



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

CAPTA¹ REPORT

In the Matter of
J.G.
Minor Child

9-03-2013-00019

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 is based on 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, Law Enforcement, and the Department of Justice.

Case Synopsis

The male child who is the subject of this review, J.G., was born in October 2012.

In August 2013, a referral was made to the Division of Family Services (DFS) Child Abuse and Neglect Report Line alleging a head injury of nine month old child. The case was opened for investigation. Upon initial evaluation at the Emergency Department (ED), J.G. was noted to have a linear skull fracture and facial bruising in various stages of healing that were inconsistent with the explanation provided by the Mother of J.G. (Mother of Baby/MOB) and the Father of J.G. (Father of Baby/FOB). Child also had elevated aspartate aminotransferase (AST), consistent with blunt abdominal trauma. He was transferred to the Children’s Hospital. A report was also made to Law Enforcement of the incident. Upon further examination at the Children’s Hospital, no fractures or broken bones were detected.

Family History: MOB

At the time of the review of this case, there was no history noted by DFS involving MOB. No alcohol or drug abuse history was noted, nor was there significant criminal history for MOB.

Family History: FOB

At the time of review of this case, FOB had no history with DFS, with the exception of the incident as noted above. FOB had multiple misdemeanor convictions in his criminal history, including underage consumption of alcohol offenses, disorderly conduct and shoplifting.

J.G.'s Near-Death Incident

In August 2013, a referral was made to the DFS Child Abuse and Neglect Report Line alleging a head injury of nine month old J.G. The case was opened for investigation. Upon initial evaluation at the ED, J.G. was noted to have a linear skull fracture and facial bruising in various stages of healing that were inconsistent with the explanation provided by FOB. J.G. also had elevated aspartate aminotransferase (AST), consistent with blunt abdominal trauma. He was transferred to the Children's Hospital for further evaluation. A report of the incident was made to Law Enforcement. Upon further examination at the Children's Hospital, no fractures or broken bones were detected.

The DFS caseworker and Law Enforcement interviewed MOB at the Children's Hospital. MOB explained that she had worked second shift, 3:30 p.m. to Midnight at a local credit card company. On the evening of the incident, she left J.G. in the care of FOB. MOB further explained that she and FOB recently had an argument that resulted in his leaving the home and staying with a friend. MOB reported that J.G. was the only child in the home.

According to MOB, FOB sent her a message the evening he was caring for their child and said that J.G. had pulled a shelf containing DVD's onto himself. FOB explained that J.G. cried at first, but then he calmed down and FOB assumed he was okay. When MOB returned home from work, J.G. was on the couch asleep with FOB. MOB picked up J.G. and put him in his crib, at which time she noticed the bruising on his face. Even though FOB said that J.G. had acted normal after the shelf fell on him, MOB still planned on taking him to his primary care physician's (PCP) office the next morning and she went to bed. MOB also mentioned that J.G. had awakened in the middle of the night and FOB got up with him and gave him a bottle, which was unusual. The following morning, FOB left to go to the friends' home where he had been staying. MOB reported that J.G. was acting fussy and inconsolable that morning. She noticed that the bruising on his face had become more pronounced than the night before. She gave J.G. acetaminophen. When she went to pick him up, she noticed that J.G. seemed really uncomfortable when she touched his arm. She decided to forgo the PCP's appointment and took J.G. directly to the ED.

MOB additionally reported to the caseworker and Law Enforcement that FOB drank alcohol occasionally. She admitted that there had been times when she had to intervene when FOB disciplined J. G.. He had yelled at J.G. on occasion and told him to "shut the fuck up". FOB had smacked J.G. hard on his bottom. MOB also stated that FOB sometimes would have to put J.G. down and walk away to cope. She said that their relationship has been stressful due to the baby. She denied any domestic violence in the past. MOB later revealed to the caseworker that FOB smoked marijuana in the home daily.

Later that afternoon, Law Enforcement responded to the residence and interviewed FOB. FOB advised that the evening before, he was in the living room watching television. J.G. was playing with a shelf that contained DVD and VCR movies. He pulled the shelf and it

fell on top of him, causing him to fall backwards and hit his head on the coffee table. FOB observed redness on the side of J.G.'s face. FOB reported that it took about 30 to 45 minutes for J.G. to calm down, but he seemed to be fine after that. FOB also reported that J.G. had also fallen off the couch and hit his head on the coffee table during this same evening. FOB had not reported that happening to MOB. A doll was used to re-enact the incident. FOB used the doll to demonstrate both the incident with the shelf and the fall from the couch. FOB reported that when MOB returned home, she noticed the bruising but he told her that J.G. was okay and that they all went to bed. The next morning, FOB went to his friend's house and when he returned, MOB and J.G. were gone.

