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CHILD PROTECTION ACCOUNTABILITY COMMISSION
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CHAIR

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EXECUTIVE DIRECTOR

May 19, 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 17 cases at its May 19, 2021 meeting.[1]

As mentioned in our last communication, Delaware experienced 9 child abuse or neglect deaths and 43 near deaths – a 24% increase from 2019. In the first four months of 2021, there has been 1 death and 20 near deaths due to child abuse or neglect. If this trend continues, there will be a 62% increase in severe child abuse cases for 2021. As you are aware, despite the pandemic, the Child Abuse and Neglect (CAN) Panel met conscientiously to assure that child abuse deaths and near deaths were timely reviewed. The volume of deaths and near deaths to children that occurred between July 2020 and now continues to overwhelm the panel. With 21 new cases in 2021 on top of the 2020 volume, the impact on the front lines and on the CAN Panel is significant. These numbers are troubling both in terms of child safety as well as in timely caseload management and retrospective review.

With respect to the 17 cases that were approved by CPAC today, here are the strengths and system breakdowns. One of the near death cases approved had been

[1] 16 Del. C. § 932.

previously reviewed and was awaiting the completion of the criminal investigation. Charges against both parents were nolle prossed. One additional finding against the medical community was made for failure to report and allowing the parents to transport the child to the emergency department for evaluation.

The sixteen remaining cases were from deaths or near deaths that occurred between July and September of 2020. Of these cases, four will have no further review as there are no criminal charges. Nine of the twelve remaining cases have pending charges and will be reviewed again once prosecution is completed. The remaining three cases are still being investigated. The children in these 2020 cases range in age from one month to three years of age with three deaths and thirteen near deaths. The children were victims of abusive head trauma, poisoning via drug ingestion, bone and skull fractures, and unsafe sleep. These twelve cases resulted in 18 strengths and 78 current findings across system areas.

For these July through September 2020 cases, 12 strengths and 33 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 is working with individual law enforcement jurisdictions on best practices, resources and compliance with the MOU. 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. The Office of the Investigation Coordinator (IC) has also instituted MDT meetings within 48-72 hours of every child abuse death, serious injury or drug ingestion. CPAC is hopeful this will have a positive impact on the post-incident investigation.

The medical response had 8 findings together with 3 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 3 strengths and 37 findings this quarter. Fourteen of those findings were regarding high caseloads. The caseloads in the DFS serious injury investigation units are at 19.7 – well above the statutory limit for the most serious of cases. 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.

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. Gaps in identification of these cases, and thorough investigation thereafter could decrease serious harm. 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

MAY 19, 2021

INITIAL REVIEWS		
	***Current**	**Grand Total**
MDT Response	**12**	**12**
General - Civil Investigation	3	3
General - Criminal Investigation	1	1
General - Criminal/Civil Investigation	8	8
Medical	**3**	**3**
Documentation	1	1
Medical Exam/Standard of Care - CARE	1	1
Reporting	1	1
Safety/ Use of History/ Supervisory Oversight	**3**	**3**
Completed Correctly/On Time	1	1
Oversight of Agreement	1	1
Use of History	1	1
Grand Total	**18**	**18**

TOTAL CAN PANEL STRENGTHS **18**

*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

MAY 19, 2021

INITIAL REVIEWS

System Area	Strength Rationale	Count of #
MDT Response		12
	General - Civil Investigation	3
	During the investigation, the DFS caseworker advocated for MDT meetings and further communication with the law enforcement agency.	1
	There was great DFS response to both investigations, which included coordination with the home visiting program, advocating for the child to be transferred to the children's hospital following the near death incident, communication with the children's hospital prior to transfer, consistent contact with Mother and the relative, appropriate collaterals, and review and modification, when necessary, of the child safety agreement.	1
	Despite Mother advising the paternal family was not involved with the child, the DFS investigation and treatment caseworkers continued communication with the paternal family, which ultimately resulted in the paternal grandmother filing for guardianship.	1
	General - Criminal Investigation	1
	During response to the local hospital ED, the law enforcement detective noticed the child's clothing had been thrown into the trash; the clothing was retrieved and collected as evidence.	1
	General - Criminal/Civil Investigation	8
	There was a good MDT response to the death investigation by the law enforcement agency and DFS, to include joint responses to the hospital and the home, joint interviews, and communication between the two agencies.	1
	There was a good initial MDT response to the near death investigation by the law enforcement agency and DFS, to include a joint response to the hospital, a joint interview with Mother, forensic interviews of the siblings residing in the home, and medical evaluations of the siblings residing in the home.	1
	There was a good initial MDT response to the near death investigation by the law enforcement agency and DFS, to include joint responses to the hospital and the home, joint interviews with the parents and relative caregiver, and communication with the medical team.	1
	There was a good initial MDT response to the near death investigation by the law enforcement agency and DFS, to include joint responses to the hospital and joint interviews.	1
	There was a good initial MDT response to the near death investigation by the law enforcement agency and DFS, to include joint responses to the child's home and the NRC's home, joint interviews with the adults in both homes, child safety agreements for both families, and medical evaluations for all children in both homes.	1

