STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION ("CPAC")
16 Del. C. § 912

NEAR DEATH REPORT

October 12, 2006
EMBARGOED UNTIL October 13, 2006

IN THE MATTER OF
Oliver Ford,
A MINOR CHILD[1]

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

Background and Acknowledgements

In the spring of 2004, the State of Delaware, in submitting its five year child protection plan to the federal government 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, CPAC voted to conduct three case reviews as the Citizen Review Panel. The particular cases CPAC chose were all near death cases of child abuse or neglect. The reviews were directed to CPAC's Near Death Subcommittee (the "Subcommittee") which chose the case of Oliver Ford for its second review. The Office of the Child Advocate ("OCA"), as staff for CPAC, gathered and compiled the records and established a schedule of witness interviews. The Subcommittee members received records on the Ford matter prior to the review and each Subcommittee member prepared for and questioned a different witness. 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 Health and Social Services, Division of Public Health
Department of Justice (Attorney General's Office)
Department of Services for Children, Youth and Their Families,
Division of Family Services
Family Court
New Castle County Police Department
Office of the Child Advocate
Superior Court

The Subcommittee members are also to be commended for their time and dedication to this comprehensive review. Each member spent approximately 30 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:

The Honorable Peggy L. Ableman, Superior Court, Chair
Tania M. Culley, Esquire, Office of the Child Advocate, Staff
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
Janice Mink, Grassroots Citizens for Children
Mary Ball Morton, Department of Services for Children, Youth and Their Families
Anne M. Pedrick, Office of the Child Advocate, Staff
Randall Williams (formerly John Humphrey), Children's Advocacy Center

Finally, the Subcommittee would like to thank those individuals who were open and willing to discuss the limitations of the child protection system. As a result of this process, several of the Subcommittee members developed a greater appreciation as to the daily life of a social worker and the limitations that are imposed by the current child protection system. Although many of the issues identified in this review were similar to the *CPAC Near Death Report in the Matter of John Davis*, the Subcommittee believes that this review was critical to helping CPAC further expand its knowledge of the child protection system and the impact that workloads and multigenerational neglect cases have on the entire child protection system.

Introduction

This tragic case exemplifies the many difficulties that the child protection system faces when working with a family that displays chronic, multigenerational neglect. The Division of Family Services ("DFS" or the "Division") workers often struggle to provide services and effectuate change with these families, who often re-enter the child protection system until a tragedy occurs, such as the near death of Oliver Ford. The families will briefly stabilize, complete case plans, show minimal functioning or refuse to cooperate and DFS will close the case, terminating its involvement with the family. Within months or a year, the families return to the attention of DFS.

In 1998, Delaware's investigation and treatment caseloads were codified in 29 Del. C. § 9015(b). Those standards were further delineated in 2004 by Senate Bill 265. Occurring during this same time frame was the implementation of the Delaware Court Improvement Project ("CIP"), passage of the federal Adoption and Safe Families Act and implementation of quality assurance measures in casework. These policy changes resulted in a greater Family Court focus on children in the legal custody of DFS ("foster care cases"), and greater scrutiny by DFS of long term involvement in cases where families have stabilized or where families were simply non-cooperative. Prior to these policy changes, DFS would often remain involved for many years to help maintain the family with support. Although Oliver's near death injuries were determined to have been accidental, the systemic issues are readily apparent in this multi-generational, chronically neglectful family. This begs the question of how long do we, as a society, allow children to remain in these chronic, long-term neglectful families without intervention? Moreover, what intervention, if any, would have the best outcome? And if no intervention will improve circumstances, and those circumstances themselves are below the standard where legal intervention is warranted, what should be done?

Facts and Information

Case Summary

The child who is the subject of this review, Oliver Ford, was born in April 1999 to Jennifer Thompson. Oliver was born prematurely and weighed two pounds eleven ounces at birth. Oliver remained in the hospital for 6 weeks and was on a ventilator for the first 3 days of life. Oliver was diagnosed with apnea and gastro-esophageal reflux. He was discharged from the hospital on an apnea monitor and continued treatment for asthma and reflux.

Before his near death injury in August 2003, Oliver exhibited cognitive and physical delays. At 4 years old, he was still in diapers. His delays can be attributed to neglect and lack of appropriate stimulation. He was the target child of physical abuse and neglect by his mother, his older siblings and from extended family members, including his mother's paramour. Oliver was removed from his family in August 2003 after he received 1st degree burns over 62% of his body. The burns, by all evidence, were accidental and were sustained while in the care of a 13 year old babysitter.

The family had extensive contact with state child protection agencies. This history is summarized as follows:

- Jennifer was removed from her mother and placed in PA foster care for 9 years due to neglect, physical abuse and sexual abuse allegations.
- By age 17, Jennifer was pregnant for the second time and delivered twin girls, Julie and Jessica. At age 22, she had Oliver. And at age 24, she had David.
- From 1995 until 2003, there were 15 hotline reports made regarding the family. The reports alleged similar themes of lack of supervision, physical neglect, medical neglect, domestic violence present in the home, physical abuse of the children by Jennifer, Steve, and the maternal grandmother.
- Of the 15 hotline reports, 10 reports led to investigations by DFS. 7 of the 10 investigations were substantiated for neglect and or physical abuse. The maternal grandmother was viewed as a safety for the children and an appropriate placement resource despite her child welfare history and allegations of substance abuse.
- DFS opened the family for ongoing treatment services on 3 separate occasions.
- While opened for treatment, Jennifer demonstrated minimal change in parental functioning, skill and knowledge. DFS and other service providers had difficulty engaging Jennifer. The family showed a pattern of accessing services when in crisis but once stabilized quickly becoming resistant to any outside intervention.
- Domestic violence was present in the home. Some incidents were documented by law enforcement beginning in 2000. In 2001, Jennifer filed for and received a PFA against Oliver's presumed father, Steve. This order, although in effect for 1 year, was immediately violated by Steve without consequence. In May 2003, Steve was convicted of Assault 3rd degree against Oliver and 2 counts Endangering the Welfare of a Child. He was sentenced to probation for a period of 12 months for the offenses.
- The family remained intact until August 2003 when Oliver was injured.

Mother's History as a Child

Jennifer was born in West Chester, Pennsylvania. She was raised by her mother until age 7. She then spent 9 years of her childhood in foster care as a result of allegations of sexual abuse, emotional neglect, dependency and physical neglect while in her mother's care. Information regarding Jennifer's biological father was unavailable. During the following 9 years in foster care, she had at least 8 placements. At the age of 16, she became pregnant, had a miscarriage and then returned to her biological family. Jennifer became pregnant again and delivered her twin girls, (hereinafter "Jessica" and "Julie") at the age of 17. The twins' father is Earl Smith. DFS records are unclear as to whether Jennifer completed high school, but the historical records repeatedly reference Jennifer's low functioning IQ and mental ability. The records also indicate statements by Jennifer that she began consuming alcohol at the age of 9.

Mother's History as a Parent

As a parent, Jennifer was unable to obtain stable employment, suffered from depression and was a repeated victim of domestic violence. Jennifer was 22 when she had Oliver and 24 when she gave birth to David. While Jennifer believed her long-time paramour, Steven Ellis, to be the father of both boys, he was genetically excluded. The fathers of these children remain unknown.

