



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

CAPTA¹ REPORT

In the Matter of
BK
Minor Child

9-03-2013-00010

May 13, 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 was prepared from 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, and the Department of Justice.

Case Synopsis

The female child who is the subject of this review, BK (“Victim”), was born in July 1998 to TB (“Mother”) and RH (“Father”).

In August 2012, a referral was made to the Division of Family Services (“DFS”) Child Abuse and Neglect Report Line alleging physical abuse of fourteen-year-old Victim. The caller stated that she had seen Victim, and she had bruising to the right side of her face and eye. When asked, Victim stated that she had injured herself. Father refused to seek medical treatment for the facial bruising. He had also discontinued the medication prescribed by her therapist without the therapist’s knowledge.

A Joint Investigation by DFS and law enforcement revealed that Victim had endured a long and chronic history of abuse by Father and SW (“Step Mother”). Upon medical examination, Victim weighed only 65 pounds. All 4 children, including Victim, were removed from the home and Victim remains in the care of her paternal great grandparents.

The DFS investigation was substantiated against Father for Suffocation, Medical Neglect, and Severe Physical Neglect, placing him on Level IV of the Child Protection Registry. DFS also substantiated against Step Mother for Blunt Force Trauma, Severe Physical Neglect, and Bizarre Treatment, placing her on Level IV of the Child Protection Registry.

In February 2014, Father pled guilty to Endangering the Welfare of a Child (felony), Assault by Abuse or Neglect (felony) and three counts of Endangering the Welfare of a Child (misdemeanor). He was sentenced to 25 years at Level 5, suspended after service of 2 years, followed by 2 years at Level 3 Probation. Step Mother pled guilty to Endangering the Welfare of a Child (felony), Assault by Abuse or Neglect (felony) and three counts of Endangering the Welfare of a Child (misdemeanor). She was sentenced to 25 years at Level 5, suspended after service of 2 years, followed by 2 years at Level 3 Probation.

Family History

In June 1998, a referral was made to the DFS Report Line alleging physical abuse of ST and JT, half-siblings to Victim. It was reported that Father was using inappropriate physical discipline with Mother's two sons. After an investigation by DFS, the case was closed, unsubstantiated. During the case, law enforcement responded to the home to check on the welfare of the boys and concluded they were fine.

In August 2001, a referral was made to the DFS Report Line alleging physical abuse of Victim by Mother. The reporter stated the child returned home from visitation with a cigarette burn on her arm. The DFS caseworker interviewed all parties involved. A medical assessment was completed by the child's primary care physician ("PCP"). Collateral contacts were completed with Mother's counselor and law enforcement (reportedly a family friend). It was determined that the burn occurred by accident when the child ran into Mother's cigarette during a family birthday party. The case was closed, unsubstantiated, due to lack of evidence.

In April 2002, a referral was made to the DFS Report Line alleging sexual abuse of Victim by her half-sibling, JT. The child was taken to her PCP. However, he opted not to examine Victim and instead instructed the parent to make a referral to DFS. A forensic interview was completed with Victim at which time she disclosed that her seven-year-old brother touched her with his finger underneath her clothes. Victim's half-brothers, ST and JT, were also interviewed and denied an incident had occurred. The case was closed, unsubstantiated. Ultimately, the court ordered the boys to visit with Mother on the weekends that Victim was not visiting (all three children resided with their respective fathers).

In September 2008, a referral was made to the DFS Report Line alleging physical abuse of Victim by Mother. The reporter stated that Victim returned home from visitation upset that Mother and her paramour were arguing, and Mother hit Victim in the face and grabbed her arm during dinner. She had a mark under her eye and a thumb/finger mark under her arm. The reporter also noted a long history of emotional and verbal abuse of Victim by Mother. The maternal grandparents lived in the same household as Mother and were noted in a court order to be the supervisors of such visitations. They were present during this time but reportedly did not intervene.

This same allegation was also reported the following day by an alternate source. The caller noted that Mother had trouble controlling her actions and therefore was no longer allowed at the school. This referral was linked to the investigation case of the initial report. The caseworker interviewed Father, Step Mother and two younger siblings (two-year-old HK and three-year-old CS) at the family's residence. Victim disclosed being hit by Mother, and reported that her maternal grandmother ("MGM") was present at the time the abuse occurred and did nothing to stop it. Reportedly, MGM was the supervising authority during visitation since the family was kicked out of the visitation center due to continued problems caused by Mother. The following day, the caseworker interviewed Victim's two half-siblings (ST and JT) along with their father (BT) and his wife (name not given). A forensic interview was scheduled for Victim and the case was referred to law enforcement. The two older boys denied any abuse or neglect by Mother. During the forensic interview, Victim disclosed abusive behavior by Mother. Additionally, Victim reported being shown pornographic websites by Mother; she denied seeing images of men and children, only women scantily dressed in nightgowns saying nasty things that she did not like.

Throughout this investigation, Mother was not contacted by the caseworker; Mother contacted the caseworker seven days following the initial report to inquire about the investigation. She denied any abuse or pornographic material and reported that the abuse was from Father's home. Mother was instructed to report any allegations of abuse to the DFS Report Line. She made a referral that same day, but it was screened out (this referral was not made available in the review documents).

A subsequent report alleging physical abuse of Victim was made thirteen days later. The caller noted bruising to Victim's back during a routine scoliosis screening. She gave two different explanations for how the injury occurred. The family was found to be active with DFS and the new referral was accepted as an urgent response. Victim was interviewed at school and Step Mother was interviewed via telephone. Both explained the bruising could have been from the children playing and Victim falling on a toy set. The case was abridged by DFS.

A court hearing occurred in October 2008 regarding visitation modification for Mother's older boys. Their father had no concerns of abuse or neglect; therefore, the visitation remained in effect. Mother reported that Victim's counselor was subpoenaed for the hearing because Victim provided a different story to her than what was reported to DFS and during the forensic interview. It should be noted that Mother was never interviewed regarding the incident and the caseworker did not follow up with Victim's counselor to identify what was stated by Victim.

Following the September allegations of abuse by Mother, she was charged with Assault 3rd and Offensive Touching. The trial was held in November 2008 and Mother was found Not Guilty on both charges. Therefore, the DFS case was closed, unsubstantiated with concern. The caseworker noted collaterals were completed with Victim's counselor; however, this collateral consisted of the caseworker leaving a voicemail. There was no further documentation of an actual conversation being held with the counselor.

In November 2008, two referrals were made to the DFS Report Line – one reporting Victim with a black eye and another reporting her younger step brother, BH ("Step Brother") threatening to harm himself (he was in the 1st grade). Step Brother's issues began the week prior when he threatened to stab himself in the eye with a pencil; he also indicated that he heard voices telling him to hurt himself. Furthermore, the teacher reported he gets very worked up and irrational. Step Brother did not disclose any abuse at home. The caseworker informed the school that DFS would not intervene at the time and instructed the school to meet with the parents and recommend an emergency evaluation for Step Brother. If the parents failed to follow through, then DFS should be contacted.

In May 2009, a referral was made to the DFS Report Line alleging physical abuse of Step Brother by Father. The reporter stated Step Brother showed his teacher bruising that occurred the week prior from Father hitting him on his butt with a "metal thing" that he described as a 24-inch rectangular metal piece used to hold trees when using a chainsaw; the hit forced him to fall onto the couch, which caused the bruise. Step Brother stated that Step Mother (his own mother) saw the bruise but did not tell Father because he would make Step Mother "go out on the road and die." The caseworker responded to the school and interviewed both Step Brother and Victim. Step Brother admitted to being spanked with fly swatters, belts, and hands. Victim denied any physical discipline in the home and reported no knowledge of a metal object. She also stated she had a recent visit with Mother at the maternal grandparents' home and everything was fine. The caseworker responded to the home and spoke with Step Mother. She denied any physical discipline. The caseworker noted the distance between the kitchen and living room, noting that it

would have been very hard for Step Brother to fall that distance as he stated. The caseworker observed the two younger siblings, but they would not speak with her.

The following day, the caseworker met with Father at the DFS office. He also denied physical discipline in the home and claimed to have no knowledge of a metal object. A collateral was completed with the children's PCP one month following the report and no concerns of abuse or neglect were noted. The case was closed eight days later, unsubstantiated due to lack of evidence.

In January 2010, a referral was made to the DFS Report Line alleging physical abuse and neglect of eleven-year-old Victim. The reporter stated that Victim came to school with a large bruise and scratches on her face and the left side of her chest just below her neck. Victim stated the injuries must have been from rough-housing with her eight-year-old step-brother. The reporter also mentioned ongoing concerns of Victim coming to school with various bruises and injuries. She referred to Victim as a "tiny, little girl" and noted that her teacher had come to the caller concerned about Victim coming to school looking disheveled with her hair a mess. Victim denied abuse or neglect at home but stated Mother abused her, and this was why she was living with Father. The case was screened out by the DFS Report line.

