic and relatives were not willing to care for Joann at that time. The case was substantiated for dependency and Joann entered care. Custody and limited

guardianship of Joann was awarded to a family friend and services were put in place. The case was eventually closed as all risk contributors no longer existed.

It was further noted that in 2003, Joann was placed on probation for twelve months, level II, as a result of fighting. In 2006, she was arrested for robbery 2<sup>nd</sup> and conspiracy 2<sup>nd</sup>. Joann was detained for twenty-four hours and upon her release all charges were dismissed.

### **Father's History:**

Father, Carl Galbin, had no history with the Division as a child. However, Carl did have history with Youth Rehabilitative Services. Such history stemmed from 2001 to 2005, and consisted of criminal trespassing and substance abuse issues. Carl was placed on probation and received substance abuse prevention counseling. In 2004, Carl was ordered to level III probation until his 19<sup>th</sup> birthday for failing Drug Court, as he was unable to remain clean. The case was closed when Carl reached his maximum discharge date with little to no success.

### **Caleb's Near Death Event**

On the day of Caleb's near death event, in August 2009, DFS received an urgent referral to the Child Abuse Reportline alleging the physical abuse of Caleb. That morning Caleb was seen by his primary care physician (PCP) for concerns of an ongoing cold and recent bump observed on his head. Caleb's physician determined that further examination was needed and, therefore, Caleb was sent to the Emergency Department of a children's hospital for further examination. Transportation to the Emergency Department was provided by Caleb's mother. Caleb's formal diagnosis was a left posterior skull fracture with a subarachnoid hemorrhage and a perostial reaction to the proximal right ulna. A suspicious area was also observed in Caleb's ribcage that was labeled as a possible left rib fracture. However, upon further examination, it was determined that the area was actually congestion in his lungs as he was diagnosed with Bronchitis.

It was further noted that Caleb's father had been uncooperative and hostile while at the children's hospital. It was reported that Caleb's father had grabbed Caleb's leg, turned Caleb over using Caleb's leg and then grabbed Caleb by the rib area while yelling that Caleb was fine. Hospital security was called in order to deescalate the situation, but father left the hospital proximity and did not return.

Caleb was observed by the Child Abuse Expert where it was determined that the skull fracture and the fracture to the right arm occurred on two different occasions, and that each occasion could have occurred within two weeks of one another. Additionally, the Child Abuse Expert stated that the explanation given by Caleb's mother and father was not consistent with Caleb's injuries. The Child Abuse Expert explained that Caleb's fall from a standing or seated position would not be a plausible explanation as to how he received his injuries, as such a fall would not be severe enough to result in a skull fracture.

Law enforcement was contacted by DFS and advised of the situation. An investigation was opened regarding the suspected abuse of Caleb and the initial findings were obtained from medical personnel.

Shortly after Caleb's admission to the children's hospital, in September 2009, DFS petitioned for and was granted custody of Caleb. In addition, the Court appointed a guardian *ad litem* to represent Caleb's best interests.

Soon after, a petition for guardianship was filed by Caleb's paternal grandparents. However, such petition was denied based upon paternal grandparent's history of domestic violence, drug abuse, mental health issues, and history with DFS.

Two days after Caleb's near death incident, mother, Joann, was interviewed by law enforcement. Mother advised that she has been with Caleb's father for four years and that they have a good relationship. Mother reported that two days before Caleb was taken to his PCP, Caleb fell while at the residence. Caleb had been crawling for approximately one month and had recently begun to pull himself up from a seated position using furniture. Mother recalled that Caleb had been doing this for about three weeks. On the day of the incident, mother reported that Caleb had been crawling around while mother was in the kitchen washing dishes. It appeared that while Caleb was crawling he may have sat up and fell backwards, possibly hitting his head on a nearby cabinet. Mother was unable to provide any further explanations as it pertained to Caleb's injuries. Mother stated that neither she nor father would intentionally cause harm to Caleb. Mother also reported that Caleb cries a lot which requires him to be held constantly. Mother advised that father's daughter, who is two years of age, has a tendency to play rough with Caleb, often bending his arms back and forth. Mother admitted to being the primary caretaker of Caleb. However, she noted that Caleb was also under the care of his paternal grandparents, cousin, and father.

