STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
C/O OFFICE OF THE CHILD ADVOCATE
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TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

November 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 9 cases at its November 8, 2017 meeting.[1]

One of the cases has been previously reviewed and was awaiting completion of prosecution. The eight remaining cases were from deaths or near deaths that occurred between January 2017 and May 2017, and half of these cases involved a substance exposed infant. These eight cases resulted in 21 strengths and 31 findings across system areas. With respect to the multidisciplinary team (MDT) response to these cases, 12 strengths and 7 findings were identified. Collaboration and communication between DFS and law enforcement continues to strengthen. Crime scene responses and investigations are improving. The work CPAC has done in trainings and development of a new MOU to support this response is beginning to show results.

[1] 16 Del. C. § 932.

With respect to the medical interventions on these cases pre and post incident, 6 strengths and 9 findings were identified. Home visiting services, safe sleep education and abusive head trauma education for parents is an area that must continue to be strengthened.

The most significant ongoing issues from these eight new cases are the use of safety agreements, unresolved risk and risk assessment by DFS. 15 findings were made in addition to 3 strengths. In every case, the DFS case worker was significantly over the statutory caseload standard. It is very difficult to implement best practices and timely safety and risk assessment tools under these circumstances.

Despite the 27 additional frontline positions, DFS caseloads remain a significant challenge for workers and a serious risk to children -- particularly infants. CPAC will continue to advocate for regular compliance with 29 Del. C. § 9015 such that caseloads can attain and then remain in statutory compliance. CPAC stands as a ready and willing partner to identify long term solutions.

This year, 13 children have died and another 25 have almost died from abuse or neglect. 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 Abuse and Neglect Panel

Findings Summary

11-8-17

INITIALS		
Row Labels	***Current**	**Grand Total**
MDT Response	**7**	**7**
Communication	1	1
General - Civil Investigation	2	2
General - Criminal Investigation	2	2
Interviews - Adult	1	1
Reporting	1	1
Medical	**9**	**9**
Documentation	2	2
Home Visiting Programs	2	2
Medical Exam/Standard of Care - Birth	3	3
Medical Exam/Standard of Care - ED	1	1
Medical Exam/Standard of Care - PCP/ED	1	1
Risk Assessment/ Caseloads	**10**	**10**
Caseloads	7	7
Reporting	1	1
Risk Assessment - Tools	1	1
Risk Assessment - Unsubstantiated	1	1
Safety/ Use of History/ Supervisory Oversight	**4**	**4**
Completed Incorrectly/ Late	4	4
Unresolved Risk	**1**	**1**
Substance Abuse	1	1
Grand Total	**31**	**31**

FINALS		
Row Labels	***Current**	**Grand Total**
MDT Response	**1**	**1**
Prosecution/ Pleas/ Sentence	1	1
Grand Total	**1**	**1**

TOTAL FINDINGS **32**

**Current - within 1 year of incident*
***Prior - 1 year or more prior to incident*

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

Child Abuse and Neglect Panel

Findings Detail and Rationale

11-8-17

INITIALS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			7
	Communication		1
		There was no documentation that the law enforcement agency and DOJ had ongoing communication about the near death incident.	1
	General - Civil Investigation		2
		During the prior investigation, another relative was utilized to translate the conversation between the caseworker and parent.	1
		During the initial response to near death incident, DFS and LE were not aware of the active PFA between the parents.	1
	General - Criminal Investigation		2
		The child abuse medical expert was not contacted directly to discuss the medical findings.	1
		The surviving children were left unsupervised at the scene with mother after first responders transported the victim to the hospital emergency department.	1
	Interviews - Adult		1
		Interviews were not conducted with other witnesses who had a caregiving responsibility for the child.	1
	Reporting		1
		DFS was not notified of the child death until immediately prior to the forensic interview of the young sibling. As a result, DFS was not able to observe any early suspect/witness interviews due to the delayed report by the law enforcement agency.	1
Medical			9
	Documentation		2
		The documentation was unclear about whether mother received newborn stay education prior to the child's discharge.	1
		The child was seen by his PCP for a follow up weight check, and it was documented that the child's weight was taken but not recorded.	1
	Home Visiting Programs		2
		Home Visiting Services were not in place at the time of the near death incident or post incident.	1
		Home Visiting Services were not in place at the time of the near death incident.	1
	Medical Exam/Standard of Care - Birth		3
		Abusive Head Trauma/Shaken Baby Syndrome and infant safe sleep education were inconsistently documented within the medical records.	2
		No referrals were made by the birth hospital after mother admitted that she had no supplies for the infant.	1
	Medical Exam/Standard of Care - ED		1
		There was no official call to the Division of Forensic Science following the child's death. The cause of death was under criminal investigation, and the hospital staff were aware of this.	1

