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

GINGER L. WARD
CHAIR

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

February 8, 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 February 8, 2017 meeting.[1]

Five of the cases have completed prosecution, or prosecution was declined. The final reviews resulted in 6 findings primarily related to the criminal outcome. These findings include inadequate sentences for child abuse crimes together with multidisciplinary partners not reporting cases to the child abuse hotline. Three strengths were also identified in these cases -- all related to the significant positive impact the leadership of the Department of Justice Special Victims Unit is having on criminal prosecutions in these most challenging child abuse cases.

The seven remaining cases were from deaths or near deaths that occurred between June 2016 and August 2016. These resulted in 41 strengths and 50 findings across system areas. The strengths demonstrate significant improvement in criminal

[1] 16 Del. C. § 932.

investigations and medical interventions. There is also some progress in the Division of Family Services' ("DFS") response. However, there is still much room for improvement. The system breakdowns and findings from the June through August 2016 cases continue to be the law enforcement and MDT response for criminally investigating child abuse cases, the medical responses to these children pre and post incident, and the use of safety plans, unresolved risk and risk assessment by DFS. In six out of the seven cases, the DFS investigation worker was significantly over the statutory caseload standard, and in every case safety agreements with the family were completed late or incorrectly.

CPAC held a retreat with the Child Death Review Commission in September 2016 which reviewed approximately 300 prior findings from child abuse death and near death reviews. An action plan was developed which is attached to this letter together with updated progress. CPAC is hopeful that 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. 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 Protection Accountability Commission & Child Death Review Commission

2016-2017 Action Plan

Summary of Action Plan: These findings stem from the review of 41 child abuse and neglect death and near death cases for incidents that occurred between January 2015 and May 2016. The result was 303 findings across 6 system areas. 31 recommendations for system improvement are below. The recommendations will be explored by CPAC and its partner agencies.

System Area 1: Legal	**CAN Panel Findings:** Court Hearings/DFS Contact with DOJ	**# of Findings:** 26	**02/08/17 Status**
Recommendations: 1. Schedule regular meetings between DFS leadership, DOJ Family Division Deputies, and DOJ Special Victims Unit Deputies to foster relationships and to encourage discussion and problem solving. **Agency Responsible**: DFS/DOJ; **Timeframe**: 3-6 months 2. Schedule DOJ Family Division Deputies to be available or on-call to DFS after hours and on weekends, to provide legal advice regarding serious injury and death or emergency cases. **Agency Responsible**: DOJ/DFS; **Timeframe**: Immediately 3. Provide training to DFS by the DOJ Family Division. In addition to CORE 101 training, DOJ will regularly conduct refresher training for DFS, which will be offered statewide. The training will include the DOJ services available to DFS, circumstances under which DFS should seek legal advice and resources available to compel cooperation of families. The training will also be made available on the DSCYF online learning system. **Agency Responsible**: DOJ/DFS; **Timeframe**: 6-18 months ***Repeat recommendation from 2015 Action Plan*** 4. Add the DOJ Family Division and the Family Court to the Investigation Coordinator's contact list for notification of child abuse and neglect serious injury and death referrals. **Agency Responsible**: IC; **Timeframe**: Immediately 5. Develop a MDT protocol for removal of life support cases. **Agency Responsible**: DOJ/OCA/Family Court; **Timeframe**: 6-12 months 6. Require litigants to disclose DFS history on Family Court Form 16 (b), so that the Court may have DFS workers available at custody proceedings or mediators can refer at-risk cases to judges. **Agency Responsible**: Family Court; **Timeframe**: 6-12 months 7. Remain cognizant of Family Court hearing timeframes in complex child abuse cases. **Agency Responsible**: Family Court; **Timeframe**: Immediately		**CPAC/CDRC Approval Date(s):** 11/9/16; 11/18/16	1. **In Progress** Quarterly meetings being scheduled for 2017 2. **In Progress** Will be discussed at DOJ/DFS quarterly meetings. 3. **In Progress** Will be discussed at DOJ/DFS quarterly meetings and scheduled for 2018. 4. **DONE** 5. **In Progress** Training Committee has created a workgroup to develop protocol. 6. **In Progress** Family Court has approved; out for comment with Bar; will require a Rule change. 7. **DONE**

