



STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION

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EXECUTIVE DIRECTOR

May 20, 2026

The Honorable Matthew Meyer
Office of the Governor
820 N. French Street, 12th Floor
Wilmington, DE 19801

RE: Reviews of Child Deaths and Near Deaths Due to Abuse or Neglect

Dear Governor Meyer:

As one of its many statutory duties, the Child Protection Accountability Commission (“CPAC”) is responsible for the review of child deaths and near-deaths due to abuse or neglect. In calendar year 2025, CPAC accepted 66 cases for review (12 deaths and 54 near-deaths) and screened out 132 cases.

As required by law, CPAC approved findings from 26 cases at its May 20, 2026, meeting.¹ These cases are divided into two sections – cases that received a final review after completion of prosecution and cases that were reviewed for the first time.

This quarter, 12 cases received a final review. These were deaths and near-deaths that occurred between July 2022 and July 2025. Six of the 12 cases resulted in charges, and one of those cases involved three defendants, for a total of eight charged individuals. Of the eight defendants, there were a total of five convictions; four of the defendants received probation, one received Level V incarceration, and the charges against three defendants were nol prossed. One defendant, who was convicted of Reckless Endangering 1st and Child Abuse 2nd, of a seven-year-old victim, received a six-year jail sentence. CPAC and its committees continue to focus on outcomes in these serious child abuse cases, continuing efforts to improve timely decision-making, strengthen civil and criminal collaboration, enhance presentence investigations, and ensure the effective use of victim impact statements. These final reviews resulted in one additional finding and two additional strengths.

The 14 remaining cases were initial reviews from deaths or near-deaths that occurred between August and October 2025. Of these cases, two deaths and three near-deaths will have no further

¹ 16 Del.C. §932.

review and were not prosecuted- these cases include unsafe sleep, subdural hemorrhage, medical neglect/failure to thrive, and abusive head trauma.

There are nine cases- one death and eight near-deaths- that will remain open pending prosecutorial outcomes. These cases involve unsafe sleep, skull fractures, bone fractures, medical neglect, failure to thrive, poisoning via drug ingestion, and abusive head trauma.

For the 14 cases from August to October 2025, there were 20 strengths and 26 findings across system areas. Ten strengths and five findings were noted for the Multidisciplinary Team Response. These results reflect continued progress in strengthening multidisciplinary collaboration and frontline investigative expertise.

Six strengths and 18 findings were identified regarding the Division of Family Services (“DFS”). Six of the findings related to caseloads, and one involved safety concerns. The remaining 11 findings involved insufficient collateral contacts, incorrect risk assessments, and unresolved risk at the time of case closure. No additional trends were identified in the other findings this quarter.

For the medical response, this quarter demonstrated four strengths and three findings. Only one of those findings indicates a breakdown in reporting the case to the DFS report line by the treating hospital. This shows improvement in reporting this past quarter and may be reflective of the 2025 recognition and reporting training for medical professionals, which emphasized identifying and reporting child abuse and neglect.

The number, complexity, and severity of child abuse cases remain high. The multidisciplinary team continues to strengthen its expertise and response to these matters, as reflected in the identified strengths. For your reference, we have included the strengths, findings, and detailed summaries of all cases discussed in this letter. In addition, the CPAC Data Dashboards and summaries of CAN findings and drug ingestions are provided to offer a comprehensive view of the volume and complexity of child welfare cases in Delaware over time. CPAC remains available and prepared to answer any further questions you may have.

Respectfully,



Kelly C. Ensslin, Esquire
Executive Director
Child Protection Accountability Commission

Enclosures

Cc: CPAC Commissioners, General Assembly

Child Protection Accountability Commission
Child Abuse and Neglect Panel
Strengths Summary

INITIAL REVIEWS	
	Current
MDT Response	10
General - Criminal Investigation	1
General - Criminal/Civil Investigation	5
General Civil Investigation	2
Interviews - Adults	1
Reporting	1
Medical	4
Documentation	1
Reporting	3
Risk Assessment/ Caseloads	2
Collaterals	2
Safety/ Use of History/ Supervisory Oversight	1
Safety Assessment of Non-Victims	1
Unresolved Risk	3
Contacts with Family	1
Parental Risk Factors	2
Grand Total	<u>20</u>

FINAL REVIEWS	
	Current
Legal	1
Prosecution/Pleas/Sentence	1
MDT Response	1
General - Criminal Investigation	1
Grand Total	<u>2</u>
TOTAL CAN PANEL STRENGTHS	
	<u>22</u>

Child Protection Accountability Commission
Child Abuse and Neglect Panel
Strengths Summary

Child Protection Accountability Commission
Child Abuse and Neglect Panel
Strengths Detail

