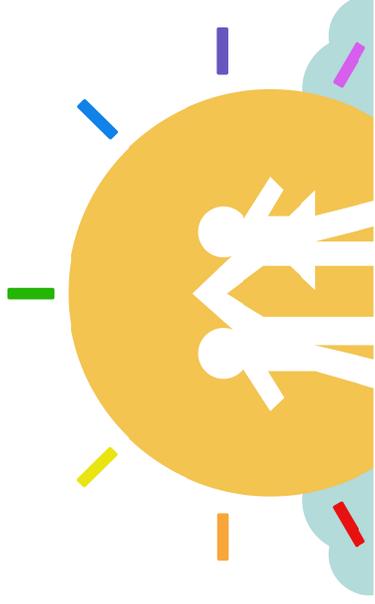


# Child Death, Near Death and Stillbirth Commission “CDNDSC”

Protecting Delaware’s Children  
Conference 2008



*Every Child Deserves a Tomorrow*

# History of “CDNDSC”

- The Child Death Review Commission was established in 1995 by [statute](#) (Section 320 et seq.). The mission is to safeguard Delaware's children by examining the deaths of children under the age of 18.



# Purpose of CDNDSC



The primary purpose of reviewing child deaths is the prevention of future child deaths. The *retrospective* review is intended to provide meaningful, prompt, system-wide recommendations in an effort to prevent future deaths and to improve services to children. A child death is considered preventable if one or more interventions might reasonably have averted the child's death.

# Key Objectives:



- Review in a confidential manner the deaths of children under the age of 18, near-deaths of abused and/or neglected children and stillbirths occurring after at least 20 weeks of gestation.
- Provide the Governor, General Assembly and Child Protection Accountability Commission with recommendations to alleviate those practices or conditions that impact the mortality of children.
- Assist in facilitating appropriate action in response to recommendations.

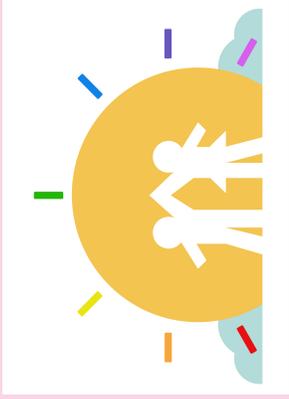
# Three Child Death Panels

By statute, CDNDSC has the authority to create up to 3 regional Child Death

Panels:

- New Castle Panel
  - Joint FIRT review
- Kent/Sussex Panel
- CAN Panel
  - Expedited/Final review for deaths /near deaths





# CDNDSC Activities

- Identify and triage cases for review.
- Prepare and review child death and near-death cases that meet the statutory criteria for review.
- Make recommendations to decrease child mortality.
- Collect and analyze data related to child deaths and near deaths.
- Issue annual reports and expedited review reports outlining recommendations and data.

# What is FIMR?



Key steps in the FIMR process include:

- Information about the fetal/infant death is collected through public health data, medical records and reviewed by a Registered Nurse.
- An interview is conducted with the mother who suffered the loss by a Senior Medical Social Worker. Referrals for bereavement support and community resources are offered.
- The CRT comprised of health professionals, social service professionals and other experts from the community review the case summary and interview, identify issues and make recommendations for community change if necessary.
- The Community Action Team (CAT), is a diverse group of community leaders who review the CRT recommendations and implement interventions to improve service systems and resources.

# Commissioners

- Attorney General
- Office of the Child Advocate
- Chief Medical Examiner
- 2 Child Advocates from state-wide non-profit
- Child Death Review Panel Chairs
- Child Protection Accountability Commission
- Delaware Health and Social Services
- Delaware Nurses Association
- Delaware State Police
- Department of Education

# Commissioners (cont.)

- Department of Services for Children, Youth and their Families
- Division of Public Health
- Family Court
- FIMR Chairs
- National Association of Social Workers
- Neonatologist
- New Castle County Police Department
- OB/GYN
- Pediatrician
- Perinatologist
- Police Chiefs Council

# Partnering Commissions

Collaboration with the **Child Protection Accountability Commission** through semi-annual joint meetings has led to the implementation of the following subcommittees:

- Caseloads/Workloads
- CAPTA disclosure of child fatalities/near fatalities caused by abuse/neglect
- Delaware Code Changes/Standardized Definitions of Abuse/Neglect
- Multi-disciplinary use of history in decision making
- Safe Sleeping Practices/SIDS



# Partnering Commissions

FIMR utilizes the Delaware Healthy Mother Infant Consortium's subcommittees as community action teams. They include the following:

- Standards of Care
- Prevention and Education
- Systems of Care
- Data and Scientific
- Health Disparities



# Annual Report Statistics

- Delaware's infant mortality rate remains the sixth worst in the nation.
- 47 % of all *natural* deaths reviewed were attributed to prematurity.
- 59% of all *infant* deaths were due to prematurity.
- African Americans make up 19% of Delaware's population. However, African American children disproportionately represent 40% of all deaths CDNDSC has reviewed.

# Annual Report Statistics

- 67% of all non-natural deaths reviewed can be attributed to motor vehicle crashes. A 19% increase from the period covered by the 2000-2002 annual report.
- The adolescent drivers accounted for 59% of deaths due to motor vehicle crashes.



# Annual Report Statistics

- 41% of all homicides involved teenagers. 91% of these deaths involved use of a firearm.
- Firearms were used in 62% of the adolescent suicides.
- The risk factors that were most prevalent in SIDS/SUIDS cases were infants not sleeping in a crib, sleeping with adults or children in the same location, and not sleeping on their backs.

# CDNDSC Initiatives

- Joint Conference with CPAC (Spring 2008)
- Full Implementation of the National Data Tool (expanded annual report demographics) and BASINET (FIMR database)
- Safe Sleeping DART Bus Media Campaign





## Next Steps

- A report card on action and implementation of recommendations
- Develop or partner with an existing group to address teenage motor vehicle crashes.
- Participation in the planning of the “Golden Link: Moving from Research to Action” 2008 Suicide Conference.

## Next Steps (cont.)

- Continued Safe Sleeping Media campaigns (Partnering with DPH to provide 4,000 posters for distribution to Physicians, medical facilities, and clinics)
- Organize medical training (Mandatory Reporting of Child Abuse/Neglect) as designated by CPAC's Abuse Intervention Medical Subcommittee.



- **Questions and Answers?**

- **Website:**

<http://courts.delaware.gov/childdeath/>