	There was a good MDT response to the near death investigation by the law enforcement agency and DFS, to include joint responses to the hospital, joint interviews with the parents and the paternal uncle, a child safety agreement while the child was hospitalized, medical evaluation of the sibling, and forensic interview of the sibling.	1
	There was a good MDT response to the near death investigation by the law enforcement agency and DFS, to include joint responses to the hospital, joint interviews with the parents, and medical evaluations of the siblings.	1
	There was a good MDT response to the near death investigation by the law enforcement detective and the DFS caseworker, to include a joint response to the home, joint interviews, medical examination of the sibling, and forensic interviews of the sibling and minor relative residing in the home.	1
Medical		3
	Documentation	1
	The treating physician in the emergency department photographed the rapid changes of the child's bruising and this documentation was included as part of the medical record.	1
	Medical Exam/ Standard of Care - CARE	1
	There was great coordination by the medical team to establish a safe discharge for the child to trained caregivers, which included several meetings with different disciplines.	1
	Reporting	1
	The initial treating hospital immediately reported concerns that the mother was demonstrating signs of impairment.	1
Safety/ Use of History/ Supervisory Oversight		3
	Completed Correctly/On Time	1
	The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. There was consistent review and modification, when necessary, of the safety agreement by the DFS caseworker.	1
	Oversight of Agreement	1
	The assigned DFS caseworker immediately amended the initial child safety agreement upon being notified by medical personnel that the child had additional injuries in varying stages of healing.	1
	Use of History	1
	Despite being unsubstantiated with perpetrator unknown, Father's prior DFS investigation was considered during implementation of the child safety agreement during the death investigation.	1
Grand Total		**18**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

MAY 19, 2021

INITIAL REVIEWS

Sum of #	Column Labels	
	*Current	Grand Total
MDT Response	**33**	**33**
Communication	2	2
Crime Scene	5	5
Documentation	1	1
Doll Re-enactment	1	1
General - Civil Investigation	2	2
General - Criminal Investigation	2	2
General - Criminal Investigation / Civil Investigation	2	2
Interviews - Adult	7	7
Interviews - Child	4	4
Medical Exam	5	5
Reporting	2	2
Medical	**7**	**7**
Medical Exam/ Standard of Care - ED	1	1
Medical Exam/ Standard of Care - Forensics	2	2
Reporting	3	3
Transport	1	1
Risk Assessment/ Caseloads	**19**	**19**
Caseloads	14	14
Collaterals	2	2
Documentation	1	1
Risk Assessment - Screen Out	1	1
Risk Assessment - Tools	1	1
Safety/ Use of History/ Supervisory Oversight	**9**	**9**
Safety - Completed Incorrectly/ Late	5	5
Safety - Inappropriate Parent/ Relative Component	1	1
Safety - Oversight of Agreement	1	1
Safety - Violations of Safety Agreements	2	2
Unresolved Risk	**9**	**9**
Child Risk Factors	1	1
Contacts with Family	2	2
Parental Risk Factors	6	6
Grand Total	**77**	**77**

FINAL REVIEWS

Count of #	Column Labels	
	*Current	Grand Total
Medical	**1**	**1**
Reporting	1	1
Grand Total	**1**	**1**

