STATE OF DELAWARE
CHILD PROTECTION ACCOUNTABILITY COMMISSION
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August 21, 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 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 (nine deaths and 50 near-deaths) and screened out another 178 cases. Thus far in 2025, CPAC has screened in 21 cases (three deaths and 18 near-deaths) and screened out another 73 cases.

As required by law, CPAC approved findings from 31 cases at its August 20, 2025 meeting.[1] These cases are divided into two sections – cases that received a final review after completion of prosecution and cases that were reviewed for the first time.

This quarter, 16 cases received a final review. These included four deaths and 12 near-deaths that occurred between December 2021 and October 2024. Seven of the 16 cases were charged. There were five convictions, one case received probation before judgment, and another case was dismissed due to the death of the defendant. Two defendants were convicted of Child Abuse 1st. In one case, where a two-month-old suffered Abusive Head Trauma and bone fractures, the defendant received a four-year jail sentence. In the other case, a two-month-old suffered Abusive Abdominal Injuries and bone fractures, and the defendant received a three and a half-year jail sentence. 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.

[1] 16 Del.C. §932.

The 15 remaining cases are from deaths or near-deaths that occurred between November 2024 and March 2025. Of these cases, one death and four near-deaths will have no further review and were not prosecuted – these include poisoning via drug ingestion, unsafe sleep, and bone fractures.

There are 10 cases – two deaths and eight near-deaths – that will remain open pending prosecutorial outcomes. These cases include bone fractures, child torture, failure to thrive/medical neglect, unsafe sleep, poisoning via drug ingestion, and rhabdomyolysis (muscle breakdown).

For these 15 cases from November 2024 to March 2025, there were 29 strengths and 27 findings across system areas. Seventeen strengths and only five findings were noted for the Multidisciplinary Team Response. These numbers continue to demonstrate the forward progress in the expertise of the frontline investigators.

For the medical response, this quarter demonstrated seven findings and five strengths. Three of those findings indicate breakdowns in reporting cases to the DFS report line by primary care physicians or hospitals; however, there were also three strengths for reporting promptly in this same review period. The 2025 recognition and reporting training for medical professionals continued to focus on how to recognize and report child abuse and neglect, and there should be a measurable impact on findings.

Seven strengths and 15 findings were noted regarding the Division of Family Services ("DFS"). Almost half of the DFS findings were regarding caseloads (seven). No trends were seen in 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,

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

Enclosures

Cc: CPAC Commissioners, General Assembly

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

INITIAL REVIEWS	
MDT Response	**5**
Crime Scene	3
General - Criminal Investigation	1
Interviews - Adult	1
Medical	**7**
Medical Exam/ Standard of Care - Birth	1
Medical Exam/ Standard of Care - ED	2
Medical Exam/ Standard of Care - ED & Specialist	1
Reporting	3
Risk Assessment/ Caseloads	**10**
Caseloads	7
Collaterals	1
Documentation	1
Risk Assessment - Tools	1
Safety/ Use of History/ Supervisory Oversight	**3**
Safety - Completed Incorrectly/ Late	1
Safety - Inappropriate Parent/ Relative Component	1
Safety - No Safety Assessment of Non-Victims	1
Unresolved Risk	**2**
Contacts with Family	2
Grand Total	**27**

FINAL REVIEWS	
Grand Total	**0**

TOTAL CAN PANEL FINDINGS	**27**

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

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Detail

INITIAL REVIEWS

MDT Response			5
	Crime Scene		3
		The scene investigation by the law enforcement agency was delayed.	2
		The initial responding law enforcement agencies allowed the suspect to leave the treating hospital and did not process the vehicle for evidence due to jurisdictional issues.	1
	General - Criminal Investigation		1
		There was not an initial MDT response to the near death incident in compliance with the MOU and statute. Two law enforcement agencies declined to handle the criminal investigation due to jurisdictional issues, which resulted in a delayed investigative response.	1
	Interviews - Adult		1
		There was no documentation that the law enforcement agency interviewed other adults that had been in or around the home prior to the death incident.	1
Medical			7
	Medical Exam/ Standard of Care - Birth		1

		A urine drug screen was not completed on the child at birth, despite the mother disclosing daily marijuana use and having a positive drug screen.	1
	Medical Exam/ Standard of Care - ED		2
		The child's temperature was not initially obtained by the treating hospital, thereby potentially deterring an accurate assessment of time of death.	1
		The physician and the nurse did not communicate with the Division of Forensic Science to determine whether the family could have bedside contact with the deceased infant.	1
	Medical Exam/ Standard of Care - ED & Specialist		1
		The CARE Team was not consulted despite the concerns of failure to thrive from various specialists, even after a report was made to the DFS Report Line for neglect.	1
	Reporting		3

