



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

CAPTA¹ REPORT

In the Matter of
Melissa Wagner
Minor Child²

9-03-2008-00019

March 11, 2011

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 Melissa Wagner is considered a near death incident due to physical abuse perpetrated by the child’s father. At the time of the near death incident, Melissa was two months of age and residing in the home of her mother, father, maternal grandfather, maternal grandfather’s paramour, paramour’s daughter, and paramour’s daughter’s fiancée.

On the day of the near death incident, Melissa was transported by ambulance to the emergency room with reported respiratory problems and bleeding from the mouth. Upon arrival, medical personnel removed Melissa’s clothing and found numerous bruises on her body. Further examination demonstrated a right posterior 8th rib fracture and possible right parietal skull fracture. As a result, Melissa was admitted to the hospital for further evaluation and treatment. She was discharged approximately 5 days after admittance into the custody of the Division of Family Services, where she was immediately placed into foster care.

An urgent referral was received by the Division of Family Services’ Child Abuse and Neglect Report Line alleging physical abuse, shaken baby syndrome. The report was accepted and a collaborative investigation between law enforcement and the Division of Family Services commenced. During the course of the investigation, father had admitted to law enforcement that he accidentally dropped Melissa while she was sleeping. However, upon learning that Melissa’s injuries were not consistent with the story that was provided, father asserted that at the time of the near death incident he had been holding Melissa with both of his hands around her chest. When she began crying and father was unable to console her, father continued to squeeze her tightly. Father explained his actions toward Melissa were an attempt to keep Melissa from her mother.

The Division of Family Services substantiated Melissa’s father for three different findings of physical abuse, level IV (suffocation, head trauma, and bone fracture). Melissa’s mother was also substantiated for severe physical neglect; level III, due to her knowledge that father was a threat/danger to Melissa. She also failed to protect Melissa which ultimately resulted in Melissa’s severe physical harm.

Father was initially arrested and charged with Assault by Abuse or Neglect, Endangering the Welfare of a Child, and Cruelty to Animals, all of which are felony offenses. Criminal prosecution resulted in Melissa's father pleading to Assault in the 2nd Degree, where he was sentenced to eight years confinement. Father was subsequently sentenced to three years suspended after two years, with six months partial confinement with intense supervision for the charge of Cruelty to Animals.

System Recommendations

Following the expedited and final review of the near death incident of Melissa, it was determined that all systems met reasonable standards of practice and therefore no system recommendations were put forth.

Ancillary Factors³

The following ancillary issues were identified and will be tracked by CDNDSC to identify potential gaps or trends:

- (1) Multi-generational history of abuse/neglect
 - a. Father: The father has a long history as the victim of child abuse allegedly inflicted by his mother in another state. His mother was reported to have mental health issues and was violent in the home. The father stated that he witnessed his mother allegedly kill the family dog as she did not want the family to have any pets. At age 12, the father was temporarily placed out of home after attacking his mother. At age 14, he left the home to reside with his father. It was also stated that the paternal grandfather believed that father was also sexually abused by his older half brothers and that he had witnessed his older half brother sexually abuse his sister.
 - b. Mother: There was past CPS involvement with the mother as a child in another state as maternal grandmother had significant mental health issues and financial instability. Maternal grandmother also had a past history of suicide attempts, two of which were witnessed by her son. The son left the home to reside with his father. Mother, then 12 years old, continued to reside in the home. Maternal grandmother and mother moved to Delaware to be around her family. A DFS investigation was conducted for allegations of neglect by maternal grandmother and it was determined that mother had family support and could meet her daughter's needs
- (2) Child witnessing domestic violence
 - a. Family members reported that father screamed at mother every night in the child's presence, but they did not feel it was appropriate to intervene.

³ 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.

- b. Family members reported that they witnessed domestic violence (including while mother was pregnant with child), but did not want to make mother mad and therefore did not contact the authorities or the DFS hotline to make a report. Father has a history of threatening to kill mother in the past as well as admitted anger and substance abuse issues.
 - c. Mother often denied domestic violence in the home but upon prompting from maternal grandmother admitted to incidents where father threw a lighter at her, had threatened to kill her, and had come after her with a hammer while she held Melissa.
- (3) Identification of risk factors so appropriate referrals may be made to Smart Start, Home Visiting Programs, etc.
- a. Teenage pregnancy and smoking were identified risk factors. Records indicated that mother did receive prenatal care and was advised of the risk of cigarette smoking. Records did not reveal any indication that she was offered Home Visiting Services.
- (4) Mandatory reporting
- a. Failure to report
 - i. Reports indicated that the maternal grandfather allegedly told father, after observing a bruise on Melissa's left ear and cheek, that if the child was ever found with another mark he would be thrown out of the house. No family members reported this incident to the Child Abuse And Neglect Report Line.