STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
C/O OFFICE OF THE CHILD ADVOCATE
900 KING STREET, SUITE 210
WILMINGTON, DELAWARE 19801
TELEPHONE: (302) 255-1730
FAX: (302) 577-6831

MARY F. DUGAN, ESQUIRE
CHAIR

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

August 21, 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 August 21, 2024 meeting.[1]

Thus far in 2024, CPAC has screened in 50 cases (5 deaths and 45 near deaths) and screened out another 86 cases. In 2023, after receiving records, CPAC ultimately screened in 58 serious child abuse cases – 10 deaths and 48 near deaths, and screened out another 141 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 nine cases that received a final review. There were 2 deaths and 7 near deaths which occurred between February 2021 and July 2023. Four of the cases were prosecuted. Of those cases, the child torture case resulted in 5 years' incarceration. One poisoning via drug ingestion death resulted in 6 months at Level IV.

The sixteen remaining cases were from deaths or near deaths that occurred between August and November 2023. Of these cases, six will have no further review and were not prosecuted – these include poisoning via drug ingestion, abusive head trauma and bone fractures. The remaining ten cases – 3 deaths and 7 near deaths - will remain open pending prosecutorial outcomes. These

[1] 16 Del. C. § 932.

cases include abusive head trauma, child torture, bone fractures and poisoning via drug ingestion (fentanyl, cocaine and Xylazine).

For these August through November 2023 cases, there were 40 strengths and 55 current findings across system areas. Nineteen strengths and 8 findings were noted for the Multidisciplinary Team Response. These numbers demonstrate significant forward progress in the expertise of the frontline teams. CPAC will continue to watch these trends. For the medical response, this quarter demonstrated 7 strengths and 11 findings. Six of those findings indicate breakdowns in reporting cases to the DFS report line. CPAC will continue to incorporate these breakdowns in the 2025 reporting training for medical providers utilizing case scenarios and follow up questions. Fourteen strengths and 36 findings were noted regarding the Division of Family Services ("DFS"). Thirteen of the DFS findings were regarding caseloads. The 23 remaining DFS findings primarily focus on breakdowns in assessing parental risk factors and implementing safety agreements. CPAC will have DFS review these findings and cases, 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 and a two-page summary of the CAN Findings are also included to provide an overall picture of the volume and complexity of child welfare cases in Delaware over time. 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

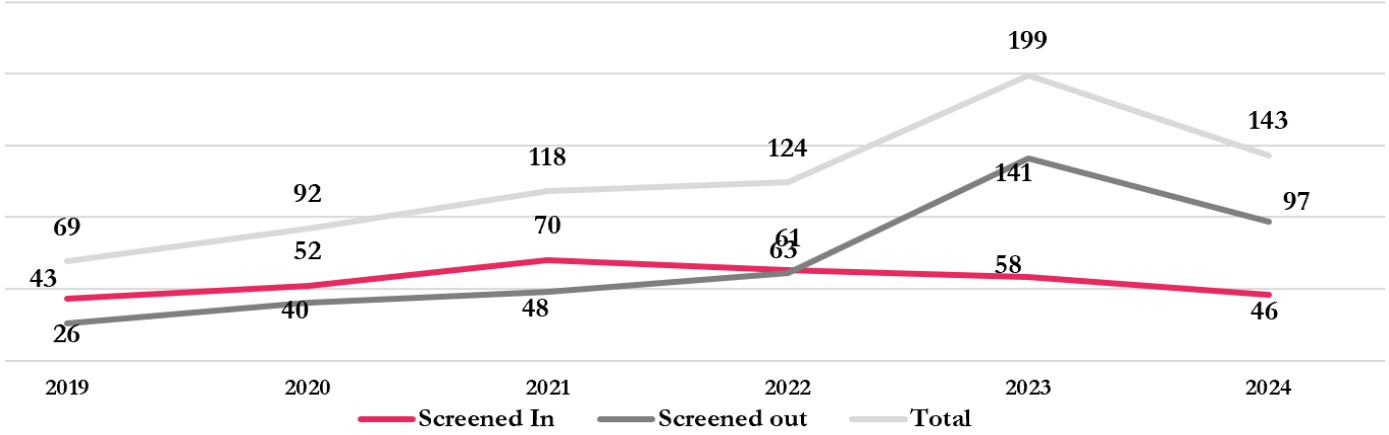
cc: CPAC Commissioners, General Assembly