TOTAL CAN PANEL FINDINGS **78**

*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

MAY 19, 2021

INITIALS REVIEWS

System Area	Finding PUBLIC Rationale	Sum of #
MDT Response		33
	Communication	2
	The law enforcement agency did not notify the DOJ Special Victims Unit of the near death incident.	1
	There was no communication initially between the Division of Forensic Science and the rest of the MDT regarding the findings from the post-mortem CT scan.	1
	Crime Scene	5
	No scene investigation was completed by the law enforcement agency. As a result, the scene was not photographed and no evidence was collected.	2
	The SUIDI form was not fully completed by the forensic investigator, and it is unknown whether this may have impacted the cause and manner of death.	1
	The law enforcement agency did not complete an evidentiary blood draw on the child after the child ingested a controlled substance.	1
	The law enforcement agency did not complete an evidentiary blood draw on the child after the child ingested an over the counter substance.	1
	Documentation	1
	There was no documentation in the police report by the lead detective.	1
	Doll Re-enactment	1
	No doll re-enactment was completed by the law enforcement agency.	1
	General - Civil Investigation	2
	There was a significant delay in closing the DFS investigation and no reason was documented by the caseworker or supervisor.	1
	DFS did not send out a Serious Injury report upon receipt of the near death investigation, and as a result, no referral was sent out by the Office of the Investigation Coordinator.	1
	General - Criminal Investigation	2
	There was a delayed response to the children's hospital by the law enforcement agency. However, the smaller jurisdiction may have had limited officers on duty at the time.	1
	There was no documentation in the police report until approximately six months after the incident.	1
	General - Criminal Investigation / Civil Investigation	2
	There was not an initial MDT response to the death incident in compliance with the MOU and statute. Law Enforcement delayed its report to DFS.	1

	There was not an initial MDT response to the near death incident in compliance with the MOU and statute. Law Enforcement declined to send a detective to the hospital.	1
Interviews - Adult		7
	There was no documentation that the DFS caseworker reviewed a copy of the law enforcement interview with father.	1
	The child was in the care of multiple caregivers 24 hours before the death incident, and these other caregivers were not interviewed by the caseworker since the focus was solely on the father.	1
	There was no documentation that the DFS caseworker reviewed a copy of the law enforcement interviews with father or other caregivers in the mother's home.	1
	For the near death investigation, there was no documentation that the mother's paramour was interviewed by the caseworker.	1
	For the near death investigation, the child was recently in the care of mother and father, but it was only suspected that mother inflicted the bone fracture and her explanation was the only one considered.	1
	During the near death investigation, the DFS caseworker did not attempt to contact the father, who resided out of state, but had frequent contact with the victim.	1
	During the near death investigation, there was no attempt by the caseworker to contact the sibling's father. The sibling was present during the incident but lived out of state.	1
Interviews - Child		4
	Forensic interviews did not occur with the other children residing in the home where the incident occurred.	1
	The half-sibling in the mother's home was not observed or interviewed by the DFS caseworker.	1
	A forensic interview was not considered for the other child residing in the home where the incident occurred.	1
	A forensic interview was not considered for the sibling present in the home where the incident occurred.	1
Medical Exam		5
	The young sibling who was present in the home during the near death incident was not medically evaluated.	1
	All of the children who resided in the home during the death incident were not medically evaluated.	1
	During the MDT meetings, the additional photos of the child's injuries and the video of the doll re-enactment were not presented to the child abuse medical expert.	1
	During the near death investigation, there was no follow up with the CARE Team or family to ensure the repeat skeletal exam occurred.	1
	During the death investigation, the DFS caseworker did not independently contact the child abuse medical expert to discuss the medical findings.	1
Reporting		2
	In the prior investigation, the DFS caseworker did not make a report to the law enforcement agency.	1

