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CHAIR

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EXECUTIVE DIRECTOR

August 21, 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 18 cases at its August 21, 2019 meeting.[1]

Eight of the cases (all near deaths) had been previously reviewed and were awaiting the completion of prosecution. All eight of the cases were prosecuted, although one was subsequently nolle prossed. The remaining six cases resulted in one Child Abuse 1st plea, two Assault 2nd pleas, one Child Abuse 3rd plea, and two Endangering the Welfare pleas (one misdemeanor and one felony). Four of these cases were abusive head trauma cases and the strongest sentence was one case with two years at Level V. One other case received a one year sentence - all others received probation. As a result, CPAC has once again made findings that the SENTAC guideline's presumptive sentence should be greater in child abuse cases. Five findings were made during these final reviews.

[1] 16 Del. C. § 932.

The ten remaining cases were from deaths or near deaths that occurred between August 2018 and January 2019. Of these cases, five will have no further review. These timely reviews enable CPAC to address current system issues as well as celebrate accomplishments. The children range in age from newborn to three years of age with 4 deaths and 6 near deaths. The children were victims of poisoning, unsafe sleep and physical abuse/torture. These ten cases resulted in 47 strengths and 46 current findings across system areas.

For this quarter, 25 strengths and 16 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. The Office of the Investigation Coordinator (IC) should continue to meet with individual jurisdictions and troops to discuss the MOU, and educate on the role of the Office. The IC should also continue to provide MOU best practices to the team at the onset of the death or near death.

Medical findings this quarter again merit attention. Medical professionals continue to be educated on reporting child abuse and neglect. However, this quarter had 8 medical findings, with most focusing on failure to report. Training was improved and delivered by CPAC once again in January through March of 2019 to all Delaware physicians. It it is hopeful that training will serve as a reminder as to these obligations.

The findings against DFS merit close attention. With caseloads still extremely high, the work of the DFS investigators in these specialty units is outstanding. There were a total of only 21 findings this quarter with 10 of those findings being caseloads. There was no real trend in those 11 remaining findings indicating that the training and coaching being provided to the front lines is having a significant and positive impact. In addition, 16 strengths were identified just for DFS processes. Couple this with the 25 strengths in the MDT response, many of which can be attributed to the work of DFS, and there is significant collaborative work occurring. These positive examples will continue to be highlighted in trainings, both locally and nationally to encourage best practices, and should we shared with the DFS Serious Injury units.

No letter from CPAC would be complete without mentioning the caseloads of DFS frontline workers. 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 every recent case 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 7 deaths and 13 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

August 21, 2019

INITIALS		
	***Current**	**Grand Total**
Legal	**2**	**2**
Court Hearings/ Process	2	2
MDT Response	**25**	**25**
Crime Scene	1	1
General - Civil Investigation	3	3
General - Criminal Investigation	5	5
General - Criminal/Civil Investigation	8	8
Interviews - Adults	1	1
Interviews - Child	2	2
Medical Exam	5	5
Medical	**4**	**4**
Medical Exam/Standard of Care - ED	1	1
Medical Exam/Standard of Care - PCP	1	1
Reporting	2	2
Risk Assessment/ Caseloads	**6**	**6**
Collaterals	3	3
Documentation	1	1
Risk Assessment - Substantiated	1	1
Risk Assessment -Opened Despite Risk Level	1	1
Safety/ Use of History/ Supervisory Oversight	**6**	**6**
Custody/Guardianship Petitions	1	1
Oversight of Agreement	5	5
Unresolved Risk	**4**	**4**
Child - Medical	1	1
Contacts	1	1
Parenting	1	1
Substance Abuse	1	1
Grand Total	**47**	**47**

FINALS		
	***Current**	**Grand Total**
Unresolved Risk	**1**	**1**
Contacts	1	1
Grand Total	**1**	**1**