System Area 2: Medical	**CAN Panel Findings:** Home Visiting Services, Medical Exam/Standard of Care – CARE, Medical Exam/Standard of Care – ED, Medical Exam/Standard of Care – Films, Medical Exam/Standard of Care – Forensics, Medical Exam/Standard of Care – PCP, Medical Exam/Standard of Care – Undress, Reporting, Substance-Exposed Infant, Transport	**# of Findings:** 61	**02/08/17 Status**
Recommendations: 1. Incorporate into the mandatory reporting training, *Child Abuse Identification and Reporting Guidelines for Delaware Medical Providers*, the following: a. Transportation of abused children from PCP to hospital for forensic exam; b. Medical exam on all other children in the home under the age of six when a sibling presents with signs of abuse; and, c. Emergency department staff will consult the hospital forensic team and request forensic exams in cases of suspected child abuse. **Agency Responsible**: CPAC Training Committee; **Timeframe**: January 2017 2. Consider requiring birthing hospitals to make an evidenced based home visiting program referral for every at-risk newborn at discharge. Train home visiting staff to recognize child abuse risk factors and to report visit findings to the medical provider for the newborn, including the inability to schedule or complete a visit. Healthy Families America/Smart Start serves newborns younger than 3 months (and pregnant women). Other home visiting programs for pregnant women or children under the age of 3 include: Nurse Family Partnership, Parents as Teachers and Early Head Start. **Agency Responsible**: Delaware Home Visiting Community Advisory Board, Delaware Healthy Mother & Infant Consortium; **Timeframe**: 12 months 3. Develop a template for the required Child Abuse Prevention and Treatment Act (CAPTA) plan of safe care and identify the responsible agencies for initiating and monitoring the plan of safe care. **Agency Responsible:** CPAC/CDRC Committee on Substance Exposed Infants/Medically Fragile Children; **Timeframe:** 12 months		**CPAC/CDRC Approval Date(s):** 11/9/16; 11/18/16	1. **DONE** 2. **In Progress** Home Visiting Meeting this month. DHMIC also to consider. 3. **In Progress** SEI Policy Academy and SEI Committee are working on priorities, including legislation and development of plan.

System Area 3: MDT Response/Criminal Investigations	**CAN Panel Findings:** Crime Scene/Documentation, Doll Reenactments, General - Criminal Investigation, Intake with DOJ, Interviews w/Adult, Interviews w/Child, Medical Exam	**# of Findings:** 72	**02/08/17 Status**
Recommendations: 1. Finalize the Memorandum of Understanding (MOU), which will include best practice guidelines for the investigation of child abuse cases involving sexual abuse, serious physical injury or death, and provide training. **Agency Responsible**: CPAC Training Committee; **Timeframe**: April 2017 **Repeat recommendation from the May 2013 Final Report of the Joint Committee on the Investigation and Prosecution of Child Abuse* 2. Finalize and implement the DOJ comprehensive case management system. The system must be capable of producing current information regarding the status of any individual case, and must be capable of producing reports on case outcomes. The system must also allow the DOJ to track the caseloads of its Deputies and staff, so that informed resource allocation decisions can be made, and must ensure cross-referencing of all cases within the DOJ which share similar interested parties. **Agency Responsible:** DOJ; **Timeframe:** Immediately **Repeat recommendation from the May 2013 Final Report of the Joint Committee on the Investigation and Prosecution of Child Abuse* 3. Consider sharing factual details of the CAN Panel reviews with the police departments so that the agency can explore the mistake and correct a possible breakdown in their agency. **Agency Responsible:** CPAC CAN Steering Committee; **Timeframe:** 6 months 4. Recommend to the Delaware Police Chiefs' Council that all police departments supply their departments with cameras to document child abuse. **Agency Responsible:** CPAC Training Committee; **Timeframe:** April 2017		**CPAC/CDRC Approval Date(s):** 11/9/16; 11/18/16	1. **DONE** CPAC has approved subject to final edits of signatory agencies. Training in April 2017. 2. **In Progress** DOJ case management system piloted in several units and will soon be available agency-wide. 3. **DONE** Confidentiality prevents CAN Panel from sharing details with non-Commissioner agencies. 4. **In Progress** Presentation to Police Chiefs' Counsel on MOU will include discussion of cameras.

