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**CHILD PROTECTION ACCOUNTABILITY COMMISSION**
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EXECUTIVE DIRECTOR

May 17, 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 21 cases at its May 17, 2023 meeting.[1]

Thus far in 2023, CPAC has screened in 32 child abuse cases – 4 deaths and 28 near deaths. It also has screened out another 17 serious injury cases which did not meet the criteria of near death. Last year ended with a total of 71 cases to be reviewed, and another 78 serious injury cases screened out. Poisoning via drug ingestions, including fentanyl, continue to be a significant trend in 2023.

With respect to the 21 cases that were approved by CPAC today, the cases are broken into two sections – cases that received a final review after completion of prosecution and cases that were reviewed for the first time. There are ten cases that received a final review. There were two deaths and eight near deaths which occurred between 2019 and 2021. Two of the cases had no charges and the investigation was closed.

[1] 16 Del. C. § 932.

One torture case resulted in a not guilty by reason of insanity. The other cases all resolved with only probation and largely misdemeanor convictions. The cases involved bone fractures, poisoning via drug ingestion (fentanyl and cocaine), and medical neglect. CPAC approved today a package of draft bills to enhance prosecution and sentencing of child torture, child poisoning via drug ingestion and child abuse, and looks forward to their support and passage by the General Assembly.

The eleven remaining cases were from deaths or near deaths that occurred between May and September of 2022. Of these cases, three will have no further review and are all poisoning via drug ingestion. The remaining eight cases – 2 deaths and 6 near deaths - will remain open pending prosecutorial outcomes. These cases include two abusive head trauma (one resulting in death) and four poisonings via drug ingestion (fentanyl, cocaine and PCP). These eleven cases from 2022 resulted in 21 strengths and 49 current findings across system areas.

For these eleven 2022 cases, 13 strengths and 12 findings were noted for the Multidisciplinary Team Response. Nearly all of the strengths focus on excellent responses and best practices by the multidisciplinary team. Findings centered around the poisoning via drug ingestion cases, in terms of securing evidentiary blood draws and medical exams. Advanced multidisciplinary trainings and coaching sessions by OCA's Training and Policy Administrator, a former law enforcement officer, are being delivered statewide to increase competencies around these cases. CPAC has also convened a Drug Ingestion Workgroup. The Workgroup continues to wait to hear if it is a grant recipient of the Opioid Abatement and Remediation Grant Program. If awarded the grant, CPAC seeks to develop and deliver a public education campaign to promote safe drug storage and raise awareness for pediatric poisoning via drug ingestion, particularly around the airborne transmission of fentanyl.

The medical response had 3 strengths together with 9 current findings. CPAC's new and improved training for medical providers received substantive positive feedback while training over 6,000 medical providers and other licensed professionals since January 2023. It is hopeful this training will have a positive impact on child safety. The 9 medical findings this quarter are varied but primarily center on responses to the poisoning via drug ingestion cases. The CPAC workgroup that assisted in development of the Mandatory Reporting Training for Medical Professionals will next develop advanced trainings which may include best practices for the medical response to poisoning via drug ingestion cases.

In this quarter, 5 strengths and 27 findings were noted regarding the Division of Family Services ("DFS"). The findings include appropriate use of safety agreements and risk assessment tools as well as unresolved parent and child risk factors. Vacancy rates statewide for DFS investigation positions continue to be high - 58% Statewide and New Castle County at 65%. These rates may impact the appropriate use of decision-making tools by frontline workers. CPAC once again 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.