	Medical Exam/Standard of Care - PCP/ED	1
	Language interpretation services were not provided consistently to this family, and as a result, there was a breakdown in what was communicated.	1
Risk Assessment/ Caseloads		10
	Caseloads	7
	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 caseload for the detectives assigned to investigate major crimes for this law enforcement jurisdiction was high and may have had an impact on the criminal investigation.	1
	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open.	4
	Reporting	1
	The family moved during the treatment case, and the DFS supervisor delayed making a report to the out of state child protection agency.	1
	Risk Assessment - Tools	1
	A consult with DOJ or a framework was not considered by DFS despite the presence of multiple risk factors. The infant was born substance exposed and died shortly after being discharged home to the family.	1
	Risk Assessment - Unsubstantiated	1
	The DFS Family and Child Tracking System (FACTS) does not identify cases where abuse has been confirmed but the perpetrator is unknown.	1
Safety/ Use of History/ Supervisory Oversight		4
	Completed Incorrectly/ Late	4
	For the near death incident, the caseworker incorrectly identified the child as safe in the SDM safety assessment. The child was hospitalized for a head injury, and it was unknown whether the father caused the injury.	1
	For the initial hotline report, the caseworker did not complete the SDM safety assessment correctly. The safety threat for drug-exposed infant was marked no. Initially, there was no agreement entered for the victim or siblings residing in the home.	1
	The caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization. Other risk factors included current/prior infants born substance exposed, history of incarcerations, prostitution and drug use, and significant DFS history.	1
	The caseworker incorrectly identified the child as safe in the SDM safety assessment due to the hospitalization. Other risk factors included an infant born substance exposed, prior infant death, history of substance abuse and DFS history involving the siblings.	1
Unresolved Risk		1
	Substance Abuse	1
	A substance abuse evaluation was not considered for father despite his past history of illicit drug use and alleged drug sales. As a result, a safety agreement was initiated with him when the victim was born substance exposed.	1
Grand Total		**31**

FINALS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			1
	Prosecution/ Pleas/ Sentence		1
		Father's charges were not handled in Superior Court. Instead, the charges were screened out to Family Court, and ultimately Nolle Prossed.	1
Grand Total			**1**

TOTAL FINDINGS **32**

Child Abuse and Neglect Panel

Strengths Summary

11-8-17

INITIALS		
Row Labels	**Current**	**Grand Total**
MDT Response	**12**	**12**
Crime Scene	1	1
General Civil Investigation	5	5
General Criminal Investigation/Civil Investigation	4	4
Interviews - Child	2	2
Medical	**6**	**6**
Documentation	1	1
Home Visiting Programs	1	1
Medical Exam/Standard of Care - Birth	1	1
Medical Exam/Standard of Care - ED	1	1
Medical Exam/Standard of Care - Forensics	1	1
Medical Exam/Standard of Care - PCP	1	1
Risk Assessment/ Caseloads	**1**	**1**
Risk Assessment - Tools	1	1
Safety/ Use of History/ Supervisory Oversight	**2**	**2**
Completed Correctly/On Time	2	2
Grand Total	**21**	**21**

*Current - within 1 year of incident

**Prior - 1 year or more prior to incident

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Child Abuse and Neglect Panel

Strengths Detail and Rationale

11-8-17

INITIALS

System Area	Strength	Rationale	Count of #
MDT Response			12
	Crime Scene		1
		Thorough scene investigation was completed by the law enforcement agency.	1
	General Civil Investigation		5
		DFS identified appropriate family members, and a foster care placement was avoided for the sibling.	1
		Excellent investigation by the DFS caseworker, to include a Framework prior to case closure and medical assessment of the older sibling.	1
		The weekend DFS caseworker reached out to the children's hospital following the allegations, and asked the medical staff to call back if there were additional concerns.	1
		The DFS caseworker maintained great communication with the family.	1
		During the prior investigation, the DFS caseworker appropriately ruled out the child's father due to his criminal and DFS history.	1
	General Criminal Investigation/Civil Investigation		4
		There was great MDT response to the investigation by all parties.	1
		There was great collaboration between the law enforcement agency, DFS, and DOJ, and a thorough investigation was conducted despite the initial presentation of the case.	1
		Great collaboration between the MDT members, and response to the death investigation, to include completion of the SUIDI Form, a doll reenactment, toxicology of the mother, forensic interviews of the siblings, and DFS obtaining custody of the siblings.	1
		Great collaboration between the MDT members, and response to the death investigation, to include completion of the SUIDI Form, a doll reenactment, toxicology of the mother, forensic interview of the older sibling, and DFS obtaining custody of the siblings.	1
	Interviews - Child		2
		Forensic interview was conducted with the young sibling although no abuse and/or neglect was initially suspected.	1
		All MDT members were present during the forensic interview of the child's older sibling.	1
Medical			6
	Documentation		1
		Excellent documentation within the medical record of communication between medical staff, DFS, and law enforcement.	1
	Home Visiting Programs		1
		Referrals for home healthcare services and Child Development Watch were completed for the family prior to discharge from the newborn hospital stay.	1
	Medical Exam/ Standard of Care - ED		1
		Despite the child being medically cleared for discharge, the child was held until a suitable placement option was arranged by DFS.	1

	Medical Exam/ Standard of Care - Forensics	1
	The children's hospital considered both medical outcomes and the forensic legal perspective by ensuring confirmatory testing was completed, as well as testing for interactions with false positive drug screens.	1
	Medical Exam/ Standard of Care - PCP	1
	The primary care physician made diligent efforts to contact the family in an attempt to reschedule the infant's no-show appointment.	1
	Medical Exam/Standard of Care - Birth	1
	The hospital utilized several tools to evaluate the child's development during the newborn stay.	1
Risk Assessment/ Caseloads		1
	Risk Assessment - Tools	1
	Since an active safety agreement was in place at the conclusion of the prior investigation, DFS completed a Framework with both the investigation and treatment caseworkers.	1
Safety/ Use of History/ Supervisory Oversight		2
	Completed Correctly/On Time	2
	The DFS investigation involving an infant with substance exposure was thorough. It included a discussion of infant safe sleeping, the safety agreement being initiated during the family meeting with all parties present, the safety agreement being completed in both English and Spanish, and unannounced home visits with the family being conducted.	1
	The modified safety agreement restricted the parents from providing any food or drink to the young sibling during scheduled visitation. All would be provided by the supervising party.	1
Grand Total		**21**