INITIAL REVIEWS

System Area	Strength	Public Rationale	Count of #
MDT Response			<u>10</u>
	General - Criminal Investigation		1
		The law enforcement agency ensured evidentiary blood draws were completed for the mother and the child.	1
	General - Criminal/Civil Investigation		5
		There was a strong, joint response to the near death investigation, with consistent MDT involvement throughout.	4
		There was a strong, joint response to the death investigation, with consistent MDT involvement throughout.	1
	Interviews - Adults		1
		The DFS caseworker conducted interviews with all adult household members.	1
	Reporting		1
		The law enforcement agency, along with emergency medical services, made an immediate referral to the DFS Report Line reporting an illicit drug ingestion by the young child.	1
	General Civil Investigation		2
		The DFS investigation and treatment caseworkers went above and beyond to assist the mother in this complex situation, specifically by implementing a child safety agreement requiring the child be enrolled in daycare, making unannounced home visits, and ensuring timely and appropriate referrals were made, which included Purchase of Care, parenting education, and other support resources for the mother.	1

Child Protection Accountability Commission
Child Abuse and Neglect Panel
Strengths Detail

	There was good collaboration between the DFS investigation and treatment caseworkers throughout the cases.	1
Medical		4
	Documentation	1
	The emergency medical services report thoroughly documented a timeline of events, the scene of the child death incident, the appearance of the child, and resuscitative efforts.	1
	Reporting	3
	The primary care physician and the initial treating hospital made referrals to the DFS Report Line when the young child presented with a head injury.	1
	Prior to the death incident, the primary care physician and the CARE Team made reports to the DFS Report Line when the child missed medical appointments. As a result, the child was previously evaluated in the emergency department.	1
	The children's hospital made an immediate referral to the DFS Report Line when imaging identified a second suspected fracture to the young child's arm.	1
Risk Assessment/ Caseloads		2
	Collaterals	2
	The DFS caseworker consulted with an out of state child protective services agency in the state the family was known to previously reside.	1
	As part of the initial response, the DFS caseworker completed good, thorough collaterals with multiple medical specialists and the childcare programs.	1
Safety/ Use of History/ Supervisory Oversight		1
	Safety Assessment of Non-Victims	1

Child Protection Accountability Commission
Child Abuse and Neglect Panel
Strengths Detail

	As part of the initial response, the DFS caseworker assessed all the household children for their safety and well-being.	1
Unresolved Risk		<u>3</u>
	Contacts with Family	1
	Once contact was established, the investigation caseworker maintained regular, quality contact with the family.	1
	Parental Risk Factors	2
	The medical team and the investigation caseworker educated the mother on infant safe sleep practices.	1
	The medical insurance provider contacted the primary care physician with concerns regarding the mother's ability to be a paid caregiver given her mental health concerns.	1
Grand Total		<u>20</u>

Child Protection Accountability Commission
Child Abuse and Neglect Panel
Strengths Detail

FINAL REVIEWS

System Area	Strength	Public Rationale	Count of #
Legal	Prosecution/ Pleas/Sentence		<u>1</u>
		During the criminal case resolution, the prosecutor did an excellent job ensuring the MDT best practices were followed, advocating for the victim child, recommending higher sentencing within the SENTAC guidelines, and presenting the aggravating factors of the case, resulting in a good criminal outcome.	1
MDT Response	General - Criminal Investigation		<u>1</u>
		The law enforcement detective assigned to the case conducted a good investigation, which included reviewing camera footage from the surrounding area to build a timeline of the parents' whereabouts.	1
Grand Total			<u>2</u>
TOTAL CAN PANEL STRENGTHS			<u>22</u>

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

INITIAL REVIEWS

MDT Response	<u>5</u>
Communication	1
General - Civil Investigation	3
Interviews - Child	1
Medical	<u>3</u>
Medical Exam/ Standard of Care - ED	1
Medical Exam/ Standard of Care - PCP	1
Reporting	1
Risk Assessment/ Caseloads	<u>9</u>
Caseloads	6
Collaterals	1
Risk Assessment - Tools	1
Risk Assessment - Unsubstantiated	1
Safety/ Use of History/ Supervisory Oversight	<u>1</u>
Safety - Oversight of Agreement	1
Unresolved Risk	<u>8</u>
Child Risk Factors	1
Contacts with Family	3
Parental Risk Factors	4
Grand Total	<u>26</u>

FINAL REVIEWS

Medical	<u>1</u>
Medical Exam/ Standard of Care - ED	1
Grand Total	<u>1</u>

TOTAL CAN PANEL FINDINGS **27**

Child Protection Accountability Commission
 Child Abuse and Neglect Panel
Findings Detail

