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**CHILD PROTECTION ACCOUNTABILITY COMMISSION**
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EXECUTIVE DIRECTOR

February 15, 2023

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 15, 2023 meeting.[1]

In 2022, there were a total of 80 cases - 65 near deaths and 15 deaths. This number was 70 in 2021, 52 in 2020 and 42 in 2019. In the last year, there was a 14% increase in cases with a 90% increase since 2019. The increases are primarily in poisoning via drug ingestion cases that resulted in a near death event. In 2022, there were 40 poisoning via drug ingestions and 2 child torture cases. The workload 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.

With respect to the 20 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 five cases that received a final review. There were three deaths and two near deaths which occurred between 2019 and 2021. Three of the cases had no charges and the investigation was closed. One case had a misdemeanor charge that was dropped. The defendant in the 2019 case was found guilty of first degree Murder by Abuse or Neglect for blunt force trauma to a three year old. There was a presentence investigation conducted in the case and the Superior Court sentenced the defendant to 30 years at Level V. This outcome was significant for our child victims of crime, and a testament to the hard work of Delaware's multidisciplinary team.

The fifteen remaining cases were from deaths or near deaths that occurred between March and May of 2022. Of these cases, seven will have no further review and none had criminal charges – five are poisoning via drug ingestion. The drugs include fentanyl, xylazine, clonidine and marijuana edibles. There was also a case with bone fractures. The remaining eight cases, which will remain open, include four poisonings via drug ingestion, abusive head trauma, bone fractures and suffocation. These fifteen cases resulted in 32 strengths and 44 current findings across system areas.

For these fifteen cases, 15 strengths and 11 findings were noted for the Multidisciplinary Team Response. No substantive trends in the findings exist this quarter. Eight strengths were documented where the multidisciplinary team conducted good compliance with the MOU, excellent investigations, consistent communication and good multidisciplinary response to the child abuse case. With the volume and complexity of these cases, these strengths by the team must be celebrated. CPAC has also convened a Drug Ingestion Workgroup and applied for a grant with the Department of Justice to support a public education campaign to promote safe drug storage and raise awareness for pediatric poisoning via drug ingestion.

The medical response had 8 strengths together with 5 findings. CPAC's new and improved training for medical providers was released this month. It has received substantive positive feedback thus far, and should positively impact the reporting of child abuse cases by physicians. The workgroup that assisted in development of the training will be considering advanced medical trainings, expansion of trainings to medical providers beyond the Board of Medical Licensure and Discipline, and the delivery of trainings in a variety of forums.

In this quarter, 9 strengths and 27 findings were noted regarding the Division of Family Services ("DFS"). Eleven of those findings were regarding high caseloads.

The remaining sixteen findings were primarily regarding child safety and contacts with the family. Vacancy rates statewide for DFS investigation positions are 28% with New Castle County at 45%. These rates pose a significant risk to child safety. CPAC requests that the Governor and General Assembly provide the needed resources, including competitive salaries, to support DFS in recruiting and retaining front line child welfare workers, as well as support Senate Bill 33.

The number, complexity and severity of child abuse cases continue to increase. The multidisciplinary team has increased its expertise and responses to these cases which is demonstrated in the strengths. 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 to answer any further questions you may have. Finally, CPAC, and its community partners, will be launching its annual Child Abuse Prevention Month campaign in April to educate the community on preventing and reporting child abuse and neglect. CPAC welcomes all partnerships to this critical campaign.

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**

**FEBRUARY 15, 2023**

## INITIAL REVIEWS

| | *Current | Grand Total |
|---|---|---|
| **Legal** | **1** | **1** |
| Court Hearings/ Process | 1 | 1 |
| **MDT Response** | **11** | **11** |
| Crime Scene | 4 | 4 |
| General - Civil Investigation | 1 | 1 |
| General - Criminal Investigation / Civil Investigation | 2 | 2 |
| Medical Exam | 3 | 3 |
| Reporting | 1 | 1 |
| **Medical** | **5** | **5** |
| Laws/Regulations/Policies/Contracts | 1 | 1 |
| Medical Exam/ Standard of Care - Birth | 1 | 1 |
| Medical Exam/ Standard of Care - ED | 1 | 1 |
| Reporting | 2 | 2 |
| **Risk Assessment/ Caseloads** | **15** | **15** |
| Caseloads | 11 | 11 |
| Collaterals | 3 | 3 |
| Risk Assessment - Closed Despite Risk Level | 1 | 1 |
| **Safety/ Use of History/ Supervisory Oversight** | **7** | **7** |
| Safety - Completed Incorrectly/ Late | 3 | 3 |
| Safety - Inappropriate Parent/ Relative Component | 1 | 1 |
| Safety - Oversight of Agreement | 2 | 2 |
| Safety - Violations of Safety Agreements | 1 | 1 |
| **Unresolved Risk** | **5** | **5** |
| Contacts with Family | 5 | 5 |
| **Grand Total** | **44** | **44** |

