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February 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:

Responsibility for reviews of child deaths and near deaths due to abuse or neglect has been transferred to the Child Protection Accountability Commission ("CPAC"). As required by law, CPAC approved findings from 29 cases at its February 10, 2016 meeting.[1] With respect to the first 13 cases, these incidents occurred from 2012 through 2014 and the findings within are being addressed in accordance with the Joint Commission Action Plan or by a CPAC Committee. Please note that several findings in these cases continue to be themes in the 2015 cases.

The remaining 16 cases, with the exception of one, all involve deaths or near deaths which occurred in 2015[2] and have resulted in 132 findings across system areas. Several themes have been identified, as follows:

1. Law Enforcement/Multidisciplinary Team Response. While there has been improvement in the law enforcement response to child abuse and neglect cases, there were 25 findings in the 2015 cases demonstrating that opportunities for improvement still exist, particularly in connection with scene investigations,

[1] 16 Del. C. § 932
[2] One case from the Fall of 2014 is included.

doll re-enactments, interviews and documentation. Opportunities for improvement also exist around compliance with the Memorandum of Understanding between the Department of Services for Children, Youth and Their Families, Delaware Children's Advocacy Center, the Department of Justice and Delaware Police Departments. The Department of Justice and law enforcement representatives on CPAC have been tasked with immediately addressing this ongoing statewide problem and presenting an interim solution at the May 2016 CPAC meeting prior to the implementation of a new MOU in 2017. If legislation is needed regarding mandatory intakes in death and serious physical injury cases or other matters, a request for assistance from the CPAC Legislative Committee can be made.

2. Medical Response. There were 23 findings from the 2015 case reviews that suggested ongoing opportunities for improvement in the medical response to child abuse and neglect. While training is provided under statute and otherwise, there is more work to do with medical professionals in helping them to recognize the signs of suspected child abuse, together with the need to communicate with members of the multidisciplinary team. These issues were identified in the Joint Commission Action Plan with a recommendation for additional training to be required by statute for some medical professionals. The CPAC Child Abuse Medical Response Committee will consider these findings and recommend an action plan designed to highlight to physicians their frontline responsibilities in the diagnosing and reporting of suspected child abuse. If legislation is needed the CPAC Legislative Committee will draft legislation in partnership with CPAC Child Abuse Medical Response Committee and the medical community. Meetings with area hospitals should also occur.

3. DFS Safety Plans/Unresolved Risk. The 2015 cases also demonstrate an ongoing struggle by the Division of Family Services regarding the proper use and development of safety plans, appropriate screening of hotline reports, and responses to cases that involve unresolved risks. There were 42 findings that fall in these categories. CPAC has requested a presentation from the DSCYF Cabinet Secretary and the DFS Director at the May CPAC meeting as to internal steps being taken to address these findings.

System responses will also be reviewed at least annually by the Child Protection Accountability Commission. We are available should further information be required.

Respectfully,

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

cc: CPAC Commissioners
General Assembly

Findings Summary of Cases to be
Reviewed at February CPAC Meeting

System Area2	Finding	Count of #
LE and MDT		
	Crime Scene	5
	Criminal Investigation	5
	Documentation	6
	Doll Re-enactment	3
	Interviews	3
	LE Contact with DOJ	2
	Non-compliance with MOU	1
Grand Total		**25**

System Area	Finding	Count of #
Medical		
	Documentation	2
	Failure to Report	3
	Medical Exam	13
	Standard of Care	3
	Substance-Exposed Infant	1
	Transport	1
Medical Total		**23**
Grand Total		**23**

Part 1

Area for Pivot Table	Finding	Count of #
DFS		
	Risk Assessment	8
	Safety Plan	13
	Unresolved Risk	21
Grand Total		**42**

Part 2

Area for Pivot Table	Finding	Count of #
DFS		
	Best Practice	5
	Caseloads	1
	Collaterals	1
	DFS Contact with DOJ	2
	Documentation	3
	Failure to Report	1
	Interviews	1
	Interviews	1
	Medical Exam	3
	Non-compliance with MOU	1
	Supervisory Oversight	2
	Use of History	1
Grand Total		**22**

