STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
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CHAIR

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EXECUTIVE DIRECTOR

February 19, 2025

The Honorable Matthew Meyer
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 Meyer:

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. In 2024, CPAC screened in 59 cases (9 deaths and 50 near deaths) and screened out another 178 cases, many of which are child poisoning via drug ingestion.

As required by law, CPAC approved findings from 22 cases at its February 19, 2025, 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 7 cases that received a final review as CPAC focused on completing final reviews of older cases this quarter. There were 2 deaths and 5 near deaths which occurred between May 2022 and November 2023. The 5 near deaths were prosecuted – the 2 deaths were unsafe sleep and were not. One case resulted in a Child Abuse 1st conviction but only two years of incarceration. The infant suffered abusive head trauma with retinal hemorrhages that has resulted in significant global developmental delays, including a feeding tube. The remaining 4 cases received no jail time. Outcomes in these cases, and two findings this quarter, are areas where CPAC and its committees continue to focus and strengthen to improve civil and criminal collaboration, presentence investigations and victim impact statements.

[1] 16 Del. C. § 932.

The fifteen remaining cases were from deaths or near deaths that occurred between April and June 2024. Of these cases, three will have no further review and were not prosecuted – these include poisoning via drug ingestion, bone fractures and failure to thrive/medical neglect. The remaining twelve cases – 3 deaths and 9 near deaths - will remain open pending prosecutorial outcomes. These cases include abusive head trauma, child torture, failure to thrive/medical neglect, unsafe sleep and poisoning via drug ingestion.

For these fifteen April through June 2024 cases, there were 28 strengths and 22 findings across system areas. Sixteen strengths and only 4 findings were noted for the Multidisciplinary Team Response. These numbers demonstrate the continued forward progress in the expertise of the frontline teams. Once again this quarter, several of these cases noted excellent or good MDT responses – in fact, 10 strengths were noted. CPAC will continue to watch these trends. For the medical response, this quarter demonstrated marked improvement with 8 strengths and 4 findings. The 2025 recognition and reporting training for medical providers is in process, and the initial content feedback has been positive. In addition to basic and refresher training, advanced trainings on drug ingestions, sentinel injuries and abusive head trauma have also been offered this session.

Four strengths and 14 findings were noted regarding the Division of Family Services ("DFS"). Most of the DFS findings were regarding caseloads (9). No trends were seen in the 5 other findings. DFS was commended in several cases this quarter in its MDT response as well as its use of collaterals.

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, as well as summaries of the CAN Findings and Drug Ingestions, 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 Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

INITIAL REVIEWS	
MDT Response	**4**
Interviews - Child	1
Medical Exam	2
Reporting	1
Medical	**4**
Medical Exam/ Standard of Care - Birth	1
Medical Exam/ Standard of Care - ED	1
Reporting	1
Transport	1
Risk Assessment/ Caseloads	**10**
Caseloads	9
Collaterals	1
Safety/ Use of History/ Supervisory Oversight	**1**
Safety - Completed Incorrectly/ Late	1
Unresolved Risk	**3**
Contacts with Family	1
Home Visiting Programs	1
Parental Risk Factors	1
Grand Total	**22**

FINAL REVIEWS	
MDT Response	**2**
Prosecution/ Pleas/ Sentence	2
Grand Total	**2**

TOTAL CAN PANEL FINDINGS	**24**

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Prepared 2/13/2025

Child Protection Accountability Commission
Child Abuse and Neglect Panel
Findings Detail

INITIAL REVIEWS

System Area	Finding	PUBLIC Rationale	Count of #
MDT Response			4
	Interviews - Child		1
		An older sibling, residing in the home but not present when the incident occurred, was not interviewed by the DFS caseworker or the law enforcement agency.	1
	Medical Exam		2
		The young sibling residing in the home at the time of the near death incident was not medically evaluated until approximately two weeks later.	1
		The DFS caseworker did not ensure the family completed the follow up specialty appointment where additional imaging was needed to diagnose the possible fracture. The child did not show for the scheduled appointment.	1
	Reporting		1
		The DFS caseworker did not notify law enforcement of the initial referral regarding physical discipline in the home.	1
Medical			4
	Medical Exam/ Standard of Care - Birth		1
		A drug screen was not conducted on the infant when the young mother tested positive for marijuana at the time of delivery.	1
	Medical Exam/ Standard of Care - ED		1
		The child's temperature was not initially obtained by the treating hospital, thereby potentially deterring an accurate assessment of time of death.	1
	Reporting		1
		The birthing hospital failed to report the substance exposed birth to the DFS Report Line.	1
	Transport		1
		The pediatrician allowed the family to transport the child to the emergency department despite having concerns of lethargy, decreased responsiveness, and eye deviation.	1
Risk Assessment/ Caseloads			10
	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.	6
		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, 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 the entire time the case was open. However, it is unclear whether the caseload had a negative impact on the DFS response to the case.	1
	Collaterals		1
		A history check with the out of state CPS agency, where the children were previously placed into relative care, was not completed by the DFS caseworker.	1
Safety/ Use of History/ Supervisory Oversight			1
	Safety - Completed Incorrectly/ Late		1
		A safety assessment was not completed following the initial referral despite the child disclosing physical discipline in the home. As a result, there was no child safety agreement implemented.	1
Unresolved Risk			3
	Contacts with Family		1
		When the initial case was received, timely contact with the family was not made by the DFS caseworker. The DFS caseworker attempted phone contact with the mother; however, when unsuccessful, no unannounced home visits, school visits, or letters were attempted to meet the assigned priority response time.	1
	Home Visiting Programs		1
		There was no documentation that the DFS caseworker referred the victim to an early intervention program.	1
	Parental Risk Factors		1
		There was no documentation that the DFS caseworker conducted a home assessment with the mother, where the incident occurred, prior to the children returning to the mother's care. However, a scene investigation was completed by the law enforcement agency.	1
Grand Total			22

