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CHILD PROTECTION ACCOUNTABILITY COMMISSION
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EXECUTIVE DIRECTOR

November 20, 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. Thus far in 2024, CPAC has screened in 52 cases (7 deaths and 45 near deaths) and screened out another 132 cases, many of which are poisoning via drug ingestion.

As required by law, CPAC approved findings from 36 cases at its November 20, 2024 meeting.[1] Those 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 21 cases that received a final review as CPAC focused on completing final reviews of older cases this quarter. There were 3 deaths and 18 near deaths which occurred between February 2021 and September 2023. Seventeen of the cases were prosecuted. Of the three deaths, two were prosecuted and resulted in pleas to Manslaughter and incarceration of 8 and 9 years. Two child torture cases resulted in 49 and 106 years incarceration. The remaining 13 cases received no jail time. Ten of the 13 cases involved poisoning via drug ingestion including fentanyl, cocaine and xylazine, and 2 cases involved abusive head trauma to infants less than 3 months old. Outcomes in these cases is an area where CPAC and its committees continue to focus and strengthen to improve civil and criminal collaboration, presentence investigations and victim impact statements. The child torture cases are an excellent example of this collaboration.

[1] 16 Del. C. § 932.

The fifteen remaining cases were from deaths or near deaths that occurred between December 2023 and March 2024. Of these cases, four will have no further review and were not prosecuted – these include poisoning via drug ingestion, bone fractures and medical neglect. The remaining eleven cases – 2 deaths and 9 near deaths - will remain open pending prosecutorial outcomes. These cases include blunt force and abusive head trauma, child torture, medical neglect, strangulation and poisoning via drug ingestion.

For these fifteen December 2023 through March 2024 cases, there were 24 strengths and 35 current findings across system areas. Sixteen strengths and 7 findings were noted for the Multidisciplinary Team Response. These numbers demonstrate the continued forward progress in the expertise of the frontline teams. Several of these cases noted excellent or good MDT responses. CPAC will continue to watch these trends. For the medical response, this quarter demonstrated marked improvement with 3 strengths and 4 findings. The 2025 reporting training for medical providers will unveil in January utilizing case scenarios and follow up questions as well as providing advanced trainings on drug ingestions and abusive head trauma.

Five strengths and 24 findings were noted regarding the Division of Family Services ("DFS"). Twelve of the DFS findings were regarding caseloads. The 23 remaining DFS findings primarily focus on breakdowns in assessing parental risk factors and use of collaterals. DFS regularly utilizes these cases for training and supervision to improve frontline outcomes. DFS was commended in several cases this quarter in implementing appropriate child safety agreements.

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

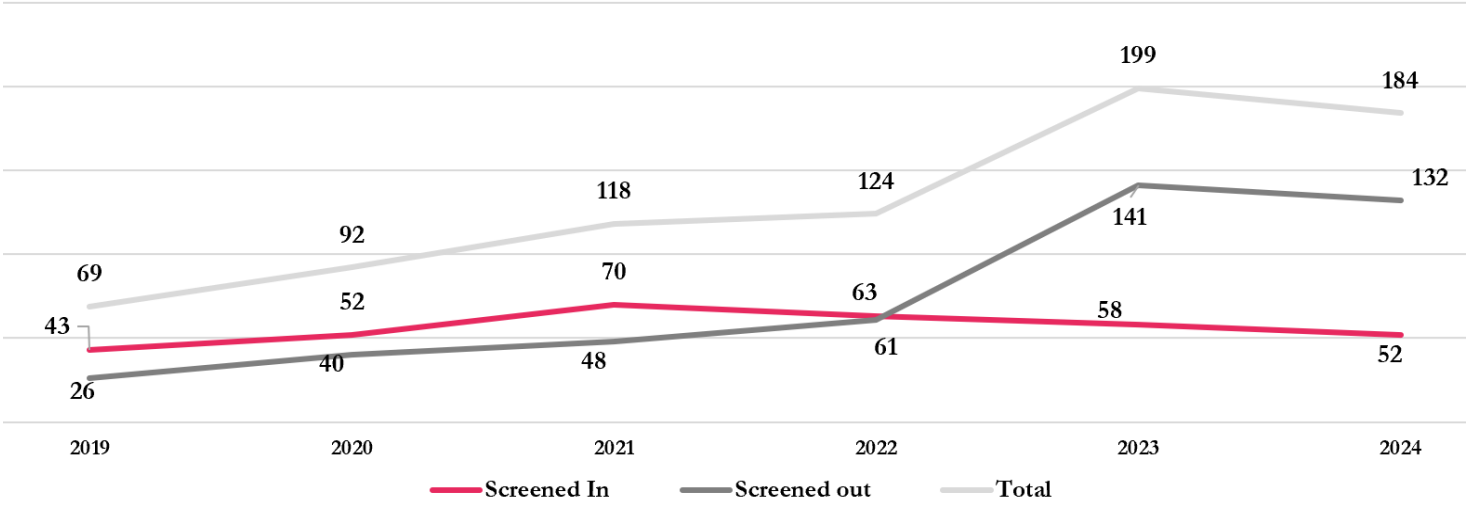
cc: CPAC Commissioners, General Assembly