In May of 1995, when Jessica and Julie were 5 months old, DFS opened its first case with Jennifer as a parent. The hotline report alleged that Jennifer was neglecting the twin girls in that she did not have the ability to meet the children's needs and was struggling with the children's recurrent illnesses. Despite the maternal grandmother's long child protection history, DFS placed the young twins with her. This investigation was founded for neglect and maltreatment. DFS then opened a treatment case in maternal grandmother's home from October of 1995 until March of 1997. It was closed in 1997 because there were no longer any children in maternal grandmother's home.

The second DFS investigation occurred during June of 1998, 15 months after the last case closed, and again involved Jennifer's care of the twins. The hotline report alleged that the three year old twin girls were home alone. DFS and the New Castle County Police Department ("NCCPD") responded and confirmed the allegation. The children's step-grandfather, William Thompson, had to go to work, leaving the children in the care of their 11 year old uncle, Jeffrey. A brief review of Jeffrey's background revealed a history of assault and weapon use which resulted in significant involvement by the Division of Youth Rehabilitative Services ("YRS"). Given the above factors, DFS quickly determined that Jeffrey was an unsuitable caretaker. This time, DFS also determined that the maternal grandmother was an unsuitable placement and sought emergency custody of the twins until William Thompson could be located. Family Court granted emergency custody to DFS on June 6, 1998.

Once Jennifer was located, she indicated she had just received her paycheck and had been in the city partying with some friends for the last twenty-four hours. She told DFS that she ran out of money and no one would give her a ride back home. Jennifer also thought the children were with a homeless couple, but that couple decided to go to a crack house and dropped the

children off at the residence without going inside to verify that there was an adult present. During the investigation, Jennifer and maternal grandmother offered to quit their jobs so they could ensure supervision of the twin girls. Despite alcohol and drugs being a risk factor in this case and contributing to Jennifer's lack of responsibility for the girls, DFS never required a drug/alcohol evaluation or treatment. William Thompson indicated he had to work and may leave the children unsupervised, with Jeffrey or with Jennifer, again in the future. Nevertheless, on June 15, 1998, DFS represented to Family Court that the children were not at risk if placed with William Thompson. During the investigation, the YRS worker for Jeffrey indicated to DFS his impression that the 3 year old girls were often home alone. On June 30, 1998, DFS closed the case without treatment services and with the girls living with William Thompson.

In April of 1999, Oliver was born prematurely at 29 weeks gestation. As a result, he was hospitalized for 6 weeks after his birth. Prior to his discharge, the hospital made a referral for Oliver to the Division of Public Health ("Public Health") as a high risk infant. Public Health quickly began providing services to the family. On May 21, 1999, the day Oliver was due to be released from the hospital, the Family Court granted legal custody of the twins to maternal grandmother, William Thompson and Jennifer.

DFS received its third hotline report in July of 1999, when Oliver was 3 months old. The report alleged that Jennifer had left the four year old twins and the newborn, who was on an apnea monitor, and had not returned for quite some time. The reporter, who was caring for the children, alleged that Jennifer was out drinking. The reporter was also concerned that the alleged father, Steven Ellis, was not trained on the apnea monitor but was providing care to the baby. DFS investigated the report. During the investigation, maternal grandmother reported to DFS that "*Steven is alright when baby starts crying but has problems when baby will not stop. He will pick up baby and start shaking baby.*" DFS also learned during the investigation that Steven did not believe he was the baby's father. DFS did not follow up on either of these allegations. During this same time frame (June to August 1999), unbeknownst to DFS, Jennifer had temporarily ceased cooperating with Public Health.

As part of the investigation, DFS contacted the children's pediatrician. The children were seen at the pediatrician's office on August 24, 1999 and the pediatrician's office did not express any concerns to DFS. However, the notes from the June visit to the pediatrician's office recorded concerns about Oliver's weight and the risk factors for this baby, including prematurity, reflux, a low functioning parent and apnea. The pediatrician requested Public Health check on the baby two times per week. When interviewed by DFS, Public Health shared no concerns about the family. DFS closed this investigation as unsubstantiated shortly thereafter. Prior to closure, no drug/alcohol evaluation or treatment was required of Jennifer despite the allegations of alcohol abuse in the report. Public Health continued to work with the family through the Child Development Watch program until Oliver was 3 years old.

The fourth DFS hotline report was made 6 months later in February 2000. The reporter, a professional involved with the twins, alleged that Jennifer tried to burn Julie with a curling iron, had beat the children with a switch, and gave the children medicine to make them sleep so she could go out, thereby leaving them unsupervised. The reporter also indicated that Jennifer had 5 year old Julie feed the baby, Oliver. DFS investigated the matter and once again placed the

children with maternal grandmother despite the prior determination that she was not an appropriate placement resource. Maternal grandmother signed a DFS safety plan prohibiting unsupervised contact between Jennifer and the children. DFS did not require a drug/alcohol evaluation of either Jennifer or maternal grandmother. The case was closed by DFS within 14 days as unfounded for neglect and prior to the custody proceedings between maternal grandmother and Jennifer being heard in Family Court. DFS was also unaware of a February domestic violence incident between Jennifer and Steven Ellis which resulted in criminal charges and a no contact order against Steven.

The same professional again called the DFS hotline in March of 2000, less than one month after the last investigation. The reporter indicated that Jessica had disclosed to her teacher that maternal grandmother's boyfriend had sexually abused her. During the investigation, DFS learned that maternal grandmother had violated the February safety plan and had returned the children to Jennifer. DFS closed the case, unfounded for sexual abuse and allowed the children to remain living with Jennifer. Public Health records indicate that during this same time period, the family was without sufficient means for food and other essentials. In April 2000, Family Court rescinded custody of the girls and returned them to Jennifer.

The sixth DFS investigation occurred in November of 2000, when Jennifer and Steven were arrested for leaving the children home alone and each charged with three counts of endangering the welfare of a child. A no contact order was put in place against Steven. Police and DFS found alcohol, cleaning products, and pornography videotapes all within the children's reach. The home was very dirty. The twins were sleeping on the floor in the bedroom and there were no beds in the room. The twins were also regularly missing school. Jennifer told the investigation worker she only drank a little alcohol. DFS again placed the three children with maternal grandmother, once again without regard to her extensive and recent history with DFS. Within twenty four hours of placement, maternal grandmother called DFS and asked if the children could be returned to Jennifer. She also shared with DFS that Jennifer had spent significant sums of money in the past three months. Within three days, DFS once again placed the children back with Jennifer requiring a safety plan for the appropriate storing of dangerous chemicals. Allegations by school personnel of absenteeism were not addressed, and DFS treated Steven as the father of all of the children despite DFS records indicating the contrary. The case was substantiated for neglect and closed with Steven in the home, in violation of the criminal no contact order. Unbeknownst to DFS, a domestic violence specialist employed by Family Court had also interviewed the family during this investigation and quickly concluded for the Judge that "*I think this mother has a history with neglect of her children. I hope DFS considers <u>not</u> placing them back anytime soon.*"

On January 5, 2001 (one month after the sixth DFS investigation was closed), Jennifer filed a Petition for Protection from Abuse ("PFA") stating that Steven was calling her, harassing her, and stalking her. On January 18, 2001, Jennifer reported to the police and filed an affidavit of probable cause that Steven had been in her apartment and threatened her, resulting in a violation of his probation. Steven was also charged with Offensive Touching and Menacing, and a no contact order with Jennifer was again imposed. Jennifer also filed for a PFA requesting drug/alcohol treatment and anger management for Steven. Four days later, she had a new boyfriend, Arnold Ford, who then threatened to kill himself in Jennifer's presence. Ten days

later, Steven threatened to hit Jennifer with a hammer and assaulted her. Steven was re-sentenced at the end of January to Level II probation for a period of 12 months. He was also ordered to have no contact with Jennifer and a third party was to be used for visitation with the children (although they were not even his children).

