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EXECUTIVE DIRECTOR

May 22, 2019

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 May 22, 2019 meeting.[1]

Three of the cases (one death and two near deaths) had been previously reviewed and were awaiting the completion of prosecution. Two of the cases were prosecuted resulting in three misdemeanor Endangering the Welfare pleas and one Assault 2nd plea. For the Assault 2nd, the parent received eighteen months in jail. The others resolved with probation. As a result, CPAC made a finding that the SENTAC guideline's presumptive sentence should be greater in child abuse cases.

The sixteen remaining cases were from deaths or near deaths that occurred between July 2018 and October 2018. Of these cases, eight will have no further review and only one was prosecuted. The death that was prosecuted resulted in a plea to felony Endangering the Welfare with five months in jail. These timely reviews enable CPAC

[1] 16 Del. C. § 932.

to address current system issues as well as celebrate accomplishments. Other than one sibling group, the children range in age from three weeks old to six years old with 4 deaths and 12 near deaths. The children were victims of poisoning, unsafe sleep and physical abuse. These sixteen cases resulted in 70 strengths and 80 current findings across system areas.

For this quarter, 34 strengths and 29 findings were noted for the MDT. While increased collaboration and investigation is occurring in the traditional child abuse cases, findings demonstrate a struggle with promptly invoking the MOU in cases such as poisoning or unsafe sleep. CPAC should continue its efforts to train the MDT on best practices and refresh all jurisdictions on the MOU and mandatory reporting laws. CPAC should also continue its efforts to provide access to local and national conferences for frontline responders, and identify advanced trainings for poisoning and unsafe sleep.

Medical findings this quarter merit attention. Medical professionals continue to be educated on reporting child abuse and neglect. However, this quarter had 11 medical findings, with most focusing on failure to report. Training was improved and delivered by CPAC in early 2019 to all Delaware physicians and it is hopeful that training will serve as a reminder as to these obligations.

Some progress with DFS regarding the use of safety agreements, unresolved risk and risk assessment is again seen this quarter. Thirty-nine findings were made in these categories. Once caseloads are subtracted, 26 findings remained again primarily focused on the improper completion of the safety assessment or involving inappropriate caregivers in safety agreements. CPAC will continue to pursue with DFS ongoing coaching in this area. DFS did provide additional staff training in June 2018 on use of the safety assessment to support decisions about the immediate safety of children. The cases seen here occurred close in time to that training – strengths are seen in this area, but there is still room for coaching. Twenty-four strengths were also noted with DFS workers performing thorough investigations. Many other strengths in frontline DFS workers were also seen in the MDT response categories. These positive examples will continue to be highlighted in trainings, both locally and nationally to encourage best practices.

The caseloads of DFS frontline workers continue to merit attention. CPAC continues to be grateful for the leadership in tackling the complex issues that face DFS in the

recruitment and retention of frontline child welfare workers. In 13 of the 16 recent cases contained in this letter, the DFS worker was significantly over the statutory caseload standard. CPAC continues to support additional frontline positions to ensure statutory compliance. There are still investigators carrying 40 plus 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.

In 2018, Delaware experienced 14 child abuse or neglect deaths and 34 near deaths. In 2019, Delaware has thus far seen 6 deaths and 10 near deaths. 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

Strengths Summary

May 22, 2019

INITIALS		
	***Current**	**Grand Total**
Legal	**2**	**2**
Court Hearings/ Process	2	2
MDT Response	**34**	**34**
General - Civil Investigation	9	9
General - Criminal Investigation	4	4
General - Criminal/Civil Investigation	14	14
Home Visiting Programs	1	1
Interviews - Child	1	1
Medical Exam	5	5
Medical	**10**	**10**
Home Visiting Programs	1	1
Medical Exam/Standard of Care - Birth	3	3
Medical Exam/Standard of Care - CARE	2	2
Medical Exam/Standard of Care - ED	2	2
Medical Exam/Standard of Care - PCP	1	1
Medical Exam/Standard of Care - Specialists	1	1
Risk Assessment/ Caseloads	**12**	**12**
Collaterals	5	5
Reporting	3	3
Risk Assessment - Substantiated	3	3
Use of History	1	1
Safety/ Use of History/ Supervisory Oversight	**10**	**10**
Completed Correctly/On Time	3	3
Custody/Guardianship Petitions	1	1
Oversight of Agreement	3	3
Safety Assessment of Non-Victims	1	1
Supervisory Oversight	2	2
Unresolved Risk	**2**	**2**
Contacts	1	1
Home Visiting Programs	1	1
Grand Total	**70**	**70**

