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

MARY F. DUGAN, ESQUIRE
CHAIR

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

November 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 19 cases at its November 14, 2018 meeting.[1]

Ten of the cases (five deaths and five near deaths) had been previously reviewed and were awaiting the completion of prosecution. All but one of the cases were ultimately prosecuted. Of the seven cases prosecuted in Delaware, the convictions were primarily Endangering the Welfare of a Child and none of the cases resulted in incarceration. For the two children whose cases were prosecuted in Maryland, the Father received 55 years at Level 5 and the Mother received 10 years at Level 5.

The nine remaining cases were from deaths or near deaths that occurred between February 2018 and May 2018. These timely reviews enable CPAC to address current system issues as well as celebrate accomplishments. The children in these 9 cases range in age from two weeks old to three years old with 4 deaths and 5 near deaths.

[1] 16 Del. C. § 932.

The children were primarily victims of abusive head trauma or unsafe sleep conditions. Two of these children were horrifically tortured. These nine cases resulted in 57 strengths and 66 current findings across system areas.

During the last quarter, the largest number of findings were again made regarding the multidisciplinary ("MDT") response to these cases. Twenty-three 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. In fact, findings in every area tracked for the MDT response were made this quarter. At the same time, 34 strengths were noted with several investigations. Within the CPAC Training Committee is a workgroup tasked with training on the new MOU. Systems breakdowns involving reporting, documentation, joint interviews, medical exams for siblings, and forensic interviews for children must be addressed and utilized in the training. To the extent breakdowns are occurring with specific jurisdictions, intensive in-person training should be offered by CPAC.

Progress with DFS regarding the use of safety agreements, unresolved risk and risk assessment is again seen this quarter. Thirty-seven findings were made in these categories. This is heartening given the unmanageable caseloads of frontline workers. Once caseloads are subtracted, 28 findings remained again primarily focused on breakdowns in the use of safety agreements. CPAC and DFS continue to partner to improve these agreements, and DFS provided additional staff training in June 2018 on use of the safety assessment to support decisions about the immediate safety of children. Twenty 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 caseloads of DFS frontline workers continue to merit attention. 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 9 of the 10 recent 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 still investigators carrying 40 to 50 cases with a statutory standard of 11. Workers continue to resign 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 13 child abuse or neglect deaths and 29 near deaths. In 2017, 13 children died and another 31 almost died from abuse or neglect in Delaware. All of the recent reviews of children reflected in this letter are from 2018. 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

November 14, 2018

INITIALS

	*Current	Grand Total
MDT Response	**23**	**23**
Communication	1	1
Crime Scene	3	3
Documentation	3	3
General - Criminal Investigation	2	2
General - Criminal Investigation / Civil Investigation	1	1
Interviews - Adult	3	3
Interviews - Child	2	2
Medical Exam	4	4
Reporting	4	4
Medical	**6**	**6**
Medical Exam/Standard of Care - Birth	2	2
Medical Exam/Standard of Care - ED	1	1
Reporting	1	1
Transport	2	2
Risk Assessment/ Caseloads	**17**	**17**
Caseloads	9	9
Risk Assessment - Closed Despite Risk Level	2	2
Risk Assessment - Screen Out	1	1
Risk Assessment - Tools	4	4
Risk Assessment - Unsubstantiated	1	1
Safety/ Use of History/ Supervisory Oversight	**15**	**15**
Completed Incorrectly/ Late	10	10
Inappropriate Parent/ Relative Component	2	2
Oversight of Agreement	1	1
Supervisory Oversight	2	2
Unresolved Risk	**5**	**5**
Contacts	1	1
Domestic Violence	1	1
Multiple	2	2
Supervisory Oversight	1	1
Grand Total	**66**	**66**

FINALS

	*Current	Grand Total
Risk Assessment/ Caseloads	**1**	**1**
Reporting	1	1
Safety/ Use of History/ Supervisory Oversight	**3**	**3**
Completed Incorrectly/ Late	3	3
Grand Total	**4**	**4**

