Current CAN Cases

7/31/2018

Total Open CAN Cases	68
Initials	*34*
Finals	*34*

INITIALS	34
Preparation	**19**
Within Compliance	*19*
Out of Compliance	*0*
Pending Review	**0**
Within Compliance	*0*
Out of Compliance	*0*
Reports	**15**
Initial Report Not Written	*3*
Initial Report Written	*12*

FINALS	34
Preparation	**0**
Pending Prosecution	**11**
Pending Review	**9**
Reports	**14**
Final Report Not Written	*5*
Final Report Written	*9*

2015 Case Summary	
Total	**32**
Deaths	*11*
Near Deaths	*21*

2016 Case Summary	
Total	**27**
Deaths	*5*
Near Deaths	*22*

2017 Case Summary	
Total	**43**
Deaths	*13*
Near Deaths	*30*

2018 Case Summary		
Month	**Near Deaths**	**Deaths**
January	2	0
February	3	1
March	1	0
April	1	0
May	3	3
June	2	1
July	5	3
Total	**17**	**8**

Office of the Child Advocate
900 King Street, Ste 350
Wilmington, DE 19801

STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
C/O OFFICE OF THE CHILD ADVOCATE
900 KING STREET, SUITE 210
WILMINGTON, DELAWARE 19801
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GINGER L. WARD
CHAIR

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

August 8, 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 21 cases at its August 8, 2018 meeting.[1]

Nine of the cases (four deaths and five near deaths) had been previously reviewed and were awaiting the completion of prosecution. Seven of the cases were ultimately prosecuted, and resulted in two convictions for Murder by Abuse or Neglect 1st, one conviction of Child Abuse 1st, one conviction of Child Abuse 2nd, 3 Felony Endangering the Welfare, and 3 Misdemeanor Endangering the Welfare.

The 12 remaining cases were from deaths or near deaths that occurred between September 2017 and February 2018. These timely reviews enable CPAC to address current system issues as well as celebrate accomplishments. The children in these 12 cases range in age from four days to 2 years old with 2 deaths and 10 near deaths. The children were abused via poisoning (drug ingestion), abusive head trauma,

[1] 16 Del. C. § 932.

fractures, or unsafe sleep conditions. These twelve cases resulted in 79 strengths and 89 current findings across system areas.

During this time period, significant findings were again made regarding the MDT response to these cases. Thirty-eight findings showed significant breakdowns within a few of the investigations involving many elements of the new MOU for the MDT Response to Child Abuse and Neglect. More broadly across several cases, breakdowns occurred in having siblings of victims interviewed and medically evaluated. At the same time, 51 strengths were noted with several investigations, and CPAC intends to utilize examples from the excellent investigative work that has happened in those cases to provide additional training on the MOU. For trends regarding siblings, the CPAC Child Abuse and Neglect Best Practices workgroup will be tasked with formulating a solution.

Progress with DFS regarding the use of safety agreements, unresolved risk and risk assessment is seen this quarter. This is heartening given the unmanageable caseloads of frontline workers. Once caseloads are subtracted, 26 findings remained again primarily focused on breakdowns in safety agreements. CPAC and DFS continue to partner to improve these agreements, and DFS has scheduled additional staff trainings in the coming months. 30 strengths were also noted with DFS workers performing diligent investigations in a few of these most difficult cases. These positive examples will also be highlighted in trainings.

The most significant issue continues to be the caseloads of DFS frontline workers. CPAC is most grateful for your leadership to tackle the complex issues that face DFS in the recruitment and retention of frontline child welfare workers. In 10 of the 12 cases contained in this letter, the DFS worker was significantly over the statutory caseload standard. The current caseloads harken back to circumstances 20 years ago prior to the passage of the Child Protection Act of 1997. CPAC is grateful that the General Assembly included in the State budget the 30 additional frontline positions. However, the funding of these positions is but the first step in a complicated recruitment and retention plan.

