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CHILD PROTECTION ACCOUNTABILITY COMMISSION
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CHAIR

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EXECUTIVE DIRECTOR

November 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 24 cases at its November 15, 2023 meeting.[1]

Thus far in 2023, CPAC has screened in 93 child abuse cases – 8 deaths and 85 near deaths. It also has screened out another 65 serious injury cases which did not meet the criteria of near death.

With respect to the 22 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 three cases that received a final review. There were two deaths and one near death which occurred between January 2019 and July 2021 and which were all prosecuted. The two deaths received probation, and all charges were dismissed in the near death. On July 31, 2023, you signed two bills (HB182 and HB183) to enhance prosecution and sentencing of child

[1] 16 Del. C. § 932.

torture, child poisoning via drug ingestion and child abuse. We look forward to these new laws better holding child abusers accountable for their actions.

The nineteen remaining cases were from deaths or near deaths that occurred between October 2022 and January 2023. Of these cases, five will have no further review – four of them were bone fractures. The remaining fourteen cases – 3 deaths and 11 near deaths - will remain open pending prosecutorial outcomes. These cases include abusive head trauma, fractures and burns, torture, and poisonings via drug ingestion (fentanyl, cocaine and Xylazine). These fourteens cases resulted in 36 strengths and 55 current findings across system areas. This is a significant increase in findings this quarter.

For these October 2022 through January 2023 cases, 15 strengths and 13 findings were noted for the Multidisciplinary Team Response. During this time frame, 42 cases were screened and at least 30 of them were accepted for review. The volume that began at the end of the summer extended. The multidisciplinary teams continued best practices despite the volume. Nearly all of the strengths focus on excellent responses and best practices by the multidisciplinary team. Findings were really spread throughout the investigations with no one area standing out. Drug ingestion cases continue to be challenging. It is hopeful the CPAC public education campaign to promote safe drug storage and raise awareness for pediatric poisoning via drug ingestion, particularly around the airborne transmission of fentanyl, will be unveiled in the coming months.. CPAC will also be holding an advanced training track at the Protecting Delaware's Children Conference in April 2024 to further address child abuse investigations and prosecutions. Finally, CPAC recently held a Joint Retreat with the Maternal and Child Death Review Commission which will have an action plan to further address these case responses.

The medical response had 7 strengths together with 9 current findings. Seven of those findings centered around failing to report child abuse by primary care providers and emergency departments. 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. These findings primarily occurred before the training was taken. CPAC is hopeful these numbers will decrease in the next quarter. 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. Findings will also be shared with the group in the next quarter should they remain high.

In this quarter, 14 strengths and 33 findings were noted regarding the Division of Family Services ("DFS"). Ten of the findings were regarding caseloads over standard. The remaining 23 findings primarily centered around the use of safety agreements. With staff vacancies and turnover, training in this area must be consistent and ongoing. Vacancy rates statewide for DFS investigation positions continue to be high - 52% Statewide and New Castle County Region 2 at 67%. 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

November 15, 2023

INITIAL REVIEWS		
	Current	**Grand Total**
MDT Response	**13**	**13**
Doll Re-enactment	1	1
General - Civil Investigation	2	2
General - Criminal Investigation / Civil Investigation	2	2
Interviews - Child	4	4
Medical Exam	2	2
Reporting	2	2
Medical	**9**	**9**
Medical Exam/ Standard of Care - ED	2	2
Reporting	7	7
Risk Assessment/ Caseloads	**16**	**16**
Caseloads	10	10
Collaterals	1	1
Reporting	3	3
Risk Assessment - Unsubstantiated	1	1
Tools	1	1
Safety/ Use of History/ Supervisory Oversight	**11**	**11**
Safety - Completed Incorrectly/ Late	5	5
Safety - Inappropriate Parent/ Relative Component	3	3
Safety - No Safety Assessment of Non-Victims	1	1
Safety - Oversight of Agreement	1	1
Use of History	1	1
Unresolved Risk	**6**	**6**
Child Risk Factors	1	1
Contacts with Family	1	1
Parental Risk Factors	4	4
Grand Total	**55**	**55**