FINALS		
	***Current**	**Grand Total**
Risk Assessment/ Caseloads	**1**	**1**
Collaterals	1	1
Grand Total	**1**	**1**

TOTAL STRENGTHS 71

**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

Strengths Detail and Rationale

May 22, 2019

INITIALS

System Area	Strength	Rationale	Count of #
Legal			2
	Court Hearings/ Process		2
		There was good collaboration between the Civil DAG and Child Attorney throughout the civil legal response.	1
		During the death investigation, there was good and consistent communication between the DFS case worker, the Civil DAG, and the Child Attorney throughout the civil legal response.	1
MDT Response			34
	General - Civil Investigation		9
		There was good communication between the DFS case worker and the medical team.	1
		The DFS case worker educated Mother on infant safe sleep practices.	1
		The DFS treatment caseworker educated Mother on infant safe sleep practices.	1
		During the near death investigation, there was excellent collaboration between the investigation and treatment caseworkers, to include a thorough investigation, timely and quality contact with the family, and appropriate follow up services for the child's medical care and Father's substance abuse treatment.	1
		In the prior investigation, the DFS caseworker conducted a thorough investigation, to include referral to an evidence-based home visiting program, good communication with said home visiting program, collaterals with Mother's substance abuse treatment facility, and a Framework.	1
		In the prior investigation, the DFS caseworker conducted a thorough investigation, to include medical evaluations of the children, referral to an early intervention program, and education of Mother on infant safe sleep practices.	1
		Following the report to the DFS Report Line by another party, the hotline worker contacted the initial treating hospital to gather additional information regarding the near death incident.	1
		For the previous report, the DFS caseworker educated Mother on infant safe sleep practices.	1
		Both DFS caseworkers for the prior reports educated Mother on infant safe sleep practices.	1
	General - Criminal Investigation		4
		The law enforcement agency requested a legal blood draw of the child for evidentiary purposes.	2
		Law enforcement and DOJ requested hair follicle testing for the child to determine ingestion of illicit substances.	1
		The law enforcement agency conducted a thorough investigation to include a scene investigation, multiple interviews, and search warrants for the child's medical equipment, Father's cell phone, and his social media pages.	1
	General - Criminal/Civil Investigation		14
		There was excellent MDT collaboration and response to the death investigation, to include joint interviews, and coordination of all children in and out of the home being medically evaluated and forensic interviews conducted.	1
		There was strong and consistent communication between the medical team, the DFS caseworker, the law enforcement agency, and the DOJ.	1
		There was excellent communication and collaboration with the medical team, DFS, the law enforcement agency, and the DOJ. The medical team was an integral part of the MDT.	2
		There was excellent communication and collaboration between the MDT and the out of state authorities, to include the child protective services agency and law enforcement.	2

