STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
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CHAIR

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

August 16, 2017

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 12 cases at its August 16, 2017 meeting.[1]

Seven of those cases have been previously reviewed and were awaiting completion or prosecution. The final reviews resulted in 8 new findings as well as 5 strengths. Of note is the difference in resolution of several Superior Court defendants initially charged with Child Abuse First Degree. For instance, one case was resolved to Assault 2nd and resulted in probation; another case was resolved to Child Abuse First Degree and resulted in two years jail time; and a third case was resolved to Child Abuse Second and resulted in two years jail time (defendant received an additional four years of jail time for a drug offense). While CPAC is cognizant that each case is unique, CPAC is exploring the reasons for disparity in resolutions with the Department of Justice and the Court.

[1] 16 Del. C. § 932.

The five remaining cases were from deaths or near deaths that occurred in December 2016 and January 2017. These cases resulted in 18 strengths and 27 findings across system areas. While noting some multidisciplinary team (MDT) struggles in the older cases that are included above, the more recent cases show 13 strengths compared to only 6 findings regarding the MDT response. Collaboration and communication between DFS and law enforcement continues to strengthen. Crime scene responses and investigations are improving. The work CPAC has done in trainings and development of a new MOU to support this response is beginning to show results. The most significant ongoing issues from these five cases are the 14[2] findings regarding the use of safety agreements, unresolved risk and risk assessment by DFS. In every case, the DFS case worker was significantly over the statutory caseload standard. It is very difficult to implement best practices and timely safety and risk assessment tools under these circumstances.

DFS caseloads remain a significant challenge for workers and a serious risk to children -- particularly infants. While keenly aware of the challenges in recruiting and retaining DFS staff, CPAC is hopeful that the 27 additional frontline positions at DFS will shortly begin to have a positive impact on caseloads and the ability to utilize safety agreements as well as to assess and resolve risk to children. CPAC will also continue to advocate for regular compliance with 29 Del. C. § 9015 such that caseloads can attain and then remain in statutory compliance. This year, 7 children have died and another 20 have almost died from abuse or neglect. In only 7 months, we have exceeded the 5 deaths from 2016, and we are on track to do the same with the near deaths, as there were 22 last year.

[2] There were 17 findings in these areas; however, 3 of the findings occurred in prior investigations in prior years. To demonstrate where ongoing current problems continue to exist, CPAC has referred only to the 14 findings that happened in the actual death or near death incident.

We are available should further information be required. For your information we have included the strengths, findings and the details behind all of the cases presented in this letter.

Respectfully,

Tania M. Culley, Esquire
Executive Director
Child Protection Accountability Commission

Enclosures
cc: CPAC Commissioners
General Assembly

Child Abuse and Neglect Panel

Findings Summary

8-16-17

INITIALS			
Row Labels	***Current**	****Prior**	**Grand Total**
MDT Response	**6**		**6**
Communication	1		1
Crime Scene	1		1
General - Civil Investigation	1		1
General - Criminal Investigation	1		1
Intake with DOJ	1		1
Interviews - Adult	1		1
Medical	**3**	**1**	**4**
Documentation		1	1
Medical Exam/ Standard of Care - Urgent Care	2		2
Medical Exam/Standard of Care - Birth	1		1
Risk Assessment/ Caseloads	**7**	**1**	**8**
Caseloads	3		3
Risk Assessment - Closed Despite Risk Level	1	1	2
Risk Assessment - Screen Out	1		1
Risk Assessment - Tools	1		1
Risk Assessment - Unsubstantiated	1		1
Safety/ Use of History/ Supervisory Oversight	**6**	**1**	**7**
Completed Incorrectly/ Late	4	1	5
Supervisory Oversight	2		2
Unresolved Risk	**1**	**1**	**2**
Substance-Exposed Infant	1	1	2
Grand Total	**23**	**4**	**27**

FINALS		
Row Labels	***Current**	**Grand Total**
Legal	**2**	**2**
Contracts/Policies	2	2
MDT Response	**5**	**5**
Crime Scene	1	1
Doll Re-enactment	1	1
Interviews - Child	1	1
Prosecution/ Pleas/ Sentence	2	2
Unresolved Risk	**1**	**1**
Child - Mental Health	1	1
Grand Total	**8**	**8**

