STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
C/O OFFICE OF THE CHILD ADVOCATE
900 KING STREET, SUITE 210
WILMINGTON, DELAWARE 19801
TELEPHONE: (302) 255-1730
FAX: (302) 577-6831

MARY F. DUGAN, ESQUIRE
CHAIR

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

May 18, 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 25 cases at its May 18, 2022 meeting.[1]

As mentioned in our February letter, in 2021 there was approximately a 40% increase in child abuse and neglect deaths and near deaths from 2020. Thus far in 2022, there have been 25 cases with 10 near deaths and one death occurring in March 2022 alone. These numbers, if sustained, will result in a further increase. The impact on the Child Abuse and Neglect (CAN) Panel, the Office of the Investigation Coordinator, law enforcement, the Department of Justice, the Division of Family Services and the medical community continues to be significant. These numbers are troubling both in terms of child safety as well as in timely caseload management and retrospective review. These unfortunate trends can be seen below.

[1] 16 Del. C. § 932.

With respect to the 25 cases that were approved by CPAC today, here are the strengths and system breakdowns. Nine of the cases (2 deaths and 7 near deaths) approved had been previously reviewed and were awaiting the completion of the criminal case or a charging decision. One of the deaths resulted in a plea to Murder by Abuse or Neglect 2nd and ten years in prison. Four cases of bone fractures and drug ingestion resulted in one year of Level III probation. One case of abusive head trauma resulted in a conviction of Child Abuse 1st and two years in prison. There were two findings made at these final reviews with one addressing the prison time for the Child Abuse 1st conviction.

The sixteen remaining cases were from deaths or near deaths that occurred between June and August of 2021. Of these cases, six will have no further review as there are no unresolved criminal charges – four are poisoning via drug ingestion. Of the remaining ten cases, six have pending charges and the other four are still under criminal investigation. Four of these cases are also poisoning via drug ingestion with another four bone fractures or abusive head trauma. The children in these sixteen cases were five deaths and eleven near deaths, and range from one month to eight years of age. They were victims of abusive head trauma, poisoning via drug ingestion, bone and skull fractures, heat exposure, unsafe sleep and drowning. These sixteen cases resulted in 38 strengths and 82 current findings across system areas.

For these cases which all occurred between April and June of 2021, 16 strengths and 21 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. A safe storage campaign is being developed. CPAC has also produced a webinar series of basic and advanced child abuse trainings, and 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 12 strengths together with 8 findings. Three of these findings surround the failure to report or delayed reporting of child abuse and neglect by medical providers. Another four findings surrounded the emergency medical response to poisoning via drug ingestion cases. CPAC has established a workgroup to tackle the 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.

While the Division of Family Services (DFS) continues to be a national leader in child safety, it also shares national challenges with recruitment and retention of frontline workers. Over the last few years, DFS with the support of the Department of Human Resources, has increased starting salaries of new staff and provided pay increases to staff through collective bargaining and compression reviews. In this quarter, 10 strengths and 52 findings were noted. Eleven of those findings were regarding high caseloads. The balance of the findings involved child safety (19) and assessment of risk (13). In the Joint Action Plan, several steps were recommended to improve DFS worker and supervisory responses to risk assessment and child safety. In response to these concerns, DFS has hired a coach to support supervisors. This coach will be working statewide with supervisors to strengthen their skills in many areas, including proper application of the Structured Decision Making (SDM) tool. In addition, DFS has a practice coach in each county that also focuses on strengthening SDM practices. These strategies are in addition to staff and supervisory trainings related to safety assessments and the SDM that were developed and implemented with support from Evident Change. Finally, 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

MAY 18, 2022

INITIAL REVIEWS

	*Current	Grand Total
MDT Response	**16**	**16**
Communication	2	2
General - Civil Investigation	1	1
General - Criminal Investigation	2	2
General - Criminal Investigation	1	1
General - Criminal/Civil Investigation	8	8
Medical Exam	1	1
Reporting	1	1
Medical	**12**	**12**
Communication	3	3
Communication / Documentation	1	1
Medical Exam/Standard of Care - CARE	3	3
Reporting	5	5
Risk Assessment/ Caseloads	**2**	**2**
Collaterals	2	2
Safety/ Use of History/ Supervisory Oversight	**8**	**8**
Appropriate Parent/Relative Component	2	2
Completed Correctly/On Time	5	5
Oversight of Agreement	1	1
Grand Total	**38**	**38**

FINAL REVIEWS

	*Current	Grand Total
MDT Response	**1**	**1**
Communication	1	1
Grand Total	**1**	**1**

TOTAL CAN PANEL STRENGTHS **39**

*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 18, 2022

INITIAL REVIEWS

System Area	Strength	Rationale	Count of #
MDT Response			16
	Communication		2
		There was good communication and collaboration between the medical team, DFS, the law enforcement agency, and the DOJ.	1
		There was good communication and collaboration between the law enforcement agency, the criminal DAG, the civil DAG, and the Child Attorney.	1
	General - Civil Investigation		1
		Given the unusual circumstances of the case, the DFS after-hours staff went above and beyond their duties to locate the twin sibling and ensure the safety of the child.	1
	General - Criminal Investigation		2
		The detective assigned to the criminal case conducted a thorough investigation, to include multiple interviews and review of video surveillance from multiple establishments along Mother's reported path of travel, which the detective documented in detail within the complaint report.	1
		Despite not having a detective assigned to the smaller jurisdiction law enforcement agency, the patrol officer conducted an excellent investigation ensuring all MOU recommendations were completed and thoroughly documented within the report.	1
	General - Criminal Investigation		1
		The law enforcement detective assigned to the case conducted an excellent investigation, which included a confession and seizure of the suspect's cell phone that corroborated the confession, resulting in criminal charges being filed.	1
	General - Criminal/Civil Investigation		8
		There was a good MDT response to the death investigation, which included a joint response to the hospital, joint interviews with Mother and other relatives at the hospital, and a child safety agreement restricting the parents' contact with the child.	1
		There was a good 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, announced and unannounced home visits to ensure the child safety agreements were being followed, and consistent communication and collaboration among the MDT members.	1
		There was excellent communication and collaboration between the MDT members, which also included joint responses to the home and joint interviews with relatives and non-relatives.	1
		There was a good MDT response to the near death, and subsequently death, investigation, which included joint responses to the hospital and the home, joint interviews with the adults in the home, a child safety agreement, forensic interview of the non-relative child, and consistent communication and collaboration among the MDT members.	1
		There was a good MDT response to the death investigation, which included a joint response to the hospital, joint interviews with the parents and other adult relatives residing in the home, a child safety agreement for the young sibling, medical evaluation and forensic interview of the sibling, and consistent communication among the MDT members.	1
		There was a good MDT response to the near death investigation, which included a joint response to the hospital, joint interviews with the parents and other adult relatives, a child safety agreement, forensic interview of the child, and consistent communication among the MDT members.	1
		There was a good MDT response to the death investigation, which included joint responses to the hospital and the home, joint interviews with the caregivers, child safety agreements for the children, medical evaluations and forensic interviews of the sibling and non-relative child, an immediate CARE Team consultation, and consistent communication among the MDT members.	1
		There was a good MDT response to the near death investigation, which included joint responses to the hospital and the home, joint interviews with Mother and the adult stepchildren residing in the home, a child safety agreement while the child was hospitalized, a medical evaluation and forensic interview of the sibling, and consistent communication among the MDT members.	1
	Medical Exam		1

	Despite the older sibling being asymptomatic and reporting not to have ingested any substances, a medical evaluation was completed for the child. The evaluation included a urine drug screen.	1
Reporting		1
	The DFS caseworker made an immediate report to the law enforcement agency with concerns surrounding the circumstances of the children's drug ingestions.	1
Medical		12
Communication		3
	There was good communication and collaboration between the initial treating hospital and the children's hospital.	2
	The CARE Team social worker went above and beyond with consistent communication with the MDT members regarding the child's multiple injuries and progressing medical condition.	1
Communication / Documentation		1
	The neurology resident identified and documented inconsistencies within Mother's account of events provided to the ED physician, the PICU physician, and the neurology resident.	1
Medical Exam/ Standard of Care - CARE		3
	At the children's hospital, there was early involvement with the Children At Risk Evaluation (CARE) Team, who advocated for the medical team to complete appropriate urine drug screens for the child, which had not previously been done.	1
	A comprehensive medical examination was completed for the child.	2
Reporting		5
	The children's hospital made an immediate report to the DFS Report Line with concerns surrounding the circumstances of the child's injuries.	2
	The initial treating hospital made an immediate report to the DFS Report Line with concerns surrounding the circumstances of the child's injuries.	2
	The children's hospital made an immediate report to the DFS Report Line with concerns surrounding the circumstances of the children's drug ingestions.	1
Risk Assessment/ Caseloads		2
Collaterals		2
	In the prior and current investigations, the caseworkers maintained regular, quality contact with the family. The contact included both in person and virtual visits.	1
	In the prior investigation, strong collaterals were completed by the DFS caseworker. The contacts included both professional and personal resources.	1
Safety/ Use of History/ Supervisory Oversight		8
Appropriate Parent/Relative Component		2
	The DFS caseworker made good use of the natural support network to provide a safe placement for the child.	1
	The DFS caseworker went above and beyond to implement detailed and creative child safety agreements to meet the family's needs.	1
Completed Correctly/On Time		5
	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 children were hospitalized. There was consistent review and modification, when necessary, of the safety agreement.	2
	The DFS caseworker immediately implemented a child safety agreement for the sibling residing in the home. There was consistent review and modification, when necessary, of the safety agreement.	1
Oversight of Agreement		1
	In collaboration with the medical team, DFS modified the child safety agreement allowing the parents to be at the child's bedside when the child's medical condition worsened.	1
Grand Total		**38**

Child Protection Accountability Commission
Child Abuse and Neglect Panel
Strengths Detail
MAY 18, 2022

FINAL REVIEWS

System Area	Strength	Rationale	Count of #
MDT Response			1
	Communication		1
		There was good communication between the Child Attorney and the law enforcement agency relating to the ongoing domestic violence between the parents.	1
Grand Total			**1**

TOTAL CAN PANEL STRENGTHS **39**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

MAY 18, 2022

INITIAL REVIEWS

	*Current	Grand Total
Legal	**1**	**1**
DFS Contact with DOJ	1	1
MDT Response	**21**	**21**
Communication	2	2
Crime Scene	8	8
Documentation	1	1
General - Criminal Investigation	1	1
General - Criminal Investigation / Civil Investigation	2	2
Interviews - Adult	2	2
Interviews - Child	3	3
Medical Exam	1	1
Reporting	1	1
Medical	**8**	**8**
Medical Exam/ Standard of Care - ED	4	4
Medical Exam/ Standard of Care - Radiology	1	1
Reporting	3	3
Risk Assessment/ Caseloads	**24**	**24**
Caseloads	11	11
Collaterals	7	7
Risk Assessment - Closed Despite Risk Level	2	2
Risk Assessment - Screen Out	1	1
Risk Assessment - Unsubstantiated	3	3
Safety/ Use of History/ Supervisory Oversight	**19**	**19**
Safety - Completed Incorrectly/ Late	8	8
Safety - No Safety Assessment of Non-Victims	2	2
Safety - Oversight of Agreement	6	6
Safety - Violations of Safety Agreements	2	2
Transport	1	1
Unresolved Risk	**9**	**9**
Contacts with Family	3	3
Parental Risk Factors	5	5
Substance-Exposed Infant	1	1
Grand Total	**82**	**82**

FINAL REVIEWS

	*Current	Grand Total
MDT Response	**1**	**1**
Prosecution/ Pleas/ Sentence	1	1
Risk Assessment/ Caseloads	**1**	**1**
Caseloads	1	1
Grand Total	**2**	**2**

TOTAL CAN PANEL FINDINGS **84**

*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

Prepared 4/28/2022

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Detail

MAY 18, 2022

INITIALS REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
Legal			1
	DFS Contact with DOJ		1
		Despite mother's extensive history, DFS did not consider immediately filing for custody of the victim and sibling after their birth.	1
MDT Response			21
	Communication		2
		During the death investigation, the law enforcement agency disengaged with the MDT, and stopped communicating updates on the criminal investigation.	1
		During the near death investigation, the law enforcement agency did not communicate with DFS about the criminal investigation.	1
	Crime Scene		8
		No scene investigation was completed by the law enforcement agency. As a result, the scene was not photographed and no evidence was collected.	3
		The law enforcement agency did not complete an evidentiary blood draw on the child after the child ingested a controlled substance.	2
		The law enforcement agency did not complete an evidentiary blood draw on the child after the child ingested a controlled substance. The case was assigned to detectives late.	1
		The law enforcement agency did not consider an evidentiary blood draw on Mother, in addition to the relative caregiver, 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 a controlled substance.	1
	Documentation		1
		There was no documentation by the DFS caseworker that a lock box to store the marijuana was discussed.	1
	General - Criminal Investigation		1
		A delay in the criminal investigation impacted the ongoing safety planning by the DFS caseworker.	1
	General - Criminal Investigation / Civil Investigation		2
		There was not an initial MDT response to the near death incident in compliance with the MOU and statute. Law Enforcement contacted DFS but was initially told the case would be forwarded to the Institutional Abuse Unit.	1
		There was not an initial MDT response to the near death incident in compliance with the MOU and statute. Law enforcement was not able to respond initially, so the DFS case worker completed the interviews.	1
	Interviews - Adult		2
		For the near death investigation, there is no documentation that the caseworker interviewed an adult daughter, who resided in the home.	1
		During the prior investigation, there was no attempt by the DFS caseworker to contact the father or relative, who were the main supports for the mother.	1
	Interviews - Child		3
		There was a delay in referring the young victim to a children's advocacy center for a forensic interview.	1
		An older sibling, residing with a non-relative caregiver, was not interviewed by the DFS caseworker, and the home was not assessed.	1
		Forensic interview did not occur with the sibling residing in the home where the incident occurred.	1
	Medical Exam		1
		The sibling who was present in the home was not medically evaluated during the prior investigation.	1
	Reporting		1
		The law enforcement agency delayed making a report to the DFS Report Line for a prior domestic violence incident.	1

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Detail

MAY 18, 2022

Medical		8
	Medical Exam/ Standard of Care - ED	4
	The child was discharged without a full CARE team assessment and evaluation when the child tested positive for illicit drugs.	1
	The children's hospital does not test for Fentanyl in its urine drug screen, and an expanded drug screen or test for Fentanyl was not ordered by the emergency department.	1
	The initial treating hospital did not complete a urine drug screen. As a result, the UDS was delayed for several hours until it was completed at the children's hospital.	2
	Medical Exam/ Standard of Care - Radiology	1
	A fracture, very specific for abuse, was not identified during the first skeletal survey.	1
	Reporting	3
	The treating hospital failed to make a report to the DFS Report Line for an infant in cardiac arrest.	1
	The infant was born with prenatal substance exposure, and the birth hospital did not notify the DFS Report Line.	1
	The physician in the hospital emergency department told the DFS Report Line staff that the Report Line was contacted prematurely even though it was suspected that the child ingested a controlled substance.	1
Risk Assessment/ Caseloads		24
	Caseloads	11
	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. However, it does not appear that the caseload negatively impacted the DFS response to the case.	1
	The DFS caseworkers were over the investigation and treatment caseload statutory standards while the cases were open, and the caseload appears to have had a negative impact on the investigation case.	1
	The DFS caseworker was over the treatment caseload statutory standards the entire time the case was open. However, it does not appear that the caseload negatively impacted the DFS response.	1
	The caseworkers were over the investigation caseload statutory standards during the current investigation and the treatment case. The caseload appears to have had a negative impact on the treatment case. However, it does not appear that the caseload negatively impacted the DFS response to the death investigation.	1
	Collaterals	7
	During the case assigned to the contract agency, a collateral contact was not completed with non-professional sources close to the family.	1
	During the prior investigation, there was a lack of communication between the assigned investigation worker and active treatment caseworker.	1
	During the prior investigation, collateral contacts were not completed with Mother's mental health provider.	1
	During the near death investigation, collateral contacts were not completed with Mother's or the relative's mental health provider.	1
	During the prior investigation, the DFS caseworker did not ensure that the parents followed through with the infant's scheduled appointments with specialists after the parents questioned the need to follow through.	1
	The DFS caseworker documented the presence of a relative, but there was no attempt to contact the relative or to establish a support network for the family.	1
	During the near death investigation, there was no documentation that the DFS caseworker confirmed that the parents were prescribed medical marijuana.	1
	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 since the victim and sibling were residing with a relative/non-relative caregiver. It was also documented that the same sibling was in the care of the mother and his father, so the case should have been opened in treatment.	1
	The SDM Risk Assessment identified the risk as high in the prior investigation. Ongoing services were recommended after a Framework was completed during a group supervision session; however, the SDM recommendation to transfer to treatment was overridden, and the case was closed.	1

Risk Assessment - Screen Out	1
The DFS Report Line received allegations that the victim was taken out of state for the purpose of an illegal adoption. This was not immediately referred to law enforcement by the Report Line.	1
Risk Assessment - Unsubstantiated	3
During a prior investigation, an older sibling made a disclosure of child sexual abuse. These allegations were not considered by DFS in the investigation findings despite a joint criminal investigation.	1
For the death incident, the policy override reason and the final case outcome contradict each other. The case was unsubstantiated, but the policy override indicated that the death was due to abuse or neglect.	1
For the investigation following the near death, there was a finding of abuse/bizarre treatment against the sibling's father but the finding does not appear to be correct in relation to the allegations.	1
Safety/ Use of History/ Supervisory Oversight	19
Safety - Completed Incorrectly/ Late	8
The assigned worker from the contract agency completed the SDM safety assessment prior to making contact with all of the children in the home.	1
The amended safety agreements completed towards the end of the near death investigation were not appropriate and allowed the parents, who were still considered suspects, to supervise each other's contact with the children.	1
During the prior investigation, the DFS investigation and treatment workers defied instructions by the DFS supervisor to take physical custody of the victim and sibling.	1
During the treatment case, the safety agreement was put in place without validating the identity of the safety person.	1
The father did not sign the safety agreement, and his signature was needed for the agreement to be valid since he held legal custody of the child.	1
During the prior investigation, the safety agreement was not appropriate as a safety participant was not included in the plan to monitor the contact and the plan was not signed by the father.	1
In the near death investigation, the safety agreement was not appropriate as it did not address all of the safety threats nor include the siblings and their fathers. In addition, none of the fathers signed the agreement.	1
During the prior investigation, the DFS caseworker instructed the mother that the children could only be returned to her care if a drug test was completed. The safety agreement should not have been contingent upon the mother completing the drug test.	1
Safety - No Safety Assessment of Non-Victims	2
A safety agreement was not completed for the non-victim child residing in the home.	1
During the prior investigation, a safety agreement was not initially completed for the siblings residing in the home.	1
Safety - Oversight of Agreement	6
During the treatment case, it was reported that the worker ignored the mother's requests to identify a new safety participant to supervise her contact with the victim and sibling.	1
During the treatment case, the original safety agreement was continued for several months. The agreement should have been terminated and incorporated into a case plan.	1
For the case involving the domestic violence incident, DFS terminated the safety agreement; however, it is not clear what resulted in the termination of the agreement, such as safety threats resolved or services completed.	1
For the prior investigation, DFS terminated the safety agreement; however, it is not clear what resulted in the termination of the agreement, such as safety threats resolved or services completed.	1
For the prior investigation, there was no documentation that the safety agreement was regularly reviewed. In addition, DFS terminated the safety agreement; however, it was not clear what resulted in the termination of the agreement, such as a collateral with the substance abuse provider.	1
During the near death investigation, the safety agreement was allowed to lapse despite information from the substance abuse provider that the mother was discharged due to noncompliance.	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 out of state hospital, and it was not immediately addressed by the DFS caseworker.	1

		During the near death investigation, the safety agreement was violated by the relative safety participant, and it was not immediately addressed by the DFS caseworker.	1
	Transport		1
		In the prior investigation, the DFS caseworker instructed the relative to pick up the sibling from daycare and transport the child to the children's hospital for a medical exam. However, no consent was obtained from the mother for the transport.	1
Unresolved Risk			9
	Contacts with Family		3
		There was no documentation that the assigned worker from the contract agency met with the parents and children at the same time to observe mother and father's interactions with each other and the children.	1
		There was no documentation that the assigned worker from the contract agency interviewed the siblings residing in the home; the children were only observed.	1
		During the treatment case, there is no documentation that contacts occurred with the victim and sibling for a two-month period.	1
	Parental Risk Factors		5
		DFS did not evaluate substance abuse issues for the parents by requesting that they complete substance abuse evaluations. The child ingested a controlled substance and the father was active with a substance abuse provider.	1
		During the prior investigation, the DFS worker did not thoroughly assess the mother's parenting practices. It was alleged that she was leaving the children home alone, and she was observed to be rough in her interactions with the children.	1
		During the prior investigation, the DFS caseworker focused on the allegations and did not assess the overall functioning of the family for potential safety issues.	1
		In the prior investigation, a referral was not made to the DFS domestic violence liaison, and the hotline report noted concerns of intimate partner violence.	1
		Multiple investigations were opened by DFS prior to or at the time of the near death incident, and more needed to be done proactively by the caseworker to get services in place and to plan with the mother's support network.	1
	Substance-Exposed Infant		1
		In the prior investigation, the DFS caseworker did not appear to monitor the Plan of Safe Care.	1
Grand Total			**82**

FINAL REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			1
	Prosecution/ Pleas/ Sentence		1
		The State's recommendation of 2 years and no presentence investigation for the Child Abuse 1st conviction was inappropriate. However, the recommendation may have been impacted by COVID.	1
Risk Assessment/ Caseloads			1
	Caseloads		1
		The DFS caseworker was over the investigation caseload statutory standards the entire time the subsequent case was open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	1
Grand Total			**2**

TOTAL FINDINGS **84**