	There was good collaboration between the child abuse medical expert, the DFS caseworker, and the law enforcement detective during the investigation, as well as follow up medical care for the child.	1
	There was good collaboration and consistent communication between DFS, the law enforcement agency, and the DOJ.	1
	There was good MDT response to the near death investigation between DFS and the law enforcement agency.	1
	During the death investigation, there was good collaboration and consistent communication between DFS, the law enforcement agency, and the DOJ.	1
	There was excellent communication between DFS, the law enforcement agency, the child abuse medical expert, and the DOJ.	1
	There was excellent collaboration and communication between DFS, the law enforcement agency, and the DOJ.	1
	During the near death investigation, there was excellent collaboration and consistent communication between DFS, law enforcement, DOJ, and the child abuse medical expert.	1
	There was a strong MDT response to the near death investigation by the DFS caseworker and the law enforcement agency, to include joint interviews and a joint response to the home.	1
	Home Visiting Programs	1
	During the two investigations, the DFS caseworkers referred Mother to an evidence-based home visiting program.	1
	Interviews - Child	1
	A forensic interview was scheduled and held at the CAC for the sibling residing in the home where the incident occurred.	1
	Medical Exam	5
	The DFS case worker ensured the child's sibling was medically evaluated.	1
	During the near death investigation, the DFS caseworker ensured the child's sibling was medically evaluated. The medical evaluation included a forensic nurse exam and a skeletal survey.	1
	During the death investigation, the DFS case worker ensured the surviving siblings were medically evaluated.	1
	For the near death report, the DFS caseworker ensured the siblings were medically evaluated.	1
	Despite the ED physician adamantly declining to complete a skeletal survey during the sibling's medical evaluation, the DFS caseworker pushed to ensure one was completed.	1
Medical		10
	Home Visiting Programs	1
	A referral to home visiting services was made prenatally for the Mother by the medical insurance provider.	1
	Medical Exam/ Standard of Care - CARE	2
	The child abuse medical expert met with the MDT and explained the organ procurement process to alleviate any fear the MDT may have had relating to the potential disruption of evidence by the process.	1
	As recommended by new research, magnetic resonance imaging (MRI) was completed of the brain and the full spine, rather than only the cervical spine, at the admitting hospital.	1
	Medical Exam/ Standard of Care - ED	2
	Given the child's presentation and lack of medical history, differential diagnosis was considered. A complete and comprehensive work-up was completed, to include consultation with the child abuse medical expert.	1
	The children's hospital followed its physical abuse pathway workup for the infant presenting with a bone fracture.	1
	Medical Exam/ Standard of Care - PCP	1
	During follow-up visit with the child's PCP, the nurse contacted DFS to confirm Mother's statement that she had been cleared for unsupervised contact with the child.	1

	Medical Exam/Standard of Care - Birth	3
	In the prior investigation, plan of safe care meetings were held prior to medical discharge of the child.	1
	For the previous report, a plan of safe care meeting was held prior to medical discharge of the child.	1
	Plan of safe care meetings were held at the birth of the child and prior to medical discharge of the child.	1
	Medical Exam/Standard of Care - Specialists	1
	The hospital social worker served as liaison between the organ donor program and the MDT investigators, and intervened when necessary to advocate for the child while on life support.	1
Risk Assessment/ Caseloads		12
	Collaterals	5
	The DFS treatment caseworker maintained quality contact with Mother and had good follow-up relating to Mother's substance abuse history.	1
	During the near death investigation, the DFS investigation caseworker and the treatment caseworker completed collaterals with Mother's substance abuse treatment provider.	1
	Strong collaterals were completed, to include parents' pain management doctors and Father's mental health treatment provider.	1
	Strong collateral contacts were completed during the prior investigation.	1
	The DFS case worker maintained quality contact with the family during the prior investigation. The contact was both announced and unannounced.	1
	Reporting	3
	The DFS caseworker made a report to the National Human Trafficking Hotline for the children.	3
	Risk Assessment - Substantiated	3
	At the conclusion of its investigation, DFS made an appropriate finding against Mother as a result of the children's injuries.	2
	At the conclusion of its investigation, DFS made appropriate findings against the perpetrator and the non-offending caregiver as a result of the child's injuries and failure to seek medical treatment.	1
	Use of History	1
	The DFS caseworker consulted with two out of state child protection agencies and completed National Crime Information Center (NCIC) checks for the adults residing in the household.	1
Safety/ Use of History/ Supervisory Oversight		10
	Completed Correctly/On Time	3
	Although verbally, not in writing, Mother's contact with the children was immediately restricted by DFS and law enforcement.	2
	The DFS caseworker traveled to Father's out of state home to conduct an assessment prior to modifying the child safety agreement.	1
	Custody/Guardianship Petitions	1
	During the near death investigation, DFS sought custody of the children quickly.	1
	Oversight of Agreement	3
	There was consistent review, and modification, when necessary, of the safety agreement by the DFS case worker.	1
	There was consistent review and modification, when necessary, of the safety agreement by the DFS caseworker. The caseworker was also seeing the family monthly.	1