Child Abuse and Neglect Panel (CAN)

Child Protection Accountability Commission (CPAC)

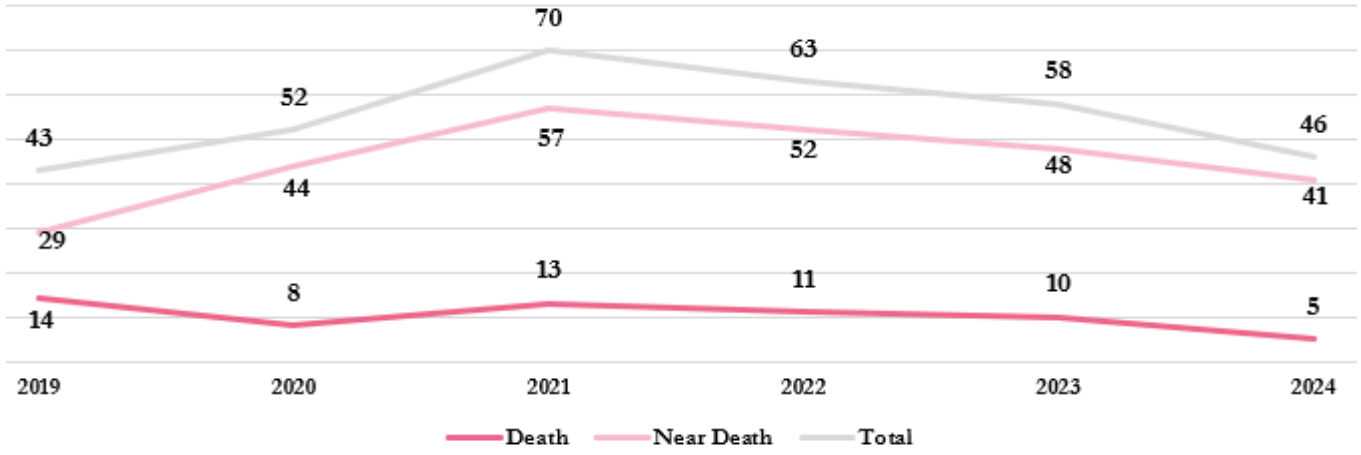
Report Updated: 8/19/2024

Screening Decisions of CAN Cases

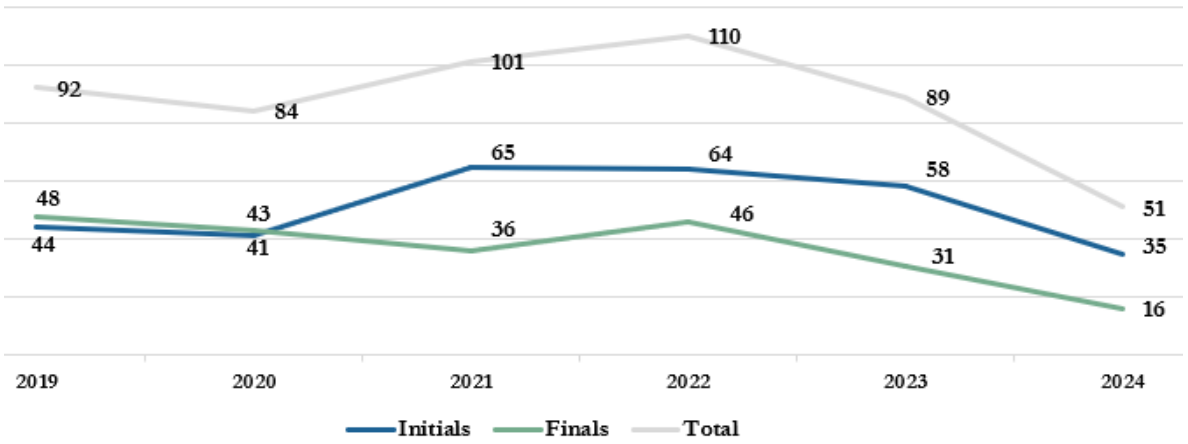


All cases are initially screened in. For the current year, some cases may be screened out after medical records are received and reviewed. Screened out cases in 2024 reflect the date of CAN closure.