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. The CPAC Data Dashboards are also included to provide an overall picture of the volume and complexity of child welfare cases in Delaware. CPAC stands ready as a partner 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**
**MAY 17, 2023**

## INITIAL REVIEWS

| | *Current | Prior | Grand Total |
|---|---|---|---|
| **Education** | **0** | **1** | **1** |
| Laws/Regulations/Policies/Contracts | 0 | 1 | 1 |
| **Legal** | **1** | **0** | **1** |
| Laws/Regulations/Policies/Contracts | 1 | 0 | 1 |
| **MDT Response** | **12** | **0** | **12** |
| Crime Scene | 2 | 0 | 2 |
| General - Criminal Investigation / Civil Investigation | 1 | 0 | 1 |
| Interviews - Adult | 2 | 0 | 2 |
| Medical Exam | 5 | 0 | 5 |
| Reporting | 2 | 0 | 2 |
| **Medical** | **7** | **1** | **8** |
| Medical Exam/ Standard of Care - ED | 2 | 0 | 2 |
| Medical Exam/ Standard of Care - PCP | 2 | 0 | 2 |
| Reporting | 3 | 1 | 4 |
| **Medical** | **2** | **0** | **2** |
| Medical Exam/ Standard of Care - ED | 2 | 0 | 2 |
| **Risk Assessment/ Caseloads** | **12** | **0** | **12** |
| Caseloads | 3 | 0 | 3 |
| Collaterals | 2 | 0 | 2 |
| Risk Assessment - Alternative Response | 1 | 0 | 1 |
| Risk Assessment - Screen Out | 1 | 0 | 1 |
| Risk Assessment - Tools | 5 | 0 | 5 |
| **Safety/ Use of History/ Supervisory Oversight** | **7** | **0** | **7** |
| Safety - Completed Incorrectly/ Late | 3 | 0 | 3 |
| Safety - Inappropriate Parent/ Relative Component | 2 | 0 | 2 |
| Safety - No Safety Assessment of Non-Victims | 1 | 0 | 1 |
| Use of History | 1 | 0 | 1 |
| **Unresolved Risk** | **8** | **3** | **11** |
| Child Risk Factors | 3 | 1 | 4 |
| Contacts with Family | 0 | 2 | 2 |
| Parental Risk Factors | 5 | 0 | 5 |
| **Grand Total** | **49** | **5** | **54** |

## FINAL REVIEWS

| | *Current | Grand Total |
|---|---|---|
| **MDT Response** | **1** | **1** |
| Crime Scene | 1 | 1 |
| **Grand Total** | **1** | **1** |

**TOTAL CAN PANEL FINDINGS** **55**

*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**

**MAY 17, 2023**

## INITIALS REVIEWS

| System Area | Finding | PUBLIC Rationale | Sum of # |
|---|---|---|---|
| Education | | | 1 |
| | Laws/Regulations/Policies/Contracts | | 1 |
| | | Per the Memorandum of Understanding between DOE and DSCYF, the school should not have informed the parents of the allegations in the hotline report. The DFS caseworker was intentionally withholding that information as to not jeopardize the criminal investigation. | 1 |
| Legal | | | 1 |
| | Laws/Regulations/Policies/Contracts | | 1 |
| | | The treatment worker did not consider filing a petition to compel the family's cooperation. The child almost died as a result of medical neglect and the parents became non-compliant and did not follow through with services or child's medical needs. | 1 |
| MDT Response | | | 12 |
| | Crime Scene | | 2 |
| | | 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 sibling after the victim ingested a controlled substance and a blood draw was completed for the victim and another sibling. | 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. Law enforcement initially declined to respond, but patrol did eventually respond. | 1 |
| | Interviews - Adult | | 2 |
| | | During the FAIR case, there was no documentation that the caseworker interviewed the paternal grandparents, who resided in the home, or utilized them as collateral resources. | 2 |
| | Medical Exam | | 5 |
| | | The medical evaluations and urine drug screens for the other children in the home were delayed. | 1 |
| | | The sibling who was present in the home was not medically evaluated. | 1 |