FINAL REVIEWS

System Area	Finding	PUBLIC Rationale	Count of #
MDT Response			2
	Prosecution/ Pleas/ Sentence		2
		MDT best practices were not followed by DOJ regarding communication between the criminal and civil attorneys impacting child victim involvement during criminal case resolution.	2
Grand Total			2

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

INITIAL REVIEWS	
	Current
MDT Response	**16**
Communication	1
General - Civil Investigation	1
General - Criminal Investigation	1
General - Criminal/Civil Investigation	10
Medical Exam	3
Medical	**8**
Documentation	1
Home Visiting Programs	1
Medical Exam/Standard of Care - Forensics	1
Medical Exam/Standard of Care - Specialists	1
Reporting	4
Risk Assessment/ Caseloads	**2**
Collaterals	2
Safety/ Use of History/ Supervisory Oversight	**2**
Completed Correctly/On Time	2
Grand Total	**28**

FINAL REVIEWS	
	Current
Legal	**1**
DFS Contact with DOJ	1
Grand Total	**1**

TOTAL CAN PANEL STRENGTHS	**29**

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Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

INITIAL REVIEWS

System Area	Strength	Public Rationale	Count of #
MDT Response			16
	Communication		1
		There was good communication between the two involved law enforcement agencies.	1
	General - Civil Investigation		1
		During the prior investigation, the DFS caseworker provided the family with a lock box and educated the family on the proper storage of substances and medications.	1
	General - Criminal Investigation		1
		The law enforcement agency ensured evidentiary blood draws were completed for the child, the parents, and other adult household members.	1
	General - Criminal/Civil Investigation		10
		There was a good MDT response to the near death incident, which included a joint response to the home, joint interviews, where applicable, consideration of a forensic interview for the young sibling, 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 by law enforcement and the Institutional Abuse (IA) worker, forensic interviews for the other children present at the in-home daycare facility, and consistent communication and collaboration among the MDT members, to include the Office of Child Care Licensing (OCCL).	1
		There was good collaboration and consistent communication between the law enforcement agency and the DFS caseworker.	1
		There was a good MDT response to the near death incident, which included joint responses to the hospital and to the parents' homes, joint interviews, where applicable, 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 initial treating hospital and to the home, 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 joint responses to the hospital and the parents' residences, joint interviews, where applicable, continual follow up with the mother and medical providers when conflicting information was learned, 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 hospital, joint interviews, where applicable, a scene investigation, forensic interviews of the siblings, evidentiary blood draws, 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, where applicable, a scene investigation, evidentiary blood draws, 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 homes, joint interviews, a scene investigation, evidentiary blood draws, and consistent communication and collaboration among the MDT members.	1
	There was a good MDT response to the death incident, which included joint interviews at police headquarters, forensic interviews of the child's half-siblings, a scene investigation, and consistent communication and collaboration among the MDT members.	1
Medical Exam		3
	A medical evaluation was completed for the sibling residing in the home. The evaluation included a urine drug screen.	1

	Medical evaluations were completed for the siblings, which included urine drug screens 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
	Medical evaluations were completed for the siblings residing in the home. The evaluations included urine drug screens.	1
Medical		8
	Documentation	1
	There was good documentation within the medical record of continued, thorough DFS involvement with the family over a number of years.	1
	Home Visiting Programs	1
	There was great effort by the evidence-based home visiting program to re-engage with the young mother, which included multiple phone calls and letters mailed to the home, and to have the mother enrolled in an alternate educational program. Additionally, the home visiting nurse reported substance use in the home to the DFS Report Line.	1
	Medical Exam/ Standard of Care - Forensics	1
	A thorough forensic nurse examination was completed, which identified multiple areas of bruising and cutaneous injuries, and raised concern for rhabdomyolysis, which was reported to the emergency department physician.	1
	Medical Exam/Standard of Care - Specialists	1
	There was great coordination by the medical team, to include the hospital social worker, Patient Outreach, Case Management, and the primary care physician to assist the mother with scheduling of appointments, financial assistance, and transportation assistance for the child's medical appointments.	1
	Reporting	4
	The CARE Team made an immediate report to the DFS Report Line when the siblings' confirmation drug screens returned positive for a controlled substance.	1
	The emergency medical personnel who responded to the home made an immediate referral to the DFS Report Line regarding the child's injuries.	1

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

		The primary care physician made an immediate report to the DFS Report Line with concerns for neglect. The primary care physician also contacted the emergency department to which the child was referred for further medical evaluation.	1
		The birthing hospital made multiple reports to the DFS Report Line regarding the young mother, her living situation, her numerous sexually transmitted infections, and the positive drug screens in a minor.	1
Risk Assessment/ Caseloads			2
	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.	1
		The DFS caseworker consulted with an out of state child protective services agency in the state the family was known to previously reside.	1
Safety/ Use of History/ Supervisory Oversight			2
	Completed Correctly/On Time		2
		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 for the siblings residing in the home. There was consistent review and modification, when necessary, of the safety agreement.	1
Grand Total			**28**

FINAL REVIEWS

System Area	Strength	Public Rationale	Count of #
Legal			1
	DFS Contact with DOJ		1
		The DFS treatment worker consulted with DOJ regarding the family's lack of cooperation an	1
Grand Total			**1**

TOTAL CAN PANEL STRENGTHS	29

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