That same day, law enforcement also interviewed Caleb's father, Carl Galbin. Carl informed law enforcement that he and Caleb's mother live with Caleb's paternal grandparents. When questioned about how Caleb received his injuries, Carl advised law enforcement that two days prior to the Emergency Department visit, Carl was watching Caleb outside and had placed Caleb on an outside deck to play. Carl reported that Caleb was crawling around, sat up and then fell backwards onto a step hitting his head. Caleb cried for some time, but did not appear to be injured. Carl had been informed that Caleb had a bump on his head shortly thereafter where it was then determined by both mother and father that Caleb would be taken to his PCP Monday morning.

Caleb's father admitted to having anger issues; however, he denied ever shaking or hitting his son. Father admitted that he becomes frustrated when Caleb cries and cannot be soothed, but he would never harm his son due to his crying. When asked if there were any other accounts in which Caleb may have been injured, father advised that his daughter often plays with Caleb and can be rough with him.

Carl was questioned further as it pertained to the incident at the hospital when father was viewed as acting inappropriate toward Caleb. Carl stated that while at the hospital he was overwhelmed and frustrated. During that time, Caleb was sitting on his lap while feeding, Caleb's leg had fallen off Carl's lap and Carl picked Caleb's leg up and placed it back on his lap. Carl recounted that at no point in time did he twist Caleb or hold Caleb around his rib cage. Carl did admit to be extremely frustrated upon arrival to the hospital and finding out his son's condition, but he did not hurt his child while at the hospital.

After mother's and father's interview, law enforcement noted that mother and father gave two separate accounts of how Caleb received his injuries and that neither parent was aware of the others account. Thus, creating an inconsistency and need for further follow up. Law enforcement also noted that mother and father were quick to conclude that father's two year old daughter often plays rough with Caleb and therefore, could have caused the injuries. However, parents were informed that the rough behavior between Caleb and the two year old did not explain the injuries sustained by Caleb.

Eight days after the interviews of Caleb's mother and father, Caleb's paternal grandmother was also interviewed via telephone by law enforcement. Paternal grandmother informed law enforcement that she was aware that Caleb had fallen twice, once inside the residence and the other outside of the residence. Paternal grandmother further advised that when Caleb fell outside she directly observed the incident. Paternal grandmother stated that Caleb's sibling can at times be rough and has been told on numerous occasions to stop pulling Caleb. Paternal grandmother was unable to provide any further information.

Upon completion of the interviews, law enforcement determined that there was no suspicion of any criminal intent, by the parents, to hurt Caleb. Parents were advised that they need to provide closer supervision as it pertains to the interaction of Caleb's two year old sibling, so that the sibling is not pulling on Caleb's arms and legs. Criminal charges were not sought in this case and the investigation was closed and referred to DFS for further follow up with the family.

Within DFS, the case was transferred to treatment, so that Caleb's mother and father could receive the necessary services in order to safely reunite Caleb. The DFS investigation resulted in both mother and father being substantiated for physical neglect.

In December 2010, Caleb was placed back in the home of Joann Thomas and Carl Galbin. Parents had successfully completed their respective case plans and continued to remain cooperative. Two months later, in February 2010, the Court found that Caleb was neither dependent, neglected or abused and that it was in Caleb's best interest for custody to be rescinded to his parents, Joann Thomas and Carl Galbin.

## **System Recommendations**

After review of the facts and findings of this case, the Child Abuse and Neglect Panel determined that all systems did not meet the current standards of practice and therefore the following system recommendations were put forth:

### **DEPARTMENT OF JUSTICE:**

1. CDNDSC recommends that a multidisciplinary team approach be used when conducting criminal and/or civil investigations, so that communication as to the circumstances of the incident and the injuries sustained by the child can be made known immediately and properly discussed with medical personnel, law enforcement, the Division of Family Services (DFS), and the Department of Justice (DOJ).
  - a. Rationale: In regard to this case, child's parents were interviewed by law enforcement two days after the alleged near death incident. Upon review of the documentation provided, it does not appear that the DFS caseworker was afforded the opportunity to observe the interviews. Also, prior to the interview, it does not appear that contact was made by law enforcement to Delaware's Child Abuse Expert in order to determine the likelihood of how the child received such injuries.
  - b. Anticipated Result: The use of a multidisciplinary team approach when conducting investigations where the allegation is physical abuse.
  - c. Responsible Agency: Delaware Police Departments, Department of Services for Children, Youth and Their Families, DOJ, and Medical Personnel