INITIAL REVIEWS

System Area	Finding	PUBLIC Rationale	Count of #
MDT Response			<u>5</u>
	Communication		1
		The Office of the Investigation Coordinator contacted the investigation and treatment workers on several occasions with concerns for the young children. There was a delay in the concerns being addressed or acknowledged.	1
	General - Civil Investigation		3
		There was no documentation that the treatment worker established a family service plan with the parents.	1
		The treatment worker should have taken a stronger approach to assist the family with getting the children to their medical appointments. Even after a TDM was held, there was no clear plan to create change for the parents.	1
		There was not a joint MDT response to the near death incident in compliance with the MOU and statute. DFS did not notify law enforcement of the near death incident.	1
	Interviews - Child		1
		An interview was not conducted with the teen relative residing in the home by the DFS caseworker or the law enforcement agency.	1
Medical			<u>3</u>
	Medical Exam/ Standard of Care - ED		1
		Due to the child being pronounced shortly after arrival to the initial treating hospital, there were no vital signs obtained, including the child's weight and body temperature, thereby potentially deterring an accurate assessment of time of death.	1
	Medical Exam/ Standard of Care - PCP		1
		The mother contacted the pediatrician on two occasions, and during both contacts, the child's lack of well child care was not discussed and the child was not scheduled for a well child visit.	1
	Reporting		1
		There was no report made to the DFS Report Line by the dietician when the provider became concerned for the child's reported oral intake, the lack of NG tube feedings, and notable weight loss. The provider consulted with another specialty service and the child was referred to the emergency department.	1

Child Protection Accountability Commission
 Child Abuse and Neglect Panel
Findings Detail

Risk Assessment/ Caseloads	9
Caseloads	6
The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	1
The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open, and the caseload appears to have negatively impacted the DFS response to the case.	2
The DFS caseworkers were over the investigation caseload statutory standards during the current and first prior investigation. However, it does not appear that the caseloads negatively impacted the cases.	1
The DFS caseworkers were over the investigation and treatment caseload statutory standards the entire time the cases were open. It does not appear that the caseload negatively impacted the DFS response to the investigation; however, the caseload appears to have had a negative impact on the treatment case.	1
The DFS caseworkers were over the investigation caseload statutory standards during the current and prior investigation. However, it does not appear that the caseloads negatively impacted the cases.	1
Collaterals	1
As the investigation progressed, there was insufficient in-person contact with the victim child to assess safety. Furthermore, there was a need for more frequent contact with the medical collaterals to assess the victim's continued safety.	1
Risk Assessment - Tools	1
The initial hotline report was assigned a Priority-3 response in contrast with the SDM Response Priority Assessment. Based on report of a young child with a head injury resulting from possible neglect and being transported to the emergency department for evaluation, the case met criteria for a Priority-1 response. However, there was no negative impact to the case as the subsequent report was screened in as a Priority-1 simultaneously.	1
Risk Assessment - Unsubstantiated	1
A finding of neglect was not recommended against the father at the conclusion of the investigation. The father was incapacitated due to alcohol use while responsible for the three children, and the infant was injured as a result.	1

Child Protection Accountability Commission
 Child Abuse and Neglect Panel
Findings Detail

Safety - Oversight of Agreement		1
	During the investigation, the child safety agreement was violated by the mother transporting the sibling to the forensic interview, and it was not addressed by the DFS caseworker.	1
Unresolved Risk		8
Child Risk Factors		1
	The contracted treatment worker did not follow up with the child's medical provider for confirmation when the caregiver reported the NG tube was no longer needed.	1
Contacts with Family		3
	For the second prior investigation, the initial response by the DFS caseworker was	1
	There was no documentation that the contracted treatment worker made sufficient contact to assess the children's safety on an ongoing basis during times that investigation was not open.	1
	Timely contact with the family was not made by the DFS caseworker. There was no indication that efforts were attempted to meet the assigned priority response time until two months later, and the actual contact did not occur for several weeks after that.	1
Parental Risk Factors		4
	There was no documentation that the investigation caseworker addressed the father's alcohol use or offered services to the father.	1
	DFS did not evaluate substance abuse issues for the father by requesting that he complete a substance abuse evaluation. There were allegations that the father also abused alcohol and marijuana.	1
Grand Total		<u>26</u>