Child Abuse and Neglect Panel (CAN)

Child Protection Accountability Commission (CPAC)

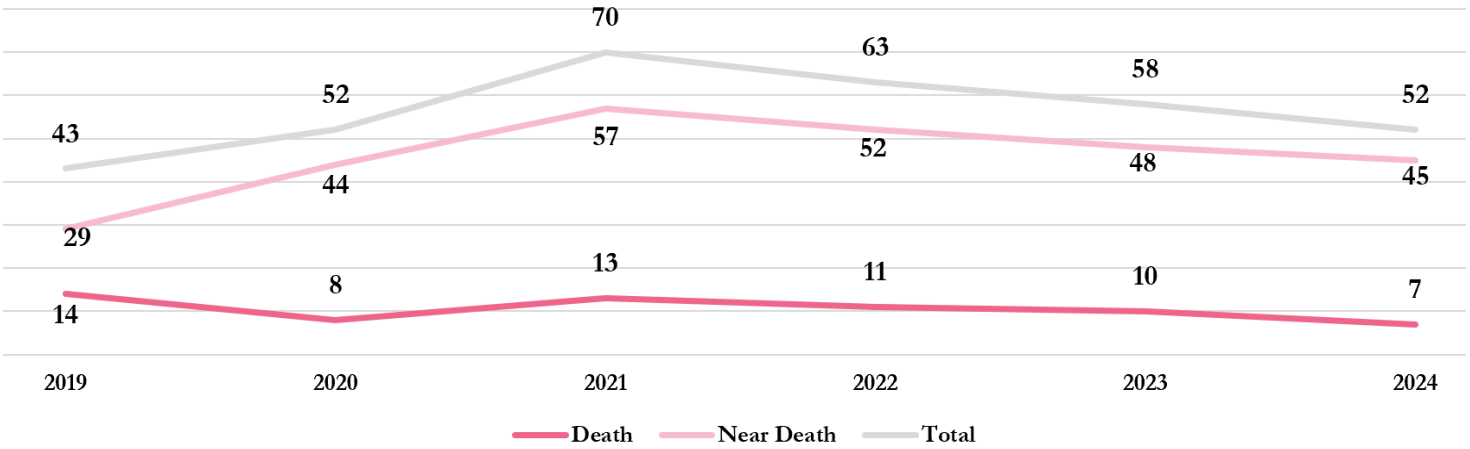
Report Updated: 10/22/2024

Screening Decisions of CAN Cases

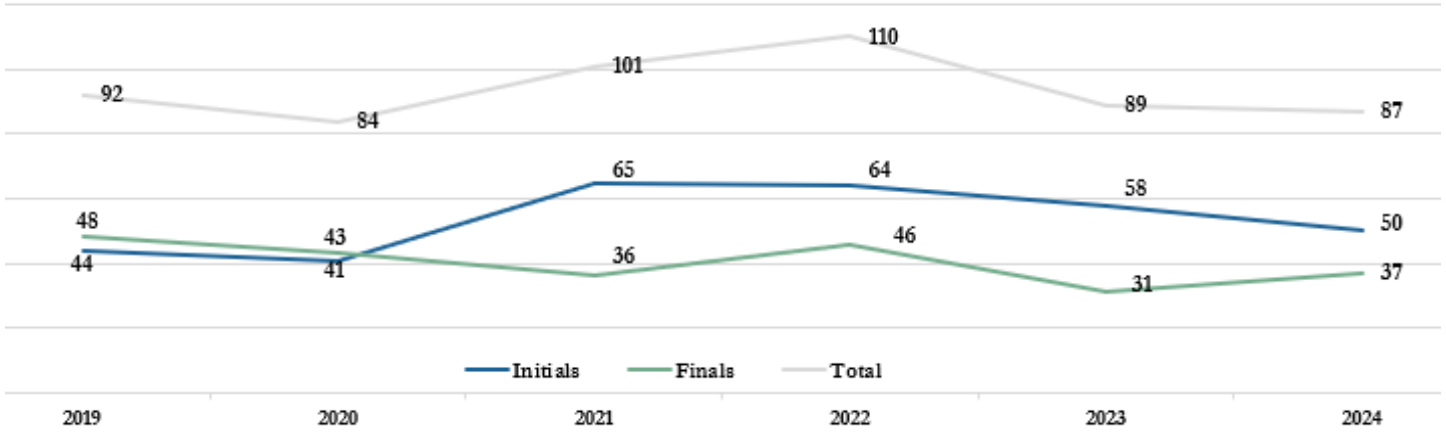


All cases are initially screened in. For the current year, some cases may be screened out after medical records are received and reviewed. Screened out cases in 2024 reflect the date of CAN closure.

