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EXECUTIVE DIRECTOR

November 20, 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 November 16, 2019 meeting.[1]

Nine of the cases (2 deaths and 7 near deaths) had been previously reviewed and were awaiting the completion of prosecution. All nine of the cases were prosecuted, although three were subsequently nolle prossed. One of the death cases resulted in an outstanding sentence of 35 years at Level V against both defendants. The other death and the four near death cases resulted in sentences of probation. Three findings were made during these final reviews.

The nine remaining cases were from deaths or near deaths that occurred between January and April 2019. Of these cases, three will have no further review and will not be prosecuted. These timely reviews enable CPAC to address current system issues as well as celebrate accomplishments. The children range in age from two months to

[1] 16 Del. C. § 932.

five years of age with 4 deaths and 5 near deaths. The children were victims of poisoning, unsafe sleep, medical child abuse and physical abuse/torture. These nine cases resulted in 28 strengths and 53 current findings across system areas. Noteworthy, is a majority of the findings – 38 – were made in four of the cases demonstrating struggles on certain investigations with exemplary work in others.

For this quarter, 18 strengths and 19 findings were noted for the MDT. The cases demonstrate further training is needed for some law enforcement jurisdictions on the collaborative nature of the MOU while also indicating a need for more specialty training and support in poisoning, unsafe sleep and medical child abuse cases. CPAC will 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, unsafe sleep and medical child abuse together with identifying additional technical assistance resources. The Office of the Investigation Coordinator (IC) will continue to meet with individual jurisdictions and troops to discuss the MOU, and educate on the role of the Office focusing -- particularly on jurisdictions that have struggled in CAN Panel cases. The IC should also continue to provide MOU best practices to the team at the onset of the death or near death.

This quarter there were 5 strengths and 29 findings against DFS. Six of the findings are regarding caseloads. It is noteworthy that eight of the findings stemmed from one death case wherein the panel determined the worker's caseload appeared to negatively impact the case. In that case and the other cases, the timely completion of safety agreements, oversight of safety agreements and timely contacts were the recurring themes. These again are likely tied to the caseloads of the frontline workers. Most of the cases contained in this letter had the DFS worker significantly over the statutory caseload standard. CPAC continues to support additional frontline positions to ensure statutory compliance with 29 Del. C. § 9015. However, it is equally critical that we continue to consider incentives that encourage workers to stay employed such as hazard pay, payment at 100% of midpoint, portable computing equipment and employee recognition. 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 11 deaths and 23 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

Findings Summary

November 20, 2019

INITIALS

	*Current	Grand Total
MDT Response	**19**	**19**
Communication	2	2
General - Civil Investigation	1	1
General - Criminal Investigation	1	1
General - Criminal Investigation / Civil Investigation	3	3
Interviews - Adult	11	11
Interviews - Child	1	1
Medical	**5**	**5**
Documentation	1	1
Medical Exam	1	1
Reporting	3	3
Risk Assessment/ Caseloads	**11**	**11**
Caseloads	6	6
Child - Medical	1	1
Collaterals	1	1
Risk Assessment - Screen Out	1	1
Risk Assessment - Tools	1	1
Risk Assessment - Unsubstantiated	1	1
Safety/ Use of History/ Supervisory Oversight	**12**	**12**
Completed Incorrectly/ Late	7	7
Inappropriate Parent/ Relative Component	1	1
No Safety Assessment of Non-Victims	1	1
Oversight of Agreement	3	3
Unresolved Risk	**6**	**6**
Child - Medical	1	1
Collaterals	1	1
Contacts	3	3
Legal Guardian	1	1
Grand Total	**53**	**53**

FINALS

	*Current	Grand Total
Risk Assessment/ Caseloads	**2**	**2**
Caseloads	2	2
Unresolved Risk	**1**	**1**
Collaterals	1	1
Grand Total	**3**	**3**