CPAC continues to encourage the State to consider opportunities to make these positions attractive with funding, hazard pay, technologic support (including Surface Pros) as well as consider creative solutions such as a Children's Corp similar to the Teach for America model. There are investigators carrying 40 to 50 cases with a

statutory standard of 11. Several workers have resigned under the pressure. contributing to the turnover rate and escalating caseloads for those that remain. It is critical that we all collectively ensure that once we tackle this crisis by employing and retaining frontline workers, we demand regular compliance with 29 Del. C. § 9015. CPAC remains a steadfast partner and the Joint Action Plan emphasizes the work of its Caseloads/Workload Committee to that end.

Thus far in 2018, Delaware has experienced 8 child abuse or neglect deaths and 17 near deaths. In 2017, 13 children died and another 30 almost died from abuse or neglect in Delaware. Three of the children reflected in this letter are from 2018 – the balance is from 2017. 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.

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
August 8, 2018

INITIALS

	*Current	**Prior	Grand Total
Legal	**1**		**1**
Court Hearings/ Process	1		1
MDT Response	**38**	**1**	**39**
Communication	2		2
Crime Scene	2		2
Documentation	2		2
Doll Re-enactment	1		1
General - Civil Investigation		1	1
General - Criminal Investigation	5		5
Intake with DOJ	1		1
Interviews - Adult	5		5
Interviews - Child	8		8
Medical Exam	9		9
Reporting	3		3
Medical	**14**		**14**
Home Visiting Programs	3		3
Medical Exam / Standard of Care - Birth	1		1
Medical Exam/ Standard of Care - ED	4		4
Medical Exam/ Standard of Care - Films	1		1
Medical Exam/ Standard of Care - Forensics	1		1
Medical Exam/Standard of Care - Birth	3		3
Reporting	1		1
Risk Assessment/ Caseloads	**18**	**1**	**19**
Caseloads	10		10
Collaterals	3		3
Risk Assessment - Alternative Response	1		1
Risk Assessment - Screen Out		1	1
Risk Assessment - Tools	3		3
Risk Assessment - Unsubstantiated	1		1
Safety/ Use of History/ Supervisory Oversight	**14**	**1**	**15**
Completed Incorrectly/ Late	4		4
Inappropriate Parent/ Relative Component	4	1	5
No Safety Assessment of Non-Victims	1		1
Oversight of Agreement	5		5
Unresolved Risk	**4**		**4**
Child - Medical	1		1
Contacts	2		2
Domestic Violence	1		1
Grand Total	**89**	**3**	**92**

FINALS

	*Current	Grand Total
MDT Response	**1**	**1**
Doll Re-enactment	1	1
Medical	**4**	**4**
Medical Exam / Standard of Care - Birth	1	1
Medical Exam/ Standard of Care - Urgent Care	2	2
Transport	1	1
Risk Assessment/ Caseloads	**1**	**1**
Collaterals	1	1
Grand Total	**6**	**6**

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

Office of the Child Advocate
900 King Street, Ste 350
Wilmington, DE 19801

Child Abuse and Neglect Panel

Findings Detail and Rationale

August 8, 2018

INITIALS

System Area	Finding	PUBLIC Rationale	Sum of #
Legal			1
	Court Hearings/ Process		1
		DFS, OCA and DOJ Civil agreed to rescind custody of the child and sibling(s) to the parents despite the mother's noncompliance with safety agreements and court ordered bail conditions, current mental health issues and ongoing concerns of domestic violence.	1
MDT Response			39
	Communication		2
		The law enforcement agency did not maintain ongoing collaboration or communication with DFS.	1
		The federal law enforcement agency communicated to DFS that there was insufficient evidence of child abuse and neglect, and this contradicted the findings from the medical expert. This had a significant impact on the civil investigation.	1
	Crime Scene		2
		No scene investigation was completed by the law enforcement agency.	1
		The law enforcement agency did not document whether any prescription medications were found at the scene.	1
	Documentation		2
		There was minimal documentation in the police report by the lead detective.	1
		There was no documentation in the police report by the lead detective.	1
	Doll Re-enactment		1
		No doll re-enactment was completed by the law enforcement agency.	1
	General - Civil Investigation		1
		In the prior investigation, the young child disclosed that she was punched, choked and dragged; however, it was not handled as a multidisciplinary case. There was no medical intervention, no forensic interview, and no follow up with the child to confirm that the alleged perpetrator did not have access to the child.	1
	General - Criminal Investigation		5
		The law enforcement agency did not complete evidentiary blood draws on the mother or child after the child tested positive for illicit drugs.	1
		The law enforcement agency did not complete an evidentiary blood draw on the child after the child tested positive for the prescription drug.	1
		There was a significant delay by the law enforcement agency in submitting the relative caregiver's blood sample to the Division of Forensic Science.	1
		The law enforcement agency assigned the investigation to a detective that is not responsible for handling child death cases.	1
		The law enforcement agency did not immediately respond to the hospital emergency department, and as a result, a joint investigation did not occur initially.	1

