

State of Delaware

**Child Protection Accountability Commission
("CPAC")**

16 Del. C. § 912

Near Death Report

**In the Matter of
Steven and Karen Green
Minor Children¹**

April 5, 2007
Embargoed until June 12, 2007

¹ To protect the confidentiality of the family, case workers, and other child protection professionals, pseudonyms have been assigned.

Background and Acknowledgements

In the spring of 2004, the State of Delaware, submitted its five year child protection plan to the federal government, and in exchange for federal funding, certified the Child Protection Accountability Commission (“CPAC” or “Commission”) as Delaware’s Citizen Review Panel. As Delaware’s Citizen Review Panel, CPAC is charged with examining the policies, procedures, and practices of state and local agencies and, where appropriate, specific cases. The requirement that CPAC review specific cases is intended to assist CPAC in evaluating the extent to which Delaware and local child protection system agencies are effectively discharging their responsibilities. 42 U.S.C. §§ 5106a(b)(2)(A)(xiv) and (c).

At the October 2004 CPAC meeting, the Commission voted to conduct three case reviews as the Citizen Review Panel. The particular cases CPAC chose were all near death cases due to child abuse or neglect. The reviews were directed to CPAC’s Near Death Subcommittee (“Subcommittee”) which chose the case of Steven and Karen Green for its third review. The Office of the Child Advocate (“OCA”), as staff for CPAC, gathered and compiled the records and established a schedule of witness interviews. OCA staff drafted the report which the entire Subcommittee thoroughly reviewed and edited. The following government agencies are to be commended for their full and candid participation in the review through the presentation of witnesses and/or records. Several private organizations also participated; however, in order to protect confidentiality, they are not included in this list.

Delaware Division of State Police
Department of Justice
Department of Services for Children, Youth and Their Families, Division of Family Services
Family Court of the State of Delaware
Office of the Child Advocate

The Subcommittee members are also to be recognized for their time and dedication to this comprehensive review. Each member spent approximately 20 hours in meetings and interviews, as well as countless hours gathering and reviewing materials. The expertise and commitment of the Subcommittee members significantly enabled the process. The Subcommittee members are as follows:

Dr. Allan DeJong, A.I. duPont Hospital for Children
Sergeant Randy Fisher, Delaware State Police
Mariann Kenville-Moore, Department of Justice
The Honorable Jennifer Mayo, Family Court
Allison McDowell, Office of the Child Advocate, Staff
Janice Mink, Grassroots Citizens for Children
Mary Ball Morton, Department of Services for Children, Youth and Their Families
Randall Williams, Children’s Advocacy Center, Chair

Finally, the Subcommittee would like to thank those individuals who were open and willing to discuss the performance of the child protection system. The Subcommittee believes that this review was critical to helping CPAC further expand its understanding of the child protection system and the impact that organizational culture, child abuse and neglect training, and multidisciplinary collaboration have on the safety and well-being of Delaware’s children.

Executive Summary

Steven and Karen Green are premature, but healthy twins born in October 2003 to Jacqueline Black and Kevin Green, young adults with no parenting experience and numerous risk factors with which to contend.

At twenty and twenty-one years of age, Jacqueline Black and Kevin Green faced meeting the needs of two premature infants. The mother was incapacitated due to surgery and the father was dealing with untreated Attention Deficit Hyperactivity Disorder and was unemployed with a history of drug use and a bad temper. Additionally, Kevin Green had history as a child with the Department of Services for Children, Youth and Their Families (“DSCYF”) through both the Division of Family Services (“DFS”) and the Division of Youth Rehabilitative Services (“DYRS”) indicating patterns of behavior that increased the risk factors in this family unit.

These risk factors played a critical role in the events that took place on or about December 8, 2003, and in those days surrounding January 21, 2004. Medical tests discovered that four separate abuse incidents, consistent with Shaken Baby Syndrome, occurred against Steven and Karen between their 41st day of life and their third month of life.

Before, during and after this time frame, numerous child protection system partners were involved with this family. The children were seen multiple times by Delaware area hospitals when the children presented with seizure-like symptoms at various times during their first three months of life. The Division of Family Services was involved with this family as they investigated suspicions of physical abuse stemming from the circumstances surrounding the hospital visits and/or admission(s).

Other members of the child protection community involved with the Green family included the primary care physician who provided routine pediatric care to Steven and Karen from the time of their birth; the Delaware State Police who investigated the allegations of physical abuse; and the Department of Justice that eventually prosecuted Kevin Green.

Despite the involvement of numerous systems with the Green family, the infants remained at risk for further abuse. As a result, areas where improvement is needed were identified.

Recommendations include: heightening the urgency of cases involving infants; creating a culture of leadership, and sound professional judgment in the field of child protection; utilizing history and risk factors in decision-making; increasing the expectation for on-going child abuse and neglect training for medical professionals; requiring the sharing of information across the medical community and every discipline involved in protecting children; and collaborating among professionals in the child welfare community.

The recommendations made by the Near Death Subcommittee and submitted to the Child Protection Accountability Commission aim to provide direction to all system partners so that the best protection can be afforded to the children of Delaware.

History

In July, 1996, allegations of medical neglect were unfounded against Kevin Green's mother, Carol. However, less than a year later, in May 1997, Parent/Child conflict was founded between mother and child, but the Department of Services for Children, Youth and Their Families closed the case without offering any services.