System Area	Finding	Count of #
Legal		
	Best Practice	1
	Court Hearings	17
	Use of History	2
Legal Total		**20**
Grand Total		**20**

Total Findings	**132**

CPAC Review Dat	Feb
Date of Incident	(Multiple Items)

System Area	Finding	Rationale	Sum of #
LE and MDT			25
	Crime Scene		5
		No scene investigation was completed by the law enforcement agency.	
		No scene investigation was completed by the law enforcement agency.	
		The scene was not preserved by the law enforcement agency.	
	Criminal Investigation		5
		DFS and LE misinterpreted the findings from the CARE team consult to be accidental whereas it was undetermined. As a result, the investigations immediately concluded.	
		DFS and LE misinterpreted the findings from the CARE team consult for the first incident as consistent with a fall. However, the CARE team consult revealed that the injuries were more severe than suspected based on the history provided, and the tibial fracture was unexplained.	
		Temporary emergency protective custody as provided for in Section 907 of Title 16 was not utilized during the initial response.	
		The investigation focused solely on the mother's paramour rather than including the mother as a suspect.	
		The law enforcement agency did not take photographs of the child.	
	Documentation		6
		The assigned detective failed to submit the master supplemental report despite the case being cleared.	
		The assisting officers did not document their actions in the case.	
		The police report did not include documentation of a consult with the medical expert.	
		There was minimal documentation in the police report by the law enforcement agency.	
	Doll Re-enactment		3
		No doll re-enactment was completed by the law enforcement agency.	
		No doll re-enactment was completed by the law enforcement agency.	
	Interviews		3
		An interview was not conducted with the mother's boyfriend, who was caring for the child at the time of the incident.	
		Forensic interview did not occur with the 3-year-old sibling.	

LE and MDT	Interviews	Forensic interviews did not occur with other children residing in the home.	
	LE Contact with DOJ		2
		A delay in the criminal investigation may have hindered or caused difficulty in charging the alleged perpetrator. In addition, a pre-arrest intake has not been scheduled with the DOJ.	
		The law enforcement agency did not notify the DOJ Child Victims Unit of the near death incident.	
	Non-compliance with MOU		1
		MDT communication was poor during the joint investigation. As a result, DFS had minimal knowledge of case details that were known by other MDT partners.	
Grand Total			**25**

Total LE and MDT Findings 25

CPAC Review Dat	Feb
Date of Incident	(Multiple Items)

System Area	Finding	Rationale	Sum of #
Medical			23
	Documentation		2
		For the June 2014 incident, the documentation was inconsistent and unclear for the bruising to the child's ears.	
		The emergency department's intake assessment revealed no safety concerns for violence yet a hotline report was made for the June 2014 incident.	
	Failure to Report		3
		A report was not made to the DFS Report Line when the victim's sibling was born substance-exposed in 2013.	
		The DFS Report Line was not contacted after the emergency department's scans revealed a skull fracture to an 11-month-old and no explanation was provided.	
		The home visiting nurse failed to report a disclosure of sexual abuse and domestic violence of a minor to the DFS Report Line.	
	Medical Exam		13
		In June 2014, the child was seen at the emergency department for bruising to both ears, but no CARE consult occurred despite suspicion for abuse.	