70

**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

November 14, 2018

INITIALS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			23
	Communication		1
		The MDT was initially told that there was no evidence of injuries or concerns for bruising. It is unclear whether this information was relayed by a member of the medical team.	1
	Crime Scene		3
		No scene investigation was completed by the law enforcement agency.	1
		The SUIDI form was not fully completed by the law enforcement agency, and it may have impacted the cause and manner.	1
		No scene investigation was documented by the law enforcement agency. In addition, measurements and photographs were not obtained from the scene related to the alleged fall.	1
	Documentation		3
		There was no documentation in the police report by the lead detective.	1
		There was no documentation by DFS after a supervisor was notified about the child's death by the Division of Forensic Science.	1
		There was no documentation in the police report by the lead detective. The caseload for the detectives assigned to this law enforcement jurisdiction was high and may have had an impact on the documentation.	1
	General - Criminal Investigation		2
		There was not an immediate call to the Criminal Investigations Unit by the law enforcement agency. As a result, the agency initially declined to respond.	1
		The law enforcement agency delayed sending the parents' blood kits to the Division of Forensic Science. As a result, the toxicology results were delayed.	1
	General - Criminal Investigation / Civil Investigation		1
		For the prior investigation, there was not a strong MDT response to an unexplained burn involving the same victim.	1
	Interviews - Adult		3
		DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	2
		The DFS after-hours workers interviewed the suspects without the law enforcement agency present, potentially impacting the criminal investigation.	1
	Interviews - Child		2
		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.	1
		Forensic interview did not occur with the young child who visited the home where the death incident occurred, and the child's parent was a witness to the death incident.	1

	Medical Exam		4
		The older sibling who was present in the home during the near death incident was not medically evaluated.	1
		The infant was not referred for a full workup by the child abuse medical expert until six days after the incident.	1
		The young child who visited the home where the death incident occurred was not medically evaluated.	1
		For the prior investigation, the DFS caseworker did not independently contact the child abuse medical expert to discuss the medical findings. It was concluded that the injury was non-accidental.	1
	Reporting		4
		The MDT did not make a report to DFS Report Line after the sibling made a disclosure during the forensic interview.	1
		The law enforcement agency did not make a report to the DFS Report Line for the near death incident.	1
		Prior to the death incident, there were 4 recent verbal disputes between the parents in which the law enforcement agency responded. One incident involved the children being present, and there was no report to the DFS Report Line.	1
		The Division of Forensic Science did not make a report to the DFS Report Line for the death incident.	1
Medical			6
	Medical Exam/Standard of Care - Birth		2
		The birth hospital rushed the safe sleep education with the family.	1
		Mother was using heroin at the beginning of her pregnancy, but she was not given a urine drug screen at the infant's birth.	1
	Medical Exam/Standard of Care - ED		1
		The abdominal bruising was not documented in the trauma team's notes, and this impacted the initial information that was communicated to the MDT about the child death.	1
	Reporting		1
		The hospital did not report the child death to the DFS Report Line.	1
	Transport		2
		PCP suspected abuse during the well visit, but the infant was permitted to leave with the mother.	1
		PCP allowed the mother to transport the child with suspected head trauma to the hospital emergency department.	1
Risk Assessment/ Caseloads			17
	Caseloads		9
		The caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	3

		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 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 workers were over the investigation and treatment caseload statutory standards while the cases were open. However, it does not appear that the caseloads negatively impacted the DFS response to those cases.	1
	Risk Assessment - Closed Despite Risk Level		2
		It does not appear that the linked investigation was considered in the decision to close the prior treatment case. The treatment case was quickly closed after the substantiated incident, and the mother failed to complete her parenting classes.	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 after a Framework was completed.	1
	Risk Assessment - Screen Out		1
		The call by the hospital to the DFS Report Line was written as a hotline progress note rather than a new report. It appears that multiple calls were made by the hospital that were not documented.	1
	Risk Assessment - Tools		4
		For the near death incident, the SDM Risk Assessment was not completed correctly. The mother's mental health and father's substance abuse was not taken into consideration.	1
		For the near death incident, the SDM Risk Assessment was not completed correctly. The mother's out of state criminal history and child protective services history was not considered.	1
		For the prior investigation, the SDM Risk Assessment was not completed correctly. The risk was scored as moderate; however, it is unclear whether the risk rating had an impact since the case was already active in treatment.	1
		For the near death incident, the SDM Risk Assessment was not completed correctly as the paramour was not included as a caregiver. The case was also closed against the risk since the paramour no longer resided in the home; however, a framework was not considered.	1
	Risk Assessment - Unsubstantiated		1
		For the near death incident, DFS did not consider a Level 4 finding after the child sustained injuries consistent with head trauma. Instead, a Level 3 finding was made.	1
Safety/ Use of History/ Supervisory Oversight			15
	Completed Incorrectly/ Late		10
		For the near death incident, the caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization.	1