Two years later, on April 15, 1999², Kevin was arrested and charged with offensive touching and disorderly conduct at school. After being insulted by a student, Kevin threw the student up against a wall and was then restrained by other students. Kevin's case was sent to arbitration in Family Court resulting in an agreement that he was to have no unlawful contact with the other student involved and upon completion of a conflict resolution class, Kevin's charges would be dismissed. His charges were, in fact, dismissed on July 29, 1999.

Five months later, on December 31, 1999, Kevin was arrested on charges of burglary 2nd, criminal mischief over \$1,500, conspiracy 2nd degree, and attempting to commit a crime (felony, non-violent). The event precipitating the charges involved Kevin and his brothers entering a vacant trailer, causing extensive damage to the kitchen, living room, master bedroom, two other bedrooms, and a bathroom. In addition, the floors, walls, light fixtures, smoke detectors, and kitchen and bathroom fixtures were damaged. Mr. Green and his brothers also attempted to set the home on fire. As part of a plea agreement, Kevin pled guilty to burglary 3rd and criminal mischief, agreed to pay court costs, agreed to cooperate with the DYRS, (which included mental health treatment) for twelve months, agreed to complete a fire starters program, wrote an apology to the victims and had to perform 100 hours of community service. The conspiracy 2nd and attempting to commit a crime charges were dismissed.

Kevin completed all the court ordered special conditions associated with the December 1999 charges. He was considered proactive and hard working as it related to his probation requirements.

During Kevin's probation, in October 2000, alleged emotional neglect of Kevin by his mother was subsequently unfounded by the Division of Family Services. The case was closed.

The Division of Youth Rehabilitative Services started working with Kevin in January 2000. Kevin began seeing a therapist after experiencing difficulties in school. Kevin shared with his therapist that he had been sexually abused by a friend of his father at the age of 14. Kevin was also being treated with Ritalin for Attention Deficit Hyperactivity Disorder at this time and began to attend night school. Kevin complied with all the requirements of probation and DYRS Community Supervision ended in April 2001.

On September 17, 2001, five months after being discharged from probation, Delaware State Police were contacted by Mr. Green's ex-girlfriend who reported that Mr. Green had threatened her over the phone. The couple had dated for one and a half months and had recently broken up. The ex-girlfriend was pregnant with his child and had been in contact with Mr. Green to obtain his medical information which he had refused to provide. Mr. Green threatened to punch and

² The incident occurred on March 19, 1999 with the warrant for Mr. Green's arrest being executed on April 15, 1999.

beat up his ex-girlfriend and also called her derogatory names. The police spoke to both parties and advised them to stop contacting each other, which they agreed to do.

On May 16, 2002, Kevin Green's former girlfriend gave birth to a son who, through paternity testing, was later confirmed to be his child. Mr. Green was not part of this child's life and was, by this time, dating another young woman, Jacqueline Black, who was pregnant with, he would come to find out, twins.

December 2003

Mr. Green, now twenty-one years of age, found himself the father to twins born at 35 weeks gestation to his twenty year old girlfriend, Jacqueline Black. Kevin and Jacqueline had not known each other long before Jacqueline became pregnant, but they moved in together. Ms. Black was at home with the twins while Mr. Green worked as a maintenance employee. The children's grandmother also helped care for the children. The family lived in a mobile home in a rural area of Delaware. There was no family history for seizures or neurological problems.

Born on October 27, 2003 via cesarean section at 35 weeks gestation, Karen (3lbs., 9 oz.) and Steven Green (4lbs., 5 oz.) were being seen routinely by their pediatrician for well-child care with no significant concerns noted.

Hospital Visit

On December 7, 2003, Kevin and Jacqueline took their daughter, Karen, to the emergency room. While Jacqueline was out shopping, Kevin alleged that he placed Karen on the bed, approximately six inches from the edge while he was straightening up the room. He left the room briefly to get something to drink, and while he was gone, he heard a "thump." When he re-entered the room, Karen was laying on her stomach on the floor, which is carpeted. Several minutes later, Kevin noticed that Karen looked pale.

When Jacqueline arrived home approximately fifteen minutes later at 9:45pm, Kevin told her what happened and they immediately decided to take Karen to Hospital 1.

The emergency room staff at Hospital 1 diagnosed Karen with an intracranial bleed at the top of her head. Additionally, there was some redness/bruising to Karen's left cheek and left brow. The diagnosing doctor was of the opinion that the injury was consistent with the explanation of the incident provided by the parents, but felt they may need assistance with providing proper supervision so a report to the Division of Family Services was made. Due to the fact that the treating hospital did not have a neurosurgeon on call, Karen was transferred via ambulance to another hospital ("Hospital 2") where the principal diagnosis was a concussion. A cranial CT scan was done which found hemorrhaging towards the front portion of her brain with no evidence of a fracture. Hospital 1 notified the primary care physician's office of the emergency room visit.

Investigation

The Division of Family Services received a hotline report about six week old Karen Green in the early morning hours of December 8, 2003. A third shift investigation worker contacted the Delaware State Police and the two investigative agencies responded together to the emergency room where they were only able to see the child for a few minutes. Prior to responding to the hospital, the DFS investigator (“Investigator 1”) checked the Family and Child Tracking System (“FACTS”) discovering that Mr. Green had history with DFS with his mother.

When Investigator 1 questioned the treating physician, the doctor reported that the injury was consistent with the parents’ account of the events that transpired and that he did not feel that Karen had been physically abused by either parent. The doctor sent Karen to another hospital for a neurological evaluation as a precautionary measure.