Intake with DOJ		1
	The law enforcement agency did not notify the DOJ Special Victims Unit of the near death incident.	1
Interviews - Adult		5
	DFS and the law enforcement agency did not conduct joint interviews with the suspects and witnesses.	1
	DFS and the law enforcement agency did not conduct joint interviews with the suspects and witnesses.	1
	The DFS after-hours worker conducted interviews with the suspects without the law enforcement agency present, potentially impacting the criminal investigation.	1
	The DFS after-hours workers interviewed the parents together and asked questions about domestic violence despite the active no contact order.	1
	The law enforcement agency did not audio record its interview with the mother.	1
Interviews - Child		8
	There was a delay by a children's advocacy center in scheduling the forensic interviews with the young children, who resided in the home where the incident occurred.	2
	The MDT did not consider compelling the family to cooperate with the forensic interviews.	1
	Forensic interviews did not occur with the young siblings who were present during the near death incident since the parent was uncooperative. However, a subpoena should have been considered.	1
	The victim's sibling was not interviewed or observed during the death investigation. This child was not present in the relative caregiver's home where the incident occurred.	1
	The father's girlfriend's young child was not observed during the near death investigation.	1
	The older sibling who was present in the home during the near death incident was not observed or interviewed by the second shift DFS case worker.	1
	Forensic interview did not occur with the mother's child who resided in the home with the victim, and there was a delay by the MDT in scheduling the forensic interview that occurred with the father's child.	1
Medical Exam		9
	The DFS caseworker did not independently contact the child abuse medical expert to discuss the medical findings. As a result, the case worker made decisions to modify the safety agreement and close the case based on the information relayed by the federal law enforcement agency	1
	The federal law enforcement agency delayed obtaining the findings from its medical expert for several months.	1
	The young siblings who were present during the near death incident were not medically evaluated.	1
	The young children who were present during the death incident were not medically evaluated.	1
	The DFS caseworker did not independently contact the child's PCP to discuss the visit for the injury to the child's limb.	1
	The young children who were present in the two households during the near death incident were not medically evaluated.	1
	The DFS caseworker did not independently contact the concussion clinic to discuss the medical findings.	1
	There was a miscommunication by the MDT about the timeline for the injury, and it impacted decisions by the MDT.	1

		The older sibling who was present in the home during the near death incident was not medically evaluated.	1
	Reporting		3
		The call to the DFS Report Line was delayed by the law enforcement agency, and, as a result, DFS did not have an opportunity to observe the interviews.	2
		The law enforcement agency did not make a report to DFS Report Line for allegations of abuse regarding the sibling. Instead, the information was reported to the assigned case worker.	1
Medical			14
	Home Visiting Programs		3
		Home Visiting Services were not in place at the time of the near death incident.	2
		The victim sustained injuries consistent with Abusive Head Trauma, and physical therapy (PT) services were recommended. However, it has been several months since medical discharge and PT services are still not in place due to insufficient resources.	1
	Medical Exam / Standard of Care - Birth		1
		The birth hospital did not submit the commitment form signed by the mother to the All Babies Cry program. Therefore, the parents did not receive a prevention call six weeks after birth.	1
	Medical Exam/ Standard of Care - ED		4
		The hospital emergency department did not initiate the telemedicine consult with the children's hospital.	1
		The hospital emergency department inaccurately listed the infant's cause of death as Sudden Infant Death Syndrome (SIDS) prior to the autopsy being completed.	1
		The hospital emergency department did not make a report to the DFS Report Line when the child's blood test was positive.	1
		Despite a brief resolved unexplained event and an increase in head circumference, neuroimaging was not considered during the child's admission.	1
	Medical Exam/ Standard of Care - Films		1
		The child's PCP ordered a three-view x-ray, which is the standard of care; however, only two images were taken by the imaging center. No fractures were initially found as a result.	1
	Medical Exam/ Standard of Care - Forensics		1
		A forensic nurse evaluation was not considered by the initial treating hospital even though the infant presented with bruising to the cheek.	1
	Medical Exam/Standard of Care - Birth		3
		Abusive Head Trauma/Shaken Baby Syndrome and infant safe sleep education were not documented within the medical records.	1
		Mother has a history of positive urine drug screens for marijuana, but she was not tested for marijuana at the infant's birth.	1
		No referrals were made by the birth hospital after it was suspected that the mother was using illicit drugs in the bathroom, and the infant was being observed for signs of withdrawal.	1