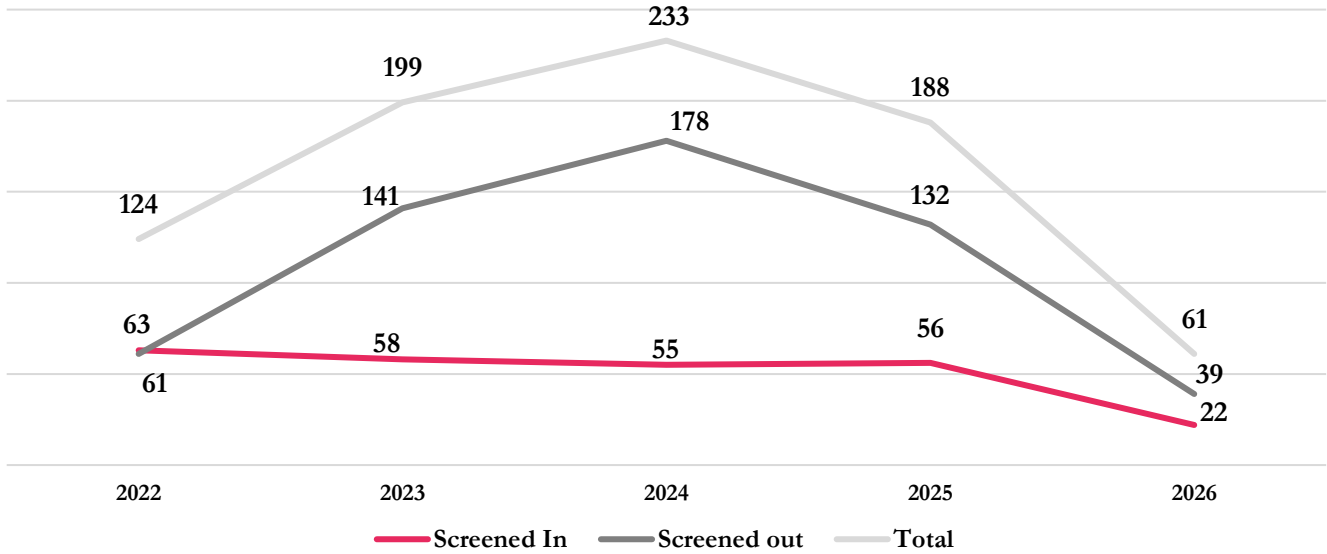
Child Protection Accountability Commission
Child Abuse and Neglect Panel
Findings Detail

FINAL REVIEWS

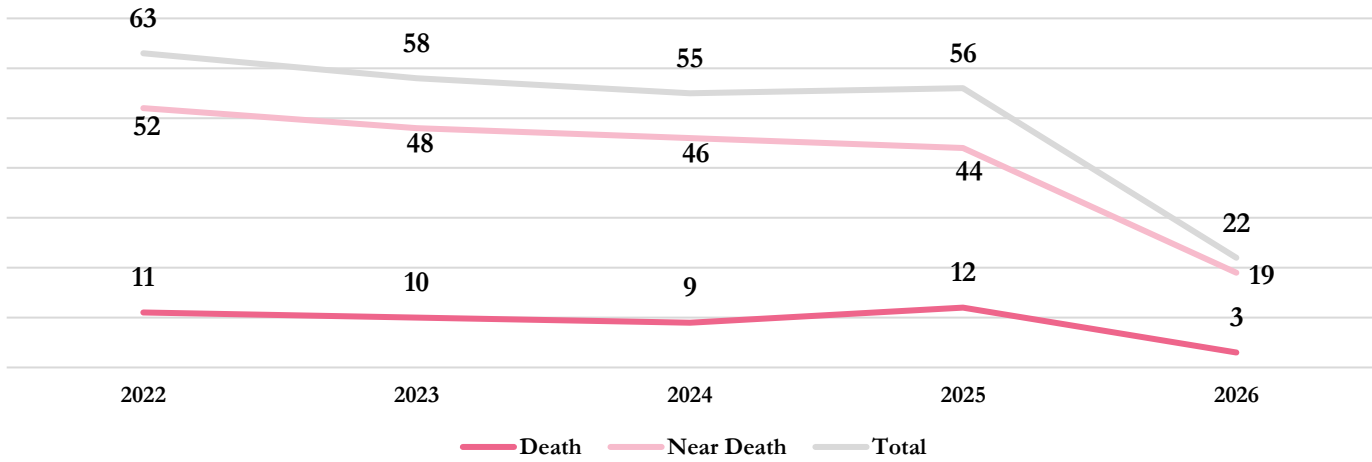
System Area	Finding	PUBLIC Rationale	Count of #
Medical			<u>1</u>
	Medical Exam/ Standard of Care - ED		1
		The child's temperature was not initially obtained by the treating hospital, thereby potentially deterring an accurate assessment of time of death.	1
Grand Total			<u>1</u>

