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CHILD PROTECTION ACCOUNTABILITY COMMISSION
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CHAIR

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

November 9, 2016

The Honorable Jack Markell
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 Markell:

The Child Protection Accountability Commission ("CPAC") is responsible for the reviews of child deaths and near deaths due to abuse or neglect. As required by law, CPAC approved findings from 15 cases at its November 9, 2016 meeting.[1] Seven of the cases have completed prosecution and were a final review that resulted in 15 findings primarily related to the criminal outcome. The eight remaining cases were from deaths or near deaths that occurred between March 2016 and June 2016. These resulted in 58 findings across system areas. The themes from the recent 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 the Division of Family Services. In every recent case, the DFS investigation worker was significantly over the statutory caseload standard.

CPAC held a retreat with the Child Death Review Commission in September 2016. During this retreat, findings from January 2015 through May 2016 death and near death incidents were reviewed. An action plan was developed which is attached to

[1] 16 Del. C. § 932.

this letter. 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.

We are available should further information be required. For your information we have included the 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

Findings Summary

11-9-16

INITIALS	
Legal	**5**
Court Hearings/ Process	4
DFS Contact with DOJ	1
MDT Response/ Criminal Investigations	**16**
Crime Scene	2
Doll Re-enactment	1
General - Criminal Investigation	3
Interviews - Adult	2
Interviews - Child	4
Medical Exam	4
Medical	**13**
Home Visiting Programs	4
Medical Exam/ Standard of Care - CARE	3
Medical Exam/ Standard of Care - ED	1
Medical Exam/ Standard of Care - PCP	2
Medical Exam/ Standard of Care - Urgent Care	1
Reporting	1
Transport	1
Risk Assessment/ Caseloads	**11**
Caseloads	7
Reporting	1
Risk Assessment - Abridged	1
Risk Assessment - Tools	1
Risk Assessment - Unsubstantiated	1
Safety/Use of History/Supervisory Oversight	**6**
Completed Incorrectly/Late	4
No Safety Assessment of Non-Victims	2
Unresolved Risk	**7**
Child - Medical	3
Child - Mental Health	1
Contacts	3
Grand Total	**58**

FINALS	
MDT Response/ Criminal Investigations	**13**
General - Criminal Investigation	6
Medical Exam	2
Prosecution/ Pleas/Sentence	5
Medical	**2**
Medical Exam/ Standard of Care - Forensics	1
Transport	1
Grand Total	**15** *

**6 findings relate to a case from 2012.*

TOTAL FINDINGS **73**

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

Prepared 10/20/2016

Child Abuse and Neglect Panel

Findings Detail and Rationale

11-9-16

INITIALS

System Area	Finding	PUBLIC Rationale	Sum of #
Legal			5
	Court Hearings/ Process		4
		The Adjudicatory Hearing was not held in compliance with Family Court Rule 215(a), which requires an Adjudicatory Hearing to be held within 30 days of a Preliminary Protective Hearing.	2
		The Court denied the first emergency ex parte order, and as a result, a custody order was not in place to provide safety or protection to the mother and injured child.	1
		The Court's requirement for the completion of parent education prior to judicial scheduling was a barrier in this case. While the non-offending parent was temporarily awarded sole legal custody of the victim with primary residential placement, the case would not be assigned to a judge without completion of a parenting class by the non-offending parent.	1
	DFS Contact with DOJ		1
		DFS delayed seeking custody of the youngest sibling, who was also a victim of abuse. The child continued to reside in the home with the suspects including the child's father, who has a history of domestic violence and inappropriate discipline with the three children.	1
MDT Response/ Criminal Investigations			16
	Crime Scene		2
		No scene investigation was completed by the initial responding law enforcement agency.	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, despite a confession being obtained from the suspect.	1
	General - Criminal Investigation		3
		After DFS attempted to report the near death incident to the law enforcement agency, the case worker is told to call back after the weekend.	1
		The case worker called the suspects initially and asked incident based and leading questions. This contact occurred prior to the police response.	1
		The report to the law enforcement agency was delayed nearly 2 weeks for the near death incident, potentially impacting the criminal investigation.	1
	Interviews - Adult		2