	Reporting		1
		The victim was seen at two hospital emergency departments for drug ingestion, and neither hospital made a report to the DFS Report Line.	1
Risk Assessment/ Caseloads			19
	Caseloads		10
		The DFS case workers were over the investigation and treatment (a portion of the time) caseload statutory standards while the cases were open. However, the caseload did not negatively impact the DFS response in those cases.	1
		The DFS case workers were over the investigation and treatment caseload statutory standards while the cases were open. It does not appear that the caseload negatively impacted the DFS response to the investigation; however, the caseload appears to have had a negative impact on the treatment case.	1
		The caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it is unclear whether the caseload had a negative impact on the DFS response in the case.	2
		The caseworker was over the investigation caseload statutory standards the entire time the case was open, and the caseload appears to have had a negative impact on the response in the case.	2
		The case worker was over the investigation caseload statutory standards the entire time the case was open. However, the caseload did not negatively impact the DFS response in the death investigation.	1
		The DFS case workers were over the investigation and treatment caseload statutory standards while the cases were open, and the caseloads negatively impacted those cases.	1
		The DFS case worker was over the investigation caseload statutory standards while the case was open. However, the caseload did not negatively impact the DFS response in the near death investigation.	1
		The DFS case worker was over the investigation caseload statutory standards while the case was open. However, the caseload did not negatively impact the DFS response in the near death investigation. Treatment was not above standard.	1
	Collaterals		3
		History with the out of state child protective services agency was not checked until DFS was court ordered to do so.	1
		For the death investigation, a collateral contact was attempted with the physician prescribing the relative caregiver's pain medication, but there was no follow through by the case worker when a response was not received.	1
		During the prior investigation, a collateral contact with the PCP was not completed for the children, and there was no communication with the PCP regarding the safety agreement.	1
	Risk Assessment - Alternative Response		1
		Consistent with DFS Policy, the SDM Screening Assessment screened out the prior report for investigation since the domestic violence was not chronic and/or severe. Since differential response is not available for this population, no intervention was provided.	1

	Risk Assessment - Screen Out	1
	The DFS Report Line screened out a prior hotline report, which alleged that the victim was born substance exposed. The following risk factors were not considered: DFS history and mother's substance abuse and mental health history.	1
	Risk Assessment - Tools	3
	For the near death investigation, the SDM Risk Assessment was not completed correctly. The father's substance abuse and previous cases were not taken into consideration, and as a result, the risk was scored as moderate.	1
	For the near death incident, the SDM Risk Assessment was not completed correctly. The policy override for a severe non-accidental injury was not selected, so the case was closed.	1
	In the near death investigation, the SDM Risk Assessment was not completed correctly. The policy override for non-accidental injury to a non-verbal child was not selected, so the case was closed.	1
	Risk Assessment - Unsubstantiated	1
	There was no finding of abuse or neglect in the investigation despite the perpetrator's admission of guilt and criminal charges.	1
Safety/ Use of History/ Supervisory Oversight		15
	Completed Incorrectly/ Late	4
	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
	DFS entered into a safety agreement with a third party, but a home assessment was not initially conducted and the contact did not occur in person.	1
	The SDM Safety Assessment was not completed correctly for the death incident. No safety threats were identified.	1
	For the near death incident, the caseworker identified the victim as safe with agreement in the SDM safety assessment. However, the initial safety agreement did not consider the hospitalized victim. There was clear communication that mom should not have contact with him though.	1
	Inappropriate Parent/ Relative Component	5
	In the prior investigation, DFS completed a safety agreement with a relative, who had criminal and DFS histories.	1
	For the death investigation, the second-shift DFS worker completed a safety agreement with the same relative, who had criminal and DFS histories. The agreement was not reassessed by the assigned worker.	1
	For the near death incident, DFS completed a safety agreement with a participant, who was not ruled out as a suspect.	1
	For the near death incident, DFS completed a safety agreement with the parents, who were not ruled out as suspects.	1
	For the near death incident, safety was not reassessed once the medical findings suggested a different timeline for the injury. DFS continued to safety plan with the mother, who could not be ruled out as a suspect.	1

