Delaware CDNDSC

REVIEW & PREVENTION OF CHILD DEATHS

CDNDSC

Child Death, Near Death and Stillbirth Commission

Annual Report for Calendar Year 2013

State of Delaware
Child Death, Near Death and Stillbirth Commission
900 King Street, Suite 220
Wilmington, DE 19801-3341

TO: The Honorable Jack A. Markell
Members of the General Assembly

FROM: Garrett H.C. Colmorgen, M.D.
Chairperson, Child Death, Near Death and Stillbirth Commission

DATE: March 6, 2015

SUBJECT: Fiscal Year 2013 Child Death, Near Death and Stillbirth Commission Annual Report

I am pleased to present to you the eleventh Annual Report of the Delaware Child Death, Near Death and Stillbirth Commission (CDNDSC). The Report provides a summary of the work of the Panels and Commission during calendar year 2013.

This report summarizes the tragedies and inflicted deaths and near deaths of Delaware's most vulnerable population, the children. As Delaware's infant mortality is slowly declining due to the good work of many professionals mentioned in this annual report, we must remember that even one child's death is too many. Therefore, the goal of the CDNDSC has been and will continue to be prevention of future child deaths. This report reflects that mission through prevention initiatives, collaborations with other Delaware agencies, increased data surveillance, and training professionals and community members.

As Chair of the Child Death, Near Death and Stillbirth Commission, I want to thank you for your continued support and action to protect and improve the lives of Delaware's children. I hope you find this report a useful tool to share findings and recommendations to improve policies, practices, and programs that will prevent future child deaths in Delaware.

Garrett H.C. Colmorgen, MD
Chair
Child Death, Near Death and Stillbirth Commission

GHCC/amp
Enclosure

CDNDSC

Child Death, Near Death and Stillbirth Commission

Executive Summary...

The Child Death, Near Death and Stillbirth Commission (CDNDSC or Commission) was established in 1995, with the mission of safeguarding the health and safety of children in Delaware as set forth in 31 *Del. C.* § 320-324. The cases reflected in this report were reviewed during Calendar Year (CY) 2013. These reviews were conducted by multi-disciplinary Child Death Review (CDR) Panels, multidisciplinary Fetal Infant Mortality Review (FIMR) Case Review Teams (CRTs) and a multi-disciplinary Maternal Mortality Review (MMR) Panel. FIMR conducted 63 retrospective reviews of the history and circumstances surrounding each fetal or infant death in Delaware. During this period, 39 death cases (two of these were child abuse/ neglect deaths) and 16 child abuse/neglect near death cases were reviewed by the CDR Panels. The work of the dedicated CDR Panels and CRTs can best be reflected in the recommendations and prevention initiative portion of this annual report.

By reviewing the facts, findings and recommendations presented in this report, please make a commitment to create a safer and healthier Delaware for our children. From this report, the Commission has drawn the following conclusions from CDR, FIMR, and MMR:

CDR

- The Commission reviewed a total of 40 child deaths in CY 2013. Two of these deaths, captured in the Child Death Demographic information section (please see page 23) were initial Child/Abuse Neglect deaths as reviewed by the Child Abuse and Neglect (CAN) Panel. The Kent/Sussex CDR panel and the New Castle County CDR panel reviewed 38 deaths during CY 2013. The three leading causes of death in child death cases reviewed during CY 2013 were motor vehicle crashes (7), suicide (8), and infant unsafe sleeping environments (6). These two panels put forth 12 case recommendations. The Kent/Sussex panel put forth one statement of recognition for great communication/collaboration during a case.
- The CAN panel reviewed five child deaths and 16 near deaths that resulted from abuse and neglect. Of these 21 CAN cases, ten cases were initial reviews and 11 CAN cases were CAPTA reports. These cases were initially reviewed in a prior year and reflected in a prior report. All CAPTA[1] reports are available on the CDNDSC website[2]. Out of the 11 final cases, six had criminal charges that occurred after the death or near death. Of these cases, 13 children were white and eight were Black/African-American. Two of these infants were diagnosed with Neonatal Abstin-ence Syndrome at birth. In four cases, the mother was positive at birth for substance abuse. One mother was diagnosed with postpartum depression. The CAN Panel put forth 77 Commis-sion approved recommendations, six supportive statements and one statement of recognition.

[1] The Federal Child Abuse Prevention and Treatment Act requires the disclosure of facts and circumstances related to a child's near death or death. 42 U.S.C. §5106 a(b)(2)(A)(x). See also 31 Del. C. § 323(a).

[2] Available at: http://courts.delaware.gov/childdeath/reports.htm

Executive Summary... *(continued from page 4)*

- The Commission reviewed three homicide cases not due to abuse or neglect. All three deaths were Black/African-American children. They were in the age range of 15 to 17 years and involved handguns. Two children were male and one was female. One of the handguns had been stolen by the perpetrator. Three causes elicited random violence, showing the gun to others, and an argument. Factors include: history of substance abuse, criminal history, time spent in juvenile detention, prior history of maltreatment as a victim, and Department of Services for Children, Youth and their Families (DSCYF) placement outside of the home.

- This report reflects eight suicides that were reviewed and approved by the Commission during 2013. Five of the 11 cases that occurred in Kent/Sussex counties between January 1 and May 4, 2012 are reflected in this total.

- In CY 2013, six deaths were reviewed in Delaware due to infant unsafe sleeping. Two of the cases are undetermined and the others may be due to another cause of death. The Commission continues to see approximately one referral every month due to this type of death. In 100% of the cases (6 out of 6), the infant was **NOT** sleeping in a crib or bassinette. Moreover, in 50% (3 of 6) of the cases, the infant was bed-sharing with another individual. Of the six infant safe sleeping deaths, only one infant was being breastfed when discharged from the birthing hospital.

- During CY 2013, the Commission reviewed seven child deaths due to motor vehicle crashes either as a passenger, driver, pedestrian, bicyclist, or on an ATV. Six of the children were male and one was female. Six children were white, one was Black/African-American and one was Hispanic/Latino. Two children were drivers (one driving an ATV) and responsible for the motor vehicle crash and the other child was a passenger. One of these incidences took place in an urban setting, two were in a rural setting and four were in a suburban area. One of the adults responsible for the crash did not have a license. There was no drug/alcohol impairment noted in these cases nor were graduated licensing rules violated. There were no apparent risk factors noted such as ice/snow, wet roads or inadequate lighting. Protective measures that were not implemented include seat belts for child passengers, helmets for children riding a bicycle/ATV and car seats for infants.

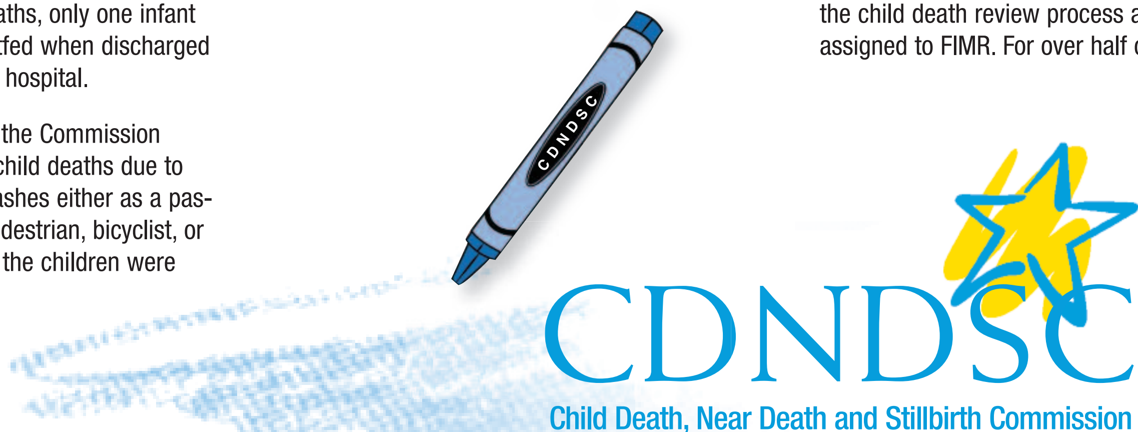
FIMR

- In 2013, 63 FIMR cases were reviewed, including 28 fetal deaths and 35 infant deaths. The cases represent losses that occurred to 57 mothers, including one triplet and five twin pregnancies. Twenty-two mothers (39%) were interviewed by the CDNDSC senior medical social worker.

- Six recommendations were drafted by FIMR CRTs and approved by the CDNDSC. While a particular recommendation may be based on a single case, often there is supporting evidence from other cases which indicates that the recommendation fits with the CRTs' findings in a subset of FIMR cases. For each recommendation, a table of aggregate CRT findings from all 63 FIMR cases notes the corresponding strengths, contributing factors and suggestions that are related to that recommendation.

- Similar to the total group of 2011 fetal deaths in Delaware, the majority of fetal deaths among FIMR cases occurred to White mothers (62%, n=16). Black/African-American mothers, however, made up the majority of infant death cases reviewed (55%, n=17), a slightly higher proportion than in the group of all 2010 Delaware infant deaths.

- 80% of FIMR infant deaths occurred in the neonatal period, the first 28 days of life, and over half (54%) occurred in the first 24 hours. Neonatal deaths represent a higher proportion of FIMR cases compared to the total 2010 Delaware infant death cohort. This may be due, in part, to the fact that certain causes of death —such as unsafe sleeping, non-accidental trauma or unexplained causes (i.e. SIDS or SUID) that may occur later in infancy are reviewed as part of the child death review process and not assigned to FIMR. For over half of FIMR



Executive Summary... *(continued from page 5)*

infant cases (57%, n=20) prematurity was ascribed as the primary cause of death. This is a higher proportion than among all 2010 Delaware infant deaths, for which prematurity and low birth weight was the primary cause of death in 22.6% of cases.[3] More Black/African-American infants died of prematurity (75%, n=15) among FIMR cases than White infants, (33%, n=5). Cardiac or respiratory failure was the second leading primary cause of death among FIMR cases. Congenital anomalies, which overall accounts for about 15% of Delaware infant deaths, was more common among FIMR cases involving White infants (13%, n=2).[4]

MMR

- In 2013 the MMR panel reviewed one maternal death dating from 2009, four cases of deaths occurring in 2010 and one case from 2012. The panel classified three deaths as pregnancy-related, two cases as pregnancy-unrelated—a cause of death not related or aggravated by the woman's pregnancy or its management, and one case as undetermined. One case included a family interview in which the CDNDSC senior medical social worker had spoken with the father of a deceased woman.

Statistics for Fiscal Year (FY) 2013 (July 1, 2012 through June 30, 2013) include:

- 46 deaths were reviewed by the Child Death Panels;
- 15 initial cases were reviewed by the Child Abuse/Neglect Panel;
- 22 cases were final reviews of child abuse/neglect;
- 124 fetal and infant deaths (62 fetal and 62 infant) were referred to CDNDSC; of those cases, six did not meet statutory authority;
- 54 cases were reviewed by FIMR Case Review Teams;
- 26 maternal interviews were conducted with mothers who have had a fetal/infant loss; and
- 2 of the maternal interviews were conducted jointly with a Spanish speaking interpreter;
- 7 maternal deaths were reviewed by the MMR;
- All fetal, infant, and child death cases that are referred to CDNDSC but not statutorily under the CDNDSC purview are still reviewed for system concerns if services were sought in Delaware. 197 cases of this type were referred and reviewed by CDNDSC staff. This is in addition to the cases reviewed by the panels or teams. These cases are classified as triage within the office.

[3] Delaware Health Statistics Center. *Delaware Vital Statistics Annual Report, 2010*. Delaware Department of Health and Social Services, Division of Public Health: 2013.

[4] Delaware Health Statistics Center. *Delaware Vital Statistics Annual Report, 2010*. Delaware Department of Health and Social Services, Division of Public Health: 2013.

Glossary 8

Purpose of Child Death Reviews 10

Prevention Initiatives and Education 12

Collaborative Initiatives 14

Delaware Child Review 20

Abuse/Neglect Deaths or Near Deaths 23

Recommendations for Cases Reviewed 29

Infant Unsafe Sleeping Deaths 31

Recommendations for CDR Cases Reviewed During CY 2013 33

Fetal and Infant Mortality Review (FIMR) 59

Maternal Mortality Review (MMR) 73

Commission and Panel Members 76

CDNDSC

Child Death, Near Death and Stillbirth Commission

Glossary...

ACOG: American Congress of Obstetricians and Gynecologists

Acute Intoxication: A condition that follows the administration of a psychoactive substance and results in disturbances in the level of consciousness, cognition, perception, judgment, affect, or behavior, or other psychophysiological functions and responses.

AHT: Abusive Head Trauma; formerly called Shaken Baby Syndrome

AMCHP: Association of Maternal and Child Health Programs

AWHONN: Association of Women's Health, Obstetrics and Neonatal Nurses

BASINET: Baby Abstracting System and Information NETwork

Birth Spacing: The optimal time for a woman to wait between pregnancies.

CAN: Child Abuse and Neglect

CAPTA: Child Abuse Prevention and Treatment Act

CCHS: Christiana Care Health System

CDNDSC: Child Death, Near Death and Stillbirth Commission (the Commission)

CDR: Child Death Review

CPAC: Child Protection Accountability Commission

CPR: Cardiopulmonary Resuscitation

CPS: Child Protective Services (in Delaware known as DFS)

CRT: FIMR Case Review Team

Delaware Juvenile Justice Advisory Group: Established by Executive order on 7/19/04. More information can be found at http://cjc.delaware.gov/juvjustice/index.shtml

DFS: Division of Family Services

DHMIC: Delaware Healthy Mother and Infant Consortium

Disparity: A lack of equality between people or things.

DPH: Division of Public Health

DSCYF: Department of Services for Children, Youth, and their Families

DTI: Department of Technology and Information

DV: Domestic Violence

Glossary... *(continued from page 8)*

Failure to thrive: A pronounced lack of growth in a child because of inadequate absorption of nutrients or a serious heart or kidney condition, resulting in below-average height and weight.

Fetal Death: Death before the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy; the death is indicated by the fact that after such separation, the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

FIMR: Fetal and Infant Mortality Review

Graduated Driver Licensing Law: A method of licensing used for granting individuals the privilege to perform a task that takes skill and may put other individuals at risk of harm if not done properly, notably driving. Graduated driver's licensing generally restricts nighttime, expressway, and unsupervised driving during initial stages, but lifts these restrictions with time and further testing of the individual, eventually concluding with the individual attaining a full driver's license. Districts that have enacted graduated driver's licensing have reported significant drops in fatal accidents.

HIV: Human Immunodeficiency Virus

HMO: Health Maintenance Organization

HWHB: Healthy Women Healthy Babies

Joint Commissions: CDNDSC and CPAC

LCP: Life Course Perspective

Maternal Interview (MI): The FIMR maternal interview provides the mother's perspective of her baby's death and allows her to describe her experiences in her own words.

MOU: Memorandum of Understanding that describes an agreement among parties.

MFM: Maternal Fetal Medicine

NICHD: National Institute of Child Health & Human Development

NFP: Nurse Family Partnership

NICU: Neonatal Intensive Care Unit

NFIMR: National FIMR

OB: Obstetrician

OCCL: Office of Child Care Licensing

P-value: Is a measure of how much evidence you have against the null hypothesis.

PCAD: Prevent Child Abuse Delaware

PROM: Preterm Premature Rupture of Membranes

RM: Resource Mothers

SIDS: Sudden Infant Death Syndrome

SS: Smart Start

STD: Sexually Transmitted Disease

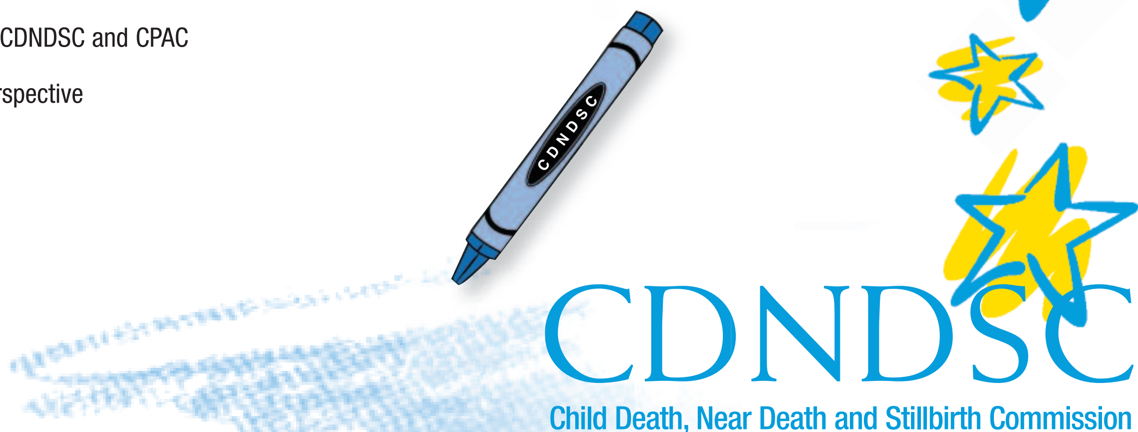
SUID: Sudden Unexplained Infant Death

VNA: Visiting Nurses Association

WIC: Women Infants and Children

Wilmington Consortium: Is a group of over 20 agencies committed to working with neighborhood residents to address health disparities, improve birth outcomes and prevent infant mortality in the City of Wilmington. The Consortium is funded by the Delaware Division of Public Health and works to advance the priorities of the Delaware Healthy Mother and Infant Consortium through Education and Outreach in Wilmington.

Z-test: Compares sample and population means to determine if there is a significant difference.



Purpose of Child Death Reviews...

The Commission provides meaningful system-wide recommendations to prevent the deaths and/or near deaths of children and improve the systems that provide services to children. The process brings professionals and experts together from a variety of disciplines to conduct retrospective case reviews, create multi-faceted recommendations to improve systems, and facilitate interagency collaboration to reduce the mortality of children in Delaware.

Background

Delaware's child death review process was statutorily established on July 19, 1995, after a pilot project showed the effectiveness of such a review process for preventing future child deaths. The legislation established the Child Death Review Commission, which has been charged to create up to three regional review panels, establish confidentiality for the reviews, and provide the Commission with the ability to secure pertinent records. In addition, legislation provides protection to members of the Commission and regional review panels from civil or criminal liability. The Commission has established three panels. The New Castle County and Kent/Sussex County Panels review all non-child abuse or neglect deaths in their respective county. The Child Abuse and Neglect (CAN) Panel review deaths and near deaths due to child abuse and neglect statewide. The New Castle County Panel and the Kent/Sussex County Panel meet bi-monthly; whereas, the CAN panel meets monthly. The Commission meets quarterly to review and approve the work of the Panels.

The Commission's statute was amended in 2002, changing the name from the Delaware Child Death Review Commission to the Child Death and Stillbirth Commission. Another significant legislative change in 2002 added the expedited review process for child death due to abuse and neglect. Deaths involving abuse and/or neglect are reviewed within six months of a referral to the Commission, notwithstanding unresolved criminal charges. In 2004, the statute was amended a second time to change the Commission's name to the Child Death, Near Death and Stillbirth Commission. Among other updates, the scope of infant review was broadened to include fetal and infant deaths from 27 weeks gestation to 20 weeks gestation. Also, the statutory change required the Commission to investigate and review all the facts and circumstances of the death or near death[5] of an abused and/or neglected child expeditiously. The amended statute also required that system-wide recommendations arising from an expedited review of a death or near death due to child abuse or neglect be made to the Governor and General Assembly, as well as any

[5] Near death is defined as a child in serious or critical condition as a result of child abuse or neglect as certified by a physician.

Purpose of Child Death Reviews... (continued from page 10)

members of the public requesting the recommendations, within 20 days following the expedited review. In addition, the chair of the Child Protection Accountability Commission (CPAC) was added as a member of CDNDSC and it was legislated that the two Commissions would meet at least annually to discuss recommendations and system improvements. Finally, a fiscal note was attached to the 2004 legislation in order to fund three staff positions dedicated to supporting the Commission.

In FY 2005, the Commission worked in collaboration with the Division of Public Health (DPH) to implement a Fetal Infant Mortality Review pilot project under the leadership of the Governor's Infant Mortality Task Force. In FY 2006, FIMR's budgetary positions were placed with the Commission. These three positions include a registered nurse III (FIMR Program coordinator), senior medical social worker, and an administrative specialist. The most significant accomplishment for FY 2007 was the full implementation of the Fetal Infant Mortality Review process. The bi-annual joint reviews with the Domestic Violence Coordinating Council's Fatal Incident Review Team began in April 2007. The cases reviewed involved child deaths and near deaths with domestic violence as a significant risk factor in the death or near death. In an effort to streamline these types of reviews, a member of the Domestic Violence Coordinating Council is now a participant at every child death panel.

During FY 2008, the Commission's statute was amended to include Maternal Death Review and allow for public disclosure of deaths and near deaths due to abuse and/or neglect, after prosecution, to fulfill the federal CAPTA statute mandate. The Maternal Mortality Review program was implemented in FY 2012.

CDNDSC
Child Death, Near Death and Stillbirth Commission

Prevention Initiatives and Education...

"When I was very young, most of my childhood heroes wore capes, flew through the air, or picked up buildings with one arm. They were spectacular and got a lot of attention. But as I grew, my heroes changed, so that now I can honestly say that anyone who does anything to help a child is a hero to me." - Fred Rogers

Every Delawarean can impact the life of a child and in some instances, prevent a future death. The following initiatives are driven by individuals and agencies that are committed to the mission of CDNDSC.

All Babies Cry® Program

The CDNDSC, in collaboration with Vida Health Communications, Inc. and Prevent Child Abuse Delaware (PCAD) (through a grant from the Federal Community Based Child Abuse Prevention Program/CBCAP) are reaching out to new parents with a statewide Abusive Head Trauma (AHT) evidence-based program entitled "All Babies Cry"® (ABC)[6] in an effort to educate parents and prevent this tragedy from occurring. Using the "Strengthening Families"[7] model's protective factors, ABC goes beyond traditional AHT prevention and additionally aims to enhance new parents' (particularly fathers) confidence in soothing their infant and themselves when feeling stressed. ABC consists of media targeted to appeal to new parent appetites for information.

All Babies Cry® launched on January 1, 2014. Approximately 10,000 to 13,000 new parents will be receiving this much-needed information. Staff at each birthing hospital will be trained to introduce the 11-minute in-hospital version of ABC to new parents and family at maternity bedside. Staff will also be providing parents with a postcard (as shown) that directs them to view the rest of the media and a 28 page booklet online or on their mobile devices at www.AllBabiesCry.com, access code: Delaware. The video and booklet have been organized into four chapters to make it easier to fit into new parents' busy schedules. Parents can watch the entire video or chapters at any time on their computer or TV. They can also print out as many copies of the booklet as they would like. This information is helpful to anyone who will be caring for their newborn, and includes a tip sheet for what soothing techniques can work for the specific newborn. All materials are in English and Spanish with closed captioning.