Screened In Death and Near Death Cases



Initials and Finals by Calendar Year



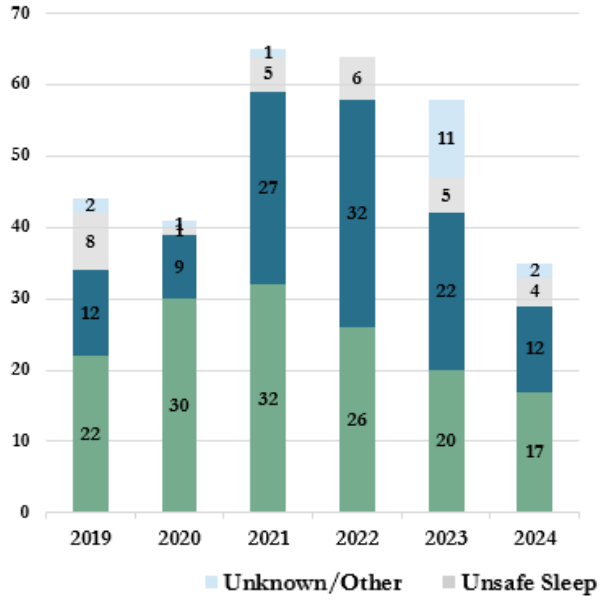
16 Del. C. § 932(c) requires CPAC to review a case within 6 months of a report. In August 2021, CPAC voted to extend the timeframe to 9 months, which is how compliance is calculated above.

Child Abuse and Neglect Panel (CAN)

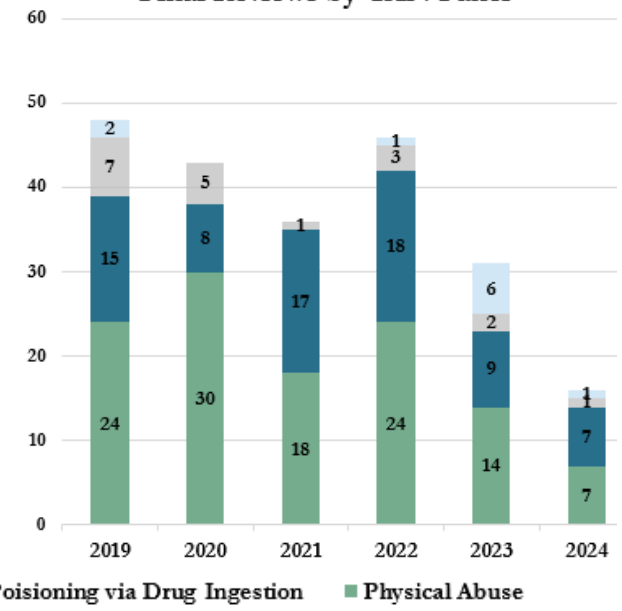
Child Protection Accountability Commission (CPAC)