Medical	Medical Exam	Child was not able to be seen by the local child abuse expert due to the ongoing dispute between the children's hospital and insurance company.	
		Despite serious non-accidental injuries to a 3-month-old infant, the physician communicated their reluctance to DFS to complete a scan on the victim's sibling, who was under 2 years of age.	
		In June 2014, a forensic consult did not occur during the emergency department visit.	
		PCP failed to refer the child to the emergency department in February 2015 after child had decreased right leg movement. Prior to incident, medical care was inconsistent and shots were delayed.	
		Radiology scans completed by the initial treating hospital misinterpreted the injury as “acute on chronic,” which is interpreted that two separate events have occurred. Whereas pediatric experts interpreted the scans as a single incident.	
		The CARE Team was consulted; however, there was no physical assessment of the injuries noted in the CARE Team record. Medical evaluation of the child was provided by the inpatient attending, and the CARE consult was provided by a member of the CARE Team but not a medical expert.	
		The hospital emergency department did not complete a skeletal survey despite the absence of a mechanism of injury.	
		There was no documentation in the medical record as to whether child was undressed during his well visit, which is standard practice for children under two years of age.	
		Unclear from medical documentation by PCP in February 2015 whether the documented decrease in limb movement was an acute versus chronic condition.	
		With assessments revealing a hematoma and healing fracture, an appropriate implementation would be to consider a forensic evaluation. No forensic evaluation on the record.	
	Standard of Care		3
		In June 2014, the inpatient hospital social worker was not consulted during the emergency department visit instead the on-call social worker was called.	
		PCP records did not contain the discharge summary from the birthing hospital, so there is no record that the PCP was ever notified of the birth.	
		The Panel identified that the child(ren) were currently at risk in the active treatment case	
	Substance-Exposed Infant		1

Medical	Substance-Exposed Infant	The Hospital High Risk Medical Discharge Protocol was not requested by the birth hospital despite the hospital's concerns at discharge.	
	Transport		1
		PCP sent child in a car to the emergency department with suspected head trauma.	
Grand Total			**23**

CPAC Review Dat	Feb
Date of Incident	(Multiple Items)

System Area	Finding	Rationale	Sum of #
DFS			42
	Risk Assessment		8
		Despite the death being identified as a homicide, DFS was unable to make a finding that abuse occurred at the conclusion of its investigation. The case was unsubstantiated with concern.	
		DFS did not consider making a finding of neglect for the near death investigation. The case was unsubstantiated with concern.	
		DFS should have made a finding of abuse based on the medical evidence for the near death incident.	
		No scene investigation was completed by the law enforcement agency.	
		Policy override was not checked for non-accidental injury to a nonverbal child in the risk assessment for the March incident resulting in the case being closed.	
		The DFS Family and Child Tracking System (FACTS) does not identify cases where abuse has been confirmed but the perpetrator is unknown.	
		The Structured Decision Making (SDM) risk assessment for the March 2013 investigation was rated high and the case was closed despite the risk level.	
		Throughout the history of the case, there was a lack of recognition of how parental risk factors could have factored into the serious injuries.	
	Safety Plan		13
		DFS addressed the repeated violations of the safety agreement by entering into subsequent plans with the same participants who were allowing mother unrestricted access to the child and sibling.	

DFS	Safety Plan	In the July 2015 Investigation, the case worker incorrectly identified the child as safe in the SDM safety assessment due to his hospitalization.	
		A Structured Decision Making (SDM) safety assessment was not completed on-time for either child.	
		Despite extensive DFS history and chronic substance abuse issues in family, the Team Decision Making Meeting only focused on victim and did not include discussion of the maternal grandmother's 5-year-old child.	
		Despite maternal grandparents' involvement as caregivers in the first investigation (where there was no explanation for injuries), they were still approved as safety plan participants in the second incident.	
		DFS entered into safety agreements with participants who had criminal and DFS histories.	
		During the near death incident, the safety assessments were not completed correctly on 5/1 and 5/4 impacting the safety decisions.	
		Mother was not considered as a potential perpetrator in the safety plan despite a serious unexplained injury to a 10-month-old. Neither parent sought medical treatment.	
		The initial contact did not occur with the victim until 3 months after the first referral was received. Face-to-face contact occurred with the non-victim 18 days after the first referral was received.	
		The SDM safety assessment was not completed correctly for June 2014 and July 2015 investigations. As a result, the child was determined to be safe in both instances.	
		The SDM safety assessment was not completed correctly. "Drug-exposed infant" and "caregiver is unwilling or unable to protect the child from serious harm or threatened harm by others" were not checked as safety threats. No protective capacties or safety interventions were checked.	
		There was a delay in assessing and planning for the safety of all other children involved in the case, particularly for victim's sibling and three children residing in the home where the death occurred (i.e., victim's mother did not immediately sign the safety agreement and DFS entered into a safety agreement via telephone with an out-of-state relative for the other three children 6 days after incident).	
		Two safety threats were not identified in the DFS Safety Assessment.	
	Unresolved Risk		21
		DFS did not evaluate substance abuse issues for father or request that he complete a substance abuse evaluation.	