After the Court hearing, Steven returned to the apartment next to Jennifer. Jennifer called the police and Steven was arrested for criminal contempt of a Family Court protective order. That same day, February 2, 2001, Jennifer filed a motion to vacate the PFA against Steven *"due to being forced by my boyfriend. I am presently pregnant by Steven, on medical bed rest. We are presently wanting to get married. I need the PFA modified due to the fact that he need to be able to take an help take care of his son due to the fact that he's son is very sickly. I would like for the court to take action as in where he can not violently put his hands on me an domestic violence counseling together on weekend visitations with his son."* The Family Court dismissed this motion because Jennifer failed to appear and the PFA remained in place through January of 2002.

Also on February 2, 2001, Child Development Watch contacted the DFS worker from the November 2000 investigation with safety concerns about Steven living next door. The DFS worker told Child Development Watch the case was closed and there was nothing DFS could do. Public Health records dated February 15, 2001 indicate concerns by contract providers as well as concrete evidence that Steven was back in the home. Child Development Watch again called the DFS hotline on February 15, 2001, the seventh report regarding Jennifer, and was instructed to call the pediatrician to examine Oliver for possible physical abuse. Public Health reiterated its concern regarding Steven and Jennifer's violations of the no contact order. DFS indicated they would consider accepting the report if the pediatrician's office called. The pediatrician examined Oliver and found no signs of physical abuse but did indicate that Jennifer was accompanied by an unidentified man and that she was provided information on domestic violence. DFS rejected this report and did not investigate the allegations.

Five days later, on February 20, 2001, the eighth report on this family was made. The report described domestic violence in Oliver's home between Jennifer and Arnold Ford. DFS rejected the hotline report and instead contacted the Wilmington Police Department ("WPD"). DFS records indicated that WPD would not respond to a PFA violation unless the victim contacted them directly. Neither DFS nor WPD took any further action. Moreover, there is no indication in any of the records reviewed that a PFA even existed between Jennifer and Arnold Ford at that time.

Two days later, the DFS hotline received the ninth hotline report on this family which it accepted for investigation. The reporter again alleged that there was domestic violence in the home between Jennifer and Arnold Ford. The reporter also indicated that Arnold Ford had just been released from prison, was stealing Jennifer's food stamps and was a drunk. The report further indicated that Arnold's probation officer had observed bruises on Jennifer and that she had gone to the emergency room as a result of domestic violence. Finally, the report once again alleged the children were being left alone – the sixth time this allegation had been made against Jennifer. Public Health continued to be involved, and their records indicated Jennifer's interest in giving Oliver to Steven. Records also confirmed that Jennifer was once again pregnant. In

April of 2001, while DFS did not substantiate the case for abuse/neglect, it still transferred the family to treatment for ongoing services.

In May of 2001, Arnold moved out of the home and Steven moved back in, in violation of the PFA. The family continued to struggle with unsanitary living arrangements, poor hygiene, improper monitoring of Oliver's asthma, bedwetting by the twins, school truancy and behavioral issues by the twins, including Jessica eating in the middle of the night and then throwing up in her bed. In June of 2001, Jennifer was charged with truancy as the twins had missed thirty days of school. Jennifer remained uncooperative with DFS and the DFS treatment case was closed on June 27, 2001. DFS records stated that the current problems within the family were "not of a DFS nature." DFS had not provided any services and had done minimal casework since Jennifer was resistant to DFS intervention. At the time of closure, a contract provider through Public Health expressed concerns that Oliver's breathing machine was not being monitored at home, the truancy charges were pending, and Steven was acting as primary caretaker of the children while Jennifer's whereabouts were unknown.

On August 21, 2001, less than two months after the last treatment case was closed, a written hotline report alleging medical neglect was made. DFS rejected the report since the report was in written rather than verbal form. According to the written report, Oliver had a burn that was allegedly caused by a light bulb for which Jennifer did not seek medical attention. DFS did not follow up with the medical professional who made the written report.[2] The written report indicated that Oliver had been withdrawn from his medical daycare program because he appeared there with a significant burn on his forearm. After receiving a hostile response from Jennifer, the daycare contacted the child's pediatrician who referred the specialized daycare to the hotline.

In the fall of 2001, Child Development Watch began working with Jennifer on how to potty train Oliver. Jennifer's fourth child, David was born in October of 2001. DFS rejected the eleventh report on this family on November 1, 2001. The reporter expressed concerns about Jennifer's ability to care for the children. It was also alleged that Jennifer may have had Munchausen Syndrome by Proxy. DFS rejected this referral and stated that the visiting nurse could keep an eye on the family or have the pediatrician call in a report.

Six days later, the DFS hotline received the twelfth report on this family. The report alleged that Jennifer took David to the hospital because he was "turning blue." When the hospital indicated the baby needed to be admitted, Jennifer left with David. DFS contacted Jennifer and she returned to the hospital. During its investigation, DFS once again contacted the family's pediatrician. The pediatrician reported that Jennifer was paranoid and bordered on Munchausen Syndrome by Proxy in that she was always claiming the children had illnesses. The pediatrician further indicated that one of the girls had bald areas on her scalp, a history of urinary tract

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[2] "When a written report is made by a person required to report under § 903 of this title, the Division shall contact the person who made such report within 48 hours of the receipt of the report in order to ensure that full information has been received and to obtain any additional information or medical records, or both, which may be pertinent." 16 Del. C. § 906(b) (13).

infections, enuresis and a history of violence. DFS unsubstantiated the case for neglect and closed without treatment on January 29, 2002. The investigator's caseload at that time was 23, 9 cases over standard. As a result, the case was in back log by 39 days past the 45 day investigation timeframe.[3]

The thirteenth report regarding this family was made to the DFS hotline on March 13, 2002. The report indicated that Steven Ellis was asleep in the car with the twin girls and Oliver. Jennifer was inside the emergency room with David. Oliver left the car without Steven realizing it. Upon leaving the hospital, Jennifer and Steven did not realize that Oliver was not in the car. Oliver was found wandering on the hospital grounds. The family did not discover that Oliver was not with them until they were almost at their residence and returned to the hospital. Once the parents were located, DFS rejected the report despite the family's extensive DFS history, including the repeated lack of supervision reports.

On June 13, 2002, the NCCPD received a call from a neighbor who was concerned about Oliver being alone in the yard. NCCPD responded to the home and immediately called the DFS hotline. Oliver was wandering in a neighbor's yard with a full diaper and feces were falling out of it. The home was dirty with six feet of clothes piled up and the back door inaccessible due to the clutter. Tools were on the floor in reach of small children and the kitchen had dirty dishes piled high. Once again, Jennifer did not take any responsibility and had excuses for every allegation. She denied any domestic violence in the home despite her documented history in previous DFS cases. DFS completed an alcohol and drug screening and substance abuse was not ruled out. However, DFS did not require an evaluation and/or treatment for alcohol or drug abuse. Instead, DFS referred the family to a community based early intervention program. Jennifer originally declined involvement with the early intervention program until she heard that financial support could be associated with the program. The DFS worker never had the opportunity to meet the family prior to closing the case as the family was non-compliant with meeting her. Instead, the DFS worker relied on the family interview completed by the after-hours DFS worker. After being in backlog for forty-three days, the DFS investigation was founded for neglect, closed and not transferred to treatment.

