STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
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CHAIR

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EXECUTIVE DIRECTOR

May 22, 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 25 cases at its May 22, 2024 meeting.[1]

Thus far in 2024, CPAC has screened in 38 cases (4 deaths and 34 near deaths) and screened out another 45 cases. In 2023, CPAC screened in 97 serious child abuse cases – 15 deaths and 82 near deaths, and screened out another 100 serious injury cases.

With respect to the 25 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 six cases that received a final review. There were 2 deaths and 4 near deaths which occurred between September 2019 and March 2024. Three of the cases were prosecuted. Of those

[1] 16 Del. C. § 932.

cases, the two near deaths resulted in Child Abuse 2nd convictions and Level III probation. The death resulted in 30 years at Level V incarceration.

The nineteen remaining cases were from deaths or near deaths that occurred between April and August 2023. Of these cases, seven will have no further review and were not prosecuted. The remaining twelve cases – 2 deaths and 10 near deaths - will remain open pending prosecutorial outcomes. These cases include abusive head trauma, bone fractures and poisonings via drug ingestion (fentanyl, cocaine and Xylazine). The twelve cases resulted in 42 strengths and 40 current findings across system areas.

For these April through August 2023 cases, 15 strengths and 8 findings were noted for the Multidisciplinary Team Response, and 11 strengths and 26 findings were noted regarding the Division of Family Services ("DFS"). Fifteen of the DFS findings were regarding caseloads. Findings for both categories however primarily focus on the DFS response. CPAC will have DFS review these findings, and it will continue to monitor to determine if trends develop.

The number, complexity and severity of child abuse cases continue. 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

Strengths Summary

INITIAL REVIEWS

	Current
MDT Response	**15**
General - Criminal Investigation	4
General - Criminal/Civil Investigatio	10
Medical Exam	1
Medical	**13**
Medical Exam/Standard of Care - C	1
Medical Exam/Standard of Care - El	3
Medical Exam/Standard of Care - ME	1
Medical Exam/Standard of Care - P(	1
Reporting	7
Risk Assessment/ Caseloads	**1**
Communication	1
Safety/ Use of History/ Supervisory	**4**
Appropriate Parent/Relative Compo	1
Completed Correctly/On Time	3
Unresolved Risk	**6**
Child Risk Factors	1
Contacts with Family	1
Parental Risk Factors	4
Grand Total	**39**

FINAL REVIEWS

	Current
MDT Response	**3**
General - Criminal Investigation	1
General - Criminal/Civil Investigation	2
Grand Total	**3**

TOTAL CAN PANEL STRENGTHS	**42**

*Current - within 1 year of incident

**Prior - 1 year or more prior to incident

INITIAL REVIEWS

System Area	Strength	Public Rationale	Count of #
MDT Response			15
	General - Criminal Investigation		4
		The law enforcement detective assigned to the case conducted an excellent investigation, which included the collection and testing of evidence, as well as DNA testing, resulting in criminal charges being filed.	1
		The law enforcement detective assigned to the case conducted an excellent investigation, which included evidentiary blood draws of all parties, adults and children, interviews with the adult household members and the maternal relative, who was responsible for the medication, and extra efforts made in contacting the pharmacies to inquire about the specifics and the accessibility of the medication bottle.	1
		The newly assigned detective consulted with more experienced detectives throughout the course of the investigation, ensuring all MOU recommendations were completed and thoroughly documented with the report, and appropriate notifications were made in a timely manner.	1
		The law enforcement agency conducted a thorough investigation, which included the collection of physical and digital evidence, and collaboration with the FBI crime lab.	1
	General - Criminal/Civil Investigation		10
		There was a good MDT response to the near death incident, which included a joint response to the hospital, joint interviews with the parents, and sharing of information between law enforcement and DFS.	1
		There was a good MDT response to the near death investigation, which included a joint response to the hospital, joint interviews where applicable, 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, medical evaluation of the child's sibling, which included a urine drug screen, evidentiary blood draws for the victim and the relative caregivers, and consistent communication and collaboration among the MDT members.	1
		There was a good MDT response to the near death investigation, which included response to the home by DFS and information sharing with law enforcement, joint interviews with the mother, polygraph examination of the mother, multiple witness interviews, medical evaluations of the child's sibling, although delayed, and consistent communication and collaboration among the MDT members.	1
		There was a good MDT response to the death investigation, despite the lack of initial joint response to the hospital and to the home. The response included information sharing between the agencies, evidentiary blood draw of the caregivers, medical evaluation and forensic interview of the relative child residing in the home, 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 home and to the hospital, medical evaluations of the siblings, a forensic interview of the oldest sibling, 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 of the family members, a CARE Team consultation, 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 where applicable, medical evaluations and forensic interviews of the other children, 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 of the parents, a CARE Team consultation, 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 where applicable, information sharing between the two agencies, a CARE Team consultation, and consistent communication and collaboration among the MDT members.	1
	Medical Exam		1
		Medical evaluations were completed for all the children residing in the home at the time of the near death incident. The children were admitted on a social hold awaiting safety disposition with DFS.	1
Medical			13
	Medical Exam/ Standard of Care - CARE		1
		Medical evaluations for the child's sibling and other relative children residing in the home were completed in the CARE Clinic, and the evaluations included urine drug screens.	1
	Medical Exam/ Standard of Care - ED		3
		For the previous incident, the treating hospital suspected physical abuse and requested medical evaluations also be completed for the siblings.	1
		The initial treating hospital consulted with the forensic nurse at the children's hospital prior to transfer and received recommendations to follow the abusive pathway while awaiting transport.	1
		The child's body temperature was obtained within fifteen minutes from arrival into the emergency department, which had been an issue in recent child death cases, and a post-mortem scan was completed shortly after one hour from pronouncement of death.	1

