



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

CAPTA¹ REPORT

In the Matter of
Alicia Santos
Minor Child²

9-03-2012-00010

December 5, 2014

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.

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

Case Synopsis

The three-month-old female child who is the subject of this review, Alicia Santos, was born in May 2011 to Amy Collier and Jonathan Santos, at 40 weeks gestation weighing 8 pounds, 2.4 ounces, via cesarean section for failure to progress. Mother admitted to smoking 10-15 cigarettes per day at time of delivery. The infant was discharged home on day three of life, bottle feeding on Similac. Infant was seen several times by her primary care physician with complaints of spitting up, gassiness, loose stools, and crying. Formula was changed twice and the infant was prescribed Zantac. Medical record notes indicate the parents were educated on reflux precaution, sleeping, colic, crib safety, and accident prevention. Between August 2nd and August 9th, the infant was seen at the primary care physician’s office four times for spitting up/vomiting and constant crying. The infant had an 8.4 ounce weight loss during this time. Some concern was noted regarding the infant’s care; however, no further action was taken. The infant’s reflux medication was increased and formula switched.

In August 2011, Alicia was taken to the Emergency Department (ED) of the local hospital by her parents. The parents stated the infant fell from the bed, approximately two feet onto a carpeted floor, landing face-down atop two television remote controls. The incident occurred almost two hours prior to arrival at the ED. The infant suffered from three left facial bruises, small contusion to the right cheek, contusion on right upper lip extending to mucous membrane of upper lip, bruising and petechiae inferior to both eyes. Computed tomography (CT) scan of the abdomen/pelvis area and one-view x-ray of the abdomen were requested. Due to the nature of the injuries and the parent’s inconsistent explanation of how the injuries occurred, abuse was suspected and the Division of Family Services was contacted. The CT scan demonstrated several old right posterior rib fractures. Initial read of the one-view x-ray by Nighthawk failed to demonstrate any abnormalities of the ribs; however, the morning staff radiologist noted healing right sided rib fractures. A diagnosis of head trauma, likely shaken baby syndrome was made. The infant was transferred to the children’s hospital for further evaluation.

At the children’s hospital, a full skeletal survey and ophthalmological exam were completed. No retinal hemorrhages were found, and the CT scan of the head was negative. The skeletal survey showed multiple fractures of the ribs. MRI of the brain was completed and within normal limits.

The Children at Risk Evaluation (CARE) team was consulted and determined the injuries were consistent with non-accidental trauma.

Parents were interviewed by the DFS caseworker and the local law enforcement. Jonathan initially denied hurting Alicia; however, after further questioning he admitted that he tossed the infant 8-10 feet to the bed because he was frustrated with her constant crying. He stated that the infant bounced on the bed and then off the mattress onto the floor, face down. Amy also initially denied hurting the infant but later admitted to squeezing the baby in frustration when she would not stop crying.

Both parents were convicted of Abuse 2nd and Endangering the Welfare of a Child (EWC) (Jonathan at felony level and Amy at misdemeanor level). Jonathan was sentenced to eight years at Level V confinement suspended to one year at Level V confinement followed by one year at Level III probation for the Assault charge and two years at Level V confinement suspended to one year at Level III probation for the EWC charge. Amy was sentenced to eight years at Level V confinement with credit for eight days previously served, the balance suspended to one year at Level IV home confinement followed by one year at Level III probation for the Assault charge and one year at Level V confinement suspended to one year at Level III probation for the EWC charge.

Civily, the DFS investigation was substantiated at Level IV against Jonathan for bone fractures and Level III for bruises, cuts and lacerations requiring medical treatment and bizarre treatment for throwing the infant across the room. Amy was substantiated at Level IV for bone fracture. The case was transferred to treatment with a goal for reunification with the parents.

Alicia was placed in the custody of her maternal uncle, Elijah Collier, upon discharge from the children's hospital. Guardianship was awarded to Elijah in September 2011.

Family History: Mother

There was one investigation with DFS from July 2007 regarding the mother of Amy Collier, Patricia Collier. Patricia filed for guardianship of her son's paramour, whom was seventeen years of age and living in a hotel with Patricia's son and their seven-month-old infant. There was no indication of abuse in the case; the son's paramour simply had no desire to live with her mother. Unstable housing had always been a concern for the young woman's family but the children's needs had always been met. DFS completed a non-relative home assessment of Patricia's home and found it to be appropriate. The young woman's mother consented to the guardianship. The case was closed, unsubstantiated with concerns of the young woman's family history of unstable housing, financial stress and the young woman residing out of the home awaiting guardianship order from the court.