System Area 3: MDT Response/Criminal Investigations	**CAN Panel Findings:** Crime Scene/Documentation, Doll Reenactments, General - Criminal Investigation, Intake with DOJ, Interviews w/Adult, Interviews w/Child, Medical Exam	**# of Findings:** 72	**02/08/17 Status**
5. Create a prioritized list of CPAC funding requests to be submitted to the Joint Finance Committee each fiscal year. Each agency impacted by the requests should identify a representative to answer questions about the request. The current CPAC funding requests to be considered include: a. DOJ Special Victims Unit (SVU): The Unit with statewide jurisdiction will handle all felony level, criminal child abuse cases including those involving serious physical injury, death or sexual abuse of a child. *Prosecutors (2 NCC, 1 KC, 1 SC), a paralegal, and* criminal investigators with expertise in the investigation of child abuse should be established within the Unit. **Variation of a recommendation to staff the SVU appropriately from the May 2013 Final Report of the Joint Committee on the Investigation and Prosecution of Child Abuse* b. CPAC Guidelines for Child Abuse Medical Response: The guidelines require the MDT to seek immediate medical evaluations for children, siblings and other children in the household when specific abuse fact patterns exist. The implementation of these guidelines in April 2017 will increase the need for non-urgent medical evaluations and will require a specialized medical service provider in Kent and Sussex counties. **Agency Responsible:** CPAC; **Timeframe:** February 2017 and annually thereafter 6. Consider and draft the following legislation: a. *Add Child Abuse First and Second degrees to the list of violent felonies and enhance the sentencing penalties*; b. *Create a negligent mens rea for child abuse and create a statute to address those who enable child abuse*; c. Modification of the crime of Murder by Abuse or Neglect; d. *Resolve inconsistencies in Title 11 due to the differing definitions of physical injury and serious physical injury*; e. Consideration of enhanced sentencing penalties for the crime of Rape involving a child to include a life sentence; f. Creation of an obligation to transport an abused child for a medical exam or forensic evaluation; and, g. Modification of the list of crimes in 16 Del. C. 906 (e)(3) to align with the revised MOU. **Agency Responsible:** CPAC Legislative Committee; **Timeframe:** February 2017 **Some are repeat recommendations from the May 2013 Final Report of the Joint Committee on the Investigation and Prosecution of Child Abuse*		**CPAC/CDRC Approval Date(s):** 11/9/16; 11/18/16	5. **In Progress** Chair and Executive Director have included DOJ SVU, DFS Caseloads, SEI, and the request for no cuts to Commission services. Medical Services need to wait until next year. 6. **In Progress** DOJ child abuse package to be reviewed by Legislative Committee. (f) and (g) are drafted and circulated to CPAC Committees.

System Area 4: Risk Assessment/Caseloads	**CAN Panel Findings:** Caseloads, Collaterals, Communication, Documentation, Reporting, Risk Assessment – Abridged, Risk Assessment – Alternative Response, Risk Assessment – Closed Despite Risk, Risk Assessment – Screen Out, Risk Assessment – Tools, Risk Assessment – Unsubstantiated	**# of Findings:** 52	**02/08/17 Status**
Recommendations: 1. Consider adjusting DFS caseloads based on complexity of the cases to better utilize staff strengths and balance workload. **Agency Responsible:** DFS; **Timeframe:** 9-12 months 2. Provide ongoing training on the SDM Risk Assessment tool to reinforce the policy and ensure consistent application. **Agency Responsible:** DFS; **Timeframe:** Immediately and ongoing 3. Explore the use of differential response for domestic violence, substance exposed infants, and chronic neglect cases accepted by DFS. **Agency Responsible:** DFS; **Timeframe:** 6-12 months 4. Explore options for tiered risk assessments for DFS families. **Agency Responsible:** DFS; **Timeframe:** March 2017 5. Recommend that DFS investigate all reported cases of suspected child abuse or neglect of children less than one year old (in alignment with National standards) to decrease deaths and near deaths of children under one. **Agency Responsible:** DFS; **Timeframe:** 3 years		**CPAC/CDRC Approval Date(s):** 11/9/16; 11/18/16	1. **Deferred** DFS will reconsider after CPAC Caseloads Committee concludes its work. 2. **In Progress** DFS pursuing grant monies with Children Research Center to conduct training in Spring 2017. 3. **Deferred** DFS cannot implement without additional funds. 4. **DONE** DFS already has tiered risk assessments. 5. **In Progress** DFS has taken no action to date.