As a result of the June 13th incident, Steven was arrested and charged for the second time with two counts of endangering the welfare of a child. He was ordered to have no contact with the children. Just two days later, Steven violated this no contact order since he was present for the DFS interview in the home on June 15, 2002. Once sentenced, he was ordered to have no unlawful contact with the children (which he later violated in March of 2003), attend parenting classes, cooperate with DFS, and supervise the children at all times.

The fifteenth hotline report was received by DFS in January of 2003. David was brought in to the emergency room with probable bronchiolitis or reactive airway disease along with an upper respiratory infection. Oliver was also seen because he had not eaten in four days. During the hospital visit, Jennifer raised a concern with the hospital staff that maternal grandmother had possibly abused Oliver because he had scars on his body. Oliver did have old scars identified during a medical exam as indicative of physical abuse. Unfortunately, the doctor did not give the

[3] A case is considered in backlog by DFS if the investigation continues longer than 45 days. This investigation lasted 84 days.

mandatory reporting form to the hospital social worker for several days. Similarly, the emergency room doctor did not call the DFS hotline or fax the mandatory reporting form while the family was at the hospital.[4]

During this investigation, Jennifer alleged that maternal grandmother was using crack again and that she caused Oliver's injuries. The police interviewed Jennifer and she agreed to keep the children with her. DFS did not participate and/or observe that interview at the hospital since there was a delay in the mandatory reporting. When assigned this "routine response time"[5] case, the DFS investigation worker had 14 cases but by the end of the month he had 21 cases. At that time, the DFS investigation worker had only been with DFS for 6 months having spent most of that time period in training. Two months after DFS received the hotline report, this DFS worker had neither seen nor interviewed the children.

Upon interview of the DFS investigator on this case (who has not worked for DFS in years), he admits that he was slow on the initial response since he had too many cases during the first month of the case. He stated that the issue of neglect is more subjective and therefore much harder to investigate. Despite Jennifer's long history and low functioning, his perceptions as a new investigation worker were that it would have been hard to justify to a judge why the children needed to come into care.

On March 4, 2003, two full months after the referral was made, this DFS investigation worker finally interviewed the twins at school. At that interview, the girls disclosed that Steven had beaten them and Oliver with a belt, leaving new, serious marks, and that one child's legs bled as a result of this beating. At this time, the twins also disclosed that they beat Oliver with a belt. One of them held him down while the other hit him. Oliver's abuse by the twins was not addressed during the investigation. DFS contacted Jennifer who told the DFS investigator that she could not respond to the school because her hand was broken. DFS did not inquire as to how her hand was broken.[6] Jennifer also reported that the twins were beaten because they were playing with a lighter and caught the closet on fire. Despite these allegations constituting a new incident of abuse or neglect, the DFS worker did not make a new hotline report. He explained that he did not know he was supposed to make a new hotline report and did not want to burden another worker.

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[4] "Any report required to be made under this chapter shall be made to the Division of Child Protective Services of the Department of Services for Children, Youth and Their Families. An immediate oral report shall be made by telephone or otherwise. Reports and the contents thereof including a written report, if requested, shall be made in accordance with the rules and regulations of the Division of Child Protective Services, or in accordance with the rules and regulations adopted by the Division." 16 Del. C. § 904 .

[5] DFS has two types of responses for their hotline reports which include routine and urgent. A worker must respond to an urgent case within 24 hours and to a routine case within 10 days.

[6] Upon reviewing the medical records the Subcommittee learned that Jennifer lied to DFS. The day before the elementary school visit, Jennifer went to a hospital emergency room stating she injured her left thumb but left the waiting room before being seen by a doctor. She then went to a different hospital emergency room and told them she fell and hurt her thumb. She was diagnosed with a wrist injury and given Motrin and Percocet. There was no evidence of a fracture or dislocation.

As a result of the disclosure of physical abuse, DFS had all of the children examined at the hospital. David's examination was normal; however, Jennifer reported David had fallen out of a wagon and hit his head but did not lose consciousness. Marks indicative of physical abuse were observed on Oliver, Julie, and Jessica. The DFS worker consulted with the DFS hotline about foster care placement. Given the alleged fire-setting incident reported by Jennifer, DFS believed locating a foster care placement that evening would have been difficult. The hotline supervisor recommended a safety plan with Jennifer for the night and then submission of a request for foster care placement the next day. The foster care placement request was never completed. A safety plan was executed that required Jennifer to keep Steven out of the home. At this point, the investigation case was in backlog by 32 days and the DFS worker was over caseload standard by 3 cases – i.e., had 17 cases.

As a result of the children's disclosures, Steven was charged with 2 counts of 3rd degree assault and 1 count of 2nd degree assault. The charges were amended to 3 counts of 3rd degree assault and 3 counts of Endangering the Welfare of a Child. Bail was set and a no contact order with the child victims was issued.

On March 7, 2003, a referral for the twins was made to the Fire Marshall's office based on Jennifer's allegations. DFS never independently verified whether the twins had set fire to the closet or had any firesetting tendencies. Unfortunately, in contrast to past investigations, the DFS worker did not contact the children's pediatrician. Instead, he used the hospital as the medical collateral. If the DFS worker had contacted the pediatrician, he would have learned of the serious allegations that Jennifer had made to the pediatrician regarding the children. Those allegations included significant behavior problems by Jessica in school resulting in calls to Jennifer at least twice a week, physical abuse of Oliver by Jessica, and both girls playing with fire and stabbing a dog with a screwdriver. Based on these reports by Jennifer, the pediatrician believed the twins needed more intense mental health care, and that the family needed in-depth services to develop and implement appropriate behavior modification plans for the children.[7] This information was never communicated to DFS.

During the month of March, the twins' school was very concerned about the safety of the children because the family disappeared for a few days and there was talk of them fleeing to Virginia. The school nurse was unsuccessful reaching the DFS investigation worker despite leaving many messages regarding the children's school attendance. On March 3, 2003, Jennifer and maternal grandmother came to the DFS office after they posted bail for Steven. They both requested that Steven be permitted back in the home despite the no contact order because "the children were out of control." Jennifer and maternal grandmother then proceeded to the school to advise the nurse that the girls lied as to how they got the marks. These events occurred the day after the court denied their request that the no contact order be lifted. On this same day, the twins stated to school personnel that Steven was back in the home. Jennifer denied this disclosure and indicated Steven was only in the home when the girls were not. On March 10, 2003, the DFS worker was again contacted by the school to report that the school nurse had observed a 1-inch diameter mark on Jessica's arm. The DFS investigator responded to the home

[7] The Subcommittee learned this information upon review of the pediatrician's records. DFS was unaware of this information.

and interviewed the child in front of Jennifer. Jessica stated she did not remember how she got the injury. She was also not seen by any medical professional to evaluate for possible abuse.

In March of 2003, the case was transferred to a DFS treatment worker with a risk assessment of 2-3 – Significant Risk.[8] This would be the third time that a treatment case had been opened with DFS to address cleanliness of the home, appropriate supervision plans and compliance with recommended services including counseling, domestic violence intervention and mental health treatment for the children. Despite DFS efforts, Jennifer and Steven remained resistant and often hostile to DFS intervention. Jennifer continued to deny issues around depression and domestic violence and was not compliant with seeking mental health treatment for the children. The DFS treatment worker did not believe she had the tools to engage and address this resistant, chronic and neglectful family.

