STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
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CHAIR

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EXECUTIVE DIRECTOR

August 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 and another 37 cases at its August 19, 2020 meeting.[1] These 55 child victim cases are all incorporated in this letter due to the pandemic. Please note that despite the pandemic, the Child Abuse and Neglect Panel met conscientiously (even holding two meetings in June) to assure that child abuse deaths and near deaths were timely reviewed.

Twenty-five of the cases (10 deaths and 15 near deaths) had been previously reviewed and were awaiting the completion of prosecution. Thirteen of the cases were prosecuted. One of the death cases and two 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. Three cases of endangering the welfare remain pending, one assault is

[1] 16 Del. C. § 932.

still awaiting sentencing and the remaining five cases resulted in sentences of probation. Ten findings were made during these final reviews.

The thirty remaining cases were from deaths or near deaths that occurred between April and December of 2019. Of these cases, ten will have no further review and eight were not prosecuted. Of the two that were prosecuted one resulted in two convictions for Child Abuse 2nd with 6 months of Level V incarceration, and the other in a conviction of misdemeanor Endangering the Welfare of a Child. The remaining twenty 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 twenty cases range in age from one month to fourteen years of age with seven deaths and twenty-three near deaths. The children were victims of abusive head trauma, torture, poisoning via drug ingestion, unsafe sleep, skull and bone fractures, burns and biting. These twenty cases resulted in 69 strengths and 142 current findings across system areas.

For these April through December 2019 cases, 29 strengths and 53 findings were noted for the Multidisciplinary Team Response. There were no significant subject matter trends. However, there were several cases where the Memorandum of Understanding (MOU) was followed and then several others where it was not. This resulted in significant strengths in one case, and repeated findings in others. The breakdowns were not only in some smaller jurisdictions, but also in larger law enforcement agencies. CPAC commits to initial and refresher training for all law enforcement agencies as well as targeted meetings on individual cases and case breakdowns. CPAC and the Office of the Investigation Coordinator will continue to push communication and collaboration with all MDT partners, and the following of best practices.

The medical community had 16 findings together with 13 strengths. Of note were eight 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. CPAC will explore what other opportunities are available for individualized training and reminders on reporting child abuse and neglect.

For the first three months of cases reviewed, there were 5 strengths and 15 findings against DFS – one of the lowest number of findings against DFS ever. In the next six

months, there were an additional 21 strengths and 55 findings. This totaled 26 strengths and 70 findings. Twenty-four of the findings were regarding caseloads. The remaining 46 findings primarily included timely and appropriate completion of safety agreements, and collateral and family contacts. While ongoing coaching and training may assist, these findings 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, 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 29 near deaths – a small decrease from 2018. As of the writing of this letter, all 2019 incidents have been reviewed and will be considered at our retreat with the Child Death Review Commission.

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 19, 2020

**Includes reviews conducted between October through June 2020.*

INITIAL REVIEWS

	*Current	Grand Total
Education	**1**	**1**
Reporting	1	1
MDT Response	**29**	**29**
Communication	1	1
Crime Scene	2	2
Doll Re-enactment	1	1
General - Civil Investigation	4	4
General - Criminal Investigation	3	3
General - Criminal/Civil Investigation	15	15
Interviews - Child	1	1
Medical Exam	1	1
Mental Health	1	1
Medical	**13**	**13**
Home Visiting Programs	1	1
Medical Exam/Standard of Care - CARE	4	4
Medical Exam/Standard of Care - ED	3	3
Medical Exam/Standard of Care - EMS	1	1
Medical Exam/Standard of Care - PCP	1	1
Medical Exam/Standard of Care - Specialists	2	2
Reporting	1	1
Risk Assessment/ Caseloads	**6**	**6**
Collaterals	3	3
Communication	1	1
Reporting	1	1
Risk Assessment - Screened In	1	1
Safety/ Use of History/ Supervisory Oversight	**11**	**11**
Appropriate Parent/Relative Component	2	2
Completed Correctly/On Time	6	6
Oversight of Agreement	3	3
Unresolved Risk	**9**	**9**
Home Visiting Programs	1	1
Legal Guardian	2	2
Parental Risk Factors	5	5
Substance-Exposed Infant	1	1
Grand Total	**69**	**69**