Screened In Death and Near Death Cases



Initials and Finals by Calendar Year



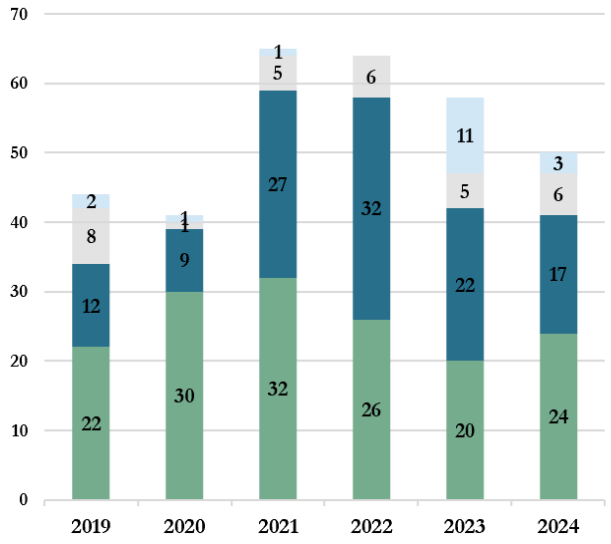
16 Del. C. § 932(c) requires CPAC to review a case within 6 months of a report. In August 2021, CPAC voted to extend the timeframe to 9 months, which is how compliance is calculated above.

Child Abuse and Neglect Panel (CAN)

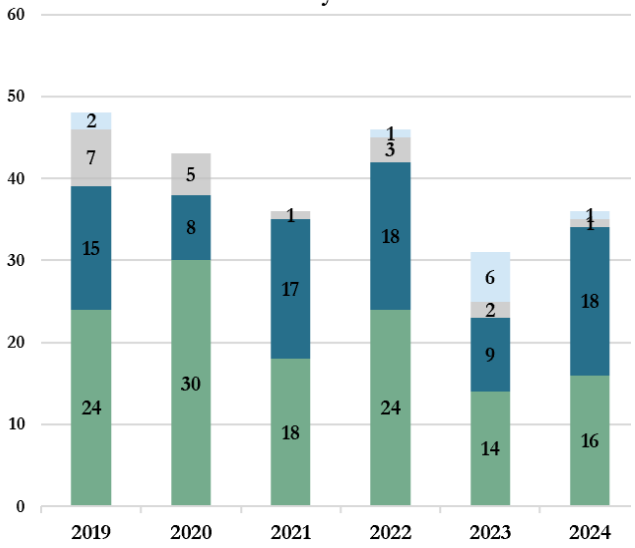
Child Protection Accountability Commission (CPAC)