DFS	Unresolved Risk	Treatment worker did not follow up to make sure services were implemented in the September 2014 case, and parents were not compliant with service providers.
		A referral was not made to the DFS substance abuse liaison and a substance abuse evaluation was not requested.
		A referral was not made to the DFS substance abuse liaison for the March 2013 investigation involving a substance-exposed infant.
		Despite identifying ongoing domestic violence issues, DFS did not make a referral to the domestic violence liaison during the investigation, and the referral was delayed in treatment.
		DFS did not verify mother's participation in services with a substance abuse provider.
		DFS involved father in the family meeting and safety agreements despite the concerns of domestic violence.
		DFS screened out the January 2015 hotline report alleging multiple inconsistent or unexplained injuries to a 2-year-old victim.
		During the May 2015 contact with the family, the caseworker discussed case closure with the parents prior to requesting substance abuse evaluations and completing safety and risk assessments.
		No documentation that the mother was referred for home visiting services
		Supervisor completed an override to screen out a hotline report alleging physical neglect by the mother in the January 2014 report.
		The caseworker had no contact or made no attempts to reach the family for 30 days.
		The caseworker's attempts to make the initial contact with the family during the February 2015 investigation were unproductive, and the following measures were not taken: contacting the birth hospital to determine when the family was visiting the victim; 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 sooner; and reviewing the Division of Motor Vehicle and Medicaid records.
		The DFS history, substance abuse allegations, and hospital's concerns were not reviewed or evaluated prior to the victim leaving the hospital. Once the concerns and the non-compliance issues were identified, there was no action taken by the caseworker.
		The family was not referred to other supportive in-home services, such as Safe and Stable Families or a Home Visiting, during the March investigation.

DFS	Unresolved Risk	The February 2015 investigation 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 substance-exposed infant, prior involuntary TPR, a family with significant DFS history, and family's whereabouts were unknown.
		The March and May investigations, involving serious unexplained bruises to a 7 week old, did not receive a higher level of review by DFS, which may have included a consult with DOJ or a framework. Risk factors included very young parents that had history of abuse as children.
		The Panel identified that the children were currently at risk in the active treatment case.
		The September 2014 treatment case 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 substance-exposed infant, a drug-addicted mother, mental health and domestic violence issues, and multigenerational history.
		Throughout the history of the case, there was a lack of recognition of how parental risk factors could have factored into the serious injuries.
		Treatment worker identified concerns with parenting behaviors and unsafe sleep practices in September of 2014 and failed to immediately provide education or services to address these issues.
Grand Total		**42**

CPAC Review Dat	Feb
Date of Incident	(Multiple Items)

System Area	Finding	Rationale	Sum of #
DFS			22
	Best Practice		5
		Differential response was not available for families with chronic neglect, only for families with high risk teens.	
		Differential response was not available for mothers with substance-exposed infants, only high risk teens.	
		Differential response was not available for this population, which could have prevented the January 2015 near death incident.	