TOTAL STRENGTHS 48

**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 8/16/2019

Child Abuse and Neglect Panel

Strengths Detail and Rationale

August 21, 2019

INITIALS

System Area	Strength	Rationale	Count of #
Legal			2
	Court Hearings/ Process		2
		Comprehensive medical evidence was presented at the Adjudicatory Hearing.	1
		The DFS caseworker, OCA Child Attorney and Civil DAG advocated for a finding of medical neglect at the Adjudicatory Hearing.	1
MDT Response			25
	Crime Scene		1
		Upon discovery of the fetal remains, the law enforcement agency immediately terminated the consent search and a search warrant was obtained prior to any further investigative steps being taken.	1
	General - Civil Investigation		3
		The DFS caseworker conducted a thorough investigation, to include a child safety agreement, home assessments, medical evaluation and forensic interview of the sibling, a family team meeting, and a Framework, which recommended transferring the case to treatment.	1
		During the death investigation, the DFS caseworker made contact with the caregivers of Mother and Father's other children.	1
		A thorough investigation was completed by the DFS caseworker, to include medical evaluation of the sibling, home assessments, medical and daycare collaterals, ensuring Mother obtained a lockbox for the medications, a Framework, and a referral to the drug and alcohol liaison for Mother.	1
	General - Criminal Investigation		5
		The law enforcement agency conducted a thorough investigation to include multiple interviews, blood draw of the parents, scene investigation, doll reenactment, photo and video documentation, and intake with the DAG.	1
		The law enforcement agency conducted a thorough investigation that included multiple interviews and search warrants for the seizure and download of the child's medical equipment.	1
		There was good MDT communication and collaboration between DFS, the law enforcement agency, the medical team, and the DOJ, to include a timely report to law enforcement, joint responses to the hospital and the home, and joint interviews.	1
		The law enforcement agency conducted simultaneous responses to the hospital and to the home, and patrol officers quickly secured the scene until the detectives' arrival.	1
		Excellent law enforcement response and investigation, which involved controlling the scene, video and photographic evidence of the scene, evidence collection from the scene, and cell phone analysis.	1
	General - Criminal/Civil Investigation		8
		Despite delayed notification to DFS, there was good collaboration and communication between DFS and the law enforcement agency.	1
		There was great MDT communication between DFS, the law enforcement agency, the medical examiner's office, and the DOJ, to include an MDT meeting with all parties present.	1
		There was good communication between DFS, the law enforcement agency, and the DOJ.	1
		There was great MDT communication and collaboration between DFS, the law enforcement agency, and DOJ, to include joint responses to the hospital, joint interviews and MDT participation in the intake.	1
		There was great communication and collaboration between the DFS caseworker, the law enforcement agency, and the medical team.	1
		There was good MDT communication and collaboration between DFS, the law enforcement agency, and the DOJ.	1

			Count
		There was great communication and collaboration between the DFS caseworker, the law enforcement agency, and the medical team, to include consultation prior to implementing and terminating the child safety agreement.	1
		For the death investigation, there was good collaboration between DFS and the law enforcement agency.	1
	Interviews - Adults		1
		In the prior investigation, the DFS caseworker advocated for Mother's paramour to be interviewed by law enforcement in an effort to rule him out as a suspect, and implemented a child safety agreement restricting contact until the interview could be completed.	1
	Interviews - Child		2
		As the family initially refused to allow forensic interviews of the other children residing in the home, subpoenas were issued to enforce the interviews.	1
		The DFS caseworker advocated for a forensic interview to be conducted for the sibling residing in the home.	1
	Medical Exam		5
		The DFS case worker ensured the child's siblings were medically evaluated.	1
		The DFS caseworker ensured medical evaluations were completed for the other children residing in the home at the time of the near death incident.	1
		The DFS caseworker advocated for consultation with the child abuse medical expert, which led to DFS obtaining custody of the child.	1
		In the prior investigation, the medical information was corroborated independently by both the DFS caseworker and the law enforcement detective.	1
		For the death investigation, the DFS caseworker advocated for the sibling to receive a skeletal survey despite his age, given the circumstances of the case.	1
Medical			4
	Medical Exam/ Standard of Care - ED		1
		There was great communication between the medical teams at both the initial treating hospital and the children's hospital.	1
	Medical Exam/ Standard of Care - PCP		1
		At the child's first pediatrician visit, the pediatrician screened Mother for post-partum depression.	1
	Reporting		2
		At the time of the near-death incident, the initial treating hospital made a referral to the DFS Report Line concerning medical neglect of the child.	1
		The hospital made a report to law enforcement once the mother's story did not match the exam findings.	1
Risk Assessment/ Caseloads			6
	Collaterals		3
		Comprehensive medical collaterals were completed for the child, and appropriate referrals made.	1
		Collateral contacts were completed by the DFS caseworker prior to case closure. The contacts included both professional and personal contacts.	1
		Strong collaterals were completed during the death investigation, to include medical and personal sources.	1
	Documentation		1
		The DFS caseworker thoroughly documented the investigation case events.	1
	Risk Assessment - Substantiated		1
		At the conclusion of its investigation, DFS made an appropriate finding against Father as a result of the child's death.	1