ALL BABIES CRY

Tried and true tips for comforting your newborn (and yourself)

1 BABY CRYING?

2 NEED HELP?

3 GO HERE! www.allbabiescry.com

Enter your access code: DELAWARE

TABLE OF CONTENTS
- What's Normal About Crying?
- Comforting Your Baby
- Self-care Tips for Parents
- Colic and How to Cope

Watch the "All Babies Cry" videos and read the booklet on your computer or phone!

This program is supported by funding from the US Department of Health and Human Services, Administration on Children, Youth, and Families, Community Based Grants for the Prevention of Child Abuse and Neglect. The number is CAN 2012099455I.

Prevent Child Abuse Delaware

REVIEW & PREVENTION OF CHILD DEATHS

[6] "All Babies Cry"® was developed by public health communications specialists and educators at Vida, with support and funding from the Massachusetts Department of Public Health and from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD).

[7] Strengthening Families is a new public health model developed by Center for the Study of Social Policy designed to prevent child abuse and neglect.

Prevention Initiatives and Education... *(continued from page 12)*

Delaware Cribs for Kids[8]

In June 2009, a partnership was developed between the Delaware Division of Public Health, Nemours Health and Prevention Services of the Nemours Foundation (Nemours), Christiana Care and CDNDSC to implement the first Cribs for Kids® program in Delaware. As a result of this program, a crib is provided to any Delaware mother if she is unable to purchase a crib on her own and meets the following criteria: is due to deliver the baby within six weeks or the infant is younger than twelve months of age; and the family has not previously received a crib from the program. The first crib was distributed in November 2009. This program is one of the biggest accomplishments from the Joint Commission Infant Safe Sleeping Community Action Team.

On December 23, 2011, CDNDSC assumed more responsibility for this program and became the gatekeeper for all crib distribution. The designated new telephone number is 302-255-1743. The education will be provided to the family by a Division of Public Health nurse or other trained staff within the community. The preventive part of the program is the education that must be given by the nurse on unsafe sleeping practices for infants. Delaware is the only state that offers this education in the home, and has been recognized by national leaders as the gold standard versus the client picking up the crib at an office or facility. Cribs for Kids® is an evidence-based program that has had successful outcomes in other states in reducing infant unsafe sleeping deaths and is an excellent example of collaborative partnerships in Delaware on behalf of children. This program is completely funded through grants, monetary donations, and fundraising efforts.

During CY 2013, 270 cribs were delivered state-wide through the Delaware Cribs for Kids program. Thus far, two infants of a parent or caretaker that received a crib and the mandatory infant safe sleep education have died as a result of unsafe infant sleeping. From the inception of the program in the fall of 2009 through December 31, 2013, 1050 cribs have been distributed.

Delaware Cribs for Kids partners/educators:

- A. I. duPont Hospital for Children
- Division of Public Health
- Children and Families First
- Christiana Care Health Services
- Delaware Adolescent Program Inc.
- Division of Family Services
- LaRed Health Center
- New Directions Early Head Start (within University of Delaware)
- Westside Health (all four locations)

[8] Since 1998, through the donation of thousands of cribs, National Cribs for Kids® has been making an impact on the rate of babies dying of SIDS and from accidental suffocation. Cribs for Kids® is a safe-sleep education program to help reduce the risk of injury and death of infants due to unsafe sleep environments. Currently, Cribs for Kids® has 310 partner programs in 43 states throughout the country that provide a Graco Pack 'n Play® crib and educational materials regarding safe sleeping and other important safety tips.

Collaborative Initiatives...

Child Protection Accountability Commission

CPAC and the CDNDSC continued their legislatively mandated collaboration through CY 2013. In addition to semiannual Joint Commission Meetings, CPAC and CDNDSC held the Protecting Delaware's Children Conference and continued to engage in joint committees to address recommendations from the state's child death and near death reviews. The Joint Committees include the following: Investigation and Prosecution of Child Abuse, Mandatory Reporting Outreach Campaign, Foster Care Medical Committee, and The Infant Safe Sleeping Program Community Action Team.

Investigation and Prosecution of Child Abuse Committee

In December 2011, CPAC and CDNDSC held their semiannual joint meeting and approved the creation of the Joint Committee on the Investigation and Prosecution of Child Abuse. The Committee began meeting in February of 2012 and considered the following information: child death and near death reviews, specific charging patterns of prosecutors and police, criminal law, conviction rates, and recurring problems encountered in the investigation and prosecution phases. The Committee met on seven occasions before forwarding its recommendations to the Joint Commission for approval. On May 17, 2013, the Final Report[9] of the Joint Committee on the Investigation and Prosecution of Child Abuse was approved by CPAC and CDNDSC, and the Committee formally disbanded. In total, nine recommendations were made and they are summarized as follows: creation of a Special Victims Unit within the Department of Justice (DOJ) to handle all felony level, criminal child abuse cases; establishment of a team of criminal investigators within the DOJ to work with the Special Victims Unit; enactment of a criminal statute that allows for prosecution of caregivers who, with criminal negligence, enable the sexual abuse, serious physical injury or death of a child; review of Delaware's sentencing guidelines as they pertain to criminal child abuse cases; develop best practice guidelines for the investigation of child abuse cases involving sexual abuse, serious physical injury or death; provide regular training opportunities and demonstrative tools for professionals involved in the investigation and prosecution of serious physical abuse cases; assign a Deputy Attorney General specializing in the prosecution of felony level child abuse to the CDNDSC Child Abuse and Neglect Panel; create a comprehensive case management system within the DOJ; and provide CPAC support to the DOJ for budgetary requests for appropriate resources.

Since the approval of this report, the DOJ has created a Child Victims Unit, and the DOJ's budgetary requests for two positions, a Child Abuse Deputy Attorney General and Investigator, have been funded. Prior to this report, the DOJ had issued a request for proposal for a case management system and implementation is anticipated within the next year.[10]

[9] The report can be accessed at http://courts.delaware.gov/childdeath/docs/JointCommitteeFinalReport-05172013.pdf

[10] http://courts.delaware.gov/childadvocate/CPACreports.stm

Mandatory Reporting Outreach Campaign

CPAC and CDNDSC's Mandatory Reporting Outreach Committee developed a campaign for the second year during the month of April 2013 for Child Abuse Prevention and Awareness Month. Funding received from DSCYF, Children's Justice Act Grant and the Protecting Delaware's Children fund enabled the group to unveil its media activities and broadly disseminate its message, See the Signs, Make the Call, through a Proclamation Signing on April 25, 2013 at Legislative Hall, public service announcements and statewide billboards in English and Spanish. The public service announcements (PSAs) were recorded by Governor Jack Markell, Attorney General Beau Biden, and Leslie Newman, Executive Director of Children and Families First, and are featured on the website Iseethesigns.org. The month's activities culminated on April 25 with the Blue Bow awareness event and Proclamation Signing at Legislative Hall. The event, coordinated by Children and Families First (CFF), featured Mayor Carleton E. Carey from the City of Dover, who presented the Proclamation Signing in Governor Markell's absence. Guest speakers included: Secretary Jennifer Ranji (DSCYF); Karen DeRasmo (PCAD); Leslie Newman (CFF); Patricia Dailey Lewis (DOJ); Rev. John Moore (United Way of Delaware); Gwen Stubbolo (CASA); State Representative Debra Heffernan; and State Senator Ernie Lopez. One hundred twenty people were in attendance, including students from Central Middle School. During the month of the campaign, DFS received 138 more hotline reports in April 2013 than April 2012 (1,559 vs. 1,421), and April was the largest single report total since May 2012. Despite the success of the campaign, the Committee voted to disband and forward its responsibilities to the Training Committee since its activities are more closely aligned. The Joint Commissions approved this proposal at its semiannual meeting on May 17, 2013.[11]

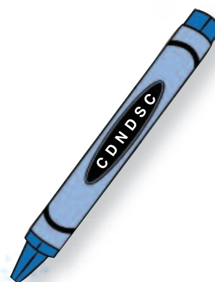
Foster Care Medical Committee

The Joint Foster Care Medical Committee had its first meeting on January 14, 2011. Shortly thereafter, the Committee prioritized the review of 40 case records representing individual children or teens in foster care statewide to evaluate the health care management as well as opportunities for improved, collaborative care. The Committee completed its review with the assistance from DFS staff. A final report will be submitted to the Joint Commissions.

The Infant Safe Sleeping Program Community Action Team (TISSPCAT)

In addition to its charge, the CPAC/CDNDSC Infant Safe Sleeping Program Community Action Team set the following goals in 2013: to expand the message from "Back to Sleep" to "Safe Sleep Environment" that will include all of the American Academy of Pediatrics taskforce recommendations on safe sleep practices; to reinforce the message whenever and wherever possible; to provide a consistent message that makes sense to the lay public; to address parental desires to keep the baby safe and comfortable; and to emphasize parent self efficacy and the preventability of infant unsafe sleeping deaths. In concert with its goals, the group provides oversight of Delaware's Cribs for Kids® program and provides safe sleep education in a variety of settings, including hospitals, daycare providers, fos-

[11] http://courts.delaware.gov/childadvocate/CPACreports.stm



The following agencies/businesses provided TISSPCAT members the opportunity to promote the Safe to Sleep message:

- Bayhealth Baby Fair
- Christiana Care Health System
- Clayton Fire Company
- Delaware Adolescent Program, Inc.
- Delaware Chapter of the American Academy of Pediatrics
- Delaware Healthy Mother and Infant Consortium Summit
- Delaware Institute for Excellence in Early Childhood through University of Delaware
- Delaware SIDS Affiliate parent support group meetings
- Delaware Technical and Community College nursing program
- Division of Family Services Georgetown staff
- Division of Family Services Foster parents
- Division of Public Health
- “I love Smyrna Day”- Smyrna School District
- Head Start Association Conference
- Lighthouse Program
- Office of Child Care Licensing
- Pregnancy Help Center of Kent county
- Second Chance Resale and Website
- The Bridge Program under the Career TEAM
- United Healthcare Community Plan- Mommy and baby Community Event
- Volunteer Fire and EMS Conference, Dover Downs
- Wilmington Career Team
- Wilmington Fire Department
- Wilmington Health Consortium

Collaborative Initiatives... *(continued from page 15)*

ter parents, community organizations, and the Protecting Delaware’s Children Conference. [12]

A continued collaboration with the Delaware Healthy Mother and Infant Consortium (DHMIC), led to the formation of an infant safe sleeping media campaign subcommittee under the DHMIC Education and Prevention Committee. Information from CDNDSC unsafe infant sleeping deaths led to the compilation of data entitled “data woman” to help the committee understand the demographics of the mothers the messages should target. The development of this statewide campaign incorporates a two part message. The public message addresses safety and preventability (billboards, PSA’s, parent education material, website, social media sites, etc.). The professional part will address healthcare providers. Worldways is the media vendor that the DPH has contracted with and developed the campaign entitled “Long Live Dreams”. The public launch date was April 17, 2013 at the Delaware Healthy Mother and Infant Consortium. The website can be accessed at http://dethrives.com/safe-sleep/overview.

In December 2013, CDNDSC and CPAC held their semiannual joint meeting and voted to dissolve the Infant Safe Sleeping Program Community Action Team as a Joint Committee under CPAC and CDNDSC. CDNDSC and the DHMIC will continue to oversee and monitor the activities of the Infant Safe Sleeping Program Community Action Team.

Protecting Delaware’s Children Conference

CPAC and CDNDSC held its fourth Protecting Delaware’s Children Conference, a multidisciplinary conference, on May 22, 2013 and May 23, 2013 at Dover Downs Hotel and Casino. The conference was attended by approximately 500 professionals, including law enforcement officers, prosecutors, judges, attorneys, DFS workers, therapists, educators, community providers, and medical professionals who regularly respond to allegations of child abuse and neglect in Delaware. In addition to national speakers who addressed multidisciplinary collaboration and various aspects of child abuse (including torture; investigation of death of infants and young children; abusive head trauma; the role of the non-offending caregiver and the priority of holding perpetrators accountable) through plenary sessions and workshops; an Advanced Training Course of the Child Abuse Multidisciplinary Team (MDT) was offered on day one. The course was taught by a group from the National Children’s Alliance, and MDT members learned how to foster teamwork and collaboration as well as how to develop county-specific action plans to strengthen system response to child abuse.

[12] http://courts.delaware.gov/childadvocate/CPACreports.stm

Collaborative Initiatives... *(continued from page 16)*

DOSE™ - Direct On Scene Education

The CDNDSC TISSPCAT and the Delaware Perinatal Cooperative (under the auspices of the DHMIC) in collaboration with the Wilmington Fire Department (WFD) have launched a state wide Infant Safe Sleep initiative entitled DOSE™. DOSE™ is a program developed by Lt. James Carroll of Fort Lauderdale Fire Rescue and Jennifer Coombs, MSN, ARNP Coordinator for Healthy Mothers, Healthy Babies Coalition of Broward County, Florida.

Funded by the Delaware Medical Education Foundation and the Delaware SIDS Affiliate, the purpose of the program is to provide first responders with the knowledge and the tools needed to understand SUID (Sudden Unexpected Infant Death), reduce the risk for Sudden Infant Death Syndrome (SIDS), and to prevent accidental sleep related infant deaths by helping families make the sleep environment safe for infants in the communities they serve.

First responders have access to homes and residents that healthcare professionals do not. Families view first responders as authority figures they can trust. It is because of this open access and trust, that first responders are in the ideal position to educate and facilitate positive behavioral changes.

DOSE™ -Training at the Wilmington Fire Department

From Left to Right: Lt. James Carroll, Angela Birney, Beverly Wilcher, Marjorie Hershberger, Anne Pedrick, Bridget Buckaloo, and Fire Chief Anthony Goode

In October 2013, Lt. Carroll trained over 175 first responders from the City of Wilmington, New Castle County EMS, St. Francis EMS, and Kent and Sussex EMS, as well as provided "train the trainer" courses at the Wilmington Fire Department and the Delaware State Fire School. First responder training occurred at the Wilm-ington Fire Department, St. Francis Hospital and the Delaware State Fire School. The "train the trainer" course will ensure that all recruits will receive the DOSE™ education as part of their training/education.

CDNDSC

Child Death, Near Death and Stillbirth Commission

Collaborative Initiatives... *(continued from page 17)*

CDNDSC National Collaboration and Training

CDNDSC staff attended several local and national conferences to further enhance the effectiveness of CDNDSC within Delaware. These include CAN 101, DHMIC Summit, CCHS Trauma Informed Conference, Stewards of Children (CDNDSC staff and CAN panel participated in this training), Pennsylvania Annual Child Death Review Summit, National Center for the Review and Prevention of Child Deaths (NCRPCD) Mid-Atlantic Coalition, SUID Case Registry Site Visit, and Association of SIDS and Infant Mortality Programs/Pregnancy Loss and Infant Death Alliance International Conference on Perinatal and Infant Death.

CDNDSC participates with and chairs the Mid-Atlantic NCRPCD Coalition. The following states are assigned to this coalition: Delaware, Maryland, New York, New Jersey, Ohio, Pennsylvania, and Washington, D.C. The NCRPCD awarded the Mid-Atlantic Coalition a mini-grant to conduct a retreat which occurred in May 2013 in Long Island, NY. The focus of that meeting was to discuss suicide statistics and prevention initiatives within each state and other child death initiatives.

The CDNDSC Executive Director was invited to attend the NCRPCD Advisory Board in Washington D.C. on March 18-19, 2013. As preparation for this meeting, other child death coordinators gathered prior to the Advisory Board to discuss and prepare a list of metrics to evaluate the NCRPCD effectiveness.

In addition, the CDNDSC Executive Director was asked to present two workshops on "Preparing the Case for Review" at the Virginia Department of Criminal Justice Services annual training entitled "One Year Later: Lessons Learned, Charting the Future."

As part of being a Safe Sleep Champion, Marjorie Hershberger was asked to present information on a NICHD webinar, entitled "What is working and what is not working as a State Safe Sleep Champion."

At the National Cribs for Kids Conference in June 2013, CDNDSC in collaboration with the Delaware March of Dimes, Delaware Perinatal Collaborative, DPH and DHMIC presented a poster on the Delaware Cribs for Kids program. It was entitled "In-home Education as a Tool for Success in a Statewide Cribs for Kids Program". In addition, several multidisciplinary team members attended this conference to participate in the child death scene response track.

Collaborative Initiatives... *(continued from page 18)*

Other Partnerships

In further fulfilling its statutory mandate, CDNDSC also actively participated in the following Committees:

- Coalition for Injury Prevention
- CPAC Committees
- Training Committee (including the Jt. Conference workgroup and the CAN Best Practices workgroup)
- Abuse Intervention Committee
- Delaware Healthy Mother and Infant Consortium including the following DHMIC subcommittees:
  - ➢ Data and Science Committee
  - ➢ Education and Prevention Committee
  - ➢ Disparities Committee
  - ➢ Standards of Care Committee
  - ➢ Systems of Care Committee
- National Center for the Review and Prevention of Child Deaths (NCR-PCD)
- Mid-Atlantic CDR Coalition
- Data Dissemination Subcommittee
- National NCRPCD Advisory Board
- Nurse Family Partnership Advisory Board
- Suicide Prevention Taskforce
- Youth Suicide Subcommittee
- Wilmington Healthy Start Consortium

CDNDSC Prevention Partners

- 2nd Chance Resale & Consignment
- Bayhealth Medical Center
- Child Protection Accountability Commission
- Children and Families First
- Christiana Care Health System
- Delaware American Academy of Pediatrics
- Delaware Birth Defects Registry
- Delaware Division of Public Health
- Delaware Healthy Mother and Infant Consortium
- Delaware SIDS Affiliate
- Delaware Suicide Prevention Coalition
- Department of Services for Children, Youth, and Their Families (DSCYF)
- Department of Justice
- Every Child Matters
- Family Court
- Medical Society of Delaware
- National Center for the Review and Prevention of Child Deaths
- National Coalition to End Child Abuse Deaths
- National Fetal and Infant Mortality Review Program
- Nemours Foundation/A.I. duPont Hospital for Children
- Nurse Family Partnership Advisory Board
- Office of the Child Advocate
- Prevent Child Abuse Delaware
- Safe Kids Delaware

Child Death, Near Death and Stillbirth Commission

2013 Demographics (Ethnicity/Race and age Group by Sex)

Ethnicity/Race	Age Group	Male	Female	Total
Hispanic/Latino (any race)	< 1 year	2	0	2
	1-4 years	0	0	0
	5-9 Years	2	0	2
	10-14 Years	0	0	0
	15-17 Years	1	0	1
	Subtotal	**5**	**0**	**5**
White	< 1 year	3	1	4
	1-4 years	2	0	2
	5-9 Years	4	2	6
	10-14 Years	2	4	6
	15-17 Years	7	2	9
	Subtotal	**18**	**9**	**27**
Black/African-American	< 1 year	2	1	3
	1-4 years	1	1	2
	5-9 Years	2	0	2
	10-14 Years	0	0	0
	15-17 Years	3	1	4
	Subtotal	**8**	**3**	**11**
Asian	< 1 year	0	0	0
	1-4 years	0	0	0
	5-9 Years	1	0	1
	10-14 Years	0	0	0
	15-17 Years	0	1	1
	Subtotal	**1**	**1**	**2**
All Races	< 1 year	5	2	7
	1-4 years	3	1	4
	5-9 Years	7	2	9
	10-14 Years	2	4	6
	15-17 Years	10	4	14
	Subtotal	**27**	**13**	**40**

Delaware Child Death Review... *(continued from page 20)*

Manner and Cause of Death By AGE GROUP

Manner	< 1 year	1-4 years	5-9 Years	10-14 Years	15-17 Years	Total
Natural	0	3	5	3	2	13
Accident	1	0	4	1	2	9
Suicide	0	0	0	1	7	8
Homicide	0	0	0	0	3	3
Undetermined	6	1	0	0	0	7
Subtotal	**7**	**4**	**9**	**5**	**14**	**40**

Delaware Child Death Review... *(continued from page 21)*

Manner and Cause of Death By AGE GROUP

Manner	< 1 year	1-4 years	5-9 Years	10-14 Years	15-17 Years	Total
Natural						
Any Injury	0	0	0	0	0	0
Asthma	0	1	0	0	0	1
Cancer	0	0	2	0	1	3
Cardiovascular	0	1	0	0	0	1
Neurological/Seizure Disorder	0	0	1	0	0	1
Other Medical Condition	0	1	2	3	1	7
Subtotal	**0**	**3**	**5**	**3**	**2**	**13**
Accident						
Motor Vehicle	1	0	2	2	2	7
Drowning	0	0	1	0	0	1
Asphyxia	0	0	1	0	0	1
Subtotal	**1**	**0**	**4**	**2**	**2**	**9**
Suicide						
Asphyxia	0	0	0	1	6	7
Poisoning, Overdose, or Acute Intoxication	0	0	0	0	1	1
Subtotal	**0**	**0**	**0**	**1**	**7**	**8**
Undetermined						
Any Medical Cause	1	0	0	0	0	1
Weapon	0	1	0	0	0	1
Unknown	5	0	0	0	0	5
Subtotal	**6**	**1**	**0**	**0**	**0**	**7**

Abuse/Neglect Deaths or Near Deaths…

Nationally, the number of child abuse victims has decreased; however, the number of fatalities attributable to child abuse and neglect appears to have increased from 1,580 in 2011 to 1,640 in 2012. At this point it is uncertain whether this is a real increase in child fatalities or if improvements to how states investigate and report child fatalities have improved the attribution of these deaths to abuse and neglect.[13]

In 2012, 69.9 % of children who died from child maltreatment suffered neglect either alone or in combination with another maltreatment type, and 44.3% suffered physical abuse either alone or in combination with other maltreatment. Medical neglect either alone or in combination was reported in 8.9%.

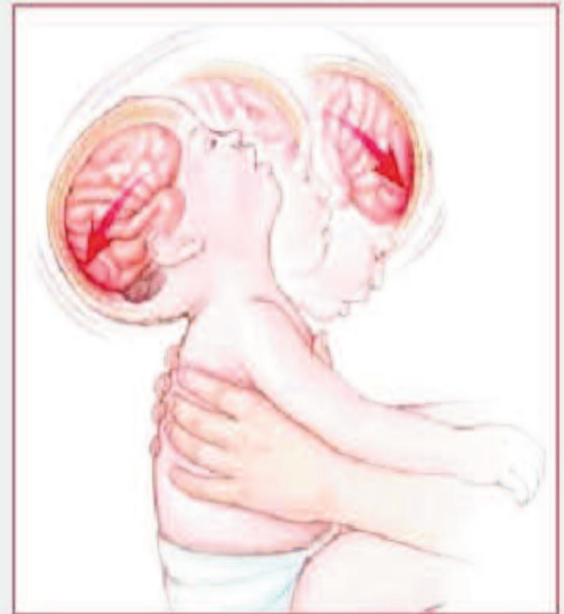
The estimated medical cost attributable to AHT in the four years after the child's diagnosis was $47,952 per patient with AHT.[14] Additional cost to society includes the loss of societal productivity and occupational revenue. Prosecution and incarceration of the perpetrator is also a significant cost to society.

