

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

NEAR DEATH REPORT

MAY 3, 2005
EMBARGOED UNTIL MAY 4, 2005

IN THE MATTER OF
JOHN DAVIS, JR.,
A MINOR CHILD¹

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

Background and Acknowledgements

In the Spring of 2004, the State of Delaware, in submitting its five year child welfare 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 they chose were all near death cases². The reviews were directed to CPAC’s Near Death Subcommittee (the “Subcommittee”) which chose the case of John Davis Jr. for its first review. The Office of the Child Advocate (“OCA”), as staff for CPAC, gathered and compiled the records and established a schedule of witness interviews. Subcommittee members received all records on the Davis/Matthews matter prior to the review, and each Subcommittee member prepared for and questioned a different witness. Several members of the Subcommittee as well as OCA staff drafted the report which the entire Subcommittee thoroughly reviewed, edited and critiqued. 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 State Police
Department of Health and Social Services, Division of Public Health
Department of Services for Children, Youth and Their Families,
 Division of Family Services
Family Court
Office of the Attorney General
Office of the Child Advocate
Superior Court
Wilmington Police Department

² The cases chosen by CPAC for this review occurred prior to July 1, 2004, and therefore do not fall within the Child Death, Near Death and Stillbirth Commission’s newly-expanded jurisdiction to review near death child abuse cases.

The Subcommittee members are also to be commended for their time and dedication to this meticulous review. Each member spent 45 hours in meetings and interviews, as well as countless hours gathering and reviewing materials. Their expertise and commitment significantly enabled the process. The Subcommittee members are as follows:

The Honorable Peggy L. Ableman, Superior Court, Chair
The Honorable Patricia Blevins, State Senate
Tania M. Culley, Esquire, Office of the Child Advocate – Staff
Dr. Allan DeJong, A.I. duPont Hospital for Children
Captain Harry Downes, Delaware State Police
Sergeant Phillip Hill, New Castle County Police Department
John Humphrey, Children’s Advocacy Center
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
Jennifer Barber Ranji, Esquire, CPAC Chair

Finally, the Subcommittee would like to express the impact this review has had on it. Collectively, the Subcommittee members learned much about the successes and challenges faced everyday in Delaware’s child welfare system – this system includes the Department of Services for Children, Youth and their Families, Family Court, Law Enforcement, the Medical Community and the Office of the Attorney General. It learned of a number of dedicated social workers who tirelessly use common sense and good judgment in protecting children’s lives. However, it also learned of a level of disconnect that continues to plague Delaware’s child welfare system and adversely impacts the safety of Delaware’s children. No matter the extent to which each member has been exposed to the child welfare system, all Subcommittee members were outraged by the facts of this case and how terribly we as a State failed this innocent child. The Subcommittee believes this review, and future reviews like it, are critical to monitoring the child welfare system and to ensuring that Commission members have exposure to these individual cases.

Introduction

This tragic case involves the convergence of two families with parents incapable of adequately providing for their children because of drugs, neglect, and physical abuse. The result in this case was the near death of 30 month old John Davis, Jr. at the hands of John Sr., the person believed to be his father. John Jr.’s liver had been lacerated – transected from front to back – by a direct force described by doctors as comparable to that present when an unrestrained driver hits a tree at 30 miles per hour. When he arrived at the Emergency Room, John Jr. was comatose, with no blood pressure and a near fatal loss of blood. Although John Sr. initially claimed no knowledge of how the injury had occurred, and alleged only that John Jr. had been having stomach problems, after investigation it was determined that the injury was caused by

John Sr. holding 30 month old John Jr. in a horizontal position, face down, and forcibly driving John Jr.'s body down so that his stomach slammed into John Sr.'s knee.

John Jr.'s mother and alleged father each had multiple children with different partners by the time John Jr. was born, and each had a significant and frightening history of care for those children. Indeed, these families had been the subject of child welfare involvement spanning nearly ten years, in at least two states, requiring the involvement of police officers, child protective agencies, the criminal justice system, medical providers, public health workers and social workers. Though the rest of the children in these families did not suffer injury to the extent that John Jr. did, they have all endured neglect, abuse, and instability. While the facts of this case are unique, the theme is not: the parents have complex histories of a failure to parent, with various partners and children; the histories include many instances of abuse and neglect involving many system contacts; and the child welfare system as a whole seems incapable of effectively handling all the dynamics.

Facts and Information

The child who is the subject of this review, John Davis Jr. ("John Jr."), was born in January of 2001 to Susan Matthews ("Susan"). At the time, Susan considered the child's father to be John Davis, Sr. ("John Sr."), although paternity was not definitively established. John Sr. is the perpetrator of the horrific abuse that led to this review. After the near-fatal injury, John Sr. was found to not be John Jr.'s father. Before moving forward with a review of John Jr.'s case, a review of Susan and John Sr.'s history is necessary.

Susan's History

Susan's history prior to John's birth was hardly promising. She had lost custody of all five of her older children: Mark Matthews (DOB: 7/90); Donald Matthews (DOB: 4/93); Shawn Nelson (DOB: 8/95); David Matthews (DOB: 4/98); and Jack Matthews (DOB: 4/99). At various points in time, all five of these children were in the physical and/or legal custody of either their maternal grandmother or maternal aunt. Susan was unable to identify the father for most of the children. Susan had a longstanding drug habit that caused her to leave precipitously for varying periods of time, and her history of prostitution, incarceration, and homelessness made her children easy targets for abuse and neglect.

The Matthews "family" first came to the attention of the Division of Family Services ("DFS") on September 1, 1995, shortly after Susan gave birth to her third child, Shawn Nelson, Jr. Although her two oldest children were then five and two years of age, her extended family had apparently been able to provide enough parental support for Susan to avoid the attention of DFS. However, when Shawn was born prematurely, low birth weight, with a terminal illness transmitted by the mother and with indications of fetal alcohol syndrome, hospital staff were concerned about releasing him to Susan without an evaluation of her home and living situation. DFS was called. Thus began a ten-year saga of Delaware's child welfare system's involvement with Susan and her children.

By the time Jack, the fifth child, was born cocaine addicted and with a terminal illness transmitted by the mother in April of 1999, DFS had given up any hope of attempting to place a child with Susan Matthews, who had proven herself incapable of caring for or raising any of her other four children, let alone a new infant with numerous special needs. The Family Court granted custody of Jack to DFS in June 1999. After a long period of struggling to determine what the proper permanency goal should be for this child, custody of Jack was transferred from DFS to Susan's sister, Michelle Jones in October of 2000³. Just three months later, Susan gave birth to John Jr. In addition to the issues Susan's other children faced at birth, she had become involved with John Sr. – a man who had his own disturbing history.

John Sr.'s History

John Sr. first came to DFS's attention on March 29, 2000, when the DFS hotline received an urgent referral from the child welfare agency in another state, naming John Davis and his then wife, Tammy, as perpetrators. The child welfare agency advised DFS that while living in another state, Mr. Davis had intentionally broken the leg of his and Tammy's four-month old son, also named John Davis, Jr. For purposes of this report, we will refer to this John Davis, Jr. as Michael. The agency further advised that John Sr. had been convicted of a misdemeanor child abuse crime as a result of the broken leg⁴ and that he also had several Court-ordered conditions with which he had failed to comply. Further, the agency indicated that John Sr. and Tammy had taken Michael, fled the other state, and were believed to be in Delaware. Tammy had apparently moved to Delaware in March, and it was suspected that John Sr. was with her and the child. The agency noted that they believed Michael to be in danger. Upon making the referral, the other state immediately faxed its child protection records to Delaware DFS to assist them in evaluating the severity of the situation.

DFS was initially unsuccessful in locating Michael, Tammy, and John Sr., and still had not located them on April 5, 2000, when DFS received another call from the other state, this time from Michael's maternal grandmother. The caller expressed grave concern about Michael's safety and again noted that John Sr. was very violent, towards both Tammy and Michael.

Despite efforts by DFS's special investigator to locate the Davis family, they did not surface until May 9, 2000, when Hospital #1 made a hotline report alleging that John Sr. had brought Michael to the emergency room for a severe eye infection. The doctor noted that the eye infection was serious and that the child should have been brought in sooner for treatment. The doctor explained that while he was arranging an eye clinic exam for Michael, John Sr. had taken Michael and left the hospital, without treatment for his badly infected eye. Fortunately, the information that John Sr. had given the hospital was sufficient for DFS to locate him the next day.

³ At the time the Subcommittee reviewed this case, maternal grandmother had passed away and Michelle Jones was raising Susan's first five children. While it is beyond the scope of this review, the level of discord, domestic violence, abuse and neglect occurring in Michelle's home throughout the history of this case is beyond disturbing, and again raises the issue of the Court and DFS having and using historical information to make decisions about a child's safety.

⁴ It is not clear to the Subcommittee why such a serious injury to a 4 month old baby resulted in only a misdemeanor conviction.

When DFS found Michael on May 10, 2000, he was in the car with Tammy, John Sr., and Michael's paternal grandmother. Michael was wearing inadequate clothing (a onesie with a towel wrapped around him and no shoes) for the 50-degree weather, and he had a swollen, pussy, and severely infected eye. The Division of Family Services filed for and was granted emergency custody of Michael on May 11, 2000. Michael was treated at Hospital #2 for a severe eye infection (which had developed into a form of herpes), ringworm, and corrective surgery on his penis. In addition, he was diagnosed with failure to thrive, due to low weight for his age. Most notably, in addition to the healing leg fracture⁵, doctors also discovered a skull fracture. The skull fracture was determined to have occurred within the last three months, making it the result of a separate incident from the broken leg for which John Sr. had already been prosecuted. The case involving Michael was transferred to a DFS treatment worker on the basis of medical neglect.

While Michael's case is not the case under review by the Subcommittee, actions taken or not taken regarding John Sr.'s role in Michael's injuries are extremely relevant to the case involving John Jr., since a successful intervention with or prosecution of John Sr. could have changed the course of John Sr.'s actions and, at a minimum, would have given even stronger evidence to later caseworkers, police, prosecutors and the Family Court as to the level of abuse of which he was capable. Moreover, as the Bryan Martin independent panel review, the Dejah Foraker independent panel review, and the Federal Child and Family Services Review concluded, historical information is critical to the assessment of future risk. We therefore review the system's response to Michael's case.

The DFS treatment worker (referred hereafter as "DFS treatment worker #1" to protect identity) appears to have performed a thorough review of John Sr.'s history and quickly concluded that John Sr. should not have access to Michael. Despite repeated attempts by John Sr. to visit with Michael – and to get the treatment worker to give him information on where he might find Tammy who left him shortly after losing custody of Michael – the DFS caseworker was diligent and consistent in denying him the ability to do so. As a result, Michael was kept safe from John Sr., had the opportunity to heal from his injuries, and was ultimately placed in the legal custody of his aunt in another state.

Regarding law enforcement's role in the investigation of Michael's injuries, it is hard to describe the disturbing lack of investigative skills and interest displayed in this case. On May 11, 2000, this incident was reported to the Wilmington Police Department ("WPD"). Initially, a Patrolwoman responded and a misdemeanor endangering charge was filed against John Sr. on June 26, 2000 for failure to seek prompt medical treatment for Michael's eye. At some point, however, after the skull fracture was discovered, a twelve-year veteran Detective was assigned to the case.

⁵ The leg fracture provided some initial confusion to the Subcommittee as all witnesses and notes seemed to indicate this fracture was separate and apart from the initial injury which occurred in another state. In fact, the criminal investigation conducted by both Wilmington Police and the Department of Justice included the leg fracture, and the testimony of DFS indicated the belief that this was a different injury. However, upon Dr. DeJong's review of the medical records in this matter, it was learned that there was no new leg fracture. Instead, it was the healing fracture from the other state.