System Area	Strength	Rationale	Count of #
	Risk Assessment -Opened Despite Risk Level		1
		Despite relative guardianship being awarded, the investigation case was transferred to treatment as Mother requested reunification.	1
Safety/ Use of History/ Supervisory Oversight			6
	Custody/Guardianship Petitions		1
		DFS sought input from the Civil DAG and convened a TDM to discuss considerations for DFS custody.	1
	Oversight of Agreement		5
		There was consistent review and modification, when necessary, of the safety agreement by the DFS caseworker.	4
		During the death investigation, there was consistent review and modification, when necessary, of the safety agreement by the DFS caseworker.	1
Unresolved Risk			4
	Child - Medical		1
		DFS contacted the birthing hospital and advised that a hotline referral was required at the birth of the sibling. Additionally, the DFS caseworker ensured the sibling's medical needs were immediately assessed, to include genetic testing for spinal muscular atrophy.	1
	Contacts		1
		The DFS investigation and treatment caseworkers maintained regular, quality contact with the family and the foster parents.	1
	Parenting		1
		The DFS investigation and treatment caseworkers encouraged the parents to attend the child's medical appointments, and assisted with transportation as this had previously been identified as a barrier by Mother.	1
	Substance Abuse		1
		The DFS investigation caseworker referred Mother and Father for substance abuse evaluations, and completed follow up with the substance abuse provider.	1
Grand Total			**47**

FINALS

System Area	Strength	Rationale	Count of #
Unresolved Risk			1
	Contacts		1
		During the treatment case, the DFS caseworker had regular, quality contact with the family, including after guardianship was awarded to relatives.	1
Grand Total			**1**
TOTAL STRENGTHS			**48**

Child Abuse and Neglect Panel

Findings Summary

August 21, 2019

INITIALS

	*Current	Grand Total
Legal	**1**	**1**
DFS Contact with DOJ	1	1
MDT Response	**16**	**16**
Crime Scene	1	1
Documentation	1	1
General - Civil Investigation	1	1
General - Criminal Investigation	1	1
General - Criminal Investigation / Civil Investigation	5	5
Interviews - Adult	1	1
Interviews - Child	2	2
Medical Exam	2	2
Reporting	2	2
Medical	**8**	**8**
Home Visiting Programs	1	1
Medical Exam/Standard of Care - Birth	1	1
Medical Exam/Standard of Care - PCP	1	1
Reporting	5	5
Risk Assessment/ Caseloads	**14**	**14**
Caseloads	10	10
Collaterals	3	3
Risk Assessment - Tools	1	1
Safety/ Use of History/ Supervisory Oversight	**5**	**5**
Completed Incorrectly/ Late	1	1
Inappropriate Parent/ Relative Component	3	3
Oversight of Agreement	1	1
Unresolved Risk	**2**	**2**
Domestic Violence	1	1
Substance Abuse	1	1
Grand Total	**46**	**46**

FINALS

	*Current	Grand Total
MDT Response	**4**	**4**
Prosecution/ Pleas/ Sentence	4	4
Risk Assessment/ Caseloads	**1**	**1**
Caseloads	1	1
Grand Total	**5**	**5**

51

*Current - within 1 year of incident

**Prior - 1 year or more prior to incident

Child Abuse and Neglect Panel

Findings Detail and Rationale

August 21, 2019

INITIALS

System Area	Finding	PUBLIC Rationale	Sum of #
Legal			1
	DFS Contact with DOJ		1
		The DFS caseworker did not consult with the Civil DAG again regarding custody after the non-related caregiver refused to sign the safety agreement. As a result, the young child with serious physical injuries and failure to thrive remained in the care of the non-related caregivers with a safety threat present.	1
MDT Response			16
	Crime Scene		1
		The law enforcement agency did not complete evidentiary blood draws on the child after the child ingested a prescription drug.	1
	Documentation		1
		DFS documented information related to the opinions of the MDT in violation of the MOU.	1
	General - Civil Investigation		1
		The DFS case worker was not aware of the criminal no contact order between the non-related caregivers.	1
	General - Criminal Investigation		1
		There was a significant delay by the law enforcement agency in submitting the parents' blood sample to the Division of Forensic Science.	1
	General - Criminal Investigation / Civil Investigation		5
		There was not an initial MDT response to the near death incident in compliance with the MOU and statute.	1
		There was not an initial MDT response to the death incident in compliance with the MOU and statute.	2
		For the prior incident, there was not an initial MDT response in compliance with the MOU and statute.	1
		For the prior incident, there was no reported history of trauma and abuse had not been ruled out for the young child with a serious physical injury. Despite this, there was no further investigation by DFS or LE.	1
	Interviews - Adult		1
		For the prior incident, the law enforcement agency initially declined to interview the suspect even though abuse was not ruled out.	1
	Interviews - Child		2
		Forensic interviews did not occur with the other children residing in the home where the incident occurred.	1
		For the prior incident, there was a delay in interviewing the young sibling, and a forensic interview was not considered.	1
	Medical Exam		2
		There was no follow up with the child abuse medical expert by the MDT to discuss possible explanations for the serious physical injuries to the young child.	1
		For the prior incident, the medical evaluation for the young sibling in the home was delayed.	1
	Reporting		2
		The law enforcement agency did not make a report to the DFS Report Line for the death incident.	1
		The Division of Forensic Science delayed making a report to the DFS Report Line for the death incident.	1

