



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

CAPTA¹ REPORT

In the Matter of
J.A.
Minor Child

9-03-2012-00027

February 20, 2015

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

Background and Acknowledgements

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

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

The case information presented below is based on documents reviewed from the treating hospitals, the Department of Services for Children, Youth and Their Families, the Office of the Child Advocate, Family Court, Law Enforcement, and the Department of Justice.

Case Summary

The child who is the subject of this review, J.A., was born in October 2010 to Mother of the Baby (MOB); J.A. was born full term via cesarean section. Immediately following birth, child was admitted to the Neonatal Intensive Care Unit (discharged after 3 days) for multiple brown Nevi (sharply-circumscribed and chronic lesions of the skin, commonly known as birthmarks and/or moles). Subsequently, child was diagnosed with benign Melanocytic Nevi.

In December 2010, the Division of Family Services’ (DFS) Child Abuse Report line received an urgent referral alleging the physical abuse of J.A. Reports indicate that J.A., who at the time was two months of age, presented to the Emergency Department for head trauma. The parents had no explanation for how the injury occurred and reported no head trauma.

MOB’s History

At the time of the review, there was no history involving the MOB, MOB, and/or her family with the Division. There was also no criminal history involving the MOB.

FOB’s History, FOB of the Baby (FOB):

At the time of the review, there was no history involving the FOB and/or his family with the Division. There was also no criminal history involving the FOB.

J.A.’s Near Death Event:

In November 2010, J.A., at approximately one month of age, was admitted to the hospital after an episode of apnea requiring cardiopulmonary resuscitation (CPR). As reported by FOB, the infant was placed in a swing approximately one hour after feeding due to continued fussiness. J.A. continued to cry, so FOB took him out of the swing and gave him to MOB. MOB placed the infant over her shoulder, and he went quiet and limp. She noted that his lips were blue and his face was pale. She and FOB took the infant to the house located next door; the neighbor was a registered nurse. Emergency Medical Services (EMS) was called and the nurse performed CPR on the infant for approximately 3 to 5 minutes; he began to breathe on his own prior to EMS arrival. The infant was transported to the hospital. Emergency room staff noted that upon arrival the infant was pale but awake. A two-view “babygram” x-ray was completed and read as normal.

The infant was admitted with a diagnosis of Gastroesophageal Reflux Disease and Apnea. The infant had a full sepsis workup, which included a spinal tap and electrocardiogram (EKG). Neither a magnetic resonance imaging (MRI) nor a skeletal survey was done by the hospital and no explanation was found for the incident. The infant was discharged on Zantac and an apnea monitor.

A follow up with J.A.'s primary care physician (PCP) occurred in November 2010. It was noted that on this same day the parents also changed the infant's PCP. No indication as to why this change occurred was noted within the medical chart; however, the parents later admitted to DFS' case worker that they were dissatisfied with the original PCP. The infant was also seen by the original PCP twice in October and once in November 2010. Telephone calls by the MOB and FOB were placed to the PCP's office once in October and twice in November. The new PCP saw J.A. for his first visit at his two-month well baby check-up in December 2010. His parents reported a concern of a bruise on his thigh which had been there for approximately two weeks. The bruise was diagnosed as a patch of eczema. His parents further reported that the child suffers from reflux and is being treated with Zantac. Upon physical examination, the PCP noted that the child's head circumference was 44 centimeters, which was a significant increase from previous measurements, as noted at his one-month well baby check-up. An ultrasound of the infant's head was ordered and scheduled for late in December at the children's hospital.

At this visit at the Children's Hospital, the infant was referred to the Emergency Room (ER) from Radiology following the finding of a subdural hematoma on a cranial ultrasound. Child was admitted and further examination showed retinal hemorrhages. Magnetic resonance imaging (MRI) of the brain showed chronic subdural hematoma, small retinal hemorrhages and bilateral subacute cerebellar hemorrhages. A skeletal survey and lab workup yielded negative results. A consult was completed with neurosurgery and ophthalmology. It was noted that the infant was suffering from chronic subdural hematoma where layering was present, indicating non-accidental trauma and more than one incident of trauma.

An urgent referral alleging abuse/head trauma was called in to the Division's Child Abuse Report line by the Children's Hospital staff. The staff felt the infant's injuries were overwhelmingly suspicious and the parents had no explanation for how the injuries may have occurred. They reported no head trauma. The parents stated that only the four of them (MOB, FOB, infant, and older sibling, who is one year and eleven months old) live in the home. They had a nanny who came into the home three days per week for approximately six to seven hours per day to assist with the children. Although the MOB was still at home on maternity leave, she did not want to let the nanny go in fear that she would find another job and not return when the MOB was ready to go back to work. The FOB worked from home. The children were not in daycare. There were also two other females (nursing students) that babysit the children on occasion but it was infrequent. Communication between medical personnel and the parents, along with maternal grandmother (MGM) was difficult. Once the suspicion of abuse was raised, the parents immediately became abrasive and adamant about transferring the infant to another hospital, out of state, for a second opinion. Law enforcement was also contacted regarding the incident.