The law enforcement officer responded to the Children's Hospital and learned that J.G. had not sustained a fractured skull or any broken bones but had sustained severe bruising to the left side of his face. He then observed J.G. in his treatment room and noticed the child's facial bruising to be consistent with a handprint. During the interview with MOB, the same consistent sequence of events was told by her as noted above. Based on this information, the officer decided to conduct a follow up interview with FOB. FOB was contacted and advised to report to the Police Headquarters. He complied and was read his Miranda Rights prior to the interview and agreed to speak with the officer about the incident. When FOB was confronted about the inconsistencies of his account of the incident, FOB admitted that the shelf never fell on J.G. He stated that he lost his temper and slapped J.G. at least five times with his open hand, causing the bruising on his face. FOB admitted that he was frustrated and snapped because J.G. would not stop crying. He advised that J.G. did fall off the couch, but that was after he had slapped him. The officer consulted the Attorney General's office regarding the investigation. Originally, a secured bail was recommended; however, upon arraignment, he was released on \$2,000 unsecured bond...not sure how to word that or that we just remove the secured bail recommendation all together and state that he was released on \$2,000 unsecured bond and a No Contact Order (NCO) between FOB and J.G.

J.G. was discharged to the care of MOB the day following his hospital admission. A safety plan was put into place addressing the NCO between J.G. and FOB that stated that FOB could only come to the residence with a police escort to obtain his belongings. MOB advised that her mother would be staying with her when she returned to work to assist with J.G.

The DFS caseworker conducted a scheduled home visit three weeks later during which time J.G. was napping. Maternal grandmother reported her concern that J.G. kept hitting himself in the face. The caseworker suggested that MOB discuss this with the pediatrician, as it may be a learned behavior from FOB. MOB reported they were doing well. She explained that she had talked to FOB a few times but he had not seen J.G. due to the NCO. MOB also asked if the NCO was still in effect. Although unable to say for certain, the caseworker did tell MOB that she assumed so based on the fact that the charges had not yet been resolved. MOB stated that FOB was depressed and agreed that he needed counseling but had no financial means to follow through with it. FOB was staying with friends; he had no job and no phone. The caseworker encouraged MOB that her focus should be on her herself and J.G. rather than concern herself with what FOB

had to do. The caseworker also advised that if the NCO was lifted, MOB should still be cautious about allowing FOB near J.G. until he received some type of treatment. MOB agreed.

Eight days later, another call was received at the DFS Report Line after Law Enforcement responded to the residence over the weekend because FOB went to the home. The DFS caseworker contacted MOB regarding the allegation. MOB stated that FOB did come to the home but was not inside the home. FOB started an argument over “relationship stuff” and was yelling at MOB because he had been “going through a lot” at the time. The caseworker stated that if DFS began questioning how protective MOB would be with J.G., they would look for other living arrangements for him. The caseworker reiterated that the terms of the NCO stated FOB could have no direct or indirect contact with J.G. or his residence. MOB understood and agreed with the DFS caseworker. Despite that incident, the caseworker closed the DFS case that day.

Criminal /Civil Disposition

In September 2013, FOB was substantiated for physical abuse (bruises, cuts and lacerations) requiring medical intervention, and the DFS investigation was closed. He was placed on the Child Protection Registry at Level III.

Following the Law Enforcement investigation, FOB was arrested and charged with Child Abuse 2nd. He was subsequently released on a \$2,000 unsecured bond with a No Contact Order in place between himself and the infant. In April 2014, FOB pled Guilty to Child Abuse 2nd, and in July 2014, was sentenced to two years at Level V, suspended for six months at Level IV (CREST), followed by 18 months Level III probation upon successful completion of the CREST (relapse prevention) program.

System Recommendations

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

Division of Family Services

1. CDNDSC recommends that the Division of Family Services (DFS) refer clients to the domestic violence liaison when violence against a non-offending caregiver or child is suspected or revealed during the investigation.
 - a. Rationale: Prior to the near-death incident, there were indications of domestic violence involving mother and child.
 - b. Anticipated Result: To ensure that the non-offending parent has the necessary resources to keep the child safe.
 - c. Responsible Agency: Division of Family Services