TOTAL FINDINGS **35**

**Current - within 1 year of incident*

***Prior - 1 year or more prior to incident*

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Wilmington, DE 19801

Child Abuse and Neglect Panel

Findings Detail and Rationale

8-16-17

INITIALS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			6
	Communication		1
		There was no communication with the law enforcement agency by DOJ.	1
	Crime Scene		1
		The law enforcement agency did not obtain a search warrant for the home. The scene was not photographed and no evidence was collected.	1
	General - Civil Investigation		1
		Although it initially appeared that the injury occurred at the daycare, DFS closed the family case prematurely when none of the parties were completely ruled out as suspects.	1
	General - Criminal Investigation		1
		Despite both parents being observed as impaired, no blood draws were completed for toxicology screens.	1
	Intake with DOJ		1
		The law enforcement agency had no immediate contact with DOJ after receiving notification of a child death.	1
	Interviews - Adult		1
		DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	1
Medical			4
	Documentation		1
		Abusive Head Trauma/Shaken Baby Syndrome and infant safe sleep education were not documented within the medical records.	1
	Medical Exam/ Standard of Care - Urgent Care		2
		Emergency medical services misread the Broselow Pediatric Emergency Tape. As a result, the child was administered a higher dosage of medications.	1
		There was no documentation of Abusive Head Trauma/Shaken Baby Syndrome education noted within the medical records.	1
	Medical Exam/Standard of Care - Birth		1
		Abusive Head Trauma/Shaken Baby Syndrome and infant safe sleep education were not documented within the medical records.	1

Risk Assessment/ Caseloads			8
	Caseloads		3
		The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open. However, the caseload did not negatively impact the DFS response in the near death investigation.	2
		The DFS caseworker was over the investigation caseload statutory standards for a portion of time while the case was open. However, the caseload did not negatively impact the DFS response in the near death investigation.	1
	Risk Assessment - Closed Despite Risk Level		2
		In two prior investigations, the SDM risk assessment identified the risk as high and recommended ongoing service; however, the cases were closed. As a result, the family was not provided treatment services prior to the near death.	1
		In the prior investigation, the SDM risk assessment identified the risk as high and recommended ongoing service; however, the case was closed. As a result, the family was not provided treatment services prior to the death.	1
	Risk Assessment - Screen Out		1
		The DFS Report Line screened out the subsequent report regarding the healing rib fractures being found on the repeat x-rays.	1
	Risk Assessment - Tools		1
		A framework was not considered for the surviving sibling prior to closing the death investigation. The SDM risk assessment identified the risk as high and recommended ongoing service.	1
	Risk Assessment - Unsubstantiated		1
		The DFS Family and Child Tracking System (FACTS) does not identify cases where abuse has been confirmed but the perpetrator is unknown.	1
Safety/ Use of History/ Supervisory Oversight			7
	Completed Incorrectly/ Late		5
		In the prior investigation, the caseworker did not complete the SDM Safety Assessment correctly. The safety threat for drug-exposed infant was marked no. No agreement was entered.	1

		For the near death investigation, the caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization.	1
		For the near death investigation, the caseworker did not specify in the safety agreement that the contact was restricted between the children and potential susptects. The restrictions were only verbally stated.	1
		In the near death investigation, the case worker incorrectly identified the child as safe in the SDM safety assessment due to her hospitalization.	1
		In the near death investigation, the case worker identified the child as safe with agreement in the SDM safety assessment due to his hospitalization, but no agreement was entered.	1
	Supervisory Oversight		2
		In the prior investigation, the safety agreement was amended prior to the case worker having contact with mother's substance abuse treatment provider.	1
		For the death investigation, the caseworker closed the case and modified the safety agreement without contacting mother's substance abuse treatment provider.	1
Unresolved Risk			2
	Substance-Exposed Infant		2
		The prior report involving the victim's substance exposure at birth was screened out since the only concern was that the mother stopped visiting the baby. The prior DFS history was not considered.	1
		Another prior report involving a substance exposed infant was screened out due to the mother's participation in treatment. However, the mother had prior history involving an infant born substance exposed, and there was a prenatal screen that was concerning.	1
Grand Total			27

FINALS

System Area	Finding	PUBLIC Rationale	Sum of #
Legal			2
	Contracts/Policies		2
		The contractual obligations for supervision of ICPC cases by the contract agency were minimal and did not contain any specifics about safety assessments or quality visits with the child and family.	1
		The contract did not require much oversight for the contract agency, and the supervision was limited to progress notes and quarterly meetings.	1
MDT Response			5
	Crime Scene		1
		There were no photographs of the scene taken by the law enforcement agency.	1
	Doll Re-enactment		1
		No doll re-enactment was completed by the law enforcement agency.	1

