STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
C/O OFFICE OF THE CHILD ADVOCATE
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MARY F. DUGAN, ESQUIRE
CHAIR

TANIA M. CULLEY, ESQUIRE
EXECUTIVE DIRECTOR

June 11, 2025

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

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

Dear Governor Meyer:

As one of its many statutory duties, the Child Protection Accountability Commission ("CPAC") is responsible for the review of child deaths and near deaths due to abuse or neglect. In 2024, CPAC screened in 59 cases (9 deaths and 50 near deaths) and screened out another 178 cases, many of which are child poisoning via drug ingestion.

As required by law, CPAC approved findings from 28 cases at its June 11, 2025, meeting.[1] Those cases are broken into two sections – cases that received a final review after completion of prosecution and cases that were reviewed for the first time.

There are 12 cases that received a final review this quarter. There were 2 deaths and 10 near deaths that occurred between August 2022 and June 2024. Eight of the 12 cases were charged with three resulting in probation before judgment or nolle prosequi. There were 4 convictions and one not guilty verdict. One defendant was convicted of manslaughter where a one-year-old died from fentanyl ingestion and the defendant received two years incarceration. One case of suffocation and child abuse went to trial, and resulted in a not guilty verdict. The remaining three cases received no jail time. Outcomes in these cases are areas where CPAC and its committees continue to focus and strengthen to improve timely decision making, civil and criminal collaboration, presentence investigations, and victim impact statements.

The sixteen remaining cases were from deaths or near deaths that occurred between June and November of 2024. Of these cases, three near deaths will have no further review and were not prosecuted – these include poisoning via drug ingestion, and failure to thrive/medical neglect.

[1] 16 Del. C. § 932.

The remaining thirteen cases – 2 deaths and 11 near deaths - will remain open pending prosecutorial outcomes. These cases include abusive head trauma, bone fractures, stabbing, burns, failure to thrive/medical neglect, strangulation, and poisoning via drug ingestion.

For these sixteen cases from June through November 2024, there were 34 strengths and 36 findings across system areas. Nineteen strengths and only 5 findings were noted for the Multidisciplinary Team Response. These numbers demonstrate the continued forward progress in the expertise of the frontline investigators. Once again this quarter, several of these cases noted excellent or good MDT responses – in fact, 13 strengths were noted. CPAC will continue to watch these trends.

For the medical response, this quarter demonstrated 9 findings and 9 strengths. Five of those findings indicate breakdowns in reporting cases to the DFS report line by primary care physicians and hospitals. The 2025 recognition and reporting training has concluded for medical providers, and the content feedback has been positive. In addition to basic and refresher training, advanced training on drug ingestions, sentinel injuries, and abusive head trauma have also been offered this session. This training continues to focus on how to recognize and report child abuse and neglect and should have a measurable impact on findings.

Six strengths and 22 findings were noted regarding the Division of Family Services ("DFS"). Half of the DFS findings were regarding caseloads (11). No trends were seen this quarter in the other findings.

The number, complexity and severity of child abuse cases continue. The multidisciplinary team has increased its expertise and responses to these cases, which is demonstrated in the strengths. For your information we have included the strengths, findings and the details behind all of the cases presented in this letter. The CPAC Data Dashboards, as well as summaries of the CAN Findings and Drug Ingestions, are also included to provide an overall picture of the volume and complexity of child welfare cases in Delaware over time. CPAC stands ready as a partner to answer any further questions you may have.

Respectfully,

Tania M. Culley, Esquire
Executive Director
Child Protection Accountability Commission

Enclosures

cc: CPAC Commissioners, General Assembly

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

INITIAL REVIEWS

	Current
MDT Response	**19**
General - Civil Investigation	1
General - Criminal Investigation	2
General - Criminal/Civil Investigation	11
Medical Exam	2
Reporting	3
Medical	**9**
Communication	1
Documentation	1
Medical Exam/Standard of Care - PCP	2
Reporting	5
Risk Assessment/ Caseloads	**1**
Collaterals	1
Safety/ Use of History/ Supervisory Oversight	**4**
Completed Correctly/On Time	3
Oversight of Agreement	1
Unresolved Risk	**1**
Legal Guardian	1
Grand Total	**34**

FINAL REVIEWS

	Current
Grand Total	

TOTAL CAN PANEL STRENGTHS	**34**

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

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

INITIAL REVIEWS

System Area	Strength	Public Rationale	Count of #
MDT Response			19
	General - Civil Investigation		1
		The DFS investigation and treatment caseworkers went above and beyond to assist this complex family, specifically working to get the mother re-established with resources and housing following the incident.	1
	General - Criminal Investigation		2
		The law enforcement agency made a referral to Victim Services, who provided ongoing assistance to the mother ensuring she received needed supplies from the home and the family was placed into safe housing.	1
		The smaller jurisdiction law enforcement agency conducted an excellent investigation, to include immediate notification to the DFS Report Line and the criminal DAG, thoroughly documenting the investigation case, and enlisted a larger jurisdiction law enforcement agency to assist with a scene investigation.	1
	General - Criminal/Civil Investigation		11

