



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

CAPTA¹ REPORT

In the Matter of
N.C.
Minor Child

9-03-2013-00024

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 female child who is the subject of this review, N.C., was born in April of 2009.

In February of 2010, The Division of Family Services (DFS) Child Abuse and Neglect Hotline received an urgent referral for alleged abuse of infant. Reports indicated that ten-month-old, N.C. was seen by her primary care physician (PCP) due to her parent’s concern that she was in pain and not bearing weight on her right leg. Although developmentally, N.C. was not walking, she was standing while holding onto furniture and cruising. Following the initial medical examination, N.C. was noted to have linear bruising to her abdomen, which was yellowish in color and consistent with healing bruises. The DFS caseworker implemented a safety plan with the maternal grandmother supervising all contact between the parents and N.C. N.C. was then transferred to the children’s hospital for further medical treatment with N.C.’s maternal grandmother providing transportation. At the children’s hospital, it was revealed that the infant suffered from a fracture of the left humerus, fracture of the 7th and 8th ribs, and a fracture of the L3 vertebrae. A nuclear bone scan was completed and highly suggestive of additional fractures of the left transverse process of T1, right distal radius, left proximal femur, and right tibia. The CARE team suggested the fractures were all of varying stages of healing. Ophthalmology was consulted and N.C. was admitted to the trauma service. No abnormal eye findings were found. Head CT was completed and was normal.

History: Mother of the Baby (MOB)

MOB had a history of anxiety, depression, post-traumatic stress disorder, and cannabis dependency. MOB stated that she had taken Xanax for these conditions prior to her pregnancy of N.C. When N.C. was born, MOB tested positive for opiates and a report was

made to DFS. The case was investigated and reports indicated that MOB admitted to caseworker that she had struggled with drug addiction in the past. The case was closed, unsubstantiated with concern. MOB failed to comply with a substance abuse evaluation. Shortly after the incident described above, the DFS abuse and neglect hotline received another report alleging drug use by MOB while caring for N.C. The caseworker found no evidence to substantiate the allegations and the case was closed, unsubstantiated with concern, with a recommendation that MOB follow through with recommended drug treatment.

Family History: Father of the Baby (FOB)

At the time of review of this case, FOB had no significant criminal history as well as no history with DFS.

N.C.'s Near-Death Incident

In February of 2010, N.C. was seen by her PCP due to concerns by parents that she was in pain and would not bear any weight on her right leg. Parents reported that this had been occurring for the past three to four days. Parents were unable to provide an explanation as to N.C.'s injuries and no known trauma or accident was reported to medical staff.

Upon initial exam, N.C. was noted to have abdominal bruising, which was old and yellowish-brown in color. The bruising on the abdomen was noted to be linear in fashion and appeared to look like thumb prints. Parents reported that within the last twenty-four hours, N.C. had also been in the care of her maternal aunt. They explained that the aunt had noticed that N.C. was not bearing weight on her leg. Developmentally, N.C. was not walking but she was holding on to furniture and cruising.

The DFS Child Abuse Reportline was immediately contacted by the PCP office for allegations of physical abuse. A DFS caseworker responded to the PCP's office and met with MOB, FOB and N.C. The DFS caseworker interviewed MOB and FOB regarding N.C.'s injuries. Photographs were also taken. A safety plan was put into place stating that N.C. would reside with maternal grandmother (MGM) and that MGM was to provide supervised contact between MOB and FOB. The PCP office referred N.C. to the Emergency Department of the Children's Hospital for further follow up. MGM provided transportation to the hospital.

Law enforcement was contacted by DFS and advised of the situation. Prior to parent's arrival at the Emergency Department, both MOB and FOB were interviewed at the police station. MOB reported during the interview the previous night, N.C. had stayed with her maternal aunt. MOB said she had informed maternal aunt about N.C.'s leg pain. That morning, when she and FOB went to pick up N.C., maternal aunt indicated that N.C. seemed to be bothered by her leg and under her armpit. MOB further indicated that that the bruise on N.C.'s stomach had been there for approximately two to three days. MOB was unsure of where the injuries came from. MOB reported that those living at the

residence included her, N.C., FOB and a roommate. It was noted that the roommate does not care for the child. N.C. was reported to be under the sole care of her mother and father for the last week with the exception of the overnight stay with her maternal aunt. N.C. was seen by her PCP approximately a week before this incident for a high fever. It was noted at that appointment that N.C. was not in pain. MOB described N.C. as fussy, cranky, and constantly wanting to be held. MOB further stated that on occasion, she would throw N.C. up in the air and catch her. Mother believed that the bruising on N.C.'s abdomen could be a result of that. Additionally, MOB reported that N.C. had fallen off a small table about three weeks prior but did not appear to be hurt.

