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EXECUTIVE DIRECTOR

February 17, 2021

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 16 cases at its February 17, 2021 meeting.[1]

In 2020, Delaware experienced 9 child abuse or neglect deaths and 43 near deaths – a 24% increase from 2019. Please note that despite the pandemic, the Child Abuse and Neglect (CAN) Panel met conscientiously to assure that child abuse deaths and near deaths were timely reviewed. With the volume of deaths and near deaths to children that occurred between July and December 2020, CPAC is currently struggling with the CAN Panel caseload. The CAN Panel has agreed to add two additional meetings in the next few months in an effort to provide timely reviews; however, it is highly likely that reviews in the future may be delayed. CPAC is considering stricter criteria for review of near death cases, but even with application of that criteria, the numbers in the second half of 2020 were nearly double of those in the first half. And five new near death abuse and neglect cases occurred in January of 2021. These numbers are

[1] 16 Del. C. § 932.

troubling both in terms of child safety as well as in timely caseload management and retrospective review.

In September of 2020, CPAC and the Child Death Review Commission (CDRC) retreated virtually to review 100 child abuse and neglect deaths and near deaths that occurred between July 2017 and December 2019. Those cases resulted in 611 findings against various system areas. As a result of the virtual retreat, and with the help of a national consultant, the Commissions have developed a Joint Action Plan which CPAC approved today. It is anticipated that CDRC will approve it in March 2021. This action plan will serve as a blueprint for the Commissions and their various committees over the next two years. It is hopeful, as discussed below, that the findings that continue to be made in these retrospective reviews will decrease as the practices, policies and financial resources are put in place to reduce child abuse, child neglect and child mortality.

The Commissions were also able to better understand where children are dying and why -- and to hopefully guide the work done with law enforcement, the Division of Family Services, the medical community, the Department of Justice and other community partners as well as in the various committees tasked with system improvement. A few highlights include children continue to be harmed by their biological parents, in particular their mothers, in their own homes, and that children less than 6 months of age are at the highest risk of serious abuse or neglect. Predictive factors include history with the Division of Family Services, and a household history of criminal behavior, substance abuse and mental health disorders.

With respect to the 16 cases that were approved by CPAC today, here are the strengths and system breakdowns. Four of the cases approved (1 death and 3 near deaths) had been previously reviewed and were awaiting the completion of the criminal investigation. Three were initially prosecuted. Convictions were obtained resulting in one and two years of Level V incarceration on two of the cases. The other case was nolle prossed. Two strengths by the Division of Family Services were acknowledged.

The twelve remaining cases were from deaths or near deaths that occurred between April and July of 2020. Of these cases, seven will have no further review as there are no criminal charges (three were drug ingestion cases). Three of the remaining five cases have pending charges and the other two are still pending criminal investigations. All five will be reviewed again once prosecution is completed. The children in these

2020 cases range in age from three months to six years of age with one death and eleven near deaths. The one death is of a child who suffered near death abuse as an infant. The children were victims of abusive head trauma, poisoning via drug ingestion, and bone fractures. These twelve cases resulted in 17 strengths and 61 current findings across system areas.

For these April through July 2020 cases, 8 strengths and 21 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 has begun 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 Joint Action Plan delineates the further steps this contracted position and CPAC must take to further best practices and MOU compliance by team members. CPAC will continue to identify resources to fund these necessary action steps.

The medical response had 5 findings together with 6 strengths. The medical response to child abuse and neglect cases was a significant focus in the retreat and resulting Joint Action Plan. Significant recommendations for improvement have been delineated that focus on more tailored education, coaching and support for various aspects of the medical profession, particularly hospitals and walk in care, as well as pediatric, family medicine and obstetrics/gynecological practices. The Joint Action Plan also focuses on getting specialized child abuse expertise downstate. CPAC is creating a workgroup chaired by medical professionals to tackle these significant tasks, and will be utilizing funds from mandatory reporting training to accomplish these goals. CPAC is hopeful with this targeted focus and the additional resources, it can begin to make a substantive impact on all aspects of Delaware's medical response to child abuse and neglect, as well as continue to empower the medical community to utilize Plans of Safe Care to assure supports for infants with prenatal substance exposure.

The Division of Family Services (DFS) had 2 strengths and 35 findings this quarter. Ten of those findings were regarding high caseloads. The rest of the findings continue to focus on timely and appropriate completion of safety agreements, unresolved risk, and collateral and family contacts. In the Joint Action Plan, CPAC

and CDRC, with full partnership by DSCYF, have recommended the following steps to improve worker and supervisory responses: develop and provide initial and ongoing training on the Structured Decision Making Safety and Risk Assessment tools; provide regular coaching and monitoring to DFS staff on child safety agreements; intensify DFS supervisory training and support on child safety agreements; develop an abbreviated DFS training for MDT partners; and utilize quarterly meetings to address findings from these cases with DFS staff.