56

*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 20, 2019

INITIALS

System Area	Finding	PUBLIC Rationale	Sum of
MDT Response			19
	Communication		2
		The law enforcement agency did not maintain ongoing collaboration or communication with DFS.	1
		The cause and manner of the victim's death was not communicated to DFS in a timely manner. The family reported the information to the caseworker.	1
	General - Civil Investigation		1
		During the treatment case, the parents were having ongoing contact despite the active criminal no contact order, and this was not addressed by the DFS caseworker.	1
	General - Criminal Investigation		1
		The law enforcement agency did not immediately secure the mother's cell phone for evidence.	1
	General - Criminal Investigation / Civil Investigation		3
		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.	1
		There was not an initial MDT response to the death incident in compliance with the MOU and statute.	1
	Interviews - Adult		11
		DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	2
		In the prior investigation, there was no documentation by the caseworker that the father was contacted or involved.	1
		In the death investigation, there was no documentation by the caseworker about the victim's father, so it is not known if he was contacted or involved.	2
		In the prior investigation, the caseworker attempted to contact the father for an interview, but a greater effort could have been made.	1
		In the near death investigation, the initial interview was not completed in a timely matter (within 24 hours). The caseworker only had telephone contact with the mother.	1
		DFS was informed about the law enforcement interview with the mother and declined to observe. In addition, DFS did not make greater efforts to independently engage mother in an interview.	1
		In the death investigation, DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	1
		During the near death investigation, a second hotline report was received by DFS, and the initial interview was not completed in a timely matter (within 24 hours) for this report.	1
		In the incident preceding the death, the caseworker's interview with mother did not occur on time for the first incident.	1
	Interviews - Child		1
		There was a delay in scheduling the forensic interviews for siblings.	1
Medical			5
	Documentation		1
		Medical providers had two opportunities to provide referrals to the mother after she made statements about adoption prior to the birth and asked to speak with someone about her feelings after the birth. There was no documentation of referrals or follow up by the medical providers.	1

	Medical Exam	1
	Medical Child Abuse should have been in the differential diagnosis once the school reported to the physician that the child's behaviors at school were inconsistent with what was reported at every medical appointment by the mother, especially given that exhaustive testing was all normal.	1
	Reporting	3
	The hospital failed to make a report to the DFS Report Line for the near death incident.	2
	There was no report to the DFS Report Line by staff at the birth hospital after the child was born with prenatal substance exposure and social issues were noted by nursing staff.	1
Risk Assessment/ Caseloads		11
	Caseloads	6
	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 caseworkers were over the investigation caseload statutory standards during the current and prior investigations. However, it does not appear that the caseload negatively impacted the DFS response to the cases.	1
	The caseworkers were over the investigation caseload statutory standards during the current and prior investigations, and the caseload appears to have had a negative impact on the response in the prior case and the first incident in the current case. There was no impact in the death investigation.	1
	The caseworker was at or 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 in these cases.	1
	The caseworker was over the investigation caseload statutory standards the entire time the current case was open, and the caseload appears to have had a negative impact on the follow up contacts and safety reviews.	1
	The caseworkers were over the investigation caseload statutory standards during the current and prior investigations. The caseload appears to have had a negative impact on the response in the prior investigation; however, it does not appear that the caseload negatively impacted the DFS response to the death incident.	1
	Child - Medical	1
	In the prior investigation, there was not sufficient follow up to rule out Medical Child Abuse. The worker contacted the PCP and attempted to gather information from specialists at the Children's Hospital, but it was not pursued and the case was closed.	1
	Collaterals	1
	During the prior incident, a collateral contact was not completed with the night nurse in the home.	1
	Risk Assessment - Screen Out	1
	The DFS Report Line screened out a prior hotline report, which alleged that the infant had scratches and bruises. The alleged incident was approximately 7 months prior to the near death report.	1
	Risk Assessment - Tools	1
	In the prior investigation, the SDM Risk Assessment was not completed correctly although it did not impact the decision to transfer the case to treatment. The risk was scored as high; however, it should have been very high.	1
	Risk Assessment - Unsubstantiated	1
	DFS did not make a finding of neglect after the young child almost died as a result of the father's actions. Instead, the investigation was unsubstantiated.	1