FINAL REVIEWS

	*Current	Grand Total
Legal	**1**	**1**
Court Hearings/ Process	1	1
MDT Response	**3**	**3**
Communication	1	1
General - Civil Investigation	1	1
General - Criminal Investigation	1	1
Medical	**1**	**1**
Home Visiting Programs	1	1
Safety/ Use of History/ Supervisory Oversight	**1**	**1**
Appropriate Parent/Relative Component	1	1
Unresolved Risk	**4**	**4**
Contacts with Family	1	1
Legal Guardian	1	1
Parental Risk Factors	2	2
Grand Total	**10**	**10**

TOTAL CAN PANEL STRENGTHS ` 79

Office of the Child Advocate
900 King Street, Ste 350
Wilmington, DE 19801

Child Abuse and Neglect Panel

Strengths Detail

August 19, 2020

**Includes reviews conducted between October through June 2020.*

INITIAL REVIEWS

System Area	Strength	Rationale	Count of #
Education			1
	Reporting		1
		Multiple calls were made to the DFS Report Line by school administration expressing their suspicions of abuse or neglect.	1
MDT Response			29
	Communication		1
		There was good communication between the two law enforcement agencies involved.	1
	Crime Scene		2
		There was a good law enforcement response to the home. The scene was controlled quickly and appropriate notifications were made.	1
		The law enforcement agency conducted a thorough investigation to include a scene investigation, multiple interviews, photographic documentation with measurements in and around the pond, and an intake with the DAG.	1
	Doll Re-enactment		1
		Despite having no explanation for how the child sustained the injury, the law enforcement agency conducted a doll reenactment with Mother.	1
	General - Civil Investigation		4
		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
		The DFS caseworker advocated for a doll reenactment and blood draw of Mother, despite the near death incident appearing to be accidental.	1
		The DFS caseworker completed a thorough review of the child's medical records to ensure there was no failure to report at the birth of the infant with prenatal substance exposure, and of Mother's Medication Assisted Treatment (MAT) records to ensure Mother was compliant.	1
	General - Criminal Investigation		3
		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
	There was a good law enforcement response to the investigation, including multiple detectives responding to the hospital and the home, immediately securing the scene, and Mother promptly being taken into custody.	1
General - Criminal/Civil Investigation		15
	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
	There was a good MDT response to the near death investigation, to include joint response to the hospital and the home, joint interviews, a doll reenactment, and communication between DFS and the law enforcement agency.	1
	There was good MDT communication and collaboration between DFS and the law enforcement agency, to include joint responses to the hospital, joint interviews, medical evaluation of the siblings, and forensic interviews of the siblings.	1

	There was a good, coordinated MDT response to the death investigation, to include joint response to the hospital, information sharing, a doll reenactment, and communication between DFS, the law enforcement agency, the medical team, and the DOJ.	1
	There was good MDT communication and collaboration between DFS, the law enforcement agency, and the DAG, to include joint responses to the hospital and to the two households, joint interviews, medical evaluation and forensic interviews of the respective siblings, and a doll reenactment with non-relative caregiver.	1
	There was good MDT communication and collaboration between DFS, the law enforcement agency, the medical team, and the DAG, to include joint responses to the hospital, joint interviews, medical evaluations of the children in the child's home and the maternal grandmother's home, and forensic interview of the sibling.	1
	There was a strong, coordinated MDT response to the death investigation by the law enforcement agency, forensic investigators, Institutional Abuse (IA) caseworkers, medical community and the DOJ. Furthermore, a community meeting was held with the families of the daycare facility, which was attended by the DSCYF Cabinet Secretary and IA caseworkers.	1
	There was a good initial MDT response to the near death investigation between DFS and the law enforcement agency, to include a joint response to the hospital and joint interviews.	1
	There was good MDT communication and collaboration between DFS, the law enforcement agency, the medical team, and the DAG, to include joint responses to the hospital, joint interviews, and medical evaluations of the children within both households.	1
	There was good MDT communication and collaboration between DFS, the law enforcement agency, the medical team, and the DAG, to include joint responses to the hospital and the home, joint interviews, and medical evaluations and forensic interviews of the siblings.	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 Exam	1
	The DFS caseworker advocated for the children to be medically evaluated by the children's hospital despite the initial treating hospital determining they were cleared for medical discharge.	1
	Mental Health	1
	The Children's Advocacy Center confirmed the children were receiving services from a mental health treatment provider following the incident.	1
Medical		13
	Home Visiting Programs	1
	There was great effort by the evidence-based home visiting program to re-engage with Mother, which included multiple phone calls to the parents, unannounced home visits, and letters mailed to the home.	1
	Medical Exam/ Standard of Care - CARE	4
	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
	Two follow-up appointments were completed by the Child at Risk Evaluation (CARE) Team to confirm the x-ray findings.	1
	Medical Exam/ Standard of Care - ED	3
	The children's hospital followed its physical abuse pathway workup for the infant presenting with a bone fracture.	1
	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
	Medical Exam/ Standard of Care - PCP	1
	The primary care physician screened Mother for post-partum depression at the child's well visit. Furthermore, the physician ensured a psychologist met with Mother following the positive postpartum depression screen.	1