System Area 5: Safety/Use of History/Supervisory Oversight	**CAN Panel Findings:** Completed Incorrectly/Late, Inappropriate Parent/Relative Component, No Safety Assessment of Non-Victims, Oversight of Agreement, Supervisory Oversight, Use of History, Violations of Safety Agreements	**# of Findings:** 49	**02/08/17 Status**
Recommendations: 1. Use the DFS chronological history event to research information related to the child, family, and family members. **Agency Responsible**: DFS; **Timeframe**: Immediately and ongoing 2. Review CAN Panel findings related to safety assessments and agreements with DFS staff and administration to identify opportunities for ongoing training and education. **Agency Responsible**: DFS; **Timeframe**: Immediately and ongoing 3. Revise the DFS non-relative/relative home safety assessment form, build it into the DFS case management system as part of the SDM Caregiver Safety Assessment when a home assessment is indicated, and provide training. **Agency Responsible:** DFS; **Timeframe:** 18 months 4. Provide supervisory training to DFS supervisors that is specific to child welfare and case management utilizing a national evidence-based curriculum. **Agency Responsible:** DFS; **Timeframe:** 18 months		**CPAC/CDRC Approval Date(s):** 11/9/16; 11/18/16	1. **DONE** DFS added a history event to last case management system update. 2. **DONE** DFS shares findings with various leadership teams and workgroups. 3. **In Progress** Assessment form has been modified and will be incorporated into new case management system. 4. **In Progress** Finding is also in the CFSR PIP. Completion targeted for 2018.

System Area 6: Unresolved Risk	**CAN Panel Findings:** Child – Medical, Child – Mental Health, Contacts, Domestic Violence, Home Visiting Services, Multigenerational History, Not Utilizing Evidence-Based Tools, Parenting, Substance Abuse, Substance Abuse/Domestic Violence	**# of Findings:** 43	**02/08/17 Status**
Recommendations: 1. Research and consider the implementation of birth match in Delaware to ensure that children at high risk of child abuse and neglect are reported to DFS at birth. **Agency Responsible:** CPAC Legislative Committee; **Timeframe:** April 2017 2. Reconvene the CPAC Caseload/Workloads Committee to review treatment caseloads and state standards. **Agency Responsible:** CPAC; **Timeframe:** 3-6 months 3. Utilize the Division of Substance Abuse and Mental Health (DSAMH)/DSCYF partnership and Casey Family Programs to better assist high risk families involved in the child welfare system, with risk factors such as mental health, substance abuse and domestic violence, and to identify appropriate services for children and caregivers. . **Agency Responsible:** DSCYF; **Timeframe:** 3-6 months 4. Provide ongoing booster training on safety assessments and safety planning to DFS staff to enhance understanding of the safety threats, interventions, and violations of safety plans. **Agency Responsible:** DFS; **Timeframe:** 6-12 months and then annually 5. Develop a mechanism that reminds DFS case workers to automatically follow up after referrals or services are requested for children and caregivers. **Agency Responsible:** DFS; **Timeframe:** 12 months 6. Provide treatment services through DFS and community-based providers that is more home-based and family centered as well as provide warm hand-offs from one provider to another. **Agency Responsible:** DFS/Community Service Providers; **Timeframe:** Immediately and ongoing 7. Establish a process between DFS and Family Court in cases where guardianship petitions are filed to ensure legal protections are in place for the child and the needs of the child are being addressed. **Agency Responsible:** DFS/Family Court; **Timeframe:** 6-12 months		**CPAC/CDRC Approval Date(s):** 11/9/16; 11/18/16	**1. DONE** CPAC supported Legislative Committee recommendation to not pursue as prior TPR is not a strong predictor of subsequent child death in Delaware. **2. In Progress** First meeting is in February 2017. **3. In Progress** DFS will continue to pursue and include IC at the state level meetings. **4. In Progress** DFS pursuing grant monies with Children Research Center to conduct booster training. **5. No Action** DFS will need additional resources/equipment. **6. DONE** **7. In Progress** Meeting being scheduled.