Despite his years of experience, the Detective candidly admitted that this was the first case he had ever investigated involving a child abuse victim. The case seems to have “fallen off the radar” for the Detective because his comfort level with this type of investigation was minimal and, according to the Detective, his caseload was unmanageable. Because he was aware that the child was in a foster home, and therefore presumably safe, the case was not a priority. The Detective did not conduct the first interview in the case until almost two weeks after the crime was reported, when the Detective interviewed a physician at Hospital #2. The Detective’s report indicated that the doctor referred to the femur fracture, a skull fracture, and failure to thrive, but it contained very little additional information or detail regarding the extent or cause of the injuries. It did note that this doctor was not certain when the skull fracture had occurred, although other medical records indicated that it had occurred within the past three months.

Following this interview with the Emergency Room doctor, the case sat for four months until the Detective conducted the next interview on September 5, 2000, with DFS treatment worker #1. Following that interview, the case sat for another 2½ months, when Tammy, the foster mother, and the current pediatrician were all interviewed. Shortly thereafter, on January 15, 2001, John Sr. – the person most likely to have caused the skull fracture to Michael – was interviewed. This interview occurred a full eight months after the initial report. The next and final action taken by the Detective occurred on April 9, 2001 when, according to the report, he met with the Deputy Attorney General (“DAG”) assigned to the case and the case was closed with no prosecution.

The handling of this criminal investigation is cause for concern on a number of levels. First, the lack of accurate record-keeping for a law enforcement agency is astounding. The Subcommittee notes it was very difficult to even develop a timeline of law enforcement’s involvement based on the Wilmington Police Department’s criminal reports since the reports have dates that are confusing and perhaps inaccurate. For example, the Supplemental Crime Report has interview dates that, according to the dates in the report, would not have occurred until *after* the report was submitted. Additionally, the date of the Supplemental Report is December 18, 2000, the Date Submitted for the report is October 19, 2000, and the report includes interviews that occurred anywhere between May 2000 and April 2001. In addition, although the Submitted Date for the Supplemental Crime Report was October 19, 2000, the *Initial* Crime Report was dated November 21, 2000 – one month *after* the Supplemental Crime Report and six months after the crime was reported. When asked about the Initial Crime Report being dated after the Supplemental Crime Report, the Detective stated very candidly that when he started the Supplemental Crime Report, it came to his attention that he had not completed an Initial Crime Report, so he believes he created one at that time.

In addition, the police reports were not on the specialized report form that is to be used by law enforcement when investigating a domestic incident. There are a number of reasons that use of the domestic incident report form is important in these cases, including the fact that use of such a form would have caused Tammy and John Sr. to be flagged in the Delaware Justice Information System (“DELJIS”) as having been part of a domestic incident – an indicator that could have been significant in later law enforcement responses to this case as well as to DFS and the Family Court in later involvement with John Sr.

Second, the timing of the interviews is disturbing, particularly given the seriousness of the injuries. It took two weeks from the time an infant was found to have a recently fractured skull before a single investigative interview was conducted. Four months passed before the second interview, and a full eight months before the final interview – with the person most likely to have caused the injuries – was completed. Although the Detective noted that the case was not a priority because Michael was in foster care and therefore no longer in danger from John Sr., this fails to take into account other reasons it is important for such an investigation to be pursued much more vigorously. First, there is simply a greater likelihood of successful prosecution if interviews are conducted and evidence is gathered closer to the time of the crime. Second, while the Detective was correct that Michael was safe, he had no way of knowing whether John Sr., who he felt was the most likely perpetrator, had access to other children that he might victimize. In fact, in January 2001, eight months after Michael’s injuries were discovered and during the long pendency of the investigation, John Jr. was born and, as will be discussed later, John Sr. became his primary caretaker.

Third, the quality of the investigation was poor. The report ultimately concludes that the case should be closed without prosecution because the injuries to Michael could have been accidental. The report stated that the skull fracture “was caused possibly by the child falling when not in the company of a parent,” and the case was classified as an “exceptional clearance.” Yet not a single aspect of a single interview the Detective conducted supports such a conclusion. Moreover, the medical records suggest the opposite. When questioned about the lack of evidence to justify the conclusion reached, the Detective reported that he recalled being confused by Michael’s various injuries – the skull fracture, medical neglect, healing femur fracture, and failure to thrive. The Detective ultimately decided that the report’s conclusion that the injuries could have been accidental was a conclusion that he had drawn on his own, not an opinion obtained from a medical professional who had reviewed or been involved in the case. The detective never did a full interview of a doctor regarding the injuries, nor did he consult with Dr. DeJong or any other child abuse expert. When he interviewed Tammy – the person who, along with John Sr., was most likely to know how the injuries to Michael had occurred – *he never asked the question*. The interview consisted of the Detective obtaining information about Tammy and John Sr.’s relationship as well as a brief explanation of the eye infection; there was no mention of the fractured skull or the previous broken leg, and the interview contained little information regarding the failure to treat the eye.

The Detective acknowledged that despite twelve years on the force, he had had *no* training in child abuse, nor does the Wilmington Police Department provide such training to their officers. Because WPD did not have a specialized unit for child abuse cases, the Detective reported that each officer got whatever case came to him or her, regardless of experience or training in that particular type of crime. The Subcommittee also was concerned that the Detective’s supervisor – the person responsible for recognizing when a detective is struggling or is not properly completing an investigation – did not recognize the problems with this investigation. Moreover, not only did the supervisor not intervene but he signed off on the Detective’s problematic reports.

The WPD’s lack of training and specialization in these complex cases is unfortunate and inexcusable – but nonetheless, we cannot let all the blame fall exclusively there. Most of the

Subcommittee members have no law enforcement training, but easily concluded that when investigating an injury that likely occurred while a child was with his parents, the parents should at some point actually be asked about the injury and that the questioning should take place less than six months after the crime occurs. The Subcommittee also easily concluded that where a professional is not an expert in a particular field, he or she should seek one out. Some things simply do not require training and are a matter of basic common sense.

While the Department of Justice (“DOJ”) attempted to fill in the gaps, the Subcommittee concluded that it also failed to take all of the necessary steps to prosecute John Sr. According to the DOJ, they conducted their own “investigation” of Michael’s injuries in order to determine whether felony prosecution was feasible. Once this case came to the attention of the DOJ, in the summer of 2000, the Deputy Attorney General (“DAG”) dropped the misdemeanor charges against John Sr., stating that she was doing so in order to bring felony charges against him. According to the DOJ, jurisdictional and other issues ultimately prevented the pursuit of the felony charges in this case. Given the limited information the DOJ had, the precise date of the injuries to the child could not be pinpointed and the criminal abuse could not be definitively said to have occurred in Delaware rather than during Michael’s prior residence in another state. The DOJ also believed it would have been difficult to prove that John Sr., and not Tammy, had abused Michael, because he had been in the care of *both* parents for the three months prior to discovery of the skull fracture. Based on these legal issues, the DOJ contends it was unable to pursue felony charges.

The DOJ failed to reinstate the misdemeanor endangering charges which did not suffer from the same potential legal challenges. Apparently the DAG who was working on the case switched units around the time that the DOJ determined that felony charges could not be pursued, and the reinstatement of the misdemeanor medical neglect charges completely fell through the cracks. The DOJ has no internal case tracking computer system which would have alerted superiors of this outstanding case, nor did the DAG ensure that the matter was passed on to someone else for prosecution. The result was that the misdemeanor charges were never recommenced, and therefore neither John Sr. nor Tammy were ever held accountable for the skull fracture, failure to thrive, or even the medical neglect arising from the eye infection. The DOJ also expressed prosecutorial frustration and concern in situations where two caretakers have care, custody and control of a child at the time the injuries occur. The Subcommittee shares this frustration and discussed a nationwide review of how various jurisdictions handle these matters.

The Subcommittee notes that although the DOJ conducted its own investigation and concluded that felony charges could not be pursued in this case, that does not mean that WPD’s failure to properly investigate this crime did not have an impact on the outcome. The legal hurdles to bringing the felony charges could have been eliminated if Tammy had cooperated with the investigation. According to the testimony from the DOJ, Tammy was interviewed by the DAG but refused to cooperate. The fact remains that Deputy Attorneys General are not the primary people who are trained to obtain information from witnesses as part of a criminal investigation – law enforcement officers are. During the course of this investigation, Tammy had left John Sr., returned to the state where her family lived, and was trying to deal with the pending charges against her in Delaware as well as the birth of another child. Tammy was also in contact with DFS to discuss Michael several times, and had indicated that she wanted to

“make things right” for Michael and her new infant. In short, Tammy had a number of reasons to cooperate with the investigation, and she should have been interviewed by a detective trained to do so. Conversely, however, the DOJ is quite skilled in how child abuse cases are investigated, and could have provided some guidance and expertise to the Detective in this matter.

Overall, there was a lack of communication regarding Michael’s case between DOJ, WPD, and DFS. According to the DOJ, they never received a single report or document from WPD regarding this case, nor could the DOJ even corroborate the Detective’s statement that he discussed the case with the DOJ DAG prior to closing it. The DFS treatment worker #1 noted (specifically with regard to this case and in general) difficulty getting information from the WPD and the DOJ regarding the prosecution of cases. Although on September 27, 2000, the DOJ had informed the DFS caseworker that it was dismissing the misdemeanor charge in order to pursue felony charges for the skull fracture, all of the sources in this case agree that no one at either the DOJ or the WPD ever advised the DFS treatment worker of the ultimate decision not to bring the felony charges. As far as DFS treatment worker #1 knew, the WPD’s investigation was ongoing and regular coordination and communication between the police and the DOJ was occurring. Had DFS been aware of the reasons for not prosecuting John Sr., the information could have been entered into FACTS (DFS’s computer system) and available to social workers in the future. The communication may also have resulted in further questioning about reinstatement of the original misdemeanor charge. DFS treatment worker #1 eventually “gave up” on the Wilmington Police Department and the DOJ because neither kept her advised of the status of the case, and because it was her experience that this routinely occurred. Fortunately, this DFS treatment worker had already recognized that John Sr. was a risk to children even in the absence of any prosecution. Multi-disciplinary collaboration among DFS, WPD and DOJ in this case would have revealed that according to the other state John Sr. posed a danger to children, especially given his confession as well as his lack of cooperation with the other state’s Division of Social Services.

Though she felt very strongly that no child was safe with John Sr., and that Michael should never be permitted to have contact with his father, the DFS treatment worker #1 had never met Susan Matthews or any of her children (or even knew or had reason to know of their existence). She also was not aware that John Sr. had yet another child -- this time with Susan -- a mother whose family was already well known to DFS.

John Jr. is Born

In January of 2001, in the midst of the investigation of Michael’s injuries, John Jr. was born to Susan. John Sr. was the alleged father. John Jr. was classified “high risk” at birth because of his mother’s terminal illness status and lack of compliance with her terminal illness treatment during pregnancy. Due to the Division of Public Health’s (“Public Health”) extensive prior involvement with Susan, they phoned in a report to the DFS hotline. DFS rejected the report. It is not known why a report was not made directly by Hospital #3. The hotline disposition note rejecting the Public Health referral focused solely on Susan and stated “[w]hile mom’s history is quite concerning, we really have no reason to investigate her with this child.”