**TOTAL CAN PANEL FINDINGS** **44**

*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**

**FEBRUARY 15, 2023**

## INITIALS REVIEWS

| System Area | Finding | PUBLIC Rationale | Sum of # |
|---|---|---|---|
| Legal | | | 1 |
| | Court Hearings/ Process | | 1 |
| | | The OCA Child Attorney and CASA were not informed of the child's placement with a relative prior to placement. | 1 |
| MDT Response | | | 11 |
| | 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. | 1 |
| | | The law enforcement agency did not complete an evidentiary blood draw on the child after the child ingested a controlled substance. | 3 |
| | General - Civil Investigation | | 1 |
| | | During the near death investigation, the DFS caseworker was not able to fully complete the initial response, which included the safety assessment and agreement, due to staffing shortages. As a result, the siblings were held over in the emergency department waiting for a dayshift worker. | 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 declined to respond and stated the response would be on a later date. | 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 as the incident did not appear criminal in nature. | 1 |
| | Medical Exam | | 3 |
| | | The mother, who was a suspect, transported the child to the treating hospital; however, the DFS caseworker should have made arrangements for transportation. | 1 |
| | | The DFS caseworker relied on a relative to seek a medical exam for her child; however, the DFS caseworker or law enforcement agency should have made arrangements since the young child was present in the home where a drug ingestion/poisoning occurred. | 1 |
| | | The other child who was present in the home during the near death incident was medically evaluated by the PCP instead of the hospital emergency department. | 1 |
| | Reporting | | 1 |
| | | During the near death investigation, the DFS caseworker delayed reporting to the law enforcement agency. | 1 |
| Medical | | | 5 |
| | Laws/Regulations/Policies/Contracts | | 1 |
| | | In the prior investigation, the protocols at the mental health facility impacted the timeliness of the initial interview with the child. | 1 |
| | Medical Exam/ Standard of Care - Birth | | 1 |
| | | Abusive Head Trauma/Shaken Baby Syndrome and infant safe sleep education were not documented within the medical records. | 1 |
| | Medical Exam/ Standard of Care - ED | | 1 |
| | | The treating hospital did not consider a differential diagnosis of drug ingestion/poisoning despite the young child presenting with an altered mental status. As a result, a urine drug screen was not completed. | 1 |
| | Reporting | | 2 |
| | | The treating hospital delayed reporting the near death incident to the DFS Report Line. A report was only made after social work was consulted, and the social worker made the report. | 2 |
| Risk Assessment/ Caseloads | | | 15 |
| | 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. | 1 |

