STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
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CHAIR

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EXECUTIVE DIRECTOR

February 14, 2024

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 February 14, 2024 meeting.[1]

In 2023, CPAC screened in 97 serious child abuse cases – 15 deaths and 82 near deaths. It also has screened out another 100 serious injury cases which did not meet the criteria of near death.

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 seven cases that received a final review. They were all near deaths which occurred between May 2020 and September 2022 and six of the cases resulted in convictions. Of the convictions, there were 3 abusive head trauma cases, 1 drug ingestion (Fentanyl) and 2 abdominal injuries and bone fractures. One abusive head trauma case received 5 years at Level

[1] 16 Del. C. § 932.

V. The child is permanently and significantly compromised from the abuse. The other cases received 3 years of Level V down to probation. All cases involved significant injuries to young children. These crimes all occurred prior to the new child abuse laws taking effect, but the sentences remain light for the heinous crimes committed. CPAC remains hopeful that the new laws will hold child abusers more accountable for their actions.

The fourteen remaining cases were from deaths or near deaths that occurred between January and April 2023. Of these cases, seven will have no further review. The remaining seven cases – 3 deaths and 4 near deaths - will remain open pending prosecutorial outcomes. These cases include abusive head trauma and poisonings via drug ingestion (fentanyl, cocaine and Xylazine). The fourteens cases resulted in 29 strengths and 24 current findings across system areas. The findings are down by half from the prior quarter.

For these January through April 2023 cases, 14 strengths and 10 findings were noted for the Multidisciplinary Team Response. During this time frame, 66 cases were screened and at least 25 of them were accepted for review. The volume is significant, but 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 concentrated on poisoning via drug ingestion cases. CPAC will be holding an advanced training track at the Protecting Delaware's Children Conference in April 2024 to further address child abuse investigations and prosecutions with an emphasis on poisoning via drug ingestion cases. 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 to include MOU updates, trainings and partnerships with hospitals on poisoning via drug ingestion cases.

In this quarter, 9 strengths and 10 findings were noted regarding the Division of Family Services ("DFS"). Nearly all of the findings this quarter were regarding caseloads over standard. DFS should be commended on its dedicated serious injury units and teams that performed at the highest level this quarter despite ongoing struggles with vacancies and turnover. 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

FEBRUARY 6, 2024

INITIAL REVIEWS

	Current	Prior	Prior & Current
MDT Response	**10**	**1**	**0**
Crime Scene	4	0	0
General - Civil Investigation	2	0	0
General - Criminal Investigation / Civil Investigation	1	0	0
General - Criminal/Civil Investigation	0	1	0
Medical Exam	1	0	0
Reporting	2	0	0
Medical	**3**	**2**	**0**
Medical Exam/ Standard of Care - Birth	0	1	0
Medical Exam/ Standard of Care - PCP	0	1	0
Medical Exam/Standard of Care - ED	2	0	0
Reporting	1	0	0
Risk Assessment/ Caseloads	**10**	**0**	**1**
Caseloads	8	0	1
Documentation	1	0	0
Reporting	1	0	0
Unresolved Risk	**1**	**0**	**0**
Parental Risk Factors	1	0	0
Grand Total	**24**	**3**	**1**

TOTAL CAN PANEL FINDINGS **28**

*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 6, 2024

INITIAL REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			11
	Crime Scene		4
		The law enforcement agency did not complete an evidentiary blood draw on the child after the child ingested a controlled substance.	2
		The law enforcement agency did not complete an evidentiary blood draw on the sibling.	2
	General - Civil Investigation		2
		A DFS caseworker was unable to make an initial joint response to the treating hospital with law enforcement due to DFS staff being occupied with other unrelated emergent investigations.	1
		The DFS caseworker did not consider the mother's paramour as a possible suspect, despite being alleged to reside in the home.	1
	General - Criminal Investigation / Civil Investigation		1
		A joint MDT investigation was not initially conducted due to a delay in the law enforcement response.	1
	General - Criminal/Civil Investigation		1
		For the prior investigation, there was not a joint MDT response to the incident in compliance with the MOU and statute.	1
	Medical Exam		1
		DFS and law enforcement did not arrange for precautionary medical exams of the siblings, who were not initially identified as symptomatic by emergency medical responders.	1
	Reporting		2
		The responding law enforcement agency did not report the ingestion incident event to the DFS Report Line, despite making an initial response to the scene to assist emergency medical personnel.	1
		The CAC delayed reporting alleged physical abuse, disclosed by the child and his sibling during their forensic interviews, to the DFS Report Line.	1
Medical			5
	Medical Exam/ Standard of Care - Birth		1
		A urine drug screen was not completed on the child at birth, despite the mother having two prior substance exposed infant births and self-reporting the use of a muscle relaxant medication during the pregnancy.	1
	Medical Exam/ Standard of Care - PCP		1
		During the child's four-month well child visit, multiple adverse social determinants of health were identified by the medical provider, and there was no documentation as to whether the family was connected to services to address those concerns.	1
	Medical Exam/Standard of Care - ED		2
		Due to the child being pronounced deceased while in route to the hospital, a full medical examination was not completed upon arrival to the emergency department. As a result, the child's body temperature was not recorded and forensic photo documentation was not obtained.	1
		The emergency department did not initially consider a differential diagnosis of non-accidental trauma despite the young child presenting with symptoms consistent with abusive head trauma. As a result, there was a delay in reporting to the CARE Team and to DFS.	1
	Reporting		1
		The initial treating hospital reported the toxicology findings for the sibling to the DFS caseworker versus completing a new report with the DFS Report Line.	1
Risk Assessment/ Caseloads			11
	Caseloads		9
		The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	4
		The DFS caseworkers were over 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.	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 investigation. However, it does not appear that the caseload negatively impacted the treatment case.	1