The Subcommittee has two concerns regarding this conclusion. First, it is disturbing that Susan's history of drug use and failure to care for her first five children did not provide enough reason for DFS to at least perform an investigation to ascertain whether Susan's known drug habit had been addressed before permitting her to take this child home. Second, the hotline did not link the case to John Sr., who had an active case regarding Michael at that time. Since John Sr. was listed as John Jr.'s father, his name should have been processed when the report was made. Such a link would have alerted the hotline worker to John Sr.'s recent and severe history of child abuse, hopefully leading to a different response to the report. It would have also led to some connection with the DFS treatment worker in Michael's case. Such a connection would have given the worker the opportunity to make the hotline aware of her many concerns regarding John Sr., and may have given the hotline worker a different perspective on the case. John Jr. should never have been sent home with John Sr. and Susan – and certainly not without a significant amount of intervention, treatment, and oversight. A demonstration to the Subcommittee of the FACTS system evidenced the ease with which this information can be acquired if someone searches for it.

Public Health proceeded to provide services to the family, but those services were limited to transportation to medical appointments and were met with frequent hostility by Susan. For example, according to the Public Health notes at one point when they communicated to Susan their concerns regarding her failure to attend medical appointments for John Jr., Susan simply responded by saying "I don't care if you call DFS – you think they're going to do anything because you say I don't take him to the doctor's?" During the time that Public Health worked with Susan, the public health worker was never permitted access to the various homes the child was living in, and was never able to provide any parenting support or direction in a home-like setting. It was clear to the Subcommittee that Public Health struggles in determining the level of neglect that would warrant a report to the DFS hotline. This struggle intensifies when a report like the one described above is made and rejected. In this case, Public Health struggled in determining the level of neglect since the client was often hostile and not at home.

Susan and John Sr. had John Jr. in their care and custody throughout 2001, despite missed doctors' appointments and evidence of significant domestic violence in the home. Relevant incidents that occurred during that time -- and that DFS was not made aware of -- include the following:

- On May 29, 2001, Susan appeared at Family Court and filed for a Protection from Abuse Order ("PFA"). In that petition, Susan alleged that John Sr. was a very abusive man, that he had been physically abusive to her on a number of occasions, that he had hit her while she was holding John Jr., and that John Sr. currently had physical custody of John Jr. and was keeping him from her. She also alleged that John Sr. was not John Jr.'s father. The PFA was granted by default on June 15, 2001⁶. It awarded custody of John Jr. to Susan and prohibited contact between John Sr. and John Jr. for a period of one year.
- On June 1, 2001, Susan appeared at Hospital #2's Emergency Room with John Jr., indicating that she wanted John Jr. checked out because he had been in his father's

⁶ On that same day Susan filed to vacate the PFA, apparently without success.

care for a period of time and she was concerned that John Sr. had abused him. She also alleged that John Sr. had abused her. Hospital #2 called the DFS hotline inquiring whether there was an active case for these individuals. The hospital was advised that there was not an active case. To the contrary, DFS treatment worker #1's treatment case regarding John Sr. and Michael was still active, but again not discovered.

- On July 28, 2001, Mother went to the Hospital #3 with a broken hand, which she claimed was the result of her defending herself against another assault by John Sr. There is no indication of any referral made to law enforcement or DFS regarding this incident.
- On December 8, 2001, Susan appeared at the Hospital #1 Emergency Room again following a domestic violence incident with John Sr. Susan had reported to the Emergency Room seeking help and refuge from John Sr. While the nurse was making arrangements for Susan and John Jr. to go to a battered women's shelter, John Sr. barged into the examining room and began to argue with Susan. At one point John Sr. grabbed Susan and scratched her on the neck. He then attempted to punch Susan while she held John Jr., but punched John Jr. in the cheek instead. The hospital called WPD and, according to their report, noted "3 scratches approximately 2½ inches long to the back of [Susan's] neck and also notices a small red spot to the right cheek of [John Jr.]." Susan was transported to a shelter. The Department of Justice indicates the charges were dismissed; however, at the time this report was completed, no additional information was available.⁷

What is most significant regarding all of these incidents – three of which involved John Jr. directly – is that DFS was not contacted for any of them, nor was DFS aware that they had occurred. The WPD report from the December 8, 2001 incident notes that the case was not active with DFS. This, of course, is incorrect, as John Sr. was active with DFS, and again the worker on John Sr.'s active case was not made aware that John Sr. had another child that was in his physical custody. But more important, regardless of whether a case was active or not, this incident – in which the perpetrator was bold enough to follow one victim to the hospital and abuse her and a second victim, John Jr., in the emergency room – should have been a clear signal of the danger that Susan and John Jr. were in – yet neither the Hospital #1 nor the WPD bothered to call the DFS hotline. In addition, the fact that at this point John Sr. had an active PFA against him – a PFA that prohibited him from even having contact with John Jr. – seems to have escaped notice despite the fact that PFAs are available on DELJIS so as to be easily accessible to law enforcement when responding to any domestic incident.

John Jr.'s Case is Investigated

⁷ The DFS records indicate that John Sr. was taken into custody on December 23, 2002, for resisting arrest and an outstanding warrant on the December 8, 2001, incident.

Finally, on October 25, 2002⁸, the hotline received and accepted a referral from John Sr. alleging physical neglect of John Jr. by Susan. At the time, Susan had been missing for over two weeks and was thought to be on a crack binge. She was also pregnant by John Sr. and had missed all prenatal appointments. John Sr. was unemployed, living with Susan's uncle, and staying home with John Jr. in Susan's absence. The hotline report noted that based on a review of CYCIS (DFS' old computer system) and FACTS, John Sr. had broken another child's leg; it also listed him as a perpetrator in this investigation. Classifying someone as a perpetrator is solely discretionary by the hotline worker and hotline supervisor based upon their assessment of the risk factors from the hotline report. This appears to be the first time that anyone noticed that John Jr.'s father and, at this point primary custodian, was the same man who had seriously abused his other son Michael just two years earlier. The case was classified as routine and assigned to a DFS investigation worker.

According to DFS procedures, a routine investigation requires a response within ten days. The DFS investigation worker first attempted a home visit with John Sr. on November 4, 2002 – exactly ten days after the report. This attempt was unsuccessful. Although she made additional attempts, she still had not established contact with Susan or John Sr. when, on November 14, 2002, twenty days after the first hotline call, the hotline received a second referral regarding John Jr. The caller this time was Susan alleging physical neglect by John Sr. Susan claimed that the house where John Sr. was staying with John Jr. had no electricity, that John Sr. had a bad temper, that he had broken his other child's leg, that she had obtained a PFA against him, and that he had been abusive to her and caused her to drop John Jr. during a fight. Susan also alleged that John Sr. was not John Jr.'s father and stated that she had left home because of "a little drug addiction." This urgent report required a 24-hour response.⁹ Notwithstanding the requirement, DFS investigation worker #1 was unable to meet with John Sr. despite unannounced home visits and phone calls until November 18, 2002 when she had her one and only visit with John Sr.

Prior to this meeting with John Sr., DFS investigation worker #1 had obtained the following information. She had spoken with DFS treatment worker #1 regarding John Sr. Her notes state that based on this conversation, she learned that John Sr. had an "abuse issue" in another state regarding a child by another woman. The notes also said that John Sr. had not complied with the orders entered in the other state as a result of the abuse and that DFS treatment worker #1 felt "that he has anger issues and ... could be a threat to a child." DFS investigation worker #1 also had John Sr.'s criminal history checked via the National Crime Information Center ("NCIC"), through which she learned of the criminal conviction in that state. However, at no time did this investigation worker review the child protective agency records from the other state which would have been critical for proper risk assessment and history review of John Sr.

⁸ Just 5 days later, on October 30, 2002, DFS treatment worker #1 would appear in Family Court supporting the relative custody petition regarding Michael and receive an order prohibiting all contact between John Sr. and Michael.

⁹ DFS investigation worker #1 had already missed the 10-day contact deadline for routine responses, taking more than 20 days and another hotline referral to connect with John Sr. She also missed the urgent response deadline of 24 hours, taking four additional days before connecting with John Sr. Regardless, she felt she had met the applicable deadlines by making attempts within the proper time frame, because diligent efforts satisfy the requirements. At no time did this investigation worker perceive that her inability to reach John Sr. was a deliberate effort by him to avoid the authorities nor did she enlist the help of second shift or the weekend unit to help meet the contact schedule.

who had already confessed to that state's social services system that he had fractured Michael's leg.

According to DFS investigation worker #1's testimony and the DFS records, this visit was the one and only time she met with John Sr. or John Jr. during her investigation. Unfortunately, she was easily fooled by John Sr., who by now had become quite savvy in his involvement with child welfare authorities. DFS investigation worker #1 believed that John Sr. was "very involved with taking care of this child," "very concerned about Susan and her situation," and was making efforts to obtain services to care for this child. Her testimony before the Subcommittee indicated that since John Sr. represented that he was "working on" daycare and a Medicaid card, had kept medical appointments and had a clean house, the placement was appropriate. Her notes from the meeting state that "he did have an incident in [another state] and there is a no contact order for his other two children that are placed there... he knows that he [will] have to get the parenting and anger mgt programs done – he is all for doing it and will cooperate when he gets stable with his job and day care ...". The notes further state that John Sr. "recognizes that DFS is concerned about risks that could occur as he has past issues [with] his other children. However, he denies that he is a threat at this time and denies that he has any problems with his child." No mention of the fact that John Sr. may not be the father was ever made.¹⁰ Approximately one month after this meeting – after a short telephone conversation with Susan and a brief discussion with Susan's probation officer, the investigation was completed and the case was transferred to treatment. Although the Risk Assessment completed by investigation worker #1 at the end of the investigation referred to a couple of other collateral contacts, there was no documentation of any such contacts in the case notes.

This investigation fell short in a multitude of ways – some related to a lack of information, but most due to poor decision making and diminishment of information that was not consistent with the investigation worker's personal view of John Sr. and the case. DFS Investigation worker #1 knew of John Sr.'s abuse of Michael from a number of sources: it was noted in the hotline report she received; she had obtained the criminal conviction information through NCIC; she had discussed the case with DFS treatment worker #1; and Susan had reported it in her hotline call. Yet this worker still disavowed knowing the seriousness of the prior abuse. Regarding the notes in the hotline report – which, based on a review of FACTS and CYCIS, said, "Fa broke his other son's leg on 12/13/99. He was convicted of that in [another state]. Then, he and mo and children fled to DE" – DFS investigation worker #1 said that a worker cannot rely on the information in the hotline reports because it is often not accurate. Regarding the discussion with DFS treatment worker #1, this worker told the Subcommittee that she did not believe that she had been made aware that John Sr. was "violent," and she felt that the treatment worker had not had enough interaction with John Sr. to offer much guidance.¹¹ Regarding the criminal conviction, she did not feel this was particularly relevant since it had only resulted in a misdemeanor conviction, and she noted her view that parents are convicted of

¹⁰ Paternity testing conducted after John Jr. entered DFS custody indicated that John Sr. is not the father of John Jr. but is the father of Scott (sibling of John Jr.).

¹¹ While the word "violent" is not found, even DFS investigation worker #1's notes of her conversation with DFS treatment worker #1 do indicate that the treatment worker told her she believed John Sr. could be a danger to John Jr. Also interesting is the investigation worker's comments that the treatment worker had not had enough contact with John Sr. to "offer much guidance," given that investigation worker #1 formulated her "opinion and conclusions" in this case from one meeting with John Sr.

misdemeanors for simply disciplining their children. Regarding the call from Susan that also referenced Michael's broken leg and other abuse by John Sr., DFS investigation worker #1 completely discounted it, despite the fact that some of the information corroborated statements from others, especially from DFS treatment worker #1. This worker simply stated "look at the source" and "Mom has her own issues." Overall, the mounting reports of John Sr.'s violence should have been an obvious warning sign that John Jr. was in danger, but this investigation worker was simply not listening.

