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EXECUTIVE DIRECTOR

March 26, 2019

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 20 cases at its March 26, 2019 meeting.[1]

Nine of the cases (three deaths and six near deaths) had been previously reviewed and were awaiting the completion of prosecution. Six of the cases were ultimately prosecuted. The eleven remaining cases were from deaths or near deaths that occurred between May 2018 and July 2018. These timely reviews enable CPAC to address current system issues as well as celebrate accomplishments. Other than one sibling group, the children range in age from two months old to two years old with 4 deaths and 7 near deaths. The children were primarily victims of abuse. These eleven cases resulted in 53 strengths and 33 current findings across system areas.

The cases reviewed and reflected in this letter coincide with CPAC concluding trainings statewide on the new Memorandum of Understanding for the

[1] 16 Del. C. § 932.

multidisciplinary ("MDT") response to these cases. For this quarter, 27 strengths were noted for the MDT while only 8 findings were made. CPAC should continue its efforts to train the MDT on best practices and to reach as many jurisdictions as possible. CPAC should also continue its efforts to provide access to local and national conferences for frontline responders.

Progress with DFS regarding the use of safety agreements, unresolved risk and risk assessment is again seen this quarter. Only 21 findings were made in these categories. This is very encouraging given the unmanageable caseloads of frontline workers. Once caseloads are subtracted, 13 findings remained again primarily focused on the use of safety agreements. CPAC and DFS continue to partner to improve these agreements, and DFS provided additional staff training in June 2018 on use of the safety assessment to support decisions about the immediate safety of children. The cases seen here occurred close in time to that training and the impact is evident. Sixteen strengths were also noted with DFS workers performing thorough investigations. These positive examples will continue to be highlighted in trainings, both locally and nationally.

The caseloads of DFS frontline workers continue to merit attention. CPAC continues to be grateful for the leadership in tackling the complex issues that face DFS in the recruitment and retention of frontline child welfare workers. In 8 of the 11 recent cases contained in this letter, the DFS worker was significantly over the statutory caseload standard. CPAC continues to support additional frontline positions to ensure statutory compliance. There are still investigators carrying 40 plus cases with a statutory standard of 11. Workers continue to resign under the pressure contributing to the turnover rate and escalating caseloads for those that remain. It is critical that we all collectively ensure that once we tackle this crisis by employing and retaining frontline workers, we demand regular compliance with 29 Del. C. § 9015. CPAC remains a steadfast partner and the Joint Action Plan emphasizes the work of its Caseloads/Workload Committee to that end.

In 2018, Delaware experienced 14 child abuse or neglect deaths and 34 near deaths. CPAC only brings you the most horrific of the cases; however, for every one of these, there are countless more cases where DFS case workers are under the same pressures and children remain at risk of serious harm. Young children with sentinel injuries are often the victims of serious abuse just months later.

For your information we have included the strengths, findings and the details behind all of the cases presented in this letter. CPAC stands ready as a partner as well as to answer any further questions you may have.

Respectfully,

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

Enclosures
cc: CPAC Commissioners
General Assembly

Child Abuse and Neglect Panel

Strengths Summary

March 26, 2019

INITIALS		
	***Current**	**Grand Total**
MDT Response	**27**	**27**
Documentation	2	2
General - Civil Investigation	5	5
General - Criminal Investigation	5	5
General - Criminal/Civil Investigation	9	9
Interviews - Adults	1	1
Interviews - Child	2	2
Medical Exam	3	3
Medical	**10**	**10**
Home Visiting Programs	4	4
Medical Exam/Standard of Care - Birth	1	1
Medical Exam/Standard of Care - CARE	2	2
Medical Exam/Standard of Care - ED	3	3
Risk Assessment/ Caseloads	**2**	**2**
Collaterals	1	1
Risk Assessment - Substantiated	1	1
Safety/ Use of History/ Supervisory Oversight	**8**	**8**
Completed Correctly/On Time	4	4
Oversight of Agreement	3	3
Supervisory Oversight	1	1
Unresolved Risk	**6**	**6**
Domestic Violence and Parenting	1	1
Home Visiting Programs	3	3
Mental Health	2	2
Grand Total	**53**	**53**

FINALS		
	***Current**	**Grand Total**
MDT Response	**1**	**1**
General - Criminal/Civil Investigation	1	1
Grand Total	**1**	**1**

