



STATE OF DELAWARE
Child Death, Near Death and Stillbirth Commission
900 King Street, Suite 220
Wilmington, DE 19801-3341

CAPTA¹ REPORT

In the Matter of
Edward Davis
Minor Child²

9-03-2009-00010

September 24, 2010

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).

² To protect the confidentiality of the family, case workers, and other child protection professionals, pseudonyms have been assigned.

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.

Summary of Incident

The case regarding Edward Davis is considered a near death incident due to severe physical and emotional abuse/neglect, perpetrated by the child’s father and father’s paramour. At the time of the near death incident, the child was eleven years of age and residing in the home of his father.

Prior to Edward Davis’ near death incident, the child’s mother and father shared natural custody with the father having weekend visitations. Approximately two months and eight days before the near death incident, the child’s mother attempted to commit suicide. When the mother was admitted to the hospital, she made arrangements for the child to stay with his father. Mother also arranged for the child’s two younger half-siblings to stay with a non-relative caregiver. The Division of Family Services (“Division”) became aware of these arrangements after they had occurred and did not physically see the children until the day after mother’s attempted suicide. At this time, the Division conducted a home evaluation and criminal background checks of the non-relative caregiver, father and father’s paramour and deemed each individual appropriate, despite the father’s criminal history. A safety assessment of the child at the father’s home was completed; however, no interview of the child by himself for evaluation of the child’s own feelings of safety in father’s home occurred. Nor was a “safety plan” completed with father and his paramour.

Although the Division was aware of the father’s criminal background, the Division determined that since the child’s father had weekend visitations and had not committed a known offense in over four years, the father was not considered a threat; therefore, he did not meet a level of significance for disrupting the arrangements made by mother. However, according to the Criminal Justice System, the child’s father is considered a habitual offender which carries increased penalties for each offense. The father’s criminal history consisted of multiple charges of assault (both felony and misdemeanor), drug offenses, possession of a deadly weapon during the commission of a

felony, and endangering the welfare of a child³, all of which show a proclivity toward violent behavior.

After mother's attempted suicide, mother was to have no unsupervised contact with the child and his two younger half-siblings, per a Division safety plan which was implemented shortly after her discharge from the hospital. The mother had a mental health, drug and alcohol abuse history as well as personal and multigenerational involvement with the Division in the investigation and treatment areas.

During the time period in which the child was residing with the father, records from the Department of Education indicate that the child was removed from one elementary school and began attending another elementary school immediately following his mother's attempted suicide. For approximately 3 months, several visits to the school nurse by the child had occurred with complaints of being ill and a constant rash on his hands and face. The child had presented to the nurse with an abrasion on the right side of his jaw, an itchy rash on both his hands and face, and cracked red hands. One month before the near death incident, the nurse called the child's father and recommended a doctor evaluation. However, there is no documentation of follow up by the nurse with regard to the medical evaluation. It was unclear as to whether or not the nurse knew that a DFS caseworker was involved with the child. While the child was in his father's care, he was absent from school for a total of twelve days within a two month period, the majority of these absences occurring after the nurse had inquired with the father about the child's condition. It was questioned whether the frequency of the child's absences should have triggered a truancy investigation. According to school policy, a student is considered truant when absent from school for more than three school days without a valid excuse. At the time of the child's absences, father was providing valid reasons and was in constant communication with the school. The father presented as very caring and concerned about his son's well-being and therefore no suspicion or further inquiry was raised by school personnel.

On the day of the near death incident, the local police agency responded to the father's residence due to a report of an alleged domestic dispute. When police entered the father's dwelling, police discovered the child in the bedroom closet rocking, moaning, and minimally responsive. The child was immediately taken to the hospital where he was found emaciated with head trauma, extreme hypothermia, and multiple bruises and lacerations, in various stages of healing, to his entire body. The injuries that the child sustained were documented as life threatening and the child was admitted to the hospital for further evaluation and treatment.