On April 2, 2003, Steven filed a motion to modify the no contact order with the children. The Family Court denied the motion on April 22, 2003.

During the treatment case, the DFS worker spoke with the twins on May 7, 2003 at the elementary school. At that time, Julie stated that she cannot control herself with Oliver. He "bugs" her so she hits him and he still does not stop. The girls complained that their new house was dirty. The DFS worker told the girls not to hit Oliver and gave them her card, but did not address this concern with Jennifer, nor conduct a home visit to assess the house for cleanliness. The treatment worker had 18 cases at the time.

In mid-May 2003, Steven pled guilty to 1 count of 3rd degree Assault and 2 counts of Endangering the Welfare of a Child. These charges stemmed from the March 4th investigation. His sentence was to serve probation at level III for 12 months. The conditions of his sentence also included a requirement to cooperate with DFS, have no contact with the children, and complete a parenting program and complete a certified domestic violence program. DFS referred the family to an intense parenting class as well as referred the girls for mental health counseling. The family did not follow through with these services despite Jennifer's longstanding concerns about the twins' behavior. Instead, Jennifer withdrew the girls from school for the remainder of the year.

The family continued to be non-compliant with all services offered by DFS. In June of 2003, the DFS treatment worker conducted a home visit and instructed Jennifer to clean the living room. At the visit, the worker noted Oliver had a bruise under his right eye. Jennifer stated that David hit him with a toy. The worker did not interview Oliver regarding this incident.

In July of 2003, the younger children were still not in daycare, despite repeated requests by DFS and Public Health. Jennifer told DFS that she was having relational problems with Steven. The girls were not taking their behavioral medication because Jennifer felt that the girls did not need the medication.

[8] Significant risk in the DFS risk assessment tool indicates high potential that child will be maltreated; complicated, explosive conditions exists which will require control to be imposed in most situations; intervention must be quick and focused.

On August 5, 2003, Jennifer advised the DFS treatment worker that she did not know how much more she could take regarding Oliver's behavior. He was constantly acting out, had problems with his bowels and was still in diapers. He hit David constantly and stole food. Steven was still not enrolled in domestic violence classes or parenting classes. This was the last contact DFS had with the family prior to August 6, 2003, when Oliver suffered injuries that nearly killed him.

Oliver is Injured

When he was 4 years old, Oliver received first degree burns over 62 percent of his body while in the care of a 13 year old babysitter. It is believed that his burns were a result of hot water and cleaning agents in a bathtub. This tragic, near death event occurred in August 2003. While at the probation office, Jennifer and Steven left the 4 children, ages 1, 4 and 8, with the babysitter – a 13 year old friend of the family who had come to stay in the home. Oliver was admitted to an out-of-state hospital with total body surface area burns, was intubated and in critical condition. He was in respiratory distress and needed surgery for his skin. He was tube fed and given antibiotics. The police and the Department of Justice decided not to press charges due to the fact that they could not prove intent on the part of the 13 year old babysitter. During interviews with the NCCPD and the Attorney General's Office, the Subcommittee learned that law enforcement struggled during the criminal investigation to obtain medical records, photos and other documentation from the out-of-state hospital. The Office of the Child Advocate was able to partially facilitate the resolution of this matter, but the Subcommittee learned this was a frequent difficulty encountered during criminal investigations where the victim was admitted to this hospital.

For the first month after the incident, Oliver's life hung in the balance. He was on a ventilator and was pharmacologically comatose. He was hospitalized for more than 4 months during which he had to suffer through numerous surgeries and skin grafts along with repeated infections. He required daily burn care and had to wear pressure garments twenty three hours a day. He also had to have lotion applied twice daily because the burns caused damage to the glands which normally lubricate his skin.

With these facts and circumstances in mind, the CPAC Near Death Subcommittee makes the following child protection system recommendations for improvement.

Findings and Recommendations

DIVISION OF FAMILY SERVICES

I. CASELOADS/WORKLOADS

Workers expend significantly more time on cases where children are in out of home care, often referred to as foster care cases. One worker interviewed estimated that 90% of a worker's time is dedicated to cases where children are in out of home placement and only 10% of their time is used to serve intact families. The children in placement are presumably safe since they have been removed from their homes while the same cannot be said for children left in their own homes. On any given day, DFS is responsible for approximately 5,000 children. About one thousand of these children are in the legal custody of DFS – foster care cases. Parents whose children are removed from their care must complete case plans in order to regain custody of their children giving DFS leverage to make parents cooperate.

However, there are an additional 4,000 children being served by DFS who remain in their homes. These families are referred to in Delaware's child protection system as intact families. Intact families do not have court oversight and receive less scrutiny, attention, and services from DFS. This is due to heavy workloads associated with children who, while in foster care, are closely monitored by the Family Court. Oliver's family was often not given the scrutiny it needed due to the high caseloads and workload that DFS workers must juggle. All DFS workers and supervisors who were interviewed believe that DFS should count cases by children or have some type of case weighting system. One DFS employee gave the example that a worker could have 19 cases in treatment but yet be responsible for 75 children.

The DFS treatment workers shared with this Subcommittee how difficult it was to provide meaningful intervention with this difficult, hostile family – a family like many others, riddled with multi-generational chronic neglect. The treatment worker shared her powerlessness in getting families to comply with services and her perceived inability to meet the standards for legal intervention. The Subcommittee saw first-hand the DFS limitations in providing services to intact families, when the treatment worker stated that even moving in with the family would not have changed the risk or lifelong patterns of neglect. The treatment worker also believed that there was no point to these system reviews of cases. In her view, nothing ever comes out of them that helps.

Caseloads and workloads were a significant component to the assessment of Oliver's safety. One investigation worker was at standard during her investigation but the case went into backlog by 45 days. This demonstrates that even if a worker had a caseload at 13, his/her workload may be unmanageable. Another investigation worker had a high caseload coupled with very little DFS experience. His caseload on average from January 2003 until March 2003 was 17 cases – 3 over the investigation caseload standard of 14. The last treatment worker maintained an average caseload of 18 – the caseload standard for treatment – but she often felt that the intact families were not being helped and were at risk since most of her time went to the foster care cases.

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

1. CPAC should assist DFS and other child protection partners with a comprehensive work study analysis **to identify barriers to quality protection of children and provide short and long term solutions for a manageable workload for the entire child protection system.**[9]

2. As stated in the last near death review, **DFS should consider weighted caseload distribution,** so that cases with a chronic risk of recurring abuse and/or neglect – i.e., families with a long child protection history with multiple children -- are counted differently than a less complex and time-consuming case, resulting in a more balanced workload.

II. CASEWORK

While preparing this report, the Subcommittee discovered that there was a separate case for the twin girls that the Subcommittee had not yet reviewed. The reason for this "missed case" is that the case was filed under William Thompson, the step-grandfather. This investigation was critical for future workers (who also did not consistently review it) because it highlighted Jennifer's use of alcohol, lack of supervision, and her difficult upbringing. In a previous Child Death, Near Death, and Stillbirth Commission letter to the Governor dated April 19, 2005, the following recommendation was made after a child's death had been reviewed: *DFS caseworkers need a user-friendly process, including automated computer access, to identify and link cases where a single person may be involved with more than one family. The current participant listing search process may be cumbersome and difficult to navigate for caseworkers.*

A repeated issue seen in this review regarding DFS casework is the interviewing and investigation skills of the workers. When the treatment worker was at the home and saw that Oliver had a bruise under his eye, she did not take appropriate measures to investigate the injury but believed Jennifer's explanation. Oliver was not interviewed alone. This also occurred in the incident where Jessica had a mark on her arm. She also was not interviewed alone but in front of

[9] CPAC voted on January 11, 2006 to reconvene the SB 265 subcommittee to address workloads within the child protection system.

the parent. Both of these incidents were not "investigated" but taken at face value despite the extensive history in this case and Jennifer's history of lying. Another concern is that during one DFS investigation, Maternal grandmother alleged that Steven had shaken Oliver and yet DFS did not obtain a medical examination or follow up.