The following day, a different caseworker received a call reporting the same incident noted above. The caller stated that she worked at Victim's school and had spoken to Step Brother and found that his story did not match Victim's story. She did not elaborate on what Step Brother reported. The caller noted several past occasions where Victim had come to school with various bruises and scratches; all were blamed on her younger brother. She also noted that Victim was not as outgoing as she was the previous year. The caller informed the caseworker that she gave Victim her home and cell phone numbers in case she needed her. In addition, she offered to be a caretaker if Victim ended up in foster care.

Later the same day, a subsequent referral was made to the DFS Report Line expressing concern that the previous report was not accepted. The caller and several members of the school administration were concerned about Victim's injuries and prior history. The school contacted Father, who reported that he did not know how the bruise got there. Father reported that Victim had emotional trauma from Mother's physical abuse, and he would be making an appointment with a psychiatrist for Victim. The DFS supervisor accepted the hotline report as a routine referral for lack of supervision, despite Victim having visible marks.

The assigned caseworker visited the school seven days later. She spoke with Step Brother and observed him to be quite animated and noted having the impression that he was not telling the truth. Step Brother reported to her that Step Mother and Father get into fights, and he has to break them up and make them hug. He stated that Step Mother and Father punch each other. Step Brother reported he was disciplined by spanking on the butt with a hand. The caseworker spoke with the school principal and counselor. They reported that Step Brother often wore clothes that were too small. He had a history of lying but his stories were bizarre and concerning. He had begun to bite himself and pull his hair because he had pain inside when people were mad at him. The counselor suggested he pause and count to 10 when this happened. The school psychologist conducted an assessment of him and results indicated that he was hyperactive, depressed and lacked social functioning and adaptive skills. Step Mother was noted to be seeking counseling for the child, but the school was unaware if she had followed through. The caseworker then met with Victim. She was noted to be thin, wearing clean clothes, but had a faint odor of cat urine. Victim claimed not to know how her bruising occurred but denied anyone hurting her or hurting herself.

She admitted to pulling her own hair a few weeks ago and scratching herself in the face last year. She reported seeing a psychiatrist. Victim stated she felt safe at home.

The caseworker conducted an unannounced home visit and met with Step Mother. The home was cluttered and unkempt; there were numerous cats and dogs around and a strong smell of cat urine. Step Mother was frustrated with the visit and reported that Victim self-harms and Father was seeking help for her. They reported restraining Victim at times due to her self-harming and were concerned that the younger children saw this and now Step Brother was beginning to harm himself as well. Father arrived home as the caseworker was leaving. He noted Victim to have been "severely abused" by Mother and said she suffered from Post-Traumatic Stress Disorder ("PTSD"), and possibly Bipolar Disorder. The caseworker noted that there was no disclosure of abuse or neglect; her concern was of Victim self-harming. No safety plan was initiated and Victim was not evaluated by a doctor to determine the nature of the bruising and whether it could have been the result of self-harming.

Less than a month later, a referral was made to the DFS Report Line alleging physical abuse of Victim. Victim's teacher sent her to the nurse's office for fingerprint-like bruising around her arm. Victim was also found to have bruising on her back and left hip, along with scratches. Victim reported that she did not know what caused the bruises except for the one on her hip, which was from her dog jumping on her. The caller also mentioned Victim coming to school with pants that are too small and smelling of cat urine. She was being picked on by other students and one student asked to have his seat moved because he could not handle the smell any longer. Father was contacted by the school but nothing had changed. The case was accepted as an urgent response and linked to the open investigation.

The caseworker responded to the school and spoke with the school nurse, who reported that she was aware of the family's history and Victim's tendency to self-harm, but she felt the bruises were not self-inflicted. The caseworker observed Victim, noting eleven marks (scratches on the right upper side of chest, left upper side of chest, cheek and stomach, and bruises on her right upper arm, left arm toward shoulder, near elbow, on forearm, right hip and left side of back). Victim said she did not know what caused the bruises and scratches and denied anyone had hurt her or that she had hurt herself. She suggested they could be from her cat or when she fell out of her bed. Victim claimed she felt safe at home. The caseworker spoke with Father over the telephone. He was aware of the new report and stated that Victim reported that she fell out of her bed; he noted her bed to be approximately one foot from the floor. He made reference to Victim's PCP being a former pediatrician that had sexually abused several children, and the prior allegations of sexual abuse by her half-brother, JT. He stated that he left a message for Victim's psychiatrist.

Father met with the caseworker at the DFS office the next day. He stated Victim was not saying what happened. He claimed she had been self-harming for quite some time but the bruising was getting worse. He reportedly asked the school to set up a meeting to discuss Victim's issues. This was not confirmed by the caseworker. Father stated that Victim threw road blocks when the psychiatrist touched on issues.

A collateral was completed with the psychologist (previously referred to by family and DFS as a psychiatrist). She reported Victim to be under her care since September 2009. There had not been any missed appointments, and she had no concerns for abuse or neglect. She noted severe physical abuse by Victim's biological mother and concern for her former pediatrician, though Victim had denied any abuse. The psychologist believed Victim was self-injuring and noted

diagnoses of Mild Depression and PTSD but explained that this was a bizarre case as Victim had delusions and memory loss as well. The psychologist was not sure if Bipolar Disorder, Dissociative Disorder or Psychosis were also possible diagnoses based on her symptoms. The case was closed, unsubstantiated due to lack of evidence.

In June 2010, another referral was made to the DFS Report Line alleging physical abuse of Victim. The reporter stated that Victim came to see her for insect bites. In checking her, the caller observed several bruises on her body in various stages of healing. Victim suggested the scratches could be from her dog or family camping in the backyard the previous weekend, but she was unsure. The reporter contacted Father, who stated he was aware of the insect bites but not of the bruises. The case was accepted as an urgent response.

The caseworker responded to the school and spoke with Victim. Victim stated that she knew DFS would be coming to see her because she had gone to the nurse's office. She denied any physical discipline, abuse or neglect at home. Once again, Victim mentioned past abuse by Mother. The caseworker looked at the marks except for the one on Victim's back, and noted that none appeared to be the result of abuse or neglect. The caseworker then spoke to Step Brother at the school. He confirmed the backyard camping the previous weekend. Step Brother stated that Victim hits and scratches herself when she's mad; he does too but not as much. He did not think anyone had hurt Victim. The school counselor met with the caseworker and expressed her concerns about Step Brother. She stated they gave him a new backpack because his smelled of cat urine. He recently choked himself and mental health mobile crisis was called. He had also pulled his hair out. She noted the parents were getting him counseling, but she felt the counselor's credentials were "iffy." The school counselor worried about Step Brother being home all summer. The caseworker noted the school counselor was making a lot of assumptions about the child's home life. The caseworker then made an unannounced home visit, finding Step Mother at home with the two younger siblings. Step Mother referred to the weekend camping as well but had no idea what caused Victim's bruising and scratches. She noted Victim to be seeing a therapist who was working on a diagnosis and then medication would be prescribed. She denied physical discipline in the home but stated DFS told her she could use it but not overdo it. The caseworker agreed and stated they could not leave a mark on the child. The caseworker spoke to Step Mother regarding the school's concerns about Step Brother and suggested a referral to the school's Family Crisis Therapist ("FCT"). The caseworker became aware of the children's former PCP and stated he would make a referral to law enforcement (this was completed the following day). The caseworker noted the children to be safe since there was no disclosure of abuse or neglect.

Seventeen days later, the caseworker spoke with Father over the telephone and informed him that the case had no evidence of abuse or neglect but concerns over unexplained bruises on Victim. Father was fine with this and again referred to Victim's prior abuse and diagnosis of PTSD, and possibly a personality disorder. He denied physical discipline. In regard to Step Brother, he explained that Step Brother was sensitive and easily upset when his card or color was changed at school; he began self-harming as he had witnessed Victim doing it. The caseworker suggested that Step Brother work with the school FCT, but Father reported that the school was not willing to work with Step Brother when he gets upset. Father stated the school would just call him to pick up Step Brother.

Three weeks later, in July 2010, a new referral was made to the DFS Report Line. The caller stated he contacted Step Mother to set up an intake for Victim due to behaviors of aggression, self-harm, PTSD and possible Bipolar and mood disorders. During the conversation, Step Mother disclosed an incident a week prior where the five-year-old witnessed Victim inappropriately

touching Step Brother and on top of him “humping” him. Step Mother had been making sure the children were kept away from each other. The caller felt there was no coercion or force, and this was an isolated incident. The caller knew there was an open investigation case with DFS and that the children could be potential victims of the former pediatrician. This report was rejected as there was less than a four year age difference between the involved children and no indication of coercion or force. A progress note was added to the on-going case.