	Medical Exam/Standard of Care - Specialists	2
	In the previous hospital admission, the General Pediatrics physician reviewed the child's medical chart; counseled Mother on delayed vaccinations and missed appointments; and sent a letter to the child's primary care physician noting his concerns and the hospital course.	1
	A referral to evidence-based home visiting services was made prenatally for the mother by the obstetrician/gynecologist.	1
	Reporting	1
	The WIC office and the pediatrician made immediate referrals to address concerns for the child's care rather than planning for follow up visits to watch the child's progress.	1
Risk Assessment/ Caseloads		6
	Collaterals	3
	Collateral contacts were completed with non-professional sources close to the family.	1
	Strong collaterals were completed by the DFS caseworker prior to case closure. The contacts included both professional and personal resources.	1
	The DFS treatment caseworker maintained consistent, quality contact with the family and monthly follow up with Mother's substance abuse treatment provider.	1
	Communication	1
	During the near death investigation, there was a good collaboration and communication between the DFS investigation and treatment caseworkers.	1
	Reporting	1
	The Division of Forensic Science made an immediate referral to the DFS Report Line reporting the death of a child.	1
	Risk Assessment - Screened In	1
	DFS accepted the hotline report for death investigation due to the circumstances of the prior treatment case despite the report not meeting criteria as set forth in the SDM Risk Assessment tool.	1
Safety/ Use of History/ Supervisory Oversight		11
	Appropriate Parent/Relative Component	2
	The DFS caseworker made good use of the natural support network to provide a safe placement for the child.	1
	During the two investigations, the DFS investigation caseworkers made good use of the natural support network to provide safe placement for the child(ren).	1

	Completed Correctly/On Time	6
	The DFS case worker immediately implemented a safety agreement prohibiting contact between the children and parents.	1
	The DFS caseworker immediately implemented a safety agreement prohibiting contact between the children, Mother, and her paramour. However, the safety agreement was modified to allow Mother supervised contact to be at the child's bedside upon his death.	1
	The DFS caseworker immediately implemented a child safety agreement restricting contact with the child while hospitalized, with the siblings and other children residing in the relative's home. The safety agreement was reviewed and modified, when necessary.	1
	The after-hours DFS caseworker implemented child safety agreements between the children and all members of both households. The safety agreement was reviewed and modified, when necessary.	1
	The after-hours DFS caseworker immediately implemented a child safety agreement restricting contact with the child while hospitalized and with the siblings in the home. The safety agreement remained in place throughout the investigation and treatment cases. The safety agreement was consistently reviewed and modified, when necessary.	1
	The DFS caseworker immediately implemented a child safety agreement restricting contact with the child while hospitalized. There was consistent review and modification, when necessary, of the safety agreement.	1
	Oversight of Agreement	3
	There was consistent review and modification, when necessary, of the safety agreement by the DFS caseworker.	3
Unresolved Risk		9
	Home Visiting Programs	1
	The DFS caseworker referred the victim to an early intervention evidence-based home visiting program.	1
	Legal Guardian	2
	Despite the relatives filing for guardianship, the case was transferred to treatment for ongoing services.	1
	Despite the maternal grandparents filing for guardianship, the case was transferred to treatment for ongoing services.	1