		During the prior investigation, there was consistent review, and modification, when necessary of the safety agreement by the DFS case worker.	1
	Safety Assessment of Non-Victims		1
		The DFS caseworker implemented a child safety agreement with the siblings residing outside the home. The safety agreement was reviewed and modified, when necessary.	1
	Supervisory Oversight		2
		Due to the extenuating circumstances of the case, the DFS supervisor was very involved with the near death investigation.	2
Unresolved Risk			2
	Contacts		1
		During the death investigation, best interest meetings were held with the older sibling's school when there was a change in placement.	1
	Home Visiting Programs		1
		During the prior investigation, the DFS case worker referred the sibling to an early intervention program.	1
Grand Total			**70**

FINALS

System Area	Strength	Rationale	Count of #
Risk Assessment/ Caseloads			1
	Collaterals		1
		The DFS permanency caseworker maintained quality contact with the adoptive family.	1
Grand Total			**1**
TOTAL STRENGTHS			**71**

Child Abuse and Neglect Panel

Findings Summary

May 22, 2019

INITIALS

	*Current	**Prior	Grand Total
Legal	**1**		**1**
DFS Contact with DOJ	1		1
MDT Response	**29**		**29**
Crime Scene	7		7
Documentation	2		2
General - Civil Investigation	1		1
General - Criminal Investigation	5		5
General - Criminal Investigation / Civil Investigation	1		1
Intake with DOJ	3		3
Interviews - Adult	5		5
Interviews - Child	4		4
Medical Exam	1		1
Medical	**11**	**1**	**12**
Medical Exam/Standard of Care - Birth	1		1
Medical Exam/Standard of Care - CARE	1		1
Regulations/Policies	1		1
Reporting	8	1	9
Risk Assessment/ Caseloads	**20**		**20**
Caseloads	13		13
Collaterals	3		3
Risk Assessment - Closed Despite Risk Level	1		1
Risk Assessment - Tools	2		2
Risk Assessment - Unsubstantiated	1		1
Safety/ Use of History/ Supervisory Oversight	**15**		**15**
Completed Incorrectly/ Late	9		9
Inappropriate Parent/ Relative Component	4		4
No Safety Assessment of Non-Victims	1		1
Oversight of Agreement	1		1
Unresolved Risk	**4**		**4**
Contacts	1		1
Substance Abuse	1		1
Substance-Exposed Infant	2		2
Grand Total	**80**	**1**	**81**

FINALS

	*Current	Grand Total
MDT Response	**2**	**2**
Crime Scene	1	1
Prosecution/ Pleas/ Sentence	1	1
Grand Total	**2**	**2**

83

*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 5/2/2019

Child Abuse and Neglect Panel

Findings Detail and Rationale

May 22, 2019

INITIALS

System Area	Finding	PUBLIC Rationale	Sum of #
Legal			1
	DFS Contact with DOJ		1
		DFS did not consider immediately filing for custody of the young victim and her siblings after the medical evaluation confirmed serious physical injuries to a young special needs child. The family also had several risk factors including: multiple children under age 3, substance abuse, domestic violence, mental illness, and criminal and DFS history.	1
MDT Response			29
	Crime Scene		7
		No scene investigation was completed by the law enforcement agency.	1
		The law enforcement agency did not complete evidentiary blood draws on the child after the child ingested a prescription drug.	3
		No scene investigation was completed by the law enforcement agency. As a result, the scene was not photographed and no evidence was collected.	2
		The SUIDI form was not completed by the medical examiner's unit despite a discussion with the law enforcement agency and an agreement to complete the tool.	1
	Documentation		2
		There was no documentation in the police report by the lead detective.	1
		There was no documentation by the DFS case worker that a lock box to store the prescription medications was observed.	1
	General - Civil Investigation		1
		An immediate report was not made to the law enforcement agency by the DFS caseworker, and it impacted the initial MDT response to the near death investigation.	1
	General - Criminal Investigation		5
		There was not a MDT response to the near death incident in compliance with the MOU and statute, and the LE agency declined to come to the children's hospital.	1
		There was not a MDT response to the near death incident in compliance with the MOU and statute.	3
		There was not an immediate call to the Criminal Investigations Unit by the law enforcement agency. Instead, the initial responding officer attempted to close the case as unfounded with no crime.	1
	General - Criminal Investigation / Civil Investigation		1
		For the near death investigation, there was not a MDT response to the incident in compliance with the MOU and statute.	1
	Intake with DOJ		3
		The law enforcement agency did not notify the DOJ Special Victims Unit of the near death incident.	3
	Interviews - Adult		5
		DFS conducted interviews with parents prior to police response.	1
		DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	3

