STATE OF DELAWARE
**CHILD PROTECTION ACCOUNTABILITY COMMISSION**
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TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

May 17, 2017

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 12 cases at its May 17, 2017 meeting.[1]

Six of the cases have completed prosecution, or prosecution was declined. The final reviews resulted in 2 new findings. Strengths in the MDT response and in the home visiting programs were noted.

The six remaining cases were from deaths or near deaths that occurred between July 2016 and November 2016. These resulted in 33 strengths and 43 findings across system areas. The strengths demonstrate significant advocacy by the DFS case workers. The system breakdowns and findings from the July through November 2016 cases continue to be the MDT response for criminally investigating child abuse cases, the medical responses to these children pre and post incident, and the use of safety agreements, unresolved risk and risk assessment by DFS. In every case, the

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[1] 16 Del. C. § 932.

DFS case worker was significantly over the statutory caseload standard, and in four of the cases, safety agreements with the family were completed late or incorrectly.

CPAC held a multidisciplinary conference in April 2017, providing advanced training to the multidisciplinary team. This training included instruction on the new Memorandum of Understanding, doll re-enactments, death scene investigations and why teamwork in these cases is critical. CPAC also continues to monitor its action plan which specifically addresses many of the findings from these cases. CPAC is hopeful that the trainings, the new MOU, and the steps reflected in the action plan will address the system breakdowns that are contributing to child deaths and near deaths due to abuse or neglect in Delaware. While keenly aware of the challenges in recruiting and retaining DFS staff, CPAC is also hopeful that the 27 additional frontline positions at DFS will shortly begin to have a positive impact on caseloads and the ability to utilize safety agreements as well as to assess and resolve risk to children.

We are available should further information be required. For your information we have included the strengths, findings and the details behind all of the cases presented in this letter.

Respectfully,

Tania M. Culley, Esquire
Executive Director
Child Protection Accountability Commission

Enclosures
cc: CPAC Commissioners
General Assembly

Child Abuse and Neglect Panel

**Strengths Summary**

5-17-17

| INITIALS | |
|---|---|
| **MDT Response** | **17** |
| Documentation | 2 |
| General DFS Investigation | 8 |
| Medical Exam | 1 |
| General Criminal Investigation/DI | 1 |
| General Criminal Investigation | 5 |
| **Medical** | **13** |
| Documentation | 1 |
| Home Visiting Programs | 1 |
| Medical Exam/Standard of Care - | 3 |
| Medical Exam/Standard of Care - | 2 |
| Medical Exam/Standard of Care - | 3 |
| Medical Exam/Standard of Care - | 2 |
| Medical Exam/Standard of Care - | 1 |
| **Risk Assessment/ Caseloads** | **1** |
| Risk Assessment - Substantiated | 1 |
| **Safety/ Use of History/ Superviso** | **1** |
| Supervisory Oversight | 1 |
| **Unresolved Risk** | **1** |
| Substance Abuse | 1 |
| **Grand Total** | **33** |

| FINALS | |
|---|---|
| **Medical** | **1** |
| Home Visiting Programs | 1 |
| **MDT Response** | **1** |
| General Criminal Investigation | 1 |
| **Grand Total** | **2** |

| **TOTAL STRENGTHS** | **35** |
|---|---|

Office of the Child Advocate
900 King Street, Ste 210
Wilmington, DE 19801

# Child Abuse and Neglect Panel

**Strengths Detail and Rationale**

5-17-17

INITIALS

| System Area | Strength | Rationale | Count of # |
|---|---|---|---|
| MDT Response | | | 17 |
| | Documentation | | 2 |
| | | The law enforcement agency thoroughly documented the investigation case events. | 1 |
| | | The DFS caseworker thoroughly documented the pending medical appointments for the child. | 1 |
| | General Criminal Investigation | | 5 |
| | | The law enforcement agency immediately notified the Special Victim's Unit within the DOJ. | 1 |
| | | Excellent collaboration between law enforcement and the Division of Forensic Science for the death scene investigation. | 2 |
| | | The law enforcement detective conducted blood draws after it was suspected that the caregiver was impaired. | 1 |
| | | The law enforcement agency requested a urine drug screen for the child, a forensic nurse consultation, and supervised contact during the child's hospitalization. | 1 |
| | General Criminal Investigation/DFS Investigation | | 1 |
| | | Great MDT response, to include all parties maintainig communication throughout the investigation, and both DFS and law enforcement conducting thorough investigations for the near death incident. | 1 |
| | General DFS Investigation | | 8 |
| | | DFS took photographs of the child to demonstrate concerns of malnutrition. | 1 |
| | | Despite opposition from other MDT members, the DFS caseworker insisted that the child's condition was due to abuse and neglect. | 1 |
| | | DFS requested that a law enforcement jurisdiction with additional resources assume responsibility for the investigation. | 1 |
| | | DFS immediately contacted the PCP to obtain the child's medical history. | 1 |
| | | The DFS caseworker consulted with the child abuse medical expert. | 1 |
| | | Referrals were made to Child Development Watch, and the substance abuse and domestic violence liaisons. | 1 |
| | | DFS completed a Framework during the treatment case. | 1 |
| | | The DFS caseworker utilized a special investigator to assist in locating the child. | 1 |
| | Medical Exam | | 1 |
| | | DFS sought an immediate medical exam for the child and insisted on a skeletal survey and transfer to the children's hospital. | 1 |
| Medical | | | 13 |
| | Documentation | | 1 |
| | | Both the initial treating hospital and the transfer hospital provided subjective reports, documented verbal history given by the family, and noted discrepancies between their accounts of events. | 1 |