Report Updated: 8/19/2024

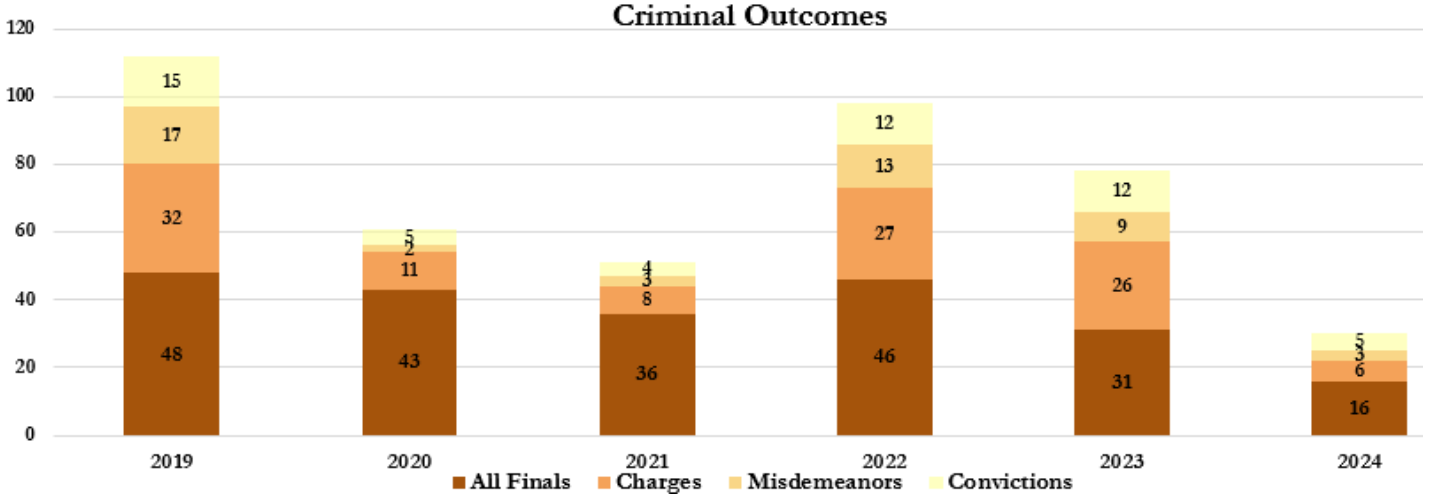
Initial Reviews by CAN Panel



Final Reviews by CAN Panel



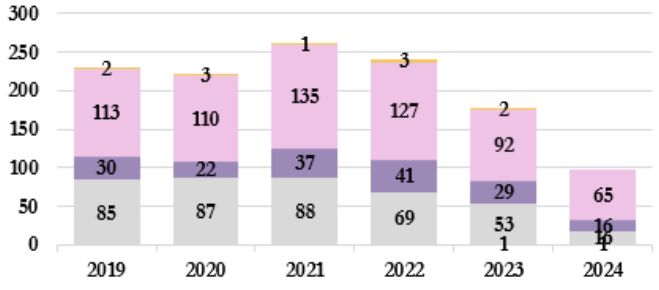
Criminal Outcomes



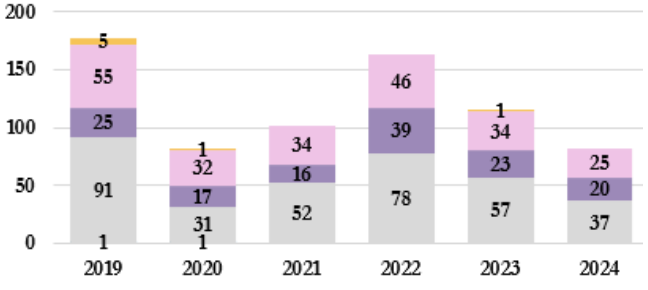
Numbers are based on when the case had the final review not the date of incident.

