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EXECUTIVE DIRECTOR

November 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 28 cases at its November 16, 2022 meeting.[1]

So far in 2022, there have been 84 near deaths and 12 deaths. There were 29 cases between August and September of 2022 and another 12 cases have been received in October. These cases are not yet captured in the reviews but demonstrate the significant increases in these most serious child abuse cases. There were 71 cases in 2021 which was a 37% increase over 2020. 2022 will 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

[1] 16 Del. C. § 932.

and cases that were reviewed for the first time. There are eleven cases that received a final review. There were two deaths and 9 near deaths all which occurred in 2020 and 2021 except for a 2018 death that resulted in a manslaughter conviction. The victims in these cases were two weeks through two years of age. Four of the cases had no charges and the investigation was closed. Those cases were bone fractures and poisoning via drug ingestion. The remaining seven cases had criminal convictions. One death case with abusive abdominal injuries was charged as Murder by Abuse or Neglect 1st and resulted in a plea to manslaughter with a sentence of 10 years at Level V. The current good time release is 8 years. The other seven cases that involved bone fractures, unsafe sleep, and drug ingestions resulted in probation for a year. There were five findings made at these final reviews.

The seventeen remaining cases were from deaths or near deaths that occurred between August of 2021 and April of 2022. Of these cases, eleven will have no further review and ten had no criminal charges – five are poisoning via drug ingestion. Of the remaining six cases, two have pending charges and four are still under criminal investigation. Two of these cases are abusive head trauma, one is torture, one is abusive abdominal injuries and bone fractures, and one is fentanyl poisoning via drug ingestion. The final case is multiple rib fractures. These seventeen cases resulted in 35 strengths and 47 current findings across system areas.

For these seventeen cases, 16 strengths and 16 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. For this quarter, a trend was seen in law enforcement either not complying with the MOU for an initial MDT response or not following the MOU as the investigation unfolded. The MDT Policy and Training Administrator and the Office of the Investigation Coordinator are working with the individual jurisdictions to provide coaching and training.

The medical response had 10 strengths together with 10 findings. Half of these findings surround the failure to report or delayed reporting of child abuse and neglect by medical providers. CPAC's new and improved training for medical providers will be unveiled in January of 2023 and will incorporate specific examples gleaned from the review of these most serious cases.

The Division of Family Services (DFS) continues to be a national leader in child safety; however, it also shares national challenges with recruitment and retention of

frontline workers. In this quarter, 9 strengths and 21 findings were noted regarding DFS. Twelve of those findings were regarding high caseloads. The remaining nine findings were primarily regarding child safety. These numbers continue to be an all-time low for DFS despite the high caseloads. The steps DFS is taking to support staff and supervisors continues to demonstrate positive results in the response system.

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

NOVEMBER 16, 2022

INITIAL REVIEWS

	*Current	Prior	Grand Total
MDT Response	**16**	**0**	**16**
Crime Scene	4	0	4
General - Criminal Investigation	1	0	1
General - Criminal Investigation / Civil Investigation	4	0	4
Interviews - Adult	2	0	2
Interviews - Child	2	0	2
Medical Exam	2	0	2
Reporting	1	0	1
Medical	**10**	**1**	**11**
Medical Exam/ Standard of Care - ED	3	0	3
Medical Exam/ Standard of Care - PCP	1	0	1
Reporting	6	1	7
Risk Assessment/ Caseloads	**15**	**0**	**15**
Caseloads	12	0	12
Risk Assessment - Screen Out	2	0	2
Risk Assessment - Tools	1	0	1
Safety/ Use of History/ Supervisory Oversight	**5**	**0**	**5**
Safety - Completed Incorrectly/ Late	5	0	5
Unresolved Risk	**1**	**0**	**1**
Substance-Exposed Infant	1	0	1
Grand Total	**47**	**1**	**48**

FINAL REVIEWS

	*Current	Grand Total
MDT Response	**1**	**1**
General - Criminal Investigation	1	1
Risk Assessment/ Caseloads	**3**	**3**
Caseloads	2	2
Risk Assessment - Closed Despite Risk Level	1	1
Unresolved Risk	**1**	**1**
Legal Guardian	1	1
Grand Total	**5**	**5**