The Subcommittee concluded that, even if DFS investigation worker #1 did not believe it wise to give much credence to any of the information she was given, at a minimum the allegations surrounding John Sr. should have caused her to perform a more detailed investigation. Regarding the criminal conviction, while the subcommittee disagrees with DFS investigation worker #1's opinion that parents regularly get criminal convictions based on simply disciplining a child, it does agree with the underlying premise that a caseworker cannot rely on a criminal conviction to determine what happened in a particular case – rather, a conviction should be viewed as a red flag that additional investigation is needed. DFS investigation worker #1 did not take steps to become informed about this serious allegation regarding John Sr. having broken Michael's leg just two years prior and having failed to comply with any of the requirements that came with that conviction.

Regarding Susan's call, while the Subcommittee agrees that Susan's actions may not have made her the most reliable reporter, the report should have been investigated – particularly those allegations that were easily verifiable, such as the domestic violence history and the fact that a PFA order had been granted in June of 2001. Although the PFA order had expired by this time, it would have given insight into the fact that the Court found against John Sr. regarding the abuse of Susan and John Jr., that John Sr. had lost custody of John Jr. under the PFA order, and that John Sr. had been prohibited from having any contact with John Jr. for one year. Moreover, the other sources tended to give Susan's claims more credibility.

In fact, despite what DFS investigation worker #1's impressions may have been from DFS treatment worker #1, Susan, the hotline report, and the criminal conviction, as an investigator it was this worker's responsibility to review the previous *founded* material from the other state's social service agency, but she failed to do this as well. A review of this information would have told her that John Sr. was not just accused of having broken Michael's leg, he had *confessed to it* (albeit after a period of claiming he had only been trying to catch Michael when Michael started to roll off of the bed). Equally important, this history would have shown John Sr. to be extremely effective at appearing to be a caring father when in fact he was a violent abuser.

In addition to the information she had regarding Michael's broken leg, DFS investigation worker #1 also had the history of the Delaware investigation regarding Michael, in which John Sr. was founded for neglect. This investigation worker was aware of this previous case, but felt that it was not relevant to the current incident and allegation of neglect. DFS's own records showed a failure to treat a serious and painful eye infection, a diagnosis of failure to thrive, a diagnosis of ringworm, a suspicious skull fracture and a healing leg fracture, all while in John Sr.'s care. Regarding this history, the worker simply stated, "We have to deal with what is going on at the time, not the history," and she was "doing it based on the current situation." When

questioned about the report that John Sr. had not cooperated with DFS's plan for Michael, her only response was that "it raises concerns."

Even assuming DFS investigation worker #1's position that this matter should be viewed as incident based, her progress notes show no evidence to confirm daycare, medical care, Medicaid, job status, etc. The narrative of her risk assessment appears to indicate that the previous DFS treatment worker (#1), primary care physician and Susan's probation officer were used as collateral contacts. Moreover, during the course of the investigation, this investigation worker was presented with evidence that Susan had returned to the home, yet she never followed up on this information. She also relied, albeit without meeting any of them, on John Sr.'s support system as a positive. This support system allegedly included paternal grandmother, who had assisted in eluding DFS and the police in the search for Michael, and Susan's uncle Jimmy, who was a known drug addict. In short, the only personal contact DFS investigation worker #1 had with anyone in the almost two months she had this case was John Sr., and the only other documented contacts made were via phone with Susan and Susan's probation officer.

Over and over again, DFS investigation worker #1 was provided with information regarding John Sr. having been abusive, and over and over she refused to take note of the information, relying instead on her view that what is relevant is "what is going on at the time." The point that seemed lost in this investigation is that what is "going on at the time" can best be seen with a complete knowledge and consideration of the case history. What the Subcommittee finds particularly disturbing is *not* the lack of information that this investigation worker had, but rather sheer volume of information she *did* have and her refusal to use that information to make decisions in this case. It is clear that no amount of historic information would have led this investigation worker to remove John Jr. from John Sr.'s custody – she stated as much in her interview. Although she initially said that the conviction from the other state did not cause her to remove John Jr. because it was only a misdemeanor, when later questioned about whether a felony level conviction would have changed her actions she said it probably would not have. Because she saw no current signs of abuse or neglect from John Sr., she did not consider the severe prior abuse of another child a portent of danger, discounted the warnings from DFS treatment worker #1 and the referral from Susan, was readily misled by John Sr.'s ostensible concern, and allowed the child to remain in the care of the man who would ultimately injure him so severely that he almost died.

DFS investigation worker #1's refusal to take note of anything other than her narrow view of John Sr. and Susan continued to the end of her investigation. On December 18, 2002 – approximately two months after receiving the case – the case was transferred to treatment with Susan founded for physical neglect. Prior to transferring a case to treatment, the investigator is to complete a DFS Risk Assessment which, according to DFS's policy manual, is used "to determine the possibility of future harm." As with other risk assessment tools, the DFS Risk Assessment prompts the worker to provide information, and then takes that information and performs an objective measurement of the risk present. In this case, when she provided the information required the Risk Assessment concluded that there was an "obvious likelihood that the child will be maltreated requiring immediate and comprehensive response. Conditions are extreme, control must certainly be imposed ...". Despite this dire report, John Jr. was not removed from the home, nor was a safety plan developed as per DFS Policy. When questioned

as to why she did not take the action suggested by the risk assessment, DFS investigation worker #1 shared her view that the risk assessment is useless and largely ignored at least in cases where one caregiver is not living with the child.

During DFS investigation worker #1's handling of this case, her caseload varied every two weeks as follows: 20, 23, 18, 14. The maximum number of cases for investigation caseworkers as established by the Child Welfare League of America, which has been adopted as the standard in Delaware, is 14. The worker insisted, however, that her caseload had no impact on her casework in this matter as "she always does a thorough job and knows what . . . is going on with her cases."

In addition to completing the "scored" portion of the Risk Assessment, DFS investigation worker #1 was also required to complete a few narratives regarding the case before it was transferred to treatment. Although the narratives regarding John Sr. were largely complimentary, they did note "[concern] is that dad has prior physical abuse case against him and he has [not] complied fully with court [ordered] services in order to get visits back with his other child[ren]. He was charged and pled to assault of another child causing broken bones and severe eye infection. He fled the other state when this all was occurring. He recently had case open for services and did not comply." The Subcommittee notes that although DFS investigation worker #1 noted the broken bones in her risk assessment, she seemed to indicate during the Subcommittee review that she was not aware of the extent of the injury in the other state. Again she stated that she only knew that he was convicted of a misdemeanor and that parents are convicted of misdemeanors for simply disciplining their children.

In addition to the Risk Assessment, an Investigation Disposition Assessment was completed by the investigation supervisor. This assessment expressed less concern regarding John Sr., stating only that "John Davis also has a DFS [history] which presents risk and need for further DFS intervention" and "Mr. Davis could benefit from a parent aide and anger management classes." This Assessment was short – only 6 or 7 statements long – and the above statements were the only mention of John Sr.

Interestingly, one of the stated bases for founding Susan for neglect was that Susan had left the child with John Sr., knowing that he had an unresolved history of abuse. Specifically, DFS investigation worker #1's risk assessment narrative stated, "case founded for neglect/physical to child by mom due to her drug abuse and non ability to care for child when she is running the streets etc. – and her leaving baby assuming that child will be safe with the father whom has past abuse case that has been unresolved." The Subcommittee finds it troubling that John Sr.'s abuse history was enough of a concern for Susan to be founded for neglect because she left John Jr. in his care, yet the history was not sufficient concern for DFS to remove the child from this situation. So in fact, the caseworker did exactly what she had founded Susan for – she left John Jr. with a man who had an unresolved history of abuse. At this point, John Sr. had broken Michael's leg, failed to provide treatment for a severe eye infection, had custody of Michael during an unexplained skull fracture, failed to cooperate with the investigation, had numerous domestic violence incidents, including several in which John Jr. was the victim, and had a PFA order entered against him. All of these incidents were recent and no intervention had been provided. In short, by this time it was clear in no uncertain terms that John Sr. was a

violent man to his partners and to his children and yet he was permitted to be the sole custodian of this baby while Susan was founded for her neglect.

John Jr.'s Case is Transferred to Treatment

When DFS treatment worker #2 was assigned John Jr.'s case on December 19, 2002, she reviewed the short Investigation Disposition Assessment completed by the investigation supervisor. As noted above, this document was very short and contained only two sentences regarding John Sr. She reported that she did not review the Risk Assessment completed by DFS investigation worker #1 or the case history. The Subcommittee interviewed the DFS Treatment Program Administrator who stated that the Risk Assessment is an important tool for treatment workers, and treatment workers rely on investigation workers to complete the history review and include it in the Risk Assessment.

Although DFS treatment worker #2 claims to have done a FACTS search on John Sr., she states that nothing came up under John Sr.'s name. She believed she had no access to DELJIS¹² for PFA information, and further felt that there was no reason to check DELJIS because the PFA and other relevant information should have been in the investigation disposition assessment. As a result, the broken leg and accompanying conviction in the other state, the history of John Sr. and Tammy contained within the DFS FACTS database, the hotline reports, the PFA order, and the warnings from DFS treatment worker #1 all escaped DFS treatment worker #2's notice. Based on the very limited information in the Investigation Disposition Assessment, this treatment worker concluded that Susan's history of drug abuse, prostitution, and other children not in her care made Susan her sole basis for concern. In contrast, John Sr.'s history was not considered remarkable or significant. This treatment worker stated that her only concern about John Sr. was her belief that he "needed some support."

DFS policy requires the treatment worker to complete a family safety assessment within ten days of receiving a case. DFS treatment worker #2's first attempted contact with the family, however, was nineteen days later on January 7, 2003. The next attempt occurred fifteen days after the first late and unsuccessful attempt, on January 22, 2003. Five days later, DFS treatment worker #2 sent a letter to John Sr. requesting a meeting. These were the only attempts this treatment worker made to meet with John Sr. until February 24, 2003 when she met John Sr. at the hospital while responding to a new hotline report based on Susan having given birth to her seventh child Scott. DFS treatment worker #2's first contact with John Sr. – which took place only because of the hotline report regarding Scott – therefore occurred more than two months after she received the case, and 50 days after the time required by DFS policy.

We now turn briefly to Scott. Susan actually gave birth to Scott at home, where he had to be resuscitated by paramedics. He was admitted to the hospital in hypovolemic shock with

¹² DFS access to this system was authorized following the Independent Death Panel recommendations in the Bryan Martin matter and the Child Protection Act of 1997. At this time, Master Family Service Specialists and Family Crisis Therapists in Investigation, Special Investigators, Supervisors, hotline staff and designated clerical staff all have access to DELJIS. However, all treatment workers and Family Service Specialists and Senior Family Service Specialists in investigations must access this information through authorized DFS users.

subdural and cerebral hemorrhages and he tested positive for cocaine. Despite both Susan and Scott testing positive for cocaine at birth, Susan denied any recent cocaine use. Scott's case was abridged in investigation and assigned directly to DFS treatment worker #2.

