STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
C/O OFFICE OF THE CHILD ADVOCATE
900 KING STREET, SUITE 210
WILMINGTON, DELAWARE 19801
TELEPHONE: (302) 255-1730
FAX: (302) 577-6831

GINGER L. WARD
CHAIR

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

February 14, 2018

The Honorable John Carney
Office of the Governor
820 N. French Street, 12th Floor
Wilmington, DE 19801

RE: Reviews of Child Deaths and Near Deaths due to Abuse or Neglect

Dear Governor Carney:

As one of its many statutory duties, the Child Protection Accountability Commission ("CPAC") is responsible for the review of child deaths and near deaths due to abuse or neglect. As required by law, CPAC approved findings from 14 cases at its February 14, 2018 meeting.[1]

Two of the near death cases had been previously reviewed and were awaiting decisions on prosecution. Unfortunately, no prosecution has yet occurred. Only one additional finding was made regarding a lack of communication between law enforcement and the Department of Justice.

Eleven of the 12 remaining cases were from deaths or near deaths that occurred between April 2017 and July 2017 – one case from January 2017 was also reviewed. These timely reviews really enable CPAC to address current system issues as well as celebrate accomplishments. The children in these 12 cases range in age from two weeks to 5 years old with 3 deaths and 9 near deaths. The children were abused via

[1] 16 Del. C. § 932.

poisoning, abusive head trauma, fractures, burns and/or unsafe sleep conditions. These twelve cases resulted in 49 strengths and 73 findings across system areas.

The collaborative efforts between law enforcement, DFS and the medical community continue to be noted. Crime scene investigations have improved. The civil and criminal legal response systems have seen increased partnerships. Eleven strengths specifically noted how the civil and criminal systems worked together to punish the perpetrator and protect the victims. An additional 11 strengths were documented where DFS workers took the time and energy, despite burgeoning caseloads, to complete thorough investigations and ensure the safety of the child victim and siblings. The work CPAC has done in trainings and development of a new MOU to support this response is demonstrating positive results. Having said that, the work must continue. Seventeen findings relating to interviews, communication and crime scene investigations were made. CPAC will continue its trainings of the MDT and provide further supports to the MDT response partners.

With respect to the medical interventions on these cases pre and post incident, 11 strengths and 15 findings were identified. The use of timely, evidence-based home visiting services for infants continues to be an issue with 4 findings this quarter. Diagnosis and reports of these cases to DFS and law enforcement by the medical community still merits further work as indicated by the remaining findings. Having said that, the strengths also lie in home visitors being partners for safety, and medical professionals reporting suspected child abuse.

The most significant ongoing issues from these twelve new cases are the use of safety agreements, unresolved risk and risk assessment by DFS. 38 findings were made in addition to 2 strengths. In almost every case, the DFS case worker was significantly over the statutory caseload standard. It is very difficult to implement best practices and timely safety and risk assessment tools under these circumstances. While workers may want to complete a thorough risk assessment, and a tool may indicate to keep a case open, with caseloads double and triple the statutory limit, poor decisions get made and children get hurt. CPAC only brings you the most horrific of the cases; however, for every one of these, there are countless more cases where DFS case workers are under the same pressures and children remain at risk of serious harm. Young children with sentinel injuries are often the victims of serious abuse just months later.

CPAC is most grateful for your recognition of the dire crisis that exists within DFS, and the 30 additional frontline positions proposed in the Governor's recommended budget. CPAC will be, as it has since its inception, advocating to the Joint Finance Committee and the entire General Assembly for compliance with 29 Del. C. § 9015 such that caseloads can attain and then remain in statutory compliance. As you well know, the DFS caseloads crisis remains a significant challenge for workers and a serious risk to children -- particularly infants. CPAC stands ready to partner for long term solutions that retain frontline workers and has a Caseloads/Workload Committee working hard on solutions in partnership with the DSCYF leadership.