Child Abuse and Neglect Panel

Strengths Summary

2-8-17

INITIALS	
MDT Response	**17**
Crime Scene	3
Documentation	2
General Criminal Investigation	4
General DFS Investigation	5
Interviews - Child	1
Medical Exam	1
Prosecution/Pleas/Sentence	1
Medical	**13**
Home Visiting Programs	1
Medical Exam/Standard of Care - CARE	1
Medical Exam/Standard of Care - ED	6
Medical Exam/Standard of Care - EMS	1
Medical Exam/Standard of Care - Forensics	2
Medical Exam/Standard of Care - ME	1
Medical Exam/Standard of Care - PCP	1
Risk Assessment/ Caseloads	**4**
Caseloads	1
Collaterals	2
Risk Assessment - Tools	1
Safety/ Use of History/ Supervisory Oversight	**4**
Completed Correctly/On Time	2
Safety Assessment of Non-Victims	1
Supervisory Oversight	1
Unresolved Risk	**3**
Home Visiting Programs	1
Mental Health	1
Substance Abuse	1
Grand Total	**41**

FINALS	
MDT Response	**3**
Prosecution/Pleas/Sentence	3
Grand Total	**3**

TOTAL FINDINGS **44**

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

Child Abuse and Neglect Panel

Strengths Detail and Rationale

2-8-17

INITIALS

System Area	Strength	Rationale	Count of #
MDT Response			17
	Crime Scene		3
		Thorough scene investigation was completed by the law enforcement agency.	2
		Excellent scene investigation by law enforcement to include photographs, evidence collection, measurements and weight of the chair reportedly used by the young child.	1
	Documentation		2
		The DFS caseworker thoroughly documented the case events.	2
	General Criminal Investigation		4
		Excellent MDT response and collaboration between the DFS caseworker and law enforcement.	2
		Great MDT response to the case to include medical evaluations of the siblings, forensic interview, and communication with DFS.	1
		The child's primary care physician was interviewed by the detective assigned to the case.	1
	General DFS Investigation		5
		A framework was completed during the investigation, which recommended transferring the case to treatment.	1
		DFS caseworker delayed interviews with the family until law enforcement gave clearance to do so.	1
		The DFS caseworker completed the initial response rather than requesting a response by the second-shift.	1
		The DFS caseworker made a finding against both parents at the conclusion of the investigation.	2
	Interviews - Child		1
		Forensic interview was scheduled for the young sibling and three attempts were made by law enforcement.	1
	Medical Exam		1
		The DFS caseworker ensured that a medical evaluation was completed for the young sibling.	1
	Prosecution/ Pleas/Sentence		1
		Both parents were criminally charged.	1
Medical			13
	Home Visiting Programs		1
		Home visiting services were offered to the mother at the birth of the child. Although the mother refused services, the reasoning for refusal was documented within the medical record.	1

	Medical Exam/ Standard of Care - CARE		1
		With the level of care being provided to the child, the CARE Team was consulted per protocol and a diagnosis of Child Physical Abuse given due to the degree of the child's injuries and the parents' delay in seeking medical treatment.	1
	Medical Exam/ Standard of Care - ED		6
		Life-saving efforts continued for the child until medical staff was confident that the family understood the child's condition.	1
		The child was transported from the local hospital emergency department to the children's hospital via ambulance rather than family transport.	1
		The medical staff enforced the no visitation order to protect the child and to not compromise the care of the child.	1
		The child remained hospitalized one additional night to allow for foster care placement.	1
		The initial treating hospital covered all aspects of medical treatment by not only following the clinical pathway of treatment for the child, but medically treated for differential diagnoses as well.	1
		The children's hospital ran tests to get a complete picture of the child's condition and needs.	1
	Medical Exam/ Standard of Care - EMS		1
		The emergency medical services (EMS) documented the position of the infant on the bed, to include exact positioning of the neck and airway.	1
	Medical Exam/ Standard of Care - Forensics		2
		Although a forensic evaluation was conducted at the initial treating hospital, a second forensic evaluation, to include photographic evidence, was conducted at the children's hospital.	1
		Medical evaluation of the siblings, and results thereof, were documented within the child's medical records.	1
	Medical Exam/ Standard of Care - ME		1
		The medical examiner contacted the primary care physician to inform him/her of the infant's death.	1
	Medical Exam/ Standard of Care - PCP		1

