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

C. MALCOLM COCHRAN, IV, ESQUIRE
CHAIR

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

May 17, 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 now responsible for the reviews of child deaths and near deaths due to abuse or neglect. As required by law, CPAC approved findings from 14 cases at its May 11, 2016 meeting.[1] With the exception of one 2016 case, these incidents all occurred in 2015 and have resulted in 90 findings across system areas. Of these 14 cases, 9 resulted in death and 5 resulted in near death. The themes have been identified, as follows:

1. Law Enforcement/Multidisciplinary Team Response. The 12 findings continue to demonstrate struggles with best practices for criminally investigating these cases. Since the last CPAC meeting, law enforcement and the Department of Justice have discussed the required intake of cases and potential solutions. CPAC's Training Committee and Best Practices Workgroup continue to tackle proper investigative techniques with a new MOU and training expected in Spring 2017. CPAC will continue to monitor this progress in its quarterly meetings and at its September 2016 retreat. In addition, these 2015 cases indicate 6 cases where forensic interviews were not

[1] 16 Del. C. § 932

conducted of child victims and witnesses who were almost exclusively younger children. The Department of Justice and law enforcement have been tasked with reviewing the findings, focusing on the identified issues and presenting a solution.

2. Medical Response. There were 18 findings that demonstrate ongoing opportunities for improvement in the medical response to child abuse and neglect. Most prevalent were ongoing failure to report issues and the appropriate multidisciplinary response to substance exposed infants. These issues were identified in the Joint Commission Action Plan from January of 2015. The CPAC Child Abuse Medical Response Committee has been tasked with considering the findings and recommending an action plan specifically targeted at highlighting to physicians their frontline responsibilities in the diagnosing and reporting of suspected child abuse. Furthermore, the findings will be incorporated into the bi-annual medical professionals training and shared in area hospital meetings. As for the multidisciplinary response on substance exposed infants, four cases were reviewed and all infants died. CPAC and the Child Death Review Commission will continue their work in the Joint Committee on Substance Exposed and Medically Fragile Infants, and CPAC will continue to champion the passage of House Bill 319, implementing federal law for reporting substance exposed infants and developing a multidisciplinary plan of safe care.

3. DFS Safety Plans/Risk Assessments/Unresolved Risk. The most voluminous findings from these cases are applicable to DFS. Forty-three findings (47% of the total findings this quarter) were made in 14 cases that demonstrate the continual struggle by the Division of Family Services regarding the proper use and development of safety plans, appropriate use of risk assessments, and responses to cases that involve unresolved risks. The DSCYF Secretary presented to CPAC at the May 11th meeting regarding steps she has taken in the last few months. She has committed to continuous staff development around these issues and will continue to keep CPAC apprised of her efforts. However, there is little doubt that the ongoing violation of DFS statutory caseload standards and the lack of statutorily mandated resources for DFS is leading to adverse outcomes for Delaware's children. CPAC has written to the Joint

Finance Committee providing data and emphasizing the urgent need for statutory compliance with caseload standards. The Joint Finance Committee promptly and appropriately requested financial detail on resources needed to statutorily comply with 29 Del. C. §9015. DFS has indicated it needs 27 new positions to just meet statutory compliance with its volume of reports to exceed 20,000 this fiscal year. This untenable risk to children must be promptly addressed.

System responses will also be reviewed at least annually by the Child Protection Accountability Commission. We are available should further information be required. For your information we have included the findings and the details behind each.

Respectfully,

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

Enclosures
cc: CPAC Commissioners
General Assembly

LE and MDT	12
Crime Scene	1
Documentation	1
Doll Re-enactment	1
Interviews	7
Non-compliance with MOU	1
Use of History	1
Grand Total	**12**
Medical	18
Delayed Report	1
Documentation	2
Failure to Report	6
Standard of Care	1
Substance-Exposed Infant	6
Transport	1
Unresolved Risk	1
Grand Total	**18**
DFS Part 1	43
Risk Assessment	8
Safety Plan	16
Unresolved Risk	19
Grand Total	**43**
DFS Part 2	17
Best Practice	3
Collaterals	1
DFS Contact with DOJ	1
Documentation	1
Medical Exam	2
Non-compliance with MOU	3
Supervisory Oversight	3
Use of History	1
Communication	2
Grand Total	**17**
Summary Findings Total	***90***