In closing, in 2017, 13 children died and another 30 almost died from abuse or neglect in Delaware. This is a significant increase from 2016 where 5 children died and 22 nearly died. Of these children, one of the deaths was at the hands of the same perpetrator who almost killed him a year before. Two of the 2016 children were seriously injured by prior child abuse perpetrators. We must continue to work hard to strengthen our criminal laws to punish perpetrators and our criminal and civil laws to protect victims.

For your information we have included the strengths, findings and the details behind all of the cases presented in this letter. CPAC stands ready as a partner as well as to answer any further questions you may have.

Respectfully,

Tania M. Culley, Esquire
Executive Director
Child Protection Accountability Commission

Enclosures
cc: CPAC Commissioners
General Assembly

Child Abuse and Neglect Panel

Findings Summary

2-14-18

INITIALS			
Row Labels	*Current	**Prior	Grand Total
Legal	**3**		**3**
Court Hearings/ Process	3		3
MDT Response	**17**		**17**
Communication	1		1
Crime Scene	3		3
General - Civil Investigation	2		2
Interviews - Adult	2		2
Interviews - Child	3		3
Medical Exam	3		3
Prosecution/ Pleas/ Sentence	1		1
Reporting	2		2
Medical	**15**		**15**
Home Visiting Programs	4		4
Medical Exam/ Standard of Care - Birth	1		1
Medical Exam/ Standard of Care - ED	5		5
Medical Exam/ Standard of Care - Films	1		1
Medical Exam/ Standard of Care - PCP	1		1
Reporting	3		3
Risk Assessment/ Caseloads	**22**		**22**
Caseloads	11		11
Collaterals	1		1
Communication	1		1
Reporting	1		1
Risk Assessment - Tools	7		7
Unsubstantiated	1		1
Safety/ Use of History/ Supervisory Oversight	**10**	**1**	**11**
Completed Incorrectly/ Late	6		6
Inappropriate Parent/ Relative Component	2		2
Oversight of Agreement	1	1	2
Supervisory Oversight	1		1
Unresolved Risk	**4**	**1**	**5**
Child - Medical	1		1
Contacts		1	1
Substance Abuse	3		3
Grand Total	**71**	**2**	**73**

FINALS		
Row Labels	*Current	Grand Total
MDT Response	**1**	**1**
Communication	1	1
Grand Total	**1**	**1**

TOTAL FINDINGS **74**

**Current - within 1 year of incident*
***Prior - 1 year or more prior to incident*

INITIALS

System Area	Finding	PUBLIC Rationale	Sum of #
Legal			3
	Court Hearings/ Process		3
		Family Court does not have access to information about persons who have been entered on the Child Protection Registry.	1
		Father petitioned for custody of the victim, and the matter was scheduled for mediation. Mother had pending criminal charges for the near death incident.	1
		Following mediation, a consent order was entered, and visitation was by mutual agreement of the parties. However, a visitation arrangement that best protects the safety of the victim was not considered even though the mother was a perpetrator in the near death investigation.	1
MDT Response			17
	Communication		1
		In the prior investigation, the treatment caseworker gathered information from witnesses about inconsistencies in the stories provided by parents, and this information was not relayed to the caseworker investigating the allegations of abuse.	1
	Crime Scene		3
		No scene investigation was completed by the law enforcement agency.	1
		The law enforcement agency did not obtain a search warrant for the home. The scene was not photographed and no evidence was collected (i.e. bottles and pills).	1
		The law enforcement agency did not obtain measurements from the scene related to an alleged fall.	1
	General - Civil Investigation		2
		The DFS caseworker did not independently contact the child abuse medical expert to discuss the medical findings. As a result, the explanation provided by the parents was determined to be plausible, and the safety agreement was modified and the case closed.	1
		At the close of the near death investigation, the mother was deemed to be a protective caregiver by DFS despite indicators that she was downplaying the perpetrator's actions.	1
	Interviews - Adult		2
		DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	1
		During the near death investigation, DFS and LE did not seek assistance from an interpreter to conduct interviews with the mother. Other adults were utilized to translate the conversations.	1
	Interviews - Child		3
		There was a delay in scheduling the forensic interview with the young child, who resided in the home where the incident occurred.	1
		There was a delay in referring the young child to a children's advocacy center for a forensic interview.	1
		Forensic interviews did not occur with the older siblings during the death investigation.	1

