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EXECUTIVE DIRECTOR

February 16, 2022

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 20 cases at its February 16, 2022 meeting.[1]

In 2021, there were 14 deaths and 61 near deaths due to child abuse or neglect. These numbers represent a 44% increase from 2020 and an 79% increase over 2019. The impact on the Child Abuse and Neglect (CAN) Panel, the Office of the Investigation Coordinator, law enforcement, the Division of Family Services and the medical community 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 20 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 or a charging decision. The death resulted in a not guilty to Murder by Abuse or Neglect and the two near death cases were not prosecuted. There were two findings made at these final reviews regarding reporting by medical providers and communications between the multidisciplinary team.

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[1] 16 Del. C. § 932.

The seventeen remaining cases were from deaths or near deaths that occurred between April of 2021 and June of 2021. Of these cases, nine will have no further review as there are no criminal charges – six are poisoning via drug ingestions. Of the remaining eight cases, five have pending charges and the other three are still under criminal investigation. Three of these cases are also poisoning via drug ingestions. The children in these seventeen cases were all near deaths and range from two weeks to five years of age. They were victims of abusive head trauma, poisoning via drug ingestion, bone and skull fractures, burns and scalding, gunshot wounds, near drowning and unsafe sleep. These seventeen cases resulted in 23 strengths and 66 current findings across system areas.

For these cases which all occurred between April and June of 2021, 12 strengths and 28 findings were noted for the Multidisciplinary Team Response. Findings were noted in the gathering of evidence at the crime scene, particularly in poisoning via drug ingestion cases, and in the interviewing, or lack thereof, of children and adults. The Office of the Child Advocate (OCA) has contracted with a MDT Training and Policy Administrator with significant law enforcement expertise who will continue to support and coach individual law enforcement jurisdictions on best practices, resources and compliance with the MOU. The Office of the Investigation Coordinator (IC) has also instituted MDT meetings within 48-72 hours of every child abuse death, serious injury or poisoning via drug ingestion. CPAC has also produced a webinar series of basic and advanced child abuse trainings to begin in April of 2022. CPAC has also supported OCA in its multi-year request to add additional positions to the Office of the Investigation Coordinator to begin to address the unmanageable caseloads.

The medical response had 14 findings together with 4 strengths. Half of these findings surround the failure to report or delayed reporting of child abuse and neglect by medical providers. 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 7 strengths and 23 findings this quarter. Ten of those findings were regarding high caseloads. The rest of the findings continue to focus on risk assessment and the proper use and enforcement of safety agreements. 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 has also championed Senate Bill 197, introduced by Senator Gay, to reduce DFS treatment caseloads.

In conclusion, CPAC asks that the General Assembly support its multi-year requests to fund additional positions in the Office of the Investigation Coordinator, and to support Senate Bill 197, reducing treatment caseloads for the Division of Family Services. In the future, CPAC may be requesting legislative action regarding the mandatory reporting training for the medical community. 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 16, 2022

INITIAL REVIEWS

	*Current	Grand Total
MDT Response	**12**	**12**
Communication	1	1
General - Civil Investigation	1	1
General - Criminal Investigation	4	4
General - Criminal/Civil Investigation	6	6
Medical	**4**	**4**
Medical Exam	1	1
Medical Exam/Standard of Care - Films	1	1
Medical Exam/Standard of Care - Forensics	1	1
Reporting	1	1
Risk Assessment/ Caseloads	**3**	**3**
Collaterals	3	3
Safety/ Use of History/ Supervisory Oversight	**4**	**4**
Completed Correctly/On Time	4	4
Grand Total	**23**	**23**

TOTAL CAN PANEL STRENGTHS 23

*Current - within 1 year of incident

**Prior - 1 year or more prior to incident

Child Protection Accountability Commission
Child Abuse and Neglect Panel
Strengths Detail
FEBRUARY 16, 2022

INITIAL REVIEWS

System Area	Strength	Rationale	Count of #
MDT Response			12
	Communication		1
		There was good communication and collaboration between DFS and the law enforcement agency.	1
	General - Civil Investigation		1
		The DFS caseworker advocated for forensic interviews to be conducted for the other children residing in the home.	1
	General - Criminal Investigation		4
		The law enforcement detective conducted an excellent investigation, to include evidentiary blood draws of all household members and fingerprinting of drug evidence collected from the residence, which resulted in both parents being criminally charged.	1
		The law enforcement detective assigned to the case conducted an excellent investigation, ensuring all MOU recommendations were completed and thoroughly documented within the report, and maintained excellent communication with the DFS caseworker.	1
		The law enforcement agency conducted evidentiary blood draws of all adults residing in the home at the time of the near death incident.	1
		Despite the near death incident appearing to be accidental, the law enforcement agency conducted a thorough investigation, to include interviews with the parents, a scene investigation, collection of evidence, and forensic examination of Mother's laptop.	1
	General - Criminal/Civil Investigation		6
		There was a good MDT response to the near death investigation, which included a joint response to the home, joint interviews with all involved parties, and medical evaluation and forensic interview of the sibling.	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, an immediate medical evaluation of the sibling residing in the home, forensic interviews of the sibling and the half-sibling, and coordination between the two local law enforcement agencies to ensure MOU recommendations were completed.	1

		There was an excellent MDT response to the near death investigation, which included a joint response to the home, joint interviews with the appropriate caregivers, all appropriate investigative steps, and consistent communication and collaboration with the medical team.	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 parents, medical evaluations of the siblings, and coordinated investigations of the child's physical abuse and the sibling's medical neglect.	1
		There was good communication and collaboration between the medical team, DFS, the law enforcement agency, and the DOJ.	1
		Following receipt of the expanded drug screen results, there was a joint response to the NRC's home by law enforcement and the DFS caseworker, and joint interviews were conducted with all involved parties.	1
Medical			4
	Medical Exam		1
		The pediatric intensive care unit social worker identified the need for CARE Team involvement, which had not yet been considered.	1
	Medical Exam/ Standard of Care - Forensics		1
		The forensic nurse coordinator at the initial treating hospital identified the lack of appropriate non-accidental trauma workup following the child's medical discharge and contacted the family to return to the emergency department for completion.	1
	Medical Exam/Standard of Care - Films		1
		For the near death incident, the x-ray technician recognized the necessity for the child abuse pathway to be completed given the child's age and injuries.	1
	Reporting		1
		The children's hospital made an immediate report to the DFS Report Line with concerns surrounding the circumstances of the child's injuries.	1
Risk Assessment/ Caseloads			3
	Collaterals		3
		The DFS caseworker maintained regular, quality contact with the family, which included the half-sibling and her biological mother.	1
		The DFS caseworker maintained regular, quality contact with the family. The contact included both in person and virtual visits.	1
		In the prior investigation, comprehensive medical collaterals were completed for the children and Mother.	1

Child Protection Accountability Commission
Child Abuse and Neglect Panel
Strengths Detail
FEBRUARY 16, 2022

Safety/ Use of History/ Supervisory Oversight			4
	Completed Correctly/On Time		4
		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.	2
		The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized and for 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 children were hospitalized. There was consistent review and modification, when necessary, of the safety agreement.	1
Grand Total			**23**

TOTAL CAN PANEL STRENGTHS **23**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

FEBRUARY 16, 2022

INITIAL REVIEWS

	*Current	Grand Total
Legal	**1**	**1**
DFS Contact with DOJ	1	1
MDT Response	**28**	**28**
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	4	4
Interviews - Child	5	5
Medical Exam	3	3
Reporting	2	2
Medical	**14**	**14**
Medical Exam/ Standard of Care - ED	4	4
Medical Exam/ Standard of Care - PCP	1	1
Medical Exam/ Standard of Care - Radiology	1	1
Medical Exam/ Standard of Care - Urgent Care	1	1
Reporting	7	7
Risk Assessment/ Caseloads	**16**	**16**
Caseloads	10	10
Collaterals	2	2
Risk Assessment - Closed Despite Risk Level	2	2
Risk Assessment - Screen Out	1	1
Screen Out	1	1
Safety/ Use of History/ Supervisory Oversight	**6**	**6**
Safety - Completed Incorrectly/ Late	1	1
Safety - Inappropriate Parent/ Relative Component	1	1
Safety - No Safety Assessment of Non-Victims	1	1
Safety - Violations of Safety Agreements	2	2
Use of History	1	1
Unresolved Risk	**1**	**1**
Contacts with Family	1	1
Grand Total	**66**	**66**

FINAL REVIEWS

	*Current	Grand Total
MDT Response	**1**	**1**
Communication	1	1
Medical	**1**	**1**
Reporting	1	1
Grand Total	**2**	**2**
TOTAL CAN PANEL FINDINGS		**68**

*Current - within 1 year of incident

**Prior - 1 year or more prior to incident

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Detail

FEBRUARY 16, 2022

INITIALS REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
Legal			1
	DFS Contact with DOJ		1
		DFS did not consider immediately filing for custody of the young victim. In the incident preceding the near death, the infant was born drug exposed, a relative caregiver could not be identified and the parents were not compliant with the recommendations by the caseworker.	1
MDT Response			28
	Communication		1
		The law enforcement agency did not notify the DFS caseworker of the charges against the father. Mother disclosed the information to the caseworker.	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.	1
		The law enforcement agency did not complete an evidentiary blood draw on the child after the child ingested a controlled substance.	3
		The law enforcement agency did not complete an evidentiary blood draw on the father during the near death incident. Father disclosed that he had been drinking.	1
		The water temperature was not measured during the scene investigation by the law enforcement agency.	1
	General - Civil Investigation		1
		For the near death investigation, the caseworker terminated the safety agreement and closed the case prior to obtaining the blood draw results from the law enforcement agency.	1
	General - Criminal Investigation		2
		There was no documentation in the police report by the lead detective.	1
		The law enforcement agency did not consider contacting an expert to opine on the drug metabolite levels found in the child's urine.	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. Law Enforcement responded to the initial 911 call and contacted DFS after the response.	3
		DFS and law enforcement focused solely on the mother rather than father as a suspect.	1
	Interviews - Adult		4
		DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	3
		For the near death investigation, there is no documentation that the law enforcement agency interviewed the father.	1
	Interviews - Child		5
		Forensic interviews did not occur with the other children residing in the home where the incident occurred. In addition, the DFS caseworker did not independently interview these children.	1
		During the prior investigation, the other children residing in the home were not interviewed by the caseworker.	1
		Forensic interviews were not considered for the other children residing in the home where the incident occurred.	1
		Forensic interview was not scheduled until approximately six months later for the sibling who resided in the home during the near death incident.	1
		Forensic interviews did not occur with the other children residing in the home where the incident occurred.	1
	Medical Exam		3
		All of the children who resided in the home during the near death incident were not medically evaluated.	1
		The young sibling who was present in the home during the near death incident was not medically evaluated until almost a month later.	1
		The half-sibling who was present in the home during the near death incident was not medically evaluated.	1

Category	Subcategory	Finding	Count
	Reporting		2
		In the near death investigation, the DFS caseworker delayed reporting to the law enforcement agency.	1
		In the near death investigation, the DFS caseworker delayed reporting to the law enforcement agency. As a result, there was not an initial MDT response, scene investigation or evidentiary blood draw.	1
Medical			14
	Medical Exam/ Standard of Care - ED		4
		The child was discharged without a full CARE team assessment and evaluation.	1
		During the near death investigation, the emergency department initially conducted an incomplete workup for the infant with unexplained bruising and discharged the child home. Multiple bone fractures were later identified.	1
		The child was discharged without a full CARE team assessment and evaluation when the child tested positive for illicit drugs.	1
		The CARE Team was not contacted by the emergency department staff until the child was close to being discharged.	1
	Medical Exam/ Standard of Care - PCP		1
		The PCP did not consider a differential diagnosis of abuse, and instead misdiagnosed the infant as having a hemangioma. As a result, the medical evaluation and treatment was significantly delayed for the infant with multiple undiagnosed fractures.	1
	Medical Exam/ Standard of Care - Radiology		1
		The radiologist misread the infant's CT scan as normal, which resulted in the child being discharged home. A CT scan completed by the children's hospital later identified bilateral subdural hematomas.	1
	Medical Exam/ Standard of Care - Urgent Care		1
		The out of state medical facility did not complete a skeletal survey despite the recommendation by the child abuse medical expert.	1
	Reporting		7
		There was no report to the DFS Report Line by the emergency department after the young child first presented with symptoms of drug ingestion/poisoning.	1
		There was no report to the DFS Report Line by the birth hospital for the past child abuse disclosed by the mother, who is now an adult.	1
		There was no report to the DFS Report Line by the PCP after the PCP documented unexplained injuries to a 6-week-old infant during two office visits.	1
		The treating hospital delayed reporting the near death incident to DFS Report Line for 72 hours, which was when the urine drug confirmation results were confirmed.	1
		The treating hospital delayed reporting the near death incident to the DFS Report Line for 72 hours.	1
		The treating hospital delayed reporting the near death incident to DFS Report Line until the CARE team was consulted.	1
		PCP failed to make a report to the DFS Report Line for an unwitnessed burn to a young child and questionable history provided by the mother.	1
Risk Assessment/ Caseloads			16
	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.	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.	1
	Collaterals		2
		During the near death incident, collateral contacts were not completed for mother's mental health providers, and concerns raised by the children's collaterals were not addressed with the parents or providers.	1
		During the prior investigation, a collateral contact was not completed with the daycare provider to confirm whether any injuries to the child were observed and to identify who drops off and picks up the child.	1

Category	Subcategory	Finding	Count
	Risk Assessment - Closed Despite Risk Level		2
		The SDM Risk Assessment identified the risk as high in the near death investigation. Ongoing service was recommended; however, the case disposition was overridden to close the investigation despite the closure factors not being met as a result of the extensive and recent DFS history.	1
		The SDM Risk Assessment identified the risk as high in the near death investigation. Ongoing service was recommended; however, the case disposition was overridden to close the investigation despite the closure factors not being met as a result of the DFS history and current substance abuse.	1
	Risk Assessment - Screen Out		1
		The call to the DFS Report Line with the positive drug screen results was initially documented by DFS as a progress note rather than a new report.	1
	Screen Out		1
		The DFS Report Line screened out the call regarding the near drowning from the treating hospital, and it resulted in a delayed response by DFS.	1
Safety/ Use of History/ Supervisory Oversight			6
	Safety - Completed Incorrectly/ Late		1
		During the near death investigation, no safety agreement was initially completed for the child and sibling. It was implemented with the father and a relative approximately 72 hours later.	1
	Safety - Inappropriate Parent/ Relative Component		1
		During the near death incident, the DFS caseworker amended the safety agreement to include the mother and to allow her to supervise contact. However, the mother should have been ruled out due to her domestic violence history with the alleged perpetrator.	1
	Safety - No Safety Assessment of Non-Victims		1
		A safety agreement was not completed for the non-victim children residing in the home.	1
	Safety - Violations of Safety Agreements		2
		During the near death investigation, the safety agreement was violated by mother during a follow up appointment to the children's hospital, and it was not addressed by the DFS caseworker.	1
		In the incident preceding the near death, the safety agreement was violated by the non-relative. The violation was not considered when the caseworker completed the new safety for the near death incident.	1
	Use of History		1
		In the first hotline report, the father's DFS history and level IV finding of abuse was not documented by the intake worker. The assigned DFS caseworker did not document the history either.	1
Unresolved Risk			1
	Contacts with Family		1
		During the prior investigation, the initial contact with the victim was delayed by the caseworker.	1
Grand Total			**66**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Detail

FEBRUARY 16, 2022

FINAL REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			1
	Communication		1
		During the near death investigation, the law enforcement agency disengaged with the MDT, and stopped communicating updates on the criminal investigation.	1
Medical			1
	Reporting		1
		There was no report to the DFS Report Line by the PCP after the PCP documented bruising of the bilateral ears and scalp swelling of the 4-month-old infant, and referred the infant to the emergency department.	1
Grand Total			**2**

TOTAL FINDINGS **68**