



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

CAPTA¹ REPORT

In the Matter of
AF
Minor Child

9-03-2013-00015

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, AF (“Victim”), was born in November 2012 to KP (“Mother”) and TF (“Father”). AF was born at forty weeks gestation, weighing seven pounds and fourteen ounces. Upon birth, the infant was noted to have a small umbilical hernia and a slight systolic murmur of the heart. She was discharged from the hospital into the care of Mother on day two of life.

In February 2013, Victim, who was three months of age, presented to the Emergency Department (“ED”) via ambulance with the chief complaint that Father had rolled over on the child while sleeping and injured her right arm. A baby gram was completed which revealed a right mid shaft humerus fracture and healing bilateral rib fractures. Due to the extent of the Victim’s injuries, she was transferred to the local children’s hospital for further evaluation and treatment.

Family History

There was no previous history with the Division of Family Services (“DFS”) for Victim and/or family. Moreover, there was no violent criminal history for Mother or Father.

Of significance in this case was the fact that Father resided in Delaware with paternal grandmother (“PGM”); whereas, Mother lived in Philadelphia with maternal grandmother (“MGM”). Victim and her sibling reside with Mother and MGM. However, Victim visits with Father in Delaware. On the day of the infant’s near death incident, she had been in the care of Father at PGM’s residence for approximately two days.

Near Death Event

In February 2013, law enforcement and the DFS Child Abuse and Neglect Report Line were contacted regarding the Victim. She had a fracture of her right humerus and healing bilateral rib fractures. Mother brought the Victim to the ED and Father came in a short time later. Father initially reported that earlier that morning, he had been in bed with Victim. He stated he accidentally rolled over on her and she cried. He described himself as a “deep sleeper.” At the time of this occurrence, Mother was not home. Father advised that it was not until after Mother returned to his house that he noticed that the infant was not moving her right arm. It was indicated by medical personnel that the explanation provided by Father was not consistent with Victim’s developmental growth (bones are too soft and would not break from Father rolling over on child) and type of injury. No other explanation was provided by Mother or PGM. It was concluded that Victim’s injuries were a result of non-accidental trauma, and she was transferred to the local children’s hospital for further evaluation and treatment.

A joint investigation was conducted by DFS and law enforcement. That same day, the DFS Investigation worker made contact with the children residing in the home of PGM in order to ensure their safety and well-being. Contact was also made with the Victim’s sibling, who was residing with MGM in Philadelphia.

Mother reported that Father watched Victim approximately four times a week. PGM watched Victim occasionally, the last time being one week prior to the infant’s near death incident.

Since Mother and Father were unable to provide an explanation pertaining to how Victim sustained her injuries, DFS filed for Emergency Custody which was granted by the on-call judge. It was noted during the initial review of the case that there were two separate Emergency Ex Parte Orders on file for this incident. One of the orders was exceptionally detailed and stipulated visitation guidelines for both parents. The issue was researched and determined to be an administrative error. The Panel was unable to determine if a Criminal Justice Information System or National Crime Information Center background check was conducted by DFS as instructed in the more detailed Emergency Ex Parte Order, as DFS only received the less detailed order which did not include the request for the background check. The Panel noted that the issuance of two Emergency Ex Parte Orders created some confusion in the process and could also result in conflicting orders.

Law enforcement assisted DFS in taking custody of the children. Victim’s sibling was placed in a foster home and Victim was determined to be safe as she was still under the care of the children’s hospital.

An attempt was made to conduct a forensic interview of the Victim’s sibling at the Children’s Advocacy Center (“CAC”) to determine whether the sibling had knowledge about how her sister received her injuries and to rule out abuse of the sibling. The multidisciplinary team (“MDT”) was present to observe this interview. However, the

interview was unsuccessful as the sibling was unable to be interviewed. She entered the room crying, stopped crying when given markers and allowed to color, but she resumed crying shortly thereafter. During this meeting, the medical child abuse expert confirmed with the MDT that the Victim was suffering from an acute humerus fracture and three rib fractures.

Law enforcement conducted follow-up interviews with the parents. Father eventually admitted to lying on the bed, grabbing the infant by the arm as she was seated in the bouncy seat, and snatching her up onto the bed beside him. The parents also admitted that Father would pick the infant up and squeeze her. No doll re-enactment was conducted as the law enforcement agency did not have the proper tools to conduct such a re-enactment at the time. When presented with the explanation by the Father, the medical child abuse expert agreed the force was likely to cause the fracture to the humerus, and the pressure from squeezing would likely cause the rib fractures. It was also noted that there was an approximate six-hour time frame that Father was alone with Victim.

Civil / Criminal Disposition

As a result of Father's confession, the DFS investigation was substantiated against Father for Physical Abuse/Bone Fracture, placing him on Level IV of the Child Protection Registry. The case was transferred to ongoing services in February 2013. In March 2013, the case was transferred to Philadelphia's Child Protective Services, as the Philadelphia Courts assumed jurisdiction.

In June 2013, Father pled Guilty to Assault 2nd, which is a class D felony. It was noted that this was Father's first offense. He was sentenced to 5 years Level V confinement, suspended after time served (130 days) to two years Level III probation. He was also required to obtain his high school diploma or general equivalency diploma ("GED"), complete parenting classes and have no unsupervised contact with Victim or her sibling, noting that Mother cannot supervise such visitation.

System Recommendations

After review of the facts and findings of this case, the Panel determined that all systems did meet the current standards of practice; however, the following ancillary recommendations were put forth:

Ancillary Recommendations

FAMILY COURT

1. CDNDSC recommends that all Emergency Ex Parte Orders statewide reflect language relating to the visitation between the child and suspected perpetrator(s).
 - a. Rationale: An Ex Parte Order was granted by the on-call judge. It is noted by the Panel that the Order was exceptionally detailed and stipulated visitation guidelines for suspected perpetrators of abuse.
 - b. Anticipated Result: To ensure the safety and well-being of the child.

- c. Responsible Agency: Family Court

MISCELLANEOUS

1. SENTAC should review the adequacy of Delaware's sentencing guidelines as they pertain to criminal child abuse cases involving serious injury.
 - a. Rationale: Members have expressed the view that 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 this was FOB's first offense, sentencing did not reflect the crime committed.
 - b. Anticipated Result: To ensure that where a child is seriously injured the range of recommended penalties fairly accounts for the severity of these serious assaults.
 - c. Responsible Agency: SENTAC Commission
 - d. Update: CDNDSC met with the SENTAC Commission on March 21, 2014.