Amy Collier's criminal history consisted of Failure to Reinstate License (Feb 2011) and four other traffic related offenses (2010).

Family History: Father

There was one prior investigation with DFS from May 2006 regarding the father of Jonathan Santos, Donald Santos. The incident alleged severe emotional abuse by the father's paramour resulting from a verbal argument between the paramour and Jonathan's sibling. The incident appeared to be an isolated event and the family was open to counseling resources.

Jonathan Santos' criminal history consisted of Drunk on a Highway (May 2007), Disorderly Conduct (Nov 2001), and Assault 3rd (Feb 2001). Jonathan was a Juvenile Found Delinquent on all three charges.

Alicia's Near-Death Incident

In August 2011, an urgent referral was made to the DFS Child Abuse and Neglect Report Line alleging physical abuse-head trauma of three-month-old Alicia, with secondary allegations of bruises, cuts and lacerations requiring medical intervention, by her parents. Alicia was taken to the ED of the local hospital with three left facial bruises, small contusion to the right cheek, contusion on right upper lip extending to mucous membrane of upper lip, bruising and petechiae inferior to both eyes. The emergency physician suspected abuse as the parent's story was not consistent with the injuries. A CT scan and one-view x-ray of the abdomen were completed and results were pending. If positive, the infant would be transferred to the children's hospital. If negative, the physician did not feel comfortable releasing the child to the parents. DFS and local law enforcement were contacted.

The CT scan demonstrated several old right posterior rib fractures. Initial read of the one-view x-ray by Nighthawk failed to demonstrate any abnormalities of the ribs; however, the morning staff radiologist noted healing right sided rib fractures. A diagnosis of head trauma, likely shaken baby syndrome was made. The infant was transferred to the children's hospital for further evaluation.

At the children's hospital, a full skeletal survey and ophthalmological exam were completed. No retinal hemorrhages were found, and the CT scan of the head was negative. The skeletal survey showed multiple fractures of the ribs. MRI of the brain was completed and within normal limits. The Children at Risk Evaluation (CARE) team was consulted and felt the injuries were consistent with non-accidental trauma.

The parents were interviewed by the DFS caseworker and local law enforcement. The parents live in the home of the maternal grandmother, Patricia Collier, and her paramour. The parents and infant stay downstairs in the basement area while the maternal grandmother and paramour remain upstairs. Jonathan advised that he put the sleeping infant down on the adult bed while he went upstairs to get something to eat. Upon return, approximately five minutes later, he found the infant on the floor with the blanket on her face, face-down on top of a couple of television remote controls. The mattress is approximately two feet from the floor; the floor is carpeted. He denied hurting the infant. He stated she only began to cry when he placed her in the car seat to go and pick up Amy from work. He also stated there was some vomiting but only a small amount following the incident.

After further questioning from law enforcement, Jonathan admitted to tossing the infant about 8-10 feet to the bed due to his frustration that she would not stop crying. He stated that she bounced off the bed and landed on the floor face-down. Amy reported that Jonathan picked her up from work at about 9:00 PM. He showed her the bruising on Alicia's face and explained what had happened. Amy contacted the infant's primary care physician and was directed to take her to the emergency department for observation. Amy stated that she and Jonathan have argued in the past, and Jonathan has tossed the infant onto the bed from a close distance. She noted that she would question him on his actions when he would do such things. She did notice bruises on the infant's face a few days prior, but Jonathan stated they must have been from the pacifier.

Jonathan was charged with one count of Assault 2nd, five counts of Reckless Endangering and one count of Endangering the Welfare of a Child. Following the results of the medical evaluation from the children's hospital and the discovery of the healing fractured ribs, Amy was questioned a second time by law enforcement. She admitted that on four separate occasions, she squeezed the infant in frustration when she would not stop crying. Amy was charged with one count of Assault 2nd, one count of Reckless Endangering, four counts of Endangering the Welfare of a Child (one misdemeanor, three felony) and one count of Assault by Abuse/Neglect.

The primary care physician also reported to the hospital and examined Alicia. He believed the injuries to be the result of a fall but questions the extent of the injuries from the fall. He noted his suspicion of abuse.

The DFS caseworker met with the maternal uncle, Elijah Collier, who expressed interest in caring for Alicia upon discharge from the children's hospital. The home assessment was completed and the home found to be appropriate. Elijah would be the primary caretaker; however, Patricia would share caretaking responsibilities. Guardianship of Alicia was granted to Elijah.

