STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
C/O OFFICE OF THE CHILD ADVOCATE
900 KING STREET, SUITE 350
WILMINGTON, DELAWARE 19801
TELEPHONE: (302) 255-1730
FAX: (302) 577-6831

MARY F. DUGAN, ESQUIRE
CHAIR

KELLY C. ENSSLIN, ESQUIRE
EXECUTIVE DIRECTOR

August 19, 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. Thus far, in calendar year 2026, CPAC accepted 46 cases for review (6 deaths and 40 near-deaths) and screened out 63 cases, some of which occurred in 2025.

As required by law, CPAC approved findings from 23 cases at its August 19, 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, eight cases received a final review. These were deaths and near-deaths that occurred between October 2022 and August 2025. Five of the eight cases resulted in charges, and one of those cases involved two defendants, for a total of six charged individuals. Of the six defendants, all were convicted; four of the defendants received probation and two received Level V incarceration. One defendant, who was convicted of Manslaughter, of a five-year-old victim, received an eight-year jail sentence. CPAC and its committees continue to focus on outcomes in these serious child abuse cases, and continue to work to improve timely decision-making, civil and criminal collaboration, presentence investigations, and the provision of victim impact statements. These final reviews resulted in one additional finding.

The 15 remaining cases are from deaths or near-deaths that occurred between September 2025 and February 2026. Of these cases, two deaths and seven near-deaths will have no further review and were not prosecuted; these cases include unsafe sleep, skull fracture, bone fractures, poisoning via drug ingestion, strangulation, and near-drowning.

[1] 16 Del.C. §932.

There are six cases- two deaths and four near-deaths- that will remain open pending prosecutorial outcomes. These cases involve blunt force trauma, skull fractures, poisoning via drug ingestion, and strangulation.

For the 15 cases from September 2025 to February 2026, there were 27 strengths and 23 findings across system areas. Sixteen strengths and six findings were noted for the Multidisciplinary Team Response. These results reflect continued progress in strengthening multidisciplinary collaboration and frontline investigative expertise.

Six strengths and 12 findings were identified regarding the Division of Family Services ("DFS"). Two of the findings related to caseloads, and seven involved safety concerns. The remaining three involved incorrect risk assessment 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 five strengths and five findings. Four of those findings indicate breakdowns in reporting the case to the DFS Report Line by the treating hospitals and emergency medical services. This past quarter indicates the need for continued improvement in reporting and will be addressed through the recognition and reporting training for medical professionals, which emphasizes 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

Findings Summary

INITIAL REVIEWS	
MDT Response	**6**
Crime Scene	1
Interviews - Adult	1
Interviews - Child	1
Medical Exam	1
Reporting	2
Medical	**5**
Medical Exam/ Standard of Care - PCP	1
Reporting	4
Risk Assessment/ Caseloads	**3**
Caseloads	2
Risk Assessment - Screen Out	1
Safety/ Use of History/ Supervisory Oversight	**7**
Safety - Completed Incorrectly/ Late	4
Supervisory Oversight	2
Use of History	1
Unresolved Risk	**2**
Contacts with Family	2
Grand Total	**23**

FINAL REVIEWS	
Medical	**1**
Reporting	1
Grand Total	**1**

TOTAL CAN PANEL FINDINGS	**24**

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

Prepared 7/15/2026

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Detail

INITIAL REVIEWS

System Area	Finding	PUBLIC Rationale	Count of #
MDT Response			**6**
	Crime Scene		1
		The law enforcement agency did not complete an evidentiary blood draw on the mother or the child after the child ingested a controlled substance.	1
	Interviews - Adult		1
		In the second prior investigation, the DFS caseworker did not conduct an interview with the maternal great-grandmother, who was a household member and there were allegations regarding her health and mental state.	1
	Interviews - Child		1
		An interview was not conducted with the two older children residing in the home by law enforcement or at the Children's Advocacy Center.	1
	Medical Exam		1
		In the prior investigation, despite the parents' explanations, a medical evaluation was not completed for the pre-mobile infant who was observed to have bruising on the back of his legs.	1
	Reporting		2
		In the prior investigation, the DFS caseworker did not notify law enforcement when injuries were identified on the young child.	1
		In the first prior investigation, the DFS caseworker did not notify law enforcement when the report was received with allegations related to drug use and dealing involving the mother and teen children, firearms in the home by a person prohibited, and theft by the mother and teen children	1
Medical			**5**
	Medical Exam/ Standard of Care - PCP		1

		During the prior investigation, the child's pediatrician failed to identify sentinel injuries to the young child. There was no additional medical testing or follow up evaluation for the pre-mobile infant.	1
	Reporting		4
		The treating hospital did not make a report to the DFS Report Line when the child was pronounced deceased.	1
		The initial treating hospital delayed making a referral to the DFS Report Line for the subsequent near death incident.	1
		The treating hospital did not make a new referral to the DFS Report Line when the young child presented with facial bruising and a bone fracture. The active DFS investigation caseworker was present.	1
		The emergency medical services delayed making a referral to the DFS Report Line for the near death incident by two days.	1
Risk Assessment/ Caseloads			**3**
	Caseloads		2
		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
	Risk Assessment - Screen Out		1
		A report of the family member causing injury to a sibling should have been screened in and linked to the active investigation, as the allegations were new.	1
Safety/ Use of History/ Supervisory Oversight			**7**
	Safety - Completed Incorrectly/ Late		4
		For the prior investigation, a child safety agreement was implemented with the parents, who were responsible for the children at the time of the alleged incident, also responsible for the children's ongoing safety.	1