The caseworker emailed the detective to whom the report was made regarding former pediatrician and asked if a forensic interview could be scheduled. The detective instructed the caseworker to follow DFS protocol; if a forensic interview was warranted, they should do so and if an allegation arose, the Attorney General’s (AG) office would step in. The detective noted that the parents had no concerns of abuse when the story broke and the children had never disclosed any abuse by the pediatrician. The caseworker spoke with Father over the telephone and discussed the sexual allegation. Father stated the incident happened over a year ago and that the detective would be calling him. Father did not want to schedule a forensic interview without first speaking with Victim’s psychologist. The caseworker clarified that the report indicated the incident occurred the week prior, not a year ago. The case was closed, unsubstantiated with concern of Victim’s mounting mental health issues and sexual behavior. One collateral was completed by the caseworker with the school counselor. The caseworker never met with Father in person, although this was a policy requirement given Father was living in the home; all contact was made via telephone.

Following closure of the case, the caseworker visited the home unannounced. Step Mother and the children were home. She stated they wanted to schedule the forensic interview with Victim. The caseworker scheduled the interview; but the family was a no show. The family claimed they thought they had cancelled the interview, because Victim’s psychologist did not feel it was appropriate since Victim was fragile and about to start medications. The family noted the psychologist would help them reschedule the interview when Victim was stabilized. The caseworker never contacted the psychologist to discuss the family during the investigation.

Two months later, in September 2010, a referral was made to the DFS Report Line alleging abuse of Step Brother by Father. Step Brother reported to the school that Father hit him while he was brushing his teeth. He had no mark but complained of pain in the mid-back area. He was crying and embarrassed, and did not want the children to see his face was red so he did not eat breakfast that morning. He stated Father had “ruined his day.” The case was accepted with an urgent response.

The caseworker responded to the school. Step Brother stated that the hit by Father hurt but he refused to cry, which was different than what he originally reported to the school. He stated Father had pushed him down and kicked him in his side once before but he did not recall when. He told Step Mother about this. Step Brother denied being afraid to go home, or that he was afraid of Father. The caseworker met with the school counselor who reported that Step Brother’s self-injurious behaviors and anxiety had increased this year, and the parents were uncooperative in getting help him. She said Step Brother seemed to be unable to decipher between reality and fantasy sometimes. He also came to school smelling like cat urine. The caseworker responded to the home; Father came around from the side of the home. He became agitated when the caseworker introduced himself and rambled on about how much he hated the school. He calmed down once the caseworker reported he observed Step Brother, and he had no visible marks. The caseworker observed four or five cats around the yard and a dog barking from the inside of the home. Father agreed to meet with the caseworker the following day and ensure that Step Mother

and the other children would be there. The caseworker determined the children to be safe and the interview could wait.

The following day, the caseworker noted the home to be overrun with cats; he counted fourteen or fifteen. There was a strong odor of cat urine in the home. He could tell the home had been cleaned prior to his arrival due to fresh vacuum markings and the smell of air freshener. The two younger siblings were home but would not engage in conversation with the caseworker. Father said he had no idea what Step Brother was talking about and denied the incident had ever occurred. He noted Step Brother not to perceive things as a normal child. He stated that Step Brother was seeing the same psychologist as Victim. He noted that Step Brother had been copying Victim's pattern of self-injurious behavior. Father reported that he and Step Mother had discussed pulling the children out of school and homeschooling them and after this latest report, they would be doing so. The parents claimed to have been in contact with the home school coordinator from the Department of Education ("DOE"). The caseworker determined that the child was disciplined by Father but there were no visible marks or pain. There was a history of Step Brother making up wild stories. The children were in counseling. The only concerns noted were of health hazards due to the number of cats in and out of the home. No safety plan was initiated.

The caseworker was informed by Step Brother's school counselor that the parents were removing him from school for the purpose of homeschooling. A few days later, in October 2010, a representative from Victim's middle school contacted DFS to inform them that Victim had been withdrawn from school for the purpose of homeschooling. The caller expressed concern for Victim's environment.

The caseworker visited the home unannounced. Step Mother provided the caseworker with homeschooling material and claimed to be in touch with DOE. The caseworker briefly spoke with Victim, who claimed to be doing fine, and asked if she witnessed physical discipline of Step Brother, to which she responded negatively. The caseworker did not ask the children about their own discipline. The caseworker attempted contact with the psychologist and left two voicemails but it does not appear the psychologist returned the phone calls. The caseworker spoke with Father's brother as a collateral contact, and he reported no concerns of abuse or neglect adding that he did not have much contact with the family. The case was closed with no evidence to substantiate in November 2010. More than 30 days had passed since the caseworker had any face to face contact with any of the children.

In April 2011, a report was made to the DFS Report Line alleging neglect of the children due to the lack of cleanliness in the home and the multiple animals. The caller stated there were at least 50 cats and some dogs. Additionally, the caller noted that Victim looked to be skin and bones while the other children looked adequately fed. The reporter's spouse was in the home a week prior and noticed Victim had a black eye. He attempted to make contact with Victim to inquire but she continued to look down. He did not address the black eye with Father or Step Mother. He had also been in the home as late as midnight on occasion and observed Victim being required to clean the house. The case was accepted for investigation and assigned a routine response.

The caseworker made an unannounced home visit and asked Step Mother to come outside. Step Mother stated she felt she was being harassed and was anxious to know who reported the family this time. She stated the animal urine smell was from her bedroom carpet because Victim allowed the animals to urinate in there. She said she was trying to get the room cleaned and get rid of the animals but this was a slow process. Step Mother reported that Victim did not eat which was why

she looked so frail. When asked for the name of the children's doctor, she had to go inside the home to get the information. The caseworker was left standing on the porch for fifteen minutes. At this time, Father returned home. He was irate and angry at DFS for "harassing them" and demanded to speak with the caseworker's supervisor. He reported that DFS had been to the home 30 to 40 times in the past two years for allegations of abuse and neglect. The caseworker asked to see the children and noted his observations. Victim appeared to be underweight and frail. The parents reported that she was seeing a therapist and had PTSD from Mother's abuse and having to deal with DFS. No safety plan was initiated. The supervisor's notes indicated that the caseworker saw no cats at the home, the home was smelly but nothing to put the children in danger, the children were happy and healthy, and the twelve-year-old was frail but under doctor's care. It should be noted that the caseworker never entered the home and no contact was made with the doctor to confirm he/she was aware of the weight issue and providing appropriate care. A collateral was completed with the mental health facility but no progress notes were provided.

While the case remained active with DFS as an investigation, a subsequent referral was received by the DFS Report Line in May 2011 expressing concern for Victim following a welfare check by law enforcement. When the reporter arrived to the home, the children were playing in the hot tub in the back yard, except for Victim, who was confined to her room on punishment because she was caught sleeping instead of cleaning. When the caller asked to see Victim, she was brought out onto the porch. From what he could see standing in the doorway, the caller estimated there to be about 30 cats living in the home and noted cat feces to be everywhere. During the conversation with Victim, she made no disclosure but seemed afraid. Her parents hovered nearby; therefore, the reporter did not feel he could adequately speak with Victim regarding what was going on inside the home and suggested DFS respond to investigate further. He could not see any visible injuries. The report was accepted as an urgent response. The caseworker and caller responded to the home later that evening. They spoke with Victim in her bedroom, with Father nearby, as she had already taken her medication, which helped her to sleep, and was in her nightclothes. The caseworker noted Victim spoke like she was in a trance – staring straight ahead without blinking. Victim stated her new medications were helping her as she no longer banged her head on the wall and no longer had delusions of an old man and four-year-old boy visiting her. She also stated she had signed herself out of school because children picked on her for her appearance and when she would get a scratch or bruise on herself from playing, the school would contact DFS or police. The caseworker noted the home to smell of cat urine and was cluttered but not with trash or food, only clothing and such. Father reported the family had just returned from a trip to Disney and the neighbor was supposed to let the cats outside to use the bathroom but did not so the cats did so inside the home. He also stated Victim appeared to have the onset of adolescent schizophrenia. She was seen by a psychologist but Victim recently stopped talking to her; it was therefore suggested that she see a new therapist. The other children were not interviewed due to the time. The caseworker and reporter assessed the children to be safe.

The caseworker sent a collateral form to the children's PCP; the results of this form are not documented. The caseworker confirmed that the children were withdrawn from school to be homeschooled by the parents. No collateral was documented with the psychologist. The case was closed, unsubstantiated with concern, risk. The caseworker noted the family to be "strange and distant, suspicious of others" but "capable of making choices for the family." The caseworker also noted "family history was taken into consideration."

In September 2011, a referral was made to the DFS Report Line alleging the physical abuse of Victim. The reporter's relatives lived next door to the family's residence and the children played together. The children told her stories of the family's children being abused and mistreated but

she did not believe them. They claimed Victim was made to clean all the time and was not allowed outside during the summer. They have also reported Victim was made to stand outside during the rain. The reporter decided to call when her sister-in-law reported seeing Step Mother take Victim out to the edge of the woods and made her stand there for over an hour. She also reported the child was yelled at and slapped in the face. The sister-in-law never called the police or intervened on the children's behalf. The caller advised that the children stated that a couple of weeks ago, Victim had to lie on her stomach with her hands behind her back while Step Mother held her feet. Victim was crying during this encounter.