	DFS delayed making a screening decision on the hotline report until corroborating the medical information with the children's hospital. As a result, the report to law enforcement was delayed, and no blood draw could be obtained.	1
Medical		7
	Medical Exam/ Standard of Care - ED	1
	For the near death investigation, the children's hospital emergency department evaluated the child's lower extremities during an initial visit and noted no concerns. However, the child was later diagnosed with a bone fracture after the father returned the child to the hospital.	1
	Medical Exam/ Standard of Care - Forensics	2
	A forensic consult did not occur during the emergency department visit since the hospital does not have an FNE on staff. This may have had an impact on evidence collection.	1
	A forensic nurse was not available in the emergency department (ED) to take photographs of the victim's injuries due to resource issues. However, the injuries were photographed by the treating physician in the emergency department.	1
	Reporting	3
	The hospital made a delayed report to the DFS Report Line for the near death incident.	1
	For the near death investigation, the child was medically discharged for the burn injuries prior to the hospital emergency department's call to the DFS Report Line.	1
	There was no report to the DFS Report Line by the PCP after the PCP documented a differential diagnosis of non-accidental trauma and received the confirmed x-ray results.	1
	Transport	1
	The PCP allowed the parents to transport the child to the emergency department, and did not send the child with alternative transportation.	1
Risk Assessment/ Caseloads		19
	Caseloads	14
	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.	7
	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 delayed final outcome and documentation.	1
	The DFS caseworker was over the investigation caseload statutory standards during the prior investigation. 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 collateral contacts and documentation.	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 delayed final outcome.	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 documentation and delayed final outcome.	1
	The DFS caseworker was over the investigation caseload statutory standards the entire time the prior and current investigations were open, and the caseload appears to have had a negative impact on the quality of work by the caseworker and supervisor in the prior 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 DFS response to the case.	1
	Collaterals	2
	During the death incident, a collateral contact was not completed with the PCP who allegedly saw the child the day prior.	1
	During the near death incident, collateral contacts were not completed for the siblings.	1
	Documentation	1
	Documentation of the hotline reports was delayed by the DFS Intake Worker.	1
	Risk Assessment - Screen Out	1
	The DFS Report Line screened out a prior hotline report, which alleged domestic violence. However, the report should have been screened in and linked to the active investigation.	1
	Risk Assessment - Tools	1
	During the near death investigation, family team meetings were not considered with the father's support network. These meetings would have helped to formalize the supports available to the father.	1
Safety/ Use of History/ Supervisory Oversight		9
	Safety - Completed Incorrectly/ Late	5
	For the near death investigation, DFS entered into a safety agreement with the sibling's father (who was mother's paramour), but did not specify the type of contact that must occur.	1
	During the near death investigation, the initial DFS safety agreement included the mother and victim, but not the other adults and children in the home.	1
	During the near death investigation, the initial safety agreement excluded the need for supervision during the child's hospitalization. As a result, the mother could remain in the hospital without supervision.	1

	For the near death investigation, DFS entered into a safety agreement with the father, but the agreement did not document who was responsible for making sure the mother was supervised.	1
	Prior to transferring the case to treatment, a safety assessment was not repeated. As a result, the agreement was terminated and the sibling was left without a plan for safety.	1
	Safety - Inappropriate Parent/ Relative Component	1
	For the near death incident, DFS initially entered into a safety agreement allowing mother to supervise contact between the victim and her paramour, but she was not ruled out as a suspect.	1
	Safety - Oversight of Agreement	1
	During the near death incident, the safety agreement was violated, and the DFS caseworker did not reassess for safety and implement a new agreement.	1
	Safety - Violations of Safety Agreements	2
	During the near death investigation, the DFS caseworker allowed the safety agreement to lapse despite being advised by law enforcement that the agreement was violated by father. In addition, the agreement was modified to allow father, who was considered a suspect, to have supervised contact.	1
	During the near death investigation, the safety agreement was violated by mother. The caseworker addressed the violation with mother over the phone instead of conducting a home visit or reaching out to the safety participants.	1
Unresolved Risk		9
	Child Risk Factors	1
	During the death investigation, concerning behaviors involving another child in the home of the victim were reported by family members. However, there was no assessment by the DFS caseworker to determine if services were needed.	1
	Contacts with Family	2
	For the incident preceding the death, the initial contact with the family was overdue by 5 days.	1
	For the incident preceding the death, there was no follow up with family until approximately seven months after the initial response, and it occurred as a result of the death incident.	1
	Parental Risk Factors	6
	In the prior investigation, the DFS caseworker allowed the suspected perpetrator to drive the victim to the children's hospital.	1
	During the treatment case, the DFS caseworker did not follow up with the children's hospital to make sure the medical concerns were addressed nor address the concerns which resulted in the transfer to treatment.	1
	DFS did not evaluate substance abuse issues for the mother by requesting that she complete a substance abuse evaluation. Risk factors included an infant born with prenatal substance exposure and a pending DUI.	1

	For the incident preceding the death, Mother reported that she was in a new relationship and suggested that there were problems, but DFS did not explore this further or request the name of her paramour to complete a background check.	1
	A referral to the domestic violence liaison was not considered despite the prior hotline reports involving domestic violence between the mother and intimate partners.	1
	DFS did not initiate a discussion with Father regarding supervision and the need for childcare. Father violated the safety agreement to go to work, and then later requested assistance from the DFS caseworker.	1
Grand Total		**77**

FINAL REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
Medical			1
	Reporting		1
		There was no report to the DFS Report Line by the urgent care center, and the parents were permitted to transport the child to the hospital emergency department.	1
Grand Total			**1**

TOTAL FINDINGS **78**