DFS	Best Practice	The call by paramedics to the DFS Report Line in May 2015 was written as a hotline progress note rather than a new report.	
		When the non-victim was placed in foster care, his half-sibling's adoptive parents were not explored.	
	Caseloads		1
		The caseworker was over investigation caseload statutory standards the entire time the case was open.	
	Collaterals		1
		A collateral contact was not made with the birth hospital regarding the victim's substance-exposed birth.	
	DFS Contact with DOJ		2
		Following the May 2015 incident, DFS did not file for temporary custody of both children at the same time. DFS delayed filing for custody of the victim due to his hospitalization.	
		Prior to closing case, DFS did not consult with Civil DAG regarding a finding against the mother for failure to protect and/or seek medical treatment.	
	Documentation		3
		DFS failed to follow policy regarding minimal documentation about a criminal investigation in FACTS.	
		DFS failed to follow policy regarding minimal documentation about the criminal investigation in FACTS.	
		The information documented by DFS regarding the medical conclusions from the child abuse expert was contradictory with the information obtained by DOJ and LE.	
	Failure to Report		1
		A new hotline report was not made by the case worker after the sibling disclosed allegations of domestic violence and physical abuse in the July 2014 investigation.	
	Interviews		2
		An interview did not occur with the father during the initial contact in March 2015 despite father being present.	
		DFS conducted interviews with parents prior to police response.	1
	Medical Exam		3
		For the May 2015 incident, there was no follow up with the medical expert after the alleged mechanism of injury was investigated and concluded to be consistent with the injury.	

DFS	Medical Exam	Given the risk factors for this family, an immediate medical evaluation was not sought for either child despite learning that the children were behind on well visits and immunizations.	
		Not all of the involved children were medically evaluated despite the death of a 16-month-old child.	
	Non-compliance with MOU		1
		Police were not notified of the potential criminal violation in the June 2014 investigation.	
	Supervisory Oversight		2
		The lack of supervisory oversight negatively impacted the critical decisions made throughout the treatment case.	
		The supervisor did not adhere to the critical due dates in the Family and Child Tracking System (FACTS).	
	Use of History		1
		Two hotline reports received in July 2014 were screened out in error. A participant's name was spelled incorrectly in one of the reports, so the reports were not linked with each other.	
Grand Total			**22**

CPAC Review Dat	Feb
Date of Incident	(Multiple Items)

System Area	Finding	Rationale	Sum of #
Legal			20
	Best Practice		1
		The attorney guardian ad litem did not talk to all specialists providing care to the victim, including the infectious disease doctor. As a result, it was not known that the brain infection was caused by the initial trauma.	
	Court Hearings		17
		A higher level of coordination was needed between OCA, DOJ, and legal counsel at the children's hospital to identify a physician for the independent medical evaluation and to have the physician designated as an expert by the Court.	
		A sentence of 12 months probation was inadequate given the diagnosis by the CARE Team of child physical abuse and blunt abdominal trauma.	

Legal	Court Hearings	An Ex Parte Order completed by the Court failed to include a narrative of the allegations to support the findings.	
		Case was scheduled for mediation when the father had a criminal no contact order with mother and child, which is a violation of Family Court procedure.	
		Delaware only has one pediatric neurologist in the state, that has no affiliation with the children's hospital, who is able to conduct an independent medical examination as needed in such cases.	
		Despite indication on the petition that interpreters were needed for both parties, the Adjudicatory Hearing needed to be rescheduled since interpreters were not present. (Finding specific to a child in foster care.)	
		No consistent procedure exists for any of the involved agencies on how to legally pursue de-escalation of a medical procedure.	
		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. (Finding specific to a child in DSCYF custody.)	
		The attorney guardian ad litem did not immediately reach out to legal counsel at the children's hospital, so the hospital did not understand who had authorization for medical procedures.	
		The Court's requirement for the completion of parent education prior to judicial scheduling was a barrier in this case, resulting in a dismissed custody petition regarding the sibling and the underlying Ex Parte Order being vacated.	
		The Visitation Center was not utilized despite an ongoing criminal investigation regarding serious physical injuries to child and a request by parent.	
		There was a disconnect between the medical and legal communities as to what constitutes an emergency with medical care. The legal community determined that the endotracheal and nasogastric tubes could remain in place for a longer period, while the medical community concluded that more permanent life support systems were needed due to various risks associated with the current treatment.	
	Use of History		2
		After dismissal of the first custody petition, a second petition was filed and scheduled before a mediator despite the initial custody petition being referred for judicial scheduling after a Commissioner's hearing on the emergency motion.	