| | | |
|---|---|---|
| | 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. | 4 |
| | 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 |
| | 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 treatment case. However, it does not appear that the caseload negatively impacted the outcome of the investigations. | 1 |
| | The DFS caseworkers were over the investigation and treatment caseload statutory standards the entire time the cases were open. However, it does not appear that the caseloads negatively impacted the DFS response to the cases. | 1 |
| | The DFS caseworker was over the treatment 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 |
| | 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 communication during the investigation and the timeliness of documentation in the treatment case. | 1 |
| | The DFS caseworkers were over the investigation and treatment caseload statutory standards during the prior investigation and treatment cases. The caseloads appear to have had an impact on the DFS response to the investigation and to the timeliness of documentation in the treatment case. | 1 |
| | Collaterals | 3 |
| | During the near death investigation, a collateral contact was not completed with non-professional sources close to the family. | 1 |
| | During the near death investigation, there was no documentation that collaterals were completed with medical providers. | 1 |
| | The DFS treatment caseworker has not reached out to the mother's substance abuse treatment provider to get any updates. | 1 |
| | Risk Assessment - Closed Despite Risk Level | 1 |
| | The SDM Risk Assessment identified the risk as high at the conclusion of the near death investigation. Ongoing service was recommended; however, the case disposition was overridden to close the investigation and a valid reason was not documented. The family could have benefited from services. | 1 |
| Safety/ Use of History/ Supervisory Oversight | | 7 |
| | Safety - Completed Incorrectly/ Late | 3 |
| | During the near death investigation, the DFS caseworker did not include the father in developing the safety agreement. | 1 |
| | During the near death investigation, the caseworker did not complete the SDM Safety Assessment correctly. The assessment was completed on the relative's household rather than the parent's household. It resulted in a safety agreement when one was not necessary. | 1 |
| | During the near death investigation, the safety agreement was amended to allow the relatives caregivers to supervise the mother's contact; however, there was no documentation that the DFS caseworker talked to the second relative caregiver. | 1 |
| | Safety - Inappropriate Parent/ Relative Component | 1 |
| | During the treatment case, a hotline report alleged substance abuse by the relative caregiver, and the DFS treatment worker continued the safety agreement with the relative to supervise the mother's contact without a thorough assessment. | 1 |
| | Safety - Oversight of Agreement | 2 |
| | The DFS treatment caseworker allowed the safety agreement to lapse, which led to the mother taking the child to a medical appointment unaccompanied. Because the agreement had lapsed, DFS did not have a legal basis to pursue custody. | 1 |
| | The Family Service Assistant should not have been tasked with renewing a safety agreement with the family because of the high risk nature of the case and the fact that there was a pending treatment response due. | 1 |
| | Safety - Violations of Safety Agreements | 1 |
| | During the treatment case, the safety agreement was violated by the mother, and it was not adequately addressed by the DFS treatment worker. | 1 |
| Unresolved Risk | | 5 |
| | Contacts with Family | 5 |
| | During the prior investigation, the initial response by the DFS caseworker was late. | 1 |
| | Contact with the family has not been made frequently enough by the DFS treatment caseworker to adequately assess for safety, especially given the high risk nature of the near death incident. | 1 |

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|---|---|---|
| | The report, that was screened in for a treatment response after the near death investigation, has not been addressed by the DFS treatment caseworker. | 1 |
| | When the treatment case was received, the DFS treatment caseworker did not follow the supervisor's very clear written directions. | 1 |
| | The report, that was screened in for a treatment response prior to the near death investigation, received a late response by the treatment worker. | 1 |
| **Grand Total** | | **44** |

**TOTAL FINDINGS** **44**

**Child Protection Accountability Commission**

Child Abuse and Neglect Panel

**Strengths Summary**

**FEBRUARY 15, 2023**

## INITIAL REVIEWS

| | Current |
|---|---|
| **MDT Response** | **15** |
| General - Civil Investigation | 3 |
| General - Criminal Investigation | 3 |
| General - Criminal/Civil Investigation | 5 |
| Medical Exam | 4 |
| **Medical** | **8** |
| Medical Exam/Standard of Care - CARE | 3 |
| Medical Exam/Standard of Care - ED | 5 |
| Reporting | |
| **Risk Assessment/ Caseloads** | **3** |
| Collaterals | 3 |
| **Safety/ Use of History/ Supervisory Oversight** | **5** |
| Completed Correctly/On Time | 5 |
| **Unresolved Risk** | **1** |
| Parental Risk Factors | 1 |
| **Grand Total** | **32** |