		During the initial contact, DFS conducted interviews with the suspects without the law enforcement agency present, potentially impacting the criminal investigation.	1
		Multiple adult household members were known in the first investigation, and the supervisor waived the interviews without determining whether the adults had caregiving responsibilities for the children.	1
	Interviews - Child		4
		Forensic interview did not occur with the two young children who were present in the home at the time of the near death.	1
		Forensic interview did not occur with the young child who was present in the home at the time of the near death.	1
		Multiple interviews occurred before the children received forensic interviews.	1
		There was a delay in scheduling the forensic interview with the young sibling, and the child was interviewed multiple times.	1
	Medical Exam		4
		Despite the near death incident involving the young child, the siblings were not medically evaluated.	1
		The half sibling, who was present in the home during the near death incident, was not medically evaluated. Interviews conducted during the criminal investigation confirm that the sibling was present.	1
		The young sibling was not medically evaluated.	1
		The youngest sibling sustained extensive bruising and linear abrasions to the face and back, which were likely non-accidental trauma. DFS and LE did not obtain the diagnosis for this child, and as a result, the child remained in the home with a safety plan.	1
Medical			13
	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 prior to the near death incident or post incident.	1
	Medical Exam/ Standard of Care - CARE		3
		The CARE Team was not consulted during the child's inpatient stay despite concerns of neglect.	1
		The child was discharged without a full CARE team assessment and evaluation.	1
		There was a delay in diagnosis, secondary to a three-week time gap between the need for a diagnostic exam and completion of the diagnostic exam. The skeletal survey on the first admission identified concerns with the spine, which was later confirmed as consistent with abuse.	1
	Medical Exam/ Standard of Care - ED		1

		There was no documentation to identify that the family received education on how to receive dental care hygiene and primary care management.	1
	Medical Exam/ Standard of Care - PCP		2
		During the year that the child did not attend the practice, there was no record of outreach with the family by the PCP for primary care.	1
		In the presence of vomiting without a fever and unexplained bruising to an infant, the assessment by the PCP did not lead to an explored differential diagnosis of suspected abuse. This visit to the PCP occurred 4 days prior to the near death incident.	1
	Medical Exam/ Standard of Care - Urgent Care		1
		Concern for possible inflicted injury was not documented as a consideration in the medical report by the urgent care facility. However, the child was sent for x-rays to the children's hospital.	1
	Reporting		1
		Staff at the hospital did not alert the police to the near death incident.	1
	Transport		1
		Despite suspected head trauma with no mechanism of injury, the PCP allowed the mother to transport the child to the emergency department.	1
Risk Assessment/ Caseloads			11
	Caseloads		7
		The DFS case worker was over the investigation caseload statutory standards the entire time the case was open.	4
		The DFS case workers were over the investigation and treatment caseload statutory standards while the cases were open.	3
	Reporting		1
		Caregiver reported sexualized language by the child, and the case worker did not contact the DFS Report Line regarding secondary allegations of abuse or obtain additional information.	1
	Risk Assessment - Abridged		1
		Child and sibling became dependent after the mother's sudden death, and DFS abridged the investigation without a guardianship order in place.	1
	Risk Assessment - Tools		1

		The near death incident was not assigned to the DFS Serious Injury Unit, and the case was mishandled by the assigned worker and initial supervisor.	1
	Risk Assessment - Unsubstantiated		1
		Despite the near death incident, DFS was unable to make a finding that abuse occurred at the conclusion of its investigation because the perpetrator was unknown. The case was unsubstantiated with concern.	1
Safety/Use of History/Supervisory Oversight			6
	Completed Incorrectly/Late		4
		A DFS safety agreement was not completed by the after-hours worker despite serious nonaccidental injuries to a young child. Therefore, there were no measures being taken to keep the child safe while in the hospital, including supervised contact between the victim and suspects.	1
		For the near death incident, the DFS safety agreement was insufficient to protect the child. Relatives agreed to monitor contact between the young child with serious physical injuries and the suspects through visits or phone calls.	1
		No safety agreement was implemented after the first report of abuse was received by DFS. Child presented with injuries, and children disclosed abuse of all 3 children by the youngest sibling's father.	1
		The safety assessment was not completed appropriately for the victim, because it assessed the victim as being safe in the hospital. Safety assessments must assess whether the child is in immediate danger in their home.	1
	No Safety Assessment of Non-Victims		2
		Despite the serious physical injuries to a young child, there was a delay in assessing the safety of the young sibling. The child was seen several days after the initial contact with the victim. Reassignment to another supervisor prompted the contact.	1
		The safety assessment and agreement did not consider the half sibling. The child did not reside in the home full time, but was present during the incident.	1
Unresolved Risk			7
	Child - Medical		3
		Guardianship was never established for the children, and medical care and mental health services were not provided as a result. Children were dependent and exhibiting significant mental health issues; mother was deceased and father's whereabouts were unknown.	1
		Parents were not referred to Child Development Watch for services for fine motor and weight gain as per the discharge instructions.	1