		There was a good MDT response to the near death incident, which included a joint response to the hospital, joint interviews where applicable, forensic interviews of the child's siblings, a scene investigation, and consistent communication and collaboration among the MDT members, to include the Office of Child Care Licensing.	1
		There was a good MDT response to the near death incident, which included joint responses to the hospital and to the parents' homes, joint interviews, a scene investigation, and consistent communication and collaboration among the MDT members.	1
		There was a good MDT response to the near death incident, which included joint responses to the hospital, a joint interview, a scene investigation, and consistent communication and collaboration among the MDT members, to include Victim Services.	1
		There was a good MDT response to the near death incident and to the subsequent investigation, which included joint responses to the hospital and to the home, joint interviews where applicable, medical evaluations and forensic interviews of the child's siblings, scene investigations, and consistent communication and collaboration among the MDT members, to include the Child Attorney and the civil DAG.	1

	There was a good MDT response to the near death incident, which included joint responses to the hospital and to the home, joint interviews where applicable, a scene investigation, consideration of forensic interviews for the teen siblings, and consistent communication and collaboration among the MDT members.	1
	For the prior investigation, there was a joint response to the family's home with law enforcement, and joint interviews were conducted with the household members.	1
	There was a good MDT response to the near death incident, which included joint responses to the hospital and to the home, joint interviews where applicable, a scene investigation, medical evaluation and forensic interview of the young sibling, and consistent communication and collaboration among the MDT members.	1
	There was a good MDT response to the near death incident, which included joint responses to the hospital and to the home, joint interviews, a scene investigation, medical evaluation of the sibling, forensic interviews, and consistent communication and collaboration among the MDT members.	1

		There was a good MDT response to the near death incident, which included joint responses to the hospital and to the home, joint interviews where applicable, medical evaluations of the younger siblings, consideration of forensic interviews, a scene investigation, and consistent communication and collaboration among the MDT members.	1
		There was a good MDT response to the near death incidents, which included joint responses to the hospital and to the homes, joint interviews where applicable, a scene investigation, consideration of forensic interviews for the relative children, and consistent communication and collaboration among the MDT members, to include the out of state child protective services agency.	1
		There was a good MDT response to the death incident, which included joint responses to the hospital and to the home, joint interviews where applicable, a scene investigation, medical evaluations and forensic interviews of the siblings, a child safety agreement, and consistent communication and collaboration among the MDT members, to include the Medical Examiner.	1
	Medical Exam		2
		Medical evaluations were completed for the siblings residing in the home. The evaluations included urine drug screens.	1

		A medical evaluation was completed for the minor relative child residing in the home.	1
	Reporting		3
		The emergency medical personnel and law enforcement patrol officers, who responded to the home, made immediate referrals to the DFS Report Line regarding the child's medical condition and the drug paraphernalia seen in the home.	1
		A report was made to the Institutional Abuse Unit for the child's medical daycare when it was unclear where or by whom the child may have sustained the injuries.	1
		The primary care physician made an immediate report to the DFS Report Line with concerns for non-accidental trauma. The primary care physician also contacted the emergency department to which the child was referred for further medical evaluation.	1
Medical			9
	Communication		1
		There was good communication and collaboration between the in-state and out of state treating hospitals, where the children were	1
	Documentation		1
		The emergency medical services report thoroughly documented the scene of the child death incident and the appearance of the child.	1
	Medical Exam/ Standard of Care - PCP		2

		For the prior investigation, upon discovery of a sentinel injury in a young child, the primary care physician referred the child to the emergency department for further medical evaluation.	1
		Upon discovery of sentinel injuries in a young child, the primary care physician referred the child to the emergency department for further medical evaluation. The primary care physician also arranged transportation for such.	1
	Reporting		5
		Social Work/Case Management from the children's hospital made a referral to the DFS Report Line regarding neglect of the child and reported concerns for the child's siblings.	1
		For the second prior investigation, the paternal relative's therapist made an immediate referral to the DFS Report Line when the relative disclosed the children presented to the home with sentinel injuries and was concerned for the infant's lack of medical follow up since birth.	1
		The CARE Team made an immediate report to the DFS Report Line when the child's confirmation drug screens returned positive for a controlled substance.	1
		When contacted by the primary care physician to transport a young child with sentinel injuries to the emergency department, emergency medical services made an immediate report to the DFS Report Line for the child's injuries.	1

		At the sibling's medical appointment following the death of the child, the primary care physician attempted to clarify the child safety agreement with the DFS caseworker. When unable to do so, the primary care physician made a report to the DFS Report Line.	1
Risk Assessment/ Caseloads			1
	Collaterals		1
		For the prior investigation, the DFS caseworker completed medical collaterals for the two young children.	1
Safety/ Use of History/ Supervisory Oversight			4
	Completed Correctly/On Time		3
		The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. The agreement included the siblings residing in the home. There was consistent review and modification, when necessary, of the safety agreement.	1
		The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. The agreement was comprehensive and included anyone who may have been a caregiver to the child. There was consistent review and modification, when necessary, of the safety agreement.	1
		The DFS caseworker immediately implemented a child safety agreement for the minor relative child residing in the home. There was consistent review and modification, when necessary, of the safety agreement.	1

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

	Oversight of Agreement		1
		Despite the detective's comfortability with lifting the contact restrictions between the non-relative caregiver, the adult daughter, and her children, the DFS caseworker ensured the child safety agreement remained in place.	1
Unresolved Risk			1
	Legal Guardian		1
		The law enforcement agency took protective custody of the child when the mother and a non-relative attempted to flee with the child.	1
Grand Total			**34**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