	Parental Risk Factors	5
	The DFS caseworker would not modify the child safety agreement to allow for supervised visitation until Mother completed the mental health evaluation.	1
	The DFS caseworker would not modify the child safety agreement to allow for supervised visitation until parents completed the substance abuse and mental health evaluations.	1
	Throughout the near death investigation, the DFS caseworker educated Mother on infant safe sleep practices.	1
	The DFS treatment caseworker made timely, appropriate referrals for the family, which included an early intervention program, alcohol or drug (AOD) liaison, domestic violence liaison, and the family interventionist.	1
	During the prior investigation, the DFS caseworker educated Mother on infant safe sleep practices and thoroughly documented the education.	1
	Substance-Exposed Infant	1
	The Plan of Safe Care was thoroughly reviewed by the DFS caseworker and follow up was conducted with Mother's MAT provider to discuss the inefficiencies.	1
Grand Total		**69**

FINAL REVIEWS

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
Safety/ Use of History/ Supervisory Oversight			1
	Appropriate Parent/Relative Component		1
		During the treatment case, the child safety agreement was re-implemented allowing Mother to have only supervised visitation with the sibling.	1

Unresolved Risk		4
	Parental Risk Factors	2
	The Domestic Violence Hotline coordinated services with the advocacy program and immediately sought to provide th	1
	Despite the hotline report alleging domestic violence being screened out, a referral was made to the domestic violence liaison for Mother.	1
	Contacts with Family	1
	The treatment caseworker maintained regular, quality contact with the family, and assisted Father in securing stable housing prior to case closure.	1
	Legal Guardian	1
	The DFS investigation remained open until permanency could be established for the children.	1
MDT Response		3
	General - Civil Investigation	1
	There was great response by the DFS caseworker, to include diligent efforts in dealing with a difficult family and excellent documentation of case notes.	1
	General - Criminal Investigation	1
	The law enforcement agency was immediately responsive to the ongoing case activities that took place following the near death incident.	1
	Communication	1
	There was excellent communication between DFS, the law enforcement agency, the DOJ, the civil DAG, and the child attorney.	1
Grand Total		**10**

TOTAL CAN PANEL STRENGTHS **79**

Child Abuse and Neglect Panel

Findings Summary

August 19, 2020

**Includes reviews conducted between October through June 2020.*

INITIAL REVIEWS

	*Current	Grand Total
Legal	**3**	**3**
Court Hearings/ Process	2	2
Laws/Regulations/Policies/Contracts	1	1
MDT Response	**53**	**53**
Crime Scene	6	6
Documentation	7	7
Doll Re-enactment	4	4
General - Criminal Investigation	3	3
General - Criminal Investigation / Civil Investigation	9	9
Interviews - Adult	10	10
Interviews - Child	7	7
Medical Exam	2	2
Reporting	5	5
Medical	**16**	**16**
Home Visiting Programs	1	1
Medical Exam/ Standard of Care - Birth	1	1
Medical Exam/ Standard of Care - ED	1	1
Medical Exam/ Standard of Care - Forensics	2	2
Medical Exam/ Standard of Care - PCP	3	3
Medical Exam/ Standard of Care - Radiology	1	1
Reporting	7	7
Risk Assessment/ Caseloads	**35**	**35**
Caseloads	24	24
Collaterals	6	6
Risk Assessment - Closed Despite Risk Level	1	1
Risk Assessment - Tools	2	2
Risk Assessment - Unsubstantiated	2	2
Safety/ Use of History/ Supervisory Oversight	**21**	**21**
Safety - Completed Incorrectly/ Late	12	12
Safety - Inappropriate Parent/ Relative Component	2	2
Safety - Oversight of Agreement	4	4
Supervisory Oversight	3	3
Unresolved Risk	**14**	**14**
Child Risk Factors	1	1
Contacts with Family	6	6
Home Visiting Programs	2	2
Parental Risk Factors	4	4
Substance-Exposed Infant	1	1
Grand Total	**142**	**142**