That same day, the Division received an urgent referral alleging the physical abuse of the child by the child's father and father's paramour. While the child was

³ The child's father received an Endangering the Welfare of a Child charge 4 years prior to this incident. This charge was a result of an incident, in a non-related case that took place between the child's father and his previous girlfriend. The child's father had pushed the girlfriend and their eight-month-old-child, whom the girlfriend was holding, into a wall causing them to strike their heads. The police report regarding this incident indicates that the Division was notified. The report was left in a bin. No documentation of this report was made by the Division.

hospitalized he relayed significant physical and emotional abuse starting after arrangements were made by the mother for the child to stay with the father and father's paramour. This abuse was triggered and escalated when the child took bits and pieces of food because he was hungry. The abuse that the child endured included having food withheld and then being fed one meal per day of disgusting mixtures of food he was known to dislike. He related being beaten repeatedly by both father and father's paramour, made to stand outside in freezing temperatures naked, punished by being made to hold ice cubes, and being made to take freezing cold baths and showers. The child relayed being scratched in the face and punched repeatedly about the face and head on the day he was found by police. Another concerning issue was in regards to the child's documented weight loss. On the date of the near death incident, upon presentation at the hospital, the child weighed 61 pounds which placed him below the 10th percentile for his age. The child was in the 50th-70th percentile for height, at that time. During a well visit, approximately 6 months before the near death incident of Edward Davis, it was noted that the child weighed 84.3 pounds. Four months earlier, the child attended another well visit where he weighed 85.8 pounds. Over that four month period, the child lost approximately 22 pounds. From the time the child became involved with the Division, immediately following the mother's attempted suicide, the Division did not take note of the child's dramatic weight loss due to the fact that the child had not been seen by a caseworker in over 90 days. Furthermore, the child's weight loss was also not noted by school personnel and therefore was not documented.

Once hospitalized, the Division was notified and responded to the hospital. Though the mother was to have no unsupervised contact with the child, the Division allowed the mother to have unsupervised and unlimited contact with the child for the duration of the child's hospital stay.

The investigation that was conducted by the local police agency revealed that three to five days prior to the removal of the child, a neighbor who had recently moved into the apartment complex, started hearing a female voice yelling at a child and that the child was being struck. These incidents were not reported to the police until the neighbor heard a male voice threatening to do physical harm to the child.

The child's father and father's paramour were charged with one count of assault by abuse and neglect, one count of maintaining a dwelling for use of a controlled substance, one count of conspiracy in the second degree and three counts of endangering the welfare of a child. The child's father pled to Assault by Abuse and Neglect and father's paramour pled to Assault in the Second Degree, both felony offenses. Father was sentenced to 25 years in prison, suspended after serving 15 years in prison. Once time is served, father will remain on probation for 18 months at level III supervision. Father's paramour was sentenced to 8 years in prison, suspended after 3 years in prison. Once time is served paramour will remain on probation for 15 months at level II supervision. The court granted a no-contact order between the child, father, and father's paramour. The no-contact order can only be amended at the will of the child and Family Court.

The child is currently residing in foster care and the case is currently open with the Division's Treatment and Adoption Unit. The child is being represented by a Guardian *ad litem* through the Office of the Child Advocate in all civil proceedings. To date, the proposed goal is Termination of Parental Rights. The child's father is no longer

part of reunification planning. Both father and father's paramour were substantiated for physical abuse/neglect at a level IV.

An ancillary issue that was also taken into consideration regarding the chronic and multigenerational involvement with the Division by the child and his family was with regard to an allegation of sexual abuse that was reported to the Division via the child abuse report line. This report occurred six years before the near death incident of Edward Davis. The child had informed a neighbor that he had been sexually molested by his 14 year old uncle and his uncle's friend. The report was accepted by the Division and an investigation commenced. Collateral contacts were completed by a DFS caseworker. The child's mother assured the caseworker that the allegation was false and that she took Edward Davis to his pediatrician and no evidence of sexual abuse was found. Mother did not call the police. The child informed the caseworker as to the facts surrounding the allegation of his sexual abuse. After 3 months, the case was transferred from the sex abuse investigation unit to low risk treatment, so that the child's mother could receive further assistance. During the sex abuse investigation, no attempt by the caseworker was made to confirm that the child was in fact seen by his pediatrician for sex abuse concerns. The child was interviewed at the Children's Advocacy Center, but no disclosure was made. The child had relayed that he no longer trusted the system because no one seemed to believe him and therefore recanted his earlier statements pertaining to the sexual molestation. It is important to note that the alleged perpetrator in this case had absconded to another state and that the child's mother was unwilling to be completely honest and forthcoming during the course of the investigation, thus impeding the criminal and civil process.