### **DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES:**

2. CDNDSC recommends that a multidisciplinary team approach be used when conducting criminal and/or civil investigations, so that communication as to the circumstances of the incident and the injuries sustained by the child can be made known immediately and properly discussed with medical personnel, law enforcement, the Division of Family Services, and the Department of Justice.
  - a. Rationale: In regard to this case, child's parents were interviewed by law enforcement two days after the alleged near death incident. Upon review of the documentation provided, it does not appear that the DFS caseworker was afforded the opportunity to observe the interviews. Also, prior to the interview, it does not appear that contact was made by law enforcement to Delaware's Child Abuse Expert in order to determine the likelihood of how the child received such injuries.
  - b. Anticipated Result: The use of a multidisciplinary team approach when conducting investigations where the allegation is physical abuse.
  - c. Responsible Agency: Delaware Police Departments, Department of Services for Children, Youth and Their Families, DOJ, and Medical Personnel

### **LAW ENFORCEMENT:**

3. CDNDSC recommends that a multidisciplinary team approach be used when conducting criminal and/or civil investigations, so that communication as to the circumstances of the incident and the injuries sustained by the child can be made known immediately and properly discussed with medical personnel, law enforcement, the Division of Family Services (DFS), and the Department of Justice (DOJ).
  - a. Rationale: In regard to this case, child's parents were interviewed by law enforcement two days after the alleged near death incident. Upon review of the documentation provided, it does not appear that the DFS caseworker was afforded the opportunity to observe the interviews. Also, prior to the interview, it does not appear that contact was made by law enforcement to Delaware's Child Abuse Expert in order to determine the likelihood of how the child received such injuries.
  - b. Anticipated Result: The use of a multidisciplinary team approach when conducting investigations where the allegation is physical abuse.
  - c. Responsible Agency: Delaware Police Departments, Department of Services for Children, Youth and Their Families, DOJ, and Medical Personnel

### **MEDICAL**

4. CDNDSC shall send a referral to the Department of Justice (DOJ) as it pertains to the failure to report on behalf of the child's primary care physician (PCP).
  - a. Rationale: Child was seen by his PCP on 8/31/09, where the PCP was suspicious about the child's presentation and the parent's account of the alleged incident. Due to concerns by the PCP, the child was sent to a children's hospital for a computed tomography scan to rule out cephalohematoma. The PCP suspected abuse hence the referral to the children's hospital, but failed to contact the DFS Child Abuse Reportline as mandated in 16 Del. C. § 903, 904, 905 and 24 Del. C. §1731A(a).
  - b. Anticipated Result: Compliance with Delaware law when abuse is suspected.
  - c. Responsible Agency: DOJ
5. CDNDSC shall send a letter to the child's Primary Care Physician and Practice stating concerns regarding the transportation 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).
  - a. Rationale: Child was seen by his PCP on 8/31/09, the PCP was suspicious about the child's presentation and the parent's account of the alleged incident. Child was transported via parents to a children's hospital for further evaluation. In this scenario, the PCP left it up to the parents to

- provide transportation when an alternative transportation service should have been sought.
  - b. Anticipated Result: When a child is examined at a PCP office and abuse is suspected, but further examination is necessary, that parents not be used to provide such transportation and instead alternative transportation service be acquired.
  - c. Responsible Agency: PCP
- 6. CDNDSC recommends that a multidisciplinary team approach be used when conducting criminal and/or civil investigations, so that communication as to the circumstances of the incident and the injuries sustained by the child can be made known immediately and properly discussed with medical personnel, law enforcement, the Division of Family Services (DFS), and the Department of Justice (DOJ).
  - a. Rationale: In regard to this case, child's parents were interviewed by law enforcement two days after the alleged near death incident. Upon review of the documentation provided, it does not appear that the DFS caseworker was afforded the opportunity to observe the interviews. Also, prior to the interview, it does not appear that contact was made by law enforcement to Delaware's Child Abuse Expert in order to determine the likelihood of how the child received such injuries.
  - b. Anticipated Result: The use of a multidisciplinary team approach when conducting investigations where the allegation is physical abuse.
  - c. Responsible Agency: Delaware Police Departments, Department of Services for Children, Youth and Their Families, DOJ, and Medical Personnel

**STATEMENTS OF SUPPORT:**

1. CDNDSC supports the continued training of medical professionals on Child Abuse Identification and Reporting Guidelines.
2. CDNDSC supports the research efforts of the Child Protection Accountability Commission (CPAC) in their efforts to create a more stringent criminal statute for child abuse.