During FOB's interview, he stated that N.C. was picked up from maternal aunt's house and noted to be in a lot of pain, and therefore was taken to see her PCP. FOB did not recall any falls or occurrences where N.C. could have been injured.

Two days after N.C. was seen by her PCP and then transported to the ED at the children's hospital, law enforcement contacted the Delaware Child Abuse Expert where they were informed that the x-rays and bone scans had been completed. N.C. was noted to have a fracture of the left humerus, fracture of the left 7th and 8th ribs, and a fracture of the L3 vertebra. A nuclear bone scan was performed and highly suggestive of additional fractures of the left transverse process of T1, right distal radius, left proximal femur and right tibia.

When MGM was interviewed by the DFS caseworker, she revealed that MOB had a significant drug history and that as of September 2010, MOB had relapsed on a cocaine binge. MOB was kicked out of maternal grandmother's house but N.C. still remained there. In November, MOB and FOB returned to her residence in order to resume care of N.C. MGM also stated that about six weeks prior to N.C. going to the children's hospital, N.C. had some marks on her ears and stomach. The DFS caseworker conducted a home assessment of maternal grandmother's residence and determined that the home was appropriate, safe, with appropriate supervision and medical attention for N.C.

MOB and FOB requested that N.C. undergo genetic testing because she displayed symptoms of Brittle Bone Disease, specifically referencing N.C.'s spinal fractures.

MGM filed a temporary guardianship petition with the Family Court and was granted temporary guardianship of N.C. seven days after this near death incident.

In March of 2010, Delaware's Child Abuse Expert was consulted again by DFS and Law Enforcement. It was determined that testing had ruled out Brittle Bone Disease and Vitamin D deficiency. Moreover, the multiple fractures occurred on multiple occasions. Some fractures such as the right tibia, left humerus and right radius were thought to have occurred more recently due to the healing stages. The fractures were determined to have likely occurred fourteen days prior to the date N.C. was examined at the Children's Hospital. The seventh and eighth rib fractures were healing during the first x-ray and therefore occurred within the previous three months. It was further reported that the second left rib fracture was unclear on the first x-ray, so it was difficult to determine if

the fracture was to the spine or the rib. Delaware's Child Abuse Expert indicated that N.C.'s injuries were caused by inflicted trauma and that the fractures were unlikely to have occurred during the same incident.

MGM contacted the caseworker in order to be advised as to how to handle visitation with MOB and FOB. She reported that when FOB visits, he always wants to take N.C. outside or into a bedroom with the door closed. MGM was advised that N.C. cannot be left alone with mother or father and that contact should be made with the visitation center or visits should occur in public settings.

In May of 2010, MOB and FOB refused to take a polygraph examination upon advice received from their attorneys. The Attorney General's Office had reviewed the case in entirety and had elected not to prosecute due to insufficient evidence. The case was cleared and prosecution was declined until further evidence was discovered and suggested otherwise.

In December 2010, law enforcement spoke with MOB regarding her recall of some behaviors that father had exhibited while caring for N.C. MOB advised that she had observed N.C. acting in certain ways, such as projectile vomiting while in FOB's care. MOB however, was unable to offer any new information pertaining to the investigation.

In January 2011, a polygraph examination was conducted on MOB. MOB agreed that the injuries inflicted upon N.C. were not a result of natural occurrences, such as, falling. MOB denied causing any of these while she was on drugs. She further denied causing these injuries or knowing who caused these injuries. Upon conclusion of the polygraph examination, it was determined to be inconclusive.

It was further noted that while DFS had an open case in treatment, N.C.'s mother had given birth to another child who had tested positive for cocaine, opiates and benzodiazepines. The report was screened out as it did not meet the definition of maltreatment. However, mother's substance abuse was noted to be of concern and linked to the active treatment case. A High Risk Infant Protocol meeting was scheduled where it was revealed that N.C.'s mother had relapsed the day before delivery. DFS petitioned the Family Court for emergency exparte custody of this baby and mother was advised to seek treatment. Upon discharge, this child was placed in a foster home.

Criminal /Civil Disposition

In May of 2010, the Division of Family Services substantiated both parents for Physical Abuse, Level IV. The parents appealed the substantiations against them, and DFS withdrew their petition at the advice of their attorney as the perpetrator could not be identified. The DFS substantiation was reverted to an unsubstantiation, and the report listed all parties as not involved.

Criminal prosecution was declined due to insufficient evidence.