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

NOVEMBER 15, 2023

INITIAL REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			13
	Doll Re-enactment		1
		A doll re-enactment was not facilitated by the law enforcement agency with the caregivers.	1
	General - Civil Investigation		2
		The DFS caseworker did not initially interview a potential suspect or the siblings in the home.	1
		The DFS response to the initial event was delayed, occurring outside of the appropriate timeframe.	1
	General - Criminal Investigation / Civil Investigation		2
		There was not an MDT response to the initial incident or thoughout the civil and criminal investigations.	1
		There was no scene investigation completed by the law enforcement agency, nor was there a home assessment completed by the DFS caseworker.	1
	Interviews - Child		4
		Forensic interviews did not occur with the other children residing in the home where the incident occurred.	1
		Forensic interview of a child, with whom the potential perpetrator had contact, did not occur.	1
		Forensic interviews did not occur with siblings or other children who reside in the home with the child.	1
		Forensic interviews did not occur with the other children present in the home where the incident occurred.	1
	Medical Exam		2
		During the subsequent investigation in which the sibling child was noted to have minor injuries, the sibling child should have been medically examined rather than the caseworker making the determination the injuries were accidental.	1
		Medical exams of the other children in the home were not completed	1
	Reporting		2
		The DFS hotline worker did not create a new hotline report for the subsequent injury identified during follow-up exam and reported by the treating hospital.	1
		Law enforcement delayed reporting the death event to DFS resulting in the DFS caseworker being unable to observe the initial interview with the alleged perpetrator.	1
Medical			9
	Medical Exam/ Standard of Care - ED		2
		The child's temperature was not initially obtained by the treating hospital and was only obtained upon request of the Medical Examiners, thereby potentially deterring an accurate assessement of time of death.	1
		The child's temperature was not initially obtained by the treating hospital, thereby potentially deterring an accurate assessement of time of death.	1
	Reporting		7
		Bruising observed on the child by the PCP, one month prior to the near death event, was not reported to DFS Report Line.	1
		There was no report to the DFS Report Line by the emergency department after the medically fragile child presented with facial injuries. The mother left with the child prior to receiving medical treatment.	1
		The initial treating hospital failed to report the near death incident to the DFS Report Line.	1
		The initial treating hospital failed to report the supsected abuse event to the DFS Report Line.	1
		The treating hospital failed to report the sibling's positive drug screen to the DFS Report Line.	1
		The child's PCP, who initially observed the child for the injury concerning for abuse, failed to make a report to the DFS Report Line.	1

		The child presented to multiple medical follow-up appointments without the approved safety person accompanying the child and parent, and these safety violations were not reported to the DFS Report Line.	1
Risk Assessment/ Caseloads			16
	Caseloads		10
		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
		For the current and the subsequent investigations, 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.	3
		The DFS caseworker was over 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.	2
		The DFS caseworkers were over investigation and treatment caseload statutory standards the entire time the cases were open, and the caseloads appear to have had a negative impact on the DFS response to the cases.	1
		For the current 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
	Collaterals		1
		The DFS investigation caseworker did not request records from the out-of-state child protective services agency despite the father self-reporting prior involvement.	1
	Reporting		3
		A prior incident involving the child was inappropriately screened at the DFS Report Line.	1
		The DFS Intake worker documented a report from the treating hospital, of additional injury to child, as a progress note to the original hotline report versus a new hotline report.	1
		The DFS intake worker documented the report from law enforcement, regarding the potential neglect situation, as a progress note to the initial hotline report versus a new hotline report, despite receiving new information.	1
	Risk Assessment - Unsubstantiated		1
		A substantiation for abuse should have been considered for the civil case disposition due to factors supporting abuse being identified during the investigation.	1
	Tools		1
		Multiple risk points in the risk assessment tool were not rated correctly, resulting in a lower score than if the tool was completed correctly. The lower score prevented potential treatment measures from being implemented for the family.	1
Safety/ Use of History/ Supervisory Oversight			11
	Safety - Completed Incorrectly/ Late		5
		The child was not included in the safety plan, created for a subsequently reported incident involving child's siblings.	1
		For the treatment case, the child safety agreement did not require appropriate supervision of the mother during her contact with the children.	1
		The child safety agreement was lifted prematurely despite continued concerns in the home related to the alleged perpetrator.	1
		A safety plan was not initially implemented due to the DFS caseworker not recognizing the child's injury as a sentinel injury.	1
		A home assessment was not completed for the safety person, who was alleged to be residing with a relative which was not approved to be a safety option.	1
	Safety - Inappropriate Parent/ Relative Component		3
		The DFS caseworker should have explored other family members as placement options earlier in the investigation.	1
		The amended safety agreement with the father was not valid per DFS policy. DFS should have filed for custody after learning additional safety concerns for the father during the course of the investigation.	1
		A relative, who questioned the need for a safety assessment, was approved as a safety person despite this concern.	1