	No Safety Assessment of Non-Victims		1
		During the near death investigation, the case worker did not assess whether the relative caregiver had child(ren) residing in his/her home. As a result, safety was not assessed for the relative caregiver's child.	1
	Oversight of Agreement		5
		The SDM Safety Agreement was not re-evaluated in a timely manner.	1
		There was a lack of oversight and communication between the assigned investigation worker and active treatment worker despite multiple risk factors for the relative caregiver.	1
		The treatment worker's first contact with the family was delayed, and the child safety agreement was not reviewed in a timely manner. The near death incident was reported several days later.	1
		The SDM Safety Agreement was not re-evaluated in a timely manner. It was reviewed in the first 30 days but subsequent reviews were not timely.	1
		DFS completed a safety agreement with the father and agreed that the victim could reside in his care, without visiting the home.	1
Unresolved Risk			4
	Child - Medical		1
		The DFS case worker delayed referring the child to an early intervention program.	1
	Contacts		2
		There was minimal contact with the children for several months during the active treatment case.	1
		Prior to closing the near death investigation, the case worker visited the sibling to complete a 30 day contact and no interview was conducted. In addition, the other children were not seen.	1
	Domestic Violence		1
		DFS involved the father in the safety agreement, which included him being responsible for supervising the visits between the mother and victim, despite the concerns of domestic violence.	1
Grand Total			**92**

FINALS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			1
	Doll Re-enactment		1
		No doll re-enactment was completed by the law enforcement agency.	1
Medical			4
	Medical Exam / Standard of Care - Birth		1
		The midwife did not respond to the home after she received notification of the infant's birth.	1
	Medical Exam/ Standard of Care - Urgent Care		2
		The victim was seen at an urgent care facility for a suspected head injury and referred to the emergency department. However, the child was never seen by a physician, and the physician did not sign off on the child's medical records until eleven days after the evaluation.	1

		The physician assistant at the urgent care facility did not consider a differential diagnosis of abuse despite the young child presenting with a head injury.	1
	Transport		1
		Despite the head injury with concern for swelling, the urgent care facility allowed the mother to transport the child to the emergency department (ED). However, a call was made to the ED to relay concerns.	1
Risk Assessment/ Caseloads			1
	Collaterals		1
		There was no documentation of collateral contacts with relatives or providers to support the case worker closing the case against the risk score.	1
Grand Total			**6**

TOTAL FINDINGS **98**

Child Abuse and Neglect Panel

Strengths Summary

August 8, 2018

INITIALS		
	***Current**	**Grand Total**
Legal	**2**	**2**
Court Hearings/ Process	2	2
MDT Response	**51**	**51**
General - Civil Investigation	13	13
General - Criminal Investigation	15	15
General - Criminal/Civil Investigation	11	11
Interviews - Adults	2	2
Interviews - Child	3	3
Medical Exam	7	7
Medical	**9**	**9**
Documentation	2	2
Home Visiting Programs	2	2
Medical Exam/Standard of Care - CARE	2	2
Medical Exam/Standard of Care - ED	1	1
Medical Exam/Standard of Care - EMS	2	2
Risk Assessment/ Caseloads	**9**	**9**
Collaterals	5	5
Risk Assessment - Substantiated	3	3
Risk Assessment - Tools	1	1
Safety/ Use of History/ Supervisory Oversight	**6**	**6**
Completed Correctly/On Time	5	5
Custody/Guardianship Petitions	1	1
Unresolved Risk	**2**	**2**
Child - Medical	1	1
Substance Abuse	1	1
Grand Total	**79**	**79**