		The primary care physician maintained contact with the medical staff throughout the child's hospitalization, and discussed ongoing medical care of the child.	1
Risk Assessment/ Caseloads			4
	Caseloads		1
		Excellent work by the DFS caseworker despite being over the caseload statutory standards. Investigation included medical evaluation of the sibling, safety agreements with relatives, and thorough background checks and home assessments completed prior to sibling's placement.	1
	Collaterals		2
		DFS caseworker consulted with the child abuse medical expert to obtain the child's medical findings.	1
		DFS caseworker provided her contact information to a relative in the home and asked her to contact the caseworker if there was anything she needed to discuss outside of mother's presence.	1
	Risk Assessment - Tools		1
		Thorough investigation by the DFS caseworker, to include a Team Decision Making (TDM) meeting and referral to Child Development Watch.	1
Safety/ Use of History/ Supervisory Oversight			4
	Completed Correctly/On Time		2
		The DFS caseworker routinely re-evaluated the safety agreement, which remained in place.	2
	Safety Assessment of Non-Victims		1
		The DFS caseworker contacted the guardians of the father's older children to ensure he had no unsupervised contact.	1
	Supervisory Oversight		1
		Group supervision was utilized in treatment case, which recommended exploring permanency options with relatives and making a referral to the domestic violence liaison.	1
Unresolved Risk			3
	Home Visiting Programs		1
		A referral for Child Development Watch was made for the child.	1
	Mental Health		1
		Referrals were made for mental health evaluations for parents.	1

	Substance Abuse		1
		The DFS treatment caseworker referred the mother to the substance abuse liaison.	1
Grand Total			**41**

FINALS

System Area	Strength	Rationale	Count of #
MDT Response			3
	Prosecution/ Pleas/Sentence		3
		As a result of this case, the Special Victim's Unit within DOJ was created.	1
		Reassignment of the case to an experienced prosecutor was effective in bringing this case to trial.	1
		Review by the Director of the Special Victim's Unit allowed for criminal charges to be filed.	1
Grand Total			**3**

TOTAL FINDINGS **44**

Child Abuse and Neglect Panel

Findings Summary

2-8-17

INITIALS	
Legal	**1**
DFS Contact with DOJ	1
MDT Response	**7**
Crime Scene	1
Doll Re-enactment	1
Interviews - Adult	1
Medical Exam	3
Prosecution/ Pleas/ Sentence	1
Medical	**11**
Home Visiting Programs	4
Medical Exam/ Standard of Care - CARE	1
Medical Exam/ Standard of Care - ED	1
Medical Exam/ Standard of Care - PCP	1
Reporting	2
Substance-Exposed Infant	2
Risk Assessment/ Caseloads	**12**
Caseloads	6
Collaterals	2
Documentation	1
Risk Assessment - Closed Despite Risk Level	1
Risk Assessment - Screen Out	1
Risk Assessment - Tools	1
Safety/ Use of History/ Supervisory Oversight	**12**
Inappropriate Parent/ Relative Component	2
Oversight of Agreement	1
Supervisory Oversight	1
Use of History	1
Completed Incorrectly/ Late	7
Unresolved Risk	**7**
Contacts	1
Substance-Exposed Infant	2
Substance Abuse and Mental Health	1
Substance Abuse	2
Legal Guardian	1
Grand Total	**50**

FINALS	
Legal	**1**
Court Hearings/ Process	1
MDT Response	**4**
General - Criminal Investigation	1
Medical Exam	1
Prosecution/ Pleas/ Sentence	2
Medical	**1**
Reporting	1
Grand Total	**6**