		In the prior investigation, DFS entered into a safety agreement with a relative, but an interview and home assessment were not conducted.	1
		The initial safety agreement permitted only unsupervised contact between the suspect, victim and siblings, but it could have been stronger at the time of the initial response.	1
		DFS entered into a safety agreement with a relative, but a home assessment was not initially conducted and the relative was not contacted in person.	1
		DFS entered into a safety agreement with a relative, but a home assessment was not initially conducted.	1
		For the first report involving the drug exposed infant, DFS completed a safety agreement with the mother and another relative prior to completing collateral contacts with substance abuse and mental health providers.	1
		For the prior investigation, DFS entered into a safety agreement with a relative, but a home assessment was not initially conducted.	1
		For the near death incident, DFS entered into a safety agreement with a relative, but a home assessment was not initially conducted.	1
		DFS entered into a safety agreement with a relative at the parents' home, but a home assessment was not initially conducted and the relative was not contacted in person.	1
		For the near death incident, the victim and sibling were initially determined to be safe. However, the victim's injury and DFS history were not considered as safety threats in the SDM Safety Assessment.	1
	Inappropriate Parent/ Relative Component		2
		For the prior investigation, DFS entered into a safety agreement with a relative, who was not an appropriate caregiver due to DFS history and the conditions of the home.	1
		For the near death incident, DFS completed a safety agreement with the mother, who was not ruled out as a suspect.	1
	Oversight of Agreement		1
		The SDM Safety Agreement was not re-evaluated in a timely manner during the near death investigation.	1
	Supervisory Oversight		2
		The safety agreement was terminated without having any face to face contact with the family, and the case worker had no contact with the family for several months after the safety agreement was terminated.	1
		The subsequent safety agreements for the victim could have been stronger. DFS entered into safety agreements with mother and two other participants, and there were several risk factors for mother and minimal oversight of the agreements.	1
Unresolved Risk			5
	Contacts		1
		During the prior investigation, the initial contact did not occur with the victim until 3 months after the referral was received. The caseload may have impacted the worker's attempts to reach the family.	1

	Domestic Violence		1
		Domestic violence was disclosed during the forensic interviews, and a referral to the domestic violence liaison was not considered. The mother was also used to supervise the father's contact with the children.	1
	Multiple		2
		In the prior investigation, the case worker had concerns with mother's compliance with probation, substance abuse and mental health services, and medical care for the infant. No immediate action was taken by the case worker with the exception of transferring the case to treatment for services.	1
		The treatment worker did not identify any safety threats after the mother and children moved into a home with a significant history of child maltreatment and substance abuse concerns.	1
	Supervisory Oversight		1
		The safety agreement was terminated even though the father failed to complete a substance abuse evaluation, and the forensic interviews revealed concerns for substance abuse and domestic violence.	1
Grand Total			**66**

FINALS

System Area	Finding	PUBLIC Rationale	Sum of #
Risk Assessment/ Caseloads			1
	Reporting		1
		During the near death incident, a sibling reported allegations of abuse by the mother's paramour, and the caseworker did not contact the DFS Report Line or conduct an interview with the mother's paramour.	1
Safety/ Use of History/ Supervisory Oversight			3
	Completed Incorrectly/ Late		3
		For the near death incident, the caseworker incorrectly identified the child as safe in the SDM safety assessment. As a result, there was no safety agreement, and second shift authorized the hospital to discharge the child to her mother, the alleged perpetrator.	1
		For the death investigation, DFS completed a safety agreement with the father prior to completing collateral contacts with substance abuse providers.	1
		For the death investigation, DFS completed a safety agreement with the mother prior to completing collateral contacts with substance abuse and other providers.	1
Grand Total			**4**