Findings and Strengths by the CAN Panel

Findings



Strengths



Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

July 30, 2024

INITIAL REVIEWS

	Current
MDT Response	**19**
General - Criminal Investigation	4
General - Criminal/Civil Investigation	12
Interviews - Child	1
Medical Exam	2
Medical	**7**
Documentation	1
Medical Exam/ Standard of Care - CARE	1
Medical Exam/ Standard of Care - ED	1
Medical Exam/Standard of Care - ED	2
Medical Exam/Standard of Care - PCP	2
Safety/ Use of History/ Supervisory Oversight	**5**
Completed Correctly/On Time	4
Use of History	1
Unresolved Risk	**9**
Contacts with Family	3
Home Visiting Programs	1
Legal Guardian	3
Parental Risk Factors	2
Grand Total	**40**

FINAL REVIEWS

	Current
Grand Total	

TOTAL CAN PANEL STRENGTHS **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

INITIAL REVIEWS

System Area	Strength	Public Rationale	Count of #
MDT Response			19
	General - Criminal Investigation		4
		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 members. The investigation resulted in an appropriate criminal charge being filed against the perpetrator.	1
		For the near death investigation, the detective made an immediate referral to the DFS Report Line. Additionally, the detective advocated for toxicology screening to be conducted on the child at the initial treating hospital emergency department despite the medical team's reluctance to do so.	1
		The law enforcement agency conducted a thorough investigation, which included a neighborhood canvass and review of home surveillance cameras that developed a timeline refuting the mother's statements.	1
		There was good communication and collaboration between the in-state and out-of-state law enforcement agencies.	1
	General - Criminal/Civil Investigation		12
		Despite the initial jurisdiction issue, 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 agencies, a CARE Team consultation, and consistent communication and collaboration among the MDT members.	1
		There was a good MDT response to the prior near death investigation, which included joint responses to the home and to the hospital, joint interviews of the parents, and consistent communication and collaboration among the MDT members.	1
		There was a good MDT response to the death investigation, which included joint interviews of the mother and other family members, where applicable, multiple medical consults, 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 hospital, multiple interviews of the mother and with other family members, appropriate collaterals, a thorough scene investigation, 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 hospital and to the home, joint interviews with the parents and other relatives, appropriate collaterals, a thorough scene investigation, 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 of the parents, medical evaluations of the siblings, forensic interview of the older 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, where applicable, medical evaluations of all three children, forensic interviews of the twin children, consultation with the DAG, 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, joint interviews, where applicable, medical evaluations and forensic interviews of the siblings, consultations with the DAG and the CARE Team, 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 hospital and to the home, a joint interview with the mother, medical evaluation and social admission of the child's siblings, 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, an evidentiary blood draw of the child and the paternal relative, forensic interview 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 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, despite the lack of joint response to the hospital. The response included joint interviews where applicable and consistent communication and collaboration among the MDT members.	1
	Interviews - Child		1

		A forensic interview was attempted with the young sibling who was present in the home at the time of the near death incident and per the mother's report was involved in an alleged fall with the child.	1
	Medical Exam		2
		Medical evaluations were completed for the child and the sibling when they entered foster care. The evaluations included urine drug screens.	1
		Medical evaluations were completed for the three non-relative children for whom the mother provided home health care, although they did not reside in the same household as the mother.	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 - CARE2		1
		In response to a subsequent injury, the child was medically evaluated by the CARE Team. A new referral was made to the DFS Report Line for the injury.	1
	Medical Exam/ Standard of Care - ED		2
		The child's body temperature was obtained immediately upon arrival into the emergency department, which had been an issue in recent child death cases, and a post-mortem scan was completed shortly after pronouncement of death.	1
		A medical evaluation was completed for the child's sibling, and it included a urine drug screen.	1
	Medical Exam/ Standard of Care - ED2		1
		A medical evaluation was completed for the child's sibling, and it included a urine drug screen.	1
	Medical Exam/ Standard of Care - PCP		2
		The child's primary care physician did due diligence in getting the mother to take the child to the emergency department for follow up laboratory studies and contacted the emergency department to discuss same.	1
		The child's primary care physician appreciated the increased head circumference and referred the child for appropriate follow up.	1
Safety/ Use of History/ Supervisory Oversight			5
	Completed Correctly/On Time		4
		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.	2
		During the prior investigation, 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 also included the sibling in the home. There was consistent review and modification, when necessary, of the safety agreement.	1
	Use of History		1
		For the near death investigation, the DFS caseworker considered the family's prior CPS history when making safety decisions. The records were obtained in the prior investigation.	1
Unresolved Risk			9
	Contacts with Family		3
		The DFS treatment caseworker maintained regular, quality contact with the family.	1
		In the prior investigation, the DFS caseworker and the PBH worker attempted a joint home visit with the family.	1
		During the second prior investigation, the investigation caseworker maintained regular, quality contact with the family.	1
	Home Visiting Programs		1
		The DFS caseworker referred the child to an early intervention program.	1
	Legal Guardian		3
		When an appropriate safety agreement could not be reached, DFS sought custody of the children.	1
		When the mother failed to present to the emergency department with the children for medical evaluations, DFS immediately petitioned for custody of the children.	1

