STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
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CHAIR

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EXECUTIVE DIRECTOR

February 19, 2020

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 February 19, 2020 meeting.[1]

Nine of the cases (5 deaths and 4 near deaths) had been previously reviewed and were awaiting the completion of prosecution. Seven of the cases were prosecuted. One of the death cases and one of the near death cases resulted in Level V incarceration. An additional perpetrator of a near death case was convicted of Manslaughter of an adult for the same incident and received 12 years of Level V incarceration. The remaining four 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 April and June of 2019. Of these cases, three will have no further review and two of those three cases will not be prosecuted. The one that was prosecuted resulted in two

[1] 16 Del. C. § 932.

convictions for Child Abuse 2nd with 6 months of Level V incarceration. The remaining six cases will be reviewed again once prosecutorial decisions are completed. These timely reviews enable CPAC to address current system issues as well as celebrate accomplishments. The children in these nine cases range in age from two months to four years of age with one death and eight near deaths. The children were victims of poisoning via drug ingestion, unsafe sleep, skull and bone fractures and biting. These nine cases resulted in 22 strengths and 34 current findings across system areas.

For this quarter, 11 strengths and 13 findings were noted for the Multidisciplinary Team Response. There were no significant trends. The medical community had 6 findings this quarter together with 6 strengths. Of note were three incidents of a failure to report or delay in reporting by the medical community. Regular mandatory training continues to be provided to the physicians and other members of the medical community, and failures to report are promptly referred to the Department of Justice and the Division of Professional Regulation.

This quarter there were 5 strengths and 15 findings against DFS – one of the lowest number of findings against DFS ever. In addition, eight of the findings were regarding caseloads. The timely and appropriate completion of safety agreements continues to be a theme, and is 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, salaries at 100% of midpoint, portable computing equipment and employee recognition. CPAC remains a steadfast partner and the Joint Action Plan emphasizes the work of the final CPAC Caseloads/Workloads report.

In 2019, Delaware experienced 13 child abuse or neglect deaths and 28 near deaths – a small decrease 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
Strengths Summary
February 19, 2020

INITIALS		
Count of #	**Column Labels**	
	***Current**	**Grand Total**
MDT Response	**11**	**11**
General - Civil Investigation	2	2
General - Criminal Investigation	2	2
General - Criminal/Civil Investigation	6	6
Interviews - Child	1	1
Medical	**6**	**6**
Medical Exam/Standard of Care - CARE	3	3
Medical Exam/Standard of Care - ED	2	2
Medical Exam/Standard of Care - EMS	1	1
Risk Assessment/ Caseloads	**1**	**1**
Reporting	1	1
Safety/ Use of History/ Supervisory Oversight	**3**	**3**
Completed Correctly/On Time	1	1
Oversight of Agreement	2	2
Unresolved Risk	**1**	**1**
Mental Health	1	1
Grand Total	**22**	**22**

FINALS		
Count of #	**Column Labels**	
	***Current**	**Grand Total**
Legal	**1**	**1**
Court Hearings/ Process	1	1
Medical	**1**	**1**
Home Visiting Programs	1	1
Unresolved Risk	**1**	**1**
Domestic Violence and Parenting	1	1
Grand Total	**3**	**3**