| | | | |
|---|---|---|---|
| | | During the FAIR case, the children were not medically evaluated despite allegations that methamphetamine was being manufactured and dealt out of the home. | 1 |
| | | The siblings and other children present in the home were not medically evaluated. | 1 |
| | | The siblings present in the home were not medically evaluated. | 1 |
| | Reporting | | 2 |
| | | The law enforcement agency did not make a report to the DFS Report Line for the death incident. | 1 |
| | | The MDT did not make a report to the DFS Report Line after the sibling made a disclosure during the forensic interview. | 1 |
| Medical | | | 8 |
| | Medical Exam/ Standard of Care - ED | | 2 |
| | | The treating hospital initially declined to complete a medical exam for the sibling. | 1 |
| | | The treating hospital declined to complete a urine drug screen (UDS) for the young sibling despite the request by the DFS caseworker. The victim had previously tested positive for a controlled substance. | 1 |
| | Medical Exam/ Standard of Care - PCP | | 2 |
| | | An increase in the child's head circumference was documented in the medical record, but there was no documentation by the PCP that it was being monitored or that other diagnostic tests should be considered. | 2 |
| | Reporting | | 4 |
| | | There was no report to the DFS Report Line by the PCP after the PCP documented multiple years of missed care, homelessness and lack of preventative care with dental and weight management. | 1 |
| | | There was no report to the DFS Report Line by the specialist after the child missed multiple appointments with the endocrinologist for monitoring of type 1 diabetes. | 1 |
| | | The treating hospital delayed reporting the near death incident to the DFS Report Line. | 1 |
| | | The early intervention provider delayed reporting concerns with the conditions of the home to the DFS Report Line until after they became aware of the child's death. | 1 |
| Medical | | | 2 |
| | Medical Exam/ Standard of Care - ED | | 2 |
| | | The treating hospital did not consider urine drug screens (UDS) for the siblings. The victim had previously tested positive for a controlled substance. | 1 |

| | | | |
|---|---|---|---|
| | | The treating hospital did not consider a urine drug screen (UDS) for the young sibling. The victim had previously tested positive for a controlled substance. | 1 |
| Risk Assessment/ Caseloads | | | 12 |
| | Caseloads | | 3 |
| | | The caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it is unclear whether the caseload has had a negative impact on the DFS response in 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. | 1 |
| | | The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open, and the caseload appears to have had a negative impact on the DFS response to the case. | 1 |
| | Collaterals | | 2 |
| | | During the near death investigation, updated collaterals were not completed with the mother's medication-assisted treatment provider, which should have included the results of any urine drug screens. | 1 |
| | | During the FAIR case, a collateral contact was not completed to assess the safety of the child in the mother's care. | 1 |
| | Risk Assessment - Alternative Response | | 1 |
| | | The prior case involving allegations related to drug manufacturing was assigned to FAIR (family assessment) and should have been reassigned to investigation following the initial response to the home. There was MDT involvement, possible safety concerns, and minimal compliance by the family. | 1 |
| | Risk Assessment - Screen Out | | 1 |
| | | The call by the treating hospital to the DFS Report Line was written as a hotline progress note rather than a new report. | 1 |
| | Risk Assessment - Tools | | 5 |
| | | In the near death investigation, the SDM Risk Assessment was not completed correctly. The assessment was completed on the wrong household. | 2 |

| | | |
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| | In the near death investigation, the SDM Risk Assessment was not completed correctly. The assessment was rated as abuse rather than neglect, and the policy override was incorrectly applied. | 1 |
| | In the FAIR case, the SDM Risk Assessment was not completed correctly. The assessment was scored lower than it should have been, and as a result, treatment was not considered. | 1 |
| | In the near death investigation, the SDM Risk Assessment was not completed correctly. The policy override was incorrectly applied, but the case was still transferred to treatment. | 1 |
| Safety/ Use of History/ Supervisory Oversight | | 7 |
| | Safety - Completed Incorrectly/ Late | 3 |
| | During the near death investigation, the caseworker did not complete the SDM Safety Assessment correctly. As a result, no safety agreement was implemented, and contact should have been supervised with all parties until they were ruled out as suspects. | 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 prior to discharge from the hospital. | 1 |
| | During the treatment case, the worker was assisting the family with identifying appropriate housing. However, once the family decided to stay in their home, the worker did not reassess whether the physical living conditions were a safety threat. | 1 |
| | Safety - Inappropriate Parent/ Relative Component | 2 |
| | In the prior investigation, the DFS caseworker was uncertain about whether a safety agreement was needed and who was appropriate to participate. This resulted in an initial safety agreement with the mother, who was not ruled out as a suspect. | 1 |
| | During the near death incident, the DFS caseworker implemented a safety agreement with the maternal grandparents, who shared the home with the family during the prior incident involving drug manufacturing and current incident involving the drug ingestion. | 1 |
| | Safety - No Safety Assessment of Non-Victims | 1 |
| | During the near death investigation, the older siblings resided in the home at the time of the incident, and safety was not adequately assessed for these children. | 1 |
| | Use of History | 1 |