		The non-custodial adults who presented to the emergency department with the children were not allowed to remain at the children's bedside. As a result, the children's demeanor immediately changed, and they had open communication with the forensic nurse.	1
	Parental Risk Factors		2
		The DFS caseworker referred the mother for parenting education, a mental health evaluation, and a domestic violence evaluation.	1
		During the prior investigation, the DFS caseworker educated the family on infant safe sleep practices.	1
Grand Total			**40**

FINAL REVIEWS

System Area	Strength	Count of #	Count of #
Grand Total			

TOTAL CAN PANEL STRENGTHS **40**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

July 30, 2024

INITIAL REVIEWS

MDT Response	**8**
Communication	2
General - Civil Investigation	1
General - Criminal Investigation	1
General - Criminal/Civil Investigation	1
Interviews - Adult	1
Interviews - Child	2
Medical	**11**
Documentation	1
Medical Exam	1
Medical Exam/ Standard of Care - ED	2
Medical Exam/ Standard of Care - PCP	1
Reporting	6
Risk Assessment/ Caseloads	**21**
Caseloads	13
Reporting	1
Risk Assessment - Closed Despite Risk Level	1
Risk Assessment - Tools	5
Risk Assessment - Unsubstantiated	1
Safety/ Use of History/ Supervisory Oversight	**5**
Safety - Completed Incorrectly/ Late	4
Safety - Inappropriate Parent/ Relative Component	1
Unresolved Risk	**10**
Child Risk Factors	1
Contacts with Family	2
Parental Risk Factors	7
Grand Total	**55**

FINAL REVIEWS

Sum of	Column Labels	
Row Labels	***Current**	**Grand Total**
Medical	**1**	**1**
Medical Exam/ Standard of Care - ED	1	1
Grand Total	**1**	**1**