| | Category | Detail | Count |
|---|---|---|---|
| | Home Visiting Programs | | 1 |
| | | Referral for home-care services was completed for the family prior to discharge from the birth hospital. | 1 |
| | Medical Exam/ Standard of Care - CARE | | 2 |
| | | While an explanation provided by the family could explain the bone fractures, the CARE Team considered the history and totality of the injuries and was suspicious about ongoing abuse and/or neglect. | 1 |
| | | Despite not having medical insurance coverage, the transfer hospital sought coverage and scheduled follow-up appointments at an out of state facility for the child. | 1 |
| | Medical Exam/ Standard of Care - ED | | 3 |
| | | Staff at the local hospital emergency department immediately reached out to the transfer hospital for further evaluation and management of the child's medical needs. | 1 |
| | | The local hospital elevated care to the transfer hospital. | 1 |
| | | A sitter was placed in the room at the hospital to provide supervision for the young child with serious physical injuries. | 1 |
| | Medical Exam/ Standard of Care - Forensics | | 2 |
| | | The forensic nurse at the hospital sought permission from the Division of Forensic Science and photographed the child's body. | 1 |
| | | The initial treating hospital completed a forensic evaluation. | 1 |
| | Medical Exam/Standard of Care - Birth | | 3 |
| | | Staff at the birth hospital requested a High Risk Medical Discharge Protocol Meeting even though the child would not be discharged for several weeks. | 1 |
| | | Abusive Head Trauma/Shaken Baby Syndrome and SIDS education was well documented within the birth record. | 1 |
| | | The birth hospital flagged the case for a home visiting referral. | 1 |
| | Medical Exam/Standard of Care - Specialists | | 1 |
| | | The hospital completed a full Child At Risk Evaluation (CARE), to include consultation with neurology, orthopedics, ophthalmology, and the CARE Team to evaluate the child. | 1 |

| System Area | Strength | Rationale | Count of # |
|---|---|---|---|
| Risk Assessment/ Caseloads | | | 1 |
| | Risk Assessment - Substantiated | | 1 |
| | | DFS substantiated Mother for both a primary and secondary finding as a result of the incident and her actions at the children's hospital. | 1 |
| Safety/ Use of History/ Supervisory Oversight | | | 1 |
| | Supervisory Oversight | | 1 |
| | | The DFS caseworker regularly contacted his/her supervisor to seek guidance and to provide updates. | 1 |
| Unresolved Risk | | | 1 |
| | Substance Abuse | | 1 |
| | | DFS utilized the substance abuse liaison to assess the mother at the hospital following the birth. | 1 |
| **Grand Total** | | | 33 |

FINALS

| System Area | Strength | Rationale | Count of # |
|---|---|---|---|
| Medical | | | 1 |
| | Home Visiting Programs | | 1 |
| | | The home visiting program was very engaged with the family for two years. | 1 |
| MDT Response | | | 1 |
| | General Criminal Investigation | | 1 |
| | | Despite the two-week delay in notification to law enforcement, the agency began investigating and collecting evidence immediately thereafter. | 1 |
| **Grand Total** | | | 2 |

