



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

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

In the Matter of  
M.L.  
Minor Child

9-03-2012-00029

February 10, 2015

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<sup>1</sup> The federal M.L. Abuse Prevention and Treatment Act requires the disclosure of facts and circumstances related to a M.L.'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 and presented from the treating hospitals, the Division of Family Services, the Office of the Child Advocate, Family Court, Law Enforcement, and the Department of Justice.

### **Case Synopsis**

M.L. was born via emergency cesarean section after induction of labor secondary to poor fetal growth at thirty-three weeks gestation, weighing four pounds three ounces. After birth, M.L. was admitted to the Neonatal Intensive Care Unit (NICU) due to low birth weight, temperature instability, and poor oral feeding. M.L. was discharged on the 16<sup>th</sup> day of life with an apnea and bradycardia monitor and on a high calorie formula.

In November 2009, M.L. (approximately five months old) was taken to the emergency department (ED) by M.L.’s FOB (FOB of baby) with a chief complaint of lethargy and “not breathing right.” FOB alleged that he had “slipped and fell while holding M.L. and her head hit tools.” FOB indicated that the incident occurred at about 1500 hours and M.L. had fallen about four feet, with no loss of consciousness, immediately crying afterward. M.L.’s Mother was working at the time of the alleged incident. In the ED, M.L. was noted to be crying, irritable, with periods of lethargy, pupils were four millimeters and non-reactive. She had paleness about her, an abrasion in her mouth on side of upper gums, laceration under the tongue, laceration to upper lip, and multiple bruises in various stages of healing on multiple surfaces of her body. The bruises were documented on her eyelids bilaterally, left frontal/temporal area, right forehead, right lower back, left upper chest, right thigh (anterior, lateral side both proximally and distally), left thigh (anterior, lateral side mid-shaft on medial side), and on left arm on the inside of her elbow. A computed tomography (CT) of the head, full body anterior/posterior X-ray, blood studies, and urine were completed and an intravenous line was placed. A “healed or healing fracture of the left clavicle,” was noted on the limited skeletal survey. A forensic nurse completed an exam on M.L. The baby was noted to be febrile to 102.3 degrees Fahrenheit and started to have periods of apnea (not breathing). Antibiotics were given to M.L. A sedative medication (Versed) was given and intubation was attempted. The sedative medication was given again and intubation attempted again, apparently at least five times, unsuccessfully. Possible seizure activity was noted and a sedative, anti-seizure medication was administered. M.L. was transported to the children’s hospital on oxygen, on a backboard, and in a cervical collar. M.L.’s temperature was 102 degrees Fahrenheit and she was noted to be in moderate respiratory distress upon arrival. M.L. was given appropriate medications for intubation, intubated, and placed on a ventilator. She was fully evaluated and remained sedated. A chest x-ray demonstrated infiltrates

(fluffy white patches) in both lower lung fields, eyes were noted to appear opaque, and bruising was again noted to be in multiple body areas in multiple stages of healing. Due to chest x-ray findings, M.L. was continued on antibiotics, started on anti-viral medication for influenza, and transferred to the Pediatric Intensive Care Unit (PICU).

A full skeletal survey and CT scan of the abdomen and pelvis was completed due to abdominal bruising. A skeletal survey demonstrated the healing fracture of the left clavicle with vertical lucency seen in this healing fracture suggestive of new fracture within old healing fracture, focal healing fracture in posterior aspect of left 5<sup>th</sup> rib and right 8<sup>th</sup> rib, and cortical irregularity of medial distal femoral metaphysis bilaterally, which could be developmental variant versus subtle healing corner fractures. M.L. then underwent a CT scan of the face and mandible which demonstrated a somewhat diminished skull base bone density but was otherwise within normal limits.

Ophthalmological exam demonstrated traumatic cataracts with anterior capsule pigment staining on the right lens, dislocation of the right lens, retinal detachment of the right with likely vitreous hemorrhage, and suspected partial retinal detachment of the left. M.L. was then examined by a retinal specialist, whose opinion was that the left retina was attached, but vitreous hemorrhage and posterior vitreous detachment was present. Also, on the right, the retina was thickened as seen on ultrasound which would indicate an older injury to the eye, occurring more than 48 to 72 hours ago. M.L. underwent magnetic resonance imaging (MRI) of the brain, orbits, and cervical spine which demonstrated encephalomalacia/gliosis in the posterior aspect of the superior frontal gyri (old insult) with subarachnoid/parenchymal hemorrhage (new insult).