Office of the Child Advocate
900 King Street, Ste 350
Wilmington, DE 19801

Prepared 8/14/2020

Child Abuse and Neglect Panel

Findings Summary

August 19, 2020

**Includes reviews conducted between October through June 2020.*

FINAL REVIEWS		
	***Current**	**Grand Total**
MDT Response	**3**	**3**
Crime Scene	1	1
General - Criminal Investigation	1	1
Prosecution/ Pleas/ Sentence	1	1
Medical	**1**	**1**
Medical Exam/ Standard of Care - Autopsy	1	1
Risk Assessment/ Caseloads	**3**	**3**
Caseloads	3	3
Safety/ Use of History/ Supervisory Oversight	**1**	**1**
Safety - Inappropriate Parent/ Relative Component	1	1
Unresolved Risk	**2**	**2**
Contacts with Family	1	1
Legal Guardian	1	1
Grand Total	**10**	**10**

TOTAL CAN PANEL FINDINGS **152**

*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

August 19, 2020

**Includes reviews conducted between October through June 2020.*

INITIALS REVIEWS

System Are:	Finding	PUBLIC Rationale	Sum of #
Legal			3
	Court Hearings/ Process		2
		The DMSS liaison did not provide the Court with accurate information pertaining to the DFS investigation. This resulted in another relative being awarded guardianship.	1
		The OCA Child Attorney was not informed of the child's placement with a relative prior to placement.	1
	Laws/Regulations/Policies/Contracts		1
		The OCA Child Attorney did not follow own Serious Injury Protocol, which requires OCA to obtain the parents' medical records.	1
MDT Response			53
	Crime Scene		6
		No scene investigation was completed by the law enforcement agency.	1
		No scene investigation was completed by the law enforcement agency. As a result, the scene was not photographed and no evidence was collected.	1
		The law enforcement agency did not complete evidentiary blood draws on the child after the child ingested illicit drugs.	1
		The scene investigation by the law enforcement agency was delayed and no photos were taken.	1
		No scene investigation was completed by the law enforcement agency. As a result, the death scene was not photographed and no evidence was collected.	1
		The law enforcement agency did not complete an evidentiary blood draw on the mother after the child's death. Mother had a history of substance use, and this information was available through the DFS history.	1
	Documentation		7
		There was minimal documentation in the police report by the lead detective.	4
		There was no documentation in the police report by the lead detective.	1
		There was no documentation by the DFS case worker that all the children were seen by DFS during the initial response.	1
		There was no documentation by the DFS case worker that the family was advised to lower the temperature on the water heater.	1

Doll Re-enactment		4
	No doll re-enactment was completed by the law enforcement agency.	4
General - Criminal Investigation		3
	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
	The law enforcement agency concluded that the injury was accidental and did not seek input from the burn center during the investigation.	1
General - Criminal Investigation / Civil Investigation		9
	There was not an initial MDT response to the near death incident in compliance with the MOU and statute.	3
	There was not an initial MDT response to the death incident in compliance with the MOU and statute.	2
	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
	During the scene investigation, MDT members observed marijuana use in the presence of children, and a report was made to DFS. However, there was not a thorough response to the allegations.	1
Interviews - Adult		10
	DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	7
	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
	A miranda warning was not given to the suspect prior to the interview at the police department.	1
Interviews - Child		7
	Forensic interview did not occur with the young child who was present during the near death incident.	1
	The forensic interview was scheduled by the law enforcement agency prior to any communication with the DFS caseworker.	1
	The young siblings in the home were not immediately observed or interviewed by the DFS case worker.	1
	Forensic interview did not occur with the young child who was present during the death incident.	1
	Forensic interviews did not occur for the children who were present during the near death incident.	1
	The siblings in the home were not immediately observed or interviewed by the DFS case worker.	1
	There was a delay in scheduling the forensic interviews for the other children in the home.	1