The responding Corporal also interviewed the emergency room physician who advised him that the redness/bruising on Karen’s face was consistent with her having fallen on her face and the cranial bleed at the top of her head was a “deceleration injury.” The physician explained that Karen was a premature infant and her brain and skull were not developed to the same extent a full-term infant’s would be and she still had a large quantity of fluid surrounding her brain. In the fall as her parents reported it, when her head struck the floor, her brain would have been able to move around quite a bit inside her skull. The doctor further explained that the movement caused blood vessels on the top of the brain to detach and bleed. A CT Scan of Karen’s head revealed no other injury.

Investigator 1 interviewed Jacqueline Black who told her that Kevin was home with both infants when the incident occurred. Ms. Black relayed that Kevin placed Karen on the bed, went to get a drink, heard a “boom,” and returned to the room to find Karen on the carpeted floor. Ms. Black stated that when she got home they immediately drove Karen to the hospital.

Ms. Black reported the same information to the Corporal who responded to the hospital with the addition of the fact that she had never seen Kevin be rough or abusive to either Karen or her twin brother, Steven.

After interviewing Ms. Black, the Corporal questioned Kevin Green about the incident. Mr. Green indicated that he had been watching both Karen and her twin brother, Steven, while their mother, Jacqueline, was out shopping. Steven was sleeping, but Karen was crying, so Kevin put her in her swing to help her fall asleep. After thirty minutes, she still had not fallen asleep, so Kevin carried her to his and Jacqueline’s bedroom where he laid her approximately six inches from the edge of the bed. At one point, Kevin left the room to get something to drink and he heard a thump from the bedroom. He came back into the bedroom and found Karen on her stomach on the carpeted floor. Kevin noticed several minutes later that Karen looked pale, but he did not know what to do. Ms. Black returned home within fifteen minutes, at which time Kevin told her what happened and they proceeded to the emergency room.

When Investigator 1 interviewed Kevin, he reported that he placed Karen “almost in the middle of the bed, but closer to the edge.” He reported that he did so because she had been crying. Kevin said that he then left the room to get a drink and returned after he heard a “boom.” Kevin picked Karen up and she began to scream. During this time period, Steven was asleep. Kevin

stated that when Jacqueline arrived home approximately 10 minutes later, Kevin informed her of the incident, and they proceeded to the emergency room.

Investigator 1 completed the Alcohol and Other Drug screening on which both parents scored "0." The investigator noted that both parents seemed to be appropriate.

Follow-up

Karen's case was transferred to a day-shift investigation worker ("Investigator 2"). Investigator 1 requested that Investigator 2 contact her to discuss the case. Despite the lack of Risk Assessment narrative statements, reliance on medical opinion was heavy and no maltreatment was indicated. The DFS Safety Assessment indicated that a safety plan was not needed and that Karen was able to protect herself despite being only 41 days old amidst numerous risk factors including the presence of a parent with DFS history, other Departmental history, substance abuse concerns, unemployment, young parenthood, twins, and a mother who shared information about the father's temper. The DFS supervisor, upon review, then downgraded the case from an urgent response to a routine one, changing the investigation completion time from 20 days to 45. Concurrently, the police determined the incident to be accidental after consultation with the treating physicians.

On December 11, 2003, four days after Karen's "fall", a detective ("Detective 1") contacted Investigator 1 to discuss concerns he had regarding the one and a half month old's ability or inability to roll off the bed and suggested contacting a medical child abuse and neglect ("CAN") expert. Investigator 1 asked Investigator 2 to contact Detective 1. Investigator 2 contacted the medical CAN expert who reviewed the infant's medical information. On December 17, 2003, Detective 1 took pictures of the bed from which the child fell, measured the height of the bed and noted the condition of the box spring and two mattresses and their downward slope. The top mattress was broken down around the edges.

During his visit to the home, Detective 1 spoke with Ms. Black who believed Kevin's account of the injury and did not have any concern for her children in their father's care. Detective 1 talked to Jacqueline about stressors in the home, such as domestic violence and financial difficulties, and found Ms. Black to be very appropriate. She reported significant involvement of the grandparents and was insistent that Mr. Green was appropriate and had no concerns with his care of Steven and Karen.

Detective 1 also spoke with the father via telephone who explained that he placed Karen on her back on the bed, approximately six to eight inches from the edge, while he went to get a bottle and a glass of water. Kevin heard a "thump" in the bedroom and then Karen began to cry. He ran back into the bedroom and picked Karen up off the floor to comfort her. When Jacqueline came home a few minutes later, Karen did not seem to be acting right, so they took her to the hospital.

Detective 1 spoke with the medical CAN expert who stated that based on the information presented, the injury could have been sustained from a fall, but a child of this age is not mobile and cannot move a great distance. The detective and the medical CAN expert discussed possibility versus probability and deduced that it was possible that Karen could have sustained the injuries from a fall, but not necessarily probable.

Notably, the children had a regularly scheduled well-child care visit days later. At no time during the visit did the physician or the staff initiate discussion about the hospital visit or the circumstances of Karen's fall.

January 2004

Investigator 2 and Detective 1 were satisfied that the incident occurred as explained by Kevin because the mattress was unusually high and overstuffed so that it sloped toward the edges. Kevin placed Karen too close to the edge, causing her to roll off the bed. The police investigation was unfounded regarding any criminal act. The DFS investigation was still pending.