**TOTAL STRENGTHS** 35

Child Abuse and Neglect Panel

**Findings Summary**

5-17-17

| INITIALS | |
|---|---|
| **MDT Response** | **12** |
| Crime Scene | 1 |
| Documentation | 1 |
| General - Criminal Investigation | 3 |
| Intake with DOJ | 1 |
| Interviews - Adult | 1 |
| Interviews - Child | 3 |
| Medical Exam | 1 |
| Prosecution/ Pleas/ Sentence | 1 |
| **Medical** | **8** |
| Home Visiting Programs | 1 |
| Medical Exam/Standard of Care - Birth | 4 |
| Medical Exam/Standard of Care - PCP | 1 |
| Reporting | 2 |
| **Risk Assessment/ Caseloads** | **11** |
| Caseloads | 6 |
| Collaterals | 2 |
| Risk Assessment - Tools | 3 |
| **Safety/ Use of History/ Supervisory Oversight** | **7** |
| Completed Incorrectly/ Late | 4 |
| No Safety Assessment of Non-Victims | 1 |
| Reporting | 1 |
| Transport | 1 |
| **Unresolved Risk** | **5** |
| Domestic Violence | 1 |
| Substance Abuse | 2 |
| Substance-Exposed Infant | 2 |
| **Grand Total** | **43** |

| FINALS | |
|---|---|
| **MDT Response** | **2** |
| General - Criminal Investigation | 1 |
| Intake with DOJ | 1 |
| **Grand Total** | **2** |

TOTAL FINDINGS 45

Child Abuse and Neglect Panel

**Findings Detail and Rationale**

5-17-17

**INITIALS**

| System Area | Finding | PUBLIC Rationale | Sum of # |
|---|---|---|---|
| MDT Response | | | 12 |
| | Crime Scene | | 1 |
| | | No scene investigation was completed by the law enforcement agency. | 1 |
| | Documentation | | 1 |
| | | There was minimal documentation in the police report by the law enforcement agency. | 1 |
| | General - Criminal Investigation | | 3 |
| | | The law enforcement agency did not maintain ongoing collaboration or communication with DFS. | 1 |
| | | The law enforcement agency's evidence detection unit was not present to record the doll re-enactment. | 1 |
| | | Limited resources and education impacted the criminal investigation in that abuse was not initially suspected by the law enforcement agency. | 1 |
| | Intake with DOJ | | 1 |
| | | The law enforcement agency did not notify the DOJ Special Victims Unit of the near death incident. | 1 |
| | Interviews - Adult | | 1 |
| | | DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews at the hospital. As a result, DFS had difficulty locating the mother and surviving children. | 1 |
| | Interviews - Child | | 3 |
| | | The law enforcement agency did not attend the forensic interview with the victim. | 1 |
| | | Forensic interview did not occur with the young child, who resided in the home where the incident occurred. | 1 |
| | | There was a delay in scheduling the forensic interview with the young child, who resided in the home where the incident occurred. | 1 |
| | Medical Exam | | 1 |
| | | DFS and LE misinterpreted the findings from the CARE Team consult for the first incident as absolutely consistent with a fall and abuse was ruled out. However, the CARE Team considered the history and totality of the injuries and was suspicious about ongoing abuse and/or neglect. | 1 |
| | Prosecution/ Pleas/ Sentence | | 1 |
| | | There was a lack of resources devoted to the criminal investigation by the DOJ. | 1 |
| Medical | | | 8 |
| | Home Visiting Programs | | 1 |
| | | A Home Visiting referral was not completed for the teen mother at the child's birth. | 1 |

| Category | Subcategory | Finding | Count |
|---|---|---|---|
| | Medical Exam/Standard of Care - Birth | | 4 |
| | | Despite what appeared to be the infant experiencing an apparent life-threatening event after the birth, there was no documentation by hospital staff as to whether discharging the child on a central monitor was considered. | 1 |
| | | There was no documentation to support whether Abusive Head Trauma/Shaken Baby Syndrome or Infant Safe Sleep education was provided to the mother or father. | 1 |
| | | Abusive Head Trauma/Shaken Baby Syndrome and infant safe sleep education were not documented within the medical records. | 1 |
| | | Infant safe sleep education was not documented within the medical record. Abusive Head Trauma/Shaken Baby Syndrome education was documented. The form was signed by the mother; however, the check boxes for education completed (viewed video, nurse discussion, and brochure given) were not marked. | 1 |
| | Medical Exam/Standard of Care - PCP | | 1 |
| | | Several months prior to the near death, the PCP had concerns for the child's weight and recommended follow up in one month. Scars were also noted during this visit. However, the follow up appointment was cancelled by the caregiver and no action was taken by the PCP. | 1 |
| | Reporting | | 2 |
| | | The initial treating hospital did not report the incident to the appropriate law enforcement jurisdiction. | 1 |
| | | The PCP documented that a call was made to the DFS Report Line, but the Report Line does not reflect a call was made. The child was seen by the PCP three days prior to the near death and observed to be extremely thin and to have multiple scars. | 1 |
| Risk Assessment/ Caseloads | | | 11 |
| | Caseloads | | 6 |
| | | The DFS case worker was over the investigation caseload statutory standards the entire time the case was open. | 1 |
| | | The DFS caseworker was over the investigation caseload statutory standards for a portion of time while the case was open. However, the caseload did not negatively impact the DFS response in the near death investigation. | 2 |
| | | The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open. However, the caseload did not negatively impact the DFS response in the death investigation. | 2 |
| | | The DFS caseworker was over the treatment caseload statutory standards for the entire time while the case was open. However, the caseload did not negatively impact the DFS response. | 1 |
| | Collaterals | | 2 |
| | | In the prior investigation, a collateral contact was not completed with the home visiting program involved with the young parent. | 1 |
| | | For the death investigation, collaterals were not completed with mother’s mental health treatment provider or the children’s PCP to assess the safety and medical needs of the surviving children. | 1 |