Please note in the Joint Action Plan, that while not the result of child abuse and neglect deaths and near deaths, there is a recommendation to improve the multidisciplinary response to child sexual abuse cases in Delaware. Led by the Office of the Investigation Coordinator, this CPAC Committee and its more than 60 members, will be tackling the systemic barriers to the investigation, prosecution and treatment of Delaware's child sexual abuse cases which exceed more than 1,700 new alleged cases each year. This will be another monumental task that will hopefully significantly reduce the number of sexually abused children in Delaware, appropriately punish perpetrators of child sexual abuse, and ensure comprehensive and targeted services for children and their families – many of whom have suffered from multigenerational familial sexual abuse.

CPAC only brings you the most horrific of Delaware's child abuse 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 Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

FEBRUARY 17, 2021

INITIAL REVIEWS

	*Current	Grand Total
Legal	**1**	**1**
Court Hearings/ Process	1	1
MDT Response	**8**	**8**
Crime Scene	1	1
General - Criminal Investigation	2	2
General - Criminal/Civil Investigation	4	4
Interviews - Child	1	1
Medical	**6**	**6**
Documentation / Reporting	1	1
Home Visiting Programs	3	3
Medical Exam/Standard of Care - Specialists	1	1
Reporting	1	1
Risk Assessment/ Caseloads	**2**	**2**
Collaterals	1	1
Risk Assessment - Opened Despite Risk Level	1	1
Grand Total	**17**	**17**

FINAL REVIEWS

	*Current	Grand Total
Safety/ Use of History/ Supervisory Oversight	**2**	**2**
Oversight of Agreement	1	1
Supervisory Oversight	1	1
Grand Total	**2**	**2**

TOTAL CAN PANEL STRENGTHS **19**

*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 Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Detail

FEBRUARY 17, 2021

INITIAL REVIEWS

System Area	Strength	Rationale	Count of #
Legal			1
	Court Hearings/ Process		1
		There was good communication and collaboration between the Criminal DAG, the Civil DAG, and the OCA Child Attorney.	1
MDT Response			8
	Crime Scene		1
		Despite a consent search initially being conducted at the paternal aunt's home, following disclosures of abuse at the forensic interview, a search warrant was executed at the home.	1
	General - Criminal Investigation		2
		The criminal investigation remained with the State police agency rather than bring transferred to the smaller law enforcement jurisdiction.	1
		The law enforcement detective assigned to the case conducted an excellent investigation, and the persistent investigative actions resulted in the arrest of both parents.	1
	General - Criminal/Civil Investigation		4
		There was good communication and collaboration between the law enforcement agency and the DFS caseworker given the parents' efforts to avoid authorities.	1
		Although there was not an initial joint response to the investigation, there was good communication and collaboration between the law enforcement agency and the DFS caseworker throughout the remainder of the investigation.	1
		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 home, joint interviews, medical evaluations of the minor children residing in the home, and attempted forensic interviews of the minor children residing in the home.	1
		There was a good MDT response to the near-death/death investigation by the local law enforcement agency and DFS, to include a joint response to the home and joint interviews, and communication with the medical team.	1
	Interviews - Child		1
		The forensic interview occurred with the victim prior to hospital discharge.	1

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Detail

FEBRUARY 17, 2021

Medical		6
	Documentation / Reporting	1
	The emergency medical services report was thoroughly documented, and an immediate report was made to the DFS Report Line.	1
	Home Visiting Programs	3
	The early intervention caseworker made a report to the DFS caseworker with concerns regarding inappropriate comments made by the foster parent during an initial visit.	1
	There was great effort by the evidence-based home visiting program to re-engage with Mother, which included multiple phone calls by the caseworker and the provider.	1
	There was great effort by the evidence-based home visiting program to re-engage with the relative caregivers, and to follow up with all the necessary service coordination ensuring the child's needs were met.	1
	Medical Exam/Standard of Care - Specialists	1
	There was good communication between the medical team and the DFS caseworker to establish an appropriate discharge plan for the child.	1
	Reporting	1
	The paramedics and emergency medical services, who responded to the home, made reports to the DFS Report Line acknowledging other minor children in the home.	1
Risk Assessment/ Caseloads		2
	Collaterals	1
	Strong collaterals were completed from the children's state of residence, to include the child protective services agency, the school, mental health and medical providers. Historical allegations were cleared and appropriate services were discussed with the child protective services agency prior to the child's medical transfer.	1
	Risk Assessment - Opened Despite Risk Level	1
	The near death investigation was transferred to treatment despite only moderate risk and no finding of abuse or neglect.	1
Grand Total		**17**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Detail