	Safety - No Safety Assessment of Non-Victims	1
	While the investigation was still open, the mother gave birth and the newborn child's safety was not assessed by the worker.	1
	Safety - Oversight of Agreement	1
	The safety agreement was permitted to lapse without any contact with the family	1
	Use of History	1
	Efforts, beyond the initial request, to obtain out-of-state CPS records were not made.	1
Unresolved Risk		6
	Child Risk Factors	1
	The prior DFS investigation did not provide adequate focus on all factors related to the safety and well-being of the children.	1
	Contacts with Family	1
	The civil investigation stalled resulting in a delay in follow-up contact with the family	1
	Parental Risk Factors	4
	The DFS caseworker did not request that the father complete a substance abuse assessment.	1
	The DFS investigation caseworker did not request the parents to complete substance abuse assessments.	1
	The DFS investigation caseworker did not request the mother to complete a mental health assessment despite having a mental health history.	1
	During the prior investigation, the DFS caseworker did not request the father to complete a substance abuse assessment despite detecting the odor of a substance during a home visit, as well as the father self-reporting usage.	1
Grand Total		**55**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

NOVEMBER 15, 2023

INITIAL REVIEWS

	Current
MDT Response	**15**
Communication	1
General - Civil Investigation	2
General - Criminal Investigation	1
General - Criminal/Civil Investigation	7
Medical Exam	3
Reporting	1
Medical	**7**
Documentation	1
Medical Exam/Standard of Care - CARE	1
Medical Exam/Standard of Care - ED	1
Medical Exam/Standard of Care - PCP	1
Reporting	3
Risk Assessment/ Caseloads	**5**
Collaterals	4
Reporting	1
Safety/ Use of History/ Supervisory Oversight	**7**
Appropriate Parent/Relative Component	1
Completed Correctly/On Time	4
Oversight of Agreement	2
Unresolved Risk	**2**
Parental Risk Factors	2
Grand Total	**36**

TOTAL CAN PANEL STRENGTHS **36**

*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 15, 2023

INITIAL REVIEWS

System Area	Strength	Public Rationale	Count of #
MDT Response			15
	Communication		1
		There was good communication and collaboration between the MDT, the medical team, and the out-of-state hospitals.	1
	General - Civil Investigation		2
		The DFS caseworker worked with the law enforcement agencies in multiple states and jurisdictions to ensure an appropriate investigation. The caseworker made diligent efforts to gain the assistance of the out-of-state child protective services agencies, although neither entity was willing to help.	1
		There was great response by the DFS caseworker, to include diligent efforts in dealing with a difficult family and ensuring a good plan for all the children.	1
	General - Criminal Investigation		1
		An evidentiary blood draw was completed quickly during the hospital admission for the young child who presented with a suspected drug ingestion.	1
	General - Criminal/Civil Investigation		7
		There was a good MDT response to the death incident, which included joint responses to the hospital and to the home, interviews with the parents, evidentiary blood draws of the parents, a child safety agreement for the sibling, and consistent communication and collaboration among the MDT members.	1
		There was a good MDT response to the near death incident, which included joint responses to the hospital and to the home, joint interviews with the parents, and consistent communication and collaboration among the MDT members, to include out of state authorities.	1
		There was a good MDT response to the near death incident, which included joint responses to the hospital and to the home, joint interviews with the parents, evidentiary blood draws of the children and the parents, and consistent communication and collaboration among the MDT members.	1
		There was a good MDT response to the near death investigation, which included a joint response to the hospital, joint interviews with the parents and other family members, and a follow up meeting with the medical team to review the various scenarios provided by the family during the joint interviews.	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, emergency custody and child safety agreements for the children, collaterals for out of state records, 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 all parties within the household, 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 parents, and consistent communication and collaboration among the MDT members.	1
	Medical Exam		3
		A medical evaluation was completed for the sibling, which included a urine drug screen that resulted positive for a controlled substance. This incidental finding supports the practice of completing drug screens for siblings despite being asymptomatic at the time of the evaluation.	1
		A subsequent medical evaluation was completed for the young sibling when additional injuries were identified during the child's follow up appointment.	1
		The MDT ensured the child's sibling was medically evaluated quickly.	1
	Reporting		1
		The DFS Report Line received multiple referrals reporting the child's drug ingestion.	1
Medical			7
	Documentation		1
		The emergency medical services report thoroughly documented the scene of the child death incident.	1

