



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

CAPTA¹ REPORT

In the Matter of
Jeremiah Verbitsky
Minor Child²

9-03-2008-00004

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 Jeremiah Verbitsky is a near death incident that was reviewed by the Child Abuse and Neglect Panel in 2008. The near death occurred when the child was five months and eleven days of age due to physical abuse, perpetrated by the child’s mother. The injuries that the child sustained were believed to be non-accidental and a result of Abusive Head Trauma/Shaken Baby Syndrome. At the time of the near death, the child was residing in the home of the mother, father, and maternal grandparents.

On the day of the near death, the child was transported to the hospital via ambulance due to seizure activity with eye deviation and body stiffening. Further evaluation of the child demonstrated bilateral subdural hematomas at varying stages of healing, bilateral retinal and vitreous hemorrhages, and a healing fracture of the right femur. These injuries were noted upon completion of a CAT scan, fundoscopic exam, and skeletal survey. The child was admitted to the hospital and remained there for approximately fifteen days. The aging of the injuries indicated that there were at least two prior incidents, one occurring more than two weeks prior to the near death and one occurring not more than three days prior to the near death. The potential consequences from this type of injury may result in serious developmental delays, which might not be noticed until the child is of school age. The child underwent surgery six days after the near death in order to alleviate swelling on the brain and stabilize the amount of seizure activity that the child was experiencing. During the child’s stay at the hospital, the mother was noted to have a depressed affect and to be extremely detached.

Further inquiry as to the mother’s and child’s medical histories revealed that the child was born at thirty one weeks gestation and was of low birth weight. The child remained in the hospital Neonatal Intensive Care Unit for a period of four weeks. Although the child was six weeks premature, upon discharge, the child’s development was within normal limits. The child was sent home with an Apnea and Bradycardia monitor. Prior to the child’s birth, the mother received appropriate prenatal care, and was followed prenatally for choroid plexus cyst and large ventricles, and severe pre-eclampsia with underlying chronic hypertension. Prior to the mother’s conception it was noted that

she was a heavy smoker and obese. Records reveal that the mother was referred prenatally for nutrition, a social worker, and a smoking cessation program.

One month prior to the near death incident, the child's physician made a Hotline Report to DSCYF for concerns of neglect by mother. The physician was concerned because the child had a history of prematurity, was considered medically high risk, and had not been seen in the office for over 6 weeks. The Hotline Report was rejected and an investigation was not initiated.

After the near death incident, approximately fifteen days later, the child was discharged from the hospital and placed in the care of his maternal grandparents. The child was prescribed an anti-epileptic (Phenobarbital) and a medication to treat esophageal reflux (Zantac).

Investigation of the near death by the police agency revealed that the mother was the perpetrator of the child's injuries. The mother admitted to shaking the child out of frustration on two occasions. The mother was arrested and charged with Assault by Abuse and Endangering the Welfare of a Child, a felony offense. A no-contact order was put in place between the child and the mother. On July 7, 2008, mother pled guilty to Assault in the second degree, a felony offense. Sentencing was imposed on September 12, 2008. Mother was sentenced to 6 months, level IV home confinement followed by 1 year at level III probation. Mother was also required to undergo continuous mental health treatment until released, satisfactorily, from care.

Furthermore, the investigation conducted by the Division was closed with a finding of physical abuse. The mother was substantiated by the Division for physical abuse and was placed on the Child Protection Registry as a level four. It was also noted by the Division, that although the child's father was not the perpetrator in the near death, there was grave concern for the father's ability to assure for the overall well-being and safety of the child.

System Recommendations

The following recommendations were put forth by the Commission:

- (1) The Division of Family Services must ensure that employees are strictly following all policies and procedures during the hotline intake process, with particular attention to all risk factors, including the status of the reporter, with greater credibility assigned to professionals. CDNDSC notes that this recommendation has been made previously on several occasions by this Commission and other review bodies.
 - a. *Rationale:* If the hotline report had been accepted one month prior to the death and an investigation begun, then the risk of further abuse of the child may have become obvious to the DSCYF.
 - b. *Anticipated Result:* An increased protection of at risk children by relying on trained professionals as well as factors such as DFS history, age of a child, and caregiver's emotional state to guide the hotline intake process.
 - c. *Responsible Agency:* DSCYF

- (2) Medical professionals should be educated regarding DSCYF policy and procedures regarding mandatory reporting and they should be trained to provide the most significant information, when making a hotline report. Intake Workers should be trained to ask appropriate questions to assure that an appropriate importance is assigned to a report.
- a. *Rationale:* If the physician had been able to better articulate the special risk faced by this premature infant and his concerns of medical neglect, perhaps the hotline referral may have been accepted.
 - b. *Anticipated Result:* To increase the knowledge of medical professionals as to what constitutes appropriate hotline referrals and what information is most helpful. This will result in decreased misunderstandings by medical professionals and the Division of Family Services.
 - c. *Agency Responsible:* CPAC's Abuse Intervention Subcommittee