	Medical Exam/ Standard of Care - ME		1
		The medical examiner gave approval for the mother to hold the child while supervised after the post-mortem examination was completed.	1
	Medical Exam/ Standard of Care - PCP		1
		The child's pediatrician contacted the emergency department to ensure the child arrived for further testing and treatment.	1
	Reporting		7
		The child's pediatrician made an immediate referral to the DFS Report Line reporting the mother's concerning behavior during a previous well child visit and referenced the active Plan of Safe Care that was implemented following the child's substance exposed birth.	1
		The paramedics who responded to the home made a referral to the DFS Report Line reporting the child's drug ingestion and acknowledging another minor child in the home. The paramedics transported both children to the emergency department for medical evaluations.	1
		The treating hospital made an immediate report to the DFS Report Line when the sibling's confirmation drug screen returned positive for a controlled substance.	1
		The child's pediatrician made an immediate referral to the DFS Report Line reporting suspicious bruising to the child. The report was made while the parents and child remained in the pediatrician's office, and the pediatrician documented the discussion regarding the parents transporting the child to the ED without a chaperone.	1
		The outpatient radiologist made an immediate referral to the DFS Report Line when the skeletal survey identified multiple fractures in the young child.	1
		The home healthcare nurse made an immediate report to the DFS Report Line with concerns of the young child with a sentinel injury.	1
		The primary care physician made an immediate report to the DFS Report Line when the mother refused to respond to the emergency department for a medical evaluation of the young child with a sentinel injury.	1
Risk Assessment/ Caseloads			1
	Communication		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			4
	Appropriate Parent/Relative Component		1
		DFS ruled out maternal relatives as safety agreement participants based on history and recent contact with the victim child. Despite suggestions by the family, the caseworker adhered to recent DFS policy that infants could not be placed with non-family members.	1
	Completed Correctly/On Time		3
		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. 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 young sibling who resided in the home.	1
Unresolved Risk			6
	Child Risk Factors		1
		The medical team and the DFS caseworker assisted Mother with establishing primary care for the child and ensuring all required follow up medical needs for the child were met.	1
	Contacts with Family		1
		The DFS treatment caseworker maintained regular, quality contact with the family.	1
	Parental Risk Factors		4

		The DFS caseworker immediately referred all parties for substance abuse evaluations.	1
		During the contracted POSC case, the caseworker maintained regular, quality contact with the family.	1
		During the current investigation, the DFS caseworker and the detective recognized the mother's efforts and struggles due to a lack of resources. The two agencies coordinated to assist the family in gathering what was needed.	1
		The parents were offered comprehensive case plans for reunification with the children and were educated on the process of doing so after DFS was no longer involved.	1
Grand Total			**39**

FINAL REVIEWS

System Area	Strength	Count of #	
MDT Response		3	
	General - Criminal Investigation	1	
	General - Criminal/Civil Investigation	2	
Grand Total		**3**	
TOTAL CAN PANEL STRENGTHS			**42**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

MAY 22, 2024

INITIAL REVIEWS

	Grand Total
Education	**1**
Reporting	1
MDT Response	**8**
Crime Scene	1
General - Civil Investigation	6
Interviews - Child	1
Medical	**5**
Documentation	1
Medical Exam	1
Medical Exam/Standard of Care - PCP	1
Reporting	2
Risk Assessment/ Caseloads	**20**
Caseloads	15
Collaterals	5
Safety/ Use of History/ Supervisory Oversight	**5**
Safety - Completed Incorrectly/ Late	4
Transport	1
Unresolved Risk	**1**
Parental Risk Factors	1
Grand Total	**40**