The DFS caseworker met with Amy in October 2011. Amy refused to discuss the case against her. The DFS caseworker focused on Amy's case plan. She noted Amy to have a flat affect. Her facial expressions did not change when discussing Alicia, and they did not match what she was saying. Amy admitted to having a normal childhood, trying marijuana at the age of 17, using for about two years, and drinking socially. The caseworker reminded her that she was not of legal age to drink. Amy believed she suffered from depression but had never been diagnosed or treated for it. Amy planned to stay with Patricia until she regained custody of Alicia. The caseworker informed Amy that she would be referred for parenting classes, mental health evaluation, and alcohol or drug (AOD) evaluation for the case plan. Referrals for parenting classes and parent aid services were made nine days later; no documentation was noted for mental health or AOD evaluation.

Twenty-three days following the visit with Amy, the DFS caseworker made an unannounced home visit with Patricia. She had Alicia there because she could not attend daycare due to a respiratory infection. There was no documented conversation with Patricia regarding Alicia being in the home where Amy resided, although a NCO remained in place.

In December 2011, the paternal grandmother filed a petition for guardianship and was denied. Throughout the investigation, Jonathan recommended the paternal grandmother for placement of Alicia; however, he noted to the DFS caseworker that he had a rough childhood and the paternal grandmother was always drunk and violent when she was drunk. He also noted her to be a liar. Based on this, the DFS caseworker was unable to determine why he identified her as an appropriate placement option.

Criminal /Civil Disposition

Both parents were convicted of Abuse 2nd and Endangering the Welfare of a Child (EWC) (Jonathan at felony level and Amy at misdemeanor level). Jonathan was sentenced to eight years at Level V confinement suspended to one year at Level V confinement followed by one year at Level III probation for the Assault charge and two years at Level V confinement suspended to one year at Level III probation for the EWC charge. Amy was sentenced to eight years at Level V confinement with credit for eight days previously served, the balance suspended to one year at Level IV home confinement followed by one year at Level III probation for the Assault charge

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Alicia was placed in the custody of her maternal uncle, Elijah Collier, upon discharge from the children's hospital. Guardianship was awarded to Elijah in September 2011.

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; therefore, the following system recommendations were put forth:

Medical

1. CDNDSC recommends that Delaware Hospitals use the American Academy of Pediatrics (AAP) guidelines when performing x-rays of children who are thought to be victims of abuse and/or neglect.
 - a. Rationale: On the day of the near death incident, child was taken to the Emergency Department and upon examination received x-rays. A full skeletal survey was not performed and therefore, upon transfer to the children's hospital, further x-rays were needed.
 - b. Anticipated Results: Compliance with best practice as stated in the AAP guidelines.
 - c. Responsible Agency: Delaware Hospitals

Division of Family Services

1. CDNDSC recommends that the Division of Family Services (DFS) follow policy as it pertains to monthly contact with children active with DFS treatment services.
 - a. Rationale: During treatment case, monthly contact was not made with Alicia in December 2011.
 - b. Anticipated Result: Compliance with policy.
 - c. Responsible Agency: Division of Family Services

Law Enforcement

1. CDNDSC recommends that the Memorandum of Understanding (MOU) be amended to include a "suspected location of incident" as it pertains to the criminal investigative duties of law enforcement. Specifically, that within the first twenty-four to forty-eight hours law enforcement should be going to the location of where the alleged death or near death occurred for scene preservation and evidence collection.
 - a. Rationale: During the criminal investigation, law enforcement did not go to the child's home.
 - b. Anticipated Result: Compliance with what is recognized as national best practice, as well as, the possible collection of evidence that can support the allegations of physical abuse and/or neglect.
 - c. Responsible Agency: Delaware Police Department

Child Death, Near Death and Stillbirth Commission (CDNDSC)

1. CDNDSC recommends that the one-page information sheet which outlines *Help Me Grow*, be disseminated to the treating hospital, as well as, all Delaware Hospitals so that services for patients are made known.
 - a. Rationale: On August 2nd through August 9th, the child had an 8.4 ounce weight loss. Concern was raised regarding the care of the child. A referral should have been made to the home visiting nurse program through the Division of Public Health, but was not as it did not appear that such service was known.
 - b. Anticipated Result: Awareness of prevention programs within Delaware.
 - c. Responsible Agency: CDNDSC