*Current - within 1 year of incident

**Prior - 1 year or more prior to incident

Office of the Child Advocate
900 King Street, Ste 350
Wilmington, DE 19801

Prepared 7/16/2018

Child Abuse and Neglect Panel

Strengths Detail and Rationale

August 8, 2018

INITIALS

System Area	Strength	Rationale	Count of #
Legal			2
	Court Hearings/ Process		2
		Both parents consented to placement on the Child Protection Registry at the Adjudicatory Hearing.	1
		The One Judge, One Family policy ensured the Judge had a broad perspective of the family history throughout the multiple case filings.	1
MDT Response			51
	General - Civil Investigation		13
		Safety agreements were implemented for the child during hospitalization, as well as for Father's older children who resided with their biological mother.	1
		The DFS case worker confirmed the child was seen by the primary care physician the day of the near death incident as reported by the parents.	1
		The DFS treatment case worker maintained quality contact with Mother, and referred Mother for a mental health evaluation.	1
		During the death investigation, the DFS case worker completed a safety agreement with the relative caregiver, and it included a stipulation about not co-sleeping with her young child.	1
		There was good communication between the DFS case worker and the medical team.	1
		Upon the child's hospital admission, the parents were restricted from having visitation with the child without DFS approval.	1
		The DFS Report Line requested that the child not be discharged without consultation with DFS.	1
		NCIC background checks were completed for the out-of-state family members.	1
		Following the miscommunication and premature case closure, DFS held a team meeting where the safety agreement was re-implemented, and consultation was completed with the Deputy Attorney General regarding re-opening the case.	1
		The DFS case worker confirmed that prescription pills were available in various colors depending on the dosage.	1
		There was good communication between the DFS investigation and treatment workers.	1
		During the prior investigation, the DFS caseworker educated Mother on infant safe sleep practices.	2
	General - Criminal Investigation		15
		The Criminal Deputy Attorney General (DAG) was present during the scene investigation.	1
		There was excellent collaboration between the law enforcement agency and the forensic investigators.	1
		The forensic investigator researched the manufacturer of the air mattress and reported the death to the Product Safety Council.	1
		The law enforcement detective conducted blood draws of the parents as they self-reported marijuana use.	1
		LE and the forensic investigator conducted a doll reenactment with the relative caregiver and completed the SUDI form.	1
		The law enforcement agency conducted a blood draw of the relative caregiver.	1

	The law enforcement agency provided the relative caregiver with a pack n' play for her nine-month-old infant.	1
	The MDT provided the child abuse medical expert with its initial investigative findings, including the doll reenactment video.	1
	The federal law enforcement agency initiated a no contact order between the father and child.	1
	The law enforcement agency proceeded with the case investigation despite the injury occurring on the military base and military authorities undecided if they were taking the case.	1
	The law enforcement agency completed the video-recorded doll reenactment expeditiously.	1
	The law enforcement agency set up surveillance to determine if the parents were violating the no contact order.	1
	In a screened out hotline report, the law enforcement agency provided information from the lethality assessment.	1
	The law enforcement agency conducted a scene investigation and a video-recorded doll reenactment expeditiously.	1
	The law enforcement agency requested evidentiary blood draw of the child.	1
General - Criminal/Civil Investigation		11
	There was excellent MDT collaboration and response to the death investigation.	1
	There was good collaboration between LE, DFS, and the medical team during the investigation, as well as with follow up medical care for the child.	1
	There was good initial collaboration between LE, DFS, and DOJ for the death investigation. DOJ was notified of the infant death immediately.	1
	A joint investigation was conducted by the MDT to include a coordinated home visit and interviews, and communication with the CARE Team at the children's hospital.	1
	There was good initial communication and collaboration between the MDT, to include state and federal law enforcement agencies, DFS, and hospitals.	1
	There was good collaboration between DFS and the law enforcement agency.	1
	There was excellent communication between DFS, the law enforcement agency, and the child abuse medical expert. As a result, a discharge planning meeting occurred for the child.	1
	There was good communication and collaboration between the MDT throughout the case and multiple investigations.	1
	Great collaborative response between the medical CARE Team, DFS, and the law enforcement agency during the near death investigation, to include an MDT meeting with all parties present.	1
	There was good collaboration and consistent communication between DFS and the law enforcement agency.	1
	Great collaborative response between the medical CARE Team, DFS, and the law enforcement agency during the near death investigation, to include joint interviews and an MDT meeting with all parties present.	1
Interviews - Adults		2
	During the law enforcement interview, the detective questioned the parents on prior child deaths within the family, and inquired if the parents received infant safe sleep education.	1
	The Deputy Attorney General (DAG) had the recording of the law enforcement interview sent out for translation.	1