FEBRUARY 17, 2021

FINAL REVIEWS

System Area	Strength	Rationale	Count of #
Safety/ Use of History/ Supervisory Oversight			2
	Supervisory Oversight		1
		An administrative review was completed of the parents' psychological evaluations to ensure child safety was appropriately assessed, which resulted in follow up evaluations being completed with the parents.	1
	Oversight of Agreement		1
		The DFS treatment worker closely monitored the family before and after trial reunification, and continued for an additional 30 days after custody of the children was rescinded to the parents.	1
Grand Total			**2**

TOTAL CAN PANEL STRENGTHS **19**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

FEBRUARY 17, 2021

INITIAL REVIEWS		
	***Current**	**Grand Total**
MDT Response	**21**	**21**
Communication	1	1
Crime Scene	2	2
Documentation	1	1
General - Civil Investigation	2	2
General - Criminal Investigation	1	1
General - Criminal Investigation / Civil Investigation	8	8
Interviews - Adult	1	1
Interviews - Child	3	3
Medical Exam	2	2
Medical	**5**	**5**
Home Visiting Programs	1	1
Medical Exam/ Standard of Care - ED	2	2
Medical Exam/ Standard of Care - PCP	1	1
Reporting	1	1
Risk Assessment/ Caseloads	**14**	**14**
Caseloads	10	10
Collaterals	3	3
Risk Assessment - Tools	1	1
Safety/ Use of History/ Supervisory Oversight	**14**	**14**
Safety - Completed Incorrectly/ Late	9	9
Safety - Inappropriate Parent/ Relative Component	3	3
Safety - Violations of Safety Agreements	1	1
Supervisory Oversight	1	1
Unresolved Risk	**7**	**7**
Child Risk Factors	1	1
Contacts with Family	3	3
Parental Risk Factors	3	3
Grand Total	**61**	**61**

TOTAL CAN PANEL FINDINGS **61**

*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 Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Detail

FEBRUARY 17, 2021

INITIALS REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			21
	Communication		1
		The law enforcement agency did not initially contact DOJ regarding the near death incident.	1
	Crime Scene		2
		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 an evidentiary blood draw on the child after the child ingested a controlled substance.	1
	Documentation		1
		There was no documentation in the police report by the lead detective.	1
	General - Civil Investigation		2
		An incident proceeding the near death was still active at the time of the near death investigation, and there was no consultation between the two DFS caseworkers.	1
		During the initial response to near death incident, the DFS caseworker did not observe where the substances were found in the home that resulted in the drug ingestion.	1
	General - Criminal Investigation		1
		The law enforcement agency did not immediately assign the case to a detective.	1
	General - Criminal Investigation / Civil Investigation		8
		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 near death incident in compliance with the MOU and statute. DFS was called by law enforcement but did not immediately respond.	1
		Due to a miscommunication between DFS and the 911 dispatcher, there was not an initial MDT response to the near death incident resulting in the following missing investigative steps: joint interviews, blood draw, crime scene and collection of evidence.	1
		There was not an initial MDT response to the near death incident in compliance with the MOU and statute. Law enforcement delayed its report to DFS.	1
		Due to a miscommunication between DFS and the 911 dispatcher, there was not an initial MDT response to the near death incident in compliance with the MOU.	1
		There was not an initial MDT response to the near death incident in compliance with the MOU and statute. DFS delayed its report to LE.	1