The Child Abuse and Neglect (CAN) Panel reviewed five child deaths and 16 near deaths that resulted from abuse and neglect. Of these 21 CAN cases, ten cases were initial reviews and 11 CAN cases were CAPTA reports. These cases were initially reviewed in a prior year and reflected in a prior report. All CAPTA[15] reports are available on the CDNDSC website[16]. Out of the 11 final cases, six had criminal charges that occurred after the death or near death. Of these cases, 13 children were White and eight were Black/African-American. Two of these infants had been diagnosed with Neonatal Abstinence Syndrome at birth. In four cases, the mother was positive for substance abuse at the time of the birth. One mother was diagnosed with postpartum depression.

Abusive Head Trauma (AHT) is a trauma that occurs when a caregiver violently shakes an infant, which can also be associated with impact injuries, blunt force trauma, and hypoxic ischemic injury.

FIGURE 1

Acceleration-deceleration injury



Violent shaking produces acceleration-deceleration forces that cause significant injury to the brain. Rotational forces exerted on the brain result in shear injury.

"What society does to its children, its children will do to society"

Cicero

[13] http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment

[14] http://pediatrics.aappublications.org/content/early/2014/06/10/peds.2014-0117.full.pdf+html

[15] The Federal Child Abuse Prevention and Treatment Act requires the disclosure of facts and circumstances related to a child's near death or death. 42 U.S.C. §5106 a(b)(2)(A)(x). See also 31 Del. C. § 323(a).

[16] Available at: http://courts.delaware.gov/childdeath/reports.htm

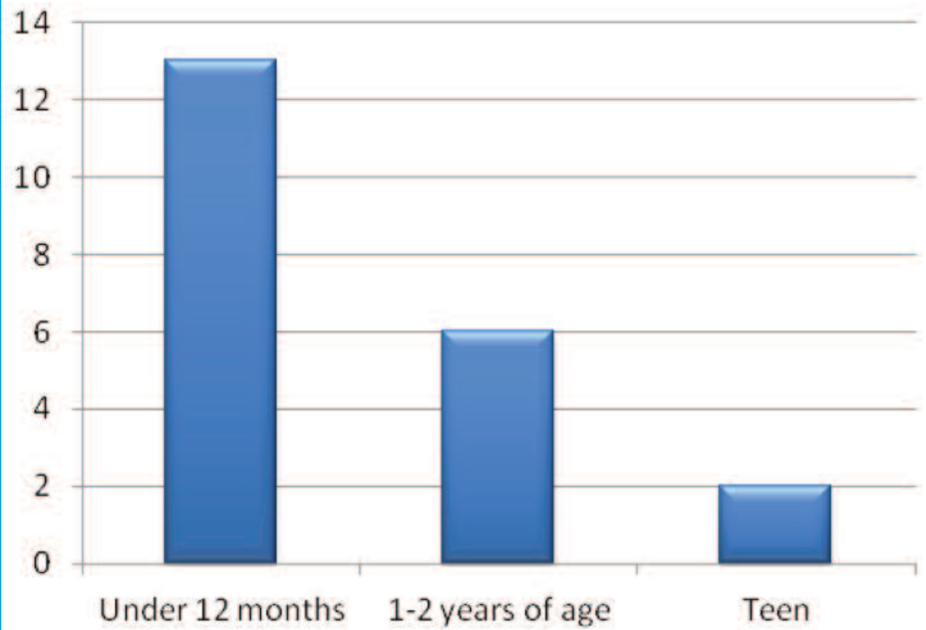
Abuse/Neglect Deaths or Near Deaths… *(continued from page 23)*

2013 Child Abuse/Neglect Death Cases Medical Examiner's Cause of Death

The Commission approved reviews concerning five deaths that were reviewed by the CAN panel in 2013. Of those, two were initial reviews and three were final reviews with a CAPTA report being completed. Four of these deaths were male and one was female.

- Undetermined: Blunt Force Head Trauma (Initial)
- Natural: Dehydration associated with non-specific febrile illness (Initial)
- Undetermined, SUDI (Final)
- Homicide (Final)
- Undetermined, acetaminophen toxicity (Final)

2013 ages of child abuse/neglect deaths or near deaths

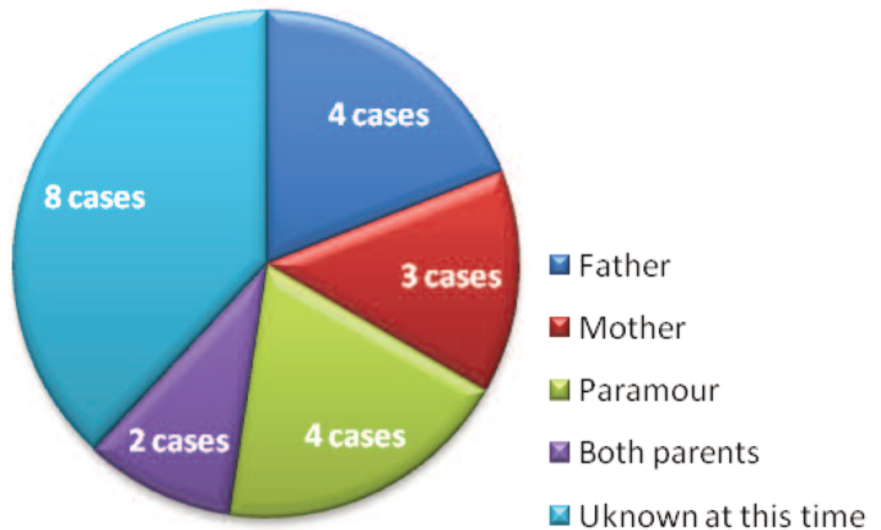


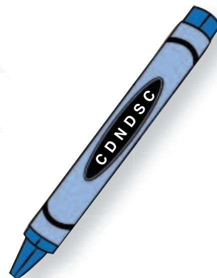
Abuse/Neglect Deaths or Near Deaths… *(continued from page 24)*

2013 Child Abuse/Neglect Near Death Cases

The Commission approved reviews concerning 16 near deaths of children that were reviewed by the CAN panel in 2013. Of those, eight were initial reviews and eight were final reviews with a CAPTA report being completed. 11 of the near deaths were male and five were female. Of the 16 near death cases, 11 were Abusive Head Trauma and five were severe physical abuse.

Perpertrator of child abuse/neglect cases
2013 cases reviewed





Abuse/Neglect Deaths or Near Deaths… *(continued from page 25)*

Bicycle/Motor Vehicle/Pedestrian Deaths

During CY 2013, the Commission reviewed seven child deaths due to motor vehicle crashes either as a passenger, driver, pedestrian, bicyclist, or on an ATV. Six of the children were male and one was female. Six children were White, one was Black/African-American and one was Hispanic/Latino. Two children were drivers (one driving an ATV) and responsible for the motor vehicle crash and the other child was a passenger. One of these incidents took place in an urban setting, two were in a rural setting and four were in a suburban area. One of the adults responsible for the crash did not have a license. There was no drug/alcohol impairment noted in these cases nor were graduated licensing rules violated. There were no apparent risk factors noted such as ice/snow, wet roads or inadequate lighting. Protective measures that were needed included a child passenger who was not wearing a seat belt, two children not wearing a helmet while riding a bicycle/ATV, and an infant not in a car seat. The following recommendation was submitted to and approved by the Commission from the child death panels: CDNDSC recommends that the State of Delaware Department of Education include all-terrain vehicle (ATV) Safety Education in the Bicycle Safety Program at school.

The three pedestrian deaths occurred in a suburban area. Some of these children were not supervised by an adult and given the time of day and age of the child, should have been.

Every year approximately 67,000 child pedestrians are fatally or non-fatally injured. Boys account for 66% of these deaths. Living in a dense, low-income, urban residential area (American Academy of Pediatrics, 2009) was noted as a risk factor and 36% of deaths of children under the age of 16 occurred between 3pm and 7pm (American Academy of Pediatrics, 2009)[17].

Bicycle/Motor Vehicle/Pedestrian Deaths

Position of Child	< 1 year	1-4 years	5-9 Years	10-14 Years	15-17 Years	Total
DRIVER	0	0	0	1 (ATV)	1	2
PASSENGER	1	0	0	0	0	1
ON BICYCLE	0	0	1	0	0	1
PEDESTRIAN	0	0	1	1	1	3
Subtotal	**1**	**0**	**2**	**2**	**2**	**7**

Safety Pedestrian Tips

- Drivers should watch out for pedestrians, especially in commercial areas.
- Drivers should slow down; pedestrians are extremely vulnerable in accidents.
- Pedestrians should not try to cross a road if they have been drinking or have drugs in their system. Walking under the influence of alcohol is illegal.
- Pedestrians should wear reflective clothing and carry a flashlight at night.
- Always cross at a marked intersection or crosswalk.
- If no sidewalk is available, pedestrians should walk facing traffic and as far off the edge of the road as possible.

Car crashes are a leading cause of death for children one to 13 years old. Many times deaths and injuries can be prevented by proper use of car seats, boosters, and seat belts[18]. The National Highway Traffic Safety Administration (NHTSA) shares these facts:

- Every 34 seconds one child, under age 13, is involved in a crash.
- In 2012, over one third (37%) of children killed in car crashes were not in car seats, booster seats, or seat belts.
- One third of kids aged 8-14 killed in crashes were riding in the front seat. All children under age 13 should ride in the back seat.

Motor Vehicle Car Seat/ Booster Seat usage

Under the age of 1 – Children must always ride rear facing

Ages 1 through 3 – Keep your children rear facing for as long as possible in either an infant or rear facing convertible seat. They should remain rear facing until the height and weight limit for rear facing use on that seat has been reached. This may result in many children riding rear-facing to age 2 or older.

Ages 4 through 7 – Keep children in a forward facing seat with a harness to the maximum height and weight limit allowed by the seat, Then transition them to a booster seat.

Ages 8 through 12 – Keep children in a booster seat until they either exceed the height/weight requirement for remaining in a booster seat or until they are big enough to fit the criteria for fitting appropriately in a seat belt. The shoulder belt should lie across the shoulder and chest, not cross the neck or face, and the lap belt must lie across the upper thighs not the stomach.

[17] http://www.childrenssafetynetwork.org/publications/pedestrian-safety-infographic

[18] Traffic Safety News~Delaware Office of Highway Safety, email dated 9/17/14

Abuse/Neglect Deaths or Near Deaths… *(continued from page 26)*

Nationally out of the 274 toddlers/infants who died in 2013, one out of three was unrestrained (National Highway Traffic Safety Administration (NHTSA), 2013), one out of five booster-age children were unrestrained (National Highway Traffic Safety Administration (NHTSA), 2010)[19]. Drivers who are 15-20 years of age make up just 6.4% of all drivers, yet they account for 10% of traffic fatalities and 14% of accidents that cause injury. Distracted driving, youth, and inexperience, play a role in many of these crashes. Cell phone use among all drivers increases crash risk, with young people even more likely to miss red or yellow lights when using their phones than are older drivers.

Drowning Deaths

The Commission reviewed one death due to drowning. This male child was in the age range of 5-9 and the incident occurred at a motel hot tub. There were no barriers to the water and child was not supervised at the time. Proper supervision of children is the best way to prevent a child from drowning.

Homicide Deaths (not due to abuse/neglect)

Manner	< 1 year	1-4 years	5-9 Years	10-14 Years	15-17 Years	Total
Weapon	0	0	0	0	3	3
Subtotal	**0**	**0**	**0**	**0**	**3**	**3**

Homicide Deaths (not due to abuse/neglect)

The Commission reviewed three homicide cases not due to abuse or neglect. All three deaths were Black/African-American children. They were in the age range of 15 to 17 years and involved handguns. Two children were male and one was female. One of the handguns had been stolen by the perpetrator. Three causes include random violence, showing the gun to others, and an argument. Factors include: history of substance abuse, criminal history, time spent in juvenile detention, prior history of maltreatment as a victim, and DSCYF placement outside of the home.

Nationally, homicide is the second leading cause of death among youth (ages 15-24). From 2005-2010, 83% of all youth homicides involved a firearm. Youth make up 29% of all homicides and 35% of all firearm-related homicides, but only 14% of the population. Firearms are used in nearly half (46%) of all suicides by youth. On average, 177 youth and 64 children (ages 0-14) die of unintentional shootings every year. Preventing unintentional fatal shootings of children and youth in the US could have saved over $439 million in 2005 alone. Unintentional shootings make up 16% of firearm-related deaths in children compared to 2% for the general public.[20]

[19] http://www.childrenssafetynetwork.org/publications/child-passenger-safety-infographic

[20] http://www.childrenssafetynetwork.org/publications/firearms-intent-infographic

CDNDSC
Child Death, Near Death and Stillbirth Commission

Abuse/Neglect Deaths or Near Deaths… *(continued from page 27)*

Poisoning, Overdose or Acute Intoxication Deaths

The Commission reviewed one death due to poisoning, overdose or acute intoxication. It was a male child between the ages of 15-17. The prescription drugs were left in an open area.

Strategies to reduce prescription medication abuse among youth include:

- Keep prescription medications locked up;
- Talk with teens about the dangers of misusing and abusing prescription drugs and over-the-counter medications;
- Properly dispose of old or unneeded medications;
- Health care providers screen patients for past or current substance use and to monitor patients' use of prescribed medications; and
- Understand the role of prescription drug monitoring programs (PDMPs) in reducing prescription medication misuse/abuse and working with PDMPs to increase their effectiveness.

The following recommendation was submitted to and approved by the Commission from a child death panel:

CDNDSC recommends that the Division of Prevention and Behavioral Health Services educate families and/or counsel families on the signs, symptoms and behaviors associated with decompensation of children with a history of substance abuse issues. Such education and/or counseling should be included in the child's discharge planning from rehabilitation programs.

Suicide

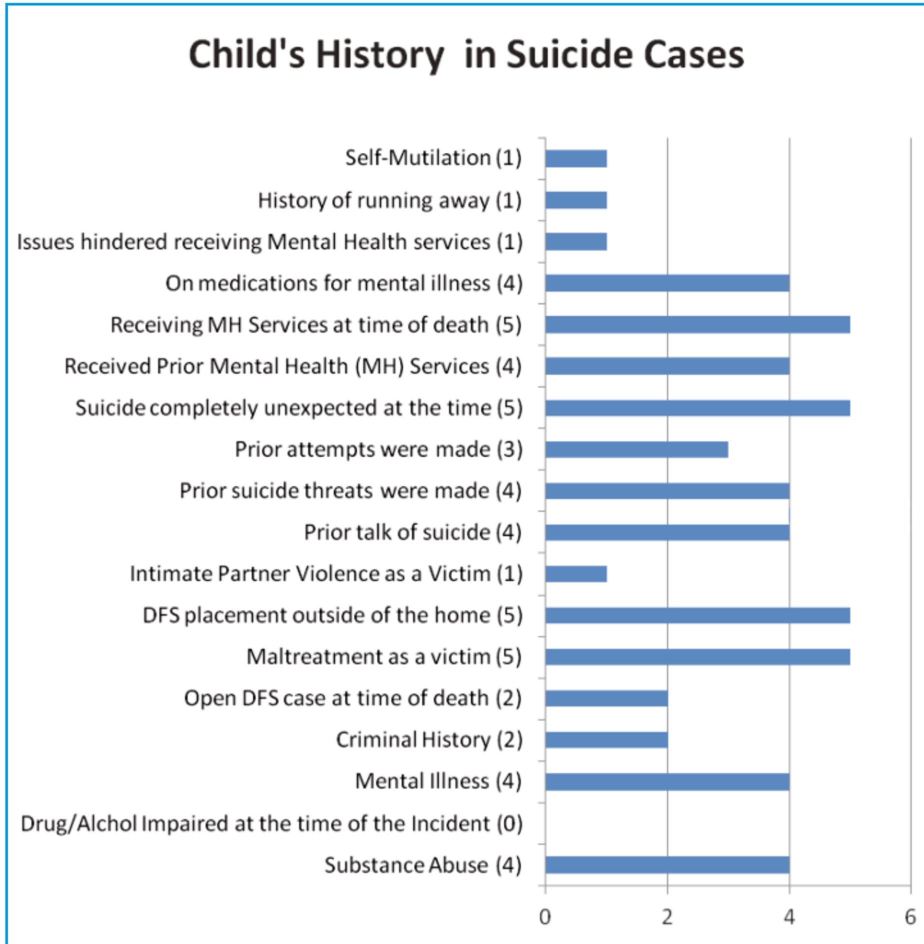
More than one in three suicides of those under age 18 occurred the same day as a crisis (such as an argument with a parent or a break-up; Suicide Prevention Resource Center & Harvard Injury Control Research Center, 2002). When someone under the age of 19 uses a firearm to complete suicide, it usually belongs to a family member. In two out of three of these cases, the firearm was kept unlocked (Suicide Prevention Resource Center & Harvard Injury Control Research Center, 2002).[21]

This report reflects many of the teen deaths by suicide that occurred in Kent and Sussex Counties between January 1 and May 4, 2012. During this time period, 11 teen deaths occurred by suicide. One high school in these counties experienced four deaths from suicide. The CDC investigated this sudden increase. The CDC estimated in their Epi-Aid Investigative report that 116 nonfatal suicide attempts occurred in youth aged 12-21 years in the same counties during this time period.[22] CDNDSC was a part of the initial meetings with the CDC during April 2012 as they visited Delaware. Although the CDC did not find any common causes, they issued a report that called for increasing Suicide Prevention awareness to more schools and increasing access to after school programs to serve more Delaware youth.

[21] http://www.childrenssafetynetwork.org/publications/firearms-intent-infographic

[22] Kids Line Newsletter, Division of Prevention and Behavioral Health Services 2012, Fall Edition

Recommendations for Cases Reviewed...



Division of Prevention and Behavioral Health Services (DPBHS) offered onsite assistance to each of the individual schools that were affected and accelerated a suicide prevention program[23] that in the beginning of 2012 was in its infancy. At the close of 2012, DPBHS trained 4,800 students in an evidenced based four-session suicide prevention program (Lifelines) and an additional 3,200 teachers and other school staff in an adult module. For 2013, DPBHS was again aggressive in offering this program to any Delaware middle or high school. They trained approximately 5,744 students, 800 teachers, 543 parents, and 419 mental health professionals. To date, DPBHS have trained 55 schools. In addition to schools, this campaign has been extended to community youth organizations such as sports, scouting, summer camps, faith based youth groups, etc. In addition, several community events occurred as a result of these tragedies. CDNDSC continues to participate in the Suicide Taskforce along with representation on their youth subcommittee.

The CDNDSC review of these deaths started in October 2012 at an all-day Kent/Sussex CDR panel. However, the reviews were not yet complete as the panel felt they needed additional information to fully review the deaths. This report reflects eight suicides that were reviewed and approved by the Commission during 2013. Five of the 11 cases that occurred in Kent/Sussex counties are reflected in this total. The data shown reflects statewide data reviewed in 2013.

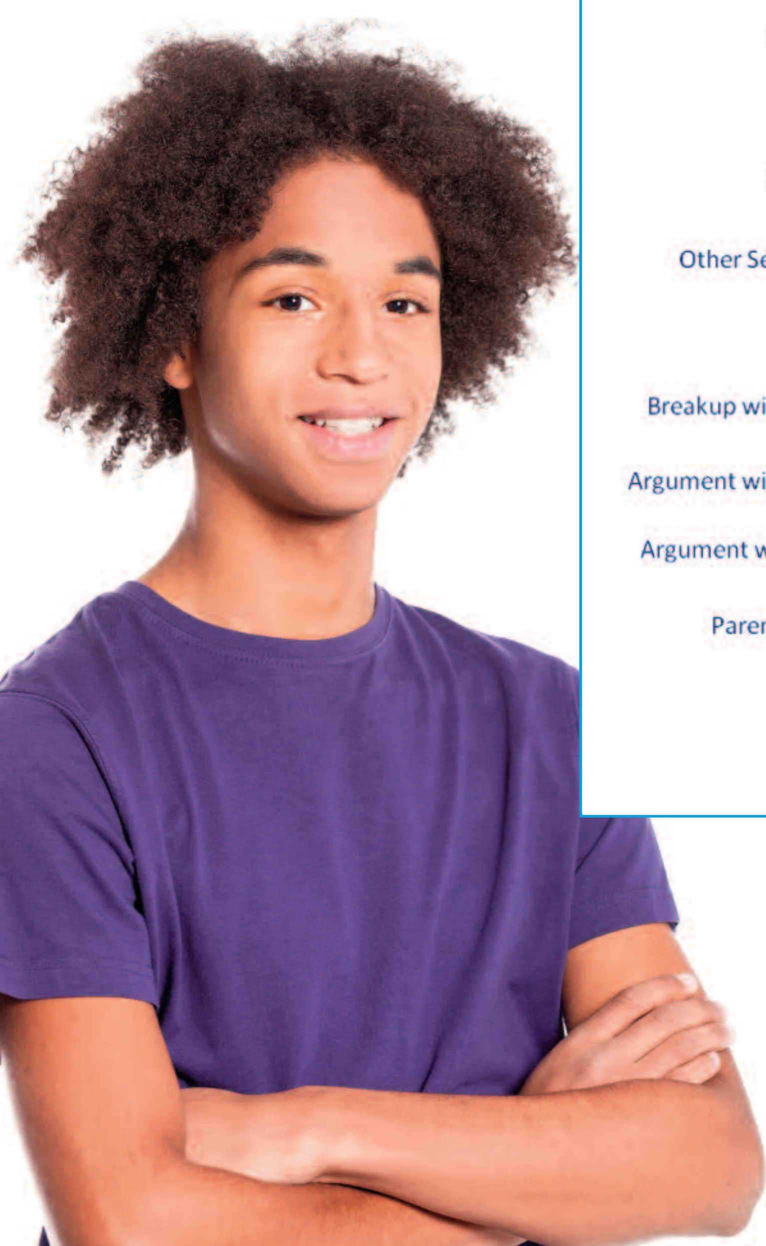
The following recommendations were submitted to and approved by the Commission from the child death panels:

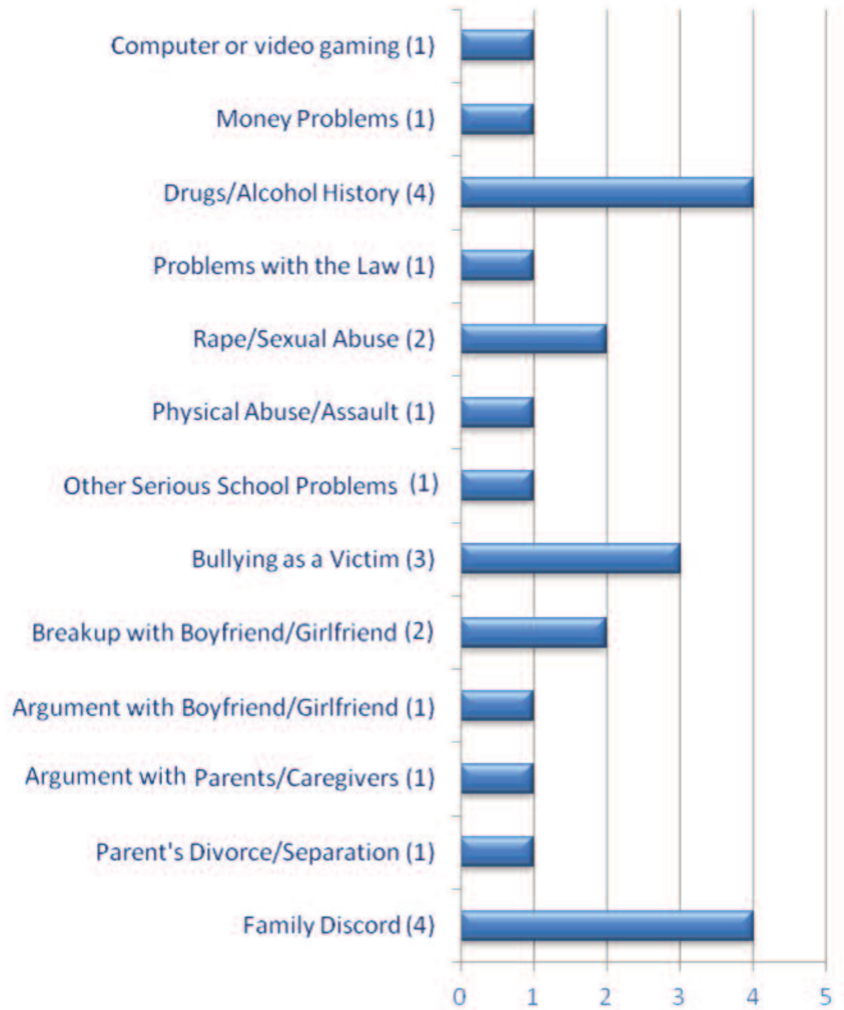
CDNDSC recommends that the State of Delaware's Department of Education mandate that all school districts participate in or provide an educational program that identifies suicidal behaviors, risk factor recognition, and intervention for school staff, parents, and children.