On March 3, 2003, DFS treatment worker #2 was informed that Scott was ready to be discharged from the hospital. She met with John Sr. and his mother, noting that Susan was back in jail. DFS treatment worker #2 felt comfortable placing Scott with his father and paternal grandmother and advised that she planned to refer John Sr. to a parent aid and public health nurse. Although the High Risk Infant Protocol Memorandum of Understanding ("High Risk Infant MOU") required that a discharge meeting – a meeting between DFS, Public Health, and the hospital – take place in this case none occurred. During her interview, DFS treatment worker #2 claimed to be unaware of the requirement of this High Risk Infant MOU. DFS points out that while the High Risk MOU had been signed at the time of Scott's birth, training of DFS workers on the protocol did not occur until March of 2003. DFS treatment worker #2 never reviewed or considered any history regarding John Sr. or paternal grandmother's prior attempts to evade DFS.

Following Scott's release, John Sr. appeared to DFS treatment worker #2 to be responsibly caring for Scott. He had obtained medical care and medication and was receptive to home visits by the Public Health Nurse who reported that he was doing well with the baby. On April 9, 2003, however, DFS treatment worker #2 learned that Scott had been admitted to Hospital #2 with a laceration to his nose which required stitches. John Sr. claimed that the "scratch" was self-inflicted. The doctors, however, concluded that the cut on Scott's nose had been inflicted, and definitely was not a "scratch." Further examination of the child revealed an old brain injury and a skull fracture as well as unexplained intra-cranial bleeding. While it was noted that the brain injury and skull fracture could possibly have occurred during birth, the intra-cranial bleed was recent and the cause was unknown. According to the treatment notes, DFS treatment worker #2 was informed by the hospital social worker that this was all "very suspicious." Her notes also indicate further discussion with the social worker about whether the hospital social worker had concerns of abuse or neglect, with the DFS treatment worker personally indicating that she "has not seen anything to that effect." The hospital social worker indicated that she was "torn over what to do" because John Sr. did appear to be appropriately caring for Scott. Although the hospital social worker stated that "all of this stuff may be accidental," her earlier caution about the case being "suspicious" remained. On April 16, 2003, DFS treatment worker #2 again spoke with the hospital social worker, who again noted that the nose injury was still suspicious and was being documented as "inflicted wound/source unknown." She also noted that the "recent intracranial bleed is still unclear."

Unfortunately, DFS treatment worker #2 independently attributed all of Scott's injuries to Susan's drug abuse or birth trauma, without any discussion with Dr. DeJong, a child abuse expert, and in contradiction to what the medical records showed and the hospital social worker indicated. DFS treatment worker #2 is the only DFS person to have had contact with the hospital social worker. Like DFS investigation worker #1, DFS treatment worker #2 had become so focused on Susan and her problems that she was readily convinced by John Sr.'s outward shows of concern, and did not suspect him as a possible abuser despite the mounting evidence to the contrary. Moreover, DFS treatment worker #2 did not report these suspicious injuries to the

hotline, despite DFS policy requiring her to make such a report to both the hotline and the police. She also failed to complete a serious injury report, as required by DFS policy. Again, DFS treatment worker #2, an employee of DFS for nearly eighteen months at this point, was unaware that such a report was required. This report would have alerted upper administration at DFS of this case. Instead, Scott was released a few days later to both Susan and John Sr. without further investigation – and once again, an unresolved injury to a child went virtually uninvestigated.

We turn back now to John Jr. As was noted above, DFS treatment worker #2's first contact with John Sr. after receiving John Jr.'s case was at the hospital when she responded to the call regarding Scott's birth (more than two months after being assigned the case). Her first noted discussion with John Sr. regarding John Jr. did not occur until several more days had passed when, on March 3, 2003, while meeting with John Sr. regarding Scott this treatment worker asked John Sr. about John Jr. She learned for the first time that John Jr. was not living with John Sr. Rather, according to John Sr., he was living with Susan's sister, Michelle Jones (the relative who had custody of Susan's other five children). This information should have prompted a couple of responses from DFS treatment worker #2. First, it should have raised some level of concern as to what had prompted a change in the living arrangements for this child. Second, according to DFS policy *and* common sense, it should have prompted a visit and assessment of Ms. Jones's home, to ensure that John Jr. was where John Sr. reported him to be and that he was receiving adequate care. DFS treatment worker #2 did nothing regarding this information.

Regarding any possible concern over the reason for the change of placement, DFS treatment worker #2's notes state that John Sr. "was not clear on explaining why John Jr. was not living with him any longer." Apparently this lack of clarity did not cause her concern, because she did not conduct any follow-up on the issue. Regarding the appropriateness of John Jr.'s current placement, DFS treatment worker #2 told the Subcommittee she was not concerned about this *de facto* placement since Ms. Jones already had Susan's five other children in her care. The Subcommittee notes that this was the sixth child of Susan's to be placed with Ms. Jones, and that there was a significant criminal (and DFS) record of domestic violence incidents at Ms. Jones's home including the following:

- On 1/25/99, a police report involving Michelle Jones and her paramour was filed. The report states that paramour pushed Michelle and threatened to kill her. Witnesses listed include David Matthews and Shawn Nelson, two of Susan's children that had already been placed with Michelle.
- On 10/18/99, another police report of a domestic incident involving Michelle and her paramour was filed. The report states that Michelle suffered a contusion after her paramour struck her in the face. Shawn Nelson and David Matthews are again listed as witnesses. The report states that paramour threatened to shoot Michelle if she left him two weeks ago, is cocaine involved, is very jealous and had told Michelle that if he could not have her, no one will. Michelle reported that her paramour dragged her by her hair and repeatedly punched her in the face. The officer responding noted overturned furniture and the telephone had been broken into pieces.

- On 4/19/00, a DFS social worker considering Michelle as a placement for Jack (one of Susan's children) spoke with the leasing office of Michelle's apartment complex. The office confirmed that the police have been out several times for domestic violence in Michelle's home. They also reported that other residents have seen paramour beat Michelle in the hallway, that he uses drugs, and that Michelle has come into the office with bruises on her, screaming that she wants the locks changed so that her paramour cannot get in to the apartment.

Further, DFS records showed serious concern about whether Susan's five other children should have been placed with Ms. Jones – so a sixth child certainly seemed to be pushing the limits. A review of DFS records regarding the placement would have revealed this information. A physical review of the home and a meeting with Michelle might also have been helpful, particularly in shedding light on John Sr.'s care for John Jr. and what led to the change in placement. DFS treatment worker #2 was once again challenged by lack of knowledge of the DFS treatment policies, this time being totally unaware that a policy required her to visit any new placement of a child with an open treatment case. Moreover, even after consulting with her supervisor, this treatment worker did nothing to ascertain whether this was an appropriate placement for John Jr. The Subcommittee is aware that having more information about John Jr.'s placement with Ms. Jones would not necessarily have changed the outcome. The point however, is that over and over again, caseworkers ignored DFS procedures, case history, and good judgment at a time when John Jr. was so desperately in need of protection.

DFS treatment worker #2's notes regarding her March 3, 2003, discussion with John Sr. also indicate that she had learned from another source that John Jr. was not being taken for his doctor appointments. Although she asked John Sr. about this, he did not provide any information, saying he "did not have any info about this." The treatment notes go on to state that she would "do collateral and follow up w/medical info asap." The Subcommittee found nothing in the treatment worker's notes, however, to indicate that any such follow-up was done. When the Subcommittee asked DFS treatment worker #2 about the follow up that her notes seemed to indicate she recognized as important, she stated that she believed she asked a Family Service Assistant to look into it and she did not recall getting any report back.

The discussion of John Jr. next came up on March 11, 2003, when DFS treatment worker #2 accompanied John Sr. to a medical appointment for Scott. While she was at the hospital, the hospital terminal illness social worker informed DFS treatment worker #2 that John Jr. had missed his 18-month appointment for terminal illness testing and that they would like to see him. No further mention of John Jr. is made in the treatment notes, and this attempt by the hospital social worker to enlist DFS' assistance in getting John Jr. to his doctor's appointments went unheeded.

In late July 2003, John Jr. entered Hospital #3 Emergency Room at 3:50 a.m. with a lacerated lip. His front tooth had also been knocked out. John Sr. reported that the child had fallen and hit a bookcase at midnight. DFS treatment worker #2 was not notified by the hospital of this visit to the ER despite the family's extensive history with this particular hospital. Home visits with John Sr. and Scott were conducted in July and August of 2003.

On September 15, 2003, treatment worker #2 responded to the hospital after John Jr. was brought in to the ER close to death due to a lacerated liver suffered at the hands of John Sr. John Jr.'s hospitalization this time left no doubt that John Sr. was not the caring, loving parent he had pretended to be. The child had a liver laceration resulting from direct, strong force, such as a kick or a car accident. John Sr.'s explanation, that the child had had an upset stomach a few weeks ago, was not reasonable. DFS was alerted by an urgent referral to the hotline. A second shift social worker was dispatched to the hospital and met there by Wilmington Police officers. The officers advised that the child's injuries were so serious that he may not survive. When questioned, John Sr. explained that he had no idea how the child was hurt "unless he did something in his sleep."

Following emergency surgery – during which John Jr. went into cardiac arrest for the second time that day – his abdomen was too swollen to be sutured. The surgeons advised that the child's liver was transected from front to back, he had no blood pressure, and was comatose. He had endured a near-fatal loss of blood. The surgeons concluded that it took great force to cause the injury, characterizing it as similar to an unrestrained driver hitting a tree at 30 m.p.h. The doctors estimated that the injury had been inflicted a couple of hours before the onset of symptoms.

Other than one incidental sighting of John Jr. during a meeting with John Sr. – a sighting not documented in her case notes, but described during the Subcommittee interview – DFS treatment worker #2's response to the life-threatening hospitalization on September 15, 2003 was the first time she had laid eyes on the child she had been assigned to protect nine months earlier. While this lack of contact with John Jr. seems to defy common sense, policy documents and interviews indicate that policy does not require a treatment worker to specifically have contact with the children on their caseloads unless the children are in foster care – rather, the policy requires only that contact occur with the "family," leading DFS treatment worker #2 to the conclusion that simply meeting with John Sr. on a regular basis was sufficient.

As with the Wilmington Police Department, while the Subcommittee believes that DFS policy should *require* contact with children involved in an active investigation or treatment case, this is not just a policy issue – it should not take a more specific policy or more training for a caseworker to simply know that he or she must actually see the child who is the subject of his or her case. No evidence exists to suggest that DFS treatment worker #2's supervisor ever questioned the adequacy of her decisions or her investigative or treatment activities with respect to this family until John Jr. was admitted to the hospital in critical condition on September 15, 2003. Apparently at some point John Jr. had again been brought back to live with John Sr. – nothing in the case notes indicate this, and it does not appear that the treatment worker was aware of this fact, although she was aware that John Jr. spent some time visiting John Sr.'s house. September 15, 2003 was not only the first time DFS treatment worker #2 saw John Jr. – it was also the first time she became aware that John Sr. had a history of severely injuring another one of his children. This information came to her attention all too late for John Jr.

As a result of John Jr.'s injuries, DFS sought custody of both John Jr. and Scott. Scott was placed in foster care and an investigation case was assigned to DFS investigation worker #2 of the DFS Serious Injury Unit. The after-hours hotline worker who had responded to the

hospital advised DFS investigation worker #2 that John Sr.'s reaction to John Jr.'s injury had been "inappropriate," that he was emotionless, and that he questioned whether he would be arrested.