	Medical Exam	2
	The young siblings who resided in the home during the near death incident were not medically evaluated.	1
	The siblings who resided in the home during the near death incident were not medically evaluated.	1
	Reporting	5
	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
	The law enforcement agency delayed making a report to the DFS Report Line for the near death incident.	1
	The law enforcement agency did not make a report to the DFS Report Line for the near death incident.	1
	The law enforcement agency did not make a report to the DFS Report Line for the death incident.	2
Medical		16
	Home Visiting Programs	1
	The home visiting provider closed the case after two visits with the victim, who was diagnosed with failure to thrive.	1
	Medical Exam/ Standard of Care - Birth	1
	Prior to postpartum discharge, mother's depression screen was noted to be high, but there was no documentation that any follow up was recommended.	1
	Medical Exam/ Standard of Care - ED	1
	The emergency department physician at the treating hospital did not support the victims receiving additional care at the children's hospital. Regardless, the children were later admitted to the children's hospital after being transported by their father.	1
	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	3
	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
	PCP did not follow through with providing the family with a prescription for the repeat skeletal survey after the family missed the appointment at the children's hospital.	1
	The PCP did not follow the standard of care for screening the mother for post-partum depression.	1
	Medical Exam/ Standard of Care - Radiology	1
	The radiologist missed the victim's rib fractures on the initial assessment of the chest x-ray.	1
	Reporting	7
	The treating hospital did not report the child death to the DFS Report Line.	1
	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.	2
		The neurologist failed to make a report to the DFS Report Line after the MRI revealed a brain bleed.	1
		The treating hospital did not report the allegations of abuse for the second victim to the DFS Report Line.	1
		There was no report to the DFS Report Line by the PCP for the frenulum tear. The PCP even documented low suspicion for abuse.	1
Risk Assessment/ Caseloads			35
	Caseloads		24
		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.	7
		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.	5
		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.	1
		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
		The SEI 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 during the prior investigation, and the treatment caseworker was over the treatment caseload statutory standards for a portion of the time while the case was open. However, it does not appear that the caseloads negatively impacted the DFS response to those cases.	1
		The DFS caseworker was over the investigation caseload statutory standards during the prior investigation, and the caseload appears to have had a negative impact on the response to the case. The treatment caseworker was also over the treatment caseload statutory standards for entire time the case was open. However, it is unclear whether the caseload had a negative impact on the DFS response to the case.	1
		The caseworkers were over the investigation and treatment (subsequent case) 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 DFS 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 response in the case.	2

	The DFS caseworker was at or 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
Collaterals		6
	During the death incident, a collateral contact was not completed with non-professional sources close to the family.	3
	During the treatment case, there was no documentation of collateral contacts with medical providers, who had ongoing contact with the victim as a result of the serious physical injuries.	1
	During the near death incident, a collateral contact was not completed with non-professional sources close to the family.	1
	During the treatment case, there was no documentation of a collateral contact with the early intervention program.	1
Risk Assessment - Closed Despite Risk Level		1
	The treatment case was quickly closed despite the ongoing risk due to unstable housing and unaddressed mental health and substance abuse issues.	1
Risk Assessment - Tools		2
	In the near death investigation, the SDM Risk Assessment was not completed correctly. The policy override for non-accidental injury to a non-verbal child was not selected, so the case was closed.	1
	During the treatment case, the recommendations from group supervision were not followed by the caseworker or supervisor.	1
Risk Assessment - Unsubstantiated		2
	For the death incident, there was a finding of neglect against the teen suspect and not against any adults responsible for the victim's safety and well-being.	1
	For the prior incident, there was a finding of neglect against the mother, who was the identified victim of domestic violence.	1
Safety/ Use of History/ Supervisory Oversight		21
Safety - Completed Incorrectly/ Late		12
	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
	For the near death incident, DFS initially completed a safety agreement with a relative, who was not ruled out as a suspect. In addition, the safety agreements were never signed by the parents.	1
	For the death incident, a safety agreement was not implemented for the surviving siblings despite concerns with lack of supervision by the mother.	1
	In the prior investigation, the SDM Safety Assessment was not completed on time.	1