	Medical Exam		3
		There was a miscommunication about the CARE Team findings by the MDT. All team members were not aware that the child abuse medical expert concluded that the victim's fractures and areas of bruising were highly concerning for child physical abuse.	1
		Pictures taken by the forensic nurse were not obtained by the DFS caseworker in the prior investigation. This could have prompted the assigned worker to seek input from the child abuse medical expert.	1
		A separate investigation was not immediately opened for the other children in the home of the near death incident, and as a result, it impacted the oversight of the medical exams for these children.	1
	Prosecution/ Pleas/ Sentence		1
		Delaware does not have a criminal negligence standard to prosecute these cases under the current child abuse laws.	1
	Reporting		2
		The DFS Report Line was not contacted despite the victim being present during a DUI and domestic incident involving the alleged perpetrator. This occurred prior to the victim's death, and a hotline report would have given DFS the opportunity to provide an intervention.	1
		The DFS caseworker delayed reporting the near death incident to the law enforcement agency, and as a result, there was no blood draw or crime scene investigation.	1
Medical			15
	Home Visiting Programs		4
		Home Visiting Services were not in place at the time of the near death incident or post incident.	1
		A Home Visiting referral was not completed after concerns with the victim's development and weight were identified.	1
		The home visiting program delayed sending the referral to the nurse.	1
		Despite a referral to a short-term visiting nurse association, evidence-based Home Visiting Services were not considered following the birth of a substance exposed infant.	1
	Medical Exam/ Standard of Care - Birth		1
		The DFS hotline report by the birth hospital did not include the prenatal information about the mother’s history of inpatient treatment for mental health and substance abuse issues.	1
	Medical Exam/ Standard of Care - ED		5
		The substance exposed infant had hospital admissions post birth, and there were no concerns documented that the infant was at an increased risk of abuse.	1
		A CARE Consult and forensic exam were not considered by the hospital emergency department after the infant presented with multiple bruises.	1
		For the prior incident, the child received an evaluation for suspected physical abuse, and the physician concluded the child’s injuries may be consistent with the explanation by the parents. However, physical abuse could not be excluded given the child’s injuries to his face and ear.	1

		The infant presented to two hospital emergency departments with multiple bruises and no explanation by the parents. Although a good evaluation was done for suspected physical abuse, it was not communicated to DFS that abuse was suspected.	1
		The imaging that was obtained at the hospital emergency department was not submitted immediately to a pediatric radiologist for review.	1
	Medical Exam/ Standard of Care - Films		1
		The out of state medical facility did not complete a follow up skeletal survey.	1
	Medical Exam/ Standard of Care - PCP		1
		A month prior to the near death incident, the medically fragile child was seen by the PCP for a follow up visit. Mother reported seizure activity, and the child was not immediately referred to the hospital emergency department.	1
	Reporting		3
		The initial treating hospital did not report the incident to the appropriate law enforcement jurisdiction.	1
		The initial treating hospital did not report the incident to the DFS Report Line or the appropriate law enforcement jurisdiction.	1
		The out of state hospitals did not report the incident to the DFS Report Line.	1
Risk Assessment/ Caseloads			22
	Caseloads		11
		The caseworker was over the investigation caseload statutory standards the entire time the case was open.	5
		The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.	1
		The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.	1
		The caseworkers were over the investigation and treatment caseload statutory standards while the cases were open.	2
		The DFS caseworker was over the investigation caseload statutory standards for a portion of the time while the case was open.	1
		The DFS caseworker and supervisor were over the investigation caseload statutory standards for a portion of the time while the case was open. The supervisor handled the case for a period of the time.	1
	Collaterals		1
		During the prior investigaton, a collateral contact with the PCP was not received for the victim, and DFS did not follow up with the PCP to corroborate the information provided by the mother.	1
	Communication		1
		DFS relayed information to the court that there were no concerns about the mother; however, the mother's history and self-reported substance abuse were not shared. As a result, the court dismissed the petition by a relative.	1
	Reporting		1
		The family moved during the treatment case, and the DFS supervisor delayed making a report to the out of state child protection agency.	1
	Risk Assessment - Tools		7
		In the prior investigation, the SDM Risk Assessment was not completed correctly. The policy override for severe non-accidental injury was not selected, so the case was closed.	1