Hospital Visit #1

On January 20, 2004, Jacqueline returned home from shopping having left Karen with Kevin. She found Karen having a seizure-like episode. Her arms were stiff in front of her and she had what appeared to be a rash on her face. Karen's face was pale and her lips were blue and quivering. Jacqueline and Kevin took Karen to Hospital 1's emergency room where, upon a physical examination, all findings were "normal" other than petechiae³ on the face, which the treating physician determined she acquired from straining with a bowel movement. Mr. Green and Ms. Black were told Karen probably had eczema and they should follow up with their primary care physician. Hospital 1 did not note any concerns, which did not lead them to notify DFS of a repeat visit to the emergency room by Karen and her parents. It is unclear if the emergency room had Karen's records and information about her previous visit just one month earlier, but no information about Karen's history, other than what the parent provided was documented. Hospital 1 did, however, communicate with the family's primary care physician's office on which it relied to provide a benchmark for the hospital's course of action.

Hospital Visit #2

On January 21, 2004, Kevin told Jacqueline that Steven was having a seizure. His eyes rolled back in his head, his lips turned blue, and his arms were stiff in front of him. Steven was taken by ambulance to Hospital 1's emergency room where the physicians found nothing of concern and discharged the child to his father with instructions to go to their primary care physician. The emergency room doctor called the primary care physician to alert the office of the emergency room visit and the impending office visit. Upon examination of Steven, the primary care physician ordered upper gastrointestinal tests and apnea monitors for both children "due to the parents' anxiety over the situation." The parents were told to implement reflux precautions and to return if the symptoms worsened or failed to improve.

³ Petechiae are fine hemorrhages in the skin. The Subcommittee learned that it is very worrisome to see this condition in an infant and should have prompted further serious evaluation to determine the cause, all of which are serious—the infant has a bleeding disorder with bleeding inside the head, a blood infection or meningitis, or head trauma. If the first two are ruled out, staff would be left with head trauma and a child abuse hotline report would have been the next step.

Paramedic Call

On January 22, 2004, Kevin reported to Jacqueline that Karen was having another seizure. She was very pale, “zoned out,” and her hands were stiff in front of her. Karen’s parents called the paramedics, but Karen was not displaying any symptoms when they arrived. The paramedics suggested that, rather than transporting Karen to the hospital for medical care, the Greens follow up with the primary care doctor the next day.

Follow-up

Karen weighed 8 pounds, 7 ounces at the paramedic-recommended appointment on January 23, 2004. Both the mother and father brought Karen in and described the episode of flailing arms, breathing difficulties, and turning pale. The family reported being scared, but upon examination, no concerns were found. The primary care physician put Karen on reflux precautions and recommended CPR training for the parents. An EEG was also recommended if a pattern developed or the symptoms worsened.

Hospital Visit #3

On January 23, 2004, two days after the last occurrence, Steven suffered another seizure-like episode. After waking, his parents reported that he became pale and clammy. His jaw tremored, he had difficulty breathing, he became stiff and rigid in the arms and legs, and then went limp and became sleepy afterwards. Steven had not eaten since the night before. Steven was seen at his primary care physician’s office where tests were ordered, including an EEG. He had yet another episode when he returned home with his parents and they were advised by his pediatrician to take Steven straight to a specialty hospital (“Hospital 3”) where this 8 pound, 14 ounce little boy was admitted. Upon admission, Steven’s anterior fontanelle was bulging, indicative of increased pressure (from the blood from the intracranial hemorrhages) within his skull. He was placed on an apnea monitor, reflux precautions, and daily head circumferences were ordered. A neurology consult was also ordered. Steven’s liver function tests were significant as was his CT scan which showed bilateral subacute (more than three days old) and acute subdural hematomas approximately one to two days old. Additional assessments revealed numerous bilateral retinal hemorrhages as well as vitreous hemorrhages, and a possible fracture of the left radius caused by non-accidental injury and consistent with Shaken Baby Syndrome.

Hospital Visit #4

On January 24, 2004, Karen was admitted to Hospital 3 after her brother was admitted with similar symptoms and a suspected inflicted head injury. Upon examination, Karen had diminished alertness and blunted visual following. Additionally, old and new intracranial hemorrhages were discovered along with numerous bilateral retinal hemorrhages, consistent with Shaken Baby Syndrome. Compared with her brother, Karen’s subdural hematomas were slightly larger, but older, more likely to be two to three weeks old. A Pediatric Trauma team also assessed Karen and recommended an abuse evaluation. The impression was that there was current and probable past trauma inflicted on this child. The skeletal survey done on Karen was normal while the bone scan revealed possible damage in one right rib and one left rib. Kevin admitted to Hospital 3 that he would playfully toss both children up in the air, however, Jacqueline and the grandmother appeared to be very upset about his actions with the children.

Investigation

On January 24, 2004, DFS received a hotline report indicating that the twins had been admitted to Hospital 3 and had been diagnosed with retinal hemorrhaging. Both children's fontanelles were full which indicated possible brain damage. The report indicated the parents recounted the children's episodes of stiffening and turning blue over the past several days, but offered no explanation for the injuries. The reporter stated that the parents had not been advised as to the full extent of the children's injuries and that hospital staff witnessed Kevin yelling at Jacqueline and saw him become so agitated with Karen when she cried that he drew his hand back as if to hit her, but he seemed to "realize where he was" and stopped his hand and comforted her instead.