The caseworker responded to the home, eleven days following the report, and was met by Step Mother on the front steps. They spoke of Victim's alleged self-injurious behavior. Step Mother reported that Victim had been committed over the summer because she was upset over an incident that escalated from her not wanting to clean her room. Victim took medications. Emergency services were called and she was committed to a behavioral health facility. Step Mother reported that Victim had changed therapists but had only seen her new therapist twice. The caseworker asked to see the children, and they were brought out to the steps. The children did not appear to have any visible markings and seemed appropriate. A collateral contact was completed with the children's PCP. He noted concerns of the children's immunizations not being up to date, Victim's history of cutting, Victim's weight and the children needing current well child check-ups. The PCP noted Victim was last seen exactly one year prior in September 2010.

There was no further documentation for this investigation provided.

Near Death Incident

In August 2012, a report was made to the DFS Report Line alleging physical abuse of Victim by Father. The caller stated that she saw Victim in the home approximately three and a half weeks ago. Her face was swollen, black and blue, and the whites of her eyes had broken blood vessels. When asked about her face, Victim responded that she hit herself with a brick in the face to get Father's attention. When Step Mother was confronted about the incident, she noted that Father would not take Victim to the doctor until the swelling had gone down. He did not want to be blamed for causing the injuries. The caller stated that the parents have threatened Victim that if she told the therapist about the household, she would "get it." The caller went back to the house to see if Victim had been seen by a doctor; she had not. She also reported Victim to be dirty, wearing dirty clothes, was distant, and huddles in the corner. The parents stated that if they gave Victim nice clothing, she would mess them up. The home had 28 cats and one sickly dog; there was animal urine throughout the home. It was also revealed that Father had stopped giving Victim her medication; the therapist was unaware of this. The report was accepted as a Priority 2 (response required within three days).

The caseworker made two attempts to contact the family. On the second attempt, she was met at the driveway by Father. She explained the allegations but Father did not invite her into the home. He claimed that Victim was diagnosed with prolonged PTSD, anxiety and Depression. Step Mother came outside and joined the conversation. When asked, Father denied stopping Victim's medication recently as when they had done so in the past "things were not good." He stated that they changed therapists because the prior one wanted to discontinue medication; her first appointment with the new therapist was that evening. Father acknowledged the bruises on Victim. He stated she would hit herself or throw herself down when she became upset. They sometimes gave her more medication to help her calm down. The therapist told them this was okay.

Father claimed that Victim overheard a conversation about 2 weeks ago, stating that maybe if Victim was sent to live with her Paternal Grandmother (“PGM”), she would do better. He said when Victim heard this; she flipped out, went outside and got a rock, and hit herself in the face with it. Step Mother complained that PGM treats Victim more like a 1-year-old than a 14-year-old. Step Mother stated that PGM was at the house yesterday and got upset when they would not allow Victim to go with her then. This, Step Mother surmised, was why DFS was again involved. Father added that the therapist did not want Victim in an environment where there was anything she could use to harm herself. Father alleged there were guns owned by his stepfather in PGM’s home and until they were removed, he would not permit Victim to stay there.

At the caseworker’s request, Step Mother brought the children outside. Step Mother and Father did not leave as the caseworker began talking to the children. Victim was noted to appear more like a 7-year-old than a 14-year-old. She was extremely small in stature and weight, with pale skin and a sunken in face. She had dark circles under her eyes and her left eye had broken blood vessels in it. Her lips were busted and there was dried blood on them. When asked, Victim stated she had hit herself. She had numerous scratches all over her neck area, which she attributed to scratching at mosquito bites. She said bruising to the right side of her face occurred because she punched herself. She admitted to the caseworker that she did not know why she does what she does; she just hurts herself when she’s mad. She reported feeling safe at home.

The caseworker observed the other children to be clean and appropriately dressed. All were home-schooled. All denied anything of concern and stated they felt safe at home. The children were sent back inside the home. Father stated that last year was one of the roughest with Victim and the suicide of her 18-year-old half-sibling, ST, did not help matters. He said Victim has gone through phases with her issues and tantrums. When questioned about Victim’s weight, Father noted that she also went through phases where she would not eat. Her therapist was aware and the medication was supposed to help with weight gain.

The caseworker never entered the home and there was no documentation to suggest she requested to do so. She noted the children to appear safe at home but had some concerns with Victim’s appearance and behavior. She later called Father and requested him to have Victim seen by her PCP the following day.

The caseworker consulted with her supervisor. It was unclear if there was a pattern of abuse with the family or if the previous DFS activity was due to the children’s mental health issues. The supervisor contacted the PCP’s office and stated they were concerned about possible child abuse/neglect. Father reported to the doctor that Victim was abused by the former pediatrician. Victim was found to have a hematoma on her ear which was so bad it had to be drained. Victim admitted to self-injurious behavior and denied abuse/neglect by anyone. The doctor was so concerned about abuse/neglect that she had two other doctors also look at Victim. They suggested Father take her to the children’s hospital for further examination; however, they did not offer transportation. The doctor contacted the children’s hospital to inform them of the situation and noted that they would contact law enforcement if the family did not show.

Father followed up with the caseworker to inform her that the doctor wanted them to go to the children’s hospital. He advised that Victim’s current weight was 70 pounds, placing her in the first percentile for her height. The doctor instructed them to put Victim on a high calorie meal replacement drink. He stated that Victim had another episode last night where she was banging her head pretty hard and her ear was swollen. Father expressed his frustration to the caseworker

that he was a firefighter and a first responder that helped people but he could not help his own daughter.

PGM contacted the caseworker again expressing her concerns for the children. She stated that she raised Victim until she was seven years old. At that time, Father went to Indiana and picked up Step Mother, bringing her back to Delaware. He took Victim back to be with his family. PGM did not think she had any other choice but to allow Father to take Victim. She stated that Step Mother had other children who were left in Indiana, taken by the state. (DFS confirmed with the Indiana Protective Services that three of Step Mother's biological children were in the custody of Indiana due to issues of neglect and dependency.) PGM reported that she used to see the family one or two times per month and talk to them regularly on the telephone. However, over the past couple of months, Victim was not allowed to talk on the phone.

The children's hospital caseworker contacted the DFS caseworker to inform her that Victim had reported to the hospital. She weighed 65 pounds and was covered from head to toe in bruises, which she reportedly caused to herself by hitting and throwing herself down. Father did not want to leave Victim alone with the doctor because of the incidents involving the former pediatrician. His demeanor and behavior were appropriate, although Step Mother "threw a fit" and was cursing and yelling at the staff. Victim was examined by the child abuse expert at the hospital. He noted concerns of chronic malnutrition and neglect. Upon consultation with PCP, it was noted that Victim had only gained four pounds in two years; she weighed 61 pounds at her last visit. Victim reported that the scratches were caused by her cat; however, she had told the caseworker that she caused the scratches herself. Victim was admitted for fluids and observation. The hospital social worker saw Victim and reported "extremely positive interaction" among the family. Father was not in agreement with a plan until there was input from the psychiatrist. Victim was transferred to an in-patient mental health facility for a psychiatric admission following consultation by the children's hospital psychiatrist.

A collateral contact was completed with Victim's psychiatrist by the DFS caseworker. He reported last seeing the Victim on July 9th; her prior appointment was cancelled and she was scheduled for August 27th but did not show. The caseworker informed him that Victim had been admitted to the in-patient mental health facility. Victim's psychiatrist described her as "pretty bizarre." He stated she was diagnosed with Major Depression with psychotic features; she heard voices and had issues with her hygiene. He denied having seen marks or bruises on her but noted her to be small for her age, but he stated he did not think much about it. The caseworker informed the psychiatrist of the alleged brick in the face incident and reported self-injuries which he advised were never reported to him. He acknowledged it would be difficult to cause injuries to one's own back.

A home visit was conducted by the DFS caseworker and a co-worker. Father stated they were in the process of making some repairs to the home. There was a strong cat odor and a large number of flies inside the home. There were no sheets on Victim's bed, her floor was only sub-flooring, and the bedroom door was off the hinges. The boys' room had normal flooring and a door. The DFS caseworker spoke with the nurse practitioner that saw Victim at the children's hospital prior to her admission to the in-patient mental health facility. The nurse did not believe that Victim harmed herself. She stated that Victim being admitted to the in-patient mental health facility was best, because it would give them a chance to see how she does outside of the home. The caseworker made contact with the facility. They reported that Victim remained quiet but was participating in group sessions. They reported the family did not inform them that DFS was involved. A family session was scheduled for the following day. The staff were concerned that

Victim did not cause all of her injuries to herself, and no one had taken her to the doctor when she had injuries.

