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CHILD PROTECTION ACCOUNTABILITY COMMISSION
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EXECUTIVE DIRECTOR

November 18, 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 14 cases at its November 18, 2020 meeting.[1] Please note that despite the pandemic, the Child Abuse and Neglect Panel met conscientiously to assure that child abuse deaths and near deaths were timely reviewed; however, with the volume of deaths and near deaths to children that occurred between July and October, it is highly likely that reviews in the future may be delayed.

Six of the cases (2 deaths and 4 near deaths) had been previously reviewed and were awaiting the completion of the criminal investigation; none ended up being prosecuted. Two findings were made.

The eight remaining cases were from deaths or near deaths that occurred between January and June of 2020. Of these cases, four will have no further review as there are no criminal charges. Three of the remaining four cases have pending charges and will be reviewed again once prosecution is completed. The one remaining death is

[1] 16 Del. C. § 932.

still under investigation. The children in these cases range in age from three months to three years of age with one death and seven near deaths. The children were victims of abusive head trauma, poisoning via drug ingestion, and bone fractures. These eight cases resulted in 9 strengths and 47 current findings across system areas.

For these January through June 2020 cases, 2 strengths and 22 findings were noted for the Multidisciplinary Team Response. The Office of the Child Advocate (OCA) has now contracted with a MDT Training and Policy Administrator with significant law enforcement expertise who will be working with individual law enforcement jurisdictions on best practices, resources and compliance with the MOU. CPAC, OCA 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 6 findings together with 4 strengths. The Division of Family Services (DFS) had 3 strengths and 19 findings this quarter. Seven of those findings were regarding high caseloads. The rest of the findings continue to focus on 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.

In 2019, Delaware experienced 13 child abuse or neglect deaths and 29 near deaths – a small decrease from 2018. These deaths and near deaths, together with all death and near death child abuse cases from July 2017 forward, were reviewed at a virtual all-day retreat held in September 2020 with the Child Death Review Commission. The two commissions reviewed 110 cases that included 611 findings, and with the assistance of a national consultant, made recommendations for system improvement. A joint action plan is being developed and will be shared upon approval.

CPAC is currently struggling with the CAN Panel caseload that has resulted from a significant increase in child abuse cases since July 2020. Initial screenings have indicated 30 near deaths and 5 deaths in the last few months. These numbers are

double from the first half of 2020 and are troubling both in terms of child safety as well as in timely caseload management and retrospective review.

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 18, 2020

INITIAL REVIEWS

	*Current	Grand Total
MDT Response	**22**	**22**
Communication	1	1
Crime Scene	6	6
General - Civil Investigation	1	1
General - Criminal Investigation	2	2
General - Criminal Investigation / Civil Investigation	4	4
Interviews - Adult	1	1
Interviews - Child	4	4
Medical Exam	2	2
Reporting	1	1
Medical	**6**	**6**
Medical Exam/ Standard of Care - Autopsy	1	1
Medical Exam/ Standard of Care - CARE Team	1	1
Medical Exam/ Standard of Care - ED	1	1
Medical Exam/ Standard of Care - PCP	1	1
Reporting	1	1
Transport	1	1
Risk Assessment/ Caseloads	**9**	**9**
Caseloads	7	7
Collaterals	2	2
Safety/ Use of History/ Supervisory Oversight	**6**	**6**
Safety - Completed Incorrectly/ Late	5	5
Safety - Inappropriate Parent/ Relative Component	1	1
Unresolved Risk	**4**	**4**
Parental Risk Factors	3	3
Substance-Exposed Infant	1	1
Grand Total	**47**	**47**

FINAL REVIEWS

	*Current	Grand Total
MDT Response	**1**	**1**
Crime Scene	1	1
Medical	**1**	**1**
Reporting	1	1
Grand Total	**2**	**2**