		Prior to case closure, DFS did not contact the PCP to verify that the family followed up with recommended services post discharge.	1
	Child - Mental Health		1
		Despite accumulation of risk due to DFS history, allegations of abuse/dependency, and children with significant mental health issues, services were never provided to children prior to the near death incident.	1
	Contacts		3
		During a subsequent investigation, the initial contact with the family was delayed, no collaterals were completed, the youngest sibling and other household members were not seen, and the child and sibling were not referred to mental health services.	1
		The half sibling was not interviewed or observed by the case worker. The child primarily resided in another residence, but was present in the home at the time of the near death incident.	1
		The treatment worker's first contact with the family was delayed, and the near death incident was reported several days later.	1
Grand Total			**58**

FINALS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response/ Criminal Investigations			13
	General - Criminal Investigation		**6**
		No criminal investigation was completed by the law enforcement agency for the first incident of alleged abuse.	1
		Photographs of the child's injuries were not taken by the law enforcement agency.	1
		The first two investigations were classified incorrectly by the law enforcement agency. The cases were classified as either a miscellaneous investigation or an assist other agency.	1
		The law enforcement agency did not consult with the child abuse medical expert or obtain the conclusions from the doctor's medical exam.	1
		The local law enforcement agency's limited resources and training impacted the criminal investigation.	1
		The medical examiner's investigative report was not considered in determining the cause and manner of death.	1
	Medical Exam		**2**
		The law enforcement agency concluded that the injury was accidental despite the conclusions from the medical professionals.	1

		While the child abuse medical expert identified that the victim was physically abused, the case was cleared as no crime by the law enforcement agency.	1
	Prosecution/ Pleas/Sentence		**5**
		DOJ did not initially review the medical records during its intake, and as a result, DOJ was not aware of the child abuse medical expert's conclusions.	1
		Father was charged with the crime of child abuse, which is a non-violent felony, and is not punishable in the same manner as assault.	1
		The defendant was charged with Child Abuse in the first degree, but pled guilty to Assault in the second degree. The felony classification for Assault in the second degree (Class D Felony - violent) carries a higher penalty then the felony classification for Child Abuse in the second degree (Class G Felony - nonviolent). As a result, assault is used more frequently for crimes against children.	1
		The felony classification for Child Abuse in the second degree (Class G Felony - nonviolent) carries less severe penalties. As a result, the defendant was sentenced to less than 2 months at Level V. However, the presumptive sentence for this crime is up to 12 months at Level II, and the sentence was above the presumptive sentence.	1
		The plea deal was not appropriate. The defendant pled guilty to Endangering the Welfare of a Child (Class G Felony - nonviolent) for inflicting injuries to a young child that included a skull fracture and subdural hematoma and was appropriately sentenced to 1 year at Level V. The presumptive sentence is up to 12 months at Level II, and the sentence was above the presumptive sentence.	1
Medical			2
	Medical Exam/ Standard of Care - Forensics		1
		A forensic consult did not occur during the emergency department visit.	1
	Transport		1
		Despite the 3rd incident of unexplained injuries to a young child, the PCP allowed the child to return home and did not send child to the hospital emergency department with alternative transportation.	1
Grand Total			**15**

TOTAL FINDINGS **73**