In the PICU, M.L. remained on a ventilator until surgery and she had a feeding tube placed in her duodenum. Five days after the near death event, M.L. underwent surgery and the cataract on the left eye was removed and an anterior vitrectomy was performed on the left. She was treated for presumed pneumonia and was treated prophylactically for influenza, though a bronchial-alveolar lavage (BAL) and influenza culture were negative. While hospitalized, an evaluation for genetic conditions that could cause this infant's constellation of findings was completed, as well as studies for bleeding, clotting or platelet disorders. All results were normal. Shortly after surgery, M.L. was able to breathe on her own and was taken off the ventilator.

Per the Division of Family Services (DFS), there was no prior contact with M.L. and/or family. In November 2009, the Child Abuse and Neglect Report Line received a report alleging the physical abuse of M.L. perpetrated by the FOB. The report was accepted and a joint investigation began between DFS and Law Enforcement. Mother claimed that she suspected FOB M.L. but she had no direct evidence to support her assumption.

The day after her eye surgery, M.L. was transferred from the PICU to the regular hospital floor and began to take oral feeds. Four days later, the feeding tube was removed and she began to take all oral feeds. She was hospitalized for eleven days, receiving Rehabilitation services, including Occupational and Physical therapy with specific visual therapies.

Upon discharge from the hospital, a safety plan was put in place by DFS for M.L. to be placed in the care of her maternal grandparents until the investigation was completed. After M.L. was placed in the grandparent's care, the FOB made allegations that the grandparents were the ones who inflicted M.L.'s injuries. Four days after discharge from the hospital, DFS petitioned for and was awarded emergency custody of M.L. A guardian *ad litem* attorney was appointed to represent M.L. A second safety plan was put in place for maternal uncle and his wife to stay with

the grandparents to provide safety for M.L. Three days later, M.L. was placed in foster care due to maternal uncle feeling as though he could not provide the safety that M.L. required as outlined in the DFS safety plan.

During the investigation, neither Mother nor FOB would admit to causing the child's injuries, nor was an explanation offered that was consistent with the child's injuries. Law Enforcement felt that the evidence was pointing to the FOB as the perpetrator. Law Enforcement did complete a scene investigation in addition to responding to the hospital.

### **Criminal /Civil Disposition**

DFS substantiated FOB for dependency and abuse by blunt force trauma, level IV. Mother was also substantiated for dependency; level I.

Criminal charges were filed against FOB (Assault by Abuse or Neglect and endangering the welfare of a child with serious physical injury) but dropped with the option to re-file if the Termination of Parental Rights (TPR) was not granted. Criminal charges were not re-filed as a result of the TPR.

### **System Recommendations**

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

### **DIVISION OF FAMILY SERVICES**

1. CDNDSC recommends that in serious injury cases, the DFS caseworker contact the civil Attorney General, so that a determination can be made as to whether or not custody should be sought OR a safety plan should be implemented.
  - a. Rationale: Child presented to the Emergency Department with serious injuries that were determined to be non-accidental. The DFS caseworker chose to implement a safety plan that included mother, maternal grandparents, and father. There was no documentation that the Attorney General's office was consulted on whether it would be appropriate to plan with the family or if custody needed to be sought due to the child's age, severity of injuries and the fact that multiple caregivers (those included in the Safety Plan) were involved.
  - b. Anticipated Result: To ensure the safety and well being of the child.
  - c. Responsible Agency: Division of Family Services

### **CHILD PROTECTION ACCOUNTABILITY COMMISSION (CPAC)/CDNDSC**

2. CDNDSC supports the Investigation and Prosecution Committee in its endeavor to revise Delaware's Child Abuse Law, so that such statute addresses the two parent/caregiver dilemma.
  - a. Rationale: Child suffered from serious injury, which had occurred over a period of time. During this time, child was under the care of her Mother and Father. Neither Mother nor Father would admit to causing the child's injuries, nor was an explanation offered that was consistent with the child's injuries.

- b. Anticipated Result: To hold parents/caregivers accountable and to allow for the Department of Justice to pursue additional charges in cases where the child is seriously injured and two individuals are culpable.
- c. Responsible Agency: CPAC/CDNDSC