		The SDM Risk Assessment identified the risk as high in both the prior and near death investigations. Ongoing service was recommended for both; however, in each investigation, the case disposition was overridden to close the case.	1
		For the near death incident, the hotline report was downgraded to a P2 in contrast with the SDM Response Priority Assessment. It was noted the alleged perpetrator's whereabouts were unknown and the mother had requested an attorney when contacted by the law enforcement agency.	1
		The treatment worker did not complete the SDM Risk Re-assessment, so it was not considered in the decision to close the treatment case.	1
		The SDM Risk Assessment identified the risk as high in the prior investigation. Ongoing service was recommended; however, the case disposition was overridden to close the investigation.	1
		The SDM Risk Assessment identified the risk as high at the conclusion of the death investigation. Ongoing service was recommended; however, the case disposition was overridden to close the investigation.	1
		During the death investigation, several next steps were identified in the initial group supervision and all the steps were not completed by DFS at the end of the investigation (forensic interview, toxicology screen results).	1
	Unsubstantiated		1
		There was no finding of abuse or neglect in the investigation despite the mother's actions, which placed the child at risk and exposed the child to illicit drug use.	1
Safety/ Use of History/ Supervisory Oversight			11
	Completed Incorrectly/ Late		6
		For the near death incident, the caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization.	1
		The initial safety agreement did not designate another participant to care for the victim or supervise contact. The agreement was later modified to include other relatives.	1
		DFS entered into a safety agreement with participants, but a home assessment was not initially conducted.	1
		For the near death incident, the caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization. The safety threats were also not identified.	1
		For the first referral involving a substance exposed infant, the caseworker did not complete the SDM Safety Assessment correctly. The safety threat for current circumstances combined with history was marked no. Family recently returned from out of state, and the mother had a history of substantiated abuse against young children. No agreement was entered.	1
		For the near death incident, the caseworker identified the victim as safe with agreement in the SDM safety assessment. However, the agreement did not consider the hospitalized victim.	1
	Inappropriate Parent/ Relative Component		2
		For the near death incident, DFS completed a safety agreement with a relative, who was an alleged perpetrator and not cooperative in the prior investigation. In addition, there was a significant amount of conflict between the mother and the relative.	1
		For the near death incident, DFS initially completed a safety agreement with a participant, who was not ruled out as a suspect, and the young sibling was placed in the care of this participant.	1

System Area	Finding	PUBLIC Rationale	Sum of #
	Oversight of Agreement		2
		During the prior treatment case, the SDM Safety Agreement was not reviewed in a timely manner.	1
		When renewing the child safety agreement, the supervisor was not aware the safety participant was charged with a felony domestic incident with the siblings present and a new DFS case was opened.	1
	Supervisory Oversight		1
		In the treatment case, the family lost their housing and were moving out of state. In addition, the family was struggling with the victim's behavior and were considering foster care. There was a lack of supervisory oversight provided during these critical points in the case.	1
Unresolved Risk			5
	Child - Medical		1
		The near death investigation was closed despite unresolved medical and behavioral issues for the victim and young sibling.	1
	Contacts		1
		During the prior treatment case, there was only sporadic contact with the family toward the end of the case.	1
	Substance Abuse		3
		The treatment caseworker incorrectly documented that mother and her paramour were not recommended for a full evaluation, so substance abuse treatment was not addressed by DFS.	1
		The DFS investigation was closed without the results of the toxicology screen for the parents, and this may have impacted the decision to close the case.	1
		DFS did not recommend substance abuse evaluations for the parents during the investigation.	1
Grand Total			**73**