	Medical Exam/ Standard of Care - CARE	1
	The Children at Risk Evaluation (CARE) Team advocated for an MDT response to the near death incident given the child's injuries, the mother's conflicting accounts of events, and the mother's obstructive behaviors while the child was hospitalized.	1
	Medical Exam/ Standard of Care - ED	1
	For the near death incident, urine drug screens were completed for the child and the siblings, despite no allegations of drug exposure being made.	1
	Medical Exam/ Standard of Care - PCP	1
	The primary care physician referred the young child to the emergency department for x-ray imaging to further evaluate the injuries. Although abuse or neglect was not initially suspected, a report was made to the DFS Report Line.	1
	Reporting	3
	The child's pediatrician made an immediate referral to the DFS Report Line reporting sentinel injuries of an infant.	1
	The emergency department made an immediate referral to the DFS Report Line when additional injuries were identified as a result of x-ray imaging.	1
	The substance abuse treatment provider made an immediate report to the DFS Report Line when the mother contacted them to engage in services and admitted the young children accessed illegal substances in the home.	1
Risk Assessment/ Caseloads		5
	Collaterals	4
	During the near death investigation, strong collaterals were completed by the DFS caseworker. The contacts included both professional and personal resources.	1
	During the prior investigation, the DFS caseworker made diligent efforts to contact the family. The contacts included unannounced home visits, telephone calls, text messages, and a compel letter.	1
	In the prior investigation, the caseworker maintained regular, quality contact with the family. The contact included both in person and virtual visits, and appropriate services were offered for the mother.	1
	The DFS caseworker maintained regular, quality contact with the family prior to the child's death, and appropriate referrals were made for the family.	1
	Reporting	1
	The MDT made a report to the National Center for Missing and Exploited Children and an Amber Alert was issued when the child did not present to the emergency department after additional injuries were identified on the skeletal survey.	1
Safety/ Use of History/ Supervisory Oversight		7
	Appropriate Parent/Relative Component	1
	The DFS caseworker made good use of the natural support network to provide a safe placement for the child.	1
	Completed Correctly/On Time	4
	The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. The agreement included the other children residing in the home.	1
	The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. The agreement included 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 sibling residing in 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-siblings who resided outside of the home. There was consistent review and modification, when necessary, of the safety agreements.	1
	Oversight of Agreement	2
	The DFS caseworker appropriately amended the child safety agreement in stages, allowing Mother short periods of unsupervised contact with the child prior to the child returning home.	1
	The DFS caseworker appropriately amended the subsequent child safety agreement in stages, allowing Mother short periods of unsupervised contact with the child prior to the child returning home.	1

Unresolved Risk			2
	Parental Risk Factors		2
		The DFS caseworker completed a thorough assessment of the mother's substance abuse prior to the child's death. The mother provided consistent negative drug screens.	1
		The DFS investigation caseworker referred both parents for substance abuse evaluations, and completed follow up with the substance abuse treatment provider.	1
Grand Total			**36**