Report Updated: 10/22/2024

Initial Reviews by CAN Panel

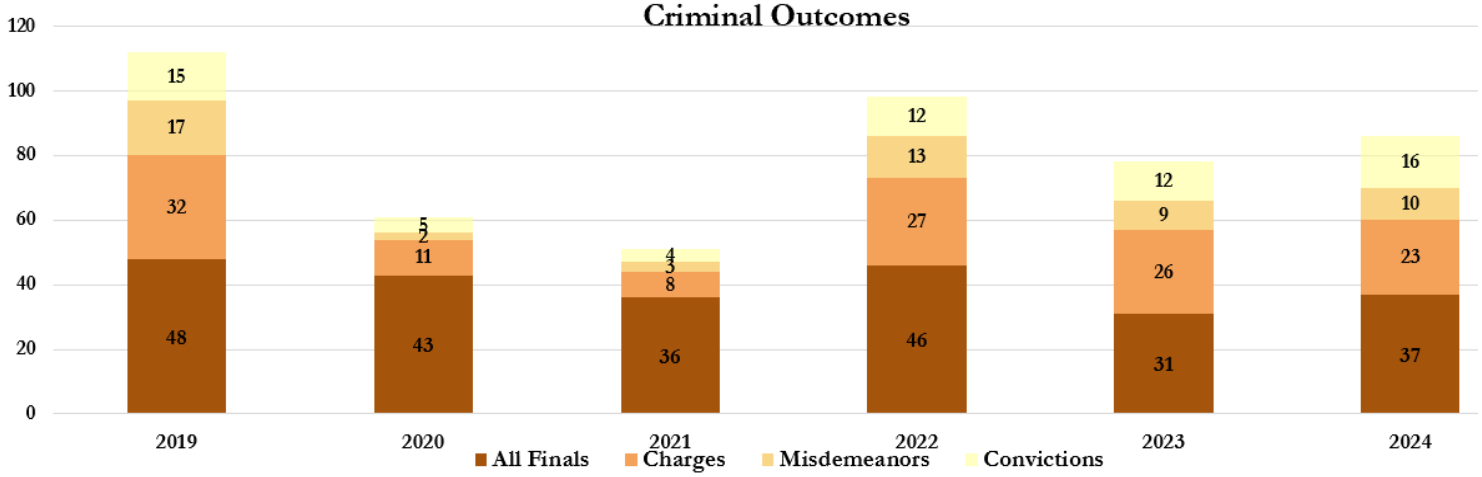


Final Reviews by CAN Panel



Unknown/Other | Unsafe Sleep | Poisioning via Drug Ingestion | Physical Abuse

Criminal Outcomes

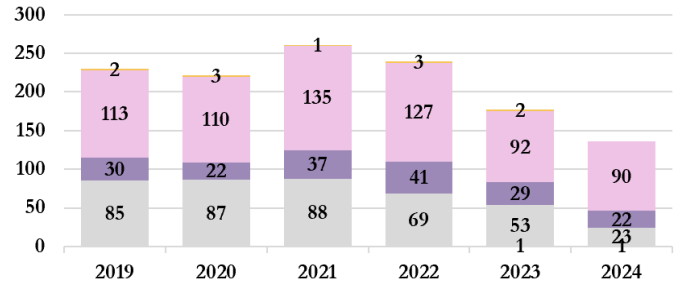


All Finals | Charges | Misdemeanors | Convictions

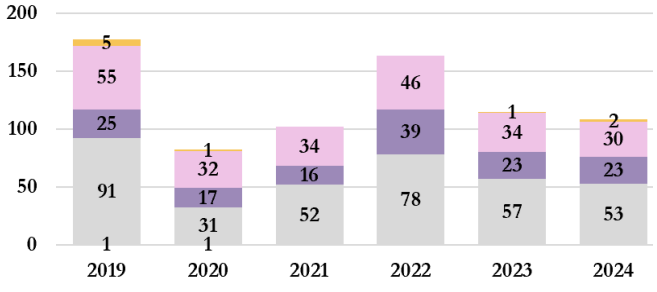
Numbers are based on when the case had the final review not the date of incident.

Findings and Strengths by the CAN Panel

Findings



Strengths



Education | MDT Response | Medical | DFS | Legal

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

INITIAL REVIEWS

	Current
MDT Response	**16**
General - Civil Investigation	1
General - Criminal Investigation	3
General - Criminal/Civil Investigation	9
Medical Exam	3
Medical	**3**
Communication	1
Reporting	2
Risk Assessment/ Caseloads	**1**
Collaterals	1
Safety/ Use of History/ Supervisory Oversight	**3**
Completed Correctly/On Time	3
Unresolved Risk	**1**
Parental Risk Factors	1
Grand Total	**24**

FINAL REVIEWS

	Current
Legal	**2**
Prosecution/Pleas/Sentence	2
Grand Total	**2**

TOTAL CAN PANEL STRENGTHS	**26**

Office of the Child Advocate
900 King Street, Ste 350
Wilmington, DE 19801

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

INITIAL REVIEWS

System Area	Strength	Public Rationale	Count of #
MDT Response			16
	General - Civil Investigation		1
		The DFS caseworker provided the mother with a lockbox and educated the mother on the proper storage for substances and medications. During a follow up home visit, the DFS caseworker ensured the lockbox was being used appropriately.	1
	General - Criminal Investigation		3
		The law enforcement agency ensured evidentiary blood draws were conducted for the child's caregivers and the surviving siblings.	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 members. The investigation resulted in appropriate criminal charges being filed against the perpetrator. During arraignment, the detective advocated for a high bail as the perpetrator was transient.	1
		The law enforcement agency ensured evidentiary blood draws were completed for the child and the mother.	1
