



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

CAPTA¹ REPORT

In the Matter of
T.J.
Minor Child

9-03-2013-00020

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, T.J. was born in December, 2012.

In July of 2013, Law Enforcement responded to a local hotel for a report of an unresponsive infant. The seven month old infant and his two older siblings, ages three and five, were left in the care of T.J.’s father (Father of baby/FOB). FOB left the hotel room, leaving the children alone in the room. The Mother of the baby’s (MOB) paramour (Father of the older siblings) arrived at the hotel room discovering the children alone and T.J. unresponsive. A call was made to 911. T.J. was taken to the Emergency Department (ED) where he was pronounced dead. The Medical Examiner determined the cause of death to be Sudden Unexplained Death in Infancy (SUDI) with a history of co-sleeping. The manner of death could not be determined.

Family History: Maternal Grandmother (MGM)

Between December 1996 and December 2000, the Division of Family Services (DFS) investigated MGM seven times with allegations of abuse, neglect and/or dependency. She was substantiated for neglect after leaving her three children home alone overnight. She was also substantiated for a second incident of neglect as a result of leaving her three children alone for days at a time, while her 15 year old child was staying home from school to care for her younger siblings. MOB was listed as a victim in these cases.

Family History: MOB

In December 2012, a referral was made to the Division of Family Services (DFS) Child Abuse and Neglect Report Line alleging that MOB tested positive for marijuana following the birth of T.J. MOB denied marijuana use but stated that she lived with heavy

users. It was noted that MOB tested positive for opiates six days prior to T.J.'s birth for allegedly taking an un-prescribed Percocet for tooth pain. She was tested for opiates following the birth of T.J. however, those tests revealed negative results. The case was screened out as there was no indication that MOB's behaviors were impacting the care of the baby.

A second referral was made to the DFS Report Line in May 2013 by local Law Enforcement following a domestic violence incident between MOB and FOB. It was alleged that a verbal argument ensued while both parties were in a vehicle. FOB pulled the car to the side of the road, at which time MOB and the children got out of the car and crossed the street. FOB followed them and he punched MOB in the head multiple times knocking her to the ground. He then kicked her in the head a couple of times and fled the scene. Law Enforcement was contacted and MOB refused medical treatment. This case was also screened out as this was noted to be the first incident of domestic violence between the couple and the children were not significantly affected.

At the time of the review of this case, MOB had no significant criminal history with the exception of one juvenile offense.

Family History: FOB

FOB was charged with Assault 3rd and three counts of Endangering the Welfare of a Child as a result of the domestic violence incident described above. He also was involved in another domestic violence incident prior to this, which occurred in May of 2011. In that incident, he was charged with Offensive Touching and Criminal Mischief. He received 30 days at Level V, suspended to 12 months at Level III. In March 2012, he violated his probation and the probation was revoked.

FOB had several other criminal offenses in his history in addition to the incidents described above.

T.J.'s Death Incident

In July 2013, at approximately 10:00am, MOB left the motel to go to a farmer's market, leaving T.J. and his two older siblings (three and five years of age) in the care of FOB. FOB left the children alone in the motel room for an unknown period of time. MOB's paramour, the father of the two older siblings, entered the motel room to find the children alone in the room and discovered T.J. was stiff, cold to the touch and had mucous coming out of his mouth. He moved the other two children to another motel room, yelled for help and for someone to call 911. At approximately 11:43 a.m., a call was made to 911 reporting an unresponsive infant. FOB then called MOB to inform her that T.J. was being taken to the ED. T.J. was pronounced dead at 12:11pm.

When Law Enforcement arrived at the motel, FOB was found in another motel room with a known prostitute and a heavy drug user. It was suspected that they were engaging in sexual relations. The father of the older siblings, had left the scene with his children. Law

Enforcement however, contacted him via telephone and requested that he return to the scene with his children. He complied and returned to the motel, however, he had dropped the older children off with the MGM.

Law Enforcement interviewed the known prostitute that FOB was found in the motel room with and there was no clear indication that she was having sexual relations with FOB at the time he was found in her room. She stated that she had known FOB for seven or eight years and he was like family to her. She reported that everyone used her bathroom because she was the only one that used bleach to clean the toilet. FOB was in fact found in the bathroom with his pants down by Law Enforcement.

Two versions of the incident had been alleged during the interviews. The first version described above was that the father of the two older siblings went to the motel to visit his children, finding them alone in the room and T.J. unresponsive. The second version reported by FOB was that he was in the room with the children but did not notice T.J. He said he went to the motel office to pay for the room and then to the known prostitute's room. FOB admitted to hearing Law Enforcement at the door. He was found in the prostitutes' bathroom by Law Enforcement and she was hiding under the covers.

Law Enforcement contacted T.J.'s MGM who was caring for the other two older siblings and she agreed to bring them to the Children's Hospital. At the same time, a referral was made to the DFS Report Line as a result of the child's death. The hotline noted a No Contact Order (NCO) in place between T.J., FOB and MOB as a result of a domestic violence incident that occurred in May 2013. Following the report, DFS responded to the hospital in time to observe the forensic interviews of the siblings at the Children's Advocacy Center (CAC).

The father of the older siblings was not in agreement with the children being interviewed at the CAC; however MOB and MGM agreed to allow the children to be interviewed with MGM accompanying them. During the interviews, the children reported observing T.J. being hit, but the team felt they were describing the cardiopulmonary resuscitation (CPR) process as there were no visible injuries to T.J.'s face/head area. Based upon the children's interviews, law enforcement detectives did not feel there was any information that would result in criminal charges.