System Recommendations

The following recommendation was put forth by the Commission:

- (1) DSCYF shall review and modify its policies and procedures to give greater weight to criminal history for any individuals responsible for the care of children, including biological parents, when making decisions regarding the risk to and safety of children receiving services from the Division of Family Services.
 - a. *Rationale:* The Division reviewed the criminal history of the father but determined that he was not a threat. The father's criminal history included multiple charges of assault (both felony and misdemeanor), endangering the welfare of a child, and possession of a deadly weapon during the commission of a felony, all of which show a proclivity toward violent behavior. Even with the history, the Division determined that it did not meet a level of significance to disrupt placement that the mother had arranged.
 - b. *Anticipated Result:* A more thorough review and more consideration will be given to the criminal history, which relate specifically to crimes against persons, the nature of charges, premise checks, domestic complaint inquiries, child endangerment, treatment, and arrest history.
 - c. *Responsible Agency:* Department of Services for Children, Youth and Their Families

- (2) DSCYF shall implement training for all supervisors and caseworkers on Delaware's criminal justice processes including, but not limited to, charges, pleas, prosecution, dismissals and definitions, and how understanding the criminal system can impact DSCYF risk assessment and decision making.
- a. *Rationale:* DSCYF's lack of knowledge on criminal justices processes resulted in improper weight being given to the father's habitual civil and criminal activity when assessing the child's safety and placement with his father.
 - b. *Anticipated Result:* DSCYF supervisors and caseworkers will have a better understanding of the criminal legal system and will be better able to effectively utilize this information in assessing the safety of a child.
 - c. *Responsible Agency:* Department of Services for Children, Youth and Their Families
- (3) DSCYF shall review and modify its policies, procedures, and training to clarify how caseworkers and supervisors can appropriately incorporate an individual's and individual family's multigenerational and chronic DSCYF history into their decision making.
- a. *Rationale:* The extensive DSCYF history for both mother and father demonstrated a pattern of poor decision making, multigenerational history of abuse and neglect, domestic violence, substance abuse, and mental health issues which were not given appropriate weight when assessing the safety of a child.
 - b. *Anticipated Results:*
 - i. A higher level of scrutiny for cases with extensive DSCYF history.
 - ii. Earlier intervention in the life of an at risk child.
 - iii. The development of guidelines created with a lower, more meaningful threshold for intervention and with a higher level of significance placed on multigenerational and chronic DSCYF history.
 - c. *Responsible Agency:* Department of Services for Children, Youth and Their Families
- (4) CDNDSC recommends that cases involving multigenerational or chronic patterns of child abuse and/or neglect be given a higher level of supervisory oversight than cases without such history.
- a. *Rationale:* If such oversight had been provided, then the child would have been seen by a caseworker to continually assess safety. In this specific instance, the child was not seen for a period of ninety days. If contact had been made sooner and more frequently, the child may have disclosed the abuse that was occurring within the home prior to his near death, or the dramatic weight loss may have been noted and an investigation of this begun. Additionally, there is extensive history alleging physical and sexual abuse of this child which dates back to 2002. History of abuse and neglect, pertaining to the mother is also reflected in the Division records

thus creating a pattern of multigenerational and chronic abuse and/or neglect.

- b. *Anticipated Results:* To ensure the safety of all children known to the Division and provide earlier intervention where needed for families with multigenerational and chronic patterns of child abuse and/or neglect.
- c. *Responsible Agency:* Department of Services for Children, Youth and Their Families

(5) DSCYF should apply its frequency of contact requirements to the population based upon a thorough safety assessment of each child known to DSCYF, even if the child is not within DSCYF custody.