TOTAL CAN PANEL FINDINGS **53**

*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 16, 2022

INITIALS REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			16
	Crime Scene		4
		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.	1
	General - Criminal Investigation		1
		It was unclear whether the babysitter was considered a suspect by the law enforcement agency.	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 initially declined to assign detectives, and as a result, there was not an evidentiary blood draw for the child.	1
		There was not an initial MDT response to the death incident in compliance with the MOU and statute. Law Enforcement interviews occurred without DFS present.	1
		There was not an initial MDT response to the near death incident in compliance with the MOU and statute. Law enforcement initially declined to respond. Patrol did eventually respond, but DFS was not notified or aware.	1
		There was not an initial MDT response to the near death incident in compliance with the MOU and statute. Law enforcement declined to respond and stated the response would be on a later date.	1
	Interviews - Adult		2
		Interviews did not occur with the other adults in the home where the near death incident occurred.	1
		DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews. DFS also contacted the detective prior to the interviews and asked to be present.	1
	Interviews - Child		2
		The mother, who was a suspect, transported the sibling to the forensic interview; however, the MDT should have made arrangements for another caregiver to transport.	1
		The mother, who was a suspect, transported the child and siblings to the forensic interview; however, the MDT should have made arrangements for another caregiver to transport.	1
	Medical Exam		2
		The other child who was present in the home during the near death incident was not medically evaluated.	1
		There is not sufficient education and training related to the identification of Medical Child Abuse. There was some confusion by the MDT regarding the difference between medical neglect versus medical child abuse, which may have impacted some initial steps.	1
	Reporting		1
		In the subsequent case, the DFS caseworker delayed reporting to the law enforcement agency.	1
Medical			11
	Medical Exam/ Standard of Care - ED		3
		The child was discharged without a full CARE team assessment and evaluation.	2
		The treating hospital did not follow through with the recommendations from the children's hospital. It was recommended that the child be transferred; however, the child's symptoms resolved, and the child was discharged home for follow up with the PCP and outpatient neurology. The child presented back to the emergency department the next day, and the findings were later determined to be consistent with abusive head trauma.	1
	Medical Exam/ Standard of Care - PCP		1
		PCP did not consider a differential diagnosis of Medical Child Abuse despite the concerns by the treating hospital and the multiple missed appointments and concerns over the years. The PCP was also noted to be a barrier to the DFS response by enabling the mother's behavior, dismissing concerns by the MDT and providing the mother and relative with regular updates.	1
	Reporting		7
		The treating hospital delayed reporting the near death incident to DFS Report Line until the CARE team was consulted.	1

	The treating hospital made a report to the DFS Report Line through the online portal instead of making a call to the 1-800 number. A call was required since the young child had a current injury.	1
	The child was born with prenatal substance exposure, and the birth hospital did not notify the DFS Report Line.	1
	The child had multiple ED visits in 2010, and the treating hospital failed to make a report to the DFS Report Line or consult with the CARE team despite indicators of child abuse or neglect.	1
	The treating hospital made a report to the DFS Report Line through the online portal instead of making a call to the 1-800 number. A call was required since an immediate response from DFS was needed.	1
	The treating hospital delayed reporting the near death incident to the DFS Report Line. A report was only made after the confirmation testing was positive, and the child had already been discharged home to the parents.	1
	The parents reported that the physician at the treating hospital called them after discharge to share that a report was made to DFS but the physician was alleged to not be in agreement with the report. As a result of this call, the father reported that he moved the evidence.	1
Risk Assessment/ Caseloads		15
	Caseloads	12
	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. However, it does not appear that the caseload negatively impacted the DFS response to the case.	1
	The DFS caseworker was over the investigation caseload statutory standards during the prior investigation. However, it does not appear that the caseload negatively impacted the DFS response to the case.	1
	The DFS caseworkers were over the investigation 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.	1
	The DFS caseworkers were over the investigation and treatment caseload statutory standards while the cases were open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	2
	The DFS caseworkers were over the investigation and treatment caseload statutory standards while the cases were open. The caseload appears to have had an impact on the outcome of the investigation. However, it does not appear that the caseload negatively impacted the treatment case.	1
	The DFS caseworker was over the investigation caseload statutory standards during the near death investigation. However, it does not appear that the caseload negatively impacted the DFS response to the case.	1
	Risk Assessment - Screen Out	2
	The call to the DFS Report Line by the treating hospital was documented by DFS as a progress note rather than as a new hotline report.	1
	The call to the DFS Report Line by the physician at the treating hospital was initially documented by DFS as a progress note rather than a new report.	1
	Risk Assessment - Tools	1
	During the near death investigation, the SDM Risk Assessment was not completed correctly. Each parent should have had a separate assessment due to their individual households, and the other adults in mother's household were not assessed.	1
Safety/ Use of History/ Supervisory Oversight		5
	Safety - Completed Incorrectly/ Late	5
	During the subsequent case, the caseworker did not complete the SDM Safety Assessment correctly. The assessment was completed on the mother's household rather than the father's household where the injury occurred, and as a result, there was no safety agreement in place preventing the child and sibling from returning home to the father's home during the investigation.	1
	During the near death investigation, the caseworker did not complete the SDM Safety Assessment correctly. No safety threats were identified, despite one or more applicable safety threats, and as a result, there was no safety agreement put in place and a medical evaluation was not indicated for the sibling.	1
	During the near death investigation, the caseworker did not complete the SDM Safety Assessment correctly. The parents were rated on the same assessment, but they reside separately and should have had separate assessments due to their individual households.	1
	The DFS caseworker delayed implementing a safety agreement for the child until after the Team Decision Making Meeting was held.	1
	During the near death investigation, no safety agreement was completed to address the sibling's safety. The caseworker only noted that supervision was needed between the victim and parent.	1
Unresolved Risk		1