Despite DFS treatment worker #2's stated inability to locate Michael's case information in FACTS and DFS investigation worker #1's disregard of that case history, DFS investigation worker #2 – who works in the DFS serious injury unit – had no difficulty locating John Sr.'s history in a very short amount of time. DFS investigation worker #2 completed a safety assessment immediately after seeing the child because Wilmington Police were anxious to learn John Sr.'s history before interrogating him. In her FACTS check, this investigation worker easily uncovered John Sr.'s history of abuse in the other state and completed a thorough progress note setting out the entire history. DFS treatment worker #1 and her supervisor had read the newspaper report, recognized John Sr.'s name and picture, and also advised this investigation worker of the extensive history regarding John Sr. Investigation worker #2's notes, written on September 16, 2003, after a check of the FACTS history, stated as follows:

FA has 2 older children. MO of those children is Tammy Davis. Those children lived with MO and FA in [other state]. One of those children is also named John Davis, born in 1999. FA was arrested for breaking that child's legs. (Some notes indicate it was one leg.) FA had no contact with child and was court ordered to do anger management, community service, parenting and a mental health eval. Before completing any of this FA and MO fled to DE. [Other state] made a report to DE. After an extensive search MO and FA were located. Older child was suffering from a serious eye infection. . . . Older child was diagnosed with a herpes infection of the eye, failure to thrive and also had a healing skull fracture.

Investigation worker #2's notes of the case history go on to mention Susan's drug use, the unexplained injury to Scott, etc. She further documented that John Sr. was definitely a "con artist." The level of factual information laid out above is the minimum of what every DFS caseworker who handled this case should have known, without question – whether an investigator, a treatment worker, a supervisor, or a hotline worker responding to a call. DFS investigation worker #2 and DFS treatment worker #1 are to be commended for their competence and thoroughness in assessing risk and gathering pertinent information on an expedited basis.

The following day, John Sr. was arrested for Assault by Abuse or Neglect, a Class B Felony. He was prosecuted and pled to Assault 2nd. He was sentenced to 4 years of incarceration – a stark contrast to the near death injuries that John Jr. received and a sad reflection on the lack of seriousness our criminal justice system places on child abuse and neglect.

Findings and Recommendations

CHILD ABUSE/NEGLECT REPORTS

Several critical breakdowns relating to the reporting of child abuse and/or neglect occurred in this case. They fall into two main categories: (1) the failure of professionals (some within the child welfare system) to report child abuse and/or neglect; and (2) the DFS' failure to accept reports of child abuse and/or neglect made in this case.

Numerous incidents of child abuse and/or neglect regarding John Jr. and/or his siblings were not reported to the hotline. These include WPD involvement in several domestic violence incidents where a child was present and/or involved, hospital involvement in several domestic violence incidents where a child was present and/or involved, hospital involvement in the birth of a child who fell within the category of a high risk infant, Family Court's repeated involvement in custody and domestic violence hearings where the child was involved and/or the subject matter of the petition, and Public Health's chronic involvement with Susan rendering a heightened concern over her care of any child.

The second breakdown was the DFS Child Abuse Hotline's failure to accept reports that were made in this case. On two occasions, professionals called the DFS hotline regarding John Jr. On both occasions, hotline worker inquiries of the reporter and in the FACTS system appeared to be inadequate. As point in fact, during neither one of those contacts was the active treatment case regarding Michael discovered, and both professionals were specifically advised that DFS was not currently involved with the "family". The Child Protection Act of 1997 requires DFS to check its internal information system to determine whether previous reports have been made regarding the child, sibling, family members or the alleged perpetrator, and to share that information with Division staff. 16 Del. C. § 905(d). These calls came in during February and June of 2001. Michael's case was not closed until October of 2002. Just one of these checks if properly performed would have alerted treatment worker #1 of John Jr.'s existence and possibly saved him from his near fatal abuse.

Regardless of the difficulty in locating the active treatment case involving Michael, however, DFS already knew enough about Susan to have accepted these reports and conducted an investigation. Again, the individual hotline worker performed an incident-based call based upon previous school of thought regarding drug addiction and neglect. There is no risk assessment or formal decision making process for the acceptance and rejection of hotline reports. This results in safety assessments, FACTS checking and in-depth inquiries/fact gathering from the reporter to be solely dependent on the experience, attitude and opinions of the DFS hotline worker.

Last, but certainly not least, in 2003, as a result of another serious injury analysis, DFS implemented the High Risk Infant Protocol. This protocol requires DFS social workers, Public Health and health care professionals to have a meeting to develop a comprehensive discharge plan to ensure safety and support for high risk infants and their families. Discharge planning is

the main responsibility of the active DFS worker. This protocol was in place at the time of Scott's birth; however, training of DFS workers regarding this protocol did not occur until after Scott's release from the hospital. Even more troubling was the acknowledgement by both DFS and Public Health that this policy is currently rarely being used, despite the number of high risk infants born in Delaware each month.

The Child Protection Act of 1997 legislated training by DFS regarding the reporting of child abuse and/or neglect. 16 Del. C. § 911(a) and (b). It also requires DFS to continuously publicize the existence of the report line and the obligations of all to report child abuse and/or neglect. 16 Del. C. § 911(c). Neither the public nor those specifically listed as mandated reporters are receiving sufficient education and information pursuant to statute, and many are not following the statutory requirements to report child abuse and/or neglect.

As such, the following recommendations for compliance and/or change are made:

- 1. DFS should review its research on nationwide risk assessments and consider modifying or replacing its current structured decision-making tool at the hotline and during the investigation process. In the short term, protocols for acceptance of a case by the report line should be reviewed and improved to consider history.** Specifically, a compilation of risk factors such as low birth weight, previous DFS history, HIV positive, drug positive at birth, fetal alcohol syndrome, criminal history etc., should trigger an automatic acceptance of a case. Such tools and protocols will help to standardize DFS responses to reports of child abuse and/or neglect.
- 2. Training regarding the reporting of abuse and neglect as required by 16 Del. C. § 911 (a) and (b) should be implemented, with an annual training schedule being developed and widely distributed to the broader child welfare community and the public. Wide publication of the child abuse report line to the public and child welfare professionals should occur immediately as required by 16 Del. C. § 911(c).**
- 3. The Wilmington Police Department, Family Court and the local hospitals should ensure that their employees are aware of the mandatory reporting laws for suspected child abuse and/or neglect and the penalties for failure to report. 16 Del. C. §§ 903 and 914. With respect to the Wilmington Police Department, they should also review and ensure employee compliance with the reporting requirements under the Memorandum of Understanding between Law Enforcement, the DSCYF and the Department of Justice ("MOU").**
- 4. DFS should take steps to ensure that hotline and investigative staff request complete information on all parents, parties, and members of the child's household, and that FACTS checks on those individuals are completed and the results clearly conveyed to others within the Division, as required by 16 Del. C. § 905(d).**
- 5. The Division of Public Health should document problems they encounter with clients and meet periodically with DFS to get clarification on what to report to the hotline and the best way to report concerns to DFS.**

6. **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. Reporters should be contacted immediately by the investigation worker (16 Del. C. § 906(b)(13)) and provided with the outcome of the decision and/or the investigation. 16 Del. C. § 906(b)(16).**

7. **In conjunction with giving the highest degree of deference to reports made by professionals, including the Division of Public Health, the High Risk Infant Protocol should be reviewed, and all parties should make a renewed commitment to its use to ensure the safety of high risk newborns.**

8. **DFS should automatically accept for investigation all hotline reports on a newborn when a parent has lost custody of previous children due to abuse and/or neglect even without a new allegation of abuse or neglect so as to give the new baby the same protections that the other children have received.**

DIVISION OF FAMILY SERVICES

I. Caseloads/Workloads

The investigator in John Jr.'s case had weekly caseloads of 20, 23, 18, and 14 throughout her investigation of the case, while the standard adopted in Delaware law (29 Del. C. § 9015(b)) is 14. This standard is actually the maximum caseload established by the Child Welfare League of America and should not be exceeded, and it should certainly not be 20 or 23 at any time under any circumstances for any investigation worker. If the caseload of the workers is too high, then it is also too high for the supervisors.

A 2002 GAO Report concluded what Delaware and other states already knew: caseloads are the best predictor of a child protective agency's ability to protect the children in its care. Despite increased resources, the DFS continues to struggle to consistently keep its caseload numbers down in all regions. While Delaware law provides the DFS with the authority to hire up to 15 overhires in order to lessen the time between a worker leaving and another worker being prepared to step in, that pool is not being maintained – in fact, only a portion of the overhire positions – now referred to by the DFS as “trainees” – are ever filled. Even at the time of this review – held 1½ years after the injury to John Jr. – the investigator and her supervisor both indicated that on the day of her interview the caseworker was carrying a caseload of 23. In actuality, she had a caseload of 21. Regardless, the resultant workload from a caseload of 21 or 23 is exponential. This is simply unacceptable for an investigation worker.

While investigation worker #1 claimed that the high workload did not impact her handling of the case, she did not perform an adequate investigation. As was described in the Facts portion of this report, in addition to a refusal to consider some of the information that she obtained, there was also significant history information that investigation worker #1 did not access, most notably the other state's records regarding Michael's broken leg. If investigation

worker #1 had been more conscientious in studying the history of John Sr, as opposed to just Susan, she would have found more concrete cause for alarm. Thoroughly reviewing history takes an inordinate amount of time, but it must be done, and it is therefore critical that the worker's caseloads be kept at or below standard. And if the caseworkers are overburdened, so too are their supervisors, who are a second-tier safety net for at-risk children. Neither of these safeguards can operate effectively if the workloads are such that an employee has insufficient time to investigate and evaluate the families for whom they are responsible.

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

1. **The Division should immediately fill all 15 overhire (“trainee”) positions and keep those positions filled pursuant to 29 Del. C. § 9015(b)(4) so that fully trained staff are always available to fill vacancies.** While the Department has indicated that filling the over hire positions will not alleviate the high caseloads that they experience on a regular basis, the Subcommittee believes that a commitment to use of the overhire positions will assist in providing the needed resources when dealing with positions of high-turnover and burnout.
2. **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. The workers who were assigned to Susan were in for far more than what they bargained. Susan had seven children at the time of John Jr.’s injuries, all of whom were not in her custody, and most of whom had prior involvement with DFS. It is neither fair nor logical to equate her with a case involving only one child.
3. **DFS should seriously consider opening cases in the name of a child, and assigning workloads by children, not by family or parent.**
4. **Caseloads must be at or below the standard set for each worker. If not, CPAC should be alerted.**
5. **DFS should commence a comprehensive work study analysis to identify barriers to quality social work and provide short and long term solutions for a manageable workload for DFS social workers.**

II. DFS Hiring Practices and Supervision Issues

While previous panels have placed blame for poor caseworker decision-making on inadequate training, that does not seem to be the case here. The larger issue in this case was the lack of sound judgment and the lack of supervision illustrated by caseworkers and supervisors responsible, coupled in some instances with a refusal to consider any information inconsistent with their own imprudent opinions regarding John Sr.’s parental fitness. One social worker testified that, even if she had infinite time to review John Sr.’s history, virtually nothing would have convinced her to change the opinion she had formed by meeting him and noting his current actions. This mode of operation is completely unacceptable. Moreover, supervisors failed to intervene where it was clearly needed. In the case of one worker, the Subcommittee identified

no less than three critical policies that had been completely ignored -- policies that could have significantly changed the outcome for John Jr. -- yet the caseworker's supervisor did nothing to intervene.

The current turnover rate for the DFS's frontline workers, including frontline workers who move to a different position within the Department, is tracking at 44% for FY '05. DFS positions are high-stress jobs subject to an alarming "burn-out" rate. This has led to a revolving door system in which DFS must constantly seek new employees to fill its vacancies, and keep caseloads per worker within the statutory guidelines. The result is that DFS regularly has a pool of workers who may not have the requisite qualifications or strong analytical, investigation skills for this demanding job. This situation, as horribly illustrated in this case, presents a palpable danger to Delaware's children.