TOTAL CAN PANEL FINDINGS **27**

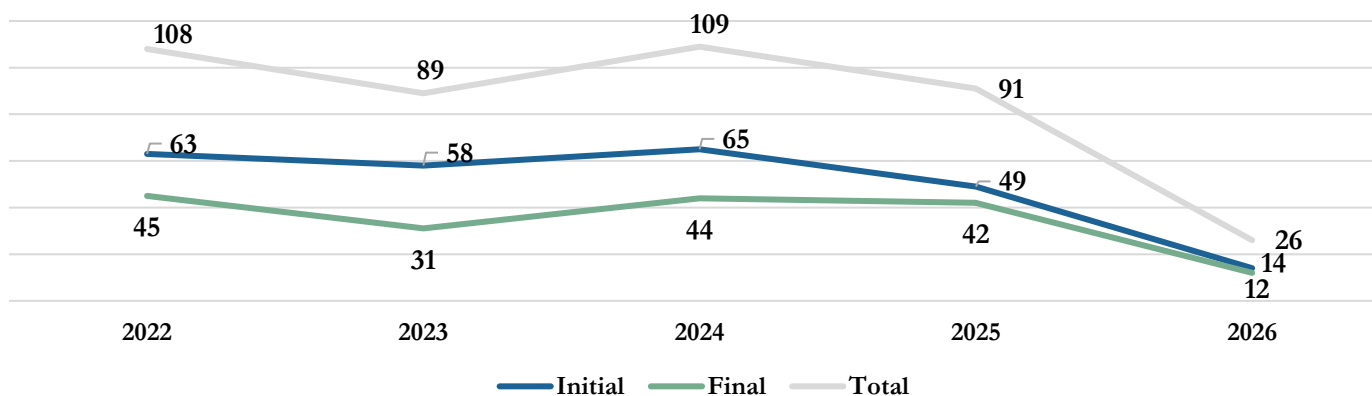
Screening Decisions of CAN Cases



Screened In Death and Near Death Cases

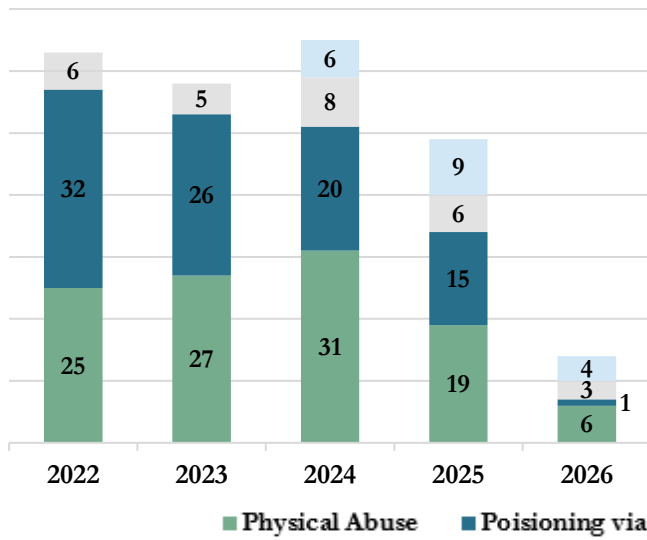


Initials and Finals by Calendar Year

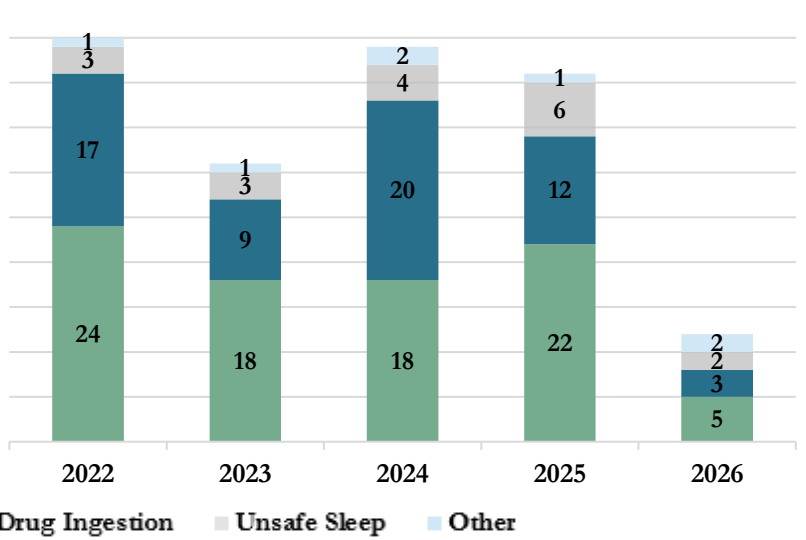


16 Del. C. § 932(c) requires CPAC to review a case within 6 months of a report. In August 2021, CPAC voted to extend the timeframe to 9 months, which is how compliance is calculated above.