CDNDSC recommends that the Department of Education direct school districts to establish an information page or link on their website that discusses the signs and symptoms of suicide and agencies to contact when in crisis.

[23] Lifelines: Suicide Prevention Program educates students on the facts about suicide and students' role in suicide prevention. It provides information on where to find suicide prevention resources in the school and community. Designed for implementation in middle schools and high schools, Lifelines targets the whole school community by providing suicide awareness resources for administrators, faculty and staff, parents, and students.

Recommendations for Cases Reviewed... *(continued from page 29)*





Infant Unsafe Sleeping Deaths (Undetermined, SUID, and SIDS)…

In CY 2013, six deaths were reviewed in Delaware due to infant unsafe sleeping. However, during CY 2013, CDNDSC was referred nine infant cases due to unsafe sleeping. Two of the cases are undetermined and the others may be due to another cause of death. The Commission continues to see approximately one referral every month due to this type of death. In 100% of the cases (6 out of 6), the infant was **NOT** sleeping in a crib or bassinette. Moreover, in 50% (3 of 6) of the cases, the infant was bed-sharing with another individual. Of the six infant safe sleeping deaths, only one infant was being breastfed when discharged from the birthing hospital.

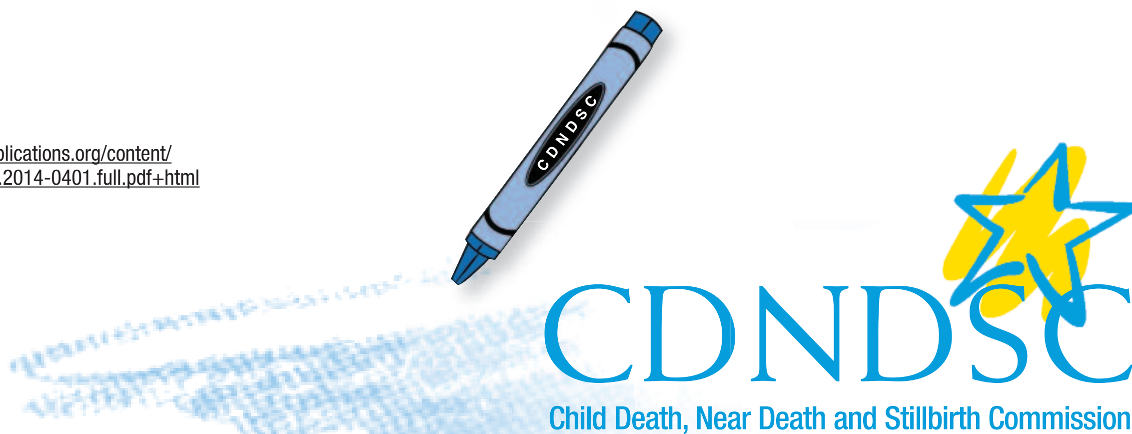
Younger babies are more likely to die when they are sharing beds, while older babies face a higher risk of sudden death when there are objects in the crib with them, such as pillows and toys. Parents of infants under four months of age should be aware that bed-sharing is a huge risk factor and should be careful to make sure their infants sleep without objects around them.[24]

The following recommendation was submitted to and approved by the Commission from the child death panels:

CDNDSC recommends that DFS incorporate the practice of providing and documenting information pertaining to safe sleeping practices into policy.

Ethnicity/Race	Age Group	Male	Female	Total
Hispanic/Latino (any race)	2-3 months	1	0	1
	Subtotal	**1**	**0**	**1**
White	2-3 months	1	1	2
	1-4 years	1	0	1
	Subtotal	**2**	**1**	**3**
Black/African-American	2-3 months	2	0	2
	8-11 months	0	1	1
	Subtotal	**2**	**1**	**3**
All Races	2-3 months	3	1	4
	8-11 months	0	1	1
	1-4 years	1	0	1
	Subtotal	**4**	**2**	**6**

[24] http://pediatrics.aappublications.org/content/early/2014/07/09/peds.2014-0401.full.pdf+html



"Do the best you can until you know better. Then when you know better, do better."

Maya Angelou

Infant Unsafe Sleeping Deaths (Undetermined, SUID, and SIDS)…

(continued from page 31)

On October 18, 2011, The American Academy of Pediatrics announced their new policy statement, "**SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment**."

The recommendations include:

- Breastfeeding is recommended and is associated with a reduced risk of SIDS.
- Infants should be immunized. Evidence suggests that immunization reduces the risk of SIDS by 50%.
- Bumper pads should not be used in cribs. There is no evidence that bumper pads prevent injuries, and there is a potential risk of suffocation, strangulation or entrapment.
- Always place your baby on his or her back for every sleep time.
- Always use a firm sleep surface. Car seats and other sitting devices are not recommended for routine sleep.
- The baby should sleep in the same room as the parents, but not in the same bed (room-sharing without bed-sharing).
- Keep soft objects or loose bedding out of the crib. This includes pillows, blankets, and bumper pads.
- Wedges and positioners should not be used.
- Pregnant women should receive regular prenatal care.
- Do not smoke during pregnancy or after birth.
- Offer a pacifier at nap time and bedtime.
- Avoid covering the infant's head or overheating.
- Do not use home monitors or commercial devices marketed to reduce the risk of SIDS.
- Supervised, awake tummy time is recommended daily to facilitate development and minimize the occurrence of positional plagiocephaly (flat heads).

Factors Involved in Sleep-Related Deaths

Age Group	2-3 months	8-11 months	1-4 years	Sub Total
Not in a crib or bassinette	4	1	1	6
Not sleeping on back	2	0	0	2
Sleeping with other people	3	0	0	3
Obese adult sleeping with child	1	0	0	1

Recommendations for CDR Cases Reviewed During CY 2013…

The Commission shall make recommendations to the Governor and the General Assembly, at least annually, regarding those practices or conditions that influence the mortality of children. Generally, an affirmative vote of 60% of all members of the Commission or any regional panel is needed to adopt any findings or recommendations of the Commission or such regional panel.
(70 *Del. C.* 256, § 1.)

In total, 91 recommendations were made by the Child Death Review (CDR) Panels, and the Child Abuse and Neglect (CAN) Panel was responsible for 79 of these recommendations.

In terms of agency specific recommendations, 44 pertained to the Department of Services for Children, Youth and Their Families, 17 pertained to the medical community and nine pertained to the multidisciplinary response to investigation of child abuse. The remaining 23 recommendations were relevant to the Child Protection Accountability Commission, Delaware Sentencing Accountability Commission, Department of Education, Department of Justice, Family Court, law enforcement, and other agencies.

The OCA Program Administrator, Rosalie Morales, took the lead in developing and implementing the Child Death, Near Death, and Stillbirth Tracking and Response Protocol, which was approved by the CPAC/CDNDSC Commission in May 2013. Effective retroactively to January 2013, recommendations from CDNDSC's review panels are formally disseminated to agencies and responses are tracked via the new protocol. Additionally, quarterly reports on the identified trends will be given at the Joint Commission meetings, and the CDNDSC and CPAC Annual Reports will include any written public responses submitted by the agencies.

Lastly, CDNDSC wishes to thank its Panel members for dedicating their time to review these difficult cases.

Acknowledgements[25]

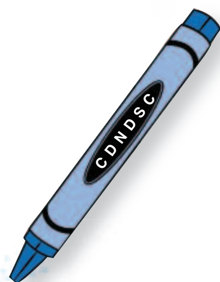
STATEMENTS OF SUPPORT:

1. CDNDSC supports the continued training of medical professionals on Child Abuse Identification and Reporting Guidelines.
2. CDNDSC supports the research efforts of the Child Protection Accountability Commission (CPAC) in their efforts to create a more stringent criminal statute for child abuse.
3. CDNDSC shall continue to support the Delaware Healthy Mother and Infant Consortium (DHMIC) in their work surrounding mothers and postpartum depression.
4. CDNDSC supports the implementation of a comprehensive and holistic Family Practice Team Model that provides continuous comprehensive case management services to pregnant women and their infants up to two years postpartum.
5. CDNDSC recommends support of The Birth Center, LLC, or any other medical facility denying referrals for home births within the state.
6. CDNDSC recommends that the Commission support legislation in making practicing without a license a criminal act for direct entry midwives. The Delaware legislature has made practicing without a license a felony with a $5,000 minimum fine. Prior to that, there was a $1,000 fine only.
7. CDNDSC recommends continuing support of The Infant Safe Sleeping Program Community Action Team (TISSPCAT) and other community outreach programs. ***This recommendation was made in two case reviews.***

STATEMENT OF RECOGNITION

1. CDNDSC acknowledges the efforts made by the Division of Family Services, Office of the Child Advocate, and mental health agencies involved regarding the communication and collaboration of services and support that were given to the child while in care.
2. CDNDSC recommends that a letter be written to the Division of Family Services acknowledging the caseworker's outstanding performance in this case.

[25] The Child Abuse and Neglect (CAN) Panel recognizes exemplary casework and investigative practices during its reviews, and as such, drafts recommendations to memorialize its findings for the respective agencies.



Agency Specfic Recommendations...

Child Protection Accountability Commission

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2012-00017 Initial	CDNDSC recommends that legislation (such as a Children's Bill of Rights) be considered and drafted in order to provide and establish further protection of children's rights.	**CPAC Response:** At the CPAC Quarterly meeting on 1/8/14, this recommendation was discussed. CPAC determined a "bill of rights" was not the right terminology or solution for the facts presented in this case. CDNDSC appears to have premised this recommendation on a chronic neglect case where DFS was not consulting with DOJ regarding legal remedies to protect the children. The appropriate response is to look at protocols and practices for DFS workers to consult with DOJ in circumstances such as these, and to utilize current legal tools such as an Imperiling Family Relations or a DSCYF Custody Petition to ensure safety. Use of DFS' new Safety Organized Practice tools should also address these circumstances. Concepts such as Motions to Compel Cooperation with Investigation and Treatment should also be considered. All of these concepts are currently being explored between DSCYF and DOJ. CPAC will follow up with DSCYF and DOJ as updated protocols are established.
9-03-2012-00017 Initial Ancillary	CDNDSC recommends that further education such as, the development of a reference book and/or guide pertaining to the psychological, developmental, and/or physical impacts of abuse and neglect on nonverbal children who sustain serious, life threatening injuries, be offered to professionals involved in the investigation and prosecution of such cases.	**CPAC Response:** At the CPAC Quarterly Meeting on 1/8/14, the Commissioners voted to forward this recommendation to the CPAC Training Committee so the topic may be considered for inclusion in the next Protecting Delaware's Children Conference. By way of further response, there are other groups addressing this. Specifically, in the last year, the Interagency Committee on Adoption's (IACOA) Community Education on Adoption Subcommittee has developed training and other resources to help professionals understand how to work with and provide support to children and adoptive families in crisis. In fact, the Subcommittee is planning to provide education on the issues faced by adoptive families to the law enforcement, mental health and education communities. Additionally, OCA, in conjunction with IACOA, is developing a training called "Best Practices for Finding Permanency for Children Experiencing Foster Care," which will be available for use by attorneys, CASAs, and other professional audiences. Lastly, the Subcommittee is creating a speakers bureau made up of individuals who will speak about their own adoption experiences to different groups that interface with adopted children and their families. In December 2013, the Governor's Steering Committee provided the Administrative Office of the Courts with a compilation of national training experts and a selection of topics on child abuse for judicial officers in the Delaware Courts. Sharon Cooper, M.D., CEO of Developmental and Forensic Pediatrics at the University of North Carolina Chapel Hill, was listed as a potential speaker, and she is experienced on the effects of children exposed to violence, child neglect and emotional abuse. Additionally, Sandeep Narang, M.D., J.D., Professor of Pediatrics at the University of Texas Health Center in San Diego and Cindy W. Christian, M.D., Associate Physician in the Department of Pediatrics at the Children's Hospital of Philadelphia, were also listed and both have vast medical knowledge on serious, life threatening injuries to infants. The Committee offered to assist the Courts in planning and coordinating the training sessions for the judicial officers.

Agency Specfic Recommendations... (continued from page 34)

Department of Justice

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2012-00017 Initial	CDNDSC recommends the establishment of a Special Victims Unit with statewide jurisdiction within the Department of Justice specializing in the investigation and prosecution of felony level, criminal child abuse cases including those involving the death, near death or sexual abuse of a child.	No response was received.
9-03-2010-00006 Final	CDNDSC shall send a referral to the Department of Justice as it pertains to the failure to report on behalf of the child's primary care physician.	No response was received.

Department of Services for Children, Youth, and Their Families

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2013-00003 Initial	CDNDSC recommends that the Division of Family Services comply with policy as it pertains to the interviewing of all individuals residing in the home during an active investigation for allegations of child abuse.	**DFS** has addressed recommendations through specific responses, as well as comprehensive efforts. Specifically, the DFS Investigation Work Group continues to review compliance with all policy related to investigations. In addition, for all of 2013, DFS has worked with a team of national experts from the Child Welfare Strategy Group of the Annie E. Casey Foundation, the Children's Research Center, and the National Resource Center on In-Home Services to improve child welfare practices. Specifically related to CDNDSC recommendations, DFS has followed the guidance offered in Preventing Severe Maltreatment-Related Injuries and Fatalities: Applying a Public Health Framework and Innovative Approaches to Child Welfare (2013), Child Welfare, 92, 2. Included in that guidance are recommendations for child welfare agencies to implement two essential comprehensive components: (1) research-based safety and risk assessment tools (DFS implemented the tools of Structured Decision Making® (SDM), and (2) a child welfare practice model (DFS is implementing Safety Organized Practice (SOP). SOP methodology is assessment-driven, incorporating the information from the SDM tools for safety and risk assessments along with a variety of best practice and evidence-informed interventions including Signs of Safety, Motivational Interviewing, solution-focused intervention, and group supervision utilizing the Framework for Critical Decision Making. These combined approaches are focused on improving ongoing casework and decision making. DFS is also engaged in Continuous Quality Improvement efforts to ensure that these methods are implemented with fidelity.

Agency Specfic Recommendations... *(continued from page 35)*

Department of Services for Children, Youth, and Their Families…

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2013-00003 Initial	CDNDSC recommends that the Department of Services for Children, Youth and Their Families reconsider the ability to find a case for physical abuse and/or neglect with perpetrator unknown.	**DFS** agrees to review the policy and procedures for substantiation of maltreatment in cases where the perpetrator is unknown. DFS is participating in a current committee of CPAC reviewing the Child Protection Registry and related issues of substantiation. DFS recognizes and appreciates the value in creating a record of such substantiation associated with a child victim. However, the current procedures for the processing of substantiation cases were all created to track substantiation associated with a known perpetrator. To associate substantiation with a victim instead, will require changes to the FACTS client information system. DSCYF is in the process of building a new FACTS II system and any additional changes will need to be phased in as resources are available.
9-03-2013-00003 Initial	CDNDSC recommends that communication occur between caseworkers when a case is either transferred within investigation OR transferred from investigation to treatment. Caseworkers should be up to date on all relevant information pertaining to the case facts and circumstances prior to engaging with the family.	**DFS** refers to above first response. DFS implementation of Safety Organized Practice addresses the sharing of information when cases are transferred.
9-03-2013-00003 Initial	CDNDSC recommends that a consultation occur with the Attorney General's office prior to case closure when there is concern of abuse and/or neglect with no perpetrator identified.	**DFS** and DOJ have reviewed procedures for consultation during the decision making regarding case closures. DFS staff have been instructed to consult with the Deputy Attorney General and document that consultation in case notes.
9-03-2012-00017 Initial *And in case* 9-03-2009-00014 Final	CDNDSC recommends that the Division of Family Services (DFS) consider implementing policy as it relates to evaluating whether a parent's mental health issue impacts the care of a child. If the parent or caretaker is receiving treatment, then the caseworker should contact the mental health professional. However, if no treatment is in place, then DFS should recommend an immediate mental health evaluation.	**DFS** refers to above first response. The implementation of SDM and SOP address the assessment and planning for caregiver risk issues.

Agency Specfic Recommendations... *(continued from page 36)*

Department of Services for Children, Youth, and Their Families…

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2012-00017 Initial	CDNDSC recommends that the Division of Family Services comply with policy as it pertains to the following areas: • Monthly contact with children when there is an active investigation. • Enforcement of agreed upon case plans. During the investigation, it was noted that over a ten month period there were repeated concerns by caseworker, intern, and supervisor regarding the deplorable conditions of the home and the consequences if such conditions did not improve.	**DFS** refers to above first response. The implementation of SDM and SOP are focused on supporting comprehensive risk assessment and responsive planning. The implementation of group supervision and consultation utilizing the Framework for Critical Decision Making is focused on comprehensive input from multiple supervisors, which is especially critical in organizing and assessing complex information to make better decisions in discerning potential neglect from the host of complicating factors that impact vulnerable families living in poverty.
	• Consultation with the Department of Justice. Mother repeatedly showed an inability to comply with case plans and provide suitable housing for her children.	**DFS** refers to the above response that references consultation with DOJ.
	• Proper advisement as to what constitutes inappropriate discipline.	**DFS** agrees to continue to develop training and consultation resources to assist workers in assessing child well-being.
	• Proper evaluation of a participant's mental health during investigation.	**DFS** refers to above first response. The SDM assessment tools include assessment of caregiver risk. The SOP practice model focuses on interviewing skills to help elicit comprehensive information from case participants.
	• Recognition of the difference between poverty and poor living conditions as a major concern for a family's well-being. It is documented that caseworker identified poor living conditions as a result of poverty.	**DFS** refers to the above responses. The SDM assessment tools are research-based and provide guidance on assessing factors related to child maltreatment versus poverty.
	• Identification of safety issues that may result in the removal of a child from the home.	**DFS** refers to the above responses. The SDM assessment tools are research-based tools that guide decision making about safety and risk.
	• Poor supervision of caseworker by supervisor. It was noted that supervision of caseworker was lacking and an unsupervised intern was permitted to perform unannounced home visits.	**DFS** agrees to review and take appropriate personnel actions.
	• Education of staff on what is considered child well-being. Caseworker failed to address mother's lack of recognition of the well-being of her children which resulted in a lack of bonding/attachment, truancy, and hygiene issues.	**DFS** refers to the above responses. The SDM safety and risk assessment tools are research-based and help guide assessment and decision-making in a comprehensive manner that focuses on the child, as well as caregiver risk factors.

Agency Specfic Recommendations... *(continued from page 37)*

(continued from page 37)

Department of Services for Children, Youth, and Their Families…

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2012-00017 Initial	CDNDSC recommends that in instances where a parent and/or caregiver is expressing concerns of mental health issues that appropriate referrals be made to mental health services for an immediate evaluation and that the Division implement a safety plan in order to ensure the parent/care-giver has the ability to properly care for his/her child(ren).	**DFS** is working with national experts and DOJ on updating safety plan format and content. SOP interventions including safety mapping, provide guidance to case-workers in comprehensive planning to address priority issues that impact safety.
9-03-2012-00017 Initial	CDNDSC recommends that the Division of Family Services con-sider revising what is considered a quality collateral contact (i.e. medical mental health).	**DFS** is researching the templates and procedures that other jurisdictions utilize for collateral contacts, especially those with medical professionals. A Collateral Contact Workgroup is being convened to review models and seek input from medical professionals familiar with child protective services.
9-03-2012-00017 Initial	CDNDSC recommends that the Division of Family Services con-tinue in the development of Struct-ured Decision Making (SDM) for treatment cases in order to aid treatment staff in making a decision to close a case.	**DFS** continues implementation of SDM assessment tools across all functions of child welfare. DFS contracts with the Children's Research Center, the dissemina-tor of SDM tools, for ongoing quality case reviews to ensure that implementation is being achieved with fidelity. The full electronic implementation of all SDM tools is dependent upon implementation of the FACTS II client information system.
9-03-2012-00017 Initial	CDNDSC recommends that the Division of Family Services consult with the appropriate Deputy Attorney General when consider-ing case closure during investiga-tion for serious physical injury or death.	**DFS** refers to above responses that address collaboration between DFS and DOJ on case closures.
9-03-2012-00005 Initial	CDNDSC recommends that the Division of Family Services' (DFS) Collateral Contact Information Sheet be amended to include questions pertaining to Neonatal Abstinence Syndrome, as well as to document DFS concern of sub-stance abuse, physical abuse, sexual abuse, emotional maltreat-ment, and neglect.	**DFS** is researching the templates and procedures that other jurisdictions utilize for collateral contacts, especially those with medical professionals. A Collateral Contact Workgroup is being convened to review best practice models and seek input from medical and other professionals familiar with child protective services.