	Interviews - Adult	1
	During the near death investigation, DFS conducted interviews with the mother and later a non-relative caregiver without the law enforcement agency present.	1
	Interviews - Child	3
	Forensic interview did not occur for the half siblings who resided in the home during the near death incident.	1
	Forensic interviews were not considered for the siblings, and there was no documentation of DFS or law enforcement interviews with the siblings.	2
	Medical Exam	2
	In the prior investigation, there was no follow up with the CARE Team to discuss the interpretation of medical findings.	1
	All of the children who resided in the home during the near death incident were not medically evaluated.	1
Medical		5
	Home Visiting Programs	1
	There was no documentation that the teen mother was referred for evidence-based home visiting services during her pregnancy.	1
	Medical Exam/ Standard of Care - ED	2
	The child was discharged by the trauma center without a full CARE team assessment and evaluation.	1
	In the prior investigation, the hospital discharged the victim prior to the arrival of the DFS caseworker.	1
	Medical Exam/ Standard of Care - PCP	1
	The child's height and weight were inaccurately documented by the PCP in the medical record. As a result, the child's growth was unclear.	1
	Reporting	1
	There was no report to the DFS Report Line by the hospital emergency department for the near death incident, but a report was made by the CARE team.	1
Risk Assessment/ Caseloads		14
	Caseloads	10
	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.	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.	1
	The DFS caseworker was over the investigation caseload statutory standards during the current and prior investigations, and the caseload appears to have had a negative impact on the response in the prior case. There was no impact in the near death investigation.	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 timeliness of the case closure.	1
	The DFS caseworker was over the investigation caseload statutory standards during the current and prior investigations, and the caseload appears to have had a negative impact on the case progress and timeliness of the case closure. There was no impact in the near death investigation.	1
	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 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
	Collaterals	3
	In the prior investigation, collateral information was not requested from service providers in the home, and the case was still abridged.	1
	During the near death incident, a collateral contact was not completed with the PCP for the siblings, and a few of the siblings also ingested the controlled substance.	1
	During the near death incident, a collateral contact was not completed with the PCP for the siblings.	1
	Risk Assessment - Tools	1
	In the near death investigation, the SDM Risk Assessment was not completed correctly. The assessment was completed on the wrong household, and the case was scored low and closed.	1
Safety/ Use of History/ Supervisory Oversight		14
	Safety - Completed Incorrectly/ Late	9
	During the near death investigation, no safety agreement was initially completed for the hospitalized victim.	3
	During the near death investigation, there was a delay in safety planning for the hospitalized victim and three other children in the home. A safety agreement was not put in place until three days after the incident.	1
	During the near death investigation, DFS was inconsistent in its safety planning. Mother's contact was restricted with the victim, but not with the victim's half siblings. It was not appropriate to plan with mother due to her history.	1
	DFS did not initially conduct a home assessment at the mother's home, where the near death incident occurred. Once completed, it was discovered that a staircase was broken and unsafe for the half siblings in the home.	1
	During the near death investigation, no safety agreement was completed for the hospitalized victim.	1
	During the near death investigation, DFS did not complete a safety agreement for the siblings and other children in the home when DFS and law enforcement first responded to the home.	1

	For the near death investigation, DFS entered into a safety agreement with a relative, but there was no documentation that a home assessment was conducted.	1
Safety - Inappropriate Parent/ Relative Component		3
	During the near death investigation, DFS implemented a safety agreement allowing the mother and non-relative caregiver to have supervised contact with the children, and restricting Father's contact. However, contact should have been restricted with all parties until they were ruled out as suspects.	1
	The paramour's three children were medically examined and discharged to her care without a safety agreement. She had not been ruled out as a suspect.	1
	During the near investigation, DFS implemented a safety agreement for the victim's half siblings; however, the caseworker entered into the agreement with mother, who was violating a criminal no contact order and allowing contact between the children and a registered sex offender.	1
Safety - Violations of Safety Agreements		1
	During the near death investigation, DFS was informed by law enforcement that the safety agreement was violated by the mother and non-relative caregiver; however, there no immediate action taken by DFS.	1
Supervisory Oversight		1
	For the near death investigation, DFS terminated the safety agreement prematurely. Collateral contacts and referrals for services were not completed, and risk factors included an unexplained injury to a young child, teen parents, and an uncooperative father who was responsible for caregiving.	1
Unresolved Risk		7
Child Risk Factors		1
	During the near death investigation, the family did not follow through with any follow up appointments by the CARE team or other specialists, and there was no documentation by the DFS caseworker that this was addressed.	1
Contacts with Family		3
	During the near death investigation, the initial contact with the victim was delayed. The victim was not seen until three days after the DFS report was received.	1
	In the prior investigation, the assigned worker did not follow up with family until approximately three months after the initial response by the after-hours worker. Timely follow up was necessary since the injury was suspicious and there were concerns with bed sharing.	1
	For the incident preceding the near death, the DFS caseworker did not collect information about who else resided in the home or complete background checks.	1

	Parental Risk Factors	3
	In the prior investigation, there was no documentation that the DFS caseworker assessed the use of substances by mother.	1
	In the prior investigation, there was no attempt by the DFS caseworker to corroborate the allegations of domestic violence (e.g., interviews with child or collaterals with family).	1
	DFS did not evaluate substance abuse issues for the parents by requesting that they complete a substance abuse evaluation. Risk factors included: admission of substance use by the parents, history of infants born with prenatal substance exposure, recent criminal history and the circumstances of the near death incident.	1
Grand Total		**61**