		There was no report to the DFS Report Line by the treating hospital, the basic life support unit, or the paramedics regarding the death of the child.	1
		There was no report to the DFS Report Line by the treating hospital when the child disclosed being hit with a brush multiple times by a paternal relative.	1
		There was no report made to the DFS Report Line by the primary care provider when the provider became aware that the mother had not taken the child to the emergency department as instructed. The provider attempted to reach the mother regarding same without success.	1
Risk Assessment/ Caseloads			**10**
	Caseloads		7
		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.	5

		The DFS caseworkers were over the investigation and treatment caseload statutory standards the entire time the cases were open. The caseload does not appear to have negatively impacted the DFS response to the investigation; however, it is unclear whether the caseload had a negative impact to the treatment case.	1
		The DFS caseworkers were over the investigation and treatment caseload statutory standards the entire the cases were open, and the caseloads appear to have had a negative impact on the DFS response to the cases.	1
	Collaterals		1
		During the near death investigation, the DFS caseworker did not complete medical or educational collaterals for the child's siblings.	1
	Documentation		1

		The DFS intake worker documented the call from the children's hospital regarding additional injuries as a progress note to the initial hotline report versus creating a new hotline report.	1
	Risk Assessment - Tools		1
		For the prior investigation, the hotline report was assigned a Priority-3 response in contrast with the SDM Response Priority Assessment. Based on report of excessive discipline with a very young child and the presence of visible injuries a week prior, the case met criteria for a Priority-1 response.	1
Safety/ Use of History/ Supervisory Oversight			**3**
	Safety - Completed Incorrectly/ Late		1
		The second child safety agreement required the mother to abide by the no-contact order. The mother was a victim of domestic violence perpetrated by the step-father; the perpetrator is responsible for abiding by the no-contact order.	1
	Safety - Inappropriate Parent/ Relative Component		1

		The initial child safety agreement allowed the child to remain in the home with the mother as a safety participant. The mother was alleged to have been aware of the physical abuse and tried to coerce the child into not disclosing, displayed a negative attitude towards the child, and was a victim of domestic violence perpetrated by the step-father.	1
	Safety - No Safety Assessment of Non-Victims		1
		During the prior investigation, there was no documentation that the non-victim children residing in the home were observed or safety was adequately assessed for these children.	1
Unresolved Risk			**2**
	Contacts with Family		2

		For the 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 months later, and the actual contact did not occur for another three months.	1
		For the treatment case, 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 one month later, and the actual contact did not occur for another week.	1
Grand Total			**27**

FINAL REVIEWS

System Area	Finding	PUBLIC Rationale	Count of #
Grand Total			
TOTAL CAN PANEL FINDINGS			27

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

INITIAL REVIEWS

	Current
MDT Response	**18**
Crime Scene	2
General - Civil Investigation	1
General - Criminal Investigation	4
General - Criminal/Civil Investigation	8
Interviews - Child	1
Medical Exam	1
Reporting	1
Medical	**5**
Medical Exam/Standard of Care - Films	1
Medical Exam/Standard of Care - Specialists	1
Reporting	3
Safety/ Use of History/ Supervisory Oversight	**4**
Completed Correctly/On Time	2
Oversight of Agreement	1
Safety Assessment of Non-Victims	1
Unresolved Risk	**3**
Child Risk Factors	1
Parental Risk Factors	2
Grand Total	**30**

FINAL REVIEWS

	Current
Legal	**1**

TOTAL CAN PANEL STRENGTHS	**31**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

INITIAL REVIEWS

System Area	Strength	Public Rationale	Count of #
MDT Response			18
	Crime Scene		2
		Following the investigation, the detective returned to the home to conduct a safety check, ensuring the relative's belongings had been removed from the home and there were no other marijuana edible gummies found in the home.	1
		The law enforcement agency conducted a thorough investigation to include interviews with all household members, adults and children, evidentiary blood draws, a scene investigation with evidence collection, and an intake with the DAG.	1
	General - Civil Investigation		1
		The after-hours DFS supervisor made exhaustive efforts and collaborated with the Deputy Investigative Coordinator to identify the correct law enforcement jurisdiction to ensure a joint MDT response in compliance with the MOU and statute.	1
	General - Criminal Investigation		4
		The Deputy Investigation Coordinator meticulously tracked the initial MDT process and did an excellent job in coordinating with the two involved law enforcement agencies to resolve the jurisdictional issues.	2