TOTAL CAN PANEL FINDINGS **49**

*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

November 18, 2020

INITIALS REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			22
	Communication		1
		Throughout the investigation, inaccurate information was shared about the victim's medical condition and history, and this resulted in early conclusions that the death was natural.	1
	Crime Scene		6
		No scene investigation was completed by the law enforcement agency. As a result, the scene was not photographed and no evidence was collected.	3
		The SUIDI form was not completed by the law enforcement agency or forensic investigator, and it may have impacted the cause and manner.	1
		No scene investigation of the mother's home was completed by the law enforcement agency as it was initially suspected the incident occurred at the daycare.	1
		The law enforcement agency did not complete an evidentiary blood draw on the child after the child ingested an unknown substance.	1
	General - Civil Investigation		1
		A DFS caseworker reported to the detective that there was no history with the family, and this may have had an impact on the initial response to the criminal investigation.	1
	General - Criminal Investigation		2
		The law enforcement agency did not immediately respond to the hospital emergency department to conduct interviews.	1
		The law enforcement agency did not immediately assign the case to a detective.	1
	General - Criminal Investigation / Civil Investigation		4
		There was not an initial MDT response to the near 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.	1
		The father was ruled out as a suspect almost immediately even though it was initially thought that the victim had a healing fracture in addition to the acute injury.	1
	Interviews - Adult		1
		In the prior investigation, DFS conducted interviews with the parents without the law enforcement agency present.	1

	Interviews - Child	4
	The father, who was not ruled out as a suspect, was permitted to transport the sibling to the forensic interview.	1
	Forensic interviews were not considered for the verbal children who attended the daycare.	1
	Forensic interview did not occur for the other child who resided in the home during the near death incident.	1
	Forensic interview did not occur for the sibling who resided in the home during the near death incident.	1
	Medical Exam	2
	Medical exams were not considered for the other children who attended the daycare.	1
	In the prior investigation, the older child in the home was not medically evaluated.	1
	Reporting	1
	In the prior investigation, the DFS caseworker delayed reporting to the law enforcement agency.	1
Medical		6
	Medical Exam/ Standard of Care - Autopsy	1
	Information, such as the victim's medical history, DFS history, and the Office of the Investigation Coordinator's referral to the MDT, was not considered in determining the cause and manner of death.	1
	Medical Exam/ Standard of Care - CARE Team	1
	There was no documentation of an evaluation by the CARE Team.	1
	Medical Exam/ Standard of Care - ED	1
	The children's hospital does not test for Fentanyl in its urine drug screen. As a result, the initial urine drug screen came back as negative, and this impacted the investigation.	1
	Medical Exam/ Standard of Care - PCP	1
	There was no documentation by the PCP that co-sleeping was discussed with the mother.	1
	Reporting	1
	There was no report to the DFS Report Line by the hospital emergency department for the first report of physical injuries, but a report was made after the child was seen by the CARE team.	1
	Transport	1
	The urgent care center allowed the mother to transport the child to the children's hospital, and did not send the child with alternative transportation.	1
Risk Assessment/ Caseloads		9
	Caseloads	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.	4
	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.	1

		The DFS 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 in those cases.	1
		The DFS caseworker was at or over the investigation caseload statutory standards the entire time the prior and current investigations were open. However, it does not appear that the caseload negatively impacted the DFS response to those cases.	1
	Collaterals		2
		In the prior investigation, history with the out of state child protective services agency was not checked by the DFS caseworker.	1
		In the prior investigation, a collateral contact was not completed with the mother's mental health provider to confirm her participation in treatment.	1
Safety/ Use of History/ Supervisory Oversight			6
	Safety - Completed Incorrectly/ Late		5
		In the prior investigation, there was a delay in safety planning for the victim, and the parents were experiencing homelessness and engaging in substance use.	1
		For the near death incident, the father was not considered in the safety agreement because he was not thought of as a possible suspect.	1
		In the prior investigation, no safety agreement was initially completed for the hospitalized victim.	1
		The hospital was told to restrict all visitors, but no formal safety agreement was completed for the near death incident.	1
		For the near death investigation, DFS entered into an initial safety agreement with a relative, but it was not completed for the hospitalized victim.	1
	Safety - Inappropriate Parent/ Relative Component		1
		In the prior investigation, DFS initially completed a safety agreement with a relative, who was not ruled out as a suspect.	1
Unresolved Risk			4
	Parental Risk Factors		3
		In the prior investigation, mental health issues were noted for the mother, but there was no documentation that the DFS caseworker attempted to assess the issues and the potential impact on child safety.	1
		In the prior investigation, DFS did not evaluate substance abuse issues for the parents by requesting that they complete a substance abuse evaluation after the victim was born with prenatal substance exposure.	1
		During the near death investigation, substance abuse issues were noted for the parents, but there was no documentation that the DFS caseworker attempted to assess the issues and the potential impact on child safety.	1