		The DFS caseworkers were over investigation caseload statutory standards during the current and the prior investigations. The caseload does appear to have had a negative impact on the response in the prior case; however, it does not appear that the caseload had a negative impact on the response in the current case.	1
		The DFS caseworkers were above 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 those cases.	1
	Documentation		1
		The report from the treating hospital, providing additional information regarding factors concerning for abuse, was documented as a progress note rather than a new hotline report.	1
	Reporting		1
		The DFS intake worker documented the report from law enforcement, regarding the ingestion event, as a progress note to the initial hotline report versus creating a new hotline report.	1
Unresolved Risk			1
	Parental Risk Factors		1
		Substance abuse evaluations were not requested by the DFS caseworker for the child's mother and the mother's paramour.	1
Grand Total			**28**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

FEBRUARY 6, 2024

INITIAL REVIEWS

	Current
MDT Response	**14**
General - Civil Investigation	3
General - Criminal/Civil Investigation	10
Interviews - Adults	1
Medical	**6**
Documentation	1
Medical Exam/Standard of Care - ED	3
Medical Exam/Standard of Care - Forensics	2
Risk Assessment/ Caseloads	**4**
Collaterals	2
Communication	2
Safety/ Use of History/ Supervisory Oversight	**3**
Completed Correctly/On Time	3
Unresolved Risk	**2**
Parental Risk Factors	2
Grand Total	**29**

TOTAL CAN PANEL STRENGTHS **29**

*Current - within 1 year of incident

**Prior - 1 year or more prior to incident

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Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Detail

FEBRUARY 6, 2024

INITIAL REVIEWS

System Area	Strength	Public Rationale	Count of #
MDT Response			14
	General - Civil Investigation		3
		The DFS investigation and treatment caseworkers went above and beyond to assist this complex family, specifically by implementing detailed and creative chi	1
		The DFS caseworker provided the family with a lockbox and educated the mother on the proper storage for substances and medications.	1
		The DFS caseworker continued to follow up with law enforcement despite being told initially that they were not moving forward with a criminal investigatior	1
	General - Criminal/Civil Investigation		10
		There was a good MDT response to the near death investigation, which included a joint response to the hospital, a joint interview with the mother, evidentiar	1
		There was a good MDT response to the near death investigation, despite the lack of joint response to the hospital. The response included joint interviews wh	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 ca	1
		There was a good MDT response to the death investigation, despite the lack of initial joint response to the hospital. The response included joint interviews w	1
		There was a good MDT response to the death investigation, which included joint interviews where applicable, a joint response to the home, collaboration wit	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 where appl	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 where appl	1
		There was a good MDT response to the near death investigation, which included a joint response to the hospital, medical evaluations of the siblings, a forensi	1
		There was a good MDT response to the near death investigation, which included a joint response to the hospital, joint interviews of the family members, mec	1
		There was a good MDT response to the near death investigation, despite the lack of initial joint response with law enforcement. The response included joint r	1
	Interviews - Adults		1
		The DFS caseworker conducted interviews with all adult household members.	1
Medical			6
	Documentation		1
		There was excellent documentation by the pediatric intensive care unit related to Gift of Life notification.	1
	Medical Exam/ Standard of Care - ED		3
		Upon discovery of a sentinel injury in a young child, the emergency department physician immediately notified the forensic nurse and the CARE Team, and i	1
		A medical evaluation was completed for the sibling and the relative child, which included a urine drug screen that resulted positive for a controlled substance.	1
		The child's body temperature was obtained within eleven minutes from arrival into the emergency department, which had been an issue in recent child death	1
	Medical Exam/ Standard of Care - Forensics		2
		The forensic nurse obtained photographs of the child in the pediatric intensive care unit prior to the child's death.	1
		The forensic nurse advocated for a urine drug screen of the child's twin sibling when it was not completed as part of the initial medical evaluation. The drug s	1
Risk Assessment/ Caseloads			4
	Collaterals		2
		The DFS caseworker consulted with an out of state child protective services agency in the state the family was known to previously reside.	2
	Communication		2
		There was good communication between the DFS investigation and treatment caseworkers, and good use of historical information to inform case decisions.	1
		During the near death investigation, there was good collaboration and communication between the DFS investigation and treatment caseworkers.	1
Safety/ Use of History/ Supervisory Oversight			3
	Completed Correctly/On Time		3
		The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. There was consistent review and modification, wher	1
		The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. There was consistent review and modification, wher	1
		The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. The agreement included the siblings residing in the	1
Unresolved Risk			2
	Parental Risk Factors		2
		The DFS investigation caseworker referred the mother for a substance abuse evaluation, and completed follow up with the substance abuse treatment provid	1

The DFS caseworker referred most of the adult household members for substance abuse evaluations. It was unclear whether the maternal grandmother was r	1
Grand Total	**29**