FINALS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			1
	Communication		1
		Ongoing communication with the law enforcement agency by DOJ did not occur to determine if additional investigative actions were needed.	1
Grand Total			**1**

TOTAL FINDINGS **74**

Child Abuse and Neglect Panel

Strengths Summary

2-14-18

INITIALS			
Row Labels	***Current**	****Prior**	**Grand Total**
Legal	**4**		**4**
Court Hearings/ Process	4		4
MDT Response	**30**	**2**	**32**
Documentation	1		1
General Civil Investigation	9	2	11
General Criminal Investigation	7		7
General Criminal Investigation/Civil Investigation	11		11
Interviews - Child	1		1
Medical Exam	1		1
Medical	**11**		**11**
Documentation	2		2
Home Visiting Programs	1		1
Medical Exam/Standard of Care - CARE	2		2
Medical Exam/Standard of Care - ED	5		5
Medical Exam/Standard of Care - Films	1		1
Risk Assessment/ Caseloads	**1**		**1**
Risk Assessment - Substantiated	1		1
Safety/ Use of History/ Supervisory Oversight	**1**		**1**
Completed Correctly/On Time	1		1
Grand Total	**47**	**2**	**49**

*Current - within 1 year of incident

**Prior - 1 year or more prior to incident

System Area	Strength	Rationale	Count of #
Legal			4
	Court Hearings/ Process		4
		A timely permanency decision was made in this case.	1
		The Adjudicatory Hearing Order extensively documented the testimony, and the Court made a finding of abuse and dependency against both parents.	1
		The Court made a finding of abuse and neglect against both parents.	1
		The Adjudicatory Hearing Order extensively documented the testimony, and the Court made a finding of abuse and dependency against both parents. At the Dispositional Hearing, the Court ordered that the DFS treatment case remain open for 90 days.	1
MDT Response			32
	Documentation		1
		The law enforcement report clearly documented all investigative steps taken and provided a timeline of events relating to the near death. Records were also obtained from an out of state hospital.	1
	General Civil Investigation		11
		The DFS safety agreement remained in place until collaterals were completed and the criminal investigation concluded.	1
		A thorough investigation was completed by the DFS caseworker, to include a Framework and referral to the drug and alcohol liaison for the mother.	1
		The DFS caseworker conducted a thorough investigation, to include seeking custody of the child, communication with the relative, visitations with maternal and paternal families, and paying special attention to the child's follow up medical care.	1
		Following a new hotline report, the DFS caseworker consulted with the treatment worker handling the active treatment case.	1
		During the near death investigation, the DFS caseworker revisited the child's bruising incident from the prior investigation, and as a result, a finding of abuse was made against the mother.	1
		The DFS caseworker consulted with an out of state child protective services agency as it was known that the family resided in that state for some time.	1
		At the conclusion of the DFS investigation, both parents were substantiated for abuse and neglect despite not knowing who caused the child's injuries.	1
		Upon closure of the prior treatment case when the family moved out of state, the DFS treatment caseworker made a referral to the out of state child protective services agency.	1
		DFS completed two group supervisions and a Framework during the death investigation.	1
		During the death investigation, the DFS caseworker contacted the mother's physician for confirmation of her prescription.	1
		After concern was raised by the CARE Team, DFS immediately transported the child back to the hospital emergency department for a medical evaluation and later sought custody.	1