		A child safety agreement was implemented for the child's sibling. However, the agreement only pertained to the father's contact with the sibling in spite of the mother also having co-slept with both children just prior to the child's death and both parents having a history of marijuana use.	1
		For the near death investigation, the caseworker did not complete the SDM Safety Assessment, and there was no safety agreement. A family plan was initiated.	1
		DFS entered into a safety agreement with the father and a paternal relative, but there was no documentation that a home assessment was conducted prior to the child's medical discharge.	1
	Supervisory Oversight		2
		During the prior investigation, after the half-sibling disclosed inappropriate behaviors by an adult relative, a child safety agreement was not implemented to ensure no contact between the child and the relative.	1
		For the initial near death incident, the DFS treatment worker did not effectively supervise the visitation between the mother and the child given the level of supervision the mother needed. The video footage from the local library showed the mother was not redirected when the child was being held inappropriately and the treatment worker appeared to be preoccupied with her phone, albeit likely communicating with the foster parent regarding the child.	1
	Use of History		1
		DFS did not give the visitation center clear and concise direction for the mother's supervised visit with the child. The history of the mother's concerning behaviors was not provided; therefore, the visitation coach did not comprehend the level of oversight and supervision required, resulting in a subsequent near death incident.	1
Unresolved Risk			**2**
	Contacts with Family		2

		The investigation has been open for more than 45 days and the DFS caseworker has not completed the standard 30-day contacts with the family per policy.	2
Grand Total			**23**

FINAL REVIEWS

System Area	Finding	PUBLIC Rationale	Count of #
Medical			1
	Reporting		1
		The treating hospital delayed making a referral to the DFS Report Line for the near death incident.	1
Grand Total			**1**

TOTAL CAN PANEL FINDINGS	**24**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

INITIAL REVIEWS

	Current
MDT Response	**16**
Documentation	2
General - Criminal Investigation	4
General - Criminal/Civil Investigation	9
Reporting	1
Medical	**5**
Documentation	1
Home Visiting Programs	1
Medical Exam/Standard of Care - ED	1
Reporting	2
Risk Assessment/ Caseloads	**2**
Collaterals	2
Unresolved Risk	**4**
Contacts with Family	1
Legal Guardian	1
Parental Risk Factors	2
Grand Total	**27**

FINAL REVIEWS

	Current
Grand Total	

TOTAL CAN PANEL STRENGTHS	**27**

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900 King Street, Ste 350
Wilmington, DE 19801

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Detail

INITIAL REVIEWS

System Area	Strength	Public Rationale	Count of #
MDT Response			16
	Documentation		2
		The law enforcement complaint report was well written and thoroughly documented the case events, which included multiple interviews and polygraph examinations conducted with the caregivers.	1
		The law enforcement complaint report was well written by patrol officers and the assigned detective, all of whom thoroughly documented the case events and provided great detail of the mother's erratic behaviors and nonsensible statements.	1
	General - Criminal Investigation		4
		There was excellent collaboration between the two involved law enforcement agencies, to include information sharing, joint interviews, a doll reenactment, and multiple subsequent referrals made to the DFS Report Line.	1
		There was a good law enforcement response to the near death incident, which included collaboration among multiple troops state-wide and a thorough investigation by the assigned detective.	1
		The law enforcement detective assigned to the case had good communication with the family concerning the need for medical follow-up of the child. The medical team had difficulty reaching the family for scheduling, and the medical follow-up otherwise would not have been completed.	1
		The law enforcement agency ensured evidentiary blood draws were completed for the mother, the child, and the young sibling.	1
	General - Criminal/Civil Investigation		9

		There was a strong, joint response to the near death investigation, with consistent MDT involvement throughout.	8
		There was a strong, joint response to the death investigation, with consistent MDT involvement throughout.	1
	Reporting		1
		The law enforcement agency made an immediate referral to the DFS Report Line after responding to the home of a young child that resulted from suspected supervisory neglect.	1
Medical			5
	Documentation		1
		The NICU staff thoroughly documented the mother's concerning behaviors with the child during the birth hospitalization.	1
	Home Visiting Programs		1
		During the mother's pregnancy, she was referred to an evidence-based home visiting program.	1
	Medical Exam/ Standard of Care - ED		1
		The treating hospital immediately documented the child's body temperature upon arrival to the emergency department.	1
	Reporting		2
		The forensic nurse coordinator at the initial treating hospital made an immediate referral to the DFS Report Line regarding the subsequent near death incident. The nurse was not directly involved in the medical response, but identified the abuse during chart review the following day and recognized that a report had not yet been made.	1
		The emergency medical services made an independent referral to the DFS Report Line after responding to the local motel for a report of a young child with injuries.	1

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Detail

Risk Assessment/ Caseloads			2
	Collaterals		2
		During the near death investigation, strong collaterals were completed by the DFS caseworker. The contacts included both professional and personal resources.	2
Unresolved Risk			4
	Contacts with Family		1
		The DFS caseworker maintained regular, quality contact with the older half-sibling to ensure his needs were met.	1
	Legal Guardian		1
		The DFS caseworker facilitated getting the parents' consent to support the relative in filing for guardianship.	1
	Parental Risk Factors		2
		The DFS caseworker educated the parents on infant safe sleep practices. A pack n' play was provided to the mother for the child.	1
		The DFS caseworker educated the mother on infant safe sleep practices.	1
Grand Total			27

FINAL REVIEWS

System Area	Strength	Public Rationale	Count of #
Grand Total			

TOTAL CAN PANEL STRENGTHS	27