LE and MDT			12
	Crime Scene		1
		No scene investigation was completed by the law enforcement agency.	1
	Documentation		1
		Toxicology results for the parents were not recorded in the police report.	1
	Doll Re-enactment		1
		No doll re-enactment was completed by the law enforcement agency.	1
	Interviews		7
		Forensic interview did not occur with the teen who was present in the home at the time of the death.	1
		Forensic interview did not occur with the young child during the investigation despite the disclosure of physical abuse and the appearance that the child was coached prior to the forensic interview.	1
		Forensic interview did not occur with the young child who was present in the home during the death incident.	1
		Forensic interview did not occur with the young child who witnessed the near death incident.	1
		Forensic interview did not occur with the young victim with developmental delays.	1
		Forensic interviews did not occur with the teen and young child who were present in the home at the time of the near death.	1
		Interviews did not occur with all adults in the home where the near death incident occurred.	1
	Non-compliance with MOU		1
		The law enforcement agency did not maintain ongoing collaboration or communication with DFS.	1
	Use of History		1
		History with two out of state child protective services agencies was not checked despite learning that the parents resided with the infant out of state in the last several months.	1
Grand Total			**12**

Medical			18
	Delayed Report		1
		After referring the child to the local hospital for suspected head trauma, the PCP learned that the child had a skull fracture and delayed reporting to the DFS Child Abuse and Neglect Report Line by one day.	1
	Documentation		2
		The adult accompanying the child to visits was not documented in the PCP records during mother's incarceration.	1
		The child's weight was not documented by the PCP during the first newborn visit.	1
	Failure to Report		6
		A report was not made to the DFS Report line after the parents were non-compliant with a voluntary home visiting service for a substance-exposed infant.	1
		The hospital failed to report the child's unexplained death to the DFS Child Abuse and Neglect Report Line.	1
		The substance abuse provider closed the case after non-compliance by mother, and DFS was not notified.	1
		There was no report to the DFS Child Abuse and Neglect Report Line by the birth hospital or PCP after a second child was born substance-exposed by Mother, and DFS was not able to intervene prior to the child's death. The positive test results were received post discharge, and the birth hospital alerted the PCP to the positive test results.	1
		There was no report to the DFS Child Abuse and Neglect Report Line by the PCP despite multiple no-show appointments, multiple caregivers, no dental care, self-infliction of harm, and fire play behaviors.	1
		Two months prior to the child's death, the child was in the care of a non-relative and this information was known by the PCP yet no report was made by the PCP to DFS Child Abuse and Neglect Report Line.	1
	Standard of Care		1
		At a young age, the child was reportedly engaging in fire play behaviors in the home, and the PCP made referrals to behavioral health systems but did not independently see the child.	1

Medical	Substance-Exposed Infant		6
		A Hospital High Risk Medical Discharge Protocol meeting was not requested by the birth hospital.	3
		No plan of safe care was completed by the birth hospital upon discharge of a substance-exposed infant, and the infant died two months later.	1
		The birth hospital did not document in its records that a report was made to the DFS Report Line.	1
		There was no documentation that the child was sent home with any supportive in-home services, such as a home visiting program.	1
	Transport		1
		Despite suspected head trauma with no mechanism of injury, the primary care physician allowed the mother to transport the child to the emergency department.	1
	Unresolved Risk		1
		No referral was made to a home visiting program for the young, first time mother who is low-income.	1
Grand Total			**18**
DFS Part 1			43
	Risk Assessment		8
		Despite multiple risk factors, the investigation was not substantiated against the mother.	1
		Despite the deplorable living conditions identified during the death investigation, DFS did not consider a finding of neglect at the conclusion of its investigation. The case was unsubstantiated with concern.	2
		For the near death incident, DFS did not consider making a finding of neglect against the relative for leaving the two young children unsupervised.	1
		The investigation for the near death incident was abridged by DFS despite concerns of neglect for the young victim.	1