TOTAL FINDINGS **56**

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

Prepared 01/26/2017

Child Abuse and Neglect Panel

Findings Detail and Rationale

2-8-17

INITIALS

System Area	Finding	PUBLIC Rationale	Sum of #
Legal			1
	DFS Contact with DOJ		1
		DFS did not consult with the Civil DAG to determine whether or not custody should be sought for a young child with serious physical injuries and no history of trauma provided by the parents.	1
MDT Response			7
	Crime Scene		1
		No scene investigation was completed by the law enforcement agency.	1
	Doll Re-enactment		1
		No doll re-enactment was completed by the law enforcement agency.	1
	Interviews - Adult		1
		DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	1
	Medical Exam		3
		The young sibling was not medically evaluated.	1
		DFS did not immediately seek a medical exam for the sibling when the caseworker responded to the incident involving the burn.	1
		The Office of the Investigation Coordinator did not remind the MDT to seek a medical evaluation for the sibling.	1
	Prosecution/ Pleas/ Sentence		1
		Father's original charges were Nolle Prossed, and he was reindicted on misdemeanors. No communication occurred between DOJ and the law enforcement agency prior to this decision.	1
Medical			11
	Home Visiting Programs		4
		Home Visiting Services were not in place at the time of the near death incident or post incident.	3
		Home Visiting Services were not in place at the time of the near death incident, and the child was an appropriate candidate for Healthy Families America.	1
	Medical Exam/ Standard of Care - CARE		1
		The child was not initially medically evaluated by a child abuse medical expert, because one was not available and a network of medical providers does not exist in Delaware.	1
	Medical Exam/ Standard of Care - ED		1
		Staff in the hospital emergency department did not take the child's weight. The history given was that a young child was having difficulty feeding.	1

	Medical Exam/ Standard of Care - PCP		1
		During a well visit, the PCP did not consider a differential diagnosis of abuse despite the rapid increase in the child's head circumference and decrease in weight. The PCP also recommended follow up in 2 months, but the child was hospitalized for the near death incident a week after the PCP visit.	1
	Reporting		2
		PCP sent the child to the emergency department for concerns of neglect, but no report was made to the DFS Child and Neglect Report Line.	1
		A new hotline report was not made by the hospital after x-rays revealed the sibling also had multiple, healing fractures.	1
	Substance-Exposed Infant		2
		No plan of safe care was completed for the infant despite the mother's drug use during the pregnancy. Mother also declined home visiting services after the infant's birth.	1
		No plan of safe care was completed for the infant despite the positive drug screen at birth.	1
Risk Assessment/ Caseloads			12
	Caseloads		6
		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 near death investigation.	1
		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 near death investigation.	1
		The DFS caseworker 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 the entire time the case was open, with the exception of a 2-week period. However, the caseload did not negatively impact the DFS response in the death investigation.	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 death investigation.	1
		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.	1
	Collaterals		2
		In the prior investigation, a collateral contact was not completed with the physician overseeing mother's pain management.	1
		In the prior investigation, a collateral contact was not completed with the PCP for the other children in the home and mother was inconsistent with their medical care.	1
	Documentation		1
		The DFS caseworker did not enter notes from the initial contact for several months. Notes were only entered after a new supervisor was assigned and noted the issue.	1

	Risk Assessment - Closed Despite Risk Level		1
		In the prior investigation, SDM risk assessment identified the risk as high and recommended ongoing service; however, the case was closed. The rationale was that mother's drug use was situational and her mental health was not a concern.	1
	Risk Assessment - Screen Out		1
		DFS screened out the hotline report despite the history with the family and the child sustaining multiple dog bites. The responding law enforcement agency reported its concerns about supervision by mother.	1
	Risk Assessment - Tools		1
		Following the death incident, a Team Decision Making meeting was not considered for the young sibling. The safety agreement with the out of state relative was violated, and DFS located the child with an inappropriate caregiver. DFS ultimately petitioned for custody of the sibling several months after the incident.	1
Safety/ Use of History/ Supervisory Oversight			12
	Inappropriate Parent/ Relative Component		2
		Following the death incident, DFS did not conduct a background check with the relative prior to entering into a safety agreement for the sibling. The relative had pending criminal charges, admitted to current substance use, and appeared to be under the influence when the agreement was completed.	1
		For the near death incident, DFS completed a safety agreement with relatives, who were the subject of a current DFS investigation, and there was no documentation that a discussion occurred between the two workers to justify the use of caregivers as safety agreement participants.	1
	Oversight of Agreement		1
		In the prior investigation, DFS modified the safety agreement and agreed that the children could return home, without visiting the home to ensure the conditions had improved. The home visit did not occur for another month.	1
	Supervisory Oversight		1
		DFS had an active investigation with the family for several months, which exceeded the 45-day timeframe. There was no documented reason for the case remaining open that long, and contact with the family was sporadic.	1
	Use of History		1
		In the prior investigation, history was not considered in overriding the SDM Risk Assessment to close the case and the case worker's justification did not indicate how history was factored into the decision to close. There were other prior investigations involving substance abuse concerns, a child placed outside of the home, and an unexplained burn.	1