Agency Specfic Recommendations... *(continued from page 38)*

Department of Services for Children, Youth, and Their Families…

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2012-00005 Initial	CDNDSC recommends that in serious injury cases, the Division of Family Services' caseworker contact the Department of Justice Child Protection Unit of the Family Division, so that a determination can be made as to whether or not custody should be sought OR a safety plan should be implemented.	**DFS** is working with national experts and DOJ on updating safety plan format and content, as well as the consultation process in cases of serious injury. SOP interventions including safety mapping, provide guidance to caseworkers in comprehensive planning to address priority issues that impact safety.
9-03-2012-00005 Initial *And also in* 9-03-2012-00017 Initial	CDNDSC recommends that cases involving multigenerational or chronic patterns of child abuse and/or neglect be given a higher level of supervisory oversight than cases without such history.	**DFS** references the above first response. SDM risk tools include research-based weighting of prior history of child protective involvement. Multi-generational and chronic patterns of involvement with the child welfare system are extremely common in child welfare. Research consistently demonstrates that prior history is predictive at a population level, but is not directly predictive at an individual case level. Only approximately 30% of individuals with prior history go on to maltreat their children. Consequently, the field of child welfare continues to utilize research to improve the assessment of how and the extent to which prior history is predictive in specific cases. The SOP group consultation approach utilizes the Critical Framework for Decision Making provides input from multiple supervisors in organizing critical information including prior history in planning for specific families.
9-03-2012-00005 Initial	CDNDSC recommends that the Division of Family Services reassess a caseworker's ability to close an investigation case prematurely when substance abuse and/or mental health was not properly assessed by a professional.	**DFS** agrees to work with the Children's Research Center to analyze SDM assessment information on caregiver risk factors in determining appropriate thresholds for case closure.
9-03-2012-00005 Initial	CDNDSC recommends that the Division of Family Services research and implement a yearly mandatory program to assess/address compassion fatigue, burnout, and vicarious trauma among employees.	**DFS** participates in the DSCYF Trauma-Informed Committee's efforts to provide broad trauma training, including training on vicarious trauma, to all department employees. Human Resource Management of OMB already provides trainings on burnout prevention and self-care.
9-03-2012-00005 Initial	CDNDSC recommends that the Division of Family Services revise policy as it pertains to the use of safety plans and the identification of appropriate caregivers.	**DFS** is working with national experts and DOJ on updating safety plan format and content. SOP interventions including safety mapping, provide guidance to caseworkers in comprehensive planning to address priority issues that impact safety.

Agency Specfic Recommendations... (continued from page 39)

Department of Services for Children, Youth, and Their Families…

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2012-00015 Initial	CDNDSC recommends that the Division of Family Services' Investigation and Treatment cases list all biological children of the parent and/or caregiver who are subject of the investigation, and physically assess the safety of these children.	**DFS** references the above responses. The implementation of SDM and SOP provide guidance for comprehensive assessment and safety mapping.
9-03-2012-00015 Initial	CDNDSC recommends that the Division of Family Services comply with the Memorandum of Understanding as it pertains to communication and collaboration with Delaware Police Departments.	**DFS** is a member of the current CPAC committee reviewing the operationalization of the MOU.
9-03-2012-00015 Initial	CDNDSC recommends that the Division of Family Services revise its procedure for interviewing and assessing the safety of children residing in the household of the alleged perpetrator when this individual resided in a different household.	**DFS** references above responses. The implementation of SOP safety mapping includes comprehensive assessment of all children.
9-03-2012-00015 Initial	CDNDSC recommends that the Division of Family Services consider documenting a rationale about why custody was either sought or not sought upon completion of the initial interview or upon case closure. Moreover, supervisory oversight should be given during this decision making process.	**DFS** references above responses. The implementation of SDM safety assessments provides greater rationale for the level of safety concerns and the intervention.
9-03-2012-00015 Initial	CDNDSC recommends that the Division of Family Services verify and confirm the residency and guardianship of any child active within their caseload through the Family Court.	**DFS** agrees to refer this issue for further review by the Investigation Work Group.

Agency Specfic Recommendations... *(continued from page 40)*

Department of Services for Children, Youth, and Their Families…

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2012-00015 Initial	CDNDSC recommends that the Division of Family Services follow its regulations pertaining to the Child Protection Registry in determining whether to substantiate a case for abuse and/or neglect.	**DFS** agrees to review the specifics of this case with regional administrators and the Investigation Work Group to reinforce the implementation of regulations in a consistent approach statewide.
9-03-2012-00015 Initial	CDNDSC recommends that the Division of Family Services refer participants for substance abuse evaluations during the investigation, so that if the participant fails to comply with such request, a motion to compel can be filed by notifying and discussing with the Department of Justice Child Protection Unit of the Family Division.	**DFS** references above first response. The implementation of SDM and SOP are focused on supporting comprehensive risk assessment and responsive planning that includes caregiver risk issues. DFS and DOJ are collaborating on the process for consultation on case closures when there are issues of noncompliance.
9-03-2012-00013 Initial	CDNDSC recommends that the Division of Family Services (DFS) follow the Memorandum of Understanding as it pertains to the contact of law enforcement prior to DFS response.	**DFS** is a member of the current CPAC committee reviewing the operationalization of the MOU.
9-03-2012-00013 Initial	CDNDSC recommends that the Division of Family Services revisit the job description of the Family Services Assistant, which is outlined within the Office of Management and Budget, in order to clarify that a Family Service Assistant should <u>not</u> be able to respond to a case, once transferred to treatment, in order to make case decisions regarding alcohol/drug abuse.	**DFS** agrees to review the respective job description and align duties and responsibilities with policy.
9-03-2012-00013 Initial	CDNDSC recommends that the Division of Family Services reconsider its decision making process when closing investigations, knowing that parents have substance abuse issues that have not been addressed. This non-compliance should be considered a possible issue for substantiation.	**DFS** references the above first response. The implementation of SDM and SOP are focused on supporting comprehensive risk assessment and responsive planning that includes caregiver risk issues. DFS and DOJ are collaborating on the process for consultation on case closures when there are issues of noncompliance.

Agency Specfic Recommendations... (continued from page 41)

Department of Services for Children, Youth, and Their Families…

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2012-00013 Initial	CDNDSC notes that the Safety Plan was violated by father on more than one occasion and that maternal grandmother was unable to provide appropriate supervision of the child. Therefore, it is recommended that in instances when a safety plan is violated or there is lack of enforcement as it pertains to visitation, that the Division of Family Services (DFS) re-evaluates the plan and assesses safety. Then, if needed, a referral can be made to the visitation centers.	**DFS** references the above responses. DFS is working with national experts and DOJ on revising the format and process for safety plans.
9-03-2012-00015 Initial Ancillary	CDNDSC recommends that the Division of Family Services revise its procedure as it pertains to collateral contacts for allegations involving parental substance abuse, as well as develop procedure for substance abuse evaluation and waiting for the results of an evaluation prior to case closure.	**DFS** references the above responses. DFS is researching templates and processes for collateral contacts and will be convening a work group to make revisions to the current procedures and policy.
9-03-2012-00017 Initial Ancillary	CDNDSC recommends that the Division of Family Services' caseworkers educate parents on the appropriate use of car seats for premature or medically fragile infants and that car seats primarily be used for transportation. Moreover, follow up must occur and documentation should be made by caseworker in the Family and Child Tracking System (FACTS) to reflect such education.	**DFS** provides training on car seat safety issues.
9-03-2012-00017 Initial Ancillary	CDNDSC recommends that the Division of Family Services consider adding multigenerational history to the current six supplements of the Structured Decision Making Risk Assessment Tool.	**DFS** references above responses. SDM risk tools include research-based weighting of prior history of child protective involvement. Multi-generational and chronic patterns of involvement with the child welfare system are extremely common in child welfare. Research consistently demonstrates that prior history is predictive at a population level, but is not directly predictive at an individual case level. Only approximately 30% of individuals with prior history go on to maltreat their children. Consequently, the field of child welfare continues to utilize research to improve the assessment of how and the extent to which prior history is predictive in specific cases. The SOP group consultation approach utilizes the Critical Framework for Decision Making and provides input from multiple supervisors in organizing critical information including prior history in planning for specific families.

Agency Specfic Recommendations... *(continued from page 42)*

Department of Services for Children, Youth, and Their Families…

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2012-00017 Initial Ancillary	CDNDSC recommends that the Division of Family Services explore best practice as it relates to cases involving multigenerational history. Furthermore, it is recommended that a program be implemented to help address issues of multigenerational history with the family when said history is present within an active investigation.	**DFS** references above response.
9-03-2006-00003 Final	CDNDSC supports the use of history in decision making process by the Division of Family Services.	**DFS** references above response.
9-03-2011-00002 Final	CDNDSC recommends that the Division of Family Services evaluate the facts and circumstances of a case, to include not only the Medical Examiner's findings, but the findings of the criminal investigation in order to determine whether or not a case should be substantiated for physical abuse and/or neglect.	**DFS** agrees with this recommendation and will refer to the Investigation Work Group. However, DFS acknowledges that the agency does not always have access to all of these various findings at the end of the child protective investigation.
9-03-2011-00003 Final	CDNDSC recommends that the Division of Family Services re-evaluate the Safety Assessment and Safety Planning policy, training and use thereof.	**DFS** references the above first response on comprehensive efforts. DFS is continuing to revise policy to reflect new practices.
9-03-2011-00003 Final	CDNDSC recommends that the Division of Family Services revise its procedure for interviewing and assessing the safety of children residing in the household of the alleged perpetrator when this individual resided in a different household.	**DFS** references the above first response.
9-03-2006-00003 Final	CDNDSC recommends that the Division of Family Services better utilize the legal option of compelling cooperation during an investigation and the legal ability to include judicial enforcement.	**DFS** references above responses. DFS and DOJ are collaborating on improving process for consultation on compelling cooperation.

Agency Specfic Recommendations... *(continued from page 43)*

Department of Services for Children, Youth, and Their Families…

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2006-00003 Final	CDNDSC recommends that the Division of Family Services (DFS) reconsider the ability to substantiate a case for physical abuse and/or neglect with perpetrator unknown.	**DFS** agrees to review the policy and procedures for substantiation of maltreatment in cases where the perpetrator is unknown. DFS is participating in a current committee of CPAC reviewing the Child Protection Registry and related issues of substantiation. DFS recognizes and appreciates the value in creating a record of such substantiation associated with a child victim. However, the current procedures for the processing of substantiation cases were all created to track substantiation associated with a known perpetrator. To associate substantiation with a victim instead, will require changes to the FACTS client information system. DSCYF is in the process of building a new FACTS II system and any additional changes will need to be phased in as resources are available.

Family Court

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2013-00015 Initial	CDNDSC recommends that all Emergency Ex Parte Orders statewide reflect language relating to the visitation between the child and suspected perpetrator(s).	**Family Court Response:** The Family Court agrees that detailed information related to visitation guidelines for suspected perpetrators of abuse is valuable for inclusion in ex parte orders when possible. The Family Court has encouraged Judges to ask the Division of Family Services' caseworker if any additional information should be considered by the on-call Judge prior to the entry of an order. DFS is encouraged to request that the on-call Judge address visitation when DFS has specific concerns that should be addressed in the ex parte order.
9-03-2011-00009 Final	CDNDSC recommends that the Court Appointed Special Advocates (CASA) Program draft policy and procedure in order to best direct and assess how a CASA should proceed in a case involving life threatening circumstances and/or life ending decision making for children in the custody of the Division of Family Services.	**Family Court Response:** The CASA Program has implemented program policy to direct how a CASA volunteer should proceed in cases that involve life threatening circumstances and/or life ending decision making for children in the custody of the Division of Family Services.

Agency Specfic Recommendations... (continued from page 44)

Law Enforcement Agencies

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2012-00013 Initial	CDNDSC recommends that law enforcement use a multidisciplinary team approach when investigating cases of child abuse and neglect, especially as it pertains to the interviews of suspected perpetrators.	No response was received.
9-03-2012-00015 Initial	CDNDSC recommends that law enforcement comply with the Memorandum of Understanding as it pertains to communication and collaboration with the Division of Family Services.	No response was received.
9-03-2012-00017 Initial	CDNDSC recommends that law enforcement conduct proper scene investigations.	No response was received.
9-03-2012-00017 Initial Ancillary	CDNDSC recommends that Delaware Police Departments comply with the Memorandum of Understanding when responding to incidents of domestic violence where a child is present. Such responses should initiate a report to the Child Abuse and Neglect Report Line and consultation with the Department of Justice for possible criminal charging.	No response was received.
9-03-2011-00005 Final	CDNDSC recommends that the Children's Advocacy Center be used at all times when a child presents as medically fragile or cognitively disabled.	No response was received.
9-03-2011-00003 Final	Delaware Police Departments shall adhere to 16 Del. C. § 903, §904, §905 and 24 Del. C. §1731A (a) when reporting child abuse and neglect via the Child Abuse and Neglect Report Line.	No response was received.

*Agency Specfic Recommendations...**(continued from page 45)*

Medical

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2013-00004 Initial	CDNDSC recommends that Delaware Emergency Departments and the Emergency Nurse's Association comply with the American Academy of Pediatrics as it pertains to the standard of care when performing full body skeletal surveys.	**Beebe:** In reviewing the details of this case, the child was being transferred to A.I. duPont Hospital for Children for a head injury. It has been our practice with transfers to this pediatric hospital to defer full body skeletal surveys at their request to lessen radiation exposure and avoid duplication of services. The primary goal was to treat life threatening injuries and stabilize for transport to the specialty hospital. We respectfully request, that when we are asked to respond to specific events that are attributed to our Medical Center, that we be given the actual name of the child. We have a robust peer review process that maintains confidentiality and allows for the sharing of information to improve the care of our patients. **NMH:** Our hospital has an osseous survey that we order for any child under the age of 24 months where there are concerns of abuse. This protocol does include hands and upper extremity views but at this time does not include oblique views of the ribs. However, based on the American College of Radiology Appropriateness Criteria on Suspected Physical Abuse this is being suggested as a view to include. Our radiology physicians are reviewing these recommendations and are considering this change. The appropriate images of our pediatric patients where there are concerns of abuse depend on the patient's age, neurological status, evidence of other injuries and discrepancy in the patient's injuries with the clinical history provided. In our patient population older than 24 months, we can order a skeletal survey but tend to adjust the order based on the areas of suspected injury.
9-03-2012-00013 Initial	CDNDSC recommends that if a child, less than one year of age, presents with significant trauma and bruising then the American Academy of Pediatric's (AAP) policy for physical abuse regarding the guidelines of head imaging be followed.	**AI:** As a Pediatric Hospital and Trauma Center, it is our intention that our patients are evaluated by using the appropriate, evidence-based guidelines, including those from the American Academy of Pediatrics. **NMH:** We do not currently have a policy for this recommendation but it is best practice that when abuse is suspected that a child has a skeletal survey completed. Spoke with Trauma Committee and will look at developing this policy. Please provide the AAP policy for physical abuse regarding the guidelines of head imaging. We can be consistent in our development of this policy for the hospital and provide it to the Trauma surgeons, Pediatricians and Emergency physicians group. **CCHS:** If a child less than one year of age presents with significant trauma and bruising, then the American Academy of Pediatric's (AAP) policy for physical abuse regarding the guidelines of head imaging should be followed. CCHS will circulate these AAP guidelines to ED physician and nursing staff and review them with Pediatric staff at an educational activity. We will also review all hospital policies and procedures relative to Child Abuse prevention and revise and update as necessary. We have extracted the AAP policy documents from the AAP website and they will be circulated to ED and to Peds staff.

*Agency Specfic Recommendations...**(continued from page 46)*

Medical…

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2012-00005 Initial	CDNDSC recommends that Delaware Hospitals with a nursery status of I or II be trained in the recommended treatment of Neonatal Abstinence Syndrome (NAS) according to the American Academy of Pediatrics.	**AI:** As a Pediatric Hospital, it is our intention to utilize appropriate abstinence score/weaning tool such as Neonatal Abstinence Scoring (NAS) as well as appropriate patient assessments when weaning infants from opioids or benzodiazepines. **CCHS:** Two years ago as a performance improvement initiative, a CCHS multidisciplinary team reviewed the frequency and severity of NAS in our nursery populations. We found that we discharged over 100 babies with that diagnosis in 2009 and another 100 in 2010. In 2012, there were about 140 such babies. We established an adhoc work group to look at how we treat these babies and are in the process of developing pathways for treatment- not just for inpatient care but for follow up medical care with attention to the complex social issues surrounding these infants and their families. The multidisciplinary team (nursing, medicine, pharmacy, social service, visiting nurse) discovered a lack of consistency on evaluation and treatment regionally and nationally. CCHS subscribed to the multi-center educational collaborative of the Vermont Oxford Network (VON). Over 40 staff of various disciplines at CCHS are participating in the network educational activities for NAS and are passing what they are learning to the rest of the staff. Our plan to be a regional center for excellence in caring for NAS babies is well along. **NMH:** We have a policy #4665 Neonatal Abstinence Syndrome (NAS): Assessment and Management and a form for documentation of the score. As part of their staff competencies, all OB nursing staff has a self-learning packet that pertains to NAS scoring.
9-03-2011-00005 Final	CDNDSC recommends that the initial treating hospital review their policies and procedures used in the treatment and care of a suspected sexual assault victim.	**CCHS:** CCHS policies are on the institutional intra-net complete with references. These are derived from expert opinion, textbooks, review articles, and state and federal recommendations. All relevant policies are in the process of being reviewed.
9-03-2011-00005 Final	CDNDSC recommends that if a decision is made to offer Human Immunodeficiency Virus (HIV) post-exposure prophylaxis to sexual assault victims that present to Delaware Hospitals, it is offered as soon as possible and within seventy-two hours after reported assault.	**AI:** As a Pediatric Hospital and Trauma Center, it is our intention to offer post-exposure counseling and prophylaxis to parents on behalf of their minor child as well as to minors who have reached the age of consent in accordance with Delaware statutes. Patients presenting after a sexual assault will be appropriately evaluated. Evidence collection, when performed, is done so using the State of Delaware Sexual Assault Evidence Collection Kit. Patients in need of care beyond the capabilities of the hospital are stabilized and transported by ambulance to an appropriate treatment facility having sufficient capability and expertise in the evaluation of such patients utilizing the Sexual Assault Nurse Examiner program. **CCHS:** CCHS child abuse prevention committee discussed this recommendation at some length. The recommendation was also reviewed by our specialist in Pediatric Infectious Disease. We noted that the CDC does not have precise guidelines regarding HIV prophylaxis in cases of sexual assault when the HIV statue of the assailant is unknown and decisions should be made individually taking into account the estimated risk of infection in the perpetrator, the nature of the assault

Agency Specfic Recommendations... (continued from page 47)

Medical…

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
		and the preference of the victim-patient. Linden in New England Journal of Medicine (NEJM, September 2011: 365"839) review on care of the patient after sexual assault said "HIV post-exposure prophylaxis may be offered if the patient presents within 72 hours after a sexual assault, but its use is controversial in cases in which the perpetrator is not known." We feel that the patient and guardian should be counseled in detail regarding risks of infection and when indicated prophylaxis be administered. **NMH:** SANE/FNE programs offer services to victims but the victim has the right to decline services at any time. The patient can decide what parts of the kit they want collected, prophylactic treatment and support. The patient is offered the treatment hopefully with a supportive person present for them. All treatment should be offered to the victim who can make reproductive health choices for herself from age 12 years and older based on age of consent in Delaware. The patient is to be given all the information about STI/HIV/pregnancy prophylactic treatment. This will be documented in their chart. **Beebe:** Sexual assault victims are treated for potentially life threatening injury first. HIV prophylaxis is offered to all victims of sexual assault, in the case of a brain injury, the child may not have understood the potential risks and benefits within the 72 hour timeframe. In this case the collection of any documentation of forensic evidence was superseded by the medical status of the patient. Additionally, it should be noted that the offender's HIV status could have been obtained and treatment offered to the victim based on the results.
9-03-2011-00005 Final	CDNDSC recommends that Delaware Hospitals' Sexual Assault Nurse Examiners (Sexual Assault Forensic Examiners) assess, collect, and document all forensic evidence; including but not limited to, completing the entire sexual assault evidentiary exam including crisis intervention, sexual transmitted infection (STI) prevention, pregnancy risk evaluation and interception, collection of forensic evidence, and referrals for additional support and care. It is further recommended that all documentation be detail oriented and that conversations between patient and/or second party regarding patient care be included in such documentation and be explicitly clear as to what was discussed and decided by patient and/or second party.	**AI:** As a Pediatric Hospital and Trauma Center, it is our intention to offer post-exposure counseling and prophylaxis to parents on behalf of their minor child as well as to minors who have reached the age of consent in accordance with Delaware statutes. Patients presenting after a sexual assault will be appropriately evaluated. Evidence collection, when performed, is done so using the State of Delaware Sexual Assault Evidence Collection Kit. Patients in need of care beyond the capabilities of the hospital are stabilized and transported by ambulance to an appropriate treatment facility having sufficient capability and expertise in the evaluation of such patients utilizing the Sexual Assault Nurse Examiner program. **CCHS:** This recommendation has been reviewed in detail by leadership of CCHS Department of Emergency Medicine. A detailed policy currently is available from this Department which includes extracts from a number of the resources referenced in other recommendations

Agency Specfic Recommendations... *(continued from page 48)*

Medical…

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2011-00005 Final	CDNDSC recommends that Delaware Hospitals familiarize and adhere to the age of consent for treatment of a child who presents as a victim of sexual assault.	**CCHS:** This is a regular part of initiation of new personnel at Christiana Care and an annual review of this and other policies is suggested for every employee and is mandated for some.
9-03-2009-00014 Final	CDNDSC encourages Delaware Hospitals, under the guidance of the Delaware Healthy Mother and Infant Consortium (DHMIC), to explore and assess patients who present with Postpartum Depression through techniques such as screening tools, referrals, and additional resources and services.	**DHMIC** is in total agreement that mental health is an important issue in the perinatal periods as it is across the life span. It will interest you to know that this issue is included in our recent 5-year strategic plan and we intend to address it to the extent that our authority and resources permit. As constructed, however, the specific recommendation on this case exceeds the current authority and resources of the DHMIC. We are encouraged that the Essential Benefits provision of the Affordable Care Act includes mental health and substance use disorder services. We are hopeful that this provision will, in part, begin to improve both the availability and quality of mental health services in our state in advance of the systems changes that we expect will be the focus of the Consortium's future efforts. We look forward to working collaboratively with the CDNDSC to move the agenda of maternal health forward in Delaware. **AI:** As our Pediatric facility doesn't provide routine maternity/postpartum care, we would facilitate a referral to an appropriate care provider in the community. **CCHS:** CCHS leadership recently approved the initiation of a comprehensive, multidisciplinary perinatal behavioral health program. We recognized the effects of postpartum depression on health and welfare of women and their babies. Two years ago, we added a social worker to our Neonatal ICU staff whose responsibility is to screen all families who have a baby in our NICU for more than a few days for postpartum depression and other perinatal mental health issues. Subsequently, we established the comprehensive program noted above and this program will be underway by Autumn 2013. Staff will include a psychologist, a psychiatric social worker and a psychiatric nurse practitioner. This team will be supported by a psychiatrist with special interest in women's health. Screening, evaluation, and treatment will be available for women with PPD but also for women with other mental health conditions found in the pre-, peri-, and postpartum periods. **NMH:** We have a behavioral health process in place. A medical screening exam would take place and then a referral would be made to have the patient evaluated by mental health (outside agency). We could welcome the Delaware Healthy Mother and Infant Consortium (DHMIC) to present to staff at a staff meeting to bring this information to our staff. There is also a policy and procedure for Depression Screening for at risk OB patients (#4119) and the OB discharge instructions address postpartum blues versus depression and symptoms to identify and offers suggestions about what to do about these symptoms.