	Interviews - Child	3
	A forensic interview was scheduled and held at the CAC for the siblings residing in the home where the incident occurred.	2
	A second forensic interview was scheduled and held at the CAC after the young sibling disclosed physical abuse to Mother by her paramour.	1
	Medical Exam	7
	The DFS case worker ensured Father's older children were medically evaluated.	1
	The DFS case worker ensured the child's sibling was medically evaluated.	2
	The child received a follow up medical evaluation at the children's hospital, and there was excellent communication between DFS, the law enforcement agency, and the child abuse medical expert.	1
	The DFS case worker ensured the child's siblings were medically evaluated.	2
	The assigned DFS case worker ensured the older sibling was also drug tested.	1
Medical		9
	Documentation	2
	The primary care physician's records were well documented.	2
	Home Visiting Programs	2
	The DFS treatment worker referred the child to an early intervention program.	1
	A referral to an early intervention program was made for the child prior to medical discharge.	1
	Medical Exam/ Standard of Care - CARE	2
	In its documentation, the CARE Team considered and debunked two medical myths offered by the parents as the probable cause of the injuries.	1
	The CARE Team was consulted to explore whether the drug was passed through the maternal breastmilk.	1
	Medical Exam/ Standard of Care - ED	1
	The local hospital consulted with the children's hospital about the child's injuries, involved its SANE to take photographs, completed an appropriate workup given the inconsistent history provided by the parents, and admitted the child to allow the MDT to investigate and plan for safety.	1
	Medical Exam/ Standard of Care - EMS	2
	There was good response time and documentation from emergency medical services.	2
Risk Assessment/ Caseloads		9
	Collaterals	5
	Within 48 hours of the incident, the DFS case worker contacted the local hospital to obtain the child's birth history.	1
	The DFS case worker maintained quality contact with the family.	1
	The DFS investigation case worker referred Mother and maternal grandfather for substance abuse evaluations.	1
	The DFS treatment case worker maintained timely and quality contact with the family.	1
	The DFS case worker maintained quality contact with the family during the investigation.	1
	Risk Assessment - Substantiated	3
	Both parents were substantiated for the near death incident; Father for abuse of the child and Mother for failure to protect the child.	1

	DFS substantiated Mother for Life Threatening Medical Neglect as a result of the near death incident.	1
	At the conclusion of its investigations, DFS made appropriate findings against the perpetrator and the non-offending caregiver as a result of the child's injuries and violation of the no contact order.	1
Risk Assessment - Tools		1
	A Framework was completed during the investigation case.	1
Safety/ Use of History/ Supervisory Oversight		6
Completed Correctly/On Time		5
	There was consistent review and modification, when necessary, of the safety agreement by the DFS caseworker.	1
	Following re-implementation of the safety agreement, the DFS case worker physically checked the child for any new bruising/marks and documented the findings.	1
	The DFS case worker implemented a safety agreement while the child was hospitalized, and it required supervised contact between the child and parents at the hospital.	1
	The DFS case worker immediately implemented a safety agreement prohibiting contact between the victim and the alleged perpetrator.	1
	The after-hours DFS case worker implemented a safety agreement while the child was hospitalized prior to the circumstances changing with the timeline.	1
Custody/Guardianship Petitions		1
	DFS petitioned for custody of the child quickly.	1
Unresolved Risk		2
Child - Medical		1
	There was good attention to the victim's well-being by the investigation and treatment case workers.	1
Substance Abuse		1
	The DFS case worker made referrals to a substance abuse treatment provider to address parental risk factors.	1
Grand Total		**79**