	Substance-Exposed Infant		1
		In the prior investigation, the Medication-Assisted Treatment (MAT) Provider did not appear to monitor the Plan of Safe Care or report Mother's ongoing substance use to DFS	1
Grand Total			**47**

FINAL REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			1
	Crime Scene		1
		The SUIDI form was not completed by the law enforcement agency or forensic investigator, and it may have impacted the cause and manner of death.	1
Medical			1
	Reporting		1
		The urgent care center did not report the near death to the DFS Report Line.	1
Grand Total			**2**

TOTAL FINDINGS **49**

Child Abuse and Neglect Panel

Strengths Summary

November 18, 2020

INITIAL REVIEWS		
	***Current**	**Grand Total**
MDT Response	**2**	**2**
General - Criminal/Civil Investigation	2	2
Medical	**4**	**4**
Home Visiting Programs	1	1
Medical Exam/Standard of Care - CARE	1	1
Medical Exam/Standard of Care - Forensics	1	1
Reporting	1	1
Risk Assessment/ Caseloads	**2**	**2**
Collaterals	1	1
Reporting	1	1
Unresolved Risk	**1**	**1**
Contacts with Family	1	1
Grand Total	**9**	**9**

TOTAL CAN PANEL STRENGTHS **9**

*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

Strengths Detail

November 18, 2020

INITIAL REVIEWS

System Area	Strength	Rationale	Count of #
MDT Response			2
	General - Criminal/Civil Investigation		2
		There was good MDT communication and collaboration between DFS, the law enforcement agency, the medical team, and the DAG, to include a joint response to the hospital, joint interviews, a child safety agreement while the child was hospitalized, social admission of the child's siblings, and a timely charging decision.	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 evaluation of the sibling.	1
Medical			4
	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 and letters mailed to the home.	1
	Medical Exam/ Standard of Care - CARE		1
		The Child at Risk Evaluation (CARE) Team submitted samples for testing of fentanyl despite there being no mention of or admission to using fentanyl by the caregivers.	1
	Medical Exam/ Standard of Care - Forensics		1
		During the prior hospitalization, the forensic nurse obtained photographs of the child's injuries upon presentation, and those photographs were shared with the law enforcement agency.	1
	Reporting		1
		The primary care physician made a referral to the DFS Report Line when Mother and child did not show for the child's scheduled well check, and noted that a Plan of Safe Care was in place due to infant born with prenatal substance exposure.	1
Risk Assessment/ Caseloads			2
	Collaterals		1
		During the prior hospitalization, there was good collaboration between DFS and the out-of-state child protection agency, which was thoroughly documented within the child's medical record.	1
	Reporting		1
		The Institutional Abuse investigator made a referral to the DFS Report Line when it was unclear where the child's suspected ingestion occurred, and the need for a family investigation was recognized.	1

Unresolved Risk		1
	Contacts with Family	1
		The treatment caseworker maintained regular, quality contact with the family throughout the treatment case, which included weekly visits. The treatment caseworker also responded jointly with the investigation caseworker throughout the death investigation. 1
Grand Total		**9**

TOTAL CAN PANEL STRENGTHS **9**