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CHILD PROTECTION ACCOUNTABILITY COMMISSION
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November 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 17 cases at its November 17, 2021 meeting.[1]

Thus far in 2021, there have been 11 deaths and 56 near deaths due to child abuse or neglect. In August alone, there were 9 near deaths and 4 deaths with an additional 12 near deaths and 2 deaths in September and October. With 67 new cases in 2021 thus far, the impact on the front lines and on the Child Abuse and Neglect (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. Three of the cases approved had been previously reviewed and were awaiting the completion of the criminal case. The death resulted in a plea to Murder by Abuse or Neglect as well as other charges with a life sentence plus 12 years. The two near death cases resulted in a plea to Assault 2nd and probation and Misdemeanor Endangering the Welfare. One additional finding was made.

[1] 16 Del. C. § 932.

The fourteen remaining cases were from deaths or near deaths that occurred between September of 2020 and April of 2021. Of these cases, five will have no further review as there are no criminal charges – four are drug ingestions. One of the nine remaining cases have pending charges and will be reviewed again once prosecution is completed. The remaining eight cases are still being investigated. The children in these fourteen cases range in age from six weeks to six years of age with one death and thirteen near deaths. The children were victims of abusive head trauma, poisoning via drug ingestion, bone and skull fractures, abdominal trauma and unsafe sleep. These fourteen cases resulted in 22 strengths and 46 current findings across system areas.

For these cases which primarily occurred in February and March of 2021, 11 strengths and 10 findings were noted for the Multidisciplinary Team Response. The Office of the Child Advocate (OCA) has 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 that these steps will positively impact multidisciplinary investigations.

The medical response had 6 findings together with 5 strengths. Three of the findings surround reporting of child abuse and neglect. CPAC has established a workgroup to tackle the significant recommendations for improvement outlined in the CPAC/CDRC Joint Action Plan such as 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 medical expertise downstate. While this will take time and resources to accomplish, 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 6 strengths and 30 findings this quarter. Thirteen of those findings were regarding high caseloads. The rest of the findings

continue to focus on timely and appropriate completion of safety agreements, inappropriate safety agreements and parental risk factors. 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 is hopeful that as these measures are implemented, improvements to these areas will be reflected in these retrospective reviews.

CPAC only brings you the most horrific of Delaware's child abuse cases; however, for every one of these cases, there are countless more cases where DFS case workers are under the same pressures with children at risk of serious harm. Young children with sentinel injuries are often the victims of serious abuse just months later. Prompt 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

NOVEMBER 17, 2021

INITIAL REVIEWS

	*Current	Grand Total
MDT Response	**12**	**12**
Communication	3	3
General - Criminal Investigation	1	1
General - Criminal/Civil Investigation	6	6
Medical Exam	2	2
Medical	**6**	**6**
Communication / Documentation	1	1
Medical Exam/Standard of Care - CARE Team	1	1
Medical Exam/Standard of Care - ED	3	3
Reporting	1	1
Safety/ Use of History/ Supervisory Oversig	**6**	**6**
Completed Correctly/On Time	6	6
Grand Total	**24**	**24**

FINAL REVIEWS

	*Current	Grand Total
Medical	**1**	**1**
Medical Exam/Standard of Care - CARE Team	1	1
Grand Total	**1**	**1**

TOTAL CAN PANEL STRENGTHS **25**

*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
NOVEMBER 17, 2021

INITIAL REVIEWS

System Area	Strength	Rationale	Count of #
MDT Response			12
	Communication		3
		There was good communication between the medical team, DFS, and the law enforcement agency.	1
		There was excellent communication and collaboration between the child abuse medical expert, the law enforcement detective, the DOJ, the civil DAG, and the Child Attorney.	1
		There was excellent communication and collaboration between the child abuse medical expert, the civil DAG, the Child Attorney, and the DFS caseworkers.	1
	General - Criminal Investigation		1
		The law enforcement detective assigned to the case conducted a thorough investigation and maintained excellent communication with the DFS caseworker.	1
	General - Criminal/Civil Investigation		6
		There was a strong MDT response to the near death investigation, which included a joint response to the hospital, joint interviews with the parents and relative guardian, and great collaboration with DFS and DOJ.	1
		There was a good MDT response to the near death incident, which included a joint response to the hospital, joint interviews with the parents, and medical evaluation and forensic interview of the sibling residing in the home.	1
		There was a good MDT response to the near death investigation, which included a joint response to the hospital, a joint response to the home, joint interviews with the appropriate caregivers, medical evaluations of the siblings, which included urine drug screens, and forensic interviews of the siblings.	1
		There was a good MDT response to the near death investigation, which included responses to the hospital and the scene, interviews with all involved parties, and a forensic interview of the child.	1
		There was a good MDT response to the near death investigation, which included a joint response to the hospital, a joint response to the home, joint interviews with the appropriate caregivers, forensic interviews of the children in the home and of the paramour's nonresidential child, and coordination with the alternate biological parent of the children.	1
		Following assignment of a detective, there was a good MDT response to the near death incident, which included a joint response to the hospital and joint interviews with the family.	1
	Medical Exam		2
		The DFS caseworker advocated for the child and the sibling to be medically evaluated by the children's hospital, to include a CARE Team consultation and blood draws of both children.	1
		The MDT members made a referral to the CARE team for the drug ingestion case.	1
Medical			6
	Communication / Documentation		1
		There was good communication with the out-of-state child protective services (CPS) agency and hospital resources regarding Mother's previous incidents, which was also well documented within the medical records.	1

	Medical Exam/ Standard of Care - ED		3
		The initial treating hospital emergency department provided a comprehensive medical response to the child prior to transfer to the children's hospital.	1
		A forensic nurse served as the triage nurse in the emergency department (ED), which allowed the child abuse pathway process to begin immediately. The child received a Child At Risk Evaluation (CARE) assessment in the ED and progression photos of the child's injuries were completed.	1
		Forensic nurses were available in the resuscitation room at the time of the child's transport to the children's hospital, as such, a forensic evidence collection kit and photo documentation were obtained prior to the child being moved to the operating room.	1
	Medical Exam/Standard of Care - CARE Team		1
		The child abuse medical expert requested an MDT meeting where child physical abuse was suspected for a medically complex child, and it resulted in the establishment of MDT meetings as a regular practice.	1
	Reporting		1
		The emergency medical services made an immediate report to the DFS Report Line due to the child's suspected drug ingestion.	1
Safety/ Use of History/ Supervisory Oversight			6
	Completed Correctly/On Time		6
		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.	3
		The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. The agreement also included the sibling residing in the home. There was consistent review and modification, when necessary, of the safety agreement.	1
		The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. The agreement also included the siblings residing in the home. There was consistent review and modification, when necessary, of the safety agreement.	2
Grand Total			**24**

FINAL REVIEWS

System Area	Strength	Rationale	Count of #
Medical			1
	Medical Exam/Standard of Care - CARE Team		1
		The child abuse medical expert participated in the review of hours of video footage, together with the Department of Justice, and it led to a good prosecutorial outcome in the case.	1
Grand Total			**1**

TOTAL CAN PANEL STRENGTHS **25**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

NOVEMBER 17, 2021

INITIAL REVIEWS

	*Current	Grand Total
MDT Response	**10**	**10**
Doll Re-enactment	1	1
General - Criminal Investigation	2	2
Interviews - Adult	2	2
Interviews - Child	2	2
Medical Exam	2	2
Reporting	1	1
Medical	**6**	**6**
Medical Exam/ Standard of Care - ED	2	2
Medical Exam/ Standard of Care - Radiology	1	1
Reporting	3	3
Risk Assessment/ Caseloads	**18**	**18**
Caseloads	13	13
Collaterals	4	4
Risk Assessment - Abridged	1	1
Safety/ Use of History/ Supervisory Oversight	**9**	**9**
Safety - Completed Incorrectly/ Late	6	6
Safety - Inappropriate Parent/ Relative Component	1	1
Safety - Violations of Safety Agreements	2	2
Unresolved Risk	**2**	**2**
Parental Risk Factors	2	2
Grand Total	**45**	**45**

FINAL REVIEWS

	*Current	Grand Total
MDT Response	**1**	**1**
Reporting	1	1
Grand Total	**1**	**1**

TOTAL CAN PANEL FINDINGS **46**

*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

NOVEMBER 17, 2021

INITIALS REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			10
	Doll Re-enactment		1
		No doll re-enactment was completed by the law enforcement agency.	1
	General - Criminal Investigation		2
		The LE agency did not initiate an MDT response to this incident resulting in the following investigative standards not being met: examination of the crime scene, response to the treating hospital(s), evidentiary blood draws completed on child or caregiver, notification to DOJ, interview with the caregiver, and forensic interview with the sibling.	1
		The LE agency delayed responding to the near death incident for several days, resulting in an MDT response not being conducted.	1
	Interviews - Adult		2
		DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	1
		During the near death investigation, DFS conducted interviews with the parents without the law enforcement agency present.	1
	Interviews - Child		2
		The sibling was not interviewed at the CAC.	1
		Forensic interviews were not considered for the other children in the home despite the infant's serious physical injury and the concerns with the mother's involvement in trafficking.	1
	Medical Exam		2
		In the prior investigation, there was no follow up with the CARE Team to discuss the interpretation of medical findings for the fractured forearm.	1
		During the initial response, the DFS caseworker observed the young sibling at the home, but there was no discussion about the need for a medical evaluation at that time.	1
	Reporting		1
		The law enforcement agency did not make a report to the DFS Report Line for the near death incident.	1
Medical			6
	Medical Exam/ Standard of Care - ED		2
		During the prior ED visit, the admitting medical team did not follow the CARE Team's recommendation to complete a skeletal survey of the child due to concern for abuse, resulting in multiple prior injuries being missed.	1
		The child was not referred to the CARE Team for an assessment.	1

	Medical Exam/ Standard of Care - Radiology		1
		During the prior ED visit, the CT scan was incorrectly read, resulting in a subdural hemorrhage not being identified.	1
	Reporting		3
		The medical professional completing the initial report to DFS utilized the online reporting portal, bypassing the prompt directing the professional to report the incident by placing a call to the Report Line, and thereby delaying the DFS response.	1
		The treating hospital delayed reporting the near death incident to DFS Report Line for 24 hours, thereby delaying the DFS response.	1
		Prior to the near death incident, concern for chronic, unexplained bruising was noted by the PCP and bloodwork was ordered. However, there was no report to the DFS Report Line and the PCP documented no suspicion for abuse.	1
Risk Assessment/ Caseloads			18
	Caseloads		13
		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.	9
		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.	2
		The DFS caseworkers were over the investigation and treatment caseload statutory standards the entire time the cases were open. However, it does not appear that the caseloads negatively impacted the DFS response to the cases.	2
	Collaterals		4
		A history check with the out of state CPS agency, where two half-siblings resided in relative care, was not completed by the DFS caseworker.	1
		Collateral contacts with the child's multiple medical providers and non-professional sources close to the family were not completed by the DFS caseworker.	1
		The DFS caseworker did not complete a collateral contact with the probation officer to ensure Mother's paramour was compliant with drug treatment standards.	1
		Collateral contacts with the child's new day care and the caregiver's counselor were not completed by the DFS caseworker, despite FAIR recommendations that same be done.	1
	Risk Assessment - Abridged		1
		The prior investigation was abridged by DFS despite the infant's serious physical injury and absent a reasonable explanation provided by the parents.	1

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Detail

NOVEMBER 17, 2021

Safety/ Use of History/ Supervisory Oversight		9
	Safety - Completed Incorrectly/ Late	6
	The SDM Risk Assessment was completed incorrectly as the risk was scored based upon assessment of the relative caregiver's household rather than the parents' household, and as a result, the safety agreement was terminated without safety being reassessed.	1
	For the near death investigation, DFS entered into a safety agreement with a non-relative, despite a home assessment not being completed for that person.	1
	For the near death investigation, DFS entered into a safety agreement with a non-relative, despite a background check not being completed on that person.	1
	The DFS caseworker delayed implementing a safety agreement for the child during the current investigation.	1
	The DFS caseworker incorrectly completed the safety assessment and delayed implementing a child safety agreement for the prior investigation.	1
	During the near death investigation, no safety agreement was initially completed for the two absent siblings; however, the caseworker arranged for the children to remain in the care of their father.	1
	Safety - Inappropriate Parent/ Relative Component	1
	During the near death incident, the DFS caseworker implemented a safety agreement with an 18-year-old relative to supervise the parents' contact with the children. However, the relative should have been ruled out due to his age.	1
	Safety - Violations of Safety Agreements	2
	During the near death investigation, the safety agreement was violated by mother. She continued to have contact with the twins while they were hospitalized, and it was not addressed by the DFS caseworker.	1
	During the near death investigation, the safety agreement was violated by the relative, and it was not addressed by the DFS caseworker. It appears, from the documentation, that the young sibling was left in the care of the suspect while the mother and relative drove to the hospital.	1
Unresolved Risk		2
	Parental Risk Factors	2
	Despite DFS providing the appropriate consents and completing multiple requests for the parents' treatment records, the medication assisted treatment provider failed to provide the requested documentation to DFS.	1
	A collateral with Mother's medication assisted treatment (MAT) provider revealed that Mother continued to test positive for marijuana, and this was not addressed by the DFS caseworker.	1
Grand Total		**45**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Detail

NOVEMBER 17, 2021

FINAL REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			1
	Reporting		1
		The MDT did not make a report to the DFS Report Line for the other victims identified during the criminal investigation.	1
Grand Total			**1**

TOTAL FINDINGS **46**