TOTAL CAN PANEL FINDINGS **56**

*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

July 30, 2024

INITIAL REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			8
	Communication		**2**
		DFS delayed notifying law enforcement of the child's positive drug test for three days, compromising law enforcement's ability to complete evidentiary measures for the criminal investigation.	1
		DFS delayed in notifying law enforcement of the child's injuries suspicious for abuse, thereby prohibiting law enforcement from being present for initial conversation with the medical provider as well as initial interviews with parents.	1
	General - Civil Investigation		1
		There was a ten-month delay between when the prior investigation was returned to DFS and when the DFS caseworker took measures to intervene with the family.	1
	General - Criminal Investigation		1
		The initial responding law enforcement agency did not initially conduct an MDT response, thereby not completing timely interviews, a scene examination, or doll re-enactment.	1
	General - Criminal/Civil Investigation		1
		An initial joint investigation did not occur. DFS conducted an interview with the mother prior to law enforcement's response, and law enforcement conducted interviews with the parents and grandparents without prior notice to DFS.	1
	Interviews - Adult		1
		There was no documentation that the DFS caseworker attempted to engage with the father during the investigation.	1
	Interviews - Child		2
		There was a delay in referring the child's sibling to the children's advocacy center for a forensic interview.	1
		The MDT did not have the half-sibling, who visited the home, or the non-relative child, who reportedly resided in the home, interviewed at the children's advocacy center.	1
Medical			**11**
	Documentation		1
		There was conflicting documentation within the emergency department assessments. The emergency department physician noted there were no subconjunctival hemorrhages and the hospital pediatrician noted potentially small subconjunctival hemorrhages on both eyes.	1
	Medical Exam		1
		A physical abuse assessment was not completed by the initial treating hospital emergency department, the child's PCP, or the child's medical specialist, despite noting physical indications of suspected abuse and neglect.	1
	Medical Exam/ Standard of Care - ED		2
		The treating hospital did not consider a urine drug screen (UDS) for the siblings. The victim had previously tested positive for a controlled substance.	1
		The child's body temperature was not initially obtained by the treating hospital, thereby potentially deterring an accurate assessment of time of death.	1
	Medical Exam/ Standard of Care - PCP		1
		The child had not received any medical care since birth despite a primary care physician being identified within the birth records.	1
	Reporting		6
		The treating hospital made a report to the DFS Report Line through the online portal instead of making a call to the 1-800 number. A call was required since an immediate response from DFS was needed.	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

		Multiple medical providers, who assessed the child on separate dates, failed to report physical indications of suspected abuse and neglect to the DFS Report Line.	1
		The treating hospital did not make a report to the DFS Report Line when the child was pronounced deceased.	1
		The mother's therapist, who visited the home around the time of the death incident and witnessed the mother returning to the home to check on the children, did not make a report to the DFS Report Line.	1
		On two occasions, the initial treating emergency department did not make a report to the DFS Report Line for injuries sustained to a non-mobile infant, one without explanation and the other inconsistent with the explanation provided by the parents. For the near death incident, the emergency department physician consulted with Pediatrics, non-accidental trauma was discussed and documented.	1
Risk Assessment/ Caseloads			**21**
	Caseloads		13
		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
		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 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 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
		The DFS caseworker was over the investigation caseload statutory standards the entire time the current and prior cases were open. The caseload appears to have had a negative impact on the investigations.	1
		The DFS caseworker was over the investigation caseload statutory standards during the prior and current cases. However, it does not appear that the caseloads negatively impacted the DFS response to the cases.	1
		The DFS caseworker was slightly over treatment caseload statutory standards the entire time the case was open. However, the caseload should not have negatively impacted the DFS response to the case.	1
		The caseworkers were over the investigation and treatment caseloads for the prior and current cases. However, it does not appear that the caseload negatively impacted the DFS response to the cases.	1
		For the second prior investigation, the DFS caseworker was over the investigation caseload statutory standards the entire time the case was open, and the caseload appears to have negatively impacted the DFS response to the case.	1
		The caseworkers were over the investigation and treatment caseloads the entire time the cases were open. However, it does not appear that the caseload negatively impacted the DFS response to the cases.	1
		The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open, and the caseload appears to have negatively impacted the DFS response to the case.	1
	Reporting		1
		The DFS intake worker documented the follow-up information from the hospital regarding additional injuries as a progress note to the initial hotline report versus creating a new hotline report.	1
	Risk Assessment - Closed Despite Risk Level		1
		For the second prior investigation, the case was closed against the risk score. The elements required to override the SDM Risk Assessment recommendation were not present.	1
	Risk Assessment - Tools		5
		The prior investigation, which was addressed by a contracted agency, should have been returned to DFS sooner due to lack of cooperation by the family.	1
		For the near death investigation, the SDM Risk Assessment was not completed correctly, which resulted in a low score. The policy override was not applied, and this may have impacted the decision to transfer the case to treatment versus case closure.	1
		In the prior investigation, the mother's mental health and out of state child protective services' history were not considered in the SDM Risk Assessment. As a result, the case was not considered for ongoing treatment services.	1