	Interviews - Child		1
		Forensic interview did not occur with the youth who was present during the incident.	1
	Prosecution/ Pleas/ Sentence		2
		All the jail time was suspended for the defendant despite the guilty plea to a violent felony with a presumptive jail sentence.	1
		The sentencing order required the defendant to complete an anger management program and not a certified batterer's treatment program.	1
Unresolved Risk			1
	Child - Mental Health		1
		DFS, DPBHS, and DOE failed to collaborate and communicate regarding the child and sibling's therapeutic, educational, and placement needs. For the several months in foster care, the children had multiple placements and received inconsistent therapy.	1
Grand Total			**8**

TOTAL FINDINGS **35**

Child Abuse and Neglect Panel

Strengths Summary

8-16-17

INITIALS	
MDT Response	**13**
Crime Scene	2
Documentation	2
General Civil Investigation	1
General Criminal Investigation	1
General Criminal Investigation/Civil Investigation	4
Interviews - Child	1
Medical Exam	2
Medical	**4**
Documentation	1
Home Visiting Programs	1
Medical Exam/Standard of Care - ED	1
Reporting	1
Risk Assessment/ Caseloads	**1**
Risk Assessment - Tools	1
Grand Total	**18**

FINALS	
Legal	**1**
Prosecution/Pleas/Sentence	1
MDT Response	**4**
Crime Scene	1
General Criminal Investigation	2
Interviews - Adults	1
Grand Total	**5**

TOTAL STRENGTHS	**23**

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Child Abuse and Neglect Panel

Strengths Detail and Rationale

8-16-17

INITIALS

System Area	Strength	Rationale	Count of #
MDT Response			13
	Crime Scene		2
		The law enforcement agency conducted a thorough scene investigation.	1
		The law enforcement agency conducted a thorough scene investigation, which included a search warrant of the daycare workers' phones.	1
	Documentation		2
		Documentation by DFS and the law enforcement agency was thorough.	1
		The law enforcement agency documented its contact with victim services.	1
	General Civil Investigation		1
		The DFS caseworker immediately followed-up on the hotline report made by the patrol officer regarding a possible violation of the No Contact Order.	1
	General Criminal Investigation		1
		The patrol officer conducting the traffic stop made a hotline report to DFS regarding a possible violation of the No Contact Order.	1
	General Criminal Investigation/Civil Investigation		4
		Excellent collaboration between DFS and the law enforcement agency.	1
		There was great collaboration between the law enforcement agency and the Institutional Abuse caseworker with DFS.	1
		There was great MDT response to the investigation by all parties.	1
		Excellent collaboration between DFS and the law enforcement agency, including consultation with the CARE Team.	1
	Interviews - Child		1
		A forensic interview was completed with the older sibling.	1
	Medical Exam		2
		The DFS caseworker had both siblings medically evaluated due to possible drug ingestion.	1
		After mother admitted to recent substance use, the law enforcement agency requested that an ambulance transport the siblings to the hospital for a medical exam.	1
Medical			4
	Documentation		1
		Staff at the children's hospital thoroughly documented that there were no other signs of physical injury and that positioning the child in a certain way and holding the child tightly were alleviating the pressure from the child's injuries.	1

	Home Visiting Programs		1
		Home visiting services were initiated for the family while the mother was still hospitalized.	1
	Medical Exam/ Standard of Care - ED		1
		The initial hospital explored a differential diagnosis and escalated care to the children's hospital.	1
	Reporting		1
		The PCP called in a report for medical neglect after the mother did not follow through with medical appointments for the sibling.	1
Risk Assessment/ Caseloads			1
	Risk Assessment - Tools		1
		A Framework and group supervision were completed during the DFS investigation case.2	1
Grand Total			**18**

FINALS

System Area	Strength	Rationale	Count of #
Legal			1
	Prosecution/ Pleas/Sentence		1
		The sentence was exemplary in this case.	1
MDT Response			4
	Crime Scene		1
		The law enforcement agency conducted a thorough scene investigation, which included a search warrant of the parents' phones.	1
	General Criminal Investigation		2
		There was good collaboration between the family services and drug squad units.	1
		There was good collaboration between the law enforcement agency and DOJ. The communication and charging decision occurred quickly.	1
	Interviews - Adults		1
		The law enforcement agency was able to obtain a partial confession from the defendant.	1
Grand Total			**5**

TOTAL STRENGTHS **23**