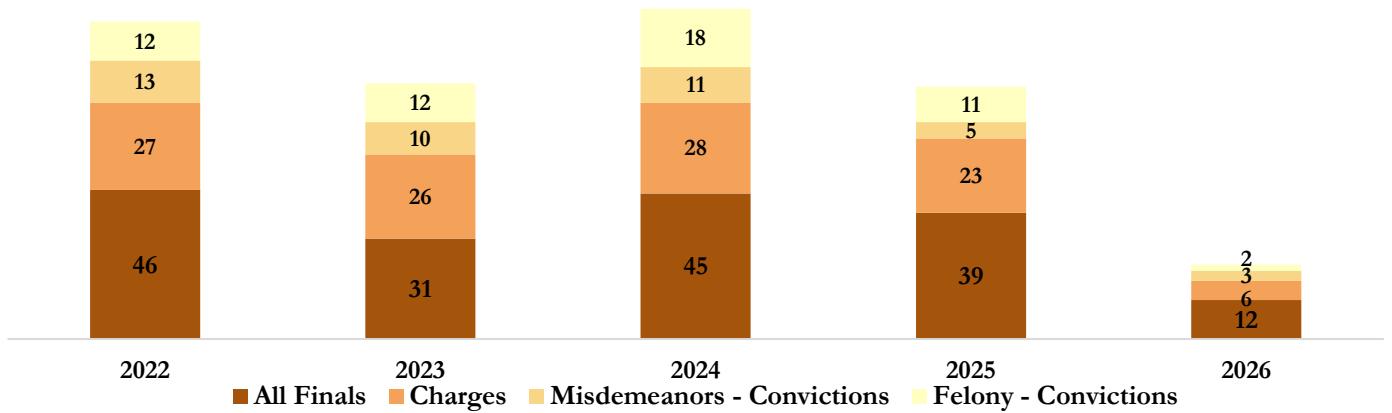
Initial Reviews by CAN Panel



Final Reviews by CAN Panel



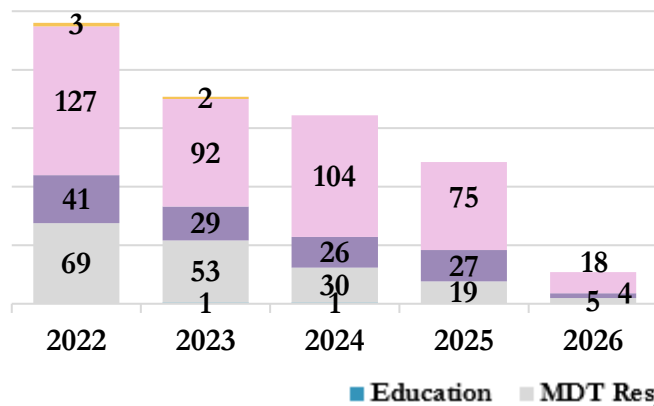
Criminal Outcomes



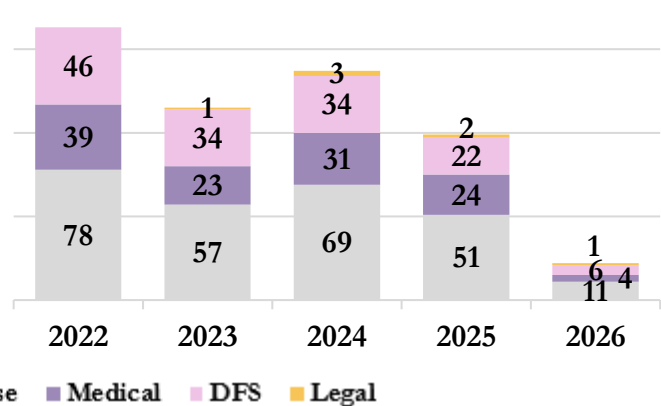
Numbers are based on when the case had the final review not the date of incident.