FINAL REVIEWS

System Area	Strength	Public Rationale	Count of #
Grand Total			
TOTAL CAN PANEL STRENGTHS			**34**

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

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

INITIAL REVIEWS	
MDT Response	**5**
Communication	1
General - Civil Investigation	1
General - Criminal Investigation	1
Medical Exam	1
Reporting	1
Medical	**9**
Medical Exam/ Standard of Care - ED	1
Medical Exam/ Standard of Care - PCP	1
Reporting	5
Transport	2
Risk Assessment/ Caseloads	**15**
Caseloads	11
Collaterals	2
Risk Assessment - Screen Out	1
Risk Assessment - Tools	1
Safety/ Use of History/ Supervisory Oversight	**4**
Safety - Completed Incorrectly/ Late	1
Safety - Inappropriate Parent/ Relative Component	2
Safety - No Safety Assessment of Non-Victims	1
Unresolved Risk	**3**
Contacts with Family	2
Parental Risk Factors	1
Grand Total	**36**

FINAL REVIEWS	
Unresolved Risk	**1**
Parental Risk Factors	1
Grand Total	**1**

TOTAL CAN PANEL FINDINGS	**37**

Office of the Child Advocate
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Wilmington, DE 19801

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Detail

INITIAL REVIEWS

System Area	Finding	PUBLIC Rationale	Count of #
MDT Response			5
	Communication		**1**
		During the near death investigation, there was minimal communication between law enforcement and DFS. Law enforcement initially responded to the home with the DFS caseworker to interview the mother, but left before the interview was completed. There was no further communication until DFS was informed that a detective had been assigned to the criminal investigation but closed out the case.	1
	General - Civil Investigation		1
		For the prior investigation, although the case was reviewed by the Administrative RED Team, the case was closed prematurely prior to repeat imaging being completed to rule out the suspected bone fractures.	1
	General - Criminal Investigation		1
		There was not a joint MDT response to the near death incident in compliance with the MOU and statute. There was a significant delay in the law enforcement agency assigning the case to a detective.	1
	Medical Exam		1
		The young siblings residing in the home at the time of the near death incident were not medically evaluated.	1

	Reporting		1
		There was no report made to the DFS Report Line after the child's sibling disclosed physical abuse during the forensic interview.	1
Medical			**9**
	Medical Exam/ Standard of Care - ED		1
		The CARE Team was not consulted after an initial report was made to the DFS Report Line for neglect.	1
	Medical Exam/ Standard of Care - PCP		1
		The primary care physician recognized the child safety agreement violation and made a report to the DFS Report Line. However, no one acted in a protective manner for the child or questioned the parents, and the parents were permitted to leave with the child unsupervised.	1
	Reporting		5
		There was no report to the DFS Report Line by the primary care physician after the child missed multiple appointments for weight checks, hospital follow up, and recommended medical testing, and there were ongoing concerns for the child's inadequate weight gain.	1
		The children's hospital delayed making a report to the DFS Report Line for the near death incident. There was no report made for the child's previous hospitalization which occurred two weeks prior.	1
		For the prior investigation, there was no report to the DFS Report Line by the primary care physician after the young child was noted to have a sentinel injury and was referred to the emergency department.	1

		During a previous emergency department visit which resulted in a hospital admission, the child was noted by two separate physicians to have subconjunctival hemorrhages. The injuries were not investigated further, nor were they reported to the DFS Report Line.	1
		There was no report to the DFS Report Line by the primary care physician after the young child was noted to have sentinel injuries and was referred to the emergency department.	1
	Transport		2
		The primary care physician referred the young child to the emergency department with concern for non-accidental trauma but did not arrange for alternate transportation.	1
		The primary care physician documented the child to be seizing and allowed the family to drive the child to the hospital ED in a personal vehicle. The PCP should have called for emergency services given the child's medical state.	1
Risk Assessment/ Caseloads			**15**
	Caseloads		11
		The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	7

		The DFS caseworker was over the treatment caseload statutory standards the entire time the case was open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	1
		The DFS caseworkers were at or over the investigation caseload statutory standards the entire time the current and subsequent investigations were open. However, it does not appear that the caseload negatively impacted the DFS response to those cases.	1
		The DFS caseworker was over the investigation caseload statutory standards the entire time the current case was open, and the caseload appears to have negatively impacted the DFS response to the case.	2
	Collaterals		2
		The SDM Risk Assessment was not completed correctly, which resulted in a low score. The policy override was not applied, and this may have impacted the decision to transfer the case to treatment versus case closure.	1
		A collateral was not completed with the child's new primary care provider to ascertain whether the child's nutritional needs were being met, as she had not reportedly gained any weight in about four months.	1
	Risk Assessment - Screen Out		1
		An anonymous report of the father slamming the young child's head into a metal table was screened out.	1
	Risk Assessment - Tools		1