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

1. **The DFS policy (that all children should be interviewed alone to rule out abuse/neglect) shall be reinforced/re-emphasized.** All investigation workers who have been with DFS two years or more should be trained in the American Prosecutors' Research Institute Finding Words curriculum.

2. **DFS must evaluate the participant group listing and search criteria for history review within their current FACTS program** so this may be remedied upon the implementation of FACTS 2010.

3. **Anytime a reference is made to a baby being shaken, DFS shall immediately have the baby seen at an emergency room.** All DFS workers should be trained on the risks and possible causal factors involving shaken baby syndrome.

II. HIRING PRACTICES AND SUPERVISION ISSUES

DFS supervisory oversight was lacking in the 2003 investigation as reflected by the case being in backlog for 32 days, the victims not being seen for over 2 months, and proper procedures not being followed with regard to a new hotline report.

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

1. **The issue of adequate supervisory review of casework should be further explored by DFS; additional training, re-training and/or supervisory workload adjustment** to allow sufficient time for completion of a full review of casework materials prior to granting supervisory approval of completed casework may be required.

III. INVESTIGATION

At the end of a DFS investigation, families are given a risk assessment rating prior to closure or transfer to a DFS treatment worker. The Subcommittee found that DFS investigation workers consistently underrated history and parental capacity when assessing safety and risk assessment. Supervisory reviews did not "catch" the underrating of history or lack of focus on history. When a long or disturbing family history exists within the DFS information system, a low risk assessment rating must be justified. In addition, relying solely on statements by family members who have a long history with DFS is a practice to be questioned when assessing risk.

An extended family's level of support must also be thoroughly assessed prior to case closure for long term stability for the children.

The Subcommittee also learned that DFS workers may manipulate the risk assessment rating to send it to treatment. One of the supervisors testified that a rating of 2.5 is often necessary to transfer a case to treatment. This supervisor also felt that DFS workers often repeat the information on the risk assessment from the computer generated drop down boxes and do not put a lot of their own thought into the risk assessment. Many workers simply copy/paste from the investigation progress notes without doing a comprehensive assessment. The old hand-written case closure forms (pre-FACTS computer system) made workers think about the work that was done; workers did not have the option of using language suggested by a computer.

One of the supervisors expressed concern to the Subcommittee that treatment workers often return children that investigation staff have placed, and change investigation safety plans. Interviewed workers indicated that investigation staff must discuss unfounded cases and the related risks with a treatment supervisor before they are accepted by treatment. Both workers and supervisors did not feel that reading only the risk assessment gave a sufficient history of the case and that the overall effectiveness of the risk assessment is questionable given that the ratings often depend upon the unit and the supervisor. Interviewed workers suggested that perhaps there should be one unit to review substantiations and to determine whether a case should be transferred to treatment.

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

1. In the short term, DFS should reiterate the importance of the current risk assessment tool and ensure that workers are using it to properly assess risk to a child.

2. It is often difficult to decipher who to contact during an investigation for a collateral contact. The pediatrician in the 2003 investigation had significant concerns regarding this family; however, DFS did not contact the pediatrician and relied only on the emergency room. Therefore, DFS is currently revising its collateral contact policy. **DFS will submit a copy of this newly revised policy to the Near Death Subcommittee and/or to CPAC once it is completed.**

3. While risk assessments offer valuable information about a family, they appear to be underutilized and easily manipulated. **A workgroup should evaluate the risk assessment tool and create or replicate an existing method to capture the most important information about a family and to assess the level of risk present.** Action must be taken based on the risk. For example children should not remain in a home where the risk assessment spells out: Significant Risk = 2-3: High potential that child will be maltreated; complicated, explosive conditions exist which will require control to be imposed in most situations; intervention must be quick and focused. (FACTS risk assessment).

4. **DFS should review research on nationwide risk assessments and consider modifying or replacing its current structured decision-making tool used during the investigation process.**

IV. TREATMENT

DFS has no power to compel families to comply with services where the family has been substantiated for abuse/neglect and has been transferred to a DFS treatment worker but retains custody of their children, leaving many children in serious risk of harm. Although children may be chronically neglected and at risk of harm, many are never removed from their homes because either the risk does not rise to the legal level for removal or workers do not believe it does.

Upon interview of one of the DFS investigation workers, the Subcommittee learned that as a seasoned worker, if she had this case today, she would probably have removed the children based upon the DFS history with this family, their passive-aggressive behavior, and their criminal history. She had only been a DFS worker for a year and a half when assigned this case. Since Jennifer was not the identified "perpetrator," the DFS investigation worker put the onus of safety on her. The DFS worker was not aware of the no contact order that had been in place and she stated that this is often the reality today in many cases. She has seen some improvement in the multi-disciplinary collaboration between the criminal division of the Department of Justice and the DFS social workers. Upon reflection on this type of chronic multi-generational neglect case, the DFS investigator stated that this is a typical DFS case and DFS treatment does not always accept these cases. It has been her experience that contracted services are more beneficial since they can see the family more often and DFS only sees the family on average once a month. The worker indicated that the current number of cases on a treatment caseload averages around 20 and they were often referring these chronic multi-generational neglect cases to a contract agency.

One of the treatment workers indicated that her focus was so narrow in engaging Jennifer that everything else in the house was in her peripheral vision. She believes that the system is built to place little to no accountability on the parents. She believes that the current system of treatment for intact families should be eliminated. It sets both the DFS workers and the children up for failure and possible injury to a child. DFS workers are also aware that they have a limited window of time to work with these families even when the families are compliant. The DFS Policy Manual states that "whenever possible, treatment cases for children remaining at home should be closed within nine months of a treatment case being opened, if possible."[10]

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

1. **DFS treatment workers should regularly consult with the civil Deputy Attorneys General assigned to represent DFS regarding possible legal remedies for non-compliant families.**

[10] DFS Policy Manual, Rev. 12/02. Treatment for Children & Intact Families: Case Decision Point #3, Scope.

2. **Where other governmental agencies, such as Probation and Parole, have the authority to compel a parent to comply with DFS treatment services via probation conditions, DFS should collaborate with those agencies to effectuate engagement and completion of necessary treatment services such as parenting classes, domestic violence programs, substance abuse programs and/or mental health programs/evaluations.**

3. **DFS must explore use of assessment tools** that early on can distinguish families likely to be successful with traditional treatment services from those who are not likely to succeed. If DFS is not going to be successful with these families, decisions should be made early to either place the children in foster care or close the cases knowing the children are at risk. Those non-successful families should be referred to community-based resources.

4. There are an insufficient number of community resources to provide to non-compliant families. **DSCYF must explore more appropriate funding of community resources for early intervention and prevention of child abuse and/or neglect.**

5. Treatment services for parents who have been substantiated for abuse/neglect must be meaningful and helpful. **DFS should explore whether successful treatment services exist in Delaware or in other states and replicate the successful, evidence-based programs**. This could include conducting psycho-social evaluations of families and tailoring treatment plans to the results. Parenting classes are not going to change many of these severely dysfunctional families. They will require a much stronger treatment program.