The DFS caseworker interviewed MGM and completed a home assessment. However, none of the occupants in the home were interviewed during that home assessment. The caseworker then responded to the Police Station and interviewed MOB. MOB denied knowing there was a NCO in place. She agreed to a safety plan with maternal grandmother supervising all contact between her and the two remaining children until given further notice. MOB additionally agreed to abide by the NCO and understood that FOB would have no unsupervised contact with the children. As a result, the two older children were placed in the care of the MGM.

Law Enforcement contacted the caseworker and reported that the Division of Forensic Services found no signs of trauma, no fractures, and no petichiae. Since this was no longer

a homicide, the case was reassigned to the Major Crimes Unit. There was still concern that the death may have been the result of neglect. Two days following the death of T.J., an administrative review of the case was completed, DFS was granted custody of the children and they were placed in foster care.

Subsequent interviews by Law Enforcement resolved any concerns or inconsistencies that were originally discovered during the investigation. For instance, the hitting described by the children during their forensic interviews was determined to be FOB smacking T.J. in the face in an attempt to arouse him. Additionally, it was determined that FOB found T.J. unresponsive and ran to a neighboring room to get help. The neighbor called 911, and the operator walked this person through CPR since FOB was unable to compose himself in order to do so. FOB also ran out of the room a second time to the known prostitutes' room to use her cell phone to call MOB. FOB and the father of the other older siblings in the room did cross paths in the parking lot. However, it did not appear that children were left alone in the room and Law Enforcement found no evidence of criminal activity.

No concerns of abuse or neglect were reported to Law Enforcement by T.J.'s day care provider or pediatrician. According to Law Enforcement, T.J. was seen by the pediatrician three days prior to his death for suspicion of pink eye. T.J. had asthma and was prescribed Pulmicort and Albuterol.

At the Preliminary Protective Hearing, DFS rescinded custody of the children to the parents and the children were immediately returned to their mother.

In August 2013, a report was made to the DFS Report Line alleging verbal abuse of the children by the MOB. It was alleged that MOB took the younger child to the ED for a laceration just below his eye, reportedly from a fall off the couch. The explanation was determined to be consistent with the injury. The concern was of the MOB yelling at the children in the exam room and the MOB's disinterest in the child's medical treatment. Caller reported that the children were not misbehaving at the time the MOB was yelling at them and that she did not seem to be under the influence of anything. The case was found to be active in treatment with DFS. As a result, the report was screened out and the report was forwarded to the treatment social worker.

Criminal /Civil Disposition

In August 2013, the case was unsubstantiated by DFS and was transferred to treatment for services. At the time of this review, the case remained active in the treatment unit. No criminal prosecution occurred in this case.

System Recommendations

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

Primary Recommendations

Division of Family Services

1. CDNDSC recommends that the Division of Family Services (DFS), through the assistance of the Children's Research Center, conduct a quality review of the Structured Decision Making® Screening Assessment to look at screened out hotline reports involving Parent Risk Factors, which include drug exposed newborns and domestic violence.
 - a. Rationale: There were two screened out hotline reports seven months prior to the death incident. The first report involved a drug positive newborn and the second involved domestic violence in the presence of children.
 - b. Anticipated Result: Adequately assess risk to the child and family at the Report Line.
 - c. Responsible Agency: Division of Family Services
 - d. Final Review Update: The SDM Intake Manual was updated in April 2014 (one month before the review). The Parental Risk Factors for drug exposed infants and domestic violence were modified slightly. Under Risk of Emotional Harm, a paragraph was added about domestic violence occurring in the presence of children. Obviously, neither the Children's Department representative nor this Panel were aware of those changes. Additionally, on-site coaching of Report Line staff by the Children's Research Center (CRC) was done at NCCPD and Milford at least twice on location and another on-site coaching will be done in May 2015 at NCCPD. Finally, the CRC did two quality review case readings after the Intake tool was implemented.

2. CDNDSC requests that DFS explore its thresholds for screening in domestic violence cases in the Structured Decision Making® Intake Policy and Procedure Manual and consider incidents that occur in other households with the same perpetrator when determining chronicity.
 - a. Rationale: When the May 2013 hotline report was screened out, the DFS Report Line Supervisor noted in the disposition that it was the "first incident between this couple". However, the alleged perpetrator had active warrants for a separate incident involving a different female victim.
 - b. Anticipated Result: Adequately assess risk to the child and family at the Report Line.
 - c. Responsible Agency: Division of Family Services
 - d. Final Review Update: DFS staff performs a search of the department's records and DELJIS when screening hotline reports. This could have been an error on the worker's part; however, the updates as discussed above in Recommendation #1 should also address this issue.

Domestic Violence Coordinating Council

1. CDNDSC recommends that the Domestic Violence Coordinating Council's (DVCC) Children and Domestic Violence Subcommittee consider revisiting its discussion about reporting cases of domestic violence involving emotional harm to a child. Specifically, there is concern that reporters will have difficulty identifying either the child's diagnosed mental health condition or behaviors that signify severe psychological harm in these cases.
 - a. Rationale: DFS screened out a hotline report involving the domestic violence incident in the presence of children since the children were not significantly affected.
 - b. Anticipated Result: To protect children exposed to domestic violence, despite whether or not the child immediately displays behaviors that reporters perceive to signify severe psychological harm.
 - c. Responsible Agency: DVCC

Ancillary Recommendation

Division of Family Services

1. CDNDSC recommends that the Division of Family Services (DFS) follow policy as it pertains to the use of history during Risk Assessment when identifying appropriate caregivers.
 - a. Rationale: Maternal grandmother was deemed to be an appropriate caregiver despite having an extensive history with DFS.
 - b. Anticipated Result: To ensure the safety and well-being of children.
 - c. Responsible Agency: Division of Family Services