TOTAL STRENGTHS 54

**Current - within 1 year of incident*

***Prior - 1 year or more prior to incident*

Child Abuse and Neglect Panel

Strengths Detail and Rationale

March 26, 2019

INITIALS

System Area	Strength	Rationale	Count of #
MDT Response			27
	Documentation		2
		The law enforcement agency thoroughly documented the investigation case events.	1
		The DFS after-hours case worker thoroughly documented the case events, to include identifying next steps.	1
	General - Civil Investigation		5
		The law enforcement agency thoroughly documented the investigation case events.	1
		The DFS case worker educated Mother on infant safe sleep practices when the parents advised of co-sleeping with the child and sibling.	1
		The DFS case worker ensured Mother obtained a lockbox to store her prescription medications.	1
		The DFS case worker educated Mother on infant safe sleep practices.	2
	General - Criminal Investigation		5
		The law enforcement agency thoroughly documented the investigation case events.	1
		The law enforcement agency conducted a blood draw for Mother after it was discovered that she had a history of substance abuse.	1
		The law enforcement agency conducted blood draws of the foster parents during the death investigation.	1
		The law enforcement agency collaborated with out of state authorities to conduct a scene investigation of Father's temporary residence and to interview Father's supervisor.	1
		The Criminal DAG recommended that the medical exam include weight and height measurements for the sibling to exclude the young child as an alleged perpetrator.	1
	General - Criminal/Civil Investigation		9
		There was great collaborative response between the DFS case worker and the law enforcement agency during the near death investigation, to include interagency communication, joint response to the hospital, joint interviews, thorough documentation, and consultation with the child abuse medical expert.	1
		There was excellent communication between the DFS case worker, the law enforcement agency, and the medical team during the near death investigation, as well as follow up medical care for the child.	1
		The MDT requested the young sibling be video-recorded during play time to rule out aggressive behaviors as reported by the parents.	1
		A joint investigation was conducted by the MDT to include a coordinated response to the hospital, and excellent communication between the DFS case worker and the law enforcement agency throughout the investigation.	1
		There was great collaborative response and ongoing communication between the medical CARE Team, DFS, DOJ, and the law enforcement agency during the near death investigation, to include joint interviews and an MDT meeting with all parties present.	1
		There was great collaborative response and communication between DFS, DOJ, and the law enforcement agency during the death investigation, to include joint interviews, forensic interviews of the children, medical evaluations, and sharing of interagency information, specifically the contract agency and Institutional Abuse investigation reports.	1
		There was good collaboration among the MDT during the near death investigations, to include interagency communication, joint interviews, thorough documentation, and consultation with the child abuse medical expert.	1
		There was good communication between the medical team, DFS, and the law enforcement agency.	1

	There was a great collaborative response between the medical CARE Team, DFS, DOJ, and the law enforcement agency during the near death investigation, to include a joint response to the hospital, joint interviews, and consultation with the child abuse medical expert.	1
Interviews - Adults		1
	Joint interviews were completed with the parents, initially at the hospital and later at the police station.	1
Interviews - Child		2
	Forensic interview was scheduled and held at the CAC for the young sibling residing in the home where the incident occurred. The interview was conducted within 24 hours.	2
Medical Exam		3
	The DFS case worker ensured the child's sibling was medically evaluated.	2
	The DFS case worker ensured the child's sibling was medically evaluated. The DFS case worker also recommended that a follow-up medical evaluation be conducted by the child abuse medical expert.	1
Medical		10
Home Visiting Programs		4
	A referral to an early intervention program was made for the child prior to medical discharge.	1
	The child abuse medical expert referred the child to an early intervention program.	1
	A referral to an early intervention program was made for the child prior to medical discharge by the birthing hospital.	1
	A referral for home visiting services was made for the child prior to medical discharge by the birthing hospital.	1
Medical Exam/ Standard of Care - CARE		2
	Follow-up medical evaluation of the young sibling included a skeletal survey, as well as measurements of the child due to aggressive behaviors reported by the parents. This would assist in determining if the young child was capable of causing injury to the infant.	1
	The child abuse medical expert met with the family to explain the child's injuries and consistently stated the child's injuries resulted from abusive head trauma.	1
Medical Exam/ Standard of Care - ED		3
	The initial treating hospital emergency department provided a comprehensive medical response to the child prior to transfer to the children's hospital.	1
	The trauma, social work, and CARE Team consults were conducted in the emergency department preventing any delays in admission, treatment, or report to DFS.	1
	While the child's injuries appeared to be consistent with a fall, a differential diagnosis of abusive head trauma/non-accidental trauma was considered by the children's hospital.	1
Medical Exam/Standard of Care - Birth		1
	Plan of safe care meetings were held prior to medical discharge of the child.	1
Risk Assessment/ Caseloads		2
Collaterals		1
	There was good follow-up and collaterals completed by the DFS case worker relating to Mother's mental health and substance abuse.	1
Risk Assessment - Substantiated		1
	At the conclusion of the investigation, DFS made appropriate findings against the perpetrator as a result of the child's injuries.	1