General Criminal Investigation		7
	A thorough infant death investigation was conducted by the law enforcement agency, to include immediate contact with MDT partners, search warrants for multiple areas, photographs of the scene, collection of evidence, and completion of the SUIDI form.	1
	The law enforcement agency conducted thorough witness interviews to include expert medical consultation.	1
	A thorough near death investigation was conducted by the law enforcement agency, to include immediate contact with MDT partners, collaboration with outside law enforcment agencies, search warrants, photographs and measurements of the scene, and creating a timeline of events by corroborating evidence.	1
	A thorough investigation was completed by the law enforcement agency, to include multiple interviews with the suspects and cell phone analysis.	1
	The law enforcement detective was present during the Family Court proceedings.	1
	A thorough investigation was completed by the law enforcement agency, to include multiple interviews with the suspects, cell phone analysis, and social media preservation.	1
	There was excellent collaboration between the two involved law enforcement agencies, to include information sharing and joint interviews..	1
General Criminal Investigation/Civil Investigation		11
	Great collaborative response between DFS and the law enforcement agency during the infant death investigation, to include the DFS caseworker observing the law enforcement interviews.	1
	DFS and law enforcement responded jointly and were both present during the witness interviews at the hospital.	1
	Great collaboration between the medical staff, DFS caseworker, and law enforcement agency.	1
	Great collaborative response between the medical facility, DFS, and the law enforcement agency during the near death investigation.	1
	There was clear and concise communication between all parties relating to the no contact order against the mother and her paramour while the child was hospitalized.	1
	Great collaboration between the MDT members to include joint interviews, a hospital meeting, child safety agreement while the child was hospitalized, and timely charging decisions.	1
	There was great MDT collaboration by all parties during the near death investigation, to include consultation with the out of state authorities.	1
	Great collaboration between DFS and the law enforcement agency, to include repsonse to both homes and safety agreements being implemented.	1
	Great collaborative response between the medical CARE Team, DFS, and the law enforcement agency during the near death investigation.	1
	Great collaboration between the MDT members to include joint interviews and consistent communication between all parties.	1
	During the near death investigation, there was a great MDT response to include joint interviews, forensic interviews of other involved children, DFS custody and relative placement of the sibling.	1
Interviews - Child		1
	A forensic interview was conducted with the sibling despite the child being outside the home at the time of injury.	1

Category	Subcategory	Detail	Count
	Medical Exam		1
		The second-shift DFS caseworker ensured the older sibling was medically evaluated.	1
Medical			11
	Documentation		2
		Photo documentation of the child's injuries was obtained prior to transferring the child for further medical treatment.	1
		There was excellent documentation within the medical records between neurology, the child's school, and DFS confirming the child's medical appointments.	1
	Home Visiting Programs		1
		The home visiting agency contacted the mother and referral source multiple times to engage the family in services.	1
	Medical Exam/ Standard of Care - CARE		2
		The children's hospital quickly consulted the CARE Team prior to transferring the child for further medical treatment.	1
		After reviewing the initial presentation, the CARE Team called the child back for further medical forensic examination.	1
	Medical Exam/ Standard of Care - ED		5
		Despite appearing well at the initial treating hospital, the child was transferred to the children's hospital for a comprehensive examination.	1
		The emergency department physician sought expert consultation to rule out accidental overdose through breastfeeding.	1
		Poison Control was contacted to verify that no other substance could provide a false positive for cocaine on urine drug screen.	1
		Although child abuse was suspected, the children's hospital conducted multiple testing to rule out various infections.	1
		A comprehensive medical examination was completed for the child, which included an MRI.	1
	Medical Exam/Standard of Care - Films		1
		There was extensive communication amongst the medical team relating to the imaging results showing degrees of normal variation versus bone fracture resulting in a third skeletal survey.	1
Risk Assessment/ Caseloads			1
	Risk Assessment - Substantiated		1
		Despite no perpetrator being identified and no criminal charges filed, the DFS investigation was substantiated against the mother for abuse.	1
Safety/ Use of History/ Supervisory Oversight			1
	Completed Correctly/On Time		1
		DFS ruled out a relative as a safety agreement participant based on his/her presence in the household where the near death incident occurred. In addition, timely reviews of the safety agreement were completed, and the agreement remained in place through the treatment case.	1
Grand Total			**49**