- a. *Rationale:* The child was not seen by a DFS caseworker for over ninety days. The last time the child was seen the day after mother's attempted suicide, when a home evaluation was conducted by DSCYF. Since the mother arranged for the child to stay in the home of the father, the child was not defined as a child to be seen by DSCYF treatment policy. DSCYF treatment policy states that, "a child's safety is assessed at the time of the initial face-to-face contact with the identified victim and household caregivers. A child is deemed safe when consideration of available information leads to the conclusion that the child in his or her current living arrangement is not in immediate danger or harm, and no safety interventions are necessary." The child's father was never made part of the original safety plan and the focus shifted to the two younger half-siblings who were residing with a non-relative caregiver. Therefore, the child was not made part of the treatment visitation schedule.
- b. *Anticipated Result:* To ensure the safety of a child through at least monthly contact with the child in person, and more frequently when case circumstances merit.
- c. *Responsible Agency:* Department of Services for Children, Youth and Their Families

(6) DSCYF shall review its policy of and further define "family" and "case."

- a. *Rationale:* The child was not viewed as a child to be seen per policy by the Division due to the fact that the child was residing in the home of his father. However, if the child was considered part of the "case" and therefore part of the "family," then the immediate focus of the caseworker would have not only been the child's two younger half-siblings, but the child himself. The only time the child had been seen by a caseworker was after mother's attempted suicide when a home evaluation was conducted and the child, father, and father's paramour were interviewed.
- b. *Anticipated Result:* To ensure the safety and well-being of all children known to the Division
- c. *Responsible Agency:* Department of Services for Children, Youth and Their Families

- (7) DSCYF shall update and/or develop policy delineating the steps and the difference between evaluating risk and safety when considering placement, via safety planning or DSCYF custody, with relative and non-custodial parents.
- a. *Rationale:* Failure to view, assess and incorporate all known information about this family led to the child being placed in a high risk, unsafe home.
 - b. *Anticipated Result:* Greater scrutiny by DSCYF of risk and safety assessments in order to ensure the safety of children.
 - c. *Responsible Agency:* Department of Services for Children, Youth and Their Families
- (8) CDNDSC recommends that the Child Protection Accountability Commission (CPAC) Risk Assessment Subcommittee research more effective and efficient risk assessment tools that will objectively evaluate risk and history and appropriately incorporate and assess criminal, multigenerational and individual DSCYF history.
- a. *Rationale:* Although a risk assessment was completed, the criminal, individual, and multigenerational histories were not given the appropriate weight.
 - b. *Anticipated Result:* A more objective tool will be researched and implemented resulting in a more reliable assessment.
 - c. *Responsible Agency:* Child Protection Accountability Commission's Risk Assessment Subcommittee and Child Death, Near Death and Stillbirth Commission
- (9) CDNDSC supports the efforts of the Child Protection Accountability Commission's Abuse Intervention Subcommittee in developing and offering training on Mandatory Reporting of Child Abuse and Neglect for the general public.
- a. *Rationale:* If the neighbor had reported the suspected abuse of the child, then the appropriate agencies would have been notified and earlier intervention would have been provided. Since the neighbor failed to report the suspected abuse, the child continued to reside in an unsafe environment which eventually led to the child sustaining life threatening injuries.
 - b. *Anticipated Result:* To create awareness and raise the level of responsibility among agencies and the lay public for reporting cases of child abuse and/or neglect.
 - c. *Responsible Agency:* Child Protection Accountability Commission's Abuse Intervention Subcommittee and the Child Death, Near Death and Stillbirth Commission
- (10) CDNDSC recommends that DSCYF no longer accept any hand-delivered reports of child abuse and/or neglect from law enforcement. Instead all reports of child abuse and/or neglect shall be reported via the report line in accordance with the law (16 Del. C. § 903, 904, and 905), DSCYF policy, and the Memorandum of Understanding between the Department of Services for Children, Youth, and

Their Families, the Children’s Advocacy Center, the Department of Justice, and Delaware Police Departments.

- a. *Rationale:* A prior domestic violence incident in 2005, involving father, another paramour and their infant which was not called into DFS, but rather only left in a bin at the DFS hotline as indicated by a police report. No hotline report was ever entered into the DFS computer system.
- b. *Anticipated Result:* Better documentation of history within the DSCYF computer system which will lead to a better assessment of risk to the child(ren).
- c. *Responsible Agency:* Department of Services for Children, Youth and Their Families

(11) Law enforcement shall adhere to 16 Del. C. § 903, 904, and 905, DSCYF policy, and the Memorandum of Understanding between the Department of Services for Children, Youth, and Their Families, the Children’s Advocacy Center, the Department of Justice, and Delaware Police Departments when reporting child abuse and neglect via the report line.