TOTAL STRENGTHS **25**

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

Child Abuse and Neglect Panel

Strengths Detail and Rationale

February 19, 2020

INITIALS

System Area	Strength	Rationale	Count of #
MDT Response			11
	General - Civil Investigation		2
		The DFS caseworker sought information from medical professionals independent of the MDT response.	1
		The DFS caseworker followed up with the child abuse medical expert to ensure no further medical interventions were necessary for the children.	1
	General - Criminal Investigation		2
		The investigative actions by the assigned detective resulted in a timely arrest and successful prosecution.	1
		Due to the circumstances of the case, the law enforcement agency obtained photographs of Father's teeth to compare with the bite marks found on the child.	1
	General - Criminal/Civil Investigation		6
		Once the Criminal Investigations Unit was notified, there was good MDT communication and collaboration between DFS and the law enforcement agency.	1
		There was good collaborative MDT response to the near death incident, to include immediate medical examinations of the child and sibling, and forensic interview of the child within 24 hours.	1
		There was great MDT communication and collaboration between DFS and the law enforcement agency, to include joint responses to the home and the hotel, joint interviews, medical evaluations for the children, and information exchange between the two agencies.	1
		There was a good MDT response to the near death investigation, to include joint interviews, medical evaluations by the forensic nurse examiner for the siblings, child safety agreements, medical consultation, and forensic interviews. Furthermore, the child abuse medical expert viewed the doll reenactment video.	1
		There was good MDT response to the death investigation, to include joint interviews, medical evaluation and forensic interview of the sibling, a doll reenactment, and communication between DFS and the law enforcement agency.	1
		There was great MDT communication and collaboration between the medical team, DFS, and the law enforcement agency, to include joint responses to the hospital, joint interviews, medical evaluation of the sibling, and forensic interviews of the children that resided in the home.	1
	Interviews - Child		1
		Forensic interviews were conducted with the sibling who was present in the home at the time of the child's near death, and with the half-siblings despite the children residing outside the home at the time of the child's near death. The interviews were scheduled as urgent although it was reported as a non-urgent case.	1
Medical			6
	Medical Exam/ Standard of Care - CARE		3
		Medical evaluations of both children included a Child At Risk Evaluation (CARE) and repeat skeletal surveys.	1
		The twin sibling was admitted to the children's hospital for medical evaluation. The evaluation included an MRI and a skeletal survey.	1
		There was excellent medical follow up for the child, which included repeat MRIs and skeletal surveys, and medical coordination with the primary care physician.	1

	Medical Exam/ Standard of Care - ED	2
	The local hospital elevated care to the treating hospital.	1
	The initial treating hospital quickly elevated care to the children's hospital.	1
	Medical Exam/ Standard of Care - EMS	1
	Upon arrival, emergency medical services immediately inquired of any potential exposure to medication, and relayed the family's DFS involvement to the local hospital.	1
Risk Assessment/ Caseloads		1
	Reporting	1
	The Division of Forensic Science made an immediate referral to the DFS Report Line reporting the death of a child.	1
Safety/ Use of History/ Supervisory Oversight		3
	Completed Correctly/On Time	1
	The DFS case worker immediately implemented a safety agreement prohibiting contact between the children and parents.	1
	Oversight of Agreement	2
	There was consistent review and modification, when necessary, of the safety agreement by the DFS caseworker.	2
Unresolved Risk		1
	Mental Health	1
	The DFS caseworker would not modify the child safety agreement to allow for supervised visitation until Mother completed the mental health evaluation.	1
Grand Total		**22**

FINALS

System Area	Strength	Rationale	Count of #
Legal			1
	Court Hearings/ Process		1
		The Court made a finding of medical child abuse against both parents.	1
Medical			1
	Home Visiting Programs		1
		There was great effort by the early intervention program case manager to engage the family, which included multiple phone calls to the parents, the child's physician, and later, the out-of-state admitting hospital; unannounced home visits; and letters mailed to the home.	1
Unresolved Risk			1
	Domestic Violence and Parenting		1
		The Domestic Violence Hotline coordinated services with the advocacy program and immediately sought to provide the Mother with an attorney.	1
Grand Total			**3**

TOTAL STRENGTHS **25**

Child Abuse and Neglect Panel

Findings Summary

February 19, 2020

INITIALS

	*Current	Grand Total
MDT Response	**13**	**13**
Documentation	1	1
Doll Re-enactment	1	1
General - Criminal Investigation	2	2
General - Criminal Investigation / Civil Investigation	3	3
Interviews - Adult	4	4
Interviews - Child	1	1
Reporting	1	1
Medical	**6**	**6**
Medical Exam/ Standard of Care - Forensics	2	2
Medical Exam/Standard of Care - PCP	1	1
Reporting	3	3
Risk Assessment/ Caseloads	**8**	**8**
Caseloads	8	8
Safety/ Use of History/ Supervisory Oversight	**5**	**5**
Completed Incorrectly/ Late	2	2
Inappropriate Parent/ Relative Component	2	2
Oversight of Agreement	1	1
Unresolved Risk	**2**	**2**
Contacts	1	1
Substance Abuse	1	1
Grand Total	**34**	**34**

FINALS

	*Current	Grand Total
Medical	**1**	**1**
Medical Exam/ Standard of Care - Autopsy	1	1
Risk Assessment/ Caseloads	**2**	**2**
Caseloads	2	2
Safety/ Use of History/ Supervisory Oversight	**1**	**1**
Inappropriate Parent/ Relative Component	1	1
Unresolved Risk	**2**	**2**
Contacts	1	1
Legal Guardian	1	1
Grand Total	**6**	**6**