Safety/ Use of History/ Supervisory Oversight		12
	Completed Incorrectly/ Late	7
	In the current investigation, the SDM Safety Assessment was not completed on time for the first incident.	1
	In the prior investigation, a safety agreement was not implemented for the infant born with substance exposure despite the safety threat being present.	1
	In the current investigation, the SDM Safety Assessment was not completed within 24 hours, only a verbal agreement existed. As a result, no safety agreement was in place.	1
	For the near death investigation, the SDM Safety Assessment was not completed within 24 hours by the after-hours staff. As a result, a safety agreement was not established for the victim until several days later.	1
	DFS did not initially make efforts to engage the victim's mother in planning for the safety of the surviving sibling. The sibling's father was engaged, and signed the safety agreement.	1
	During the prior investigation, the safety assessment was erroneously abridged before the case was transferred to treatment. This may have impacted the treatment worker's ongoing assessment of safety.	1
	During the prior investigation, the caseworker documented a response to a new hotline report and made arrangements for the children to reside with a relative, who would also supervise the mother's contact with the children. However, a formal safety agreement was not implemented until a month later.	1
	Inappropriate Parent/ Relative Component	1
	For the near death incident, DFS initially completed a safety agreement with the father and another relative, who were not ruled out as suspects.	1
	No Safety Assessment of Non-Victims	1
	During the death investigation, one other non-related child resided in the home at the time of the incident, and safety was not assessed for this child.	1
	Oversight of Agreement	3
	In the prior investigation, the SDM Safety Agreement was not re-evaluated in a timely manner. There was no documentation of any follow up until three months later, when the safety was renewed again.	1
	The SDM Safety Agreement was not updated and re-evaluated in a timely manner during the near death investigation.	1
	During the active treatment case, the safety agreement developed during the DFS investigation was not reassessed or enforced by the assigned treatment worker. As a result, the parents were caring for the victim and siblings for 4 months without supervision and in violation of the agreement.	1
Unresolved Risk		6
	Child - Medical	1
	During the prior investigation, interviews completed during a home visit with the mother and children revealed a recent injury to one child, but there was no follow up by the caseworker.	1
	Collaterals	1
	During the treatment case, the PCP and children's hospital separately reported concerns about the child's medical care, and there was no documentation that the caseworker addressed the concerns with the family.	1
	Contacts	3
	During the near death investigation, the caseworker did not maintain regular contact with the child and family.	1
	Prior to the death incident, DFS received a report involving felony domestic violence, and the initial contact did not occur with the family until over a month after the referral was received.	1

		Timely contacts with the family did not occur during the active treatment case.	1
	Legal Guardian		1
		A legal guardian was not established for the victim prior to DFS case closure. The child was in the putative father's care, but custody or paternity had not been established by the court.	1
Grand Total			**53**

FINALS

System Area	Finding	PUBLIC Rationale	Sum of #
Risk Assessment/ Caseloads			2
	Caseloads		2
		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
		The caseworker was significantly 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
Unresolved Risk			1
	Collaterals		1
		There was no documentation of collateral contacts to support the treatment worker's decision to terminate the safety agreement.	1
Grand Total			**3**

TOTAL **56**

Child Abuse and Neglect Panel
Strengths Summary
November 20, 2019

INITIALS		
	***Current**	**Grand Total**
Education	**1**	**1**
Reporting	1	1
MDT Response	**18**	**18**
Documentation	1	1
General - Civil Investigation	2	2
General - Civil Investigation	1	1
General - Criminal Investigation	3	3
General - Criminal/Civil Investigation	3	3
Interviews - Adults	1	1
Interviews - Child	5	5
Medical Exam	2	2
Medical	**4**	**4**
Medical Exam/Standard of Care - CARE	1	1
Medical Exam/Standard of Care - PCP	1	1
Reporting	2	2
Risk Assessment/ Caseloads	**3**	**3**
Collaterals	3	3
Safety/ Use of History/ Supervisory Oversight	**2**	**2**
Appropriate Parent/Relative Component	1	1
Completed Correctly/On Time	1	1
Grand Total	**28**	**28**

FINALS		
	***Current**	**Grand Total**
MDT Response	**4**	**4**
General - Criminal Investigation	2	2
Prosecution/Pleas/Sentence	2	2
Risk Assessment/ Caseloads	**1**	**1**
Risk Assessment - Tools	1	1
Grand Total	**5**	**5**

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

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Child Abuse and Neglect Panel