- a. *Rationale:* A prior domestic violence incident in 2005, involving father, another paramour and their infant which was not called into DFS, but rather only left in a bin at the DFS hotline as indicated by a police report. No hotline report was ever entered into the DFS computer system. According to the Child Welfare Compilation this issue was originally made as a recommendation in 2006 as part of an expedited case review.
- b. *Anticipated Result:* For law enforcement agencies to be in compliance with law and policy and to reemphasize the role of DFS and police when reporting child abuse and/or neglect.
- c. *Responsible Agency:* Delaware Police Departments

(12) CDNDSC asks that the Department of Services for Children, Youth, and Their Families (“Department”) investigate the number of cases that are being assigned to investigative caseworkers to ensure that each caseworker is not exceeding the caseload set by the statutory standard as put forth in 29 Del.C. § 9012 (b) (1). In addition, CDNDSC asks that the Department report these numbers as a raw figure rather than an average.

- a. *Rationale:* The Commission is aware that the number of cases assigned to the investigative caseworkers exceeds the statutory requirement and therefore raises concerns as to the caseworker’s ability to adequately assess cases in a timely and thorough manner. In reference to this particular case, a complex set of factors exist, such as the multigenerational and chronic DFS history and the father’s criminal history, that were not given proper weight which may have led to misjudgments by the caseworker.
- b. *Anticipated Result:* Compliance with the Delaware statute
- c. *Responsible Agency:* Department of Services for Children, Youth and Their Families

Ancillary Factors⁴

The following ancillary factors were identified and will be evaluated by CDNDSC for possible action:

- (1) CDNDSC recommends that the Child Protection Accountability Commission (CPAC) conduct an external review of past recommendations to see how these recommendations have been implemented by said agencies.
- (2) CDNDSC recommends that the Division of Family Services consider a way to track all changes made by caseworkers in the FACTS system in order to prevent the falsification/alteration of documents.
- (3) CDNDSC suggests that all DFS caseworkers and supervisors attend the five day Child First Delaware Training coordinated by the Children's Advocacy Center, the Department of Justice, and the Division of Family Services. This course provides DFS caseworkers and supervisors with a comprehensive introduction to the forensic interview process, which is used by forensic interviewers at the Child Advocacy Center in the presence of a multidisciplinary team.
- (4) At the time of the expedited review, safety concerns existed regarding the father's paramour and her ability to appropriately care for children. Although the paramour has pled to Assault 2 and was sentenced to 8 years in prison, suspended after serving 3 years in prison, the concern was raised regarding future attempts at reunification with her children.
- (5) Safety concerns exist regarding the mother's compliance with the DSCYF safety plan and reunification attempts with Edward Davis and her two other children. The Panel is concerned about the mother and her ability to care for the children and their safety when in her care due to the mother's mental health issues, domestic violence relations, poor decision making ability, and alcohol and drug abuse.
- (6) After the near death occurred the Panel has concerns regarding DSCYF having permitted the mother to have unsupervised and unlimited contact with Edward Davis while he was hospitalized and in a very fragile medical and psychological state. After the mother's suicide attempt, DFS prohibited the mother from having unsupervised contact with her children. At the time of the near death, mother was still to have supervised contact. However, the day following the near death incident of Edward Davis, a weekend shift caseworker gave verbal and written approval, seemingly unaware of the existing safety plan, to hospital staff for mother and her relatives to have unsupervised visits with Edward Davis.. This

⁴ In some cases there may be no system practices or conditions that impacted the death or near death of the child; however, if the Panel determines that there are ancillary factors which impact the safety or mortality of children, those factors are compiled by CDNDSC staff and presented at least annually to the Commission for possible action.

issue was rectified when Edward Davis was placed in foster care. Mother's contact with Edward Davis returned to supervised visits.

- (7) The DFS policy that all children should be interviewed alone for a safety assessment and to rule out abuse and/or neglect shall be re-enforced/re-emphasized.
- (8) DSCYF caseworkers seem to lack recognition of the relationship between domestic violence and child abuse and/or neglect. Training and education of DSCYF caseworkers need to be provided concerning this issue. In addition, there remains a lack of knowledge on utilizing a premise history check when assessing on-going domestic violence.