The caseworker met with Victim at the mental health facility. Victim gained 10 pounds in the five days since her admission. When asked about her injuries, she insisted she had caused them herself but denied using a brick or cinder block to cause any of the injuries. In regard to the marks on her back, she stated she flung herself from the porch to cause them. She stated she did not eat much at home, because she was not hungry. She did not shower much at home, because she did not like water, although she had showered every day at the mental health facility because she told staff she did not want to smell bad. The caseworker noted Victim to look much improved from the first time she saw her.

The mental health facility contacted the caseworker to note the family session went well and they were planning to discharge Victim the following week. They wanted DFS to know that they were still suspicious of the situation and felt Victim's bruises were too severe to have been self-inflicted.

A home assessment was completed of the paternal great-grandparent's home and she was found to be appropriate for placement of Victim upon her discharge. When told of the requirement of a safety plan for Victim to reside outside of the home, Father became upset and claimed that Victim's psychiatrist could attest to her self-harming. When asked who that would be, Father reported that Victim did not have one but gave the name of a prior psychiatrist that she was seeing more than a year ago. Father downplayed every injury and circumstance brought to his attention regarding Victim and the home environment. He requested a meeting with the DFS supervisor. That meeting occurred the following day with the paternal great-grandparents in attendance. At that time, a safety plan was signed by Father, the paternal great-grandparents, the caseworker and the DFS supervisor. Father was cooperative but expressed his desire that Victim's biological mother have no contact with her as he had a court order stipulating this.

Father suggested that Victim withdrew herself from school and chose homeschooling, because she was being picked on at school. Victim's psychiatrist thought it was best for her. A collateral contact was completed with Victim's school. They reported that Father withdrew Victim from school. They felt something was going on with Victim and tried to talk him out of it, to no avail. The school counselor had the impression that Victim was withdrawn because of the multiple DFS calls. She confirmed that Victim was bullied at school due to her coming to school looking unkempt and dirty. The school was willing to make any accommodations necessary for Victim that was deemed helpful.

Victim's former psychologist contacted the caseworker. She reported that she stopped seeing Victim in April 2011 because of the travel distance for the family and because it was her opinion that Victim needed more intensive treatment. She confirmed Victim's self-injurious behavior but stated the bruising she observed was always in places that could be reached herself, i.e. her arms, legs, etc. She admitted to having grave concern for Victim and that "something didn't sit right" with her. However, she did not feel that she had enough information to make a report to DFS. The psychiatrist also noted that Victim was referred to an outpatient mental health treatment facility in 2010 and a case was opened but Father pulled her from services shortly thereafter. She stated that Victim and Step Mother made comments regarding Father, such as "you don't know him or what he is capable of" and he "covers up everything." These comments were denied when later questioned. She stated she strongly discouraged the parents from withdrawing Victim from

school and urged them to look at other options. She too felt that the family was upset because of the multiple DFS reports made by the school.

The caseworker visited Victim at her paternal great-grandparents' home. Victim appeared clean, well-dressed and smiling. She agreed to return to school and was excited. She asked about Father but the caseworker suggested she get settled first and then they would make arrangements for a visit. A few days later, the paternal great-grandmother reported Victim was having nightmares, was mad at DFS for taking her out of her home and felt as if it were her fault that her 18-year-old half-brother committed suicide. She had spoken to Victim at length about her feelings and ensured her that nothing was her fault.

Victim had a follow up appointment at the children's hospital. A Computed Topography ("CT") scan and skeletal survey showed negative results. She reported to be happier than she used to be. The hospital contacted the caseworker and reported that the staff was amazed at how good Victim looked.

Victim began to open up about her abuse to her paternal great-grandmother. She reported that she was going to commit suicide by hanging herself but was worried about who would care for her sister. She reported that Step Mother would put her outside, hose her down with cold water and lock her out of the home. Step Mother would also put her in a cold shower as punishment. Step Mother would call her a liar and put two teaspoons of hot pepper in her mouth. Victim believed Step Mother hated her, and she would tell Victim it was her fault when Step Mother and Father would fight. Both Step Mother and Father told her she was crazy.

Father reported to the caseworker that Victim would be seeing a new therapist for weekly counseling. The therapist wanted to mix up the sessions with regard to who would be present during the sessions. Reportedly, Step Mother was scheduled to be in the session with Victim this evening. The caseworker contacted the therapist and expressed concerns with this; the therapist agreed to not allow Step Mother in the session.

During this time, Victim's second half-brother was killed in a motor vehicle collision. Father asked that Victim not be told. However, the paternal great-grandparents did not want her to find out from news or another outlet. Victim was upset at first but was handling the situation well. She wished to attend the funeral but was nervous about seeing Mother. After speaking with the therapist, a private viewing was arranged for Victim. She opted not to attend when she learned it would be a closed casket. Victim asked the caseworker to get a picture of her brother and a program from the funeral for her.

Victim requested to spend the weekend with her paternal grandparents. When Father learned of this, he became upset and told the caseworker the paternal grandfather was an alcoholic and owned firearms. The caseworker contacted the paternal grandmother and informed her that the firearms should be removed and no drinking was allowed in the presence of Victim. The overnight went well but, Victim returned to her paternal great-grandparents early due to the grandmother's back hurting. Father claimed that Victim was sent home from the previous visit due to the grandfather's drinking. Victim denied anyone had been drinking in the home.

The caseworker visited Victim at her school. As soon as she saw the caseworker, Victim informed her that she was ready to talk and tired of holding everything in. The caseworker stopped her and asked her to wait until a forensic interview was scheduled so that she would not have to tell her story twice. When asked how the visits were going with Father, Victim reported

that Father patronized her. Father told her he loved her and if she wanted to come home with her brothers and sister, she needed to make sure to not say anything about what happened. Victim stated she knew Father did not love her, because he used to tell her that he wished she were never born and that he hated her. Victim stated she never wanted to go back home.

Victim's forensic interview was scheduled for the beginning of October. During her interview, Victim reported she had not seen Mother in three to four years. She expressed she did not want to return to Father's home. She stated the hitting began when she was 10- years-old. Victim disclosed that Father hit, kicked, and punched her. Step Mother kicked her in the ear and mouth, and she required stitches on her ear. Father and Step Mother only did this to her, not her siblings. She had scars on her leg from being hit with a belt by Father. Step Mother had grabbed her by her hair and pulled her hair out and hit her on her feet with a switch. Step Mother had also gotten on top of her and forced cat feces with worms in it into Victim's mouth, holding her nose to ensure she swallowed it. When Step Mother would hurt Victim, she would say, "How do you like me now?" and call her "bitch" and "cunt." Victim was locked out of the house twice. The first time, she was 13 and was able to choose where she slept outside with no blanket or pillow wearing only a t-shirt and shorts. She chose the back porch. The second time, she was 14. This time, they soaked her with a water hose and sprayed her face for about one minute and she could not breathe. Step Mother kicked Victim in the face approximately 100 times. Step Mother kicked her in the mouth breaking her tooth. Step Mother threatened and pretended to burn her with an iron; she burned her fingertips. Food was withheld from Victim when she did not clean the house sufficiently. She stated she had gone as long as three days without food. Victim was made to sleep on the floor because the beds belonged to Step Mother. Victim would sometimes fall asleep on the floor while cleaning and her siblings would wake her, warning her to get up or she would get in trouble. Step Mother threw out Victim's clothes, because the dog urinated on them. She stated there were maggots all over the house. Victim reported that she got her black eyes from Step Mother punching her twice in each eye and grabbing her hair and banging her head on the counter top five times. Victim reported the other children were sometimes hit with a wooden spoon or a belt. One time, Father kicked Step Brother in the side so hard that it caused blood in his urine. Victim did not disclose the abuse earlier because Father and Step Mother told her if she did, her brothers and sister would be put into foster care and in foster care, they put children in cages. They also told her she would never see her siblings again. Victim stated she had never self-injured.

DFS filed for custody of the other children and placed them in a foster home. Father and Step Mother were at Troop 4, where they believed they were to sort through some things Victim disclosed to her counselor. When they learned that DFS had taken custody of the children, Step Mother became angry, threatened to sue, and requested that the children stay with her mother. This request was denied.

The foster family was concerned for the children's weight, but noted that at meal time, they would only eat small portions. Step Brother stated he did not eat much, because he wanted to lose weight. The caseworker spoke with the children. Step Brother talked negatively of Victim, blaming her for them being removed from their home. He reported that he did not want to see Victim, because she did bad things to him. He stated Victim locked the door, so he could not get out and forced him to "put his thing inside her." This happened about a month ago, when he was seven years old. When asked if he remembered this or someone just told him, he stated Step Mother told him and Step Mother never lied. Step Brother stated he was homeschooled because he missed his family when he was in school. CS, Victim's step sibling, reported that Victim was in the hospital with an infection because Step Mother had to punch her in the ear "for her own

good” and that Victim only had to be good and it would not happen again. He stated he was spanked on his butt with no clothes on with his parents’ hands, a switch or a stick when he was in trouble. He stated he was not in school but did not know why and wanted to go to school. HK, Victim’s half sibling, did not report anything negative. She stated Victim was at the hospital and she missed her. HK reported she was spanked with a belt or her parents’ hands for discipline. She wanted to go to school but Step Mother said she had to wait until she was bigger.