Safety/ Use of History/ Supervisory Oversight			8
	Completed Correctly/On Time		4
		The DFS case worker implemented a safety agreement while the child was hospitalized, and it restricted contact between the child and the parents at the hospital.	2
		The DFS case worker implemented a safety agreement while the child was hospitalized, and it required supervised contact between the child, the parents, and the maternal grandmother at the hospital.	1
		The DFS case worker implemented safety agreements for the surviving children in the home, and it restricted contact between the children and the foster parents, as well as included safeguarding the pool.	1
	Oversight of Agreement		3
		There was consistent review and modification, when necessary, of the safety agreement by the DFS case worker.	1
		There was consistent review, and modification, when necessary, of the safety agreement by the DFS case worker.	1
		There was consistent review and modification, when necessary, of the safety agreement by the DFS case worker. The safety agreement was MDT-informed.	1
	Supervisory Oversight		1
		There was strong adminitrative oversight during the investigation and treatment cases as the parents and relatives were adamant that the child was not abused, and as a result, the safety agreements were not necessary.	1
Unresolved Risk			6
	Domestic Violence and Parenting		1
		The DFS treatment case worker referred Mother to the domestic violence liaison and a Family Interventionist.	1
	Home Visiting Programs		3
		The DFS case worker referred the child to an early intervention program.	2
		The DFS case worker addressed the no-show at the early intervention program appointment with Mother, and had Mother contact to reschedule during a visit.	1
	Mental Health		2
		The DFS treatment worker referred the parents for mental health evaluations.	1
		Civil DOJ recommended the DFS case worker make referrals for mental health evaluations for the parents due to their presumed cognitive delays.	1
Grand Total			**53**

FINALS

System Area	Strength	Rationale	Count of #
MDT Response			1
	General - Criminal/Civil Investigation		1
		There was good communication between the DFS and the law enforcement agency. DFS was particularly helpful in sharing the DFS history on the family.	1
Grand Total			**1**
TOTAL STRENGTHS			**54**

Child Abuse and Neglect Panel

Findings Summary

March 26, 2019

INITIALS

	*Current	**Prior	Grand Total
Legal	**1**		**1**
DFS Contact with DOJ	1		1
MDT Response	**8**		**8**
Crime Scene	2		2
Doll Re-enactment	1		1
General - Criminal Investigation / Civil Investigation	1		1
Interviews - Adult	1		1
Interviews - Child	1		1
Medical Exam	1		1
Reporting	1		1
Medical	**3**	**1**	**4**
Medical Exam/Standard of Care - Birth	1	1	2
Medical Exam/Standard of Care - PCP	1		1
Reporting	1		1
Risk Assessment/ Caseloads	**13**		**13**
Caseloads	8		8
Collaterals	3		3
Risk Assessment - Closed Despite Risk Level	1		1
Risk Assessment - Tools	1		1
Safety/ Use of History/ Supervisory Oversight	**8**		**8**
Completed Incorrectly/ Late	3		3
Inappropriate Parent/ Relative Component	2		2
Oversight of Agreement	1		1
Reporting	1		1
Use of History	1		1
Grand Total	**33**	**1**	**34**