	General - Criminal/Civil Investigation		9
		There was a good MDT response to the death investigation, which included joint responses to the home, joint interviews, where applicable, medical evaluations and forensic interviews of the siblings, and consistent communication and collaboration among the MDT members.	1
		There was a good MDT response to the death incident, which included joint responses to the family's and the relative's homes, joint interviews with the mother, medical follow up for the victim and the siblings, and consistent communication and collaboration among the MDT members.	1

	There was a good MDT response to the near death incident, which included a joint response to the family's home, joint interviews, where applicable, medical evaluation and forensic interviews of the siblings, recording of the water temperature in the home, a doll reenactment, 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 initial treating hospital and to the family's home, joint interviews, where applicable, medical evaluation of the twin sibling, forensic interviews of the children, 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 family's home, joint interviews, medical evaluations and forensic interviews of the siblings, and consistent communication and collaboration among the MDT members.	1
	There was an excellent MDT response to the near death incident, despite the lack of initial joint response to the hospital. The response included joint responses the following day to the hospital and to the daycare facility, joint interviews where applicable, offers of medical evaluations for the other children attending the daycare facility, 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, medical evaluation and forensic interview of the sibling, appropriate referrals made for the family, 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 two treating hospitals and to the shelter where the mother resided, joint interviews, where applicable, and consistent communication and collaboration among the MDT members.	1