	Substance-Exposed Infant		1
		In the prior investigation, there was no documentation that the DFS caseworker provided the Plan of Safe Care to the PCP. In addition, the monitoring of the Plan of Safe Care by the caseworker could have been more robust. The infant had several missed appointments with the PCP, and the mother was not responding to the caseworker to set up visits and moved without notifying DFS.	1
Grand Total			**48**

FINAL REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			1
	General - Criminal Investigation		1
		The law enforcement agency has limited resources and few investigators, which delayed the criminal investigation and impacted the prosecution.	1
Risk Assessment/ Caseloads			3
	Caseloads		2
		The DFS caseworker was over the investigation caseload statutory standards while the case was open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	1
		For the subsequent investigation, 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
	Risk Assessment - Closed Despite Risk Level		1
		The SDM Risk Assessment identified the risk as high at the conclusion of the death investigation. Ongoing service was recommended; however, the case disposition was overridden to close the investigation and a Framework was not considered.	1
Unresolved Risk			1
	Legal Guardian		1
		A legal guardian was not established for the victim's siblings prior to DFS case closure. The children were in the care of relatives, but guardianship had not been established by the court.	1
Grand Total			**5**

TOTAL FINDINGS **53**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

NOVEMBER 16, 2022

INITIAL REVIEWS

MDT Response	**16**
General - Civil Investigation	3
General - Criminal Investigation	2
General - Criminal/Civil Investigation	8
Interviews - Child	1
Medical Exam	2
Medical	**10**
Communication	1
Communication & Documentation	1
Medical Exam/Standard of Care - Birth	1
Medical Exam/Standard of Care - CARE	4
Medical Exam/Standard of Care - EMS	1
Medical Exam/Standard of Care - Forensics	2
Safety/ Use of History/ Supervisory Oversight	**5**
Completed Correctly/On Time	5
Unresolved Risk	**4**
Child Risk Factors	1
Contacts with Family	1
Parental Risk Factors	2
Grand Total	**35**