		For the second prior investigation, the hotline report was assigned a Priority-3 response in contrast with the SDM Response Priority Assessment. However, there was recent concern for an unexplained sentinel injury, which met criteria for a Priority-1 response.	1
Safety/ Use of History/ Supervisory Oversight			**4**
	Safety - Completed Incorrectly/ Late		1
		A child safety agreement was implemented with three safety participants supervising contact with the child. However, the agreement did not clearly identify how the supervision was to occur, i.e. where the parties were residing or the sleeping arrangements.	1
	Safety - Inappropriate Parent/ Relative Component		2
		The child safety agreement inappropriately identified the mother, a victim of domestic violence perpetrated by the step-father, as the safety participant to ensure no contact between the step-father and the children. A third party should have been identified as a safety participant.	1
		The child safety agreement did not include the father as he resided across state lines. This is not DFS policy, although the investigation caseworker documented it to be.	1
	Safety - No Safety Assessment of Non-Victims		1
		While the investigation was still open, the mother gave birth and the newborn child's safety was not assessed by the worker.	1

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Detail

Unresolved Risk			**3**
	Contacts with Family		2
		For the second prior investigation, timely contact with the family was not made by the DFS caseworker. There was no indication that efforts were attempted to meet the assigned priority response time until three weeks later, and the actual contact did not occur until six weeks after that.	1
		For the second prior investigation, there was no documentation that the DFS caseworker observed or interviewed either child.	1
	Parental Risk Factors		1
		During the treatment case, there were no case plans offered to the parents prior to case closure.	1
Grand Total			**36**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Detail

FINAL REVIEWS

System Area	Finding	PUBLIC Rationale	Count of #
Unresolved Risk			1
	Parental Risk Factors		1
		During the treatment case, there was no documentation that the DFS caseworker referred the mother to any resources to support the family.	1
Grand Total			**1**

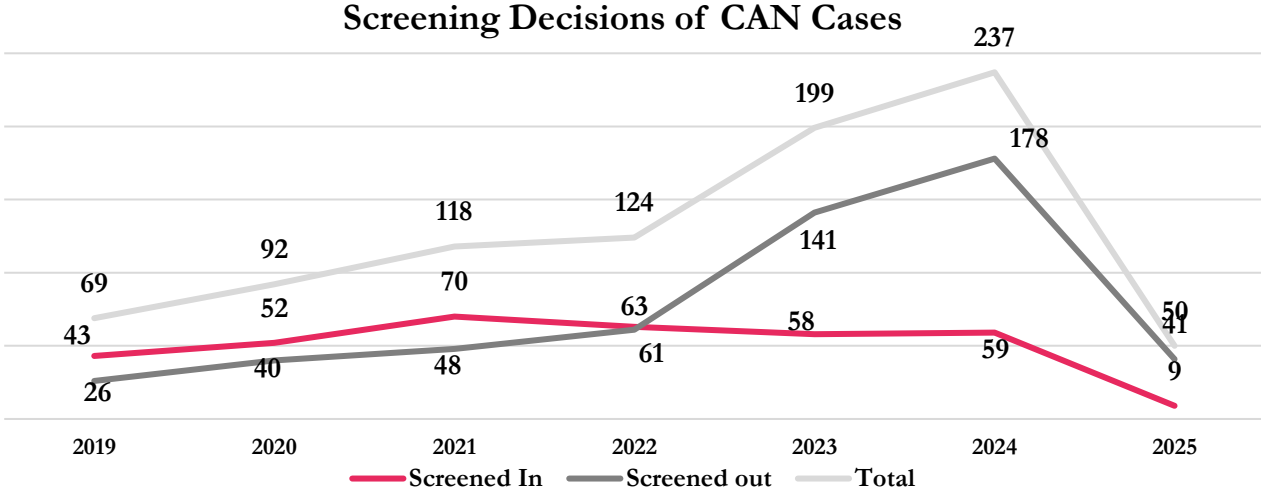
TOTAL CAN PANEL FINDINGS	**37**

Child Abuse and Neglect Panel (CAN)

Child Protection Accountability Commission (CPAC)