An initial interview was conducted with the maternal grandparents (MGP) by law enforcement and DFS' case worker. The MGPs spoke of the November incident where J.A. stopped breathing and was taken to the hospital. They stated that the parents became very upset with the infant's PCP because she never came to the hospital to check on the child, she never called about him, and when the parents passed her in the hallway, she did not ask how he was.

The MGP's noticed the infant's head grew significantly larger after that incident and seemed to be bigger each time they saw him. They were aware of the appointments with the PCP and the need for further testing of the child. They stated there have not been any falls with the infant as the MOB was very vigilante over him; she addressed each snuffle and cough, etc. They instructed the case worker and law enforcement to "do what they need to do."

An initial interview was conducted separately with the parents by law enforcement and DFS. They both spoke of the November incident. Neither parent could provide an explanation of how the most recent injury occurred. The MOB stated she could not imagine anyone hurting the child. The parents gave permission for law enforcement to search their home and for detectives to take pictures.

Upon consult with the doctor at the children's hospital, the MRI scans confirmed old subdural collections. There are retinal hemorrhages in both eyes that appear to be approximately six to eight weeks old. The skeletal survey is normal – no fractures. He stated that subdural hematomas are not generally symptomatic of choking babies or reflux. Given the timeframe that the original event occurred in November, they may never know what happened or by whom due to the initial treating hospital not conducting any brain imaging. The location of the old blood indicated shaking but this collection can also occur by a head injury to the top of the head.

Doctors recommended that a shunt be placed in the infant's head to remove the fluid; they would like to perform the procedure on Monday. The parents opposed the procedure and again requested that the child be transferred to an out of state hospital, or they be allowed to take the infant home and return to the children's hospital on Monday.

The DFS case worker discussed the case with her supervisor and a safety plan was completed so that the infant could be discharged to the parents, with the maternal grandmother (MGM) supervising contact between the MOB and the children. The family would return on Monday for the necessary procedure. As all were preparing to leave the hospital, it was decided that the infant would remain in the hospital until the procedure on Monday. The infant's room was located directly in front of the nurse's station; they agreed the door to the room would remain open at all times and the FOB would remain at the hospital with the infant. The MGM agreed to follow the safety plan and supervise contact between the MOB and the older sibling in the home.

Law enforcement and the DFS case worker reported to the home and interviewed the nanny. She met the family through her MOB's business as a massage therapist. She had been working for the family since May 2009. She reported they were a fine family and the parents were wonderful with the children. She stated the parents take turns caring for the infant. The parents had a great marital relationship and there were no marital difficulties. She had also noticed the infant's head getting larger but stated he was growing all over; he was sixteen pounds and not even three months of age. She attributed the growth to the cereal added to the infant's formula to help reduce the reflux. She reported no problems having both parents in the home while she worked with the children. She was aware of the November incident but was not in the home when it occurred. While at the home, law enforcement took photos of the infant swing mentioned from the November incident, which was fully padded, and the infant's crib had bumper pads within the crib.

The hospital contacted the DFS case worker to address the infant's discharge. DFS understood that the child's discharge would not occur until the procedure on Monday; however, the hospital's position had changed and they were planning to discharge the infant. DFS

completed the safety plan whereby MGM would move into the family home and supervise all contact between the parents and children. The case worker conducted a home assessment with no significant findings. The safety plan was modified to include no unsupervised contact with the nanny as well; the safety plan was implemented. Law enforcement wanted no contact between the parents and children, and did not understand why this was not followed. The physicians never made a clear statement as to what caused the injury and there could have been 20 to 30 suspects as the family hosted a holiday party around the time of the November incident.

At this time the parents were insistent on taking the infant home. They refused to allow the doctor to perform the procedure on Monday since he reported the incident as abuse. During telephone contact between the case worker and the MOB, the MOB was frustrated as to why she was never told of the safety plan and she is just now receiving the order verbally. She did not understand why there was so much lack of communication. She felt the hospital judged them and was not giving them all of the medical information. Due to the MOB's refusal of the procedure, the case worker refused to allow the infant to be discharged without a procedure scheduled. The MOB became angry that the infant was supposed to be discharged the night before; however, the children's hospital kept him for observation. The case worker explained to the MOB that her child had a head injury, was hospitalized for a reason and she needed to stop minimizing the situation. The MOB gave the telephone to the MGM. The MGM did not understand why things were changed today; the case worker repeated the explanation to the MGM.

The DFS case worker and the doctor spoke on the telephone. The doctor explained a scheduling issue with the primary doctor being on vacation. She agreed to coordinate scheduling of the procedure, or at least a clinical follow-up until the procedure could be scheduled. The case worker reiterated that the infant could not be discharged until the procedure is scheduled but agreed to the follow-up clinical, if need be.

