



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

CAPTA¹ REPORT

In the Matter of
OPJ
Minor Child²

9-03-2009-00013

January 25, 2013

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 O.PJ is considered a near death incident due to physical abuse with perpetrator unknown. At the time of the near death incident, child was five months of age.

In March 2009, the child presented to the Emergency Department of the children's hospital with facial bruising, lethargy, and parental concern of inactivity. A computed tomography (CT) scan of the head was performed and demonstrated bilateral subdural hematomas and retinal hemorrhages.

The next day, the child was further examined by Delaware's Child Abuse Expert, where he determined that the hematomas could have resulted from impact, shaking, or a combination of the two. The Child Abuse Expert reported that the hematomas were located on either side of the child's head and that one hematoma had been present longer than the other, thus signifying two episodes of abuse. The Child Abuse Expert was able to determine that the older brain bleed occurred within the last three weeks; whereas, the newer brain bleed occurred within the last 72 hours.

That same day the Division of Family Services' (DFS) Child Abuse Reportline received an urgent referral alleging physical abuse, abusive head trauma, with secondary allegations of bruises, cuts and lacerations of the child.

Parents informed the medical staff that child had been under the care of his cousin for the past 12 hours while the child's parents were at work. On the morning of the near death incident, parents had dropped the child off at the cousin's residence. The child appeared well at the time with no visible signs of injuries. That evening the child's cousin had called the parents as the child had been crying for approximately two hours. When parents arrived, child was observed to be non-responsive, blue around the mouth, and bruising was noted on the left side of the child's face.

History gathered through DFS revealed that four months prior, in November of 2008, the Child Abuse Reportline received an urgent referral alleging severe physical neglect of the child. It was reported that the child had recently been seen by his pediatrician for vomiting and a fever. The child was referred to the Emergency Department of the children's hospital where a distended abdomen was noted. The child had an apneic episode which required intubation. During further medical testing the child was found to be positive for marijuana. When questioned, mother and father reported that they had run into a friend who at the time was smoking marijuana and the child must have inhaled the smoke. The next day, the child was retested and found to be negative for tetrahydrocannabinol (THC). Alternative history checks did not reveal any history of alcohol or other substance abuse by any member in the home. The case was unsubstantiated and closed. The child improved medically and was discharged home to the parent's care.

It was further noted by DFS that the cousin had been watching the child, approximately seven times over the last three to four weeks. It was noted that four other individuals reside at the cousin's home. The child had also been watched by his aunt approximately one week ago where no apparent problems were noted. Mother and father also share their residence with three other couples, totaling seven people within their home.

Seven days after the near death incident, the child's cousin was interviewed by local law enforcement. The cousin described occasions where the child was injured while in her care; however, none of those incidents were extreme enough to explain the injuries sustained by the child. All other individuals residing in the home of the cousin as well as the parents were interviewed, but no one was determined to be a suspect as they were either not involved in the care of the child or such care was done while in the company of others.

DFS closed the case as unsubstantiated for physical abuse with risk and concern as a perpetrator was not able to be identified.

No criminal prosecution occurred in this case as there was no perpetrator and the limited evidence to substantiate.

System Recommendations

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

DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES:

1. CDNDSC recommends that the Division of Family Services (DFS) reconsider the ability to substantiate a case for physical abuse and/or neglect with perpetrator unknown.
 - a. Rationale: Grave concern was raised by members of the Panel about the closure of cases. Specifically, cases that are unsubstantiated because the perpetrator is unknown, but it is clear that abuse is occurring within the child's residence.
 - b. Anticipated Result: To ensure the safety and well being of the child
 - c. Responsible Agency: Department of Services for Children, Youth and Their Families