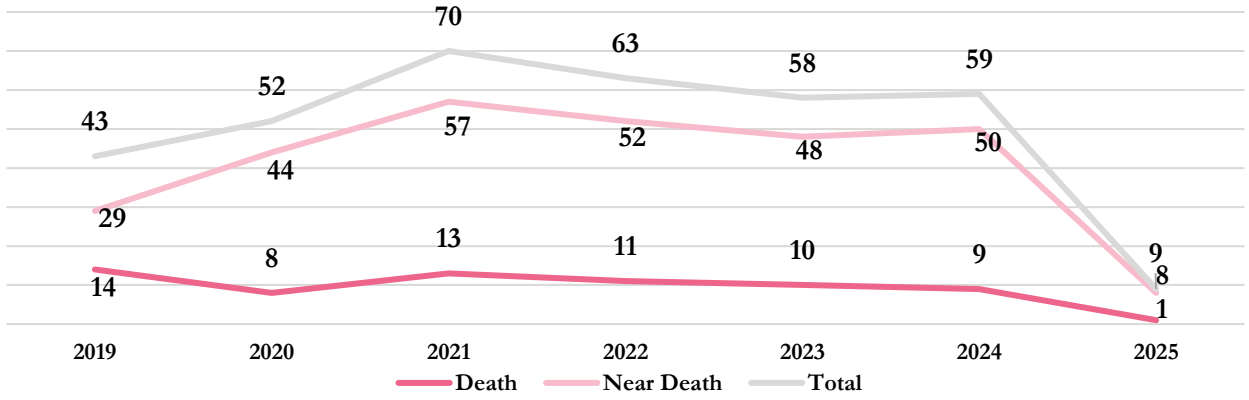
Report Updated: 5/15/2025

Screening Decisions of CAN Cases

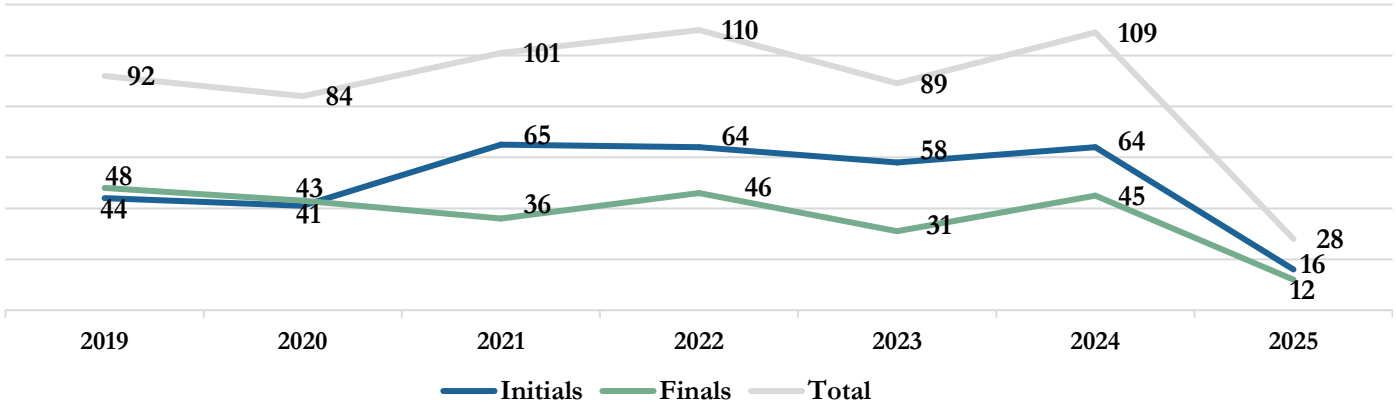


All cases are initially screened in. For the current year, some cases may be screened out after medical records are received and reviewed. Screened out cases in 2024 reflect the date of CAN closure.