	Completed Incorrectly/ Late		7
		In the prior investigation, the father's substance abuse was not identified as a safety threat in the SDM safety assessment despite the child being present during the DUI, the caregiver possessing prescription pills not prescribed, and a disclosure of recent heroin use. The caregiver was permitted to continue providing supervision while the mother worked. The SDM safety assessment was not re-evaluated once a collateral contact revealed ongoing drug use by the father, who was primarily responsible for supervising the child.	1
		For the near death incident, the after-hours case worker incorrectly identified the child as safe in the SDM safety assessment due to his hospitalization. No safety threats were marked.	1
		A safety agreement was completed with the family for the first report involving the sibling, but a SDM safety assessment was not entered into the database until months later. A safety assessment was only entered after a new supervisor was assigned and noted the issue.	1
		Throughout the investigation, DFS entered into several safety agreements with multiple caregivers. The agreements were ineffective in ensuring the child(ren)'s safety.	1
		The SDM safety assessment and safety agreement were completed late, approximately 12 days after the hotline report was received. As a result, a safety agreement was not implemented while the child was in the hospital to restrict contact between the victim and potential suspects.	1
		The DFS safety agreement did not restrict contact between the victim and potential suspects while the child was hospitalized.	1
		In the prior investigation, the case worker did not complete the SDM safety assessment correctly. The safety threat for drug-exposed infant was marked no. No agreement was entered.	1
Unresolved Risk			7
	Contacts		1
		Following the near death incident, the treatment worker's first contact with the family was delayed.	1
	Substance-Exposed Infant		2
		No plan of safe care was completed for the infant despite the mother's drug use during the pregnancy. Mother also declined home visiting services after the infant's birth.	1
		No plan of safe care was completed for the infant despite the positive drug screen at birth.	1
	Substance Abuse and Mental Health		1
		Although it was documented throughout the investigation that mother had substance abuse and mental health issues, there was no documentation to support such referrals were made for the mother and that the mother complied with such. No petition to compel was filed by DFS nor was a safety agreement considered.	1
	Substance Abuse		2
		In the prior investigation, DFS did not utilize the substance abuse liaison to assess mother for substance abuse when father disclosed current substance abuse and resided in the same home. It was later revealed that mother was in a substance abuse program during this investigation.	1

		In the prior investigation, DFS did not utilize the substance abuse liaison or refer the mother to complete a substance abuse and/or mental health evaluation. Mother was using drugs and had a significant mental health and trauma history.	1
	Legal Guardian		1
		A legal guardian was not established for the sibling following the death incident, and parental risk factors and safety concerns prevented the child from returning home. As a result, the child was placed with multiple caregivers.	1
Grand Total			**50**

FINALS

System Area	Finding	PUBLIC Rationale	Sum of #
Legal			1
	Court Hearings/ Process		1
		Mother filed a petition for guardianship of a relative's young child, and DFS did not include the mother's history in a court report filed. As a result, the mother was awarded visitation.	1
Medical			1
	Reporting		1
		Staff at the initial treating hospital did not make a report to the DFS Child and Neglect Report Line for the death incident.	1
MDT Response			4
	General - Criminal Investigation		1
		The Law Enforcement Agency did not make a report to DFS Child and Neglect Report Line for the death incident.	1
	Medical Exam		1
		The medical evaluations for the other children in the home at the time of the death incident were delayed.	1
	Prosecution/ Pleas/ Sentence		2
		There is not a negligent mens rea for child abuse or a statute to address those who enable child abuse, which impacted the prosecution. The defendant was charged with Murder by Abuse or Neglect and found guilty of Criminally Negligent Homicide.	1
		A sentence of 18 months probation was inadequate given that the defendant criminally negligently caused the death of this young child. The presumptive sentence is up to 2 years at Level V and the statutory maximum is 8 years. There is no enhanced penalty for Criminally Negligent Homicide when the offense is committed against a child.	1
Grand Total			**6**

TOTAL FINDINGS **56**