DFS advised Hospital 3 not to allow Kevin and Jacqueline to be alone with their children. DFS then called the police who sent a detective ("Detective 2") to meet the assigned caseworker ("Investigator 3") at Hospital 3 where they were informed that the injuries sustained by the children were the result of abuse and that both children had extensive retinal hemorrhaging of both eyes.

DFS Investigator 3 interviewed Jacqueline Black who stated that due to the gall bladder surgery she had on January 14, 2004, Kevin had to take care of both children. She disclosed that she did not know him long before becoming pregnant and that he had a temper, but he had never hurt her. She admitted that he became agitated and visibly frustrated when the babies cried, but other than yelling at them, she had never seen him hurt them.

Ms. Black reported that Kevin was excited about the children being born, but had not seemed as excited since the birth. He was fired from his job for failing a drug test (she further stated he was using marijuana) and then from another job for stealing money. Ms. Black also stated that once she learned her children's injuries were caused by being shaken or struck, she believed Kevin hurt them and put him out of the home.

DFS Investigator 3 and Detective 2 interviewed Kevin Green, who initially denied any wrongdoing, but later confessed to shaking both babies on separate occasions for five to seven minutes until their lips turned blue. He admitted to doing so because the children would not stop crying and they were getting on his nerves. After hurting them, Mr. Green stated he would put them down to cry or sleep. Mr. Green reported that on January 23, 2004, Karen would not stop crying, so he slammed Karen on the bed as hard as he could which resulted in her bouncing back up about one foot high. He then put her in the baby swing to cry herself to sleep. Mr. Green also admitted that sometime, possibly during the week of January 12, 2004, he shook both Karen and Steven on different occasions because they were crying and he was frustrated. He stated he knew he shook them too hard. During the interview, Kevin also admitted to using marijuana regularly. These actions by Kevin placed Karen and Steven at risk of death and as a result, caused serious injury to both children. Mr. Green was arrested on January 24, 2004 on three counts of first degree assault.

Ms. Black was not charged for a variety of reasons. First, the investigators and detective believed that she did not know what Mr. Green had done; Second, Ms. Black had done what she was supposed to do as far as seeking appropriate medical treatment; and third, she could not be faulted for the previous misdiagnoses of the children's injuries.

On January 29, 2004, despite concerns expressed by Hospital 3, Karen was discharged to Ms. Black with a DFS safety plan in place which required no contact between the twins and Kevin Green; protective daycare for the twins; therapy and a psychological or psychiatric evaluation for Ms. Black; the provision of emotional support via frequent visitation by the maternal grandmother; and the agreement to work with the Division of Family Services treatment services.

On March 1, 2004, Mr. Green was indicted on three counts of Assault I.

December 2004

The Children—An Update

Both Steven and Karen were evaluated and followed by Child Development Watch which recommended physical therapy for both children. Karen had a 25% delay in both cognitive and motor skills. Steven required a ventriculoperitoneal shunt until January 2005 to drain the excess fluid from inside his skull so that excessive pressure did not build up while his brain's fluid production and recycling system regained normal functioning. He was also diagnosed with astigmatism and hypermetropia as a result of the injuries he sustained during the first three months of his life. Karen was diagnosed with intermittent alternate exotropia in addition to the subarachnoid hemorrhage her father caused when he took his frustration out on her on at least two different occasions in her first 90 days of life. Despite their challenges, Karen laughs and squeals and appears to be a well-adjusted child, as does her brother.

The Sentencing

While Steven and Karen embarked upon their journey toward recovery from being shaken by their father on what appears to be at least four separate occasions, in July 2004, Kevin Green pled guilty to one count of first degree assault and two counts of second degree assault. On December 15, 2004, Kevin Green was sentenced to six years of incarceration, followed by one year in a semi-locked drug treatment facility, followed by two years at level three probation. The Judge justified the sentence, which was above the SENTAC guidelines, with the aggravating circumstances in this case including, among other issues, Mr. Green's lack of amenability, the vulnerability of the victim, and his lack of remorse. Additionally, Ms. Black offered a victim impact statement on behalf of the children and was very involved and cooperative prior to the sentencing.

The conditions of Kevin Green's sentencing include that he is allowed no contact with Karen and Steven for a period up to twenty-two years and shall successfully complete anger management, counseling, and treatment programs. Mr. Green must also participate in and complete a certified domestic violence intervention program as well as a parenting class. He must be evaluated for substance abuse and follow all recommendations for counseling, testing, and treatment. Further, Mr. Green is required to undergo a mental health evaluation and comply with all recommendations for counseling and treatment as deemed appropriate.

FINDINGS AND RECOMMENDATIONS

Division of Family Services

Casework

During Mr. Green's youth, he displayed troublesome and destructive behavior and ultimately, albeit via court-order, entered therapeutic services for mental health treatment. While the Division of Family Services learned through their investigation that Kevin had involvement with the Division of Youth Rehabilitative Services, had a temper, and was living with untreated Attention Deficit Hyperactivity Disorder, these risk factors were not assessed to the full extent that they should have been. These pieces of the father's history would have proven helpful in determining the level of risk that existed in the home of Steven and Karen Green, particularly in combination with the other factors which required consideration, including Mr. Green's recent loss of employment, drug use, DFS history, young parenthood, and parenting twins.