Findings and Strengths by the CAN Panel

Findings



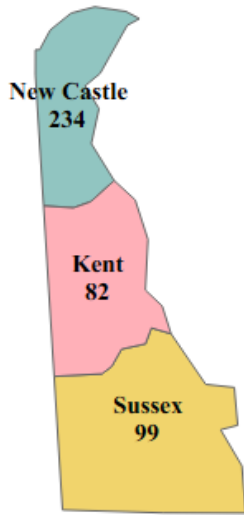
Strengths



Time Period - January 1, 2021 through March 31, 2026

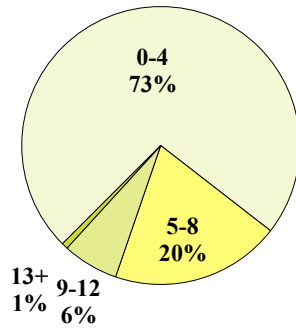
Drug Ingestion Victims by County

Victims = 415



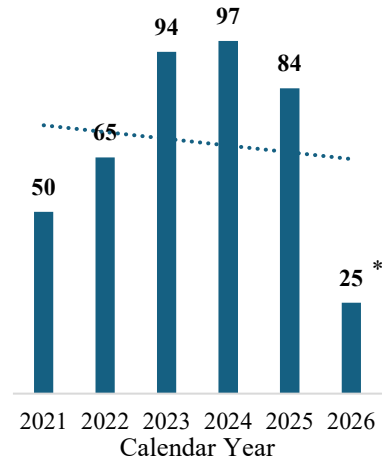
Age Break Down

Victims = 415



of Victims Entered

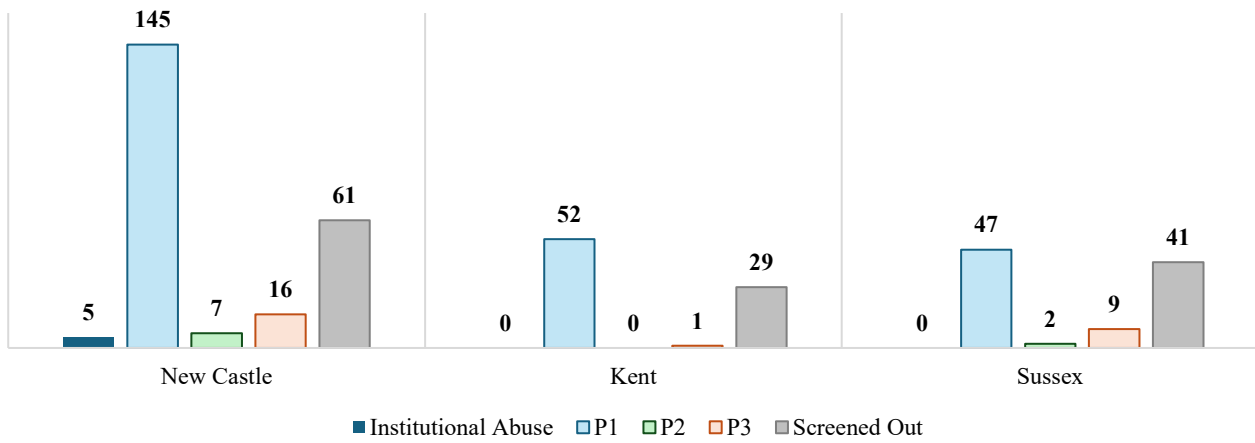
Victims = 415



*As of 04/21/2026

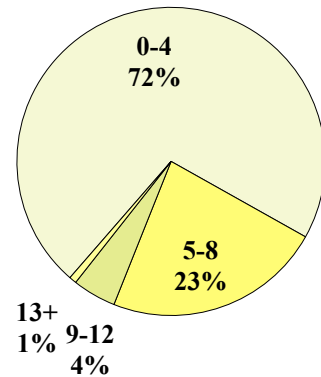
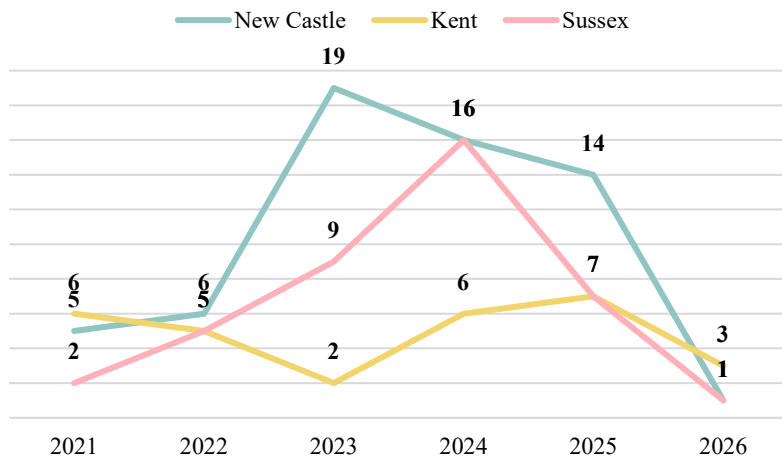
Division of Family Services Screening Responses

Time Period - 01/01/2021 through 03/31/2026 | Total Victims = 415



Division of Family Services Screened Out Victims

Time Period: 01/01/2021 - 03/31/2026 | Total Victims = 130 | Average Age = 3.51 YO | Youngest Victim = 4 Days Old