DFS Part 1	Risk Assessment	The investigation was abridged despite the DFS history, father's absence from the home, and the child being left in the care of the non-relative who was previously substantiated for abuse against the same child.	1
		The Structured Decision Making (SDM) risk assessment for the investigation was rated high and the case was closed despite the risk level.	1
		The Structured Decision Making (SDM) risk assessment for the near death investigation was rated high and the case was closed despite the risk level.	1
	Safety Plan		16
		After the death incident, DFS history was not considered in determining the safety for the surviving siblings. A safety plan was temporarily completed with a relative, and the children returned home a few days after the incident. The conditions of the home were deplorable, prescription medication was within reach of the children, and the child's death was still unexplained.	1
		After the death, DFS addressed the repeated violations of the safety agreement by entering into a subsequent plan with the same participants, who were allowing mother unrestricted access to the child and siblings.	1
		After the death, DFS did not appropriately evaluate the placements for the surviving siblings. The three youngest children had multiple moves, and the older siblings' father's home was not evaluated and substance abuse was not assessed.	1
		After the near death incident, DFS entered into a safety agreement allowing mother only supervised contact with the child. However, only mother signed the plan, and no other participants were identified to supervise her interactions.	1
		DFS entered into safety agreements with participants who had criminal and DFS histories.	1

DFS Part 1	Safety Plan	During the death investigation, three other non-related children resided in the home with deplorable living conditions. Safety was not assessed for these children and a separate report of neglect was not made to the DFS Report Line.	1
		During the investigation, DFS learned that the safety agreement was being violated but failed to reassess safety.	1
		During the investigation, the safety agreement was lifted prior to transferring the case to treatment and the child was still at risk for abuse.	1
		Following the death, a safety agreement was completed with a participant who was present during the death and part of the original safety agreement. One of the participants was also terminally ill and had significant criminal history.	1
		Following the report of a substance-exposed infant, DFS entered into a safety agreement with the drug addicted mother. No other participants were identified in the safety agreement, and mother had no restrictions with her contact despite two substance-exposed infants.	1
		For the investigation involving a substance-exposed infant, the case worker did not complete the SDM safety assessment correctly, and there was no safety plan.	1
		For the investigation involving a substance-exposed infant, the case worker did not complete the SDM safety assessment correctly.	1
		In the investigation, the victim made a disclosure of sex abuse by her step father, but after she recanted, there was no ongoing actions taken to limit unsupervised contact between the victim and step father. The criminal charges were Nolle Prossed, and the DFS investigation was also unfounded.	1
		Neither safety agreement participant was present during the three contacts, and DFS did not address the repeated violations of the safety agreement.	1
		The safety agreement developed during the DFS investigation was not reviewed by the assigned treatment worker.	1

DFS Part 1	Safety Plan	The treatment worker was unaware the family had moved into the hotel until after the baby died, and safety agreement participants did not report the move to DFS.	1
	Unresolved Risk		19
		Despite extensive reports and investigations, there was not a heightened level of concern during the treatment case and parental risk factors were not considered.	1
		Despite multiple reports regarding drug use by mother, including a report of a substance-exposed infant, there was not a heightened level of concern during the treatment case and parental risk factors were not considered.	1
		Despite the DFS history involving substance abuse and domestic violence, there was not a heightened level of concern during the investigation and subsequent treatment case regarding the report of a substance-exposed infant.	1
		Despite the DFS history, non-relative placement, inability of the non-relative to obtain services for the child, and homelessness and substance abuse by the parent, there was no documentation that DFS considered placing the child with family members or petitioning the court for custody prior to the child's death.	1
		DFS did not evaluate substance abuse issues for father or request that he complete a substance abuse evaluation.	1
		During the investigation, there was no referral to the domestic violence liaison or substance abuse liaison.	1
		During the treatment case, it was reported to the caseworker that the child threatened suicide; however, there was no follow through with mental health services for the child.	1
		In the investigation, DFS did not contact mother's substance abuse provider to verify that she was compliant with treatment after it was reported that heroin was found in her car.	1
		In the investigation, no referral was made to the substance abuse liaison despite admission of marijuana use by the mother and allegations of cocaine use.	1