TOTAL FINDINGS **40**

*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 2/7/2020

Child Abuse and Neglect Panel

Findings Detail and Rationale

February 19, 2020

INITIALS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			13
	Documentation		1
		There was no documentation in the police report by the lead detective.	1
	Doll Re-enactment		1
		No doll re-enactment was completed by the law enforcement agency.	1
	General - Criminal Investigation		2
		There was not an immediate call to the Criminal Investigations Unit by the law enforcement agency. Instead, the initial responding officer sent the report through LEISS.	1
		There was not an immediate call to the Criminal Investigations Unit by the law enforcement agency. It impacted the detective's ability to secure a blood draw and schedule forensic interviews.	1
	General - Criminal Investigation / Civil Investigation		3
		There was not an initial MDT response to the death incident in compliance with the MOU and statute.	2
		During the near death incident, there was no report or investigation after the sibling was medically evaluated and found to have multiple bruises, including a handprint on the buttocks. The DFS case worker later incorrectly assessed the bruising to be a result of rough play.	1
	Interviews - Adult		4
		DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	2
		In the incident preceding the near death, DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	1
		Interviews with the parents did not occur until 10 days after the incident.	1
	Interviews - Child		1
		The forensic interview was scheduled by the law enforcement agency prior to any communication with the DFS caseworker.	1
	Reporting		1
		The law enforcement agency did not make a report to the DFS Report Line for an alleged abuse incident involving the victim that occurred prior to the near death investigation.	1
Medical			6
	Medical Exam/ Standard of Care - Forensics		2
		A forensic nurse was not immediately available at the time the children were brought in for medical exams.	2
	Medical Exam/Standard of Care - PCP		1
		During a well visit, bruising was identified on the young child's face, and the PCP allowed the child to return home and did not refer the child to the hospital emergency department.	1
	Reporting		3
		The PCP made a delayed report to the DFS Report Line for the near death incident.	1
		The hospital made a delayed report to the DFS Report Line for the near death incident.	1
		The neurologist failed to make a report to the DFS Report Line after the MRI revealed a brain bleed.	1

Risk Assessment/ Caseloads			8
	Caseloads		8
		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.	5
		The caseworkers 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
		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 case.	2
Safety/ Use of History/ Supervisory Oversight			5
	Completed Incorrectly/ Late		2
		A safety agreement was not initially implemented for the near death incident. Instead, the hospital staff was charged with monitoring the mother's contact with the victim.	1
		A safety agreement was not initially implemented for the near death incident, and once implemented, DFS completed a safety agreement with mother, who was not ruled out as a suspect.	1
	Inappropriate Parent/ Relative Component		2
		In the incident preceding the near death, DFS completed a safety agreement with mother. However, she was not an appropriate caregiver due to her DFS history, and the explanation she provided for the sibling's injury was questionable.	1
		For the near death incident, DFS initially completed a safety agreement with a relative, who was not ruled out as a suspect.	1
	Oversight of Agreement		1
		The SDM Safety Agreement was not re-assessed, and it was unclear when the assigned caseworker terminated the agreement.	1
Unresolved Risk			2
	Contacts		1
		Prior to the death incident, DFS received a report involving neglect/inadequate supervision, and the initial contact did not occur with the family until almost two months after the referral was received.	1
	Substance Abuse		1
		DFS did not follow up with the parents or the substance abuse liaison to confirm whether the parents completed their substance abuse evaluations.	1
Grand Total			**34**

FINALS

System Area	Finding	PUBLIC Rationale	Sum of #
Medical			1
	Medical Exam/ Standard of Care - Autopsy		1
		The Division of Forensic Science failed to do a complete review of the images and medical records provided by the treating hospital prior to the autopsy.	1

Risk Assessment/ Caseloads		2
	Caseloads	2
	The caseworker was over the treatment caseload statutory standards the entire time the case was open, and the caseload appears to have had a negative impact on the case.	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 the cases.	1
Safety/ Use of History/ Supervisory Oversight		1
	Inappropriate Parent/ Relative Component	1
	During the post-incident treatment case, two new reports were received and DFS completed a safety agreement with the father as a result of the new investigation. However, father was not an appropriate caregiver due to his history of domestic violence and the unexplained injury to the child from the near death case.	1
Unresolved Risk		2
	Contacts	1
	During the treatment case, there was no documentation that child was seen more than once in the almost six-month timeframe, although the child may have been present during the family team meeting.	1
	Legal Guardian	1
	A legal guardian was not established for the victim's sibling prior to DFS case closure. The child was in the care of a relative, but guardianship had not been established by the court.	1
Grand Total		**6**

TOTAL FINDINGS **40**