Strengths Detail and Rationale

November 20, 2019

INITIALS

System Area	Strength	Rationale	Count of #
Education			1
	Reporting		1
		Multiple calls were made to DFS by school administration expressing concern of the children.	1
MDT Response			18
	Documentation		1
		The law enforcement agency thoroughly documented the investigation case events, to include a good description of the scene.	1
	General - Civil Investigation		2
		There was excellent collaboration between the school administration, the medical team, and the DFS caseworker, that enabled medical child abuse to be identified early on in the investigation.	1
		In the prior investigation, a specialized substance exposed infant (SEI) caseworker was assigned to the investigation.	1
	General - Civil Investigation		1
		The DFS caseworker advocated for law enforcement to conduct a doll reenactment with Mother.	1
	General - Criminal Investigation		3
		There was good communication between the law enforcement agency, the medical team, and the OCA Child Attorney.	1
		There was good communication between DOJ and the law enforcement agency.	1
		The law enforcement agency conducted a thorough investigation, to include verification of text messages from Mother prior to the incident, conducting multiple interviews, and collaborating with out of state authorities.	1
	General - Criminal/Civil Investigation		3
		There was good collaboration between DFS and the law enforcement agency.	1
		There was great MDT communication and collaboration between DFS and the law enforcement agency, to include joint responses to the home, joint interviews, medical evaluations for the siblings, and multiple checks by DFS to verify the medications were properly stored in the lockbox.	1
		There was great MDT communication and collaboration between DFS, the law enforcement agency, and the medical team.	1
	Interviews - Adults		1
		The DFS caseworker abstained from interviewing the parents prior to the law enforcement interviews and the children prior to the forensic interviews.	1
	Interviews - Child		5
		Forensic interviews were scheduled and held at the CAC for the child and the siblings residing in the home, including an older sibling with developmental delays.	1
		A follow-up forensic interview was conducted with the child after she had shown great medical improvement while hospitalized and contact with Mother was restricted.	1
		Forensic interviews were conducted with the sibling who was present in the home at the time of the child's death, and with a half-sibling despite the child being outside the home at the time of the child's death.	1
		The DAG advocated that a doll re-enactment be conducted during the forensic interview with the young child that witnessed the death incident.	1
		The DFS caseworker advocated for forensic interviews to be conducted for the siblings residing in the home.	1

	Medical Exam	2
	The DFS caseworker ensured the siblings, to whom Mother provided caretaking responsibilities, were medically evaluated.	1
	The DFS caseworker ensured the child's siblings were medically evaluated.	1
Medical		4
	Medical Exam/ Standard of Care - CARE	1
	Despite no findings on the initial skeletal survey, a repeat survey was completed at the child's follow up appointment.	1
	Medical Exam/ Standard of Care - PCP	1
	At a well visit, the primary care physician documented and photographed the child's bruising despite acknowledging them being a result of the medication injections.	1
	Reporting	2
	The health insurance company made two reports to the DFS hotline after review of the incident.	1
	There was excellent communication between the home visiting nurse, the primary care physician, and DFS regarding Mother's noncompliance with the child's medical care.	1
Risk Assessment/ Caseloads		3
	Collaterals	3
	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, to include the children's medical providers, the schools, the sibling's mental health treatment provider, and personal resources.	1
	In the previous investigation, strong collaterals were completed by the DFS caseworker prior to case closure. The contacts included both professional and personal contacts.	1
Safety/ Use of History/ Supervisory Oversight		2
	Appropriate Parent/Relative Component	1
	DFS ruled out a relative as a safety agreement participant based on his/her presence in the household where the near death incident occurred.	1
	Completed Correctly/On Time	1
	The safety agreement was implemented immediately by DFS, and it excluded relatives who resided in the home.	1
Grand Total		**28**

Child Abuse and Neglect Panel

Strengths Detail and Rationale

November 20, 2019

FINALS

System Area	Strength	Rationale	Count of #
Risk Assessment/ Caseloads			1
	Risk Assessment - Tools		1
		The treatment unit accepted the investigation case prior to the FOCUS transition in an effort to expedite case planning and implement services for the family.	1
MDT Response			4
	Prosecution/ Pleas/Sentence		2
		The Judge took into account the horrific nature of this crime, and sentenced the defendants above the presumptive guidelines.	1
		The DOJ secured a conviction to the charges and advocated for a sentence above the presumptive guidelines due to the horrific nature of the offense.	1
	General - Criminal Investigation		2
		The law enforcement detective assigned to the case conducted an excellent investigation and advocated for prosecution of the case.	1
		The investigative actions by the assigned homicide detective resulted in a timely arrest and successful prosecution.	1
Grand Total			**5**

TOTAL STRENGTHS **33**