Legal	Use of History	It is not routine practice for mediators to check with DFS regarding any history with the family on private filings.
Grand Total		**20**

Total Findings from all System Areas - 132

Child Protection Accountability Commission & Child Death Review Commission

Joint Meeting/Retreat – January 22, 2015

Prioritized CAN Panel Recommendations with # of Occurrences in 2015

System Area	Finding	Joint Commission Recommendations	Joint Commission Action Plan	# of Findings At Joint Retreat 1/22/15	# of Findings 10/10/2015	# of Findings 2/10/16
DFS Investigation & Treatment	Safety Plan & Unresolved Risk	1. Consider legislation to add the Secretary or Division Directors of DHSS as Commissioners to CPAC, (barriers to services provided by DPH, DSS, and DSAMH in recommendations).	1. Provide update to Joint Commission at next meeting.	52	5	42
		2. Conduct an analysis of DFS system improvements over the last 2 years to determine impact on child death and near death cases.	2. Provide update to Joint Commission at next meeting.			
		3. Develop policies and procedures to ensure that information from mental health, substance abuse, and domestic violence assessments are incorporated into safety planning, and no case will be closed without a supervisory review documenting that referral services are underway, as appropriate.	3. Provide update to Joint Commission at next meeting.			
		4. Establish a Joint Committee to identify recommendations to assure high risk families are engaged in early intervention /prevention services (i.e., home visiting to decrease risk of abuse or neglect).	4. Provide update to Joint Commission at next meeting.			

Child Protection Accountability Commission & Child Death Review Commission

Joint Meeting/Retreat – January 22, 2015

Prioritized CAN Panel Recommendations with # of Occurrences in 2015

System Area	Finding	Joint Commission Recommendations	Joint Commission Action Plan	# of Findings At Joint Retreat 1/22/15	# of Findings 10/10/2015	# of Findings 2/10/16
LE and MDT Response	Crime Scene, Interviews & Non-compliance with MOU	1. Implement MOU between DSCYF, DOJ, Law Enforcement, and CAC and develop a training program on the best practice guidelines for investigating and prosecuting these cases. 2. Develop and provide advanced training programs annually for members of the MDT. This shall include: a. Drug and Alcohol Abuse; b. Abusive Head Trauma; c. Safety & Medical Assessments; d. Warning Signs & Indicators of Abuse and Torture; and, e. Developmental, psychological & emotional impact of abuse. 3. Identify resource constraints for DOJ and support appropriate budgetary requests for additional resources, to include the recruitment, addition and development of felony level prosecutors with expertise in the prosecution of felony level child abuse cases.	1. Assigned to CPAC Training Committee - CAN Best Practices Workgroup. 2. Assign to CPAC Training Committee – Joint Conference Workgroup. 3. CPAC to monitor and pursue budget request by FY17.	38	20	25

System Area	Finding	Joint Commission Recommendations	Joint Commission Action Plan	# of Findings At Joint Retreat 1/22/15	# of Findings 10/10/2015	# of Findings 2/10/16
		1. Research and develop best practices and/or trainings to help professionals recognize and appropriately respond to cases of child torture. Specific examples from the CAN Panel will be utilized.	4. Assigned to Joint Committee on Child Torture.			
Medical	All	1. Consider modification to Delaware law to include an education requirement for medical professionals that incorporates the appropriate evaluation and management of a child suspected of child abuse and neglect as per the guidelines of the AAP, ACR, AAFP and ACEP. It shall emphasize: a. Assignment of an appropriate provider; b. Comprehensive history taking; and c. Complete age appropriate exam, including disrobing, radiologic survey, and sexual assault evaluation.	1. CDNDSC shall write a letter to the agencies responsible. Provide update to Joint Commission at next meeting.	22	14	23