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:

Medical

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: During the February 2010 investigation, child was seen by her PCP who suspected abuse. DFS was called and advised the PCP to release the child to the family/suspected perpetrators, so that the child could undergo x-rays prior to DFS arrival at the children's hospital.
 - b. Anticipated Result: To ensure the safety of Delaware's children when abuse is suspected
 - c. Responsible Agency: Primary Care Physician

2. CDNDSC recommends that if a child presents with significant trauma and bruising then the American Academy of Pediatrics policy for physical abuse regarding the guidelines of head imaging be followed.
 - a. Rationale: Child had bruises to the face, noted on both sides of the nose and possible head trauma. A CT scan should have been considered for a child less than 2 years of age. Ophthalmology was to be consulted in 1 to 2 days for concerns of retinal hemorrhaging, however, such concerns were not noted in documentation. Child received a skeletal survey and was released. Child was then re-admitted for further follow up.
 - b. Anticipated Result: Best practice as it pertains to the examination of children presenting with significant trauma as identified through the AAP.
 - c. Responsible Agency: Emergency physicians, pediatricians and other primary care providers for children

Division of Family Services

1. CDNDSC recommends that the Division of Family Services follow the Memorandum of Understanding as it pertains to the contact of law enforcement prior to DFS response.
 - a. Rationale: In the February 2010 investigation, DFS did not contact law enforcement prior to their arrival at the hospital or after confirmation that the child had suffered from multiple unexplained injuries. In addition, the caseworker proceeded to interview parents without the presence of law enforcement. Law enforcement was contacted after the interviews were conducted.

- b. Anticipated Result: Compliance with the MOU
 - c. Responsible Agency: Department of Services for Children, Youth and Their Families
- 2. CDNDSC recommends that the Division of Family Services (DFS) follow best practice as it pertains to the utilization of staff personnel, specifically, only a properly trained DFS caseworker should be authorized to respond to a case, once transferred to treatment, in order to make case decisions regarding alcohol/drug abuse.
 - a. Rationale: A new hotline report was received after mother gave birth to another child who also tested positive for drugs. Substance abuse was a known risk factor, per policy the case was screened out and the allegations were referred to treatment to be addressed. Treatment completed the response within 24 hours; however, the response was completed by a Family Services Assistant.
 - b. Anticipated Result: Case decisions will be made by proper staff personnel.
 - c. Responsible Agency: Department of Services for Children, Youth and Their Families
- 3. CDNDSC recommends that the Division of Family Services reconsider its decision making process when closing investigations knowing that parents have substance abuse issues that have not been addressed. This non-compliance should be considered a possible issue for substantiation.
 - a. Rationale: According to FACTS, mother had two open investigations in the last 10 months due to substance abuse issues. Mother failed to comply with her recommended treatment.
 - b. Anticipated Result: Possible substantiation for non-compliance of recommended treatment.
 - c. Responsible Agency: Department of Services for Children, Youth and Their Families
- 4. CDNDSC notes that the Safety Plan was violated by father on more than one occasion and that the maternal grandmother was unable to provide appropriate supervision of the child. Therefore, it is recommended that in instances when a safety plan is violated or there is lack of enforcement as it pertains to visitation, that the Division of Family Services re-evaluate the plan and assess safety. Then if needed a referral can be made to the visitation centers.
 - a. Rationale: On more than one occasion father violated the safety plan that was implemented by DFS. Grandmother was unable to provide appropriate supervision as father would directly undermine her.
 - b. Anticipated Result: To ensure the safety of the child as well as provide a safer environment in order to reduce the risk of future abuse.
 - c. Responsible Agency: Department of Services for Children, Youth and Their Families

5. CDNDSC recommends that the Division of Family Services revisit policy concerning 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: During the February 2010 investigation, child was seen by her PCP who suspected abuse. DFS was called and advised PCP to release the child to the family/suspected perpetrators, so that the child could undergo x-rays prior to DFS arrival at the children's hospital.
 - b. Anticipated Result: To ensure the safety of Delaware's children when abuse is suspected.
 - c. Responsible Agency: Division of Family Services

Law Enforcement

1. CDNDSC recommends that law enforcement use a multidisciplinary team (MDT) approach when investigating cases of child abuse and neglect, especially as it pertains to the interviews of suspected perpetrators.
 - a. Rationale: In the February 2010 investigation, law enforcement conducted interviews with the parents without giving DFS the opportunity to observe.
 - b. Anticipated Result: MDT approach
 - c. Responsible Agencies: Delaware Police Departments
2. CDNDSC recommends that the Memorandum of Understanding be amended to include a suspected location of incident as it pertains to the criminal investigative duties of law enforcement. Specifically, that within the first twenty-four to forty-eight hours law enforcement should be going to the location where the alleged incident occurred for scene preservation and evidence collection.
 - a. Rationale: From documentation that was reviewed thus far, it does not appear that law enforcement established the location where the alleged incident occurred or obtain evidence from said location.
 - b. Anticipated Result: Compliance with best practice as it pertains to the investigation of child abuse cases.
Responsible Agency: Delaware Police Departments