		Interviews did not occur with all adults in the home where the near death incident occurred. These adults were also prescribed the medication that the child ingested.	1
	Interviews - Child		4
		Forensic interview did not occur with the young child who was present during the near death incident.	1
		Forensic interview did not occur with the young victim.	1
		The DFS caseworker did not conduct a comprehensive interview with the victim. It was limited to the allegations.	1
		Forensic interview did not immediately occur with the young victim.	1
	Medical Exam		1
		The DFS caseworker did not independently contact the child abuse medical expert to discuss the medical findings and to determine if the mechanism of injury was consistent with a fall. There was also no confirmation that the child was seen for the follow-up visit.	1
Medical			12
	Medical Exam/Standard of Care - Birth		1
		The infant was born with prenatal substance exposure, and the birth hospital did not confirm the mother's prescription.	1
	Medical Exam/Standard of Care - CARE		1
		The child was discharged by the trauma center without a full CARE team assessment and evaluation.	1
	Regulations/Policies		1
		An organ donor program was not following their policies around talking to families about harvesting organs.	1
	Reporting		9
		The outpatient rehabilitation therapist failed to make a report to the DFS Report Line after it was noted that the special needs child presented with leg swelling and tenderness.	1
		There was no report to the DFS Report Line by staff at the birth hospital after the child's sibling was born with prenatal substance exposure.	1
		Staff at the two hospitals, where the child was treated, did not report the near death incident to the DFS Report Line.	1
		The walk in clinic failed to make a report to the DFS Report Line after it was noted that the young child presented with bruises to his face.	1
		The emergency department made a delayed report to the DFS Report Line despite a young child with head trauma.	1
		The treating hospital did not report the child death to the DFS Report Line.	1
		The Division of Forensic Science delayed making a report to the DFS Report Line for the death incident, and it may have impacted the joint response in the case.	1
		The child's young sibling sustained a skull fracture, and the DFS Report Line had no documentation of a report by the treating hospital.	1
		The children's hospital delayed making a report to the DFS Report Line for the near death incident.	1

Risk Assessment/ Caseloads			20
	Caseloads		13
		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.	1
		The DFS 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.	2
		The DFS caseworker was over the investigation caseload statutory standards the entire time the current case was open. However, it is unclear whether the caseload had a negative impact on the DFS response in the case.	2
		The DFS caseworkers were over the investigation caseload statutory standards during the current and prior investigations. The caseload does appear to have had a negative impact on the response in one prior case; however, it was unclear whether the caseload had a negative impact on the DFS response in the other cases, including the death investigation.	1
		The DFS caseworkers were over the investigation caseload statutory standards during the current and prior investigations. However, it is unclear whether the caseload had a negative impact on the DFS response in these cases.	2
		The DFS caseworkers were over the investigation caseload statutory standards during the current and prior investigations. The caseload does appear to have had a negative impact on the response in one prior case; however, it does not appear that the caseload negatively impacted the DFS response to the death investigation.	1
		The DFS caseworker was over the investigation caseload statutory the entire time the current case was open, and the caseload appears to have had a negative impact on the response in the 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 caseworkers were over the investigation caseload statutory standards the entire time the cases were open, and the caseload appears to have had a negative impact on the response in the prior case. There was no impact in the death investigation.	1
	Collaterals		3
		History with the out of state child protective services agency was not checked by the DFS caseworker.	1
		For the prior investigation, a collateral contact was not completed with the physician prescribing the mother's benzodiazepine.	1
		The primary care physician noted the young sibling's skull fracture in its collateral contact with DFS; however, the DFS caseworker did not follow up to gather additional details about the injury.	1
	Risk Assessment - Closed Despite Risk Level		1
		The SDM Risk Assessment identified the risk as high at the conclusion of the prior investigation. Ongoing service was recommended; however, the case disposition was overridden to close the investigation. It was not clear whether substance abuse treatment services were in place for the parents.	1
	Risk Assessment - Tools		2
		In the prior investigation, the SDM Risk Assessment was not completed correctly. The risk was scored as moderate; however, the DFS history was not considered.	1