Screened In Death and Near Death Cases



Initials and Finals by Calendar Year

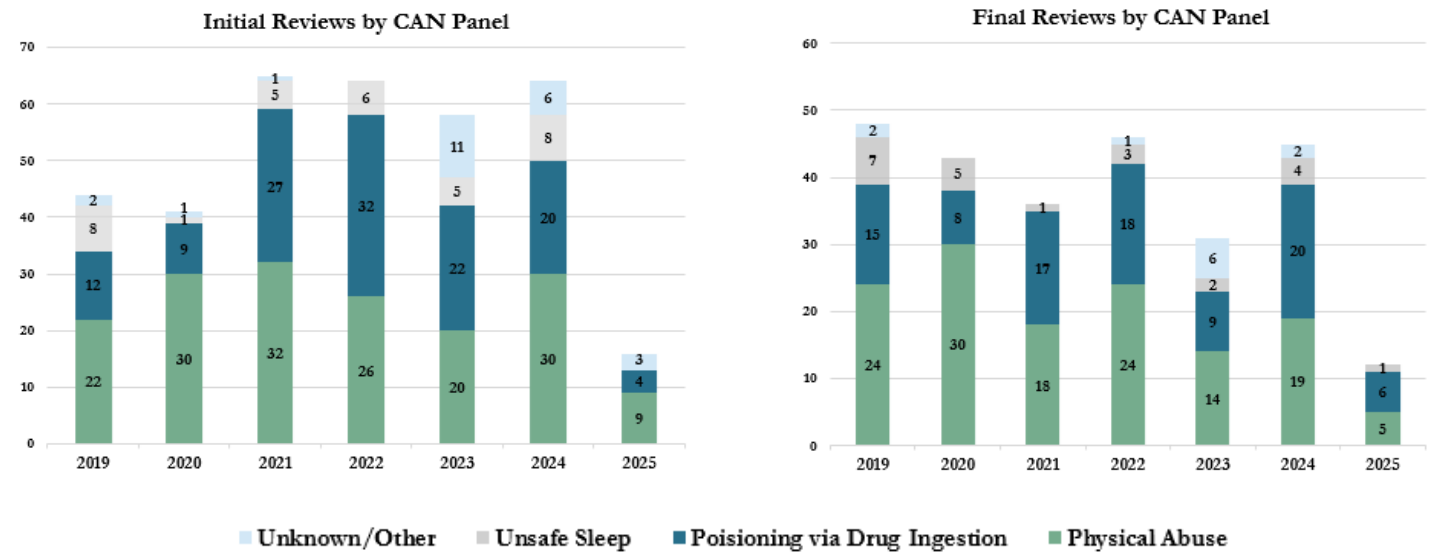


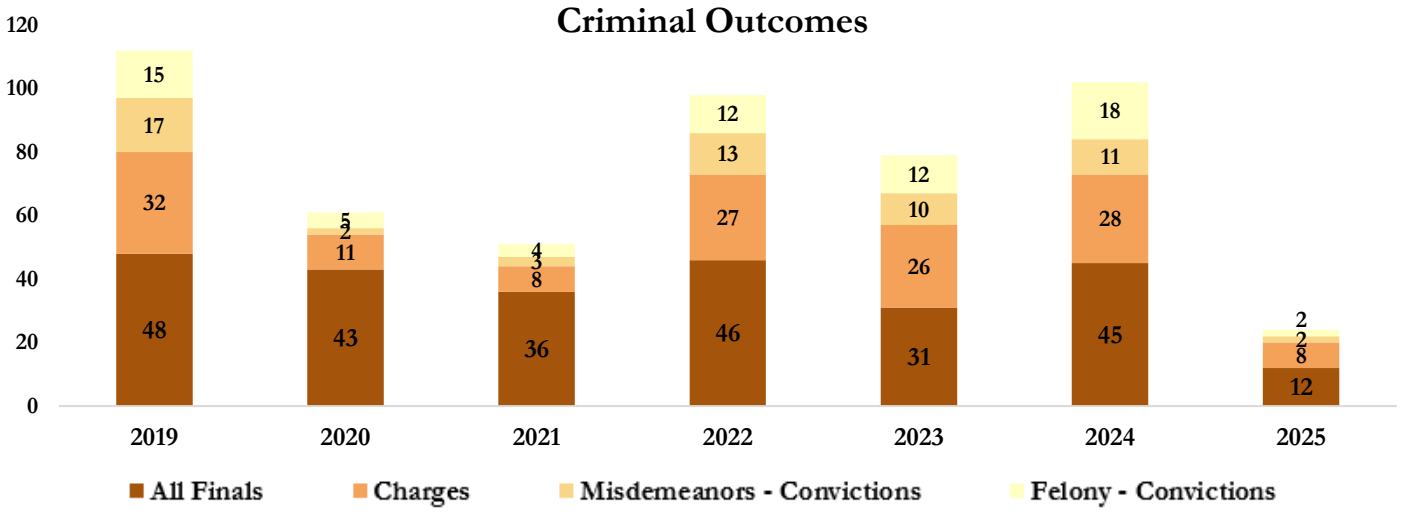
16 Del. C. § 932(c) requires CPAC to review a case within 6 months of a report. In August 2021, CPAC voted to extend the timeframe to 9 months, which is how compliance is calculated above.

Child Abuse and Neglect Panel (CAN)

Child Protection Accountability Commission (CPAC)