Agency Specfic Recommendations... (continued from page 49)

Medical…

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2010-00006 Final	CDNDSC shall send a letter to the child's Primary Care Physician and Practice stating concerns regarding the transportation of child(ren) by parent(s) when there is a suspicion of child abuse and/or neglect and it is believed that the abuse and/or neglect was inflicted by the parent(s) and/or caretaker(s).	Response from Physician: Child abuse was not suspected and therefore no failure to report such. **CCHS** is not the practice referenced here. However the following CCHS policy was reviewed: Transport, Adult and Pediatric Patient.
9-03-2009-00016 Final	CDNDSC shall send a letter to the treating hospital recommending that consultation occur with an expert when infants present with intracranial hemorrhages and history of abnormal neurological activity.	This was distributed in July 2013.
9-03-2011-00003 Final	Delaware Hospitals shall adhere to 16 Del. C. § 903, §904, §905 and 24 Del. C. §1731A (a) when reporting child abuse and neglect via the Child Abuse and Neglect Report Line.	**AI:** As a Pediatric Hospital and Trauma Center, it is our intention that all Associates, Medical Staff and Physicians-in-Training comply with Delaware child protective service laws pertaining to child abuse and neglect and sexual abuse, including the required reporting under such laws. **CCHS:** We will review these laws with ED and Pediatric Staff on a regular basis. **NMH:** We have a Child Maltreatment – Neglect Policy and Procedure (#4032). Will attach mandatory reporting law to the policy for reference for staff. FNE staff and ED staff are reminded on a quarterly basis about reporting. Staff is aware that they do not have to be able to prove the abuse just suspect that the child is being abused.
9-03-006-00003 Final	CDNDSC will send a letter to the Delaware hospital involved in the care and treatment of this child who failed to report the suspected child abuse and neglect of the child.	**CCHS:** No response required; however, our new pediatric radiologist will be asked to review AAP recommended policies at CCHS regarding imaging in situations in which child abuse is suspected. **NMH** requests clarification on "baby gram." It is unclear if this is a CT scan or x-rays of bones. All radiology reads are read by two providers, and we have a discrepancies procedure and report tool that we utilize to address this issues with follow up for the patient.
9-03-2006-00003 Final	CDNDSC recommends that all Delaware hospitals follow the standard of care as depicted in the American Academy of Pediatrics on how to properly examine a child for child abuse using skeletal surveys.	**AI:** As a Pediatric Hospital and Trauma Center, it is our intention that our patients are evaluated by using the appropriate, evidence-based guidelines. **CCHS:** We have abstracted the AAP guidelines referenced in the recommendation. CCHS recently had a full time Pediatric Radiologist join our staff who will lead educational activities with Pediatrics and Emergency Departments around an appropriate imaging approach to evaluation of a child with suspected child abuse.

Agency Specfic Recommendations... *(continued from page 50)*

Medical…

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2006-00003 Final	CDNDSC will send a letter to the hospital involved with this child asking them to review their policies and assessment regarding computed tomography (CT) scans.	**CCHS:** No response required; however, our new Pediatric Radiologist will be asked to review AAP recommended policies at CCHS regarding imaging in situations in which child abuse is suspected.
9-03-2011-00009 Final	CDNDSC recommends that Delaware hospitals document all correspondences and/or communications that occur between the hospitals and the Division of Family Services (DFS) and/or the Department of Justice (DOJ).	**AI:** As a Pediatric Hospital, it is our intention that all Associates and Medical Staff and Physicians-in-training comply with hospital policies and procedures related to withholding and/or withdrawing of life sustaining therapies. It is also our intention that a physician member of the Medical Staff or physician-in-training will ask permission from the parent or legal guardian to obtain an autopsy, unless the medical examiner has asserted jurisdiction. Consent for autopsy as well as documentation of any communications with government/law enforcement agencies, organ procurement organizations or family/social service agencies is expected to be placed in the medical record. **CCHS:** CCHS will make reasonable efforts to maintain written documentation with DFS and/or DOJ, and will also make reasonable efforts to document phone conversations with DFS and/or DOJ.
9-03-2011-00009 Final	CDNDSC recommends that the treating hospital review its policy and procedure pertaining to withholding and/or withdrawing a child from life support with specific regard to a child who is in the State's custody and that current policy establishing a uniform language with reference to the party who is able to make these decisions on behalf of the child.	**AI:** As a Pediatric Hospital, it is our intention that all Associates and Medical Staff and Physicians-in-training comply with hospital policies and procedures related to withholding and/or withdrawing of life sustaining therapies. It is also our intention that a physician member of the Medical Staff or Physician-in-training will ask permission from the parent or legal guardian to obtain an autopsy, unless the medical examiner has asserted jurisdiction. Consent for autopsy as well as documentation of any communications with government/law enforcement agencies, organ procurement organizations or family/social service agencies is expected to be placed in the medical record. **CCHS:** Christiana Care policies were reviewed: the topic will be brought to the hospital Ethics Committee for further discussion.
9-03-2011-00009 Final	CDNDSC recommends that treating hospital follow the recommended guidelines from the Centers for Disease Control and Prevention to perform an autopsy when Sudden Unexplained Death in Infancy (SUDI) or Sudden Infant Death Syndrome (SIDS) is the suspected cause of death.	**AI:** As a Pediatric Hospital, it is our intention that all Associates and Medical Staff and Physicians-in-training comply with hospital policies and procedures related to withholding and/or withdrawing of life sustaining therapies. It is also our intention that a physician member of the Medical Staff or Physician-in-training will ask permission from the parent or legal guardian to obtain an autopsy, unless the medical examiner has asserted jurisdiction. Consent for autopsy as well as documentation of any communications with government/law enforcement agencies, organ procurement organizations or family/social service agencies is expected to be placed in the medical record. **CCHS** agrees that an autopsy by an appropriately trained pathologist is an essential part of the evaluation of an apparent SUDI death. CCHS will cooperate with the Office of the Medical Examiner in assuring such an autopsy is completed.

Agency Specfic Recommendations... (continued from page 51)

Delaware Sentencing Accountability Commission (SENTAC)

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2013-00015 Initial	CDNDSC recommends that the Sentencing Accountability Commission (SENTAC) should review the adequacy of Delaware's sentencing guidelines as they pertain to criminal child abuse cases involving serious injury.	As a result of this recommendation, CDNDSC was invited to present this recommendation at the March 21, 2014 SENTAC meeting.

Department of Health and Social Services

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2011-00009 Final	CDNDSC recommends that the Medical Examiner's (ME) Office follow the recommended guidelines from the Centers for Disease Control and Prevention to perform an autopsy when Sudden Unexplained Death in Infancy (SUDI) or Sudden Infant Death Syndrome (SIDS) is the suspected cause of death.	Per the ME's office, an autopsy was performed by a hospital out of state. The panel did not have access to those records. Therefore, this recommendation is no longer valid.

Multi-Disciplinary CAN Recommendations

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2012-00013 Initial Responsible Agencies: • DFS • Medical	CDNDSC shall send a letter to the child's Primary Care Physician (PCP) and the Division of Family Services (DFS) addressing concerns regarding the transportation of child(ren) by parent(s)/caregiver(s) when there is a suspicion of child abuse and/or neglect and it is believed that the abuse and/or neglect was inflicted by the parent(s) and/or caretaker(s).	**DFS** agrees to refer to the Investigation Work Group for review and development of procedures.

Agency Specfic Recommendations... (continued from page 52)

Multi-Disciplinary CAN Recommendations…

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2013-00004 Initial Responsible Agencies: • DFS • Law Enforcement	CDNDSC recommends that the language line or an official interpreter be utilized during a Child Abuse/Neglect investigation by the Division of Family Services instead of the use of minors or other persons as interpreters.	**DFS** agrees that an official interpreter is the appropriate resource. DFS is working with the Office of Management and Budget to ensure that there is adequate and appropriate access to contracted interpretation services.
9-03-2012-00017 Initial Responsible Agencies: • DOJ • Law Enforcement	CDNDSC recommends a team of criminal investigators with expertise in the investigation of child abuse should be established within the Department of Justice. This investigation team should work directly with the special victims unit in the investigation and prosecution of felony level, criminal child abuse. Referral to the investigation teams should be mandatory in all such cases, statewide. The investigation team should have authority to seek the assistance of police agencies with appropriate expertise, when necessary to support resource constrained, local police jurisdictions in the investigation phase, although local police should be permitted to partner in the investigation.	No response was received.
9-03-2013-00003 Initial *And in case* 9-03-2013-00015 Initial Responsible Agencies: • CPAC • Law Enforcement	CDNDSC recommends that the Memorandum of Understanding be amended to include a suspected location of the incident as it relates to the criminal investigative duties of Delaware Police Departments. Specifically, that within the first twenty-four to forty-eight hours law enforcement should identify and inspect the location where the alleged incident occurred for scene preservation and evidence collection.	**CPAC Response:** As recommended in the Final Report of the Joint Committee on the Investigation and Prosecution of Child Abuse, on July 10, 2013, CPAC approved the creation of a new workgroup, titled CAN Best Practices, under the CPAC Training Committee, with Corporal Adrienne Owen as the Chair. The charge of this workgroup is as follows: 1) To develop and publish "best practice" guidelines for the investigation of child sexual abuse, death and near death cases. 2) To provide regular training opportunities and demonstrative tools for professionals involved in the investigation or prosecution of serious child abuse cases. 3) To publish its best practice guidelines, including protocols on scene preservation and evidence collection. The workgroup concluded that a revision to the Memorandum of Understanding (MOU) between DSCYF, CAC, DOJ, and the Delaware Police Departments was necessary. CPAC approved this revision to the MOU at its Joint Commission meeting with CDNDSC on December 6, 2013.

Agency Specfic Recommendations... (continued from page 53)

(continued from page 53)

Multi-Disciplinary CAN Recommendations…

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-03-2010-00001 Final Ancillary Responsible Agencies: • CPAC • DOJ	CDNDSC recommends that research be conducted and legislation be drafted in order to enhance the criminal penalties for assaults on children under the age of 18.	**CPAC Response:** In December 2011, CPAC and CDNDSC approved the creation of the Joint Committee on the Investigation and Prosecution of Child Abuse, which was charged with researching and developing statutes, policies, procedures and/or trainings that reflect best practices for better protecting children from abuse by optimizing the opportunities to appropriately punish perpetrators of abuse crimes against children. After meeting on seven occasions, the Committee forwarded its Final Report, which included nine recommendations, to CPAC and CDNDSC for approval on May 17, 2013. The following recommendations from the Final Report pertain specifically to the above recommendation: 1) Develop and pass a criminal statute that will allow for the effective prosecution of caregivers who, with criminal negligence, enable felony level, criminal child abuse involving the death, serious physical injury, or sexual abuse of a child; and 2) SENTAC should review the adequacy of Delaware's sentencing guidelines as they pertain to criminal child abuse cases involving serious injury, including (but not limited to) guidelines applicable to the crime of Endangering the Welfare of a Child, where violence or physical injury are involved. At its last quarterly meeting on July 10, 2013, CPAC discussed the two recommendations above and developed follow up activities to ensure implementation of each. To address the criminal statute, CPAC plans to create a workgroup under its Legislative Committee. However, for the review of SENTAC Guidelines, CPAC will need to discuss it further at its quarterly meeting to determine if the Department of Justice has already begun to address this item.
9-03-2010-00006 Final Responsible Agencies: • DOJ • DFS • Law Enforcement • Medical	CDNDSC recommends that a multi-disciplinary team approach be used when conducting criminal and/or civil investigations, so that communication as to the circumstances of the incident and the injuries sustained by the child can be made known immediately and properly discussed with medical personnel, law enforcement, the Division of Family Services (DFS), and the Department of Justice (DOJ).	**DFS** supports the use of a multi-disciplinary team approach in cases of serious injury, death or near death, sexual abuse, as well as other cases when unusual circumstances warrant such an approach. **AI:** As a Pediatric Hospital and Trauma Center, it is our intention that all Associates, Medical Staff and Physicians-in-Training comply with Delaware child protective service laws pertaining to child abuse and neglect and sexual abuse, including the required reporting under such laws. As a Pediatric Hospital and Trauma Center, it is our intention to cooperate with law enforcement investigations with regards to suspected abuse. **CCHS:** CCHS' Department of Emergency Medicine has a multidisciplinary team with established policies on evaluation, follow up and documentation. **NMH** attempts to utilize a multidisciplinary team approach when possible. It is noted that in the hospital setting, DFS investigators and the DOJ are not present unless there is an emergent issue. We often make an initial DFS report with the hotline and a road officer is the person here taking the initial complaint. It is not

(continued on page 55)

Agency Specfic Recommendations... (continued from page 54)

Multi-Disciplinary CAN Recommendations…

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
		our practice to allow any child to leave this institution unless the safety plan is cleared or approved by DFS. NMH has a policy in place that identifies which agency is to be notified. Domestic Violence (#4031) and the Child Maltreatment – Neglect (#4032). Based on these recommendations and our practice, these policies will be revised to specifically document agency contact. Documentation will include who was spoken to and the date and time of contact. Though our policy does not currently address these elements, our practice does include this information. The Forensic Nurse Examiner (FNE) meetings include the importance of this documentation at least quarterly.
9-03-2011-00005 9-03-2011-00006 Final Responsible Agencies: • DOJ • DFS	CDNDSC recommends the continued use of the Children's Advocacy Center (CAC) for forensic interviewing and the use of the Memorandum of Understanding between the Department of Services for Children, Youth and Their Families, the CAC, the Department of Justice, and Delaware Police Departments when investigating all cases alleging physical and/or sexual abuse.	**DFS** agrees that the use of the Children's Advocacy Center is important for forensic interviews. DFS is participating in the CPAC Committee reviewing the operationalization of the MOU.

NCC Panel

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-01-2012-00012	CDNDSC recommends that the Division of Prevention and Behavioral Health Services educate families and/or counsel families on the signs, symptoms and behaviors associated with decompensation of children with a history of substance abuse issues. Such education and/or counseling should be included in the child's discharge planning from rehabilitation programs.	No response received.

Agency Specfic Recommendations... (continued from page 55)

NCC Panel…

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-01-2012-00005	CDNDSC recommends that the Division of Family Services incorporate the practice of providing and documenting information pertaining to safe sleeping practices into policy.	**DFS** agrees to ongoing collaboration with CDNDSC on training for caseworkers in safe sleeping and supporting a public health approach to reducing fatalities associated with unsafe sleeping practices.
9-01-2012-00005	CDNDSC supports the following recommendations from the Department of Services for Children, Youth and Their Families' Safety Council (DSC): 1. Policy will be reviewed to ensure that when new information comes to light after the investigation case is closed, that such information shall be put into the open treatment case. 2. In instances in which the assigned worker is having a difficult time making contact with a family, the Division of Family Services (DFS) will now use other unit members and over-hire staff to assist with such contacts.	**DFS** is in the process of a complete review and revision of its policies and manuals. DFS is in the process of implementing Structured Decision Making® Safety and Risk Assessment tools and Safety Organized Practice in both investigation and treatment units statewide. These tools and processes provide for a more robust assessment of harm, risk and protective factors. Safety Organized Practice also contains a Framework for Critical Thinking and Case Consultation. All supervisors are receiving ongoing training and coaching in this. DFS recognizes the risks of unsafe sleeping practices and commends the Division of Public Health (DPH) for the much needed current public education campaign. DFS has and will continue to offer training to workers on safe sleep practices in partnership with DPH and the Child Death, Near Death and Stillbirth Commission (CDNDSC). DFS continues to have regular meetings with hospital staff across the state to discuss the High Risk Discharge Protocol, including DFS management staff who can assist in its implementation.
	3. Policy will be modified to ensure that the death of any child, regardless of cause, is reported to the supervisor and DFS Office of Children's Services administrator.	**DFS** agrees to use other appropriate caseworker staff to assist in ensuring that required contacts are made. All deaths are reported widely within DFS and to DSCYF departmental leadership through the Serious Injury Reporting form and process.
	4. The Serious Injury/Child Death policy will be added to the agenda for the next Treatment Workgroup to remind supervisors and caseworkers of this policy.	
	5. Delaware Hospitals and DFS shall utilize the High Risk Infant Discharge Protocol prior to discharging an infant or child with special medical needs.	**DFS** representatives continue to hold regular meetings with hospital staff statewide to discuss collaboration on reporting and the utilization of the High risk Discharge Protocol.
	In addition to the recommendations made by the DSC, CDNDSC put forward three additional recommendations:	

Agency Specfic Recommendations... (continued from page 56)

NCC Panel…

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
	6. CDNDSC recommends that DFS incorporate the practice of providing and documenting information pertaining to safe sleeping practices into policy.	**DFS** agrees to collaboration with CDNDSC on training for caseworkers in safe sleeping and supporting a public health approach to reducing fatalities associated with unsafe sleeping practices.
	7. CDNDSC recommends that DFS investigation and treatment workers be trained in infant unsafe sleeping practices.	**DFS** references above response.
	8. CDNDSC recommends that DFS review its policy on the High Risk Medical Discharge Protocol. The Commission requests that DFS provide how this protocol is implemented and carried out and if training and/or retraining on this protocol is needed among caseworkers and medical personnel. Additionally, the Commission requests that statistics on how often this protocol is used be provided to the Commission by DFS.	**DFS** representatives continue to hold regular meetings with hospital staff statewide to discuss collaboration on reporting and the utilization of the High risk Discharge Protocol. The DFS Child Abuse Report Line supervisor and statewide administrator communicate with hospitals on this procedure and provide the direct connection to DFS investigation caseworkers to mobilize this response. DFS will compile statistics and provide to the Commission. In spite of the regular meetings with hospitals, this intervention remains infrequently utilized.
9-01-2012-00023	CDNDSC recommends that the DHMIC develop an educational initiative whereby all providers interfacing with obstetrical patients less than 22 weeks gestation are educated on the terminology and definitions of stillbirth (fetal death) versus live birth for documentation purposes and accurate vital statistics reporting.	No response received.
9-01-2012-00023	CDNDSC recommends that education be provided to the public via the Internet giving more clarification of home birthing, showing the legality, risks, statistics, etc.	No response received.

Agency Specfic Recommendations... *(continued from page 57)*

Kent/Sussex Panel

SOURCE	RECOMMENDATION	RESPONSE FROM AGENCY
9-02-2012-00018 *And in case* 9-02-2012-00016 *And in case* 9-02-2012-00019 *And in case* 9-02-2012-00015 *And in case* 9-02-2012-00023	CDNDSC recommends that the Department of Education mandate that all school districts participate in or provide an educational program that identifies suicidal behaviors, risk factor recognition, and intervention for school staff, parents, and children.	No response received.
9-02-2012-00019	CDNDSC recommends that the Department of Education direct school districts to establish an information page or link on their website that discusses the signs and symptoms of suicide and agencies to contact when in crisis.	No response received.
9-02-2013-00001	CDNDSC recommends that the Department of Education include all-terrain vehicle (ATV) safety education in the Bicycle Safety Program at school.	No response received.

In its seventh year of programming, Delaware FIMR continues to evolve with new initiatives and refinements to improve the qualitative review of a subset of fetal deaths occurring after 20 weeks gestation and infant deaths. FIMR is based on a national model focusing on in-depth case review to inform systems change and continuous quality improvement. This report presents the major updates to the program in 2013 and describes the cases reviewed and the recommendations put forth.

National FIMR (NFIMR) Life Course Perspective Grant: September 2012-July 2013

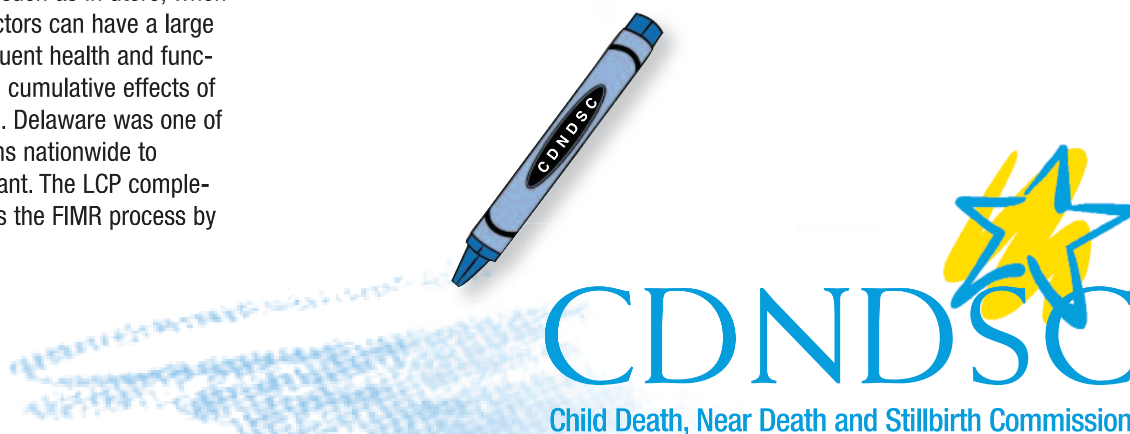
By Delaware statute, FIMR is tasked with alleviating "those practices or conditions which impact the mortality of children and pregnant women."[26] In keeping with the national model, Delaware's FIMR program has always had a focus on the larger social, community and systemic factors that impact mothers' health and pregnancy outcomes. In the summer of 2012, FIMR staff applied for a National FIMR (NFIMR) grant to incorporate the Life Course Perspective (LCP) into the FIMR process. A life course approach looks at health outcomes with a temporal and social perspective, across a person's life experiences or across generations, to identify risk and protective factors that impact health.[27] The LCP recognizes critical periods in development such as in utero, when risk or protective factors can have a large influence on subsequent health and functioning, and also the cumulative effects of exposures over time. Delaware was one of seven FIMR programs nationwide to receive the initial grant. The LCP complements and enhances the FIMR process by providing a theoretical framework to conceptualize risk and protective factors and consider interventions. Delaware FIMR used the opportunity afforded by the grant to modify the FIMR data collection and case review process to better capture the multiple sectors impacting women's health and experiences; biological, behavioral, psychological, social, environmental, and community factors. In Delaware, we developed two new forms to enhance data gathering and deliberation of cases: 1) the maternal interview (MI) summary checklist, to quickly and concisely summarize key protective and risk factors on each case; and 2) the case discussion guide, to facilitate deeper consideration of a case's salient issues over the lifespan of the mother [Appendix A]. FIMR staff introduced the theory of LCP to the case review teams (CRT) with a presentation in September 2012. The CRTs began using the new LCP forms to deliberate cases with a MI from September 2012.

For the June and July 2013 CRT meetings, FIMR cases were grouped and prioritized by geographical areas in the state identified as high-risk zones for poor maternal child health outcomes by the Division of Public Health (DPH) Maternal, Infant and Early Childhood Home Visiting Program needs assessment.[28] The intent for grouping cases by high-risk zone—a geographic area comprising several zip codes—was to help CRTs consider community-level factors that may be contributing to the fetal or infant death or mothers' experiences. Each CRT meeting in these months began with a brief presentation of the key demographic and health indicators from the targeted zone(s). In June, the New Castle County CRT reviewed cases from center city Wilmington, and in July all cases reviewed in New Castle County hailed from western Wilmington. In July, the Kent/Sussex CRT reviewed cases from two high-risk zones: southern Kent/northern Sussex and western Sussex.