| Category | Subcategory | Finding | Count |
|---|---|---|---|
| | Risk Assessment - Tools | | 3 |
| | | In the prior investigation, DFS did not rate the minor mother as the primary caregiver in the SDM Risk Assessment. Primary caregiver mental health, primary caregiver substance abuse or drug use, and positive toxicology screen at birth were not considered in the neglect index. As a result, the investigation was closed. | 1 |
| | | The call by the PCP to the DFS Report Line was written as a hotline progress note rather than a new report. | 1 |
| | | A Framework during the investigation was not considered to determine the next steps for a young child with serious physical injuries and no history of trauma provided by the caregivers. | 1 |
| Safety/ Use of History/ Supervisory Oversight | | | 7 |
| | Completed Incorrectly/ Late | | 4 |
| | | The SDM Safety Assessment was not completed correctly for the near death incident. The safety threat for the caregiver not meeting the child's immediate needs was marked no, and the child was determined to be safe. | 1 |
| | | In the prior investigation, the caseworker did not complete the SDM Safety Assessment correctly. The safety threat for drug-exposed infant was marked no. No agreement was entered. | 1 |
| | | The DFS safety agreement did not restrict contact between the victim and potential suspects while the child was hospitalized given father's behavior. | 1 |
| | | For the near death investigation, the caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization. | 1 |
| | No Safety Assessment of Non-Victims | | 1 |
| | | A safety agreement was not completed with caregivers of the surviving children, and risk factors included the death of a child and suspected substance abuse and mental health issues for the mother. | 1 |
| | Reporting | | 1 |
| | | The agency contracted to monitor the child's placement failed to recognize the signs of abuse and neglect during its monthly contacts with the child. As a result, no hotline report was made to the DFS Report Line. | 1 |
| | Transport | | 1 |
| | | DFS did not transport the caregiver and child to the hospital emergency department after the caseworker determined that an immediate medical examination was needed. The alleged perpetrator was responsible for transportation. | 1 |

| | | | |
|---|---|---|---|
| Unresolved Risk | | | 5 |
| | Domestic Violence | | 1 |
| | | Following the near death incident, DFS was not aware of the active PFA between the parents when the caseworker allowed contact over the holiday and modified the safety agreement to allow for supervised contact between the parents and children. | 1 |
| | Substance Abuse | | 2 |
| | | In the prior investigation, the supervisor closed the investigation despite not having the collateral information from the substance abuse provider. | 1 |
| | | In the prior investigation, DFS did not recommend a substance abuse evaluation or utilize its substance abuse liaison prior to abridging the case. This outcome influenced the disposition of a later hotline report. | 1 |
| | Substance-Exposed Infant | | 2 |
| | | In the prior investigation, there was a delay in safety planning for the substance exposed infant. Other risk factors included a teen mother, substance abuse history and multigenerational history. | 1 |
| | | The report involving the substance exposed infant was screened out, in accordance with DFS policy, and no safety planning was completed. Other risk factors included a teen mother with two young children, substance abuse history, domestic violence history, multigenerational history and no involvement with home visiting services. | 1 |
| **Grand Total** | | | 43 |

**FINALS**

| System Area | Finding | PUBLIC Rationale | Sum of # |
|---|---|---|---|
| MDT Response | | | 2 |
| | General - Criminal Investigation | | 1 |
| | | The law enforcement agency failed to complete the additional investigative actions, which impacted the criminal prosecution and resulted in a plea deal. | 1 |
| | Intake with DOJ | | 1 |
| | | The law enforcement agency did not notify the DOJ Special Victims Unit of the near death incident. | 1 |
| **Grand Total** | | | 2 |

TOTAL FINDINGS 45