TOTAL CAN PANEL STRENGTHS **35**

*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
NOVEMBER 16, 2022

INITIAL REVIEWS

System Area	Strength	Rationale	Count of #
MDT Response			16
	General - Civil Investigation		3
		Upon discovery of the safety agreement violations, the DFS caseworker immediately sought custody of the children.	1
		The DFS caseworker ensured Mother obtained a lockbox to store her prescription medications.	1
		DFS created an enhancement in their data system, whereby child drug ingestion cases can more easily be identified on the intake report, thus ensuring more timely and accurate notification to the Investigation Coordinator's office.	1
	General - Criminal Investigation		2
		Despite law enforcement's initial response, the Criminal Investigations Unit assigned a detective to the case and a thorough criminal investigation was completed, which included joint responses to the parents' homes, joint interviews of the parents, and a scene investigation.	1
		The law enforcement detective sought expert consultation to rule out accidental overdose through breastfeeding.	1
	General - Criminal/Civil Investigation		8
		There was a good MDT response to the near death investigation, which included joint responses to the hospital and to the home, joint interviews of the parents and other caregivers, safety assessment of all potential caregivers, a child safety agreement, medical evaluation and forensic interview of the sibling, and consistent communication among the MDT members.	1
		The DFS supervisor advocated for law enforcement involvement although there were no clear criminal allegations identified at the time of response.	1
		There was a good MDT response to the death investigation, which included joint responses to the hospital and to the home, joint interviews of Mother and other relatives, a child safety agreement, medical evaluations of the siblings, forensic interview of the older 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 of the caregivers, medical evaluations of the siblings, and forensic interview of the older sibling.	1
		There was a good MDT response to the near death investigation, which included responses to the hospital and the home, interviews of the parents and other caregivers, child safety agreements, medical updates, 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 of the parents, a child safety agreement, 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 home and the hospital, joint interviews of the parents, DFS custody of the child and siblings residing in the home, and medical evaluations and forensic interviews of the siblings.	1
		The MDT recognized the indicators of child torture victimization and identified the case as such early in the investigation.	1
	Interviews - Child		1
		A forensic interview was conducted with the young sibling who was present in the home at the time of the child's death. When the initial interview was unsuccessful, the MDT members made subsequent attempts to have the child re-interviewed.	1
	Medical Exam		2
		The MDT ensured the child's sibling was medically evaluated quickly.	1
		The DFS caseworker ensured the child's siblings were medically evaluated and arranged transportation for such.	1
Medical			10
	Communication		1
		There was good communication and collaboration between the two children's hospitals regarding child safety concerns, with continued implementation of safety planning during the subsequent admission.	1

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

	Communication & Documentation	1
	The hospital social worker and the CARE Team social worker went above and beyond with consistent communication with the MDT members regarding the child's medical condition, and thorough documentation of the child's medical history, identifying any discrepancies between Mother's reports and the medical findings.	1
	Medical Exam/ Standard of Care - CARE	4
	A comprehensive medical examination was completed for the child.	3
	The CARE Team social worker contacted the Criminal Investigations Unit and advocated for an MDT response by law enforcement.	1
	Medical Exam/ Standard of Care - EMS	1
	Emergency medical services pronounced the death on-scene allowing the investigation to begin there.	1
	Medical Exam/ Standard of Care - Forensics	2
	Despite the child not being a patient at the children's hospital, a chart was created for the child and the post-mortem examination was completed.	1
	The forensic nurse obtained photo documentation of the child's injuries in the emergency department, which allowed the conjunctival hemorrhages to be documented as they had resolved prior to the Ophthalmology examination.	1
	Medical Exam/Standard of Care - Birth	1
	A plan of safe care meeting was held prior to medical discharge of the child.	1
Safety/ Use of History/ Supervisory Oversight		5
	Completed Correctly/On Time	5
	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
	The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. The agreement included the siblings residing in the home. There was consistent review and modification, when necessary, of the safety agreement.	1
	The DFS caseworker advocated for safety of the child despite initial reports of the incident being accidental.	1
	The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized.	1
	The DFS caseworker immediately implemented child safety agreements for the minor children residing in the home. There was consistent review and modification, when necessary, of the safety agreement.	1
Unresolved Risk		4
	Child Risk Factors	1
	DFS sought custody of the child due to the suspicion of medical child abuse despite not having physical evidence of such.	1
	Contacts with Family	1
	In the prior investigation, the DFS caseworker maintained regular, quality contact with the family. At each visit, the caseworker assessed for safety and encouraged the mother to engage in domestic violence services.	1

	Parental Risk Factors	2
	Referrals were made for counseling and domestic violence services for the mother. A referral to an early intervention program was also considered for the child; however, the services were addressed in the hospital setting.	1
	The DFS caseworker immediately identified mental health concerns with the mother, and appropriate referrals were made.	1
Grand Total		**35**

TOTAL CAN PANEL STRENGTHS **35**