**TOTAL CAN PANEL STRENGTHS** **32**

*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 15, 2023**

INITIAL REVIEWS

| System Area | Strength | Rationale | Count of # |
|---|---|---|---|
| MDT Response | | | 15 |
| | General - Civil Investigation | | 3 |
| | | During the first prior investigation, the investigation caseworker consulted with the treatment caseworker to ensure appropriate services were offered to Mother. | 1 |
| | | The DFS treatment supervisor provided very clear written direction to the treatment worker about next steps to be taken when the treatment response was screened in, which included making immediate contact with the children to assess for safety, updating the safety agreement, addressing the children's medical needs, and scheduling a Family Team Meeting to discuss DFS's next steps if medical appointments were not made immediately. | 1 |
| | | The DFS caseworker made a referral to the out of state child protective services agency from which the family resided. There was good communication between the two agencies throughout the investigation. | 1 |
| | General - Criminal Investigation | | 3 |
| | | The law enforcement detective assigned to the case conducted an excellent investigation, which included multiple interviews, the collection of video evidence at the residence and a report of the suspect being a known flight risk, which resulted in criminal charges being filed quickly. | 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 and the DAG. | 1 |
| | | Evidentiary blood draws were completed for the mother and the child. | 1 |
| | General - Criminal/Civil Investigation | | 5 |
| | | There was a good MDT response to the near death investigation, which included a joint response to the hospital, joint interviews of the parents and maternal relatives, medical evaluation and forensic interview of the sibling, and consistent communication among the MDT members, to include the Child Attorney and the Civil DAG. | 1 |
| | | There was a good MDT response to the near death investigation, which included joint responses to the hospitals, joint interviews of the Mother and paramour, shared video evidence, 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 a joint response to the hospital, joint interviews of the parents and paternal relatives, medical evaluation of the sibling, and consistent communication and collaboration among the MDT members. | 1 |
| | | There was good collaboration between the MDT and out of state authorities, to include the child protective services agency and law enforcement. | 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, medical evaluations of the siblings, forensic interviews of the siblings, and consistent communication among the MDT members. | 1 |
| | Medical Exam | | 4 |
| | | The MDT ensured the child's sibling was medically evaluated quickly. | 1 |
| | | Law enforcement ensured the child's sibling was medically evaluated and arranged transportation for such. | 1 |

| | | |
|---|---|---|
| | Despite there being no visible injuries to the child following the initial referral, a medical evaluation was completed for the child, which identified a bone fracture. The child's siblings were also medically evaluated. | 1 |
| | The MDT ensured the child's sibling was medically evaluated. The medical evaluation included drug screens, and transportation was arranged for the sibling and parent. | 1 |
| Medical | | 8 |
| | Medical Exam/ Standard of Care - CARE | 3 |
| | A comprehensive medical examination was completed for the child. | 1 |
| | The admitting medical team consulted with the child's primary care physician to obtain a medical history. | 1 |
| | The children's hospital medical team included drug ingestion as part of the differential diagnosis and a referral was made to the DFS Report Line, although the expanded drug screen resulted after the child was medically discharged. | 1 |
| | Medical Exam/ Standard of Care - ED | 5 |
| | The medical team included drug ingestion as part of the differential diagnosis and a referral was made to the DFS Report Line, although the expanded drug screen resulted after the child was medically discharged. | 1 |
| | A medical evaluation was completed for the child's sibling, and it included a urine drug screen. | 1 |
| | For the near death incident, medical evaluations were completed for the child's siblings, and they included urine drug screens. | 1 |
| | The treating hospital provided the mother with a lockbox for medication and educated the parents on proper storage. | 1 |
| | The medical team included drug ingestion as part of the differential diagnosis and a referral was made to the DFS Report Line. | 1 |
| | Reporting | |
| | The initial treating hospital made an immediate report to the DFS Report Line with concerns surrounding the circumstances of the child's injuries. | |
| Risk Assessment/ Caseloads | | 3 |
| | Collaterals | 3 |
| | During the first prior investigation, the investigation caseworker considered Mother's case history and the collaterals utilized in the previous investigation. | 1 |
| | In the second prior investigation and for the near death investigation, strong collaterals were completed by the DFS caseworker. The contacts included both professional and personal resources. | 1 |
| | For the near death investigation, the DFS caseworker considered Mother's case history and the collaterals utilized in the previous investigation. | 1 |
| Safety/ Use of History/ Supervisory Oversight | | 5 |
| | Completed Correctly/On Time | 5 |
| | 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 immediately implemented a child safety agreement while the child was hospitalized. A separate agreement was implemented for the sibling residing in the home. | 1 |
| | The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. The agreement included the young sibling who resided in the home. 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. The agreement was effective while the family was in-state and upon return to their state of residence. | 1 |
| Unresolved Risk | | 1 |
| | Parental Risk Factors | 1 |

| | | |
|---|---|---|
| | The DFS caseworker provided education to Mother related to infant safe sleeping practices and ways to prevent substance exposure to the child. | 1 |
| **Grand Total** | | **32** |

**TOTAL CAN PANEL STRENGTHS** **32**