Category	Subcategory	Finding	Count
Medical			8
	Home Visiting Programs		1
		The teen mother was not referred for evidence-based home visiting services during her pregnancy.	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 - PCP		1
		There was no care coordination through the PCP to manage the specialty services for the medically fragile child and to facilitate regular communication and collaboration between providers and services.	1
	Reporting		5
		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
		There was no report to the DFS Report Line by the PCP for the medically fragile child. The PCP noted concerns with non-compliance with routine medical care and poor interaction between the mother and child.	1
		The out of state hospital failed to report concerns of medical neglect to the DFS Report Line.	1
		The emergency department made a delayed report to the DFS Report Line despite the concerns for drug ingestion for the young child and an odor of alcohol for the parent.	1
		The family became non-compliant with routine medical care after the child sustained a serious physical injury without an explanation and following a DFS intervention. Despite this, the PCP failed to make a report to the DFS Report Line.	1
Risk Assessment/ Caseloads			14
	Caseloads		10
		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.	8
		The DFS caseworker assigned to the first report involving the sibling was over the investigation caseload statutory standards, and the caseload appears to have had a negative impact on the response for that incident as there was no documentation regarding the outcome.	1
		The DFS case workers were over the investigation and treatment caseload statutory standards while the cases were open. It is unclear whether the caseload had a negative impact on the DFS response in the near death investigation; however, the caseload appears to have had a negative impact on the treatment worker's contacts.	1
	Collaterals		3
		During the investigation, a collateral contact was not completed with the mother's substance abuse treatment provider to confirm her participation in treatment.	1
		During the investigation, a collateral contact was not completed with the physician prescribing the mother's amphetamines.	1
		During the prior incident, a collateral contact was not completed with non-professional sources close to the family.	1
	Risk Assessment - Tools		1
		The treatment case was closed with a discretionary override shortly after the investigation concluded. A safety threat was still present, and there was no documentation about the override.	1

System Area	Finding	Rationale	Sum of #
Safety/ Use of History/ Supervisory Oversight			5
	Completed Incorrectly/ Late		1
		There was no indication that the worker conducted a follow up home visit to confirm proper storage of the medications.	1
	Inappropriate Parent/ Relative Component		3
		For the near death investigation, DFS entered into a safety agreement with a non-related caregiver. However, she was not an appropriate caregiver due to her DFS and criminal histories, and she was not ruled out as a suspect.	1
		For the near death incident, DFS initially completed a safety agreement with a participant, who was not ruled out as a suspect.	1
		For the prior incident and death incident, DFS initially completed a safety agreement with mother, who was not ruled out as a suspect.	1
	Oversight of Agreement		1
		Prior to terminating the safety agreement, DFS did not conduct a home visit to confirm the medications were secure nor had the substance abuse evaluation been completed. However, the home visit and substance abuse evaluation were conducted prior to closing the investigation.	1
Unresolved Risk			2
	Domestic Violence		1
		The DFS treatment worker did not consider domestic violence services for the family.	1
	Substance Abuse		1
		DFS did not evaluate substance abuse issues for mother or request that she complete a substance abuse evaluation.	1
Grand Total			**46**

FINALS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			4
	Prosecution/ Pleas/ Sentence		4
		There was sufficient evidence to move forward with the prosecution based on mother's admission; however, the case was Nolle Prossed.	1
		Superior Court did not include "no contact with the victim" as a condition in the sentencing order.	1
		The SENTAC Guidelines presumptive sentence should be greater in child abuse cases.	2
Risk Assessment/ Caseloads			1
	Caseloads		1
		The caseworker was over the treatment 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
Grand Total			**5**

TOTAL **51**