TOTAL FINDINGS **70**

Child Abuse and Neglect Panel
Strengths Summary
November 14, 2018

INITIALS		
	***Current**	**Grand Total**
Legal	**2**	**2**
Court Hearings/ Process	1	1
DFS Contact with DOJ	1	1
MDT Response	**34**	**34**
Documentation	2	2
General - Civil Investigation	5	5
General - Criminal Investigation	4	4
General - Criminal/Civil Investigation	10	10
Interviews - Adults	1	1
Interviews - Child	5	5
Medical Exam	7	7
Medical	**6**	**6**
Home Visiting Programs	2	2
Medical Exam/Standard of Care - PCP	1	1
Reporting	3	3
Risk Assessment/ Caseloads	**6**	**6**
Collaterals	3	3
Risk Assessment - Tools	2	2
Use of History	1	1
Safety/ Use of History/ Supervisory Oversight	**8**	**8**
Completed Correctly/On Time	1	1
Custody/Guardianship Petitions	1	1
Oversight of Agreement	3	3
Safety Assessment of Non-Victims	2	2
Use of History	1	1
Unresolved Risk	**1**	**1**
Mental Health	1	1
Grand Total	**57**	**57**

FINALS		
	***Current**	**Grand Total**
MDT Response	**2**	**2**
General - Criminal Investigation	1	1
General - Criminal/Civil Investigation	1	1
Grand Total	**2**	**2**

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

59

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

Child Abuse and Neglect Panel

Strengths Detail and Rationale

November 14, 2018

INITIALS

System Area	Strength	Rationale	Count of #
Legal			2
	Court Hearings/ Process		1
		DFS moved quickly to change the permanency plan and to request to be excused from making reasonable efforts in this case due to the death incident involving a young child residing in the same home.	1
	DFS Contact with DOJ		1
		The DFS case worker consulted with DOJ regarding medical consent for the child.	1
MDT Response			34
	Documentation		2
		The law enforcement agency thoroughly documented the investigation case events.	1
		The DFS case worker thoroughly documented the investigation case events.	1
	General - Civil Investigation		5
		During the prior investigation, the DFS case worker educated Mother on infant safe sleep practices.	1
		The after-hours DFS case worker challenged the law enforcement agency and medical staff to ensure certain interventions were completed despite early assumptions that the injury was accidental.	1
		The DFS case worker communicated with multiple parties regarding the suspect's young child, and there was strong attention to his well-being.	1
		The DFS case worker 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
		The DFS case worker and medical team immediately identified the medical consents needed for the child as Mother was incapacitated. Both parties worked with the Courts to ensure maternal grandparents obtained emergency guardianship in order to make the medical decisions on the child's behalf.	1
	General - Criminal Investigation		4
		The law enforcement agency provided the Father's explanation for the injuries to the CARE Team, and this information helped the medical team to understand the complexity of the fall.	1
		The law enforcement agency conducted blood draws after it was suspected that the parents were intoxicated while co-sleeping with the child.	1
		The law enforcement agency conducted a blood draw for Mother after it was suspected that she was under the influence while co-sleeping with the child.	1
		The law enforcement agency requested blood draw of Mother during the criminal investigation.	1
	General - Criminal/Civil Investigation		10
		Great collaborative response between the DFS investigation and treatment case workers, and the law enforcement agency during the near death investigation, to include interagency communication, joint response to the home, joint interviews, thorough documentation, and an independent consultation with the child abuse medical expert.	1
		There was good communication between the assigned DFS case worker and the law enforcement detective.	1
		There was a strong MDT response to the death investigation by the after-hours case worker and the law enforcement agency, to include joint responses to locate the young child residing in the home where the incident occurred and joint interviews.	1