DFS Part 1	Unresolved Risk	Prior to closing the investigation, DFS did not verify services were being provided by the substance abuse provider, and the mother had a DFS history as a result of giving birth to a substance-exposed infant.	1
		Prior to the incident, the family was resistant to treatment services provided by DFS. The family was not seen for almost 2 months, and the following measures were not taken: requesting assistance from the DFS after-hours unit; adhering to the client lack of cooperation policy; filing a petition to compel cooperation; involving the special investigator; and reviewing the Division of Motor Vehicle and Medicaid records.	1
		The cases prior to the death incident did not receive a higher level of review by DFS, which may have included a consult with DOJ, a TDM meeting, or a framework. Risk factors included a family with significant DFS history, allegations involving several maltreatment types and different children, and calls by different professionals.	1
		The hotline report alleging drug use by mother was screened out, because it was labeled a prenatal case even though the then young sibling was in mother's care. The hotline worker also did not see that the case was active in treatment, so the worker was not notified of the report.	1
		The investigation was a Tier 1 (family assessment of low risk case) closure despite the extensive DFS history and recent child death.	1
		The investigation was a Tier 1 closure (family assessment of low risk case) despite the unsuitable living conditions. The family agreed to stay with the father and relative; however, no home assessment was completed and the father had restricted access to children due to his sex offender status.	1
		The near death case was not given a heightened level of concern given the risk factors: mother's incarceration, extensive criminal record, history of substance abuse, lack of providing care for the child, and an older child previously removed from the mother's care.	1
		The Panel identified that the child(ren) were currently at risk in the active treatment.	1

DFS Part 1	Unresolved Risk	There was no contact with the children for several months during the treatment case.	1
		Throughout the history of the case, the children's physical, medical, mental health and behavioral issues were not being adequately addressed. The children had chronic issues with poor hygiene, lice and an odor of urine and feces. They were frequently absent from school and ostracized by classmates. Each child also had a combination of developmental delays, speech delays, or mental health disorders. One child suffered from a chronic medical condition.	1
Grand Total			**43**
DFS Part 2			17
	Best Practice		3
		A Root Cause Analysis was not completed even though the child was active with DFS at the time of the child's death.	1
		In the investigation, group supervision and a framework were not utilized despite the active treatment case and DFS history.	1
		The DFS Child Abuse and Neglect Report Line screened out the report regarding an unexplained death to an infant, and the incident involved an impaired caregiver bed-sharing with an infant.	1
	Collaterals		1
		Collateral contacts were minimal in the 2011 and 2013 cases, which prevented DFS from obtaining additional information to verify or refute the allegations. All three cases were unsubstantiated.	1
	DFS Contact with DOJ		1
		DFS filed for temporary custody of the sibling, but did not file for custody of the victim due to the child's hospitalization.	1
	Documentation		1
		In the investigation, the PCP reported that mother no-showed for the sibling's medical appointments and sibling was due for a well visit, but there was no documentation that DFS addressed this with mother prior to closing case.	1
	Medical Exam		2

DFS Part 2	Medical Exam	During the death investigation, the two other young children were not medically evaluated despite the unexplained death of the victim. Significant concerns also existed with the conditions of the home.	1
		In the investigation, the young child was not medically evaluated despite allegations in two hotline reports that the child was punched in the back and head.	1
	Non-compliance with MOU		3
		A medical assessment was not completed for the 2013 and 2014 reports involving allegations of abuse with different victims. Bite marks, black eyes, and scratches from knives and keys were reported.	1
		Following the report of physical abuse, law enforcement was not notified of the potential criminal violation against the child, and a forensic interview was not scheduled at the Children's Advocacy Center.	1
		In the investigation, police were not notified of the potential criminal violation against the young child by the mother.	1
	Supervisory Oversight		3
		After the death, the supervisor communicated to the family that the surviving siblings should not have been placed in foster care, which contradicted the actions taken by the investigation worker.	1
		The lack of supervisory oversight negatively impacted the critical decisions made throughout the treatment case.	1
		Throughout the history of the case, the lack of supervisory oversight negatively impacted the critical decisions made, including assessing child safety.	1
	Use of History		1
		In the subsequent investigation, history was not considered from the near death investigation.	1
	Communication		2
		Lack of communication between DFS and substance abuse providers regarding this high risk family.	2
Grand Total			**17**
Summary Findings Total			***90***