STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
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CHAIR

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

August 10, 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 13 cases at its August 10, 2016 meeting.[1] Eight of the cases were older cases that received a final review after completion of prosecution. The five remaining cases were from late 2015 and early 2016 and resulted in 27 findings across system areas. An additional four findings were made in the older cases. 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 and risk assessment by the Division of Family Services. Most striking was that in each recent case, the DFS investigation worker was significantly over the statutory caseload standard.

CPAC has a retreat scheduled in September 2016. During this retreat, findings from the last year will be reviewed, trends identified and an action plan developed to

[1] 16 Del. C. § 932.

address priority areas. CPAC will share this plan in the next report on the child abuse death and near death reviews.

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

8-10-16

INITIALS

LE and MDT	4
Crime Scene	1
Documentation	1
Interviews	1
LE Contact with DOJ	1
Grand Total	**4**

Medical	6
Documentation	1
Failure to Report	2
Standard of Care	2
Transport	1
Grand Total	**6**

DFS Part 1	9
Safety Plan	4
Unresolved Risk	5
Grand Total	**9**

DFS Part 2	3
DFS Contact with DOJ	1
Employee Performance	1
Medical Exam	1
Grand Total	**3**

Caseloads	5
DFS Caseloads	5
Grand Total	**5**
TOTAL FINDINGS	**27**

FINALS

Legal	2
Court Hearings	2
Grand Total	**2**

DFS Part 1	1
Unresolved Risk	1
Grand Total	**1** *

DFS Part 2	1
Coordination of Care	1
Grand Total	**1** *
TOTAL FINDINGS	**4**

**These two findings relate to a case from 2014.*

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

Prepared 08/05/2016

Child Abuse and Neglect Panel

Findings Detail and Rationale

8-10-16

INITIALS

System Area 2	Finding	PUBLIC Rationale	Count of #
LE and MDT			4
	Crime Scene		1
		No scene investigation was completed by the law enforcement agency. As a result, the water temperature was not checked.	1
	Documentation		1
		Investigative procedures followed by the law enforcement agency were not recorded in the police report.	1
	Interviews		1
		Forensic interview did not occur with the young child who was present in the home at the time of the near death despite his disclosure of being hit by the mother's paramour with a closed fist.	1
	LE Contact with DOJ		1
		The law enforcement agency did not complete an intake with the Department of Justice for the first incident involving suspicion of inflicted injury to an infant.	1
Grand Total			**4**
Medical			6
	Documentation		1
		Staff at the initial treating hospital did not document in the medical record that a call was made to the DFS Report Line for the near death incident.	1
	Failure to Report		2
		Staff at the secondary treating hospital documented that a report was made to DFS but no hotline report was identified by DFS for the near death incident.	1
		Staff at the initial treating hospital did not consider abuse as a potential mechanism for injury and no call was made to the Report Line.	1
	Standard of Care		2
		Child was high risk as a result of the injury and was not recommended by the PCP to be seen more frequently for increased medical supervision. At the follow up visit, the PCP requested to see the child in a couple months.	1
		There was no PCP contact with the child or family until almost two months of life. Child was only seen after an inpatient stay and an intervention by DFS.	1
	Transport		1
		Despite suspected abuse, it is unknown as to whether the PCP allowed the mother to transport the child to the emergency department or sought alternative transportation.	1
Grand Total			**6**
Caseloads			5
	DFS Caseloads		5
		The caseworkers were almost double the investigation caseload statutory standard the entire time the case was open.	1
		The caseworker was over the investigation caseload statutory standards the entire time the case was open.	1
		The caseworker was significantly over the investigation caseload statutory standards the entire time the case was open.	2
		The caseworker was over the investigation caseload statutory standard the entire time the case was open.	1
Grand Total			**5**

System Area 2	Finding	PUBLIC Rationale	Count of #
DFS Part 1			9
	Safety Plan		4
		The safety agreement, implemented after the first suspected abuse incident, did not specify the adult who would supervise contact between the child and mother's paramour.	1
		For the near death incident, the DFS safety agreement was insufficient to protect the child. It did not specify the measures being taken to keep the child safe while in the hospital, including supervised contact between the victim and suspects.	1
		A DFS safety agreement was not completed by the after-hours worker since one child was hospitalized and the other was with the non-offending parent.	1
		DFS authorized the treating hospital to discharge the child to the mother despite unexplained serious physical injuries to a young child, mother being identified as a suspect, and an ongoing criminal investigation.	1
	Unresolved Risk		5
		Despite suspicions by medical staff that the infant sustained an inflicted injury, the caseworker had no contact with family in 2 months although there was one attempted home visit with the family within 30 days.	1
		A home visiting referral was not made by the caseworker after the first incident despite concerns about the mother and her paramour's parenting abilities.	1
		The caseworker did not corroborate mother's statement that she completed parenting classes after noting parenting deficiencies for mother.	1
		The DFS history search did not immediately identify that the suspect in this case was involved as a suspect in an earlier investigation. As a result, the suspect was permitted access to the child and DFS did not immediately seek custody.	1
		The DFS supervisor overrode the hotline report to screen it out. There was no investigation into the allegations of medical neglect, including follow up to make sure child was seen by PCP. No history on the father was documented.	1
Grand Total			**9**
DFS Part 2			3
	DFS Contact with DOJ		1
		DFS did not immediately file for custody upon receiving a report of serious physical injuries to a young child victim, who medical providers confirmed was a victim of child physical abuse.	1
	Employee Performance		1
		The caseworker concluded the injury may have been caused by the child even after medical experts concluded that it was improbable. This decision may have impacted the caseworker's decisions regarding the child's safety.	1
	Medical Exam		1
		The young non-victim was not medically evaluated despite the serious physical injuries to a young child victim.	1
Grand Total			**3**

TOTAL FINDINGS **27**

Child Abuse and Neglect Panel
Findings Detail and Rationale
8-10-16

FINALS

System Area 2	Finding	PUBLIC Rationale	Count of #
Legal - Finals			2
	Court Hearings		2
		The plea deal was inappropriate given the history of strangulation reported by the child and the diagnosis of neck and back pain by the children's hospital.	1
		The sentence was not appropriate for the offenses pled to by the defendant.	1
Grand Total			**2**
DFS Part 1 - Finals			1
	Unresolved Risk		1
		Mother was permitted to remove the child from a psychiatric treatment center prior to establishing a transition plan for him to move out of state.	1
Grand Total			**1**
DFS Part 2 - Finals			1
	Coordination of Care		1
		Communication did not occur between DSCYF sister divisions regarding the shared client and the seriousness of his mental health issues and the need for ongoing treatment. PBH was also not present at the hearing.	1
Grand Total			**1**
TOTAL FINDINGS			**4**