	For the near death investigation, the policy override was not considered for the SDM Risk Assessment. As a result, the risk was scored as moderate and the case was closed.	1
Risk Assessment - Unsubstantiated		1
	For the prior investigation, DFS did not consider a finding of medical neglect despite the mother's delay in seeking medical care for her special needs child.	1
Safety/ Use of History/ Supervisory Oversight		15
Completed Incorrectly/ Late		9
	For the prior report, the case worker did not complete the SDM safety assessment correctly, and there was no safety agreement. The victim was permitted to remain in the home with a primary caregiver, who had significant DFS history and a child in foster care.	1
	For the near death investigation, the case worker did not complete the SDM safety assessment correctly, and there was no safety agreement. Mother was verbally told that she was permitted no contact with the children.	1
	In the prior investigation, the case worker did not complete the SDM safety assessment correctly, and there was no safety agreement. The victim was evaluated for bruising to his face and abuse could not be ruled out.	1
	For the near death investigation, the case worker did not complete the SDM safety assessment correctly, and there was no safety agreement. As a result, there was no follow up about use of a lock box to store the medications.	1
	For the death investigation, DFS entered into a safety agreement with a relative, but an interview and home assessment was not conducted to assess her ability to act as a safety participant.	1
	For the near death investigation, DFS did not conduct a home assessment prior to the infant's discharge from the hospital.	1
	The SDM Safety Assessment was not completed correctly for the near death incident. The safety threat for access to dangerous objects in the house was marked no, and the child was determined to be safe.	1
	For the near death investigation, DFS entered into a safety agreement with several participants, but interviews were not conducted with these participants to assess their ability to act as a safety participant.	1
	For the near death incident, the child was released to the mother with a child safety agreement. However, it did not adequately address the safety threat.	1
Inappropriate Parent/ Relative Component		4
	For the near death incident, DFS completed a safety agreement with a relative, who was not ruled out as a suspect.	1
	Following the report of a substance-exposed infant, DFS entered into a safety agreement with the father. However, he was not an appropriate caregiver due to DFS and criminal history.	1
	Following the report of an infant with prenatal substance exposure, DFS entered into a safety agreement with the father. However, he was not an appropriate caregiver due recent DFS and substance abuse history.	1
	For the near death investigation, DFS entered into a safety agreement with a relative. However, she was not an appropriate caregiver due to her ongoing substance abuse.	1

	No Safety Assessment of Non-Victims		1
		The DFS caseworker left the siblings in the home with the alleged perpetrator when the victim was taken to the hospital for an immediate medical evaluation. As a result, the alleged perpetrator fled with the siblings.	1
	Oversight of Agreement		1
		For the case involving the infant with prenatal substance exposure, DFS terminated the safety agreement; however, the mother's substance abuse issues continued to be an ongoing risk factor.	1
Unresolved Risk			4
	Contacts		1
		Prior to the death incident, DFS received a report involving illegal drug activity in the home, and the initial contact did not occur with the victim until almost 3 months after the referral was received.	1
	Substance Abuse		1
		DFS did not evaluate substance abuse issues for mother by requesting that she complete a substance abuse evaluation or by verifying her prescribed medications after the sibling was born with prenatal substance exposure.	1
	Substance-Exposed Infant		2
		A plan of safe care was not completed for the siblings who were born with prenatal substance exposure during the active treatment case.	1
		A plan of safe care was not completed for the infant born with prenatal substance exposure.	1
Grand Total			**81**

FINALS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			2
	Crime Scene		1
		The law enforcement agency did not obtain a search warrant for the home to collect other corroborative evidence.	1
	Prosecution/ Pleas/ Sentence		1
		The SENTAC guidelines' presumptive sentence for crimes against children should be greater.	1
Grand Total			**2**

TOTAL FINDINGS **83**