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|---|---|---|
| | There is no indication in DFS documentation that the assessment of father as a caregiver, pursuant to the court order, included an evaluation of his DFS and criminal history. Based on father's history, consideration should have been given to requiring a substance abuse evaluation. | 1 |
| Unresolved Risk | | 11 |
| | Child Risk Factors | 4 |
| | There was no documentation that the DFS caseworker referred the victim to an early intervention program. | 1 |
| | During the prior case, the DFS caseworker did not follow up with family to address concerns that the child had several missed appointments with the endocrinologist. | 1 |
| | During the treatment case, the caseworker did not ensure the family followed up with the child's medical, dental or mental health needs or the parents' substance abuse issues. | 1 |
| | During the treatment case, the caseworker did not ensure the family followed up with the child's medical appointments or the mother's substance abuse issues. Mother repeatedly missed appointments for the child and did not follow through with her substance abuse evaluation. | 1 |
| | Contacts with Family | 2 |
| | During the prior investigation, a second hotline report was received and the initial response was delayed. No unannounced home visits or school visits were attempted by the DFS caseworker to meet the assigned priority response time. | 1 |
| | During the prior investigation, there were a few allegations reported against the parents, and the child was moving back and forth between the relative and parent's homes. However, the DFS caseworker did not make earlier attempts to locate and assess the child' safety in the parents' care. | 1 |
| | Parental Risk Factors | 5 |
| | The allegations that the father overdosed while the child was present was not addressed by the caseworkers during the near death investigation or treatment case. | 1 |
| | In the prior investigation, mental health issues were noted for the father, but there was no documentation that the DFS caseworker attempted to assess the issues and the potential impact on child safety. | 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. | 1 |

| | | |
|---|---|---|
| | DFS did not evaluate substance abuse issues for the mother by requesting that she complete a substance abuse evaluation. It was alleged that drugs were being manufactured in the home. | 1 |
| | In the prior FAIR case, DFS did not evaluate substance abuse issues for the father by requesting that he complete a substance abuse evaluation. DFS had prior history with the father involving drug abuse, and he admitted to past use. | 1 |
| **Grand Total** | | **54** |

## FINAL REVIEWS

| System Area | Finding | PUBLIC Rationale | Sum of # |
|---|---|---|---|
| MDT Response | | | 1 |
| | Crime Scene | | 1 |
| | | The SUIDI form was not completed by the forensic investigator or law enforcement agency. | 1 |
| **Grand Total** | | | **1** |

**TOTAL FINDINGS** **55**

**Child Protection Accountability Commission**

Child Abuse and Neglect Panel

**Strengths Summary**

**MAY 17, 2023**

## INITIAL REVIEWS

| | Current |
|---|---|
| **MDT Response** | **13** |
| General - Civil Investigation | 4 |
| General - Criminal Investigation | 2 |
| General - Criminal/Civil Investigation | 6 |
| Medical Exam | 1 |
| **Medical** | **3** |
| Reporting | 3 |
| **Risk Assessment/ Caseloads** | **1** |
| Collaterals | 1 |
| **Safety/ Use of History/ Supervisory Oversight** | **3** |
| Appropriate Parent/Relative Component | 1 |
| Completed Correctly/On Time | 1 |
| Use of History | 1 |
| **Unresolved Risk** | **1** |
| Contacts with Family | 1 |
| **Grand Total** | **21** |