**Current - within 1 year of incident*

***Prior - 1 year or more prior to incident*

Office of the Child Advocate
900 King Street, Ste 350
Wilmington, DE 19801

Prepared 2/9/2019

Child Abuse and Neglect Panel

Findings Detail and Rationale

March 26, 2019

INITIALS

System Area	Finding	PUBLIC Rationale	Sum of #
Legal			1
	DFS Contact with DOJ		1
		DFS did not consult with the Civil DAG to determine whether or not custody should be sought for the young child with a serious physical injury and failure to thrive and for a sibling with similar malnutrition concerns.	1
MDT Response			8
	Crime Scene		2
		No scene investigation was completed by the law enforcement agency.	1
		The law enforcement agency did not complete evidentiary blood draws on the child after the child ingested a prescription drug.	1
	Doll Re-enactment		1
		No doll re-enactment was completed by the law enforcement agency.	1
	General - Criminal Investigation / Civil Investigation		1
		There was not a strong MDT response to the near death investigation due to the following: lack of communication; lack of coordinated response between after-hours worker and LE, including joint interviews; and inaccurate information provided about DFS history.	1
	Interviews - Adult		1
		The after-hours worker declined to participate in the joint interview by LE at the hospital.	1
	Interviews - Child		1
		Forensic interview did not occur with the older sibling who was present during the near death incident despite the victim's injuries resulting from neglect and the significant DFS history.	1
	Medical Exam		1
		The older sibling who was present in the home during the near death incident was not medically evaluated.	1
	Reporting		1
		The law enforcement agency did not make a report to the DFS Report Line for the death incident.	1
Medical			4
	Medical Exam/Standard of Care - Birth		2
		The birth hospital did not submit the commitment form signed by the mother to the All Babies Cry program. Therefore, the parents did not receive a prevention call six weeks after birth.	1
		The birth hospital documented suspected abuse for the mother, but there was no other information documented in the record.	1
	Medical Exam/Standard of Care - PCP		1
		The PCP did not consider a differential diagnosis of abuse despite the rapid increase in the child's head circumference. The PCP had a relationship with the family, and it may have influenced the plan of care.	1

	Reporting		1
		The young child and sibling were being followed by the PCP for Failure to Thrive. Despite a decline in their weight, concern with feedings and multiple hospitalizations, the PCP did not make a report to the DFS Report Line.	1
Risk Assessment/ Caseloads			13
	Caseloads		8
		The DFS caseworker was over the investigation caseload statutory standard during the prior investigation, and the caseload appears to have had a negative impact on the response in the case.	1
		The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	3
		The DFS family and institutional abuse caseworkers were over the investigation caseload statutory standards the entire time the case was open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	1
		The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it is unclear whether the caseload had a negative impact on the DFS response in the case.	1
		The DFS caseworker was over the investigation caseload statutory standards the entire time the current case was open. However, it is unclear whether the caseload had a negative impact on the DFS response in the case.	1
		The DFS caseworkers were over the investigation caseload statutory standards during the current and prior investigations. However, it does not appear that the caseload negatively impacted the DFS response to those cases.	1
	Collaterals		3
		The supervisor closed the prior investigation against the risk score despite not having the collateral information from the substance abuse provider.	1
		In the prior investigation, the home visiting agency reported concerns that the parents were under the influence, and the case worker addressed the concerns by phone and not in person.	1
		At the close of the near death investigation, a Framework was completed and recommended a collateral with the substance abuse provider. However, no collateral was completed, and the case was closed against the risk score.	1
	Risk Assessment - Closed Despite Risk Level		1
		The SDM Risk Assessment identified the risk as high at the conclusion of the prior investigation. Ongoing service was recommended; however, the case disposition was overridden to close the investigation and a Framework was not considered.	1
	Risk Assessment - Tools		1
		In the prior investigation, the SDM Risk Assessment was not completed correctly. The risk was scored as moderate; however, the parents' substance abuse issues were not rated.	1

Safety/ Use of History/ Supervisory Oversight			8
	Completed Incorrectly/ Late		3
		In the near death investigation, the case worker incorrectly identified the child as safe in the SDM safety assessment due to his hospitalization and no safety agreement was initially completed for the hospitalized victim.	1
		In the prior investigation, a safety agreement was not implemented for the infant born with prenatal substance exposure despite safety threats being present due to the current circumstances and DFS history.	1
		In the prior investigation, DFS completed a safety agreement with the father prior to completing collateral contacts with substance abuse providers.	1
	Inappropriate Parent/ Relative Component		2
		For the near death incident, DFS completed a safety agreement with relatives, who were not ruled out as suspects.	1
		After the near death incident, DFS entered into a safety agreement allowing mother only supervised contact with the child by an appropriate adult. However, the safety intervention did not adequately address the safety threat as no other participants were identified.	1
	Oversight of Agreement		1
		DFS terminated the safety agreement without consideration of the following: infant with injuries resulting from neglect, new report of domestic violence, collateral information from the substance abuse provider, and the family's significant DFS history.	1
	Reporting		1
		The agency contracted to monitor the child's placement failed to make a hotline report to the DFS Report Line after the child sustained an injury to his forehead.	1
	Use of History		1
		DFS custody could have been considered much earlier for the young child and sibling due to the serious physical injury to one child and failure to thrive, decline in weight and multiple hospitalizations for both children.	1
Grand Total			**34**