The case worker contacted the MOB and informed her of the hospital scheduling. She instructed the MOB to keep the appointment that is made for her; otherwise, DFS would make other arrangements for the care of the infant. The case worker spoke with the MGM advising her that the procedure would be performed on Monday by a different doctor.

The infant was discharged home into the care of his parents with MGM as the safety plan. The children's hospital nurse contacted DFS's Report line to inform them that the parents were instructed to call the hospital on Monday and the procedure would take place on Tuesday. The FOB did tell the nurse that he wanted the infant seen at another out of state hospital due to the allegations made against them by the children's hospital staff.

Two days later, the FOB contacted the DFS case worker because the infant had a runny nose and respiratory issues that were similar to the beginning stages of the original November incident. The DFS case worker instructed the FOB to take the infant to the emergency department, with the MGM present to comply with the safety plan. The FOB did such, and the infant was diagnosed with bronchitis and transferred to the children's hospital via ambulance. The FOB is upset that the children's hospital did not diagnose this while the child was admitted. He believed the combination of reflux and bronchitis caused the infant to stop breathing during the November incident. The hospital case worker permitted the parents to be at the hospital with the infant without the MGM present so long as medical personnel were present.

The next day, a meeting took place at the children's hospital, with the parents, two doctors and the case worker. The doctors agreed with the parent's decision to obtain a second

opinion at an out of state hospital; however, in all likelihood, the procedure would be performed at this children's hospital and was tentatively scheduled for three days later. The scheduling may also depend on the infant's congestion. It is explained that the surgery is not an emergency but it must be done. The MOB expressed her frustration with the lack of communication at the hospital, stating that she still did not clearly understand what was wrong with her son. The safety plan is revised to include both MGP's, the maternal aunt and the maternal uncle as supervisors.

The DFS case worker spoke privately with the doctor. He stated they will never know who did what or when. The nanny spent little time with the infant as her main duty was with the older child. Without having the brain imaging done when the first crisis occurred, all else was mere speculation. They do not know when the first brain bleed took place and who was with the infant at the time. Parents were appropriate and nothing stood out.

The DFS case worker updated law enforcement on the most recent events. The FOB contacted the DFS supervisor to inquire as to removing the nanny from the safety plan. She was the main caretaker for the older child and it was a major burden on the family not having her in the home to assist. The supervisor had to contact law enforcement to see where the investigation stood before doing so. The FOB also inquired about taking the infant to the out of state hospital. The supervisor saw no reason why they should not so long as someone from the safety plan is present.

The detective on the case stated that they suspected the FOB as the perpetrator; however, with limited evidence, they had little to go on. They expected there would be no criminal charges filed. The parents obtained an attorney; therefore, the detective could no longer speak with them without the attorney present.

The DFS supervisor contacted the FOB again to inform him that the nanny had been cleared and removed from the safety plan; she was allowed unsupervised contact with the children. The FOB informed the supervisor that the nanny had also obtained an attorney.

The DFS supervisor contacted the children's hospital case worker to obtain an update on the infant. The family was going to the out of state hospital. The children's hospital forwarded the medical records. This case worker informed the supervisor that she has had more and more contact with the parents lately and she had more concerns with them. She did not elaborate on specifics and the supervisor did not ask. The case worker felt the FOB was manipulative.

The family scheduled the procedure to be performed at the out of state hospital in January 2011. The hospital agreed to allow one parent in the room with the child without a designated supervisor from the safety plan. The nurses agreed to accept responsibility and understood that the parents were not to be left alone with the child.

The FOB informed the DFS supervisor that the procedure was a success. He was happy with the outcome but stated he would never return to the children's hospital. He stated they received more answers for their concerns of the infant's injuries in the short time at the out of state hospital than they received from the children's hospital. The infant was discharged in January 2011 and was doing well.

Criminal /Civil Disposition

Due to the nature of the case, intake was completed with the Attorney General's office; however, due to insufficient evidence of abuse, prosecution was declined by their office. The safety plan was canceled.

System Recommendations

After review of the facts and findings of this case, the Commission determined that all systems met the current standards of practice; therefore, no primary system recommendations were put forth; however, the following ancillary recommendation was put forth by the Panel.

Ancillary Recommendation

1. CDNDSC recommends that Divisions of Family Services' (DFS) caseworkers adhere to DFS policy regarding the use of collateral contacts when obtaining information pertaining to the child's health, safety, and well being.
 - a. Rationale: In this case, the DFS caseworker relied on information obtained from parents, the suspected perpetrators, regarding the child's medical status and how the child received his injuries. Follow up did not occur between with child abuse experts as it pertains to the child's injuries, nor did follow up occur with the treating hospital.
 - b. Anticipated Result: To ensure the safety and well-being of the child.
 - c. Responsible Agency: Division of Family Services