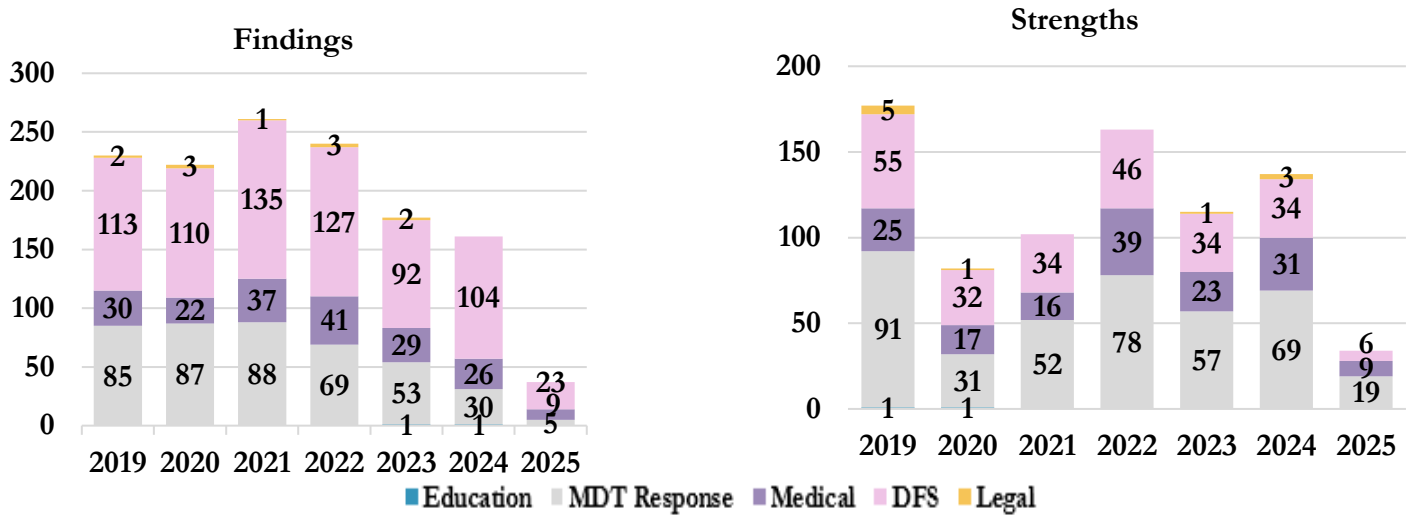
Report Updated: 5/15/2025





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

Findings and Strengths by the CAN Panel

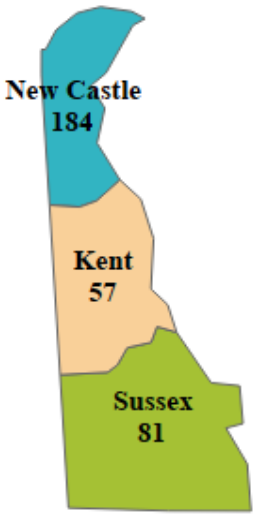


Poisoning via Drug Ingestion Cases

Time Period - January 1, 2021 through March 30, 2025

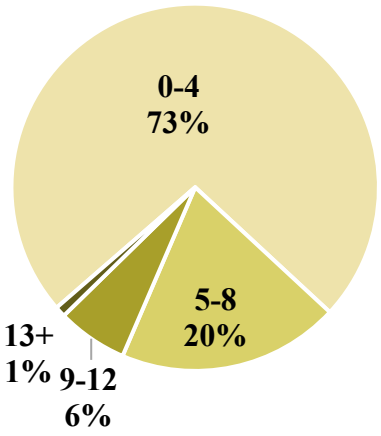
Drug Ingestion Victims by County

Victims = 322



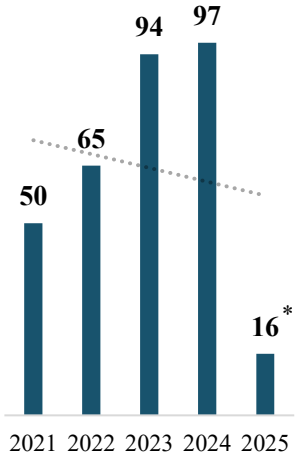
Age Break Down

Victims = 322



# of Victims Entered

Victims = 322

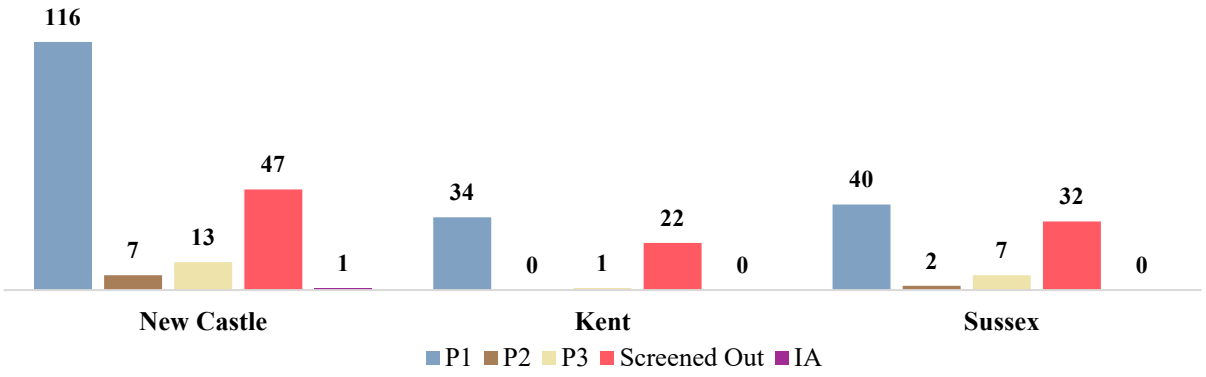


Calendar Year

**As of 04/30/2025*

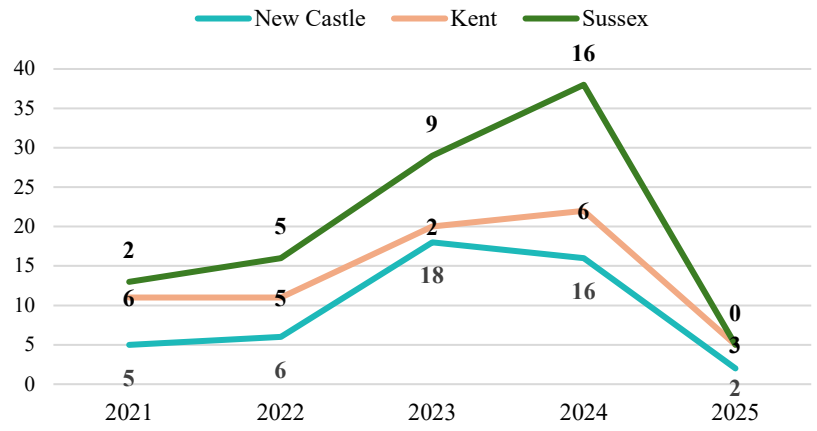
Division of Family Services Screening Responses

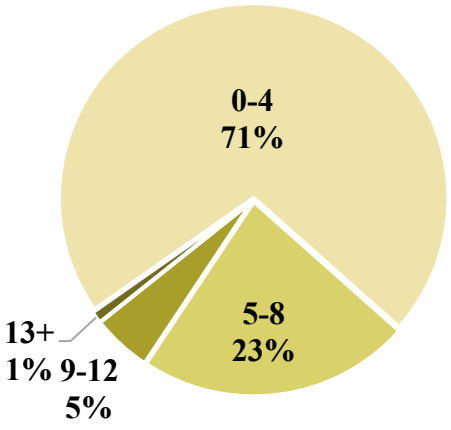
Time Period - 01/01/2021 through 03/30/2025 | Total Victims = 322



Division of Family Services Screened Out Victims

Time Period: 01/01/2021 - 04/30/2025 | Total Victims = 101 | Average Age = 3.68 YO | Youngest Victim = 4 Days Old