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

1. **DFS should reexamine its hiring policies, especially recruitment and selection of new workers.** Specifically, all candidates should undergo a personal interview with human resources staff in which their energy, decision-making skills, common sense, and other relevant attributes are carefully screened. The philosophy of the candidate should be explored to ensure it meshes with the philosophy of the Children's Department. If it is determined that DFS does not pay enough to consistently lure candidates who, in addition to having the required education, also meet these qualifications, salaries or minimum hiring requirements should be increased accordingly. Finally, DFS should reward and publicly commend DFS workers who show exemplary casework – such as treatment worker #1 and investigation worker #2. Conversely, DFS must take appropriate personnel action against workers who consistently display the poor judgment illustrated in this case.
2. **DFS workers need to be closely monitored to ensure that they are adequately performing their job.** Mistakes, poor judgment, lack of knowledge and differing philosophies by workers can cost children their lives. Supervisors who cannot adequately monitor and supervise their subordinates' work should not be in the role of a supervisor.
3. **DFS Management should perform reviews of other cases handled by investigation worker #1 and treatment worker #2 to ensure that decisions were not and are not being made that leave children at grave risk of abuse, neglect and possibly death.**

III. Investigation

Investigation worker #1 missed policy deadlines for contact with the family regarding both the routine and urgent referrals. Policy requires contact in routine cases within 10 days – investigation worker #1 took 20 days. Policy requires contact in urgent cases within 24 hours – investigation worker #1 took 5 days. A system in which diligent efforts to meet with a parent satisfies the guidelines does not adequately protect children from abuse. Under this system, a parent could injure a child, and then miss months of meetings with DFS without explanation, without triggering any action.

Moreover, when the risk assessment was completed in December of 2002, it showed a score of 3 out of a possible 4, indicating “High Risk – Obvious likelihood that the child will be maltreated requiring immediate and comprehensive response. Conditions are extreme....” The purpose of the risk assessment is to determine acceptable versus unacceptable levels of risk. Despite this, John Jr. was left in John Sr.’s care, rendering the risk assessment tool meaningless in this case. Investigation worker #1 also shared her opinion that the risk assessment meant little to her as an investigation worker, likely in stark contrast to its intended purpose.

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

1. **DFS should review its research on nationwide risk assessments and consider modifying or replacing its current structured decision-making tool used during the investigation process.** Any new tool should include separate risk assessments for each parent. See Section on Child Abuse/Neglect Reports as well.
2. **In the short term, DFS should reiterate the importance of the current risk assessment tool and ensure that workers are using it.** Clearly there is a disconnect for some between policy and practice regarding the Risk Assessment Tool. Policy states this tool is important and should be used by workers in decision making, yet one worker and supervisor say it is useless and largely ignored.
3. **DFS should require an actual meeting, not a diligent attempt to make one, to occur within the DFS investigation guidelines. After one contact is missed and the time deadline for making the contact has passed, a plan should be developed by the DFS regional administrator for ensuring that prompt contact with the family and children is made.** If statutory changes are needed to provide workers with additional tools to compel parents whose cases are opened with DFS to cooperate, that issue should be brought to light. Most important, workers must recognize that a parent’s failure to meet with DFS may be a warning sign that the parent is attempting to conceal abuse by evading authorities.

IV. Treatment

This case illustrates a troubling lack of urgency and thoroughness in DFS’s treatment visits. The worker responsible for John Jr. did not visit his home or follow up on hotline reports for weeks or months on end. When they finally did make contact, it was almost always solely with John Sr., and only once, tangentially, with John Jr., the child whose welfare was at stake. This allowed John Sr. to easily fool the attendant workers, who took practically all of his reports at face value.

The Subcommittee heard more than once that this lack of time and focus on John Jr.’s case was due in part to an imbalance caused by the Court’s increased attention to cases in which a child is *removed* from his/her parents’ custody. Under the Adoption and Safe Families Act, the Court must review these cases on a regular basis and, as a result, the caseworker must visit the child on a frequent basis in order to have appropriate and updated information to provide to the Court. No such requirements exist for children whose cases are opened with the Division with services being provided, but who are not removed from their parents’ custody. The result is that

treatment workers spend inordinately more time with those cases in which DFS has taken custody, rather than those cases in which the child has been left in the parent's care, with services in place – and yet it is the latter case that often presents a more dangerous situation in terms of the potential for abuse. In this case, the treatment worker went nine months without ever formally meeting John Jr., and candidly admitted that the circumstances of the case rendered her focus on him minimal. Sadly, the first time the treatment worker ever truly met John Jr. was after he was lying in the hospital from his near death injuries.

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

1. **DFS should reevaluate its protocols regarding home visits.** At a minimum, DFS workers should be required to meet with the child at least once per month. They should also be provided the resources to permit them to spend the same amount of time with cases in which the child remains in the parent's care as those in which the child has been removed from the home. Moreover, workers should also visit with other members of the household, especially other resident children, so that a parent's reports can be corroborated. The Subcommittee is aware that this may impact caseloads, but it is a necessary recommendation to ensure children's safety.
2. **Case plans and services should focus on the risk factors set out in the investigation risk assessment tool.** While other issues crop up in these cases, resulting in additional or different services, workers must not lose sight of the issues that required initial DFS involvement. In this case, when Scott was born, the treatment worker's focus shifted completely from John Jr. and the risks present in John Sr.'s care of him, to Susan and John Sr.'s ability to care for Scott.
3. **Risk assessment should continue to occur during the treatment process, and treatment workers should be thoroughly trained on same, including the protocol for serious injury reports.**

FAMILY COURT

Family Court had no fewer than fifteen related civil files on this family. However, it is not the routine practice of the Family Court to cross-reference and review related files. This failure resulted in cross-petitions for custody and protection from abuse being filed and reviewed in an incident-based fashion. By way of example, in May of 2003, Family Court entered a custody order between Susan and John Sr. that awarded primary residence of John Jr. to Susan. At the time that this order was entered, DFS had an open treatment case for John Jr. in which Susan had been founded for neglect. Family Court was unaware of the case and DFS caseworkers – who believed Susan to be the more significant threat to John Jr. – were unaware of the custody order.

The family also made an appearance in Family Court in June of 2001, alleging domestic violence involving an infant; however, DFS was never informed. Currently, pursuant to the MOU, law enforcement must report domestic violence involving children to DFS – no such agreement exists for Family Court, although the mandatory reporter law still applies. 16 Del. C. § 903. See also Section I of this report.

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

1. **Family Court and DFS should implement policies and procedures similar to those employed by law enforcement to ensure prompt and consistent notification to DFS of children seen by Family Court who are at-risk in intrafamilial relationships.** While the Judiciary is designing a new computer system called COTS (“Courts Organized To Serve”), there is an immediate need for DFS and Family Court to enter into discussions about how to achieve a better notification system regarding at-risk children seen by the Family Court but unknown to DFS. This should include a review of all matters brought before Family Court such as custody petitions, PFAs (“Protection from Abuse”), visitation matters and delinquency proceedings which should trigger notification to DFS and other child welfare systems.
2. **Family Court Commissioners and Judges, as statutorily mandated reporters, should notify DFS on all PFA petitions and “no contact orders” in which children are involved.**
3. **Family Court and the Children’s Dept. should develop a policy or procedure similar to the procedure between police and DFS regarding the referral of civil and criminal domestic violence incidents that result in Court orders where children are involved.**
4. **All related files on a “family” should be presented to judicial officers when making civil determinations regarding children.** Long term, the subcommittee recommends that this particular issue be incorporated into the new COTS computer system, enabling a full and complete picture of a family to be provided to the judicial officer to enable them to make the best possible decision on behalf of a child that first and foremost protects their safety.

LAW ENFORCEMENT

The Wilmington Police Department did not put enough emphasis and resources on this child abuse case. WPD Officers received little or no training in this area, and are therefore not adequately equipped to investigate crimes against children. While there now appear to be a few officers in WPD who focus on child abuse cases, that was not the case at the time of Michael’s injury, and there is still no formal, specialized child abuse unit. Moreover, WPD violated policy (MOU) regarding the reporting of domestic violence incidents where children are present and did not use the domestic violence incident report where required. Further, the Subcommittee consistently heard that WPD fails to communicate with DFS during a pending investigation – not just in this instance.

Such failure is in violation of 16 Del. C. § 906(b)(4), which states, “[t]he assisting law enforcement agency shall promptly conduct its own criminal investigation, and keep the Division regularly apprised of the status and findings of its investigation. Law enforcement agencies and the Division shall develop protocols to ensure compliance with this subsection.” These failures rendered numerous police responses to John Sr.’s violence unknown to other agencies charged with assessing the safety of children in John Sr.’s care.

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

- 1. Wilmington Police Department must have supervisors and officers who are fully trained in investigating child abuse/neglect cases and committed to working and communicating with all members of the child welfare system. If Wilmington Police Department is unable to investigate a child abuse and/or neglect matter, they should invoke 16 Del. C. § 906(b)(3), permitting the Delaware State Police to assist in such cases.** This is critical not just for the intrafamilial cases where DFS is involved, but also for the countless City of Wilmington children subjected to extrafamilial abuse and/or neglect whose sole government agency protector is the WPD.
- 2. WPD should review Title 16, Ch. 9 and the Memorandum of Understanding, to ensure compliance by all of its employees, including but not limited to using the proper domestic violence incident reports, and keeping DFS regularly apprised of the status and findings of its investigation. 16 Del. C. § 906(b)(4).**

LEGAL

Several legal issues have resulted from the review of this case. First, DFS workers expressed that if they had attempted to remove John Jr. from John Sr.'s custody based solely on history, no Family Court judge would have granted DFS custody. This belief has some merit, based on current case law and the complicating issue of several definitions of neglect appearing in the Delaware Code.

The Subcommittee was dismayed with the plea and resultant sentence for this horrific crime against John Jr., as well as troubled by the difficulty in charging adults in crimes against children when two or more adults are involved.

Moreover, in April of 2004, CPAC was designated as the federally-required Citizen Review Panel for the State of Delaware. As such, CPAC is required to review individual cases of abuse and neglect to determine how the system is functioning. Delaware does not, however, have a statute giving CPAC the ability to compel cooperation in these reviews. Rather, in performing this review, CPAC was indebted to the voluntary cooperation of Delaware agencies and individual professionals.

In addition, given the stunning insights this review has provided into the child welfare system as a whole, and the federal funding mandate that CPAC perform such reviews, statutory authority and subpoena power should be given to CPAC to effectively discharge its responsibility in overseeing the child welfare system. A mechanism for future publication and distribution of CPAC facts, findings and recommendations must also be included in Delaware statute (instead of constantly relying on federal law). DSCYF objects to this statutory expansion. *See footnote 13 for further information.*

Finally, CAPTA requires that Delaware have a means for disclosing findings and information on death and near death child abuse/neglect cases. At present, Delaware has no such state statute but remains bound by the federal law.