6. **DFS should establish a treatment review team comprised of professionals experienced in engaging non-cooperative families to provide guidance or case planning assistance on the most difficult DFS cases involving non-compliant families**. The team would provide suggestions such as strategies for engaging the family, recommending other supportive resources, pursuing custody for out of home placements or terminating services.

7. **DFS should contract for parenting classes specifically geared to perpetrators of child abuse**.

8. **DFS workers need to receive more training on grounds for removing children active in treatment in situations where chronic neglect is present** and the children's safety and well-being are in jeopardy. This will require discussions/agreement with Family Court as well.

9. **Investigation and treatment workers should receive expert ongoing training on strategies to engage non-compliant families**.

LAW ENFORCEMENT

DFS often felt helpless when Jennifer and Steven would violate the PFA or no contact order. DFS stated that they have called law enforcement and probation/parole in the past and

received minimal assistance. They were often told that the matter was one for Family Court. This is one component of the system that could have been successful in holding the parents more accountable and compelling them to engage in services. The Subcommittee is well aware of the high volume of PFA and no contact orders managed in this state. However, it cannot allow violations in homes where children are present to be overlooked because of the lack of resources. The system must hold the offender accountable.

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

1. **Law enforcement should assist DFS when a no contact order or PFA has been violated and there are children at risk in the home.**

2. **DFS workers must contact law enforcement or probation/parole if they know a PFA or no-contact order is being violated.**

3. **Offenders should be held accountable when they violate court orders. The information and technology project started through the DVCC's *Grants to Encourage Arrests* should be completed and implemented.**

4. **Where Probation and Parole has the authority to compel a parent to comply with DFS treatment services via probation conditions, Probation and Parole should collaborate with DFS to effectuate engagement and completion of necessary treatment services such as parenting classes, domestic violence programs, substance abuse programs and/or mental health programs/evaluations.**

LEGAL

As stated previously, the Subcommittee had an expanded view of day to day realities of a DFS treatment worker. Every DFS worker interviewed had the same consistent message: the child protection system needs to evaluate the outcomes of these long-term chronic neglectful families. DFS workers shared the following statements about these cases with the Subcommittee:

- *It is very difficult to place children if the case is out of the investigation stage. Investigation is based on allegations, treatment is supposed to work on the issues. If there is physical or sexual abuse of kids, we can file. Treatment cannot compel to cooperate even if mom may benefit from parenting help. We close if they are not cooperating after discussing with supervisor.*

- *The foster care cases take all of our time (visitation, transport, appointments, doctor visits, dentists, and court ordered weekly requirements). Activities associated with placement are overwhelming and take weeks to resolve. Intact cases do not get the same intensity.*

- *Maybe we need to get rid of intact treatment altogether or give them the ability to compel cooperation. I think we should break out intact families versus foster care.*

- *Trying to work with intact families that are uncooperative set the DFS workers up to fail. Very frustrating because we need to make parents more accountable, more consequences for neglect.*

- *Without court involvement we cannot stop this chronic neglect.*

- *Not sure if we effectuate any change, even with best shot, sometimes no change. Sort of a band-aid, frustrating. It is hard to ask these families to undo a life long learning in a year. Intact cases that have no change we close, better to close than keep them open. More frightening to be involved -- feels better to close. We can't keep them open because something might happen especially if they are stable.*

- *Frequent fliers most difficult to deal with. They are borderline and are never going to get it together, they need more scrutiny.*

- *DFS provides services to the family but not really involved due to volume of cases and lack of time. Treatment stands on the outside and wants to be the client's buddy, does not want to upset the parents, must engage them.*

- *Treatment often tells investigation that they do not take risk cases.*

- *Not comfortable not working with this family and giving up on them.*

One treatment worker told the Subcommittee that in her caseload, 6 or 7 cases were foster care cases. The other 12 were intact families. Of those, on average, only 2 out of the 12 intact families would voluntarily cooperate with DFS and show any real behavioral changes. Just looking at one treatment worker's caseload, children in 10 families are left at risk

In this particular case, the worker knew that the family did not take DFS seriously. She did not believe the family would make changes. Nevertheless, she created a case plan. Her entire focus was to get Jennifer to cooperate. The treatment supervisor stated that failure to comply with a case plan is not grounds to keep a case open. DFS felt that there was very little that could be done in this case. Jennifer was not capable of following a case plan and Steven was also non-compliant.

The Subcommittee also learned that DFS had great success with the low risk contracted treatment services. On low risk cases, families used to be referred to contracted treatment. Families were seen weekly and 75% of cases were closed in three months. Eighty five percent of these cases were successful and did not have another investigation within 12 months from the date of closure. DFS treatment staff underutilized this service (for reasons unknown) and it was eliminated. The resources went to fund visitation within the state for foster children.

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

1. **A work group consisting of Family Court, DFS, the Department of Justice and community partners should be convened to explore**:

   A. ways to compel parents to cooperate with DFS to address and resolve the issues that place their children at risk;
   B. whether there is a discrepancy between policy and practice regarding bringing neglected children into care;
   C. whether it is necessary to lower the threshold for bringing children who are too young to protect themselves into care;
   D. how to impose extra scrutiny of "frequent flyer families" – families who continually come to the attention of DFS;
   E. what risks the state is willing to assume by closing some of these chronic low-level neglect families;
   F. research on how other child protection systems throughout the country handle these types of cases;
   G. the feasibility of re-implementing contracted treatment services.

MEDICAL

During the review, the Subcommittee learned that law enforcement and the Attorney General's Office have great difficulty in gaining cooperation with one out of state hospital regarding criminal investigations. The hospital would not permit photographs of the injuries to be taken. The hospital also refused to release the medical records to the NCCPD.

The Subcommittee also noted that after Oliver's premature birth, little primary care follow up was done with him despite the intervention of Public Health. After the report that Steven was allegedly shaking Oliver, no pediatric follow up was conducted for possible abuse.

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

1. **Public Health needs to take a more active role in ensuring that families comply with visits to the pediatrician. If the family is non-compliant, DFS needs to accept these high risk cases and assist Public Health in seeking medical treatment for children in these cases. At the same time, all primary care physicians must make diligent efforts in trying to reach the family for no-show appointments, follow through, etc. If the family is not cooperative in bringing a high risk child to the doctor, then the primary care physician should also call the DFS hotline.**

2. **Establish a liaison between the specific out of state hospital, the Division of Family Services, Law Enforcement and the Attorney General's Office to assist in cooperation and collaboration for investigation of child abuse cases where the victim is placed in the out of state hospital.**

MULTI-DISCIPLINARY REPORTING AND INVESTIGATION OF CHILD ABUSE AND NEGLECT

During the life of this case, several medical professionals made referrals to the DFS hotline. Research has shown that there is a greater likelihood of future maltreatment when medical professionals have made one or more referrals.[11] In this case, the emergency room physician from the January 2003 investigation did not call the DFS hotline when the child was in the emergency room with marks. A mandatory reporting form is helpful for DFS, but it is not meant to be a substitute for an acute case being called into the DFS hotline.