[26] *courts.delaware.gov/childdeath*

[27] World Health Organization. The implications for training of embracing a life course approach to health. Geneva, 2000.

[28] Division of Public Health. Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Updated State Plan. June 2011.



Delaware Fetal and Infant Mortality Review (FIMR): Annual Report for Calendar Year 2013...

(continued from page 59)

Some important lessons have been learned in the process of undertaking the changes to the FIMR process. First, it was helpful to have a training of all CRT members on the LCP. This can help ensure that all members have a common basis for understanding the LCP theory and the range of factors to consider. Second, we found that introducing a case discussion guide to help summarize salient risk and protective factors and health equity issues was important to return the conversation to the "big picture" to wrap up a case and consider it in its totality. This discussion guide can be located in Appendix A on page 72. Finally, we feel that ongoing feedback and refinement is crucial. NFIMR delegates visited the July Kent/Sussex CRT as part of the grant for on-site feedback. They observed that the CRT discussion of LCP factors arose quite organically from the case review and going through the strengths, risk factors and suggestions in the BASINET computer database system. In July 2013, a CRT member survey was conducted to get feedback on the specific changes to the review process. 50% of the 22 CRT respondents found the MI summary checklist "very helpful," and 54% found the case discussion guide "very helpful." Overall, 58% of respondents described the CRT deliberation process as "somewhat improved" by the addition of LCP changes, and 26% reported the process "improved." 36% of CRT members responding to the feedback survey indicated that they would like to have more experience with the targeted, high-risk zone approach to grouping cases in order to decide on the utility of this approach; 23% of respondents said they like the zone-based approach "very much" and 18% had no opinion on the matter. FIMR staff will continue to group cases by high-risk zone whenever possible beginning in January 2014. Further feedback on this approach will be solicited with the next CRT member survey in 2014.

Delaware Fetal and Infant Mortality Review (FIMR): Annual Report for Calendar Year 2013...

(continued from page 60)

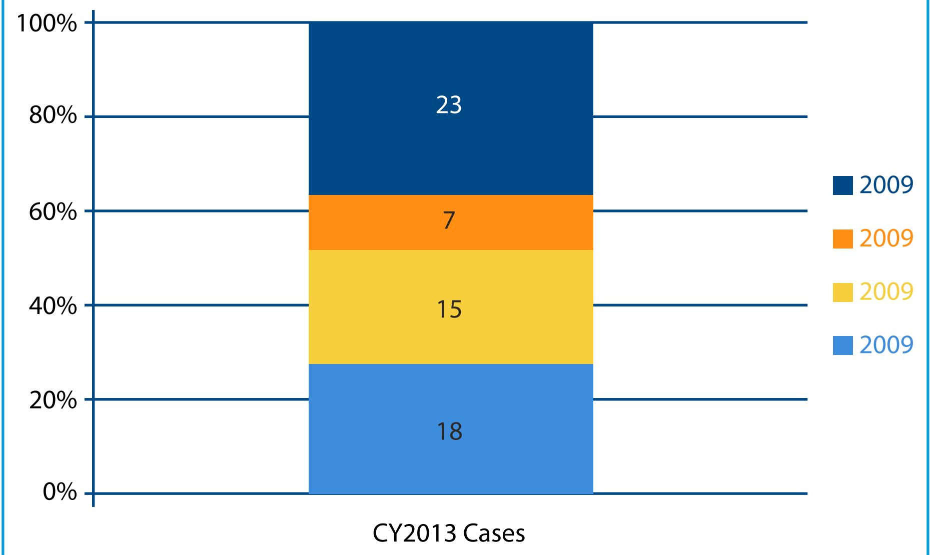
FIMR Policy Changes: December 2013

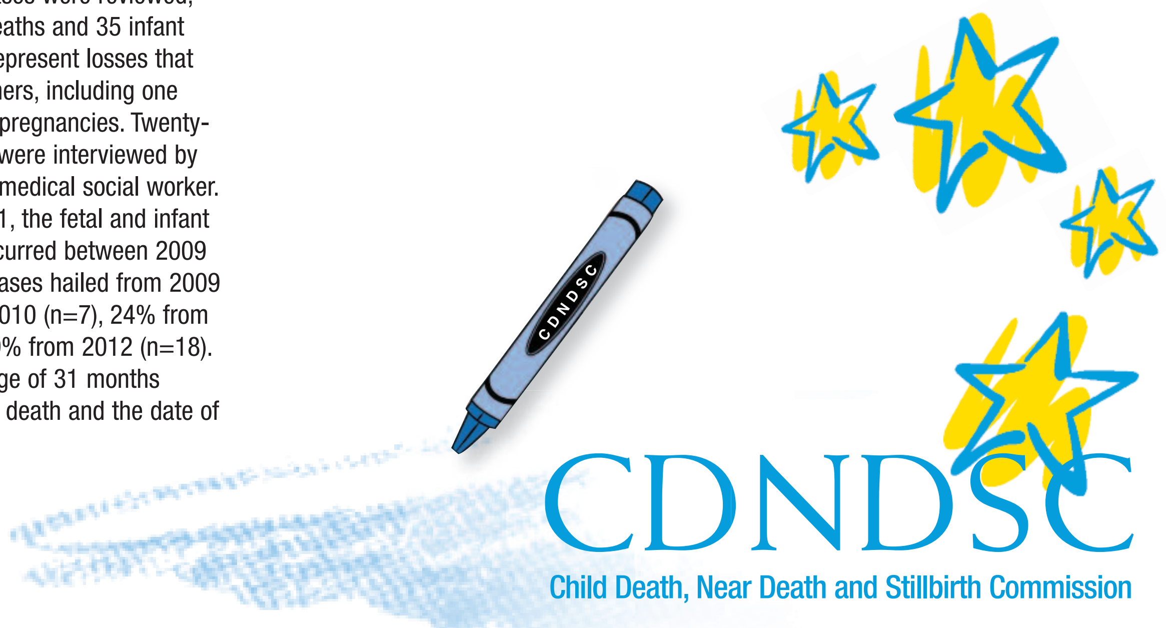
The Delaware FIMR policy was updated at the end of 2013 to more clearly delineate some core roles and responsibilities. The CDNDSC approved the changes to the FIMR policy in December 2013. A CRT training was conducted in January 2014 to disseminate the following policy changes in conjunction with their full implementation. Beginning in 2014, each FIMR CRT will elect a Chair and Co-chair on an annual basis. The CRT Chairperson is expected to facilitate the case discussion and come prepared to each meeting. The CRT Chair also represents the CRT at the CDNDSC meeting, presenting case synopses and the recommendations drafted, if applicable, with interest and knowledge. The CRT Co-chair is responsible for fulfilling the Chair's duties in his or her absence. CRT members are recruited regularly to help maintain a diversity of expertise and rich discussion of the social, medical and public health systems of care that touch women and children's lives.

Description of Cases Reviewed

In 2013, 63 FIMR cases were reviewed, including 28 fetal deaths and 35 infant deaths. The cases represent losses that occurred to 57 mothers, including one triplet and five twin pregnancies. Twenty-two mothers (39%) were interviewed by the CDNDSC senior medical social worker. As shown in Figure 1, the fetal and infant deaths reviewed occurred between 2009 and 2012: 37% of cases hailed from 2009 (n=23), 11% from 2010 (n=7), 24% from 2011 (n=15) and 29% from 2012 (n=18). There was an average of 31 months between the date of death and the date of review.

Figure 1: Number of FIMR cases by the year death occurred





Delaware Fetal and Infant Mortality Review (FIMR): Annual Report for Calendar Year 2013...

(continued from page 61)

Some key demographic characteristics of the 57 mothers whose infant or fetal deaths were reviewed in 2013 are presented in Table 1. Similar to the total group of 2011 fetal deaths in Delaware, the majority of fetal deaths among FIMR cases occurred to White mothers (62%, n=16). Black/African-American mothers, however, made up the majority of infant death cases reviewed (55%, n=17), a slightly higher proportion than in the group of all 2010 Delaware infant deaths. The breakdown of FIMR cases by county of maternal residence, maternal age and maternal education are similar to the 2011 Delaware live birth cohort, the most recent year for which data is available. Marital status is notably different depending on maternal race: among FIMR cases, 83% of Black/African-American mothers were single, while 63% of White mothers were married. About two-thirds of FIMR mothers (65%, n=37) began prenatal care in the first trimester, while only 5% of mothers (n=3) had no prenatal care. Similar to the total population of mothers giving birth in Delaware, 44% (n=25) of FIMR mothers were insured by Medicaid.

Table 1: Maternal characteristics among FIMR cases reviewed in 2013 compared to all Delaware live births, fetal deaths or infant deaths

	% Total FIMR cases (n=57)	% Fetal deaths (n=26)	% Infant deaths (n=31)	% White mothers (n=30)[1]	% Black mothers (n=24)	% Total DE live births 2011 (n=11,227)[3]	% Total DE fetal deaths 2011 (n-77)[4]	% Total DE infant deaths 2010 (n=88)[5]
Maternal Race								
White	53%	62%	45%			67%	62%	53%
Black	42%	27%	55%			27%	36%	41%
Other	5%	12%	0%			0.4%	1%	6%
Hispanic[2]	14%	15%	13%			13%	6%	Not reported
County of Residence								
New Castle	70%	69%	71%	63%	79%	61%	70%	66%
Kent	11%	4%	16%	13%	8%	19%	16%	17%
Sussex	19%	27%	13%	23%	13%	19%	14%	17%
Maternal Age (years)								
<20	5%	0%	10%	3%	8%	8%	8%	
20-29	44%	54%	35%	40%	54%	53%	*	
30-39	47%	42%	52%	50%	38%	36%	*	
40+	2%	4%	0%	3%	0%	3%	*	
No information	2%	0%	3%	3%	0%	0%		
Maternal Education								
<12 years	25%	27%	23%	23%	21%	21%	13%	
High school diploma or GED	28%	23%	32%	10%	50%	25%	42%	
College 1-3 years	25%	27%	23%	27%	25%	26%	25%	
College 4+ years	21%	19%	23%	37%	4%	27%	12%	
No information	2%	4%	0%	3%	0%	1%	9%	
Marital Status								
Single	56%	46%	65%	33%	83%	49%	51%	
Married	42%	54%	32%	63%	17%	51%	49%	
No information	2%	0%	3%	3%	0%	0%	0%	
Entry into Prenatal Care								
1st trimester	65%	69%	61%	70%	58%			
2nd trimester	23%	19%	26%	17%	29%			
3rd trimester	2%	4%	0%	3%	0%			
No prenatal care	5%	4%	6%	7%	4%			
No information	5%	4%	6%	3%	8%			
Method of Payment								
Medicaid	44%	38%	48%	30%	63%	49%		
Private	46%	46%	45%	53%	38%	46%		
Self-pay	5%	8%	3%	10%	0%	2%		
Other	2%	4%	0%	3%	0%	3%		
No information	4%	4%	3%	3%	0%	1%		

[1] Includes 8 White mothers of Hispanic descent

[2] Women of Hispanic origin can be of any race

[3] Delaware Health Statistics Center. *Delaware Vital Statistics Annual Report, 2011*. Delaware Department of Health and Social Services, Division of Public Health; 2014.

[4] Delaware Health Statistics Center. *Delaware Vital Statistics Annual Report, 2011*. Delaware Department of Health and Social Services, Division of Public Health; 2014.

[5] Delaware Health Statistics Center. *Delaware Vital Statistics Annual Report, 2010*. Delaware Department of Health and Social Services, Division of Public Health; 2013.

*Categories not comparable

(continued from page 62)

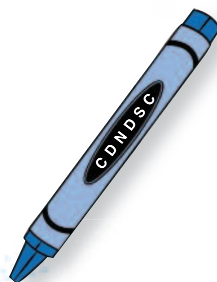
Table 2: Infant/fetal characteristics of FIMR cases reviewed in 2013 compared to total Delaware infant deaths over five years

	% Total FIMR cases (n=63)	% Fetal deaths (n=28)	% Infant deaths (n=35)	% White infants/ fetuses (n=32)[1]	% Black infants/ fetuses (n=28)	% Total DE infant deaths 2005-2009 (n=482)[2]
Sex of Fetus or Infant						
Male	43%	36%	49%	34%	50%	53%
Female	57%	64%	51%	66%	50%	47%
Plurality						
Single	79%	86%	74%	84%	71%	82%
Multiple gestation	21%	14%	26%	16%	29%	18%
Gestational Age (weeks)						
<28	57%	46%	66%	44%	75%	59%
28-36	29%	43%	17%	38%	18%	20%
37+	14%	11%	17%	19%	7%	21%
Birth Weight (grams)						
<500	27%	25%	29%	22%	32%	31%
500-1499	40%	43%	37%	31%	50%	34%
1500-2499	14%	18%	11%	25%	4%	13%
2500+	19%	14%	23%	22%	14%	21%

Table 2 presents some demographic characteristics of FIMR fetal and infant cases. When available, the proportion of these characteristics among the five-year total group of Delaware infants deaths from 2005-2009 (n=482) is also shown. A higher proportion of Black/African-American infants/fetuses resulted from multiple gestation (29%, n=8). In contrast to FIMR infant deaths and the five-year total cohort of Delaware infant deaths, a higher proportion of FIMR fetal deaths occurred at 28-36 weeks gestation (43%, n=12). Most infant deaths among FIMR cases occurred in babies delivered prior to 28 weeks gestation (66%, n=23).

[1] Includes 8 White mothers of Hispanic descent

[2] Delaware Health Statistics Center. *Delaware Vital Statistics Annual Report, 2010*. Delaware Department of Health and Social Services, Division of Public Health: 2013.



(continued from page 63)

Tables 3 and 4 present the age and primary cause of death, respectively, among FIMR infant cases. Eighty percent of FIMR infant deaths occurred in the neonatal period, the first 28 days of life, and over half (54%) occurred in the first 24 hours. Neonatal deaths represent a higher proportion of FIMR cases compared to the total 2010 Delaware infant death cohort. This may be due, in part, to the fact that certain causes of death—such as unsafe sleeping, non-accidental trauma or unexplained causes (i.e. SIDS or SUID), that may occur later in infancy are reviewed as part of the child death review process and not assigned to FIMR. Over half of FIMR infant cases (57%, n=20) were ascribed to prematurity as the primary cause of death. This is a higher proportion than among all 2010 Delaware infant deaths, for which prematurity and low birth weight was the primary cause of death in 22.6% of cases.[29] More Black/African-American infants died of prematurity (75%, n=15) among FIMR cases than White infants, (33%, n=5). Cardiac or respiratory failure was the second leading primary cause of death among FIMR cases. Congenital anomalies, which overall accounts for about 15% of Delaware infant deaths, was more common among FIMR cases involving White infants (13%, n=2).[30]

FIMR Recommendations

Six recommendations were drafted by FIMR CRTs and approved by the CDNDSC. Following are listed the six recommendations and their rationale, a brief description of the case context on which the recommendation is based. While a particular recommendation may be based on a single case, often there is supporting evidence from other cases which indicates that the recommendation fits with the CRTs' findings in a subset of FIMR cases. For each recommendation, a table of aggregate CRT findings from all 63 FIMR cases notes the corresponding strengths, contributing factors and suggestions that are related to that recommendation. The aggregate CRT findings are also reported out by maternal race for the 32 cases involving White mothers and 28 cases involving Black/African-American mothers. Three FIMR cases involved mothers with another race/ethnicity, and since these numbers are so small they are not reported here.

Table 3: Age of infant deaths

Age at death	%FIMR infant deaths (n=35)	% Total DE infant deaths 2010 (n=88)
<24 hours	54%	Not reported
0-28 days	80%	66%
29-364 days	20%	34%

Table 4: Primary cause of infant deaths

Primary cause of death	% FIMR infant deaths (n=35)	% White infant deaths (n=15)	% Black infant deaths (n=20)
Prematurity	57%	33%	75%
Cardiac or respiratory distress/failure	17%	20%	15%
Congenital malformations & chromosomal abnormalities	6%	13%	0%
Renal failure	3%	0%	5%
Other	14%	27%	5%

[29] Delaware Health Statistics Center. *Delaware Vital Statistics Annual Report, 2010.* Delaware Department of Health and Social Services, Division of Public Health: 2013.

[30] Delaware Health Statistics Center. *Delaware Vital Statistics Annual Report, 2010.* Delaware Department of Health and Social Services, Division of Public Health: 2013.

(continued from page 64)

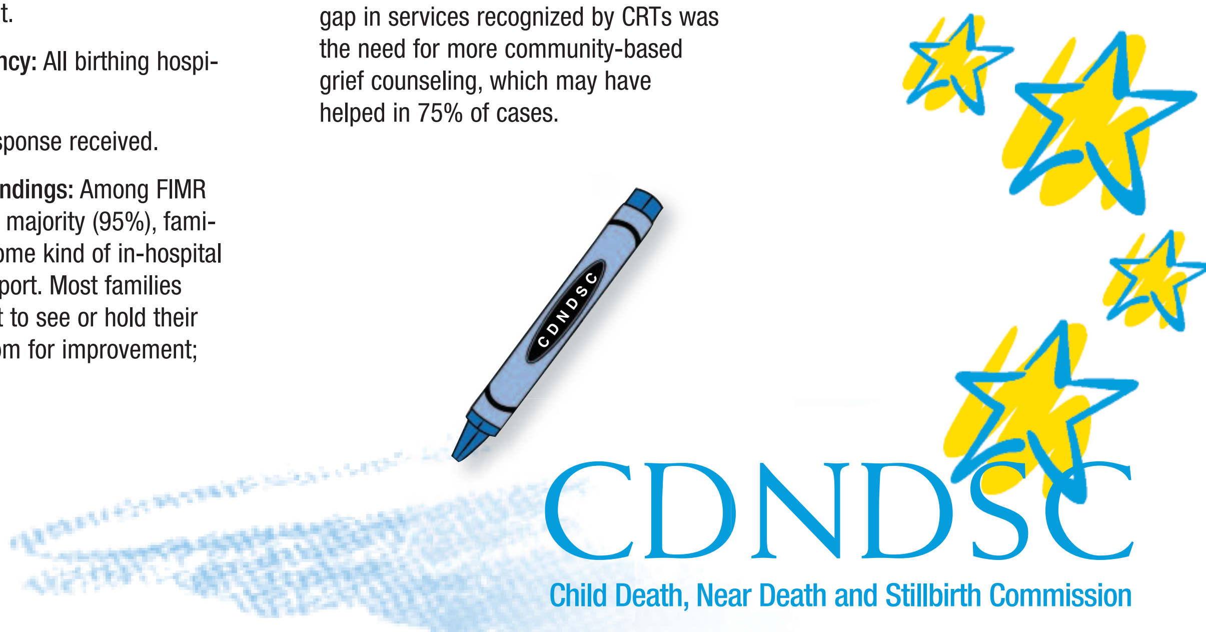
Bereavement support and maternal transfer

Recommendation 1: The CDNDSC recommends that in cases of fetal/infant loss whereby the mother of the baby is transferred to a higher level of care and the medical staff wishes to provide bereavement services for the mother (i.e. see/hold baby), a clearly defined protocol should be established related to the disposition of the fetal remains between both facilities.

- **Rationale:** The mother of this baby suffered a complete placental abruption resulting in fetal demise. She was critically ill and needed surgical intensive care services and was transferred to a level III facility for care. The baby's remains were transferred with her for bereavement purposes (i.e. see/hold baby). The father of baby's family was unaware of the transfer of the remains as they were trying to make funeral arrangements and were emotionally upset.
- **Anticipated result:** All birthing hospitals in Delaware will institute a policy addressing the status of fetal/infant remains in cases where the mother is transferred to a higher level of care for ongoing treatment.
- **Responsible agency:** All birthing hospitals in Delaware
- **Response:** No response received.
- **Aggregate CRT findings:** Among FIMR cases, in the vast majority (95%), families did receive some kind of in-hospital bereavement support. Most families (65%) did request to see or hold their baby. There is room for improvement; however, as CRTs frequently recommended that the prenatal care provider take a more active role in addressing grief issues (94% of cases). The largest gap in services recognized by CRTs was the need for more community-based grief counseling, which may have helped in 75% of cases.

Table 5: Aggregate CRT Findings Relating to Bereavement Support

	% of all FIMR cases (n=63)	% of White mothers (n=32)	% of Black mothers (n=28)
Strength			
Chaplain, pastor, nurse, Smart Start, NFP, RM or social work grief support in hospital	95%	97%	93%
Family requested to see baby to bond	65%	72%	61%
Suggestion			
Prenatal care provider to take an active part in addressing grief and denial issues	94%	97%	89%
Referral to community agency for grief counseling	75%	69%	79%
Grief counseling/support at delivery and/or pediatric care facility	17%	16%	18%



(continued from page 65)

Interconception care

Recommendation 2: The CDNDSC recommends in cases of fetal/infant loss, the parents should be offered an interconception visit and review events of the death to prepare a plan of care for future pregnancies with a goal for an improved outcome.

- **Rationale:** The mother did not keep her postpartum appointment but presented three months later noting she wished to become pregnant again. She did and lost that baby as well, despite Maternal Fetal Medicine (MFM) intervention and treatment.
- **Anticipated result:** Those mothers who have suffered a fetal demise/infant loss will be appropriately debriefed as to the cause of death and contributing factors so as to plan for future childbearing.
- **Responsible agency:** American Congress of Obstetricians and Gynecologists (ACOG)
- **Response:** No response received.
- **Aggregate CRT findings:** While overall 40% of FIMR cases (n=25) involved a pregnancy that was at least 24 months after a prior pregnancy, this desired inter-pregnancy interval was much more common in cases involving White mothers (53%) compared to Black/African-American mothers (21%). With 25% of cases resulting from an unplanned pregnancy and 30% with an inadequate pregnancy interval of less than 18-24 months, there is need for more consistent interconception education and care to optimize subsequent birth outcomes. In 44% of cases, CRTs recommended that families be debriefed a few months after a loss to help them understand the circumstances of the death. This debriefing is particularly important for mothers with a history of fetal or infant loss, a high-risk group that makes up half of all cases involving Black/African-American mothers.

Table 6a: Aggregate CRT Findings on Interconception Care Following a Fetal or Infant Loss

	% of all FIMR cases (n=63)	% of White mothers (n=32)	% of Black mothers (n=28)
Strength			
Pregnancy interval at least 24 months	40%	53%	21%
Contributing Factor			
History of fetal or infant loss	32%	19%	50%
History of fetal loss >20 but <23 weeks (previable)	6%	19%	14%
Unplanned pregnancy	25%	22%	29%
Inadequate birth spacing	30%	31%	32%
Suggestion			
Debrief patients 2-3 months after a loss to assess understanding of cause(s)/ circumstances of death	44%	34%	54%
Importance of family planning, reconception and interconception care	63%	56%	71%
Appropriate birth spacing	79%	84%	71%

For several years now CRTs have been tracking the provision of birth spacing education at the postpartum visit. In 78% of the 58 cases with a postpartum visit, there was no documentation of birth spacing education. In addition, no cases had documentation of education consistent with the recommended 18-24 months inter-pregnancy interval. In some cases the birth spacing messages were very vague, leading to confusion and frustration as expressed by mothers during the maternal interview (see text box below). In 79% of FIMR cases, CRTs recommended appropriate birth spacing education in the postpartum period.