		There was good communication between the DFS case worker, the law enforcement agency, and the medical team.	1
		As the case was reported to the traffic division of DOJ, notification to the MDT members by the Investigation Coordinator allowed the Special Victim's Unit to consult with the traffic division regarding cases such as this involving serious injury to a child(ren).	1
		There was good and consistent communication between the DFS case worker, the law enforcement agency, and the DOJ.	1
		There was good and consistent communication between the DFS case worker and the law enforcement agency.	1
		Great collaborative response between DFS, the law enforcement agency, and the forensic investigator during the death investigation, to include joint interviews and doll reenactment.	1
		There was good collaboration between the DFS case worker and the law enforcement agency, to include joint interviews and the case worker observing the doll reenactment.	1
		There was good collaboration and consistent communication between the DFS case worker and the law enforcement agency.	1
	Interviews - Adults		1
		A forensic interview was scheduled and held at the CAC for the young child residing in the home where the incident occurred, and a second interview was scheduled and held after the initial interview could not be completed.	1
	Interviews - Child		5
		A forensic interview was scheduled and held at the CAC for the siblings residing in the home where the incident occurred. The interviews were conducted within 24 hours.	1
		The after-hours DFS case worker pushed for forensic interviews to be conducted for the siblings residing in the home.	1
		Forensic interviews were scheduled and held at the CAC for the siblings residing in the home where the incident occurred.	1
		A forensic interview was scheduled and held at the CAC for the sibling residing in the home where the incident occurred.	2
	Medical Exam		7
		The DFS case worker ensured the child's siblings were medically evaluated.	2
		The DFS case worker ensured the suspect's young child was medically evaluated.	1
		The after-hours DFS case worker ensured the child's siblings were medically evaluated.	1
		The DFS case worker ensured the child's siblings were medically evaluated. The medical evaluation included a toxicology screen and skeletal survey.	1
		The hospital social worker and the DFS case worker communicated prior to giving an update to the family, and this helped the family understand the need for the hospital admission.	1
		The DFS case worker ensured the child's siblings were medically evaluated.	1
Medical			6
	Home Visiting Programs		2
		A referral to an early intervention program was made for the child prior to medical discharge.	1
		Home visiting services were initiated for the family during the Mother's pregnancy. She presented to a local hospital and a visiting nurse identified her as high risk.	1
	Medical Exam/ Standard of Care - PCP		1
		The PCP obtained the child's birth records following the near death incident.	1

Reporting		3
	The birthing hospital made a referral to the DFS Child Abuse and Neglect Report Line at the time of Mother's release from incarceration, with concerns of Mother being overwhelmed with caring for the infant while treating her own substance abuse and mental health issues. At this time, the infant remained in the neonatal intensive care unit (NICU).	1
	The PCP made a referral to the DFS Child Abuse and Neglect Report Line, and advised that Mother was en route to the children's hospital with the child.	1
	The hospital made a report to the DFS Child Abuse and Neglect Report Line despite this type of injury being rare for children.	1
Risk Assessment/ Caseloads		6
Collaterals		3
	Strong collateral contacts were completed during the current and prior DFS investigations.	1
	The DFS treatment case worker maintained quality contact with the family, and ensured appropriate referrals were made for Mother and child.	1
	Strong collaterals were completed, to include Mother's OB/Gyn physician.	1
Risk Assessment - Tools		2
	A Framework was completed during the investigation case.	1
	During the prior investigation, a Framework was completed.	1
Use of History		1
	The DFS case worker consulted with an out of state child protection agency regarding any history for the step-father.	1
Safety/ Use of History/ Supervisory Oversight		8
Completed Correctly/On Time		1
	The DFS case worker implemented a safety agreement while the child was hospitalized, and it required supervised contact between the child and the mother at the hospital.	1
Custody/Guardianship Petitions		1
	During the near death incident, the DFS investigation case worker immediately petitioned for custody.	1
Oversight of Agreement		3
	There was consistent review and modification, when necessary, of the safety agreement(s) by the DFS caseworker.	1
	The DFS case worker reassessed safety when new information was received from Mother's substance abuse treatment facility.	1
	There was consistent review and modification, when necessary, of the safety agreement by the DFS case worker.	1
Safety Assessment of Non-Victims		2
	The after-hours DFS case worker immediately implemented a safety agreement for the two siblings residing in the home.	1
	The after-hours DFS case worker implemented safety agreements for the children and ensured home assessments were completed for all participants.	1
Use of History		1
	Upon receipt of the second hotline call following the child's birth, an investigation case was opened.	1

Unresolved Risk			1
	Mental Health		1
		The suspect's young child was not intially recommended for therapy until the DFS supervisor provided additional information regarding the child's adverse childhood experiences.	1
Grand Total			**57**

FINALS

System Area	Strength	Rationale	Count of #
MDT Response			2
	General - Criminal Investigation		1
		There was good follow-up relating to Mother's substance abuse history.	1
	General - Criminal/Civil Investigation		1
		There was good and consistent communication between the DFS case worker, the law enforcement agency, and the DOJ.	1
Grand Total			**2**

TOTAL STRENGTHS **59**