



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

## **CAPTA<sup>1</sup> REPORT**

In the Matter of  
Danielle Williams  
Minor Child<sup>2</sup>

9-03-2009-00003

December 2, 2011

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<sup>1</sup> 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).

<sup>2</sup> 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 Danielle Williams is considered a near death incident since the child sustained severe burns due to lack of supervision on behalf of the foster mother. At the time of the near death incident, Danielle was fifteen months of age and residing within a foster home approved through the Division of Family Services.

Records from the Department of Services for Children, Youth and Their Families’ Division of Family Services (“DFS”) indicate that about one year prior to the near death incident, DFS substantiated Danielle’s biological parents for emotional neglect. In addition, Danielle was placed in foster care. Danielle’s mother failed to comply with the necessary case plan that was agreed upon by mother and DFS. It was also noted that mother was struggling to find stable employment and housing. When Danielle entered care, the foster home was exceeding the number of children that were allowed to be placed per DFS policy.<sup>3</sup> This situation was quickly resolved when three children were removed and placed in alternative foster homes. Through the course of this placement, Danielle was seen by a DFS caseworker and a guardian *ad litem*. During these visits nothing suspicious or concerning was noted pertaining to the care of Danielle by the foster parents. In fact, one month prior to the near death incident, the foster parents submitted a letter of intent for the adoption of Danielle. No concerns regarding the family were raised by DFS and the foster parents were deemed appropriate.

On the day of the near death incident, DFS’ Child Abuse and Neglect Report Line received a complaint alleging physical abuse of Danielle by her foster mother. The child was brought to the hospital where she presented with submersion burns on both legs. While she was running a bath for Danielle and two other children, foster mother left the room and went downstairs to check on her infant nephew, who was asleep on the couch. Foster mother stated that she used the bathroom downstairs and shortly thereafter heard

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<sup>3</sup> Six children (five years of age and younger) were residing in the foster home including the three biological children.

Danielle screaming. Once foster mother reached the master bedroom she noticed that the child was sitting under the faucet and the hot water had been turned on. Upon retrieving the child from the bath tub, foster mother observed skin to be floating in the tub. Foster mother immediately applied burn ointment to the injured areas and stated that the child began to go into a seizure like state.<sup>4</sup> Foster mother called Emergency Medical Services; however, the phone call was not immediate. It was also noted that the foster mother thought the paramedics were taking too long, so foster mother transported Danielle to the emergency room. When questioned about the incident, foster mother stated that her two year old child must have turned the hot water on. No further explanation was offered.

The injuries that Danielle sustained were on both legs from just below the knees, down to and including the bottoms of Danielle's feet. The attending physician concluded that the burns were from the child being immersed and therefore could not have occurred the way foster mother described. Moreover, the physician noted that if the child was seated under the faucet with the water running, then similar burns appearing in splash marks would have been visible on the remainder of Danielle's body. A further evaluation of Danielle also revealed that she was considered failure to thrive, dropping from the 90<sup>th</sup> percentile to the 20<sup>th</sup> percentile. This decrease in weight had occurred gradually while Danielle was in care and was not reported as a concern by Danielle's Primary Care Physician. Further inquiry with the DFS and the guardian *ad litem* revealed that Danielle was an extremely picky eater, and she also presented with symptoms of pica. Neither the caseworker or guardian *ad litem* suspected or had concerns about Danielle's weight while she was in foster mother's care.

Foster mother pled guilty to felony Endangering the Welfare of a Child which resulted in serious physical injury, to a child. Foster mother was sentenced to one year in prison, suspended for six months of intensive probation. Since sentencing, foster mother's license as a daycare provider has been suspended and the foster home has been closed. DFS substantiated foster mother for physical neglect.

### **System Recommendations**

Upon review of the facts and findings of this case, it appears that not all of the systems met current standards of practice. Therefore, the following recommendations were put forth:

- (1) CDNDSC shall send a letter to the child's Primary Care Physician stating the panel's concerns regarding the lack of attention to the child's lack of growth, with particular attention to the lack of dietary, environmental, family, and social history, as is recommended by the American Academy of Pediatrics and is considered standard of care.

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<sup>4</sup> This was later determined that the child went into shock due to the pain the child was enduring as a result of her injuries.

- (2) CDNDSC shall recommend that DSCYF monitor and comply with the standard temperature of water for foster homes, daycares and contracted foster homes per the Delacare rules. In addition to childcare centers, CDNDSC recommends that DSCYF require DFS foster homes and contracted foster homes to comply with the requirements similar to rule 270 of Delacare prohibiting water temperatures higher than 120 degrees Fahrenheit.
- (3) CDNDSC recommends that in addition to the child's medical records, growth charts be included and made available for DSCYF and Family Court so that proper tracking of the child's growth can be reviewed by all agencies involved.
- (4) CDNDSC and the Child Protection Accountability Commission shall continue to support the Joint Commission Foster Care medical subcommittee.