		Despite the initial jurisdictional issues and prior to a detective being assigned, the subsequent law enforcement agency's Special Victims Unit Supervisor assumed the investigation and attended the MDT meeting to prevent any delay to the criminal investigation, which resulted in criminal charges being filed for both parents.	1
		Despite the initial jurisdictional issues, the subsequent law enforcement agency's supervisor collaborated with the Deputy Investigation Coordinator and assumed the investigation in an effort to prevent any further delay to the criminal investigation, which resulted in criminal charges being filed for the suspect.	1
	General - Criminal/Civil Investigation		8
		There was a good MDT response to the near death incident, which included a joint response to the home, joint interviews where applicable, medical evaluation and forensic interview of the older sibling, a scene investigation, and consistent communication and collaboration among the MDT members.	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, and consistent communication and collaboration among the MDT members.	1

		There was early involvement of the Investigation Coordinator as requested by DFS to assist with MDT collaboration on this case, as it was initially unclear whether there were concerns for abuse or	1
		There was a good MDT response to the near death incident, which included joint responses to the hospitals and to the home, joint interviews, and consistent communication and collaboration among the MDT members.	1
		Given the language barrier, there was a good use of resources to communicate with the family, to include the bilingual DFS caseworker and detective and the use of the language translation services.	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, evidentiary blood draws, and consistent communication and collaboration among the MDT members.	1
		There was a strong, joint response to the near death investigation, with consistent MDT involvement throughout.	2
	Interviews - Child		1
		A forensic interview was scheduled and held at the CAC for the victim. The interview had to be rescheduled multiple times due to the child's medical condition. The MDT was persistent and continued to give the child a chance to get his story out.	1
	Medical Exam		1
		A medical evaluation was completed for the teen sibling residing in the home.	1
	Reporting		1

		The caregiver to the child's siblings and the DFS caseworker made immediate referrals to the DFS Report Line with concerns of neglect after the mother delivered the newborn child. The caseworker did due diligence in following up on the matter and requested a welfare check of the newborn despite the family residing out of state.	1
Medical			5
	Medical Exam/Standard of Care - Films		1
		The expeditious reading of post-mortem CT scan allowed for a post-mortem MRI to be completed, which confirmed the rib fractures.	1
	Medical Exam/Standard of Care - Specialists		1
		The children's hospital social worker provided the family with a lock box and educated the family on the proper storage of substances and medications.	1
	Reporting		3
		The treating hospital made an immediate referral to the DFS Report Line when new suspected injuries were identified as a result of the repeat skeletal survey.	1
		The admitting provider made an immediate referral to the DFS Report Line when the child failed to report for a scheduled admission.	1
		The nutritionist made a referral to the DFS Report Line when the child missed multiple appointments.	1
Safety/ Use of History/ Supervisory Oversight			4
	Completed Correctly/On Time		2

		The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. There was consistent review and modification, when necessary, of the safety agreement.	1
		The DFS caseworker immediately implemented a child safety agreement. The agreement included the teen sibling residing in the home and required the father to leave the home. There was consistent review and modification, when necessary, of the	1
	Oversight of Agreement		1
		The DFS caseworker implemented a child safety agreement when the child was medically cleared for discharge. The DFS caseworker ensured the child's providers were aware of the safety plan and attended a PCP visit with the family.	1
	Safety Assessment of Non-Victims		1
		As part of the initial response, the DFS caseworker assessed all three siblings residing in the home.	1
Unresolved Risk			3
	Child Risk Factors		1
		The victim child was not medically discharged from the hospital until a home assessment and medical evaluations of the siblings were completed.	1
	Parental Risk Factors		2
		In the family's previous state of residence, the child protective services agency was actively involved and provided good support to the mother.	1
		The DFS treatment worker made timely, appropriate referrals for the family.	1

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

FINAL REVIEWS

System Area	Strength	Public Rationale	Count of #
Legal			1
	Prosecution/ Pleas/Sentence		1
		During criminal case resolution, the prosecutor did an excellent job ensuring the MDT best practices were followed by having a pre-sentence investigation completed, giving the mother an opportunity to make a victim impact statement, recommending sentencing within the SENTAC guidelines, and presenting the aggravating factors of the case, resulting in an appropriate outcome	1
Grand Total			**1**

TOTAL CAN PANEL STRENGTHS	**31**