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

1. As stated in the previous CPAC near death report, **reports made by professionals should be given the highest degree of deference and accepted in all cases unless good cause exists for rejecting the report. The investigation worker should contact reporters immediately (16 Del. C. § 906(b)(13) and provide reporters with the outcome of the decision and/or the investigation. 16 Del. C. § 906(b)(16).**

2. **It is imperative that the dayshift DFS investigation workers meet with the family before the case is transferred and that investigation workers and treatment workers discuss the case.** Hotline calls received and investigated by second or third shift workers are eventually transferred to investigators on day shift where the investigation is completed and either founded and transferred to treatment or unfounded and closed. Treatment workers create case plans relying on the investigation worker's knowledge of the family. If the investigation worker transferring the case has not met the family, critical information will never be considered in making a treatment plan.

3. **CPAC should support the Abuse Intervention Committee in its current initiative to educate the medical community on mandatory reporting of child abuse and neglect**.

[12] North Carolina did research that suggests that children who were reported to child abuse hotlines by medical professionals were 2.5 to 3 times more likely to die as those who were reported by other categories of reporters. The study examined the cases of 89 children in a two year period that had died and of those, 39 had been reported to the hotline by medical professionals. (Cole, George P. and Hussey, Jon M. "Birth Certificate Predictors of Child Maltreatment Reports". Paper presented at the 13th Annual Conference on Child Abuse and Neglect, April 27, 2001, Albuquerque, New Mexico).

MULTI-DISCIPLINARY TRAINING

As issues are repeatedly raised in reviews of child deaths and near deaths, it is apparent that a multi-disciplinary training must occur in a timely manner. There appears to be repeated breakdowns from the professional community in reference to mandatory reporting. This needs to be a focus of multi-disciplinary training. 16 Del. C. § 906(b)(15) and § 911 require various CPAC participants to be instrumental in ensuring regular and comprehensive training occurs. Delaware must once again make training of the multi-disciplinary units a priority.

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

1. **All CPAC members should make a renewed commitment to pool resources and training to ensure annual comprehensive, multi-disciplinary training on child abuse and/or neglect.** Training should use the recommendations in this report and specifically focus on the various components of the child protection system and how critical multi-disciplinary collaboration is to ensuring the safety of children. Immediate training issues shall include:

    a. Reporting of child abuse and/or neglect;
    b. Detecting child abuse and/or neglect;
    c. DFS hotline responses to reports of child abuse and/or neglect;
    d. Communication between the Department of Justice, law enforcement, and DFS on the civil and criminal aspects of a case, and the inclusion of Family Court for communication regarding policies and procedures;
    e. Child protection and domestic violence;
    f. Importance of child protection history; and
    g. Investigative techniques to address cases where there is more than one suspected perpetrator.

    This recommendation shall be referred to the CPAC Training Subcommittee for action.

MULTI-DISCIPLINARY USE OF CHILD PROTECTION HISTORY IN DECISION MAKING

A thorough history review is as important as meeting a family and should guide a DFS worker in both his/her investigation of allegations as well as in creating treatment plans. While most DFS workers agree that history is important they do not have time to complete a thorough review which can result in investigations being incident based. A review and understanding of

the history of a family must be mandated and expected of all workers. Without this, children are not safe. The lack of time workers have available to review history bolsters the need for exploring the replacement of caseload standards with workload standards.

Testimony from the 2003 treatment worker validated that DFS workers would like to do a thorough history review and they agree that it is good practice but there is not enough time to do it. In reality, so many other things take priority over a history review such as home visits, client contact, Family Court hearings, etc. This issue is directly related to the workload problem.

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

1. **CPAC is once again recommending that DFS evaluate its policies to clarify *how* history should be used by caseworkers.** There are **ten** different investigations with this family where history was not utilized properly in assessing safety and risk to the child.

2. **DFS needs to establish a summary time line within the DFS computer system.** This summary timeline (similar to a court docket sheet) should be attached to a case when it is transferred from the hotline to the investigation worker and then on to treatment. [12]

3. **All DFS staff should be provided with continued instruction/training regarding appropriate use of history**.

These recommendations shall be referred to the CPAC and Child Death, Near Death and Stillbirth Commission joint committee on the Multi-Disciplinary Use of History in Decision Making.

WELL-BEING

I. Education

DFS overlooked the twin girls' education. Jennifer had been charged with truancy and the girls missed approximately 30 days of school in 2001. This is a direct reflection on Jennifer's inability to parent and the chronic neglect that was prevalent in the home. The report from Delaware's Federal Child and Family Services review in June of 2001 stated that "*educational information was generally not gathered for the in-home child protective service cases evaluated by one of the review teams unless education was singled out as a significant issue. Serious educational needs were not assessed or addressed in some of the cases evaluated.*"

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

[12] It is anticipated that some type of history review data will be incorporated into the DFS computer system FACTS 2010.

1. **DFS treatment workers need to consider educational issues as part of the DFS focus for well-being**. It is not enough to say that the issue is not of a DFS nature. However, this must be balanced with appropriate work-load and staffing.

II. Foster care

During the course of the review, the Subcommittee learned that foster homes remain overloaded and that recruitment is not optimal especially for youth with more challenging behaviors. Since this review, CPAC has revived its Foster Care Subcommittee[13] to take a closer look at foster care resources. During this case, the children were not placed in foster care in March of 2003 due to the fact that it would be highly unlikely to find a specialized foster home after hours given the girls' alleged fire setting behavior. It was recommended by the after hours supervisor that a request be made the following day for foster homes. However, the assigned investigation worker did not do so. The lack of specialized foster homes may have been an issue discouraging placement.

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

1. **It is recommended that the CPAC Foster Care Subcommittee meet with the DFS committee working on lack of foster home placements and make recommendations to CPAC for modifications and/or improvements to the current foster care resource pool.**

III. Substance Abuse

DFS had five investigations where allegations of substance abuse were made regarding Jennifer and Maternal grandmother. Not once were these allegations addressed. Substance abuse issues often lead to chronic neglect and lack of supervision, both recurrent problems for this family. The absence of any requirement by DFS for Jennifer to obtain a substance abuse evaluation put the children at risk.

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

1. **DFS should not close cases until substance abuse allegations are ruled out**. If the family is uncooperative regarding an evaluation or treatment, then a treatment review team (See recommendation #6 under the treatment section) should be enlisted to assist the worker/supervisor in making the decision to open or close the case.

IV. Victim Services

Jennifer suffered from domestic violence problems with almost all of her male partners. She was often seen with injuries such as a black eye, an injured hand or injuries from falling

[13] This Subcommittee was reconstituted at the January 2006 CPAC Quarterly meeting.

(such as abdominal injuries). Oliver's pediatrician's office did give her literature on domestic violence but did this in front of her possible abuser. Jennifer did reach out and obtain a PFA order but would inevitably allow the partner back into her home. Given her childhood history, limited intellect, depression and low-income, Jennifer should have had more support in dealing with the domestic violence. DFS did not review the Family Court records during any of the investigations since it is not the current practice. However, in both this case, and the prior CPAC Near Death Review, Family Court documents were an invaluable source of information regarding the family situation.

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

1. **If domestic violence is an issue, DFS should retrieve the Family Court records through the DFS liaison or by some other method.** Due to the nature and cycle of domestic violence, victims and offenders may often minimize and deny the extent of the abuse. Victims may fear retaliation by the offender or may fear being held responsible for the violence if they honestly report the extent of the violence to the DFS worker. By accessing police reports, PFA petitions and other documents, the worker is able to obtain more accurate information about the extent of the violence without placing the victim at risk.

2. There are an insufficient number of community resources to provide to non-compliant families. **DSCYF must explore more appropriate funding of community resources for early intervention and prevention of child abuse and/or neglect.**