**TOTAL CAN PANEL STRENGTHS** **21**

*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**
**MAY 17, 2023**

INITIAL REVIEWS

| System Area | Strength | Rationale | Count of # |
|---|---|---|---|
| MDT Response | | | 13 |
| | General - Civil Investigation | | 4 |
| | | The DFS caseworker ensured the child's siblings were medically evaluated and arranged transportation for such. | 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 |
| | | During the course of the multiple investigations, there was good collaboration between the investigation and treatment caseworkers. | 1 |
| | | The DFS caseworker educated the family on the use of lock box and proper medication storage. | 1 |
| | General - Criminal Investigation | | 2 |
| | | The law enforcement agency obtained a search warrant for the maternal grandfather's residence and a scene investigation was completed. The search warrant was pursued despite the time lapse between the near death incident and receipt of the results for the child's expanded drug screen. | 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 MDT. | 1 |
| | General - Criminal/Civil Investigation | | 6 |
| | | Following the report of sexual abuse, there was a good MDT response to the investigation, which included a joint response to the home, joint interviews with the child and parents, a child safety agreement, a forensic interview of the child, 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 hospital and to the home, joint interviews with the family members residing in the home, a child safety agreement, and consistent communication and collaboration among the MDT members. | 1 |
| | | In the prior investigation, there was a good MDT response to the near death investigation, which included joint responses to the hospital and to the home, joint interviews with the family members residing in the home, medical evaluations of the children, and consistent communication and collaboration among the MDT members. | 1 |
| | | There was a good MDT response to the death investigation, which included joint responses to the home, joint interviews with the family members, medical evaluations of the siblings, and consistent communication and collaboration 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 hospital and to the home, joint interviews with the parents, medical evaluation of the sibling, and consistent communication and collaboration among the MDT members. | 1 |
| | | There was a good MDT response to the near death investigation, which included joint responses to the hospital and to the home, joint interviews with the family members, a medical evaluation of the sibling, and consistent communication and collaboration among the MDT members. | 1 |
| | Medical Exam | | 1 |
| | | The DFS caseworker requested that a medical evaluation, to include a urine drug screen, be completed for the child's sibling. | 1 |
| Medical | | | 3 |
| | Reporting | | 3 |

| | | |
|---|---|---|
| | The initial treating hospital made an immediate report to the DFS Report Line due to the child's suspected drug ingestion without having a positive urine drug screen. | 1 |
| | The children's hospital radiologist made a report to the DFS Report Line when additional injures were revealed during the post-mortem examination. Additionally, the medical examiner consulted with the radiologist during the autopsy. | 1 |
| | The initial treating hospital made an immediate report to the DFS Report Line with concerns surrounding the circumstances of the child's drug ingestion. | 1 |
| Risk Assessment/ Caseloads | | 1 |
| Collaterals | | 1 |
| | During the near death investigation, strong collaterals were completed by the DFS caseworker. The contacts included both professional and personal resources. | 1 |
| Safety/ Use of History/ Supervisory Oversight | | 3 |
| Appropriate Parent/Relative Component | | 1 |
| | In the near death investigation, the paternal grandparents were ruled out as safety agreement participants based on their presence in the household where the near death incident occurred. A home assessment and thorough background checks were completed for the non-relative safety agreement participants. | 1 |
| Completed Correctly/On Time | | 1 |
| | 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 |
| Use of History | | 1 |
| | During the FAIR case, despite the allegations only relating to domestic violence, the caseworker considered the family's history and required the parents to complete substance abuse evaluations. | 1 |
| Unresolved Risk | | 1 |
| Contacts with Family | | 1 |
| | The DFS treatment caseworker maintained regular, quality contact with the family. | 1 |
| **Grand Total** | | **21** |

**TOTAL CAN PANEL STRENGTHS** **21**