		There was a good MDT response to the near death incident, which included a joint response to the home, joint interviews with the family members, appropriate referrals made for the family, follow up with the school staff, and consistent communication and collaboration among the MDT members, to include the child's medical team.	1
	Medical Exam		3
		The law enforcement agency ensured a medical evaluation was completed for the infant sibling after a urine drug screen for the young child resulted positive for a controlled substance. The medical evaluation included a urine drug screen despite the infant sibling being asymptomatic at the time of the evaluation.	1
		The DFS caseworker advocated for the twin sibling to be medically evaluated by the children's hospital despite the initial treating hospital determining the child was cleared for medical discharge.	1
		A medical evaluation was completed for the sibling residing in the home. The evaluation included a urine drug screen.	1
Medical			3
	Communication		1
		There was good communication and collaboration between the initial treating hospital and the out of state hospital, where the mother and the child were transferred.	1
	Reporting		2
		Upon learning of the child's death, the primary care physician made a report to the DFS Report Line with concerns for the siblings' most recent missed medical appointments.	1
		The CARE Team made an immediate report to the DFS Report Line when the child's caregiver reported a violation of the child safety agreement.	1
Risk Assessment/ Caseloads			1
	Collaterals		1
		The DFS caseworker consulted with the out of state child protective services agencies in the states the family was known to previously reside.	1
Safety/ Use of History/ Supervisory Oversight			3
	Completed Correctly/On Time		3

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

		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. The agreement also included the sibling 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. The agreement included the siblings residing in the home and was specifically structured to meet the family's needs. There was consistent review and modification, when necessary, of the safety agreement.	1
Unresolved Risk			1
	Parental Risk Factors		1
		The DFS caseworker made timely, appropriate referrals for the family, which included parent education, family therapy, protective daycare for the child, and counseling resources for the older half-sibling to address past trauma disclosed during the forensic interview.	1
Grand Total			24

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

FINAL REVIEWS

System Area	Strength	Public Rationale	Count of #
Legal			2
	Prosecution/ Pleas/Sentence		2
		The mother received a structured sentence that focused on substance abuse treatment and protection for the child.	1
		There was good communication and collaboration between the Criminal DAG, the Civil DAG, and the Child Attorney. The defendants were sentenced at the highest ends of the sentencing guidelines.	1
Grand Total			**2**

TOTAL CAN PANEL STRENGTHS	26

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

INITIAL REVIEWS	
MDT Response	**7**
Crime Scene	1
General - Civil Investigation	3
Interviews - Adult	2
Transport	1
Medical	**4**
Medical Exam/ Standard of Care - ED	1
Reporting	2
Transport	1
Risk Assessment/ Caseloads	**18**
Caseloads	12
Collaterals	3
Risk Assessement - Tools	1
Risk Assessment - Abridged	1
Risk Assessment - Screen Out	1
Safety/ Use of History/ Supervisory Oversight	**2**
Use of History	2
Unresolved Risk	**4**
Child Risk Factors	1
Contacts with Family	1
Parental Risk Factors	2
Grand Total	**35**

FINAL REVIEWS	
MDT Response	**1**
Prosecution/ Pleas/ Sentence	1
Medical	**2**
Reporting	2
Safety/ Use of History/ Supervisory Oversight	**1**
Safety - Completed Incorrectly/ Late	1
Grand Total	**4**

TOTAL CAN PANEL FINDINGS	**39**

Office of the Child Advocate
900 King Street, Ste 350
Wilmington, DE 19801

Prepared 11/7/2024

Child Protection Accountability Commission
Child Abuse and Neglect Panel
Findings Detail