Case in Point: Messages on Birth Spacing

In maternal interviews, mothers recollect the advice they received from healthcare providers on birth spacing.

- *One woman's physician would normally tell a woman to wait eight months, but in this case she told the mother "she should try to get pregnant whenever she feels emotionally ready."*
- *According to another woman, one "doctor…told her to wait six months to five years to get pregnant again. Her maternal fetal medicine (MFM) doctor told her as soon as she has her period that is her body's way of telling her she is ready to get pregnant again."*

(continued from page 66)

Recommendation 3: The CDNDSC recommends improved provider communication at the postpartum visit to initiate a referral to maternal fetal medicine (MFM) for genetic counseling and a follow up appointment for interconceptual counseling.

- **Rationale:** The mother kept her six-week postpartum appointment but did not have further follow up until her annual gynecological visit. Her baby lived for six months.
- **Anticipated result:** Those mothers who have a baby born with multiple anomalies with a life-limiting diagnosis may benefit from a follow up visit with MFM for genetic counseling for optimal interconceptual counseling for an improved outcome in future pregnancies.
- **Responsible agency:** Delaware Healthy Mother and Infant Consortium (DHMIC)
- **Response:** No response received.
- **Aggregate CRT findings:** While 68% of FIMR mothers had a postpartum visit, in only one case was there documentation of interconceptual care counseling and an MFM referral. In about one-quarter of FIMR cases there was evidence of a genetic anomaly (lethal or nonlethal), and in that same proportion, CRTs recommended the need for genetic counseling prior to the next pregnancy. Genetic anomalies were more common in cases involving White mothers (13% with lethal anomalies and 31% with a nonlethal condition), and hence it was among these mothers that CRTs more frequently recognized the need for education on genetic counseling prior to the next pregnancy.

Table 6b: Aggregate CRT Findings on Postpartum Care and Genetic Counseling

	% of all FIMR cases (n=63)	% of White mothers (n=32)	% of Black mothers (n=28)
Strength			
Kept postpartum visit	68%	75%	57%
Interconceptual care counseling and MFM referral discussed at postpartum visit	2%	0%	4%
Genetic counseling	24%	34%	14%
Contributing Factor			
Genetic or congenital anomaly incompatible with life	8%	13%	4%
Pre-existing medical condition (including nonlethal anomalies and metabolic disorders)	16%	31%	0%
Suggestion			
Genetic counseling prior to next pregnancy	24%	38%	11%

Recommendation 4: The CDNDSC recommends interconceptual care counseling while the mother is hospitalized for those women with multiple losses, without a stated etiology and a history of non-compliance in keeping postpartum appointments.

- **Rationale:** The mother had a loss at 20 weeks in 2009 and again in 2011 at 23 weeks. She also had a history of two miscarriages and a termination of pregnancy. She has a history of not keeping her post-partum appointment and therefore a clear etiology for her losses was unknown.
- **Anticipated result:** For those mothers who fail to keep their postpartum appointments and have multiple losses, interconceptual care teaching will be initiated in the postpartum period while hospitalized and appropriate referrals initiated.

(continued from page 67)

- **Responsible agency:** ACOG and Medical Society of Delaware (MSD)
- **Response:** No response received.
- **Aggregate CRT findings:** 94% of mothers received some kind of postpartum teaching in the hospital prior to their discharge. However, only in two cases did mothers have documentation of a preconception visit. Almost 40% of all FIMR mothers—and 50% of Black/African-American mothers—have a history of a first trimester miscarriage (spontaneous abortion) or a miscarriage between 13 and 20 weeks gestation. FIMR mothers, with a history of at least one fetal or infant death, are a high-risk group for future poor pregnancy outcomes. They are a group that warrants close follow up in the interconception period to optimize management of any maternal health issues and to provide appropriate genetic counseling.

Table 6c: Aggregate CRT Findings on Interconception Care

	% of all FIMR cases (n=63)	% of White mothers (n=32)	% of Black mothers (n=28)
Strength			
Mother had preconception care visit and took prenatal vitamins	3%	3%	0%
Postpartum teaching done in the hospital	94%	94%	93%
Preconceptual care recommended prior to next pregnancy	2%	3%	0%
Contributing Factor			
History of spontaneous abortion <13 weeks	24%	13%	32%
History of spontaneous abortion >13 weeks but <20 weeks	14%	3%	18%
Suggestion			
Improve effort to locate mothers with chronic medical conditions who have missed postpartum visit	13%	9%	18%
Interconceptual care teaching	43%	41%	46%

Multiple prenatal providers: patients' preferences

Recommendation 5: The CDNDSC recommends that physicians be made aware that FIMR has found, based on FIMR statistics from 2006 to present and specific cases reviewed, that pregnant women receiving obstetrical care be given the option to request only one or two doctors for their care in a multiple provider practice.

- **Rationale:** Women have identified this issue as a negative in their prenatal care in 18.4% of all maternal interviews. Many women feel that seeing multiple providers in a practice has an impact on the quality of care they receive.
- **Anticipated result:** By limiting the number of providers seen during pregnancy there will be consistent care and information presented to pregnant women. Providers will also have more awareness of any issues that are occurring in a specific pregnancy.
- **Responsible agency:** ACOG and the Medical Society of Delaware
- **Response:** The American Congress of Obstetricians and Gynecologists (ACOG) recommends preconception care in order to best be prepared for pregnancy. ACOG also recommends that women seek prenatal care once they know that they are pregnant; this allows there to be an early accurate estimate of gestational age, the risk for complications in pregnancy can be assessed, patient education can be performed, and communication established between the patient and the practice. Whereas patients may request that only certain providers be involved in their prenatal care, there is no absolute way to provide this. There are practices with differing numbers of providers and each practice has their own method of delivering prenatal care. There are a variety of ways that Ob/Gyn practices manage coverage with the health care providers in order to provide access 24 hours a day, seven days a week. Obstetricians strive to maintain safe, quality care. When there are multiple provider practices, it is important that all in the practice are involved in the care of their patients. It is not unreasonable to conduct the first prenatal appointment around eight weeks gestation. Whether a pregnancy is viable can generally be determined between six and seven weeks from the last menstrual period. A large number of miscarriages will occur prior to eight weeks (not amenable to medical intervention). When the patient is seen at eight weeks, dating can be confirmed, risks assessed and prenatal testing options in pregnancy discussed. When there are other medical issues to be addressed (hypertension, diabetes, depression, etc.), the patient can access their primary care doctor and/or their obstetrician.
- **Aggregate CRT findings:** In 63% of cases, FIMR CRTs noted patient-provider communication was a strength, and in 56% of cases providers respected patients' wishes and allowed co-management of the pregnancy. CRTs noted this latter strength as well as that of pro-

(continued from page 68)

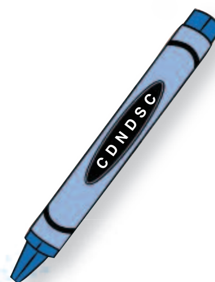
fessional staff's being respectful of parents' wishes more commonly in cases involving White mothers, 69% and 38% respectively. In 29% of all cases there was poor communication noted between provider and patient, and in 16% of cases CRTs recommended better communication during pregnancy to ensure patients understand the plan of care. CRTs have been tracking mothers' satisfaction with seeing multiple prenatal providers, and this has been an issue that has come up year after year, particularly as told in maternal interviews.

Case in Point: Care from Multiple Prenatal Providers

- *The mother went to a provider who had two doctors in the practice. The parents went in for an appointment after the diagnosis and they saw the other doctor. He had not read the mother's file and was not aware their baby had Trisomy 13. He was not very sensitive, and the mother had to explain what was going on to him. The mother said she started to cry and he handed her a box of tissues and then walked out. The mother requested the other doctor from that point forward.*
- *The mother said they rotated doctors, so she only saw her own doctor one time and saw three other doctors at her other appointments. She said her doctor was the only one who made her feel like she was the only patient there. She felt rushed by the other doctors. She said in an ideal world she would see her doctor only and her doctor would also do the delivery.*

Table 7: Aggregate CRT Findings Relating to Multiple Providers and Quality of Provider-Patient Interaction in the Prenatal Period

	% of all FIMR cases (n=63)	% of White mothers (n=32)	% of Black mothers (n=28)
Strength			
Patient-provider communication regarding pregnancy & plan of care	63%	66%	61%
Provider allowed co-management with patient and respected atient's wishes	56%	69%	39%
Professional staff respectful of parents' wishes to continue pregnancy despite poor prognosis	25%	38%	11%
Contributing Factor			
Poor communication between provider and patient	29%	31%	29%
Patient fear of or dissatisfaction with system	14%	16%	14%
Suggestion			
Better communication by provider of issues during pregnancy or infant's care and evaluation of patient/caregiver's understanding	16%	16%	18%



CDNDSC

Child Death, Near Death and Stillbirth Commission

(continued from page 69)

Early prenatal care and education

Recommendation 6: The CDNDSC recommends prenatal care and education as soon as a pregnancy is identified, particularly for women with previous poor outcomes or first pregnancies.

- **Rationale:** It was noted in the maternal interview that the mother of the baby could not get an appointment with her doctor once the pregnancy was identified because the doctor's preference was to wait until eight weeks to see clients. This is a repeated issue in other FIMR cases.
- **Anticipated result:** Early education could impact the health and well-being of mother and child. Education concerning fetal alcohol syndrome and prenatal vitamins should be addressed as early in pregnancy as possible. CDNDSC is asking that the recommendation be disseminated through the Delaware ACOG and MSD.
- **Responsible agencies:** ACOG and MSD
- **Response:** The American Congress of Obstetricians and Gynecologists (ACOG) recommend preconception care in order to best be prepared for pregnancy. ACOG also recommends that women seek prenatal care once they know that they are pregnant; this allows there to be an early accurate estimate of gestational age, the risk for complications in pregnancy can be assessed, patient education can be performed, and communication established between the patient and the practice. Whereas patients may request that only certain providers be involved in their prenatal care, there is no absolute way to provide this. There are practices with differing numbers of providers and each practice has their own method of delivering prenatal care. There are a variety of ways that Ob/Gyn practices manage coverage with the health care providers in order to provide access 24 hours a day, seven days a week. Obstetricians strive to maintain safe, quality care. When there are multiple provider practices, it is important that all in the practice are involved in the care of their patients. It is not unreasonable to conduct the first prenatal appointment around eight weeks gestation. Whether a pregnancy is viable can generally be determined between six and seven weeks from the last menstrual period. A large number of miscarriages will occur prior to eight weeks (not amenable to medical intervention). When the patient is seen at eight weeks, dating can be confirmed, risks assessed and prenatal testing options in pregnancy discussed. When there are other medical issues to be addressed (hypertension, diabetes, depression, etc.), the patient can access their primary care doctor and/or their obstetrician.

Table 8: Aggregate CRT Findings on Prenatal Care

	% of all FIMR cases (n=63)	% of White mothers (n=32)	% of Black mothers (n=28)
Strength			
Adequate prenatal care with appropriate referrals	59%	69%	43%
Early prenatal care (1st trimester)	71%	78%	64%
Comprehensive prenatal teaching	56%	59%	50%
Prenatal education appropriate in each trimester	37%	41%	32%
Folic acid teaching	22%	22%	21%
Contributing Factor			
Lack of or inadequate prenatal education	19%	22%	18%
Late entry into prenatal care after 13th week	19%	13%	25%
Inconsistent prenatal care (missed appointments)	21%	19%	25%
Suggestion			
Early referral to social services	30%	25%	32%
Smart Start/Nurse Family Partnership/Resource Mother prenatal screening on initial prenatal visit	57%	53%	57%
Education on folic acid intake	40%	34%	43%
Improve prenatal education in appropriate trimester	16%	22%	11%
Importance of early and consistent prenatal care	48%	44%	50%

- **Aggregate CRT findings:** Overall, in 48% of FIMR cases, CRTs recommended that the importance of early and consistent prenatal care be promoted. In particular, early screening for qualification for home visiting or community-based support services such as Smart Start and Nurse Family Partnership was a recognized gap in 57% of cases. In 30% of cases, mothers may have benefited from early referral to social services as well.

(continued from page 70)

Life Course Perspective

CRTs identified the presence of LCP risk factors in 54% of all 2013 FIMR cases (n=34), including 59% of cases involving White mothers and 46% of cases involving Black/African-American mothers. As part of the NFIMR grant activities, Delaware FIMR adopted a more intensive review of cases that had an MI to more thoroughly capture and discuss risk and protective factors pertinent to the mother's life perspective. Use of the MI summary checklist complements and enhances the information recorded in BASINET by specifying the risk and protective LCP factors in a case. LCP findings from the 22 mothers interviewed with infant/fetal losses (comprising 25 cases reviewed in 2013) are summarized in Table 9. Almost three-quarters of FIMR mothers (73%) had at least one major adverse issue during childhood, and four women (18%) had five or more adverse issues. An adverse childhood issue included such factors as financial hardship, being raised in a single parent family, experiencing frequent moves or a chaotic household, experiencing emotional, physical or sexual abuse, being neglected, witnessing domestic violence in the home, or having a parent with a substance abuse problem. 36% of women had a transportation issue that may have impeded their access to services. 30% of women, or six out of 20 mothers, had a history of domestic violence or abuse.

Based on maternal interviews, a particular theme that arises is that of stress in women's lives. Almost two-thirds of women (64%) reported significant social stressors. The CDNDSC senior medical social worker asked about the sources of

[1] Total n=22 mothers unless otherwise noted for a category

Table 9: Summary of maternal interview checklist factors by category

Risk or Protective Factor	Percent of mothers[1]
Issues during mother's childhood	
Any adverse issue during childhood	73%
Financial hardship	32%
Raised in single parent family	18%
Emotionally abused as child	9%
No adverse issue during childhood	27%
Employment history	
Father employed full-time	82%
Mother employed full-time	64%
Mother unemployed	18%
Housing	
Lives in a house	55%
Lives with father of baby	32%
Frequent moves in last 5 years	23%
Lives with parents or relatives	18%
Environment and community	(n=20)
Adverse environment or community factor	70%
Exposed to second-hand smoke	40%
No adverse environment or community factor	30%
Transportation	
Transportation issue	36%
No transportation issue	64%
Social support	
Social support	100%
Father of baby	82%
Family members	82%
Friends	41%
Church/clergy	32%

Risk or Protective Factor	Percent of mothers[1]
Social stressors	
Social stressors	64%
Unplanned pregnancy	36%
Difficulty paying bills	23%
No social stressors	36%
Cultural	n-21
Cultural issue	38%
Language barrier	19%
No cultural issue	62%
Violence/abuse	n=20
Violence/abuse	30%
No violence/abuse	70%
Financial assistance during pregnancy	n=21
Financial assistance during pregnancy	48%
WIC	38%
Food stamps	29%
No financial assistance during pregnancy	52%
Referrals during pregnancy	n=21
Referrals during pregnancy	38%
WIC	29%
No referrals during pregnancy	62%
Referrals after pregnancy	n=20
Referrals after pregnancy	85%
Bereavement support	75%
Other	55%
No referrals after pregnancy	15%

(continued from page 71)

stress in mothers' lives. About a quarter of mothers (n=6) had job-related stress; 23% (n=5) had financial stressors and 23% had stress caused by their living situation; four mothers (18%) had stress due to their baby's diagnosis; and three mothers (14%) had mental health issues. Examples of mothers' stories are given in the "Case in Point" box below.

Over time, as more cases with a MI are reviewed using the LCP format, the numbers of cases with this in-depth, multifactorial review will present more data to analyze and track trends among Black/African-American and White mothers.

Tracking Issues

FIMR CRTs are tracking a few issues of interest to them. In addition to continued documentation of birth spacing education provided to women postpartum, CRTs are also interested in the appropriate screening and education of women for postpartum depression. In 63% of cases, CRTs recognized the need for depression screening and assessment of grief status with appropriate initiation of referrals.

CRTs are also continuing to track the receipt of fetal movement monitoring education in late pregnancy. As promoted by the Fetal Kicks Count education campaign and materials that rolled out beginning in 2010, fetal movement tracking should be encouraged after 24 weeks gestation. In 37% of FIMR cases, fetal kicks count teaching was documented. In 19% of cases parental lack of knowledge about fetal kicks count was identified as a contributing factor; and in 27% of cases, CRTs made the suggestion that fetal kicks count education continue.

FIMR continues to support work around issues tracked in past years of review, including work to reduce preterm labor and prevent and manage obesity and its complications among women of childbearing age.

1. What were the key factors—either risk factors and/or protective factors—over the mother's lifespan that had a significant impact on her health and well-being? Did these key factors vary during critical periods in the mother's life?
2. Does this case highlight or suggest equity issues (disparities) that affected the mother's health or pregnancy outcome?

Appendix A: FIMR Case Review Team Discussion Guide

Case in Point: Taking a Life Course Perspective

- *The mother's parents got divorced when she was young and they were both addicts. She was left alone in the house to fend for herself for weeks at a time. She said she had food, but her mother was not there so she was neglected in that way. She did witness her step-brother being abused and she saw some domestic violence. No one ever took care of her, she did that herself. Her mom now lives across the street, and the mother of the baby is still taking care of her and her addiction problems and health issues.*
- *The mother of the baby saw a lot of alcoholic fights between her parents. She said at the age of ten she started getting in the middle of the fights to try and defend her mother. She never was injured doing that, but it was a big responsibility for a little girl.*
- *The mother was in an abusive relationship for five years before getting together with the father of the baby. The mother stayed because she was fearful about leaving him. After she graduated from law school, she told him she would have to move to get a job. She said it would be temporary, but she took all of her things and left.*
- *The mother bought a home in a high crime neighborhood. They have heard gunshots and someone was killed on their corner. Her adopted twins cannot go outside to play. The mother said none of the residents have jobs. She is not used to living in this type of neighborhood and she would like to move.*
- *The father of the baby was abused as a child and his two sisters were killed by one of the sister's boyfriends in a domestic violence incident. This made a huge impact on the father of the baby. He was abusive to the mother of the baby prior to the pregnancy.*

Maternal Mortality Review (MMR) in Delaware...

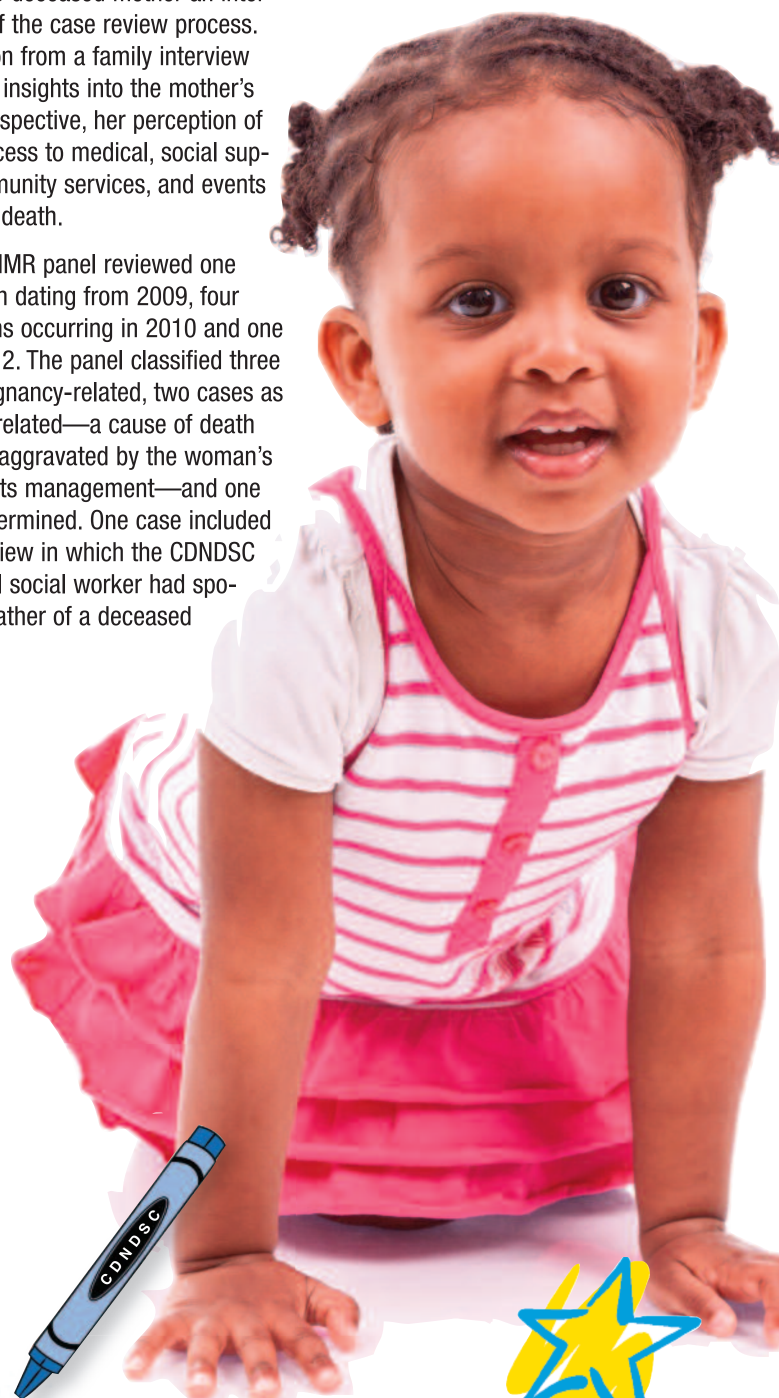
In its second full year of programming, the Delaware MMR panel met two times in 2013 and reviewed six cases. The MMR panel is a statewide group of interested participants representing the disciplines of obstetrics and gynecology, maternal fetal medicine, midwifery, public health, social work, internal medicine and nursing. Four birthing hospitals (out of six in the state) are represented on the MMR panel. Maternal mortality reviews are conducted on select maternal deaths. A maternal death is defined as the death of a woman while pregnant or within one year of the end of her pregnancy, irrespective of cause. A pregnancy-related death is defined as the death of a woman while pregnant or within one year of the end of her pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by her pregnancy or its management, but not from accidental or incidental causes.

The Office of Vital Statistics sends death certificates in which the pregnancy check box is marked to the CDNDSC office on a monthly basis. CDNDSC staff also review local newspapers and obituaries for possible maternal deaths and follow up with the Office of Vital Statistics if a potential case is found. Based on information from the death certificate and the Office of the Medical Examiner, if available, CDNDSC staff select cases for MMR based on the following criteria:

1. Cases with a pregnancy-related cause of death;
2. Cases involving proven or suspected domestic violence, