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EXECUTIVE DIRECTOR

August 17, 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 28 cases at its August 17, 2022 meeting.[1]

So far in 2022, there have been 63 near deaths and 6 deaths. There were 38 cases between May and July of 2022 alone and another 8 cases have been received so far in August. These cases are not yet captured in the reviews but demonstrate the significant increases in these most serious child abuse cases. There were 70 cases in 2021 which was a 35% increase over 2020. 2022 is on track to far surpass 2021. 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 and traumatic.

With respect to the 28 cases that were approved by CPAC today, the cases are broken into two sections – cases that received a final review after completion of prosecution

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[1] 16 Del. C. § 932.

and cases that were reviewed for the first time. There are twelve cases that received a final review. There were two deaths and 10 near deaths which all occurred in 2020 and 2021. The victims in these cases were one month through four years of age. Four of the cases had no charges and the investigation was closed. The remaining eight cases had criminal convictions. One case with abusive head trauma and bone fractures resulted in an Assault 2nd conviction and 1.3 years of incarceration. The other seven cases that involved abusive head trauma, skull and bone fractures, gunshot wounds, brain bleeds and drug ingestions resulted in Level II and III probation for a year. There were four findings made at these final reviews.

The sixteen remaining cases were from deaths or near deaths that occurred between August and November of 2021. Of these cases, seven will have no further review as there are no criminal charges – five are poisoning via drug ingestion. Of the remaining nine cases, six have pending charges and the other three are still under criminal investigation. Three of these cases are child torture, and four are poisoning via drug ingestion. These sixteen cases resulted in 44 strengths and 50 current findings across system areas.

For these cases which again occurred between August and November of 2021, 21 strengths and 14 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. Delayed or lack of reporting to the report line was also noted. CPAC continues to work with individual law enforcement agencies on these complex cases, incorporating evidentiary blood draws and CPAC's torture checklist into coaching and training.

The medical response had 6 strengths together with 17 findings. Thirteen 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 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.

As noted last quarter, 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. In this quarter, 17 strengths and 19 findings were

noted. Nine of those findings were regarding high caseloads. The remaining eleven findings are the fewest findings in several years and were primarily regarding child safety. DFS coaching and training of supervisors as well as staff has had a positive impact.

In conclusion, the number, complexity and severity of child abuse and neglect cases continue to increase. The multidisciplinary team has increased its expertise and responses to these cases, but opportunities for improvement are still present. 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

Findings Summary

AUGUST 17, 2022

INITIAL REVIEWS

	*Current	Grand Total
MDT Response	**14**	**14**
Communication	1	1
Crime Scene	5	5
General - Civil Investigation	1	1
General - Criminal Investigation / Civil Investigation	1	1
Interviews - Adult	2	2
Interviews - Child	1	1
Reporting	3	3
Medical	**17**	**17**
Medical Exam/ Standard of Care - ED	3	3
Reporting	13	13
Transport	1	1
Risk Assessment/ Caseloads	**11**	**11**
Caseloads	9	9
Risk Assessment - Alternative Response	1	1
Screen Out	1	1
Safety/ Use of History/ Supervisory Oversight	**4**	**4**
Safety - Completed Incorrectly/ Late	1	1
Safety - Inappropriate Parent/ Relative Component	3	3
Unresolved Risk	**4**	**4**
Child Risk Factors	2	2
Parental Risk Factors	1	1
Substance-Exposed Infant	1	1
Grand Total	**50**	**50**

FINAL REVIEWS

	*Current	Grand Total
Legal	**1**	**1**
Court Hearings/ Process	1	1
MDT Response	**2**	**2**
Communication	1	1
Interviews - Child	1	1
Risk Assessment/ Caseloads	**1**	**1**
Caseloads	1	1
Grand Total	**4**	**4**

TOTAL CAN PANEL FINDINGS **54**

*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

AUGUST 17, 2022

INITIALS REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			14
	Communication		1
		During the near death investigation, the law enforcement agency disengaged with the MDT, and stopped communicating updates on the criminal investigation.	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.	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 or adult caregivers after the child ingested a controlled substance.	1
		The law enforcement agency did not complete an evidentiary blood draw on the children after the children ingested a controlled substance.	1
		No scene investigation was completed by the law enforcement agency for the child on child sexual abuse allegations. As a result, the scene was not photographed and no evidence was collected.	1
	General - Civil Investigation		1
		During the near death investigation, the sibling reported that he was hit with an object and pointed to a body part; however, the DFS caseworker did not observe the child for any potential physical injuries.	1
	General - Criminal Investigation / Civil Investigation		1
		There was not an initial MDT response to the near death incident in compliance with the MOU and statute. Detectives were not assigned to the case, and as a result, there was not an evidentiary blood draw for the child, scene investigation or timely report to DFS.	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, the mother reported that the child was cared for by a babysitter on the date of the incident; however, no information was obtained regarding that individual.	1
	Interviews - Child		1
		The father, who was not ruled out as a suspect, was permitted to transport the child to the forensic interview.	1
	Reporting		3
		MDT communication was poor during the joint investigation. As a result, DFS had minimal knowledge of case details that were known by other MDT partners.	1
		The MDT did not make a report to the DFS Report Line after the sibling made a disclosure during the forensic interview.	1
		Multiple professionals had contact with the family and did not recognize the signs of child torture due to the history provided by the parents and the lack of disclosure by the children.	1
Medical			17
	Medical Exam/ Standard of Care - ED		3
		The treating hospital did not initially complete a urine drug screen for the young child. As a result, the child had to return to the ED for a UDS.	2
		The emergency department physician at the children's hospital attempted to pressure the DFS caseworker into allowing contact between the victim and a non-related caregiver, who was not ruled out as a suspect.	1
	Reporting		13
		The treating hospital delayed reporting the near death incident to DFS Report Line until the CARE team was consulted.	1
		The treating hospital delayed reporting the near death incident to the DFS Report Line until the CARE team was consulted.	2
		The treating hospital failed to make a report to the DFS Report Line once the urine drug screen came back positive for a controlled substance.	2
		The treating hospital delayed reporting the near death incident to DFS Report Line until the CARE team was consulted. The social worker consult was also delayed.	1

Category	Subcategory	Finding	Count
		Multiple professionals had contact with the family and did not recognize the signs of child torture due to the history provided by the parents and the lack of disclosure by the children.	1
		There was no report to the DFS Report Line by the PCP after the PCP documented concerns for failure to thrive and noted that interventions must occur due to pronounced poor growth in weight and height - a sign of very significant poor nutrition. An immediate evaluation in the ED was recommended.	1
		The treating hospital failed to make a report to the DFS Report Line after the child disclosed he must stand all day and food is withheld as punishment during both a telepsychiatry evaluation and in-person assessment.	1
		A mental health facility failed to make a report to the DFS Report Line and instead told the DFS caseworker that the child made statements about not being allowed out of the bedroom, eating only in the bedroom and only being allowed to eat certain foods. The father also disclosed that the child and sibling should be institutionalized and he was thinking of terminating his parental rights.	1
		The treating hospital failed to make a report to the DFS Report Line after the child disclosed that his parents make him wear diapers and put him in the closet. This information was relayed to a crisis worker at a different agency, who made the report and shared additional information about the family.	1
		There was no report to the DFS Report Line by the specialist after the child missed multiple appointments with the oncologist and the family reported their impression of previous visits was to skip oral chemo treatments. The physician also noted concerns of medical neglect with plans of reaching out to DFS.	1
		A hotline report was made on behalf of the doctor alleging child on child sexual abuse. However, the stepmother made the allegations to the doctor, and the doctor was responsible for making the report because of having the direct knowledge.	1
	Transport		1
		The PCP recommended an evaluation at the emergency department and did not send the child with alternative transportation. The infant was presenting with neurological concerns and the mother verbalized that she would not be seeking care immediately.	1
Risk Assessment/ Caseloads			11
	Caseloads		9
		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.	3
		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.	5
		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
	Risk Assessment - Alternative Response		1
		The prior case involving allegations related to the near death was assigned to FAIR (family assessment), and should have been reassigned to investigation following the initial response to the home.	1
	Screen Out		1
		The DFS Report Line screened out a prior hotline report alleging that the child's parents make him wear diapers and put him in the closet. It was concluded that the allegations were vague; however, the intake worker should have asked additional follow up questions.	1
Safety/ Use of History/ Supervisory Oversight			4
	Safety - Completed Incorrectly/ Late		1
		During the prior case, the DFS caseworker did not consider completing a new SDM safety assessment once collateral contacts, home visits and observations of the children revealed potential safety threats.	1
	Safety - Inappropriate Parent/ Relative Component		3
		During the near death incident, the DFS caseworker implemented a safety agreement with the maternal relative to care for the infant and to not allow any contact with the parents. However, the relative should have been ruled out and DFS should have sought custody since the relative was not supportive of the mother and any reunification efforts.	1
		During the case assigned to the contract agency, the worker implemented a safety agreement with a maternal relative; however, the relative should have been ruled out due to reported substance abuse allegations.	1

System Area	Finding	PUBLIC Rationale	Sum of #
		During the near death incident, the DFS caseworker implemented an initial safety agreement with a maternal relative, who had pending criminal charges involving substance use, and these charges were not noted by the caseworker.	1
Unresolved Risk			4
	Child Risk Factors		2
		During the near death investigation, the family did not follow through with any follow up appointments with neurology, and there was no documentation by the DFS caseworker that this was addressed.	1
		During the prior case, the DFS caseworker conducted a home visit and noted that the child could barely walk; however, no medical intervention was recommended. The parents reported that the child was just seen by a doctor, and that he refuses to eat and cannot stand on his own.	1
	Parental Risk Factors		1
		DFS did not evaluate substance abuse issues for the mother by requesting that she complete substance abuse evaluations. Mother admitted to a history of use, and relatives reported concerns of substance abuse.	1
	Substance-Exposed Infant		1
		During the case assigned to the contract agency, a family team meeting was not considered by the worker despite the concerns regarding substance abuse by the parents and the young infant with prenatal substance exposure.	1
Grand Total			**50**

FINAL REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
Legal			1
	Court Hearings/ Process		1
		Lack of coordination between the guardianship and custody proceedings resulted in conflicting Family Court orders for the half-siblings.	1
MDT Response			2
	Communication		1
		During the near death investigation, the law enforcement agency disengaged with the MDT, and stopped communicating updates on the criminal investigation.	1
	Interviews - Child		1
		Forensic interviews did not occur with the other children residing in the home where the incident occurred.	1
Risk Assessment/ Caseloads			1
	Caseloads		1
		The DFS caseworker was over the treatment caseload statutory standards for a portion of time while the case was open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	1
Grand Total			**4**

TOTAL FINDINGS **54**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

AUGUST 17, 2022

INITIAL REVIEWS

	*Current	Grand Total
MDT Response	**21**	**21**
General - Civil Investigation	4	4
General - Criminal Investigation	2	2
General - Criminal/Civil Investigation	10	10
Interviews - Child	2	2
Reporting	3	3
Medical	**6**	**6**
Documentation / Reporting	2	2
Medical Exam/Standard of Care - Birth	1	1
Medical Exam/Standard of Care - ED	2	2
Reporting	1	1
Risk Assessment/ Caseloads	**4**	**4**
Caseloads	1	1
Collaterals	2	2
Risk Assessment - Opened Despite Risk Level	1	1
Safety/ Use of History/ Supervisory Oversight	**6**	**6**
Completed Correctly/On Time	6	6
Unresolved Risk	**7**	**7**
Child Risk Factors	2	2
Legal Guardian	3	3
Parental Risk Factors	2	2
Grand Total	**44**	**44**

TOTAL CAN PANEL STRENGTHS 44

*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
AUGUST 17, 2022

INITIAL REVIEWS

System Area	Strength	Rationale	Count of #
MDT Response			21
	General - Civil Investigation		4
		The DFS caseworker advocated for the children to be medically evaluated by the children's hospital despite the initial treating hospital determining they were cleared for medical discharge.	1
		The DFS caseworker advocated for a scene investigation and evidentiary blood draws to be completed by the law enforcement agency.	1
		During the previous investigation, the DFS caseworker made several attempts to locate and communicate with Mother.	2
	General - Criminal Investigation		2
		During the criminal investigation relating to the sexual abuse allegations, the DOJ requested an external review of the children's medical records by the CARE Team.	2
	General - Criminal/Civil Investigation		10
		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, the neighborhood park, and the home; joint interviews with the parents; a child safety agreement; 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 joint responses to the hospital and the home, joint interviews with the parents and other relatives, a child safety agreement, a forensic interview of the child, and consistent communication among the MDT	2
		There was a good MDT response to the death investigation, which included a joint response to the hospital and information sharing between	1
		There was a good MDT response to the near death investigation, which included a joint response to the hospital, a joint interview with Mother, a child safety agreement for the child and siblings, medical evaluation and forensic interviews of the younger sibling, and consistent communication among the MDT members.	1
		There was a good MDT response to the death investigation, which included a joint response to the home, joint interviews of the parents and other relatives, child safety agreements for the minor children in the home, medical evaluations of the minor children in the home, forensic interviews of the half-sibling of which the father had weekend visitation, and consistent communication among the MDT members.	1
		There was an excellent MDT response to the near death investigation, which included joint responses to the home, joint interviews with the parents, a child safety agreement for the other children in the home, and consistent communication and collaboration among the MDT members, to include the Child Attorney.	2
		There was a good MDT response to the investigation, which included a joint response to the home, joint interviews with the parents and other witnesses, custody of the half-siblings, forensic interview of the older half-sibling, and consistent communication among the MDT members, to	1
	Interviews - Child		2
		The forensic interviewer recognized the indicators of child torture victimization and followed up with appropriate questions to gain sufficient information to corroborate the suspected abuse of the children.	2
	Reporting		3
		The law enforcement agency made an immediate referral to the DFS Report Line reporting the death of an infant.	1
		For the near death investigation, the IC Case Review Specialist advocated for the case to be accepted for investigation by the Serious Injury/Sexual Abuse Unit despite it initially being screened out by the hotline.	2

Child Protection Accountability Commission
Child Abuse and Neglect Panel
Strengths Detail
AUGUST 17, 2022

Category	Subcategory	Detail	Count
Medical			6
	Documentation / Reporting		2
		The child abuse medical expert completed medical record reviews for the children and reviewed home video footage provided by law enforcement. As a result, the physician advocated for civil and criminal investigations to be conducted.	2
	Medical Exam/ Standard of Care - ED		2
		The treating hospital ensured confirmatory testing was completed when the initial drug screens returned positive for fentanyl.	2
	Medical Exam/Standard of Care - Birth		1
		During the previous investigation, a plan of safe care meeting was held prior to medical discharge of the child. The child's primary care physician was included in the Plan of Safe Care.	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
Risk Assessment/ Caseloads			4
	Caseloads		1
		The DFS caseworker conducted a good investigation despite being significantly over the caseload statutory standards.	1
	Collaterals		2
		During the previous investigation, strong collaterals were completed by the DFS caseworker. The contacts included the children's medical providers, the child's school, and the contract agency's caseworker.	2
	Risk Assessment - Opened Despite Risk Level		1
		Despite the relatives filing for guardianship, the investigation case was transferred to treatment as the parents requested reunification.	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.	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.	2
		The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. The agreement included the half-siblings residing outside of the home. There was consistent review and modification, when necessary, of the safety agreement.	1
		The DFS caseworker immediately implemented child safety agreements for the minor children residing in the home. The agreement also included the half-sibling who had weekend visitation in the home. There was consistent review and modification, when necessary, of the safety	1
		The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. The caseworker did not modify the agreement despite requests from the attending physician and other family members.	1
Unresolved Risk			7
	Child Risk Factors		2
		During the previous investigation, the DFS caseworker conducted a subsequent interview with the child at the school outside the presence of the legal guardians.	2
	Legal Guardian		3
		When an appropriate safety agreement could not be reached, DFS sought custody of the children.	2
		The DFS caseworker petitioned for custody of the half-siblings following the death of the child.	1

Child Protection Accountability Commission
Child Abuse and Neglect Panel
Strengths Detail
AUGUST 17, 2022

Parental Risk Factors		2
	During the previous investigation, the DFS caseworker educated the parents on infant safe sleep practices and the education was repeated during each home visit.	1
	During the previous investigation, Mother's mental health was assessed on multiple occasions by various professionals.	1
Grand Total		**44**

TOTAL CAN PANEL STRENGTHS **44**