INITIAL REVIEWS

System Area	Finding	PUBLIC Rationale	Count of #
MDT Response			7
	Crime Scene		1
		There was a delay in the law enforcement agency obtaining search warrants. As a result, the scene investigation was delayed.	1
	General - Civil Investigation		3
		There was not an initial MDT response to the near death incident in compliance with the MOU and statute.	1
		A DFS caseworker was unable to make an initial joint response to the treating hospital with law enforcement due to staffing issues.	1
		There was no initial response by DFS. There was an erroneous understanding of DFS's role in afterhours Institutional Abuse cases.	1
	Interviews - Adult		2
		There was no documentation that the law enforcement agency provided the DFS caseworker an opportunity to observe the formal interviews conducted.	1
		The DFS caseworker was delayed in conducting initial interviews with the family.	1
	Transport		1
		The mother, who was a suspect, transported the siblings to the emergency department for medical evaluations; however, the DFS caseworker should have made arrangements for transportation. The medical evaluations were not completed timely.	1
Medical			**4**
	Medical Exam/ Standard of Care - ED		1
		The treating hospital did not consider a urine drug screen for the sibling. The victim had previously tested positive for a controlled substance.	1
	Reporting		2
		In the three years prior to the child's death, there were documented concerns for the mother's lack of medical follow up for the child and the siblings by the pediatrician and other subspecialties involved in the child's care. During this time, there were no reports made to the DFS Report Line.	1
		The child's primary care physician did not make a report to the DFS Report Line when x-rays for the young child identified a skull fracture.	1
	Transport		1
		The child's primary care physician referred the young child to the emergency department for further evaluation but did not arrange for alternative transportation.	1
Risk Assessment/ Caseloads			**18**
	Caseloads		12
		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.	7
		The DFS caseworkers were over 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 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
		The DFS caseworkers were 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 over the investigation caseload statutory standards the entire time the current case was open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	2
	Collaterals		3

		For the prior investigation, a history check with the out of state CPS agency, where the older sibling was previously placed into foster care, was not completed by the DFS caseworker.	1
		For the current investigation, a history check was not completed in a timely manner. As a result, the prior cases with concerns of physical abuse and food restriction were not known at the start of the investigation.	1
		During the prior investigation, a collateral contact was not completed with non-professional sources close to the family.	1
	Risk Assessement - Tools		1
		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
	Risk Assessment - Abridged		1
		The prior investigation was abridged by DFS after the mother complied with weight checks, despite medical collaterals indicating the teen was still significantly underweight and only lost weight when in the mother's care. There were additional concerns of the mother's lack of follow through with medical providers.	1
	Risk Assessment - Screen Out		1
		The initial hotline report of a young child with a positive drug screen for marijuana was screened out in error by the DFS Report Line.	1
Safety/ Use of History/ Supervisory Oversight			**2**
	Use of History		2
		For the prior investigation, history was not sufficiently considered before abruptly closing the case. There had been multiple cases involving concerns for physical abuse and food restriction.	1
		For the prior investigation, history was not sufficiently considered before abridging the case. The history showed a pattern of medical neglect behaviors resulting in prior hospitalizations for the teen.	1
Unresolved Risk			**4**
	Child Risk Factors		1
		There was no documentation that the DFS caseworker referred the victim to an early intervention program.	1
	Contacts with Family		1
		For the prior investigation, the DFS caseworker did not complete the standard 30-day contacts with the child for a two-month period.	1
	Parental Risk Factors		2
		There was no documentation as to whether the DFS caseworker provided a lockbox to the mother for safe medication storage and no documentation that the caseworker addressed how the child accessed the sibling's prescribed medication.	1
		The DFS caseworker did not prioritize confirming the mother and child had safe, stable housing prior to the near death incident. Furthermore, it does appear that there was any follow up action taken by the DFS caseworker when the out-of-state CPS agency confirmed that the mother provided a false address.	1
Grand Total			**35**

FINAL REVIEWS

System Area	Finding	PUBLIC Rationale	Count of #
MDT Response			1
	Prosecution/ Pleas/ Sentence		1
		MDT best practices were not followed by DOJ regarding communication between the criminal and civil attorneys impacting child victim involvement during criminal case resolution.	1
Medical			2
	Reporting		2
		The birthing hospital reported the positive drug screen results to the ordering physician, a temporary resident, rather than to the infant's primary care physician. As a result, the Plan of Safe Care for the substance exposed infant was not updated.	1
		The treating hospital did not make a report to the DFS Report Line when the child presented with cutaneous injuries.	1
Safety/ Use of History/ Supervisory Oversight			1
	Safety - Completed Incorrectly/ Late		1
		During the prior investigation, a child safety agreement was not implemented when an instant read drug screen for the mother returned positive for a controlled substance. The mother had multiple prior positive drug screens, all of which she contested.	1
Grand Total			**4**