Time Period - January 1, 2021 through March 30, 2025

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

Final Drug Screen Count = 312 | Screened Out = 100

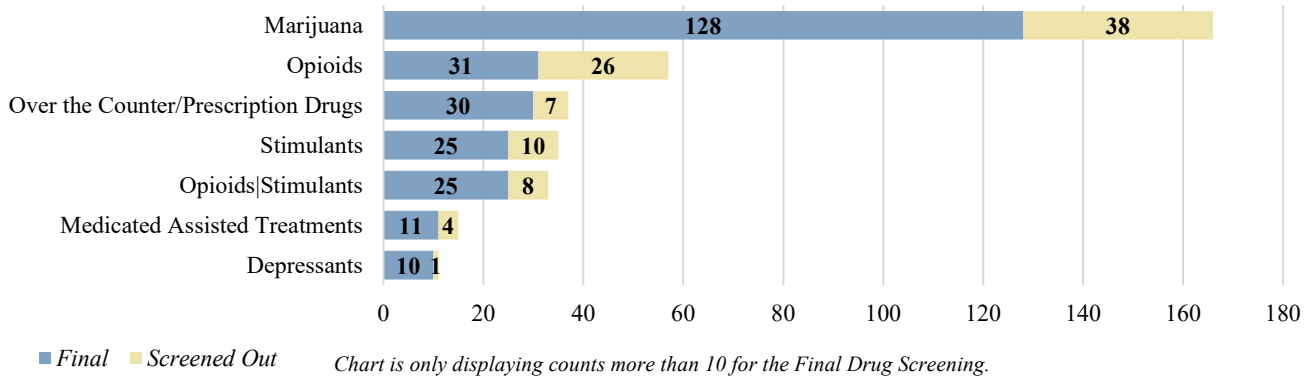
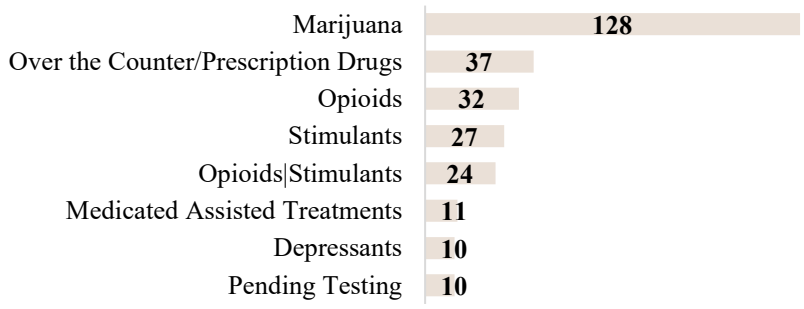


Chart is only displaying counts more than 10 for the Final Drug Screening.

Emergency Room Referrals

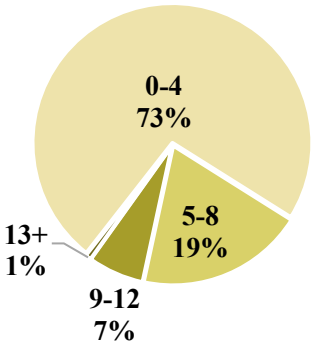
Suspected Drugs Involved in Emergency Room

Total Referrals with Substances = 312



Demographics of Referral

Victims = 312 | Average Age = 3.5 | Percent Referred to ER = 88%



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

Victims Referred to the CAN Panel

Victims Referred to CAN = 118 | Percentage = 37%

Top Substances Associated in Cases

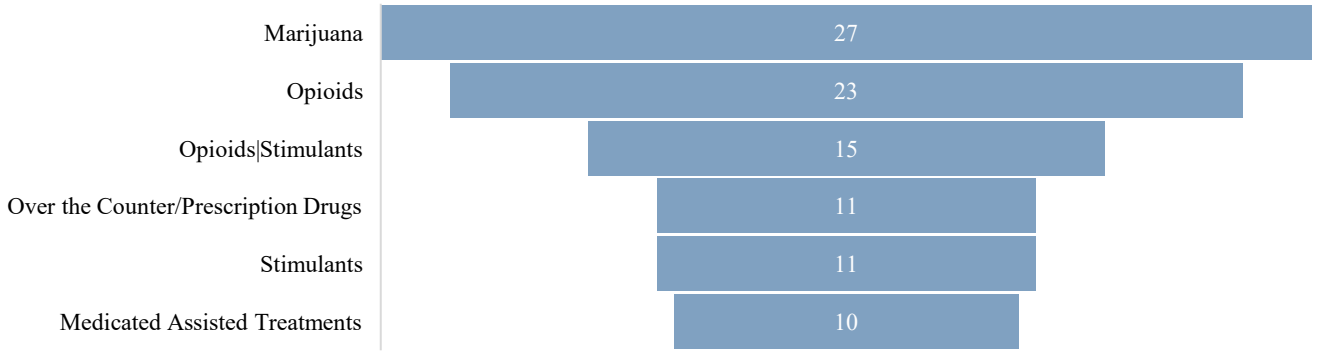


Chart is only displaying counts more than 10.

Child Protection Accountability Commission | Child Welfare Dashboard

A Tableau dashboard is a powerful tool that allows us to showcase our data points and trends that we have accumulated over the years to anyone who accesses it. It is a fully interactive platform with data visualizations, tooltips, and adjustable filters that allow the users the ability to narrow down or expand the parameters of the data that they would like to see.

We included Glossary tabs in the dashboards to define some of the language that is used and to provide extra context about the data, if needed.

Click this link to redirect to the Tableau Dashboards - https://public.tableau.com/app/profile/cpac

Sections Featured in the Dashboard