	For the near death incident, DFS initially completed a safety agreement with mother, who was not ruled out as a suspect. However, the agreement was later amended.	1
	In the prior investigation, the safety assessment was not completed at the time of the birth for the infant with prenatal substance exposure.	1
	During the active treatment case, the need for a safety agreement was documented by the caseworker; however, the terms of the agreement and the participants were unclear.	1
	For the near death incident, the caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization. As a result, there was no agreement in place to ensure mother would have no contact with the victims.	1
	During the near death investigation, DFS implemented a safety agreement allowing Father to have supervised contact with the children. However, there was no documentation that the agreement was put in place on the date of the initial response, so the parents had unsupervised contact with the victim at the hospital.	1
	For the near death investigation, DFS entered into a safety agreement with a relative, but it was not completed for the hospitalized victim and a home assessment was not conducted.	1
	In the prior investigation, the safety assessment indicated the need for an agreement; however, the agreement and any necessary safety interventions were not initiated. This also meant that extended family members with extensive DFS history were not assessed as safety resources.	1
Safety - 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
Safety - Oversight of Agreement		4
	The SDM Safety Agreement was not re-assessed, and it was unclear when the assigned caseworker terminated the agreement.	1
	The DFS caseworker did not consider using informal resources to support the family as part of the safety agreement. Professional resources were identified instead.	1
	During the near death investigation, DFS implemented a safety agreement allowing Mother and a relative to have supervised contact with the children, and despite this, Mother moved the children to a daycare, where this relative worked without notifying DFS. There was no documentation that the case worker addressed the current safety agreement with the family.	1

	The safety agreement was modified by the mother and her attorney without the input of the DFS case worker. As a result, the children were replaced with a non-relative caregiver, and a home assessment was not initially conducted to assess the non-relative's ability to act as a safety participant.	1
Supervisory Oversight		3
	For the prior incident involving lack of supervision, DFS terminated the safety agreement prematurely. Collaterals and a home visit had not been completed.	1
	For the death incident, DFS terminated the safety agreement prematurely for the children residing in the home of the suspect.	1
	DFS terminated the safety agreement without a thorough assessment of collaterals, including the mother's mental health provider.	1
Unresolved Risk		14
Child Risk Factors		1
	There was no documentation by the DFS caseworker that the missed skeletal survey was addressed with the family.	1
Contacts with Family		6
	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
	During the treatment case, there was no documentation that the surviving children were seen until approximately 6 weeks after the case was opened.	1
	An after-hours worker responded to a report of lack of supervision prior to the death incident, and implemented a safety agreement. However, the initial contact by the assigned worker did not occur with the family until three weeks after the referral was received.	1
	In the prior investigation, DFS received a report involving domestic violence, and the initial contact did not occur until almost 3 months after the referral was received.	1
	During the treatment case, the initial contact with the family was significantly overdue.	1
	There is no documentation to suggest that the caseworker maintained regular contact with the family following the victim's death.	1
Home Visiting Programs		2
	There was no documentation that the DFS caseworker referred the victim to an early intervention program.	1
	The DFS treatment worker made a delayed referral to an early intervention program for the victim.	1
Parental Risk Factors		4
	DFS did not follow up with the parents or the substance abuse liaison to confirm whether the parents completed their substance abuse evaluations.	1

	Mother was identified as having no mental health issues by the DFS case worker. As a result, a mental health evaluation was not included in the case plan.	1
	During the treatment case, there was no documentation that the caseworker attempted to meet with the parents or to offer case plans.	1
	There was no documentation by the treatment worker that the unfenced pond posed a safety hazard to young children and that this was discussed with the family.	1
Substance-Exposed Infant		1
	The Medication Assisted Treatment (MAT) provider did not initiate the Plan of Safe Care correctly for the infant born with prenatal substance exposure.	1
Grand Total		**142**

FINAL REVIEWS

System Are:	Finding	PUBLIC Rationale	Sum of #
MDT Response			3
	Crime Scene		1
		The SUIDI form was not fully completed by the forensic investigator, and it is unknown whether this may have impacted the cause and manner.	1
	General - Criminal Investigation		1
		There was not an immediate call to the Criminal Investigations Unit by the law enforcement agency.	1
	Prosecution/ Pleas/ Sentence		1
		The SENTAC guidelines' presumptive sentence for crimes against children should be greater.	1
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			3
	Caseloads		3

	The treatment and permanency caseworkers have been 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 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
Safety - 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 with Family		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		**10**

TOTAL FINDINGS **152**