Time Period - January 1, 2021 through March 31, 2026

All DFS Response Screening | Final Suspected Drug vs. Cases Screened Out

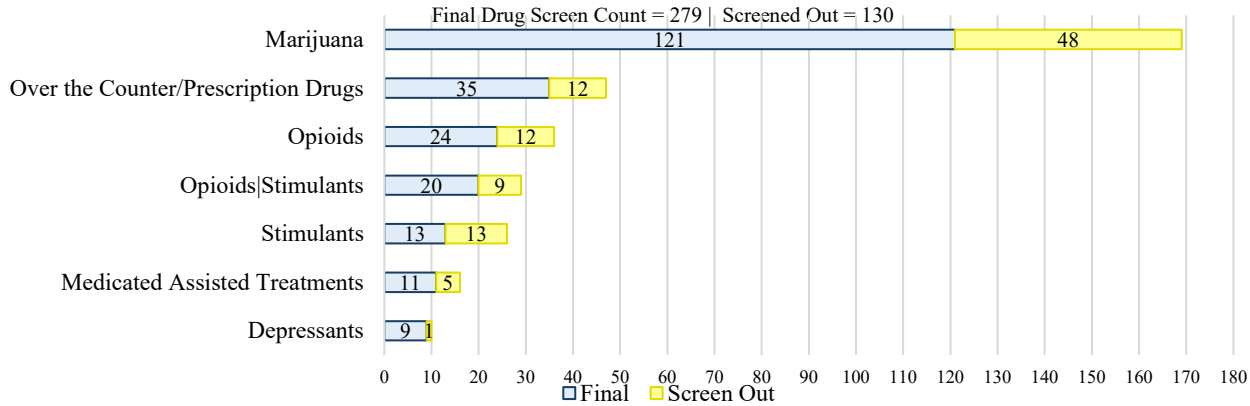
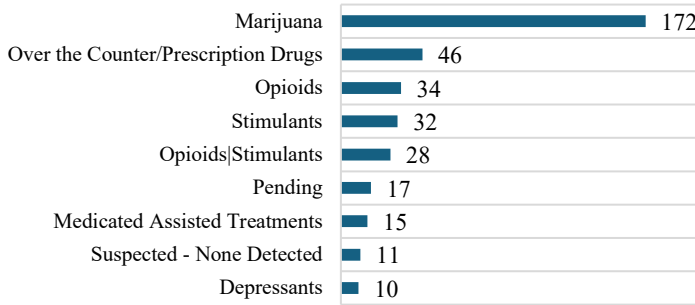


Chart is only displaying counts more than 10 for the Final Drug Screening.

Emergency Room Referrals

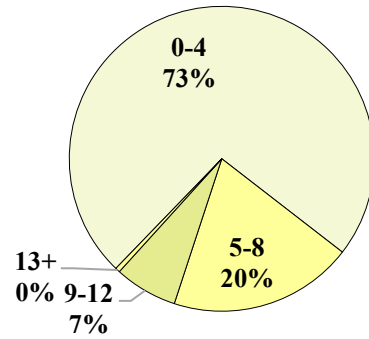
Suspected Drugs Involved in Emergency Room

Total Referrals with Substances = 404



Demographics of Referral

Victims = 404 | Average Age = 3.5 | Percent Referred to ER = 97%



Hospital protocol and procedures, including those related to testing may vary between institutions.

Victims Referred to the CAN Panel

Victims Referred to CAN = 160 | Percentage = 39%

Top Substances Associated in Cases

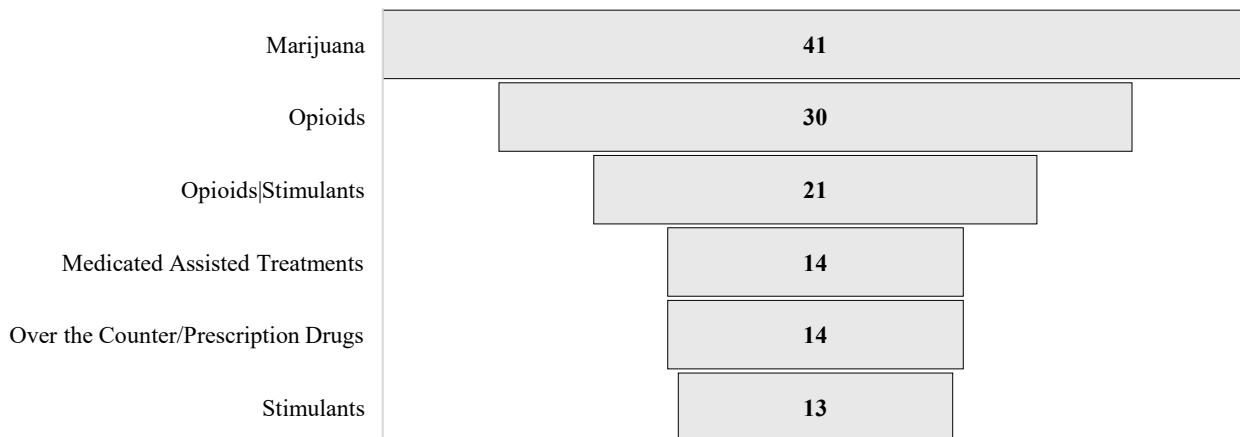


Chart is only displaying counts more than 10.