The following recommendations for change are made:

1. **16 Del. C. § 912 should be modified to include statutory authority for CPAC to conduct future reviews of child welfare cases, including a provision for subpoena power in conducting reviews, and in cases of death or near death of the child, public distribution of any resulting reports.**¹³
2. **Delaware law should be modified to comply with the CAPTA requirement for disclosure of findings and information in death and near death cases due to abuse and/or neglect, regardless of reviews.**
3. **Increasing prison time and scrutinizing plea agreements for abuse that results in the near death of a child should be explored.** The plea agreement and jail sentence for this horrific crime committed against John Davis, Jr. was grossly insufficient. The punishment should fit the crime.
4. **The statutory definitions of neglect should be reviewed and standardized, and should incorporate history as a basis for a finding of abuse or neglect.** The current definitions and accompanying case law derived therefrom have cultivated incident-based findings that do not adequately consider the relevance of history in determining risk to children.
5. **A representative of the Wilmington Police Department needs to be added as a member of CPAC.** The CPAC statute currently requires the appointment by the Governor of two law enforcement representatives. The New Castle County Police Department and the Delaware State Police have been critical participants in the Commission and this review. However, it is equally critical that a representative of the Wilmington Police Department be added to the Commission.

MULTI-DISCIPLINARY COORDINATION AND COLLABORATION

As is evidenced by the review of the facts in this matter, as well as the recommendations put forth regarding the individual agencies, little multi-disciplinary collaboration occurred in this case. Despite the existence of the 1998 Memorandum of Understanding and the Child Protection Act of 1997, the child welfare system continues to struggle with communication and

¹³ While CPAC supports this change, DSCYF does not. DSCYF believes that while CAPTA does allow CPAC to review near death cases, statutory authority in Delaware was given to the Child Death, Near Death and Stillbirth Commission (“CDNDSC”) and DSCYF believes that CPAC should support that. DSCYF believes that CPAC can provide oversight by reviewing the findings from CDNDSC and taking appropriate advocacy action.

collaboration. Other than use of history, no other subject has received more recommendations from prior child death reviews than this one. As a result of prior reviews, the MOU was to be updated to include the Children's Advocacy Center. To date, that has not occurred, despite the recommendation having been made in 2002. Regardless, the current MOU and laws were not followed.

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

1. **Immediately finalize the proposed updated MOU between law enforcement, DFS, the Children's Advocacy Center and the DOJ. This review and revision process should include how staff will work together in the field to address child welfare cases.** If there are legal issues as to what information can and cannot be shared among these agencies, those issues should be clearly defined so that all of the partner agencies understand any limitations on information sharing.
2. **A process should be developed for interagency meetings to review and discuss particularly complex cases-- a system similar to the CAC's Case Review Team meetings, where agencies update each other on open and pending cases. This process must focus on the civil as well as the criminal components of the case.** This process greatly minimizes the chances of cases falling through the cracks. Had a meeting such as this occurred regarding the injuries to Michael, charges may have been re-filed and certainly DFS would have been fully aware of the charging decisions.
3. **Multidisciplinary protocols must be established to address breakdowns in intra-agency and interagency communication.** Front line personnel should be made aware of liaisons, contacts, etc. in their own agency and in other agencies that can facilitate communication breakdowns.
4. **Law Enforcement as well as other disciplines should consult with child abuse/neglect medical experts when investigating a possible child abuse/neglect case.**

MULTI-DISCIPLINARY TRAINING

As raised in countless sections of this report, a repeat of actions taken in 1998 must happen. Specifically, after several child abuse deaths which revealed multiple breakdowns in multi-disciplinary collaboration, a Memorandum of Understanding was developed between law enforcement, DFS and the Department of Justice. In addition, significant state funds were allocated for a comprehensive multi-disciplinary conference presented by the American Prosecutors Research Institute. Since at least 2001, reports by bodies which encounter child abuse and/or neglect have consistently documented breakdowns in the MOU resulting in tragedy. 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 put training of the multi-disciplinary units as a priority.

As such, the following recommendations are made:

1. **All CPAC members should make a renewed commitment to pooled 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 welfare 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 DOJ, 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 welfare and domestic violence;
- f. Importance of child welfare history; and
- g. Investigative techniques to address cases where there is more than one suspected perpetrator.

MULTI-DISCIPLINARY USE OF CHILD WELFARE HISTORY IN DECISION MAKING

The most obvious problem in this case was the glaring failure of the child welfare system to place the proper emphasis on a parent's history of child abuse and neglect. At virtually every juncture, individuals involved missed or ignored warning signs that were both clear and cumulative. Rather than considering past events as important predictors of future behavior, social workers lapsed into the old habit of hyper-compartmentalizing each abuse event and each family member. This method left them "unable to see the forest for the trees." The grave and obvious danger that John Sr. presented therefore went undetected.

The flaws in this short-sighted, inefficient approach are readily apparent. A history of drug abuse and inability to care for other children did not dissuade workers from placing yet another newborn at risk by letting Susan keep custody of him without so much as an investigation, even though the infant was born cocaine addicted, and even though Susan had done virtually nothing to address her known drug problem. Most distressing, John Sr. had been the repeated subject of abuse investigations, including a case in which he broke his child's leg, and yet this did not dissuade the workers involved from placing another defenseless child in his care. Not only should the fact that John Sr. was extremely violent – to both his partners and his children – have been obvious, but reviewing the other state's child protection records would also have shown that he was very skilled at appearing to be a caring and appropriate parent.

These risk factors were evident throughout the FACTS and DELJIS systems as well as the Family Court records, and should have been immediate cause for alarm for any and all who encountered this family. Instead, the available information was either not reviewed, was not considered significant, or was minimized in an effort to give the parent another chance. For some

unknown reason, the importance of family history continues to be devalued, and this simply must change. The fact that John Sr.'s history was so consistently ignored is simply inexcusable. This alarming trend directly resulted in the mistakes made with this family. This failure is particularly disturbing in light of the fact that recommendations on a need for better use of historical information were made in the child death reviews of Bryan Martin (3/17/97), Dejah Foraker (1/8/99), the Federal Children and Family Services Review (2001), and, with respect to criminal history, the Child Death Review Commission's Expedited Review (10/24/02) and the Domestic Violence Coordinating Council's Fatal Incident Review Team 2001 Annual Report.

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

1. **DFS must once again re-evaluate the adequacy of its training regarding the use of history in making decisions on removal and placement of children.** This is not the first time this recommendation has been made, as stated above. Yet caseworkers in this case clearly did not rely on history and even during the Subcommittee interviews they continued to struggle in identifying how history should be used and when history is sufficient reason for removal of a child. Any DFS worker employed since the Bryan Martin review should have been, in accordance with the recommendations in that case, extensively trained in reviewing a potential placement's history and analyzing risk accordingly. It should be absolutely clear to social workers that history is the most reliable predictor of risk to a child, and that it cannot be ignored in any placement or removal decision. This case should be used in future trainings. Quality control measures should be used to ensure that history is being taken into consideration in all casework.

2. **DFS must evaluate its policies to clarify *how* history should be used by caseworkers.** Despite years of discussion regarding the importance of history in caseworker decision-making, a review of DFS policies made clear why workers continue to struggle. While current policies – even those that were put in place after this case -- require investigators to review history and provide a list of sources to be checked for information, they still do not provide guidance on the most critical issue: how and whether to use the information learned in deciding whether to remove a child from his/her home. This places investigation caseworkers in the untenable position of being responsible for getting the historic information needed, but not having guidance in terms of how to use it. Policies for treatment workers are equally unsatisfactory, stating only that treatment workers “may” access historic information. DFS policy should, at a minimum, clearly state that history of abuse/neglect by a parent can be a sufficient justification, in and of itself, for removal of a child from that parent's custody. The policy should also provide factors to be considered in making such a decision, including the nature and severity of the past abuse, the length of time since it occurred, and any treatment or other intervention that has been accessed.

3. **DFS caseworkers should be trained that history, especially abuse history, does not depend upon charging decisions or legal classifications of conduct.** The social worker involved in this case completely discounted the fact that John Sr. had previously broken another child's leg because that “was only a misdemeanor.” This total reliance upon the outcome of a plea agreement reflects a misunderstanding both of the law and of DFS's proper focus. Likewise, the DOJ's decision to not prosecute John Sr. did not mean that John Sr. did not

fracture Michael's skull; it only meant that the DOJ could not determine whether he had done so in Delaware or the other state. This is just one of many reasons that abuse may not be prosecuted to the level it deserves; plea bargains, witness availability, and a focus on other charges also come to mind. The DOJ's decision to lessen or drop charges does not mean that abuse history should be ignored. The DOJ's decision to avoid the risk of a trial or jurisdictional problems by pleading out a case often reflects the difficulty of meeting the reasonable doubt standard. DFS does not labor under the reasonable doubt regime. In determining whether a child is safe in a particular person's care, DFS social workers are free to, and indeed must, consider any likelihood of abuse, even if it cannot be proven beyond a reasonable doubt. Again, the best predictor of future abuse is past abuse, whether charged as a felony, misdemeanor, or not at all.

4. **The importance of history should be incorporated into multi-disciplinary child welfare training.** In this case, DFS, law enforcement and Family Court also operated in an incident-based fashion rendering decisions in this case being flawed.

5. **DFS continues to operate an "incident based" belief system for removal of a child from his or her home. The Bryan Martin review found that "the Division was waiting for a specific incident of serious risk to remove the child from his home, when ongoing victimization can be even more damaging than a severe single incident. Documented patterns of abuse or neglect may warrant removal even in the absence of a single serious incident"**. It was clear from investigation worker #1 and treatment worker #2 that prior history had little impact on their decision making, and that the sole focus of their work was on the current incident and circumstances.

6. **Incorporate into the current system a flag for workers to check DELJIS as part of their case work. To the extent workers do not have DELJIS access, access must be expanded.** It is disturbing to hear that treatment worker #2 did not know whether or not she even had access to DELJIS to check the history of their clients. DELJIS information is critical in making safety and treatment decisions regarding children.

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DOJ failed to inform DFS of the outcome of the criminal case involving Michael, despite treatment worker #1's attempts to get information. According to DFS, DOJ failed to inform DFS on the progress of the case as well. DFS indicated it often struggles with obtaining criminal information clearly relevant to their work, such as outcomes of pending charges, the sentence outcome, probation conditions, etc. – this often leaves the caseworker in the position of learning this information directly from the perpetrator, at least in the first instance. 16 Del. C. § 906(d) clearly contemplated this problem, and requires some notification to DFS upon release of a person from custody. 16 Del. C. § 906(b)(4) also acknowledges these issues by requiring law enforcement to keep DFS regularly apprised of the criminal investigation.

DOJ failed to prosecute John Sr. and possibly Tammy on the misdemeanor charges regarding Michael. Through delays in the investigatory process, lack of any case tracking system within DOJ and a change in DAGs without a commensurate transfer of files, no re-filing of the misdemeanor charges against John Sr. occurred. With respect to the December 2001

charges, DOJ indicates the charges were dismissed; however, no further information exists rendering the Subcommittee without specific knowledge as to why. Regardless, absence of a comprehensive database for all DOJ cases, coupled with an absence of communication and cooperation with other agencies, left crimes against two children, John Jr. and Michael, unprosecuted.

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

1. **Implement a Department of Justice case tracking system** to ensure that cases do not fall through the cracks when personnel are reassigned from their unit or charges are filed at different levels. This system should apply to both the civil and criminal Divisions of DOJ and be fully accessible by both.
2. **Criminal case outcomes involving child victims or an open DFS case should be transmitted to DFS workers.** This may require some type of liaison to assist in tracking such cases and facilitating communication between DOJ, DFS, law enforcement, Children's Advocacy Center and Family Court.
3. **DOJ should review 16 Del. C., Ch. 9, and the 1998 Memorandum of Understanding requiring multi-disciplinary collaboration between state agencies involved in child protection and apply those principles to the DOJ internally.**