TOTAL CAN PANEL FINDINGS **40**

*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 22, 2024

INITIAL REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
Education			1
	Reporting		1
		The sibling's school made an anonymous report to the DFS Report Line regarding disclosures by the sibling.	1
MDT Response			8
	Crime Scene		1
		The law enforcement agency did not complete an evidentiary blood draw on the child after the child ingested a harmful substance.	1
	General - Civil Investigation		6
		The DFS caseworker did not have contact with the family or complete collateral contacts for a seven-month timeframe while the investigation was open.	1
		For the first four months of the case, the treatment caseworker did not meet with the family or establish a family service plan.	1
		The child nor the other children in the home were interviewed in the subsequent case investigation.	1
		During the second prior investigation, the DFS caseworker was delayed in completing an initial intervview with the mother.	1
		During the second prior investigation, the DFS caseworker completed a 30-day contact with the child virtually versus in-person, violating policy and preventing the caseworker from accurately assessing the child's physical condition.	1
		During the second prior investigation, the child's sibling was not included in the investigation by the DFS caseworker.	1
	Interviews - Child		1
		A forensic interview with the child did not occur.	1
Medical			5
	Documentation		1
		There was no documentation within the pediatrician's records of the results from the ultrasound or skeletal survey after multiple injuries were identified.	1
	Medical Exam		1
		The medical evaluations completed for the child's siblings were delayed.	1
	Medical Exam/Standard of Care - PCP		1
		The child was not referred to the emergency department for a non-accidental workup after the skeletal survey identified multiple fractures.	1
	Reporting		2
		The treating hospital delayed in reporting the co-sleeping event to the DFS Report Line.	1
		The child's PCP failed to report bruising, concerning for abuse, which was observed during an office visit prior to the near death event to the DFS Report Line.	1
Risk Assessment/ Caseloads			20
	Caseloads		15
		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.	2
		The DFS caseworkers were at or over the investigation caseload statutory standards the entire time the prior and current investigations were open. However, it does not appear that the caseload negatively impacted the DFS response to those cases.	1

		The DFS caseworkers were at or over the investigation and treatment caseload statutory standards the entire time the cases were open. However, it does not appear that the caseload negatively impacted the DFS response to those cases.	1
		For the prior 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
		The DFS caseworker was over the investigation caseload statutory standards, and the caseload appears to have negatively impacted the DFS response to the case.	1
		The DFS caseworker was over the investigation caseload statutory standards for the prior and the current cases. The caseload appears to have impacted timely closure of the prior investigation and the caseworker's ability to complete timely contacts with the family for the current investigation.	1
		The DFS caseworkers were over the investigation and treatment caseload statutory standards the entire time the current and subsequent cases were open. The caseload appears to have had a negative impact on the subsequent investigation; however, it does not appear that the caseload negatively impacted the current investigation or the treatment case.	1
		The DFS caseworker was over the treatment 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 caseworkers were over the investigation caseload statutory standards for the prior and current cases. The caseload appears to have had a negative impact on the prior investigation; however it does not appear that the caseload negatively impacted the current investigation.	1
		The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it does not appear to have negatively impacted the case.	1
	Collaterals		5
		The DFS caseworker delayed in obtaining in collaterals from the mother's medication assisted treatment (MAT) provider.	1
		The DFS caseworker did not have contact with the family or complete collateral contacts for a seven month timeframe while the investigation was open.	1
		During the first prior investigation, the DFS caseworker did not contact the child's medical providers to confirm that mother was meeting the child's medical needs which were noted to be elevated due to the child's medical diagnosis.	1
		During the first prior investigation, the DFS caseworker did not complete collateral contacts for the siblings.	1
		During the second prior investigation, collateral contacts were not repeated by the DFS caseworker prior to case closure.	1
Safety/ Use of History/ Supervisory Oversight			5
	Safety - Completed Incorrectly/ Late		4
		The safety agreement did not include a third party safety person and was completed incorrectly.	1
		The child safety agreement did not address other persons who had access to the child at the time of the near death incident.	1
		The safety agreement restricted the parents contact with the child, but did not clarify what persons were permitted contact with the child.	1
		For the prior investigation, the child safety agreement was not completed correctly. The agreement inappropriately identified the threat upon which the safety assessment was based, thereby prompting a response which did not effectively address the mother's service needs nor clearly identify which persons were permitted to reside in and visit the home.	1
	Transport		1
		DFS approved the primary care physician (PCP) to allow the parents to transport the child from the PCP's office to the emergency department, despite the suspicion of abuse.	1
Unresolved Risk			1

	Parental Risk Factors		1
		During the second prior investigation, assessment of the mother's needs, as a parent of two medically complex children, was not completed by the DFS caseworker.	1
Grand Total			**40**