The Division of Family Services currently contracts with agencies to supply in-house substance abuse and domestic violence liaisons. These individuals are available to DFS staff for consultation, client meetings, and limited case management. Their expertise is invaluable given the number of cases that involve domestic violence and/or substance abuse.

The following recommendation for compliance and/or change is made:

1. A mental health liaison similar to the substance abuse and domestic violence liaisons should be co-located with DFS staff in order to assist caseworkers in the analysis of clients' mental health history and understanding of how an individual's mental health challenges may interfere with his/her ability to maintain a child's safety, participate in the investigation process, and plan with DFS.

Supervision Issues

Case reviews offer opportunities to ascertain what could have been done differently from a systems perspective, but they also provide case studies for DFS staff to learn what specific steps were effective and in what areas improvements could be made. The facts and issues in the Green case reiterate that leadership is critical to the proper functioning and decision-making of caseworkers in the Division of Family Services.

It is imperative that such leadership be embodied in DFS supervisors because they create the culture in which decisions are made and should be instilling the passion and professional judgment which is necessary to protect children. Supervisors provide coaching and support of the ever-developing caseworker instinct. Without such sound leadership skills, the caseworker is at risk of losing this critical piece of the assessment tool box and investigations will not be of the highest quality. Most importantly, children will not be protected to the degree they should.

The following recommendation for compliance and/or change is made:

1. In addition to the examination that CPAC's Caseload/Workload Subcommittee has undertaken of the Division of Family Services' caseload and workload, the effects that DFS' workload demands have on morale and decision-making shall be scrutinized, with supervisors being a particular area of focus. Supervisors are the thread which holds caseworkers together, but also which create the culture in which caseworkers operate, assess, and execute their job responsibilities.

Investigation

The Green twins were barely six weeks old when Karen was first injured and they were not quite three months old when their near death injuries were discovered. Yet, the safety assessment completed in investigation, by a worker who had never seen Karen, determined that Karen could protect herself and the investigation response time was downgraded from urgent to routine.⁴ Furthermore, safety plans were not put in place for these infants despite their young age and the nature of their injuries. Finally, there appeared to be a blurred sense of what the role of DFS was in the investigation.

Rather than utilizing their expertise, the investigators relied heavily on others involved in the case, such as law enforcement and medical personnel, to come to conclusions regarding the children's injuries and the culpability of Mr. Green, particularly in the first investigation.

First, the safety assessment presented a barrier in this case. The Subcommittee learned that a good deal of confusion exists among investigators about the item in the safety assessment that addresses if the child is able to protect him or herself and is in immediate danger. The general feeling on the part of DFS staff is that both parts of the statement must be either true or false to answer the question one way or the other. The DFS supervisor explained that because Karen was not in immediate danger at that moment, the question was answered "No" which indicated that she was able to protect herself despite being only 41 days old. Additionally, the investigation disposition time was downgraded by the supervisor from urgent to routine, thereby lengthening the time the investigator had to determine whether abuse had occurred and the children were, in fact, safe. All of these decisions were based on a safety assessment which was completed based upon the initial interview, a moment in time, instead of on an on-going basis. The assessment was also completed by Investigator 2 who received the case from the initial responder and had never seen the child in question.

Steven and Karen's case raised additional concerns regarding safety planning in that a safety plan was only put in place one time throughout the life of the case. The only time a safety plan was implemented was after Mr. Green confessed to and was arrested for abusing the twins. Despite the young age of the children and the presence of a head injury, no planning to protect Steven and Karen was done for the duration of the investigation.

⁴ The 2006 DFS Policy Manual states that an urgent investigation requires a disposition within 20 days, while a routine investigation can be completed within 45 days. The 2006 DFS User Manual states that the decision to downgrade the investigation response time should be based on information from the Safety Assessment and the Safety Plan. Additionally, there are only two reasons to downgrade to a routine response timeframe: 1) the danger loaded elements noted in the hotline report are not present or apparent or there are no safety issues present or apparent; or 2) a safety plan was implemented.

Finally, the DFS investigators operated under a blurred sense of their role in the investigation of Steven and Karen's injuries. A superficial acknowledgement seems to exist that DFS investigators should approach an investigation with a neutral mindset and no premature decisions, but the Subcommittee discovered that a culture has been created by workload, overwhelming expectations, and supervision styles that fosters a sense of helplessness, a lack of confidence in their own expertise, a lack of accountability, and a desire to believe the parent's explanation of the injury, thereby discounting the occurrence of abuse or neglect. The DFS investigators, while following policy, did not employ sound professional judgment when arriving at the decisions involved in the Green investigation, but instead relied almost entirely on the opinion of their system partners and on the parents' statements to form their conclusions.

The following recommendations for compliance and/or change are made:

1. The Division of Family Services shall provide training on the use of the Safety Assessment tool to ensure that sound professional judgment is being employed throughout its application and completion of the tool is, in fact, an on-going process and not simply a rote response to policy.
2. The Division of Family Services shall explore the possibility of modifying the Safety Assessment tool to provide greater clarification for caseworkers and, therefore, greater safety for the children it has been created to assess. In particular, the statement, "the child is unable to protect self, has exceptional needs, behaviors, or medical concerns, and is in immediate danger" seems to generate a good deal of confusion for its users in that it addresses multiple factors at once.
3. The Division of Family Services shall label reports of abuse and neglect for children less than six months of age "urgent" and may not downgrade such reports. Since infants are largely immobile and, therefore, do not sustain injuries from activity, any injury to an infant shall be investigated as an urgent response by DFS to allow for the implementation of protective measures, such as a safety plan or other appropriate mechanisms to ensure child safety, if necessary.
4. The Division of Family Services shall ensure that all investigation caseworkers who investigate a case see every child in the case. This recommendation has been made previously and continues to impact the safety and well-being of children suffering abuse and neglect. DFS should eliminate the supervisory option to waive an investigatory contact with a child.
5. The Division of Family Services shall communicate to its staff its role as an investigative body versus that of a social work agency. The Department of Services for Children, Youth, and Their Families must ensure the proper skill sets are provided to its staff via training, support, and organizational culture to make certain that investigators are prepared to respond to allegations of abuse and neglect and objectively determine what occurred.
6. The Division of Family Services must participate in multidisciplinary investigations by sharing history, employing sound professional judgment, and synthesizing the proficiency of all involved professionals to arrive at conclusions regarding abuse and

neglect. These measures shall be undertaken while recognizing that the Division of Family Services has the unique mandate and expertise of investigating child abuse and neglect.

7. CPAC shall consider taking a larger sampling of DFS cases to gain a better understanding of the issues surrounding safety assessments, risk assessments, and organizational culture under its Citizen Review Panel responsibilities.

Law Enforcement Agencies

Law Enforcement played an integral role throughout the Green case as collaborative first responders, follow-up investigators, and partners in bringing about justice on behalf of Steven and Karen.

During their investigation, the corporals and detectives involved in this case gathered and assessed information in order to make determinations about criminal activity. In doing so, they completed a follow-up interview with Ms. Black with the intention of re-enacting the December 7, 2003 incident. However, Ms. Black was not present during the alleged incident and would not have been able to provide the sought after information. Had the law enforcement personnel interviewed Mr. Green in person, they may have gotten a “gut feeling” as to whether or not he was being truthful.

The following recommendation for compliance and/or change is made:

1. Law Enforcement shall conduct in-person an interview with the parent who witnessed the incident rather than accepting hearsay from the parent who was not present at the time the incident occurred.

Medical Community

The medical community was involved in the Green case both as consultants with the Division of Family Services and the Law Enforcement agency handling the case and as physicians providing medical examinations.

When approached with questions regarding the plausibility of Mr. Green’s explanation of Karen’s injury, the medical community delivered an opinion. Given the information provided, it was determined *possible* that Karen’s injuries were sustained as described by her father. However, it was discovered during the Subcommittee’s review of the case that it was not *probable* that her injuries were incurred in this manner. The use of such terminology, given the weight given to medical opinion in this case, may have clouded the judgment of decision-makers.

The medical community was also involved as providers of medical care to both Karen and Steven. Hospital 1 was involved with Steven and Karen on four different occasions, but did not conclude that either child was a victim of child abuse despite the presence of symptoms commonly indicative of such. Hospital 1 relied heavily on the primary care physician for Steven

and Karen to raise any red flags and given that this hospital had little to no expertise in child abuse and neglect, felt that in the absence of those red flags, they had no reason to suspect any foul play on the part of the parents.

Hospital 1 has policies in place regarding reporting of child abuse and neglect and training takes place during new employee orientation, but there is no other training provided to emergency room physicians or other hospital staff about child abuse and neglect. Furthermore, there is no one on staff who would be considered an expert in this area. Additionally, Hospital 1 has very few specialists on staff and counts on other hospitals to provide specialty care.

The following recommendations for compliance and/or change are made:

1. The medical community, DFS, and law enforcement agencies must collaborate more readily around explanation of injuries. The medical community often uses “possible” and “probable” to describe the likelihood that a parent’s explanation of an injury is plausible. The system partners share the burden to ask more questions and share more information to ensure a thorough understanding of the cause of a child’s injury(ies).
2. All medical providers, including, but not limited to hospitals, primary care physicians, and emergency medical technicians, must seek out, receive, and/or provide annual training on child abuse and neglect, reporting child abuse and neglect, and child development.
3. The Child Protection Accountability Commission shall, in accordance with its statutory duties, review and support the implementation of, as appropriate, the recommendations coming out of the Abuse Intervention Committee for the development and provision of quality child protection training to the medical community.
4. The Division of Family Services shall advocate for the cultivation of additional child abuse and neglect experts in Delaware to provide guidance and consultation during child abuse and neglect investigations. Such experts could synthesize the information gathered by the investigator, translate the medical terminology, find experts as needed, and provide a context in which decisions could be made regarding child safety.
5. Hospitals shall have access to each other’s records and those of their respective emergency rooms. Emergency room personnel must have immediate access to both historical and current information in order to develop an understanding of the patient’s condition and any patterns of injury. While movement in this direction is under way, it is limited in scope and should be broadened to include access to all types of records. Furthermore, collaboration among various medical entities, such as emergency medical technicians and emergency rooms, should occur so that children can be afforded high quality and prompt medical care.
6. All hospitals shall follow policies required for accreditation.

7. The Child Protection Accountability Commission shall send letters to every Delaware hospital outlining the need to examine and adhere to their child abuse and neglect policies.
8. Awareness, education, and prevention programs shall be offered in all birthing centers and hospitals to every parent, upon the birth of a child. Consideration should be given to the outreach education program developed by Dr. Mark Dias, a pediatric neurosurgeon in Pennsylvania. The Pennsylvania Shaken Baby Syndrome Prevention and Awareness Program provides consistent Shaken Baby Syndrome education to parents, upon the birth of their child, in 100% of Pennsylvania's birthing hospitals.