		For the second prior investigation, the subsequent hotline report was assigned a Priority-3 response in contrast with the SDM Response Priority Assessment. It was noted that drug paraphernalia was consistently being left where the children would have access, which met criteria for a Priority-1 response.	1
		During the treatment case, a Family Strengths and Needs Assessment was not completed for the maternal relative as the primary caregiver for the older siblings. The siblings were removed from the family service plan, which only focused on the child, and the plan did not address the conditions of the home.	1
	Risk Assessment - Unsubstantiated		1
		For the near death incident, DFS did not consider a Level 4 finding of Poisoning, instead substantiating at Level 3 for Neglect.	1
Safety/ Use of History/ Supervisory Oversight			**5**
	Safety - Completed Incorrectly/ Late		4
		The original safety agreement was not promptly amended when information regarding additional injuries was learned, which could have allowed the perpetrator access to the child.	1
		DFS placed a child from another home, with the family while the family was still under an active DFS response.	1
		For the second prior investigation, a child safety agreement was not immediately implemented for the infant born with prenatal substance exposure when the hospital reported behaviors of co-sleeping. An agreement was initiated several days later.	1
		During the near death investigation, a child safety agreement was not implemented while the child was in the hospital prior to the father obtaining custody. Furthermore, a child safety agreement was not implemented with the father preventing unsupervised contact by the mother and maternal relative, where there were concerns of the child's safety in the relative's home.	1
	Safety - Inappropriate Parent/ Relative Component		1
		During the near death investigation, the child safety agreement for the siblings inappropriately identified the maternal relative as a safety participant despite multiple concerns of the relative's ability to be adequately protective.	1
Unresolved Risk			**10**
	Child Risk Factors		1
		There was no documentation by the DFS caseworker that the sibling's behavioral issues were addressed with the family, which resulted in multiple hotline reports.	1
	Contacts with Family		2
		The DFS treatment caseworker delayed in conducting required contacts with the family and child.	1
		During the treatment case, there was minimal contact made with the maternal relative and the siblings, and the conditions of the home, which was condemned and the family was evicted, were not documented.	1
	Parental Risk Factors		7
		For the prior investigation, upon completion of group supervision, the DFS investigation was closed and not transferred to treatment, despite remaining concerns for the child's safety related to the mother's risk factors.	1
		Prior to and during the previous investigation, the mother expressed frustration of being overwhelmed with the children, and there was no documentation as to whether those concerns were addressed. An initial report by the children's primary care physician was screened out as no information of maltreatment to the children.	1
		In the prior investigation, a thorough home assessment was not completed. The basement of the home was not observed and there was no description of the children's bedrooms documented.	1
		For the second prior investigation, there was not a strong response to the subsequent allegations reported. There was no documentation of a home assessment or observations of the home, an appropriate safe sleep environment was not observed for the infant prior to hospital discharge, and there was no follow up with the older sibling who initially refused to be interviewed by the DFS caseworker.	1
		For the second prior investigation, substance abuse issues were noted for the mother, but the documentation did not show that the DFS caseworker adequately assessed the issues and the potential impact on child safety.	1

		There was no documentation by the DFS caseworker that the subsequent reports of the maternal relative making connections for the mother while she remained incarcerated were addressed. This was concerning for the maternal relative's appropriateness as a guardian for the two older siblings.	1
		The mother's case plan was not adequately written to allow the mother to make progress while incarcerated.	1
Grand Total			**55**

FINAL REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
Medical			1
	Medical Exam/ Standard of Care - ED		1
		The treating hospital ED permitted the family to have contact with the child, after death and prior to response by the law enforcement agency or the forensic investigators.	1
Grand Total			**1**

TOTAL FINDINGS **56**