A Preliminary Protective Hearing was held in the middle of October. Father and Step Mother had been criminally charged and there was a No Contact Order in place between them and the children. The Judge ordered the children enrolled into school by the end of the week. The parents were ordered to bring the children’s clothing and personal belongings to the caseworker. Mother was present and requested visitation; DFS agreed to case plan with her. The three younger children had completed physical exams with their doctor and all three received immunizations. Step Brother was found to be in the 4th percentile for weight and 20th for height. CS was in the 55th percentile for weight and 16th for height. HK was in the 1st percentile for weight and 6th for height.

The DSCYF Safety Council conducted a thorough review of the case and concluded that the repeated abuse of Victim was not preventable. A Root Cause was not identified. The team identified ancillary issues involving the quality of collateral contacts, the screened out reports and the use of history.

Potential training topics resulting from this case include:

- Utilizing case history to identify a pattern of child maltreatment or violence (to rule cases in rather than out) and how to guard against developing preconceived notions.
- Reiterating the importance of having strong collateral contacts by identifying the appropriate persons to contact and individualizing the questions to obtain information relevant to the alleged issue/concern. Requests for immunizations should be in addition to the information gathered through medical/PCP contacts, not considered a collateral contact by itself.
- Ensuring all reports alleging marks that are unexplained or are not consistent with the explanation provided are accepted for investigation (i.e. September of 2010 Hotline Report).
- Enhancing interviewing skills that assist caseworkers in asking probing questions that elicit detailed information. It was during the recent investigation case (eighth DFS investigation case opened) that it was discovered that Step Mother had three other children in the care and custody of the state of Indiana. Additional probing questions such as number of children, where children were born, etc., may have uncovered this information at an earlier point in time.

Civil/Criminal Disposition

The DFS investigation was substantiated against Father for Suffocation, Medical Neglect, and Severe Physical Neglect, placing him on Level IV of the Child Protection Registry. DFS also substantiated against Step Mother for Blunt Force Trauma, Severe Physical Neglect, and Bizarre Treatment, placing her on Level IV of the Child Protection Registry.

All children were placed in DSCYF Custody in October of 2012. Parental rights as to the three younger children were terminated by the Family Court in January of 2015. Father's parental rights in Victim were terminated in January 2015 but Mother's rights were left intact.

In February 2014, Father pled Guilty to Assault by Abuse/Neglect (sentenced to 25 years Level V {with credit for 5 days previously served} suspended after service of 2 years for 2 years Level III), Endangering the Welfare of a Child (felony; sentenced to 2 years Level V suspended to 1 year Level III), and three counts of Endangering the Welfare of a Child (misdemeanor; sentenced to 1 year Level V suspended to 1 year Level III for each count). Father's sentencing to be served concurrent; cumulative sentence is 30 years Level V suspended after service of 2 years to 2 years Level III. Step-mother pled Guilty to Assault by Abuse/Neglect (sentenced to 25 years Level V {with credit for 8 days previously served} suspended after service of 2 years for 6 months at Level IV {Home Confinement} followed by 2 years Level III), Endangering the Welfare of a Child (felony; sentenced to 2 years Level V suspended for 1 year Level III), and three counts of Endangering the Welfare of a Child (misdemeanor; sentenced to 1 year Level V suspended to 1 year Level III for each count). Step-mother's sentencing to be served concurrent; cumulative sentence 30 years Level V, suspended after service of 2 years to 6 months Level IV (Home Confinement) followed by 2 years Level 3.

As a result of this investigation, a referral was made to the Division of Professional Regulation due to the child's therapist's failure to report child abuse/neglect of the child.

Strengths of the Case

1. The DFS caseworker, who handled the final investigation, should be praised for her work and efforts to bring this child to safety.
2. The CAN panel acknowledged the Department of Justice and law enforcement for their efforts in prosecuting the perpetrators in this case.
3. The Family Court should be commended for its thorough findings of abuse in this case and its comprehensive decision regarding all four children.
4. The Family Court judge should be commended for his excellent interaction with the child regarding questions from both the defense and prosecuting attorneys with ease despite the horrific detail of such questioning.
5. Victim's counselor post-incident has provided excellent treatment to Victim.
6. The efforts of the school administrative staff and school nurses to continually push for services for the family, and continued efforts to address Victim's needs.

Concerns of the Panel

1. The Panel discussed concern that the child's therapist did not refer the family to the Division of Family Services as concerns of abuse were discovered.
2. No collaboration amongst the mental health community during the course of the child's treatment although four mental health facilities were involved.
3. Although the CAN Panel acknowledges the Department of Justice and law enforcement for their efforts in prosecuting the perpetrators in this case, both the father and step-mother's sentencing of 25 years for the offenses committed were suspended after service of only two years.

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; therefore, the following system recommendations were put forth:

Primary Recommendations

Division of Family Services

1. CDNDSC recommends that the Division of Family Services (DFS) comply with policy as it pertains to the Medical Examination Protocol for children between the ages of nine and eighteen years old, indicating the child must be seen by a registered nurse or physician's assistant to determine if more in-depth medical care is needed.
 - a. Rationale: In September 2008, there were four reports made to the DFS Report Line alleging physical abuse of the child. Three of these reports noted visible bruises on the child's right arm and upper back. However, during the course of the investigation, no medical assessment was initiated. In January 2010, a hotline report alleging physical abuse of the child was made, indicating Victim had various bruising and scratches on her body. The child denied she had self-injured and claimed not to know how she obtained the marks. No medical assessment was initiated. The next month, while the case remained active in Investigations, another hotline report alleging abuse was received, this time with bruising in a different location. There was no medical assessment. Again, in June 2010, yet another referral was received reporting bruising to Victim. The caseworker observed the bruises and determined that the marks did not appear to be the result of abuse. No medical assessment was initiated. In September 2010, a referral was received regarding the physical abuse of Victims' younger sibling by Father. The caller reported that Step-brother complained of pain in the mid-back area, which he later denied to the caseworker. No medical assessment was initiated. In April 2011, a referral was received alleging abuse and neglect of the children, with particular concern for Victim, who recently was observed with a black eye and described to be "skin and bones." Following a home visit, the caseworker noted the child to be underweight and frail. Step-mother reported the child was under the care of a doctor, but this was never confirmed. In May 2011, while the case remained active with a caseworker, a hotline referral was received alleging concern for Victim following a welfare check by law enforcement. Although both law enforcement and the DFS caseworker seemed concerned about the child's appearance and weight, again, no medical assessment was initiated.
 - b. Anticipated Result: Compliance with policy.
 - c. Responsible Agency: DFS
2. CDNDSC recommends that the Division of Family Services (DFS) identify and contact collateral sources that have relevant information pertaining to the allegation, and as necessary, directly address concerns identified during the investigation with collateral sources when the information is inconsistent. (Revised by panel on 4/30/15)
 - a. Rationale: Throughout the life of this case, there were several instances where collateral contacts were not completed or not completed to standard per policy manual. In 2008, there was an investigation during which three additional hotline reports were made. During the investigation of the fourth report, one collateral contact was completed with the child's therapist, which consisted of only a voicemail left for the therapist. There was no other documentation to confirm a return call following the voicemail. The cases were ultimately abridged or closed,

unsubstantiated with concern. A subsequent report was made in 2009 regarding physical abuse of the child's sibling. During this investigation, there was one collateral contact completed with that child's primary care physician. No second collateral was documented. In 2010, during the investigation of a hotline report, two attempts were made to contact the child's therapist for a collateral contact. However, there was no documentation to support that a conversation ever took place. The paternal uncle was utilized as a collateral contact, and although he noted no concerns of abuse or neglect, he admitted that he did not have much contact with the family. In April 2011, a hotline referral was received alleging abuse and neglect of the children. The caseworker made a home visit and noted the child to be underweight and frail. Step-mother stated the child was under the care of a doctor. No collateral was pursued to confirm the doctor was aware of the weight issue and providing appropriate care. Following a May 2011 hotline report expressing concern for the child, the caseworker submitted a collateral form to the child's primary care physician; results of this form were not documented. Throughout the history of this case, the child's psychologist was referred to as a collateral contact. But in September 2012, the caseworker was contacted by said psychologist who stated that the family had been transferred to another practice in April 2011 due to transportation issues and the child requiring more intensive treatment. Hence, the prior notations of collateral contacts with said psychologist are in reference to a previous contact and not an appropriate, updated contact.

- b. Anticipated Result: To ensure compliance with policy.
 - c. Responsible Agency: DFS
3. CDNDSC recommends that the Division of Family Services (DFS) ensure appropriate services are being rendered as identified by collateral contacts.
- a. Rationale: On multiple occasions, the children's school counselor was utilized as a collateral contact. The counselor noted concerns of the children being abused and/or neglected; however, appropriate services were not explored for the family. On one occasion, the children's primary care physician noted the children to be out of date with immunizations and well child check-ups, and concern for Victim's weight and history of cutting; however, arrangements were not made to update the children's medical treatment nor to address Victim's needs.
 - b. Anticipated Result: To ensure the child(ren) are receiving proper treatment.
 - c. Responsible Agency: DFS
4. CDNDSC recommends that the Division of Family Services' (DFS) caseworkers make reasonable attempts to interview the children alone when a joint investigation is not yet necessary.
- a. Rationale: In this case, the DFS caseworker failed to interview the children involved and failed to gather additional collateral information to investigate the allegations made. Following the April 2011 hotline report, the caseworker conducted an unannounced home visit and spoke with Father and Step-mother on the front steps. The children were asked to come outside for observation, but then were not interviewed regarding the allegations. The caseworker never entered the home. The twelve-year-old appeared underweight and frail; Step-mother stated she was under the care of a doctor. No collateral contact was attempted with the doctor.
 - b. Anticipated Result: To ensure the safety and well-being of the children.
 - c. Responsible Agency: DFS

5. CDNDSC recommends that in cases where the family has an accumulation of risks, and additional risk factors are made known during each subsequent investigation the Division of Family Services (DFS) should consider screening the report in for investigation.
 - a. Rationale: Cumulatively, there were sixteen hotline reports made between September 2008 and August 2012 alleging physical abuse and/or neglect of the children. The majority of these reports were made by school officials. The Panel was concerned that DFS failed to properly investigate the allegations of child abuse and neglect or address such issues once they were made known. As a result, DFS failed to properly identify risk and ensure the safety and well-being of each child residing in the home.
 - b. Anticipated Result: To ensure the safety of all children known to DFS and provide earlier intervention when needed for families with multigenerational and chronic patterns of child abuse and/or neglect.
 - c. Responsible Agency: DFS

6. CDNDSC recommends that in compliance with the Memorandum of Understanding (MOU), the Division of Family Services (DFS) notify law enforcement when a crime against a child has been reported.
 - a. Rationale: In February 2010, a hotline report alleging physical abuse of the child was received, indicating that the child had various marks of bruising and scratches on her body. The child stated she did not self-injure nor know how she obtained the marks. Law enforcement was not contacted regarding this incident. In June 2010, another report was received alleging physical abuse of the child, also with various bruising and scratches. Again, law enforcement was not contacted.
 - b. Anticipated Result: Compliance with the MOU.
 - c. Responsible Agency: DFS

7. CDNDSC recommends that the Division of Family Services (DFS) adhere to policy and transfer the case to treatment when risk is significant at case closure.
 - a. Rationale: In a span of approximately four years, there were numerous referrals made to the hotline alleging physical abuse of the children by the mother, father and/or step-mother. During many of the investigations, the children revealed they were physically disciplined as a form of punishment. These investigation cases were never referred to treatment so that the family could receive services to address their parenting skills and methods of discipline, or any other needs the family may have had.
 - b. Anticipated Result: To ensure the safety of the children by providing the family with alternate, more appropriate discipline techniques, and address any other needs the family may have.
 - c. Responsible Agency: DFS
 - d. Update: Structured Decision Making® (SDM) Risk Assessment Tool was implemented by DFS since this incident.

8. CDNDSC recommends that the Division of Family Services (DFS) adhere to policy in Investigation and Treatment cases by listing all children in the household of the parent and/or caregiver who are subject to the investigation, and physically assessing the safety of all of the children.
 - a. Rationale: During several of the investigations alleging physical abuse of a child regarding this family, only the child identified as the victim in that particular investigation was assessed. The other children residing in the home were not properly assessed for safety.

- b. Anticipated Result: To ensure the safety and well-being of all children residing in the home.
 - c. Responsible Agency: DFS
- 9. CDNDSC recommends that the Division of Family Services (DFS) not close a case until all related assessments and interviews have been completed and reviewed.
 - a. Rationale: In the June 2010 investigation alleging physical abuse of the child, the case was closed, unsubstantiated with concern on July 20th. However, an interview was scheduled with the Children's Advocacy Center (CAC) on July 29th. The family did not attend the scheduled interview and informed the caseworker that the child's psychologist advised the child was too fragile and beginning a new medication regime. They claimed the psychologist would assist in rescheduling the interview when the child was stabilized. The caseworker never followed up with the psychologist and the interview was never rescheduled. New referrals alleging physical abuse were received in September 2010.
 - b. Anticipated Result: To ensure the safety and well-being of the child.
 - c. Responsible Agency: DFS
- 10. CDNDSC recommends that in serious injury cases, the Division of Family Services' (DFS) caseworker/supervisor confer with the Child Protection Unit in the Family Division of the Department of Justice in order for a determination to be made as to whether or not custody should be sought or a safety plan should be implemented.
 - a. Rationale: Throughout the life of this case, following multiple hotline reports, home visits, and disclosures of abuse and neglect by the children, the Child Protection Unit was never consulted and no safety plans were implemented by the DFS caseworker.
 - b. Anticipated Result: To ensure the safety and well-being of the children.
 - c. Responsible Agency: DFS
- 11. CDNDSC recommends that the Division of Family Services (DFS) consider closure or ongoing service only after the parents have completed evaluations recommended by DFS on behalf of themselves and the child, and providers' recommendations have been reviewed by DFS and then incorporated into the safety planning and risk assessment.
 - a. Rationale: Throughout the life of this case, multiple investigations were closed prior to the family following through with recommended services and/or prior to the results of such recommendations were considered by the DFS caseworker/supervisor.
 - b. Anticipated Result: To ensure the safety and well-being of the children.
 - c. Responsible Agency: DFS

Multidisciplinary Team

- 1. CDNDSC recommends that a forensic interview at the Children's Advocacy Center (CAC) be strongly considered for cases involving physical injury for purposes of conducting an effective joint investigation **AND** for the utilization of the multidisciplinary team for communication and collaboration. Moreover, when considering whether a forensic interview should occur, one should take into account the child's cognitive, developmental, and emotional abilities, as well as, safety issues including the environment and suspect's access to the child.
 - a. Rationale: In 2001, DFS received a report alleging the physical injury of child by mother. Child presented with a cigarette burn to her arm. The Division of Family Services (DFS) responded to the child's residence where the injury was photographed; however, the child was not interviewed by the caseworker as it was

late and the child was reported to be emotional. This case was closed as unfounded due to lack of evidence. During this investigation it does not appear that child was ever questioned about the circumstances surrounding how she received her injury, child was only observed by the caseworker. In 2008, DFS received two hotline reports, within 13 days of one another, alleging physical injury to the child. Child presented with bruising to her back and to her face. When the child was questioned as to how these bruises occurred child gave inconsistent statements. This case was unfounded as well. In January 2010, a report was made to the hotline alleging physical injury, a bruise to the child's right cheek, and concern regarding the child looking disheveled. This report was screened out. Two additional reports came in that month alleging physical injury, including various bruises and scratches to child's body. It should be noted, that at the point of this report, various professionals had concerns regarding the child as the child was unable to articulate how her injuries were occurring. This case was unfounded. Six months after the January 2010 report, a fourth report was made alleging physical injury, various bruises and marks to the child's body. A fifth report was also received four months later, stating that child has been removed from school and enrolled in homeschooling. Both of these reports were unfounded. In the summer of 2011, two reports were received alleging physical injury and neglect. Law enforcement responded to the child's residence. Contact was made with the child but no visible injuries were observed and child was interviewed in front of the alleged perpetrator. Additionally, in the fall of 2011, a report was received alleging concerns of bizarre behavior/discipline. The caseworker responded to the home, but was not allowed into the residence. Child was observed by caseworker in front of perpetrator, child was not interviewed. During the course of the above mentioned reports and investigations, the alleged perpetrators repeatedly advised the caseworkers and other professionals that the child was self-injurious and the family was continuing to seek services for the child. However, these allegations relating to the child's mental health status were never confirmed. Between 2001 and 2011, there were nine investigations conducted by DFS in which physical injury was alleged. At no point during these investigations did the child receive a forensic interview or did an initial joint investigation between DFS and law enforcement occur. Noteworthy, there were also two referrals screened out, one being from a professional. Only because of the persistence of the reporter, who contacted the DFS Administration was the case accepted for investigation.

- b. Anticipated Result: It is firmly believed that if a joint investigation and forensic interview had been conducted then an opportunity would have been created for the multidisciplinary team to analyze the chronic history presented with the child and family, collaborate the case facts, assess the accumulation of risk presented to the child, and provide an overall safe environment for the child to potentially disclose. The use of the CAC would have allowed the child to be interviewed without a suspect present as suspects are not permitted to attend the interviews. This would have allowed the child a better opportunity to talk about what was happening in the home. Furthermore, the use of the CAC is considered best practice for the most successful case outcomes, as multiple interviews by multiple interviewers can be detrimental to the child and can create issues for successful civil and criminal case dispositions.
- c. Responsible Agency: DFS, CAC, Department of Justice and Law Enforcement

Medical – Primary Care Physicians

1. CDNDSC recommends that primary care physicians (PCP) comply with best practice as it pertains to the transportation of child(ren) by parent(s)/caregiver(s) when there is a suspicion of child abuse and/or neglect and it is believed that the abuse and/or neglect was inflicted by the parent(s) and/or caretaker(s).
 - a. Rationale: In August 2012, the child was seen at the pediatric physician’s office by three doctors. All three confirmed their concerns of abuse and neglect and instructed the child be taken to the children’s hospital. Despite their concerns, the doctors allowed the child to be taken by her father, presumably the alleged perpetrator of the abuse, with the understanding that law enforcement would be called if they did not report to the children’s hospital within a few hours.
 - b. Anticipated Result: To ensure the safety and well-being of the child.
 - c. Responsible Agency: Primary care physicians

Child Protection Accountability Commission

1. CDNDSC recommends that the Child Protection Accountability Commission (CPAC) develop a tool to educate professionals about the warning signs and indicators of physical abuse and neglect by torture. This tool shall be focused for all professionals to include school administration and staff, law enforcement, social workers, caseworkers and other professionals that may be involved in such cases. This tool shall also reflect that the child’s denial of allegations of physical abuse and/or neglect should be expected.
 - a. Rationale: In hindsight, there were many indicators throughout this case that could have prompted further intervention and/or treatment with a potential to have prevented the serial abuse and neglect of the child by providing services to the family or removal of the children from the household. Some examples are the parents not allowing the children to be interviewed alone with the caseworker and/or law enforcement, one child standing out from the others in terms of appearance and discipline, removal of the children from public school for home schooling, and multiple hotline reports made by various non-related sources, such as medical professionals, law enforcement and school administration.
 - b. Anticipated Result: To provide professionals with an overview of signs to look for and expectations regarding serious injury or torture, resulting in appropriate assessment of the child’s safety and well-being.
 - c. Responsible Agency: CPAC
 - d. Update: Action in progress.
2. CDNDSC recommends that the Child Protection Accountability Commission (CPAC) review and discuss the current regulations regarding home schooling. CPAC will address any changes that need to be made to the regulations with the Department of Education (DOE).
 - a. Rationale: The current home schooling guidelines require parents to submit an application request. At the time of submission, there are no requirements to demonstrate curriculum and/or lesson plans. Single family home school means the education of one’s own child(ren) primarily by the parent or legal guardian of such child(ren) mainly in their own residence. The only state requirements are that end of year attendance is submitted to the DOE by July 31 and a statement of pupil enrollment be submitted to the DOE by October 31 annually. In this particular case, following multiple hotline reports of physical abuse and neglect of the children, the father withdrew the children from public school for the purpose of home schooling. The step-mother had primary responsibility for the children’s education, although she only had an eighth grade education.

- b. Anticipated Result: To provide more safety and protection for those children who are removed from a school setting and provide structure, guidance and oversight to home schooled children.
- c. Responsible Agency: CPAC and DOE

Department of Education

1. CDNDSC recommends that Child Protection Accountability Commission (CPAC) review and discuss the current regulations regarding home schooling. CPAC will address any changes that need to be made to the regulations with the Department of Education (DOE).
 - a. Rationale: The current home schooling guidelines require parents to submit an application request. At the time of submission, there are no requirements to demonstrate curriculum and/or lesson plans. Single family home school means the education of one's own child(ren) primarily by the parent or legal guardian of such child(ren) mainly in their own residence. The only state requirements are that end of year attendance is submitted to the DOE by July 31 and a statement of pupil enrollment be submitted to the DOE by October 31 annually. In this particular case, following multiple hotline reports of physical abuse and neglect of the children, the father withdrew the children from public school for the purpose of home schooling. The step-mother had primary responsibility for the children's education, although she only had an eighth grade education.
 - b. Anticipated Result: To provide more safety and protection for those children who are removed from a school setting and provide structure, guidance and oversight to home schooled children.
 - c. Responsible Agency: CPAC and DOE

Society for the Prevention of Cruelty to Animals

1. CDNDSC recommends that the Society for the Prevention of Cruelty to Animals (SPCA) receive training on the correlation of animal cruelty and interpersonal violence including child abuse, child neglect and domestic violence.
 - a. Rationale: Three complaints were investigated with the family which brought professionals into the home. The professionals failed to recognize the negative environment thus failing to report concerns to the proper authorities. Had the professionals been aware of the warning signs and reported concerns to the Division of Family Services' Child Abuse and Neglect Report Line, interventions would have occurred sooner rather than later.
 - b. Anticipated Result: Animal control officers will be able to recognize the warning signs and/or red flags associated with child abuse and/or neglect.
 - c. Responsible Agency: SPCA

Division of Professional Regulation

1. CDNDSC recommends that the Division of Professional Regulation (DPR) address the failure of the mental health community in the following ways:
 - Failure to recognize and report child abuse;
 - Failure to communicate with other mental health providers regarding the child's care;
 - Failure to meet with child alone during outpatient treatment as the child clearly showed improvement while inpatient;
 - Failure to implement a higher risk level when the child's mental health condition became worse and/or remained unchanged over time; and
 - Training of mental health professionals in child abuse and neglect. The use of this case as a concrete example is recommended.

- a. Rationale: As evident in the review of the child's mental health records, the above listed failures remained consistent throughout the child's treatment with no action taken.
- b. Anticipated Result: Mental health professionals will be trained in the recognition and reporting of child abuse and/or neglect; and therefore, better able to serve the child(ren)s' needs.
- c. Responsible Agency: DPR

Ancillary Recommendations

Division of Family Services

1. CDNDSC recommends that cases involving multigenerational or chronic patterns of child abuse and/or neglect should require and be given a high level of supervisory oversight.
 - a. Rationale: Following a report in June 2010, a collateral contact was completed with the school nurse. The nurse reported that she had concerns about the children in the past. Specifically, they were becoming more withdrawn and coming to school with poor hygiene. The concerns were documented in the case history. However, no follow-up was completed to ensure the child's medical needs were met. Again, in June 2010, the school counselor for the child's sibling noted her concerns for the sibling coming to school with a backpack that smelled of cat urine, reported he had recently choked himself at school and Crisis was called, and at another point in time, he was pulling out his hair. The caseworker commented that the counselor was making assumptions of the child's home life and he failed to follow up on the expressed concerns.
 - b. Anticipated Result: To ensure the safety and well-being of the child.
 - c. Responsible Agency: DFS

2. CDNDSC recommends that the Division of Family Services (DFS) consider the children's behavior and/or mental health concerns such as suicidal/homicidal ideation, as potential indicators of child maltreatment.
 1. Rationale: In November 2008, school administration made a report alleging that the child, Step Brother, threatened to harm himself. There was an ongoing, active investigation of abuse of another child, Victim, within this family. DFS declined to intervene at the time. The school was instructed to direct the parents to obtain an emergency evaluation for the child and follow through with recommendations. If they failed to follow through, then DFS should be contacted.
 2. Anticipated Result: To ensure the safety and well-being of all children in the household.
 3. Responsible Agency: DFS
 4. Update: Mental health and behavior problems of a child in the household is now included in the Structured Decision Making® (SDM) Risk Assessment tool.

Child Death, Near Death and Stillbirth Commission (CDNDSC)

1. CDNDSC will track sentencing for all criminal investigation cases related to child abuse and/or neglect where prosecution has occurred for comparison and statistical purposes.
 - a. Rationale: The Panel expressed concern that the sentences for criminal child abuse involving serious physical injury may not be consistent, in some cases, with the severity of the crime and the impact on the victim. It was acknowledged that although the perpetrators in the case were each sentenced to twenty-five years Level V confinement for the charge of Assault by Abuse/Neglect, the sentence was suspended

after service of only two years at Level V followed by six months at Level IV (home confinement) and two years at Level III probation.

- b. Anticipated Result: To ensure that where a child is seriously injured, the range of recommended penalties fairly account for the severity of the crime.
- c. Responsible Agency: CDNDSC

Statement from the Panel

The CAN panel strongly disagrees with the DSCYF Safety Council assessment that this case was not preventable. From a broader multidisciplinary team perspective, there were several systems that interacted with this child and had the opportunity to intervene by preventing further abuse and torture.