Multi-Disciplinary Coordination and Collaboration

The Division of Family Services and Law Enforcement agencies conducted joint investigations throughout the life of the Green case and openly shared information. Furthermore, these system partners reached out to a medical child abuse and neglect expert to help them understand the injuries sustained by Karen despite initial medical conclusions to the contrary. Despite these efforts, additional collaboration, especially with and among the medical community is needed to further the protection of all the children in Delaware from abuse and neglect and to stop the lack of awareness in its tracks, thereby enabling every citizen to do his or her part in curbing this epidemic.

The following recommendation for compliance and/or change is made:

1. The Division of Family Services, Law Enforcement agencies, The Division of Child Mental Health, and the Children's Advocacy Center, and the medical community shall collaborate to exchange thoughts, protocol, and procedures as they relate to child safety. Regular roundtable discussions shall be held with all child protection system partners with the purpose, among others, of infusing enthusiasm, building multidisciplinary teams, and cultivating a sense of professional mission all of which will enhance the safety and protection of Delaware's children.

Multi-Disciplinary Training

Both Steven and Karen displayed signs and symptoms often associated with Shaken Baby Syndrome, but those symptoms – the seizure-like activity, petechiae, and hemorrhaging—if recognized and given more cautious attention, might have prevented further harm to these children.

The following recommendation for compliance and/or change is made:

1. The Child Protection Accountability Commission's Training Subcommittee shall undertake the provision of routine training on Shaken Baby Syndrome to all partners in the child protection system.

Multi-Disciplinary Use of Child Welfare History in Decision-Making

While the Green family did not have an extensive history with the child protection system, one member of that family system did—Mr. Green. As a child, his family had been active with DFS and he had been active with DYRS due to criminal behavior. Kevin Green had mental health issues and substance abuse issues, both of which were largely untreated and he had a history of employment instability and anger management issues.

The DFS staff looked at Mr. Green's history and acknowledged the stressors in this young family, including the financial strains on a family with twins living on little to no income. However, DFS acknowledged that they may not have had all the history, and did not analyze what they did know, until after the second report—after both children were diagnosed with retinal hemorrhaging and brain damage resulting from Shaken Baby Syndrome.

The following recommendations for compliance and/or change are made:

1. The Division of Family Services must fully analyze caretaker history and the corresponding risk factors when investigating cases of abuse and neglect.

Office of the Attorney General

In many reviews of child abuse and neglect cases, caseload is mentioned as a factor as it relates to the Division of Family Services. In Steven and Karen's case, it was not DFS caseloads, but Department of Justice caseloads that were a consideration in the handling of the case, despite Mr. Green receiving the outcome which he most likely would have received had the case proceeded to trial.

On average, a Deputy Attorney General in the criminal division has between ten and thirty-seven felony cases scheduled for trial per week. Likewise, 2,400 felony cases in Kent County are heard by only three judges. Ninety-five percent of the cases are pled because they cannot all possibly go to trial and because the just result is being sought after and obtained.

Mr. Green was sentenced to six years of incarceration, followed by one year in a semi-locked drug treatment facility, followed by two years at level three probation. While this sentence was above the SENTAC guidelines, the damage that Steven and Karen suffered was irreparable and will last much longer.

The following recommendations for compliance and/or change are made:

1. Although current guidelines have harsher penalties for crimes against children than crimes against adults, increasing those sanctions should be further enhanced by SENTAC.
2. Workload in the criminal justice system must be addressed. The Office of the Attorney General should consider developing child abuse specialization within the pool of Deputy Attorney General prosecutors.

3. The investigating law enforcement officer shall continue the current practice of scheduling an intake for any case concerning a child if the allegation involves:
 - Any felony
 - Any sex offense
 - The death of a child if a police investigation is being conducted, if the death is suspicious, or appears to have been caused by Sudden Infant Death Syndrome or suffocation
 - Any misdemeanor involving a child age 12 or younger if the child suffered any kind of physical injury that required any kind of medical treatment and if the injury was allegedly caused by an act of abuse or neglect committed by a parent, relative or any temporary or permanent caregiver or custodian; or
 - Endangering the Welfare of a Child pursuant to 11 Del. C. § 1102(a)(1) involving a child age 12 or younger, regardless of whether the child was injured, if the child was exposed to a risk of injury or death.

An intake should be done on cases that meet one or more of the criteria outlined above within five days of any arrest or before the case is cleared without an arrest. If possible, the Investigating Officer shall inform the DFS Caseworker of the date, time, and location of the intake appointment.

4. If the offender is arrested, the Investigating Officer shall continue the current practice of requesting a no contact order with the victim or any child, as per 11 Del. C. § 2108(a) & (b), as a specific condition of bail, or no contact during commitment, and/or any other conditions that may be necessary to protect the victim and any other members of the community.

While the recommendations from this review are numerous, with the partnerships of the child protection community, they are not insurmountable. This is evidenced by the accomplishments made by the system partners after the two previous near death reviews. For example, DFS caseload standards are now more closely monitored⁵ and all related “family” files are presented to Family Court Judges when making civil determinations⁶.

It is the hope that this review, and others like it, sheds light on what occurred in Steven and Karen’s lives, and on what can be done to strengthen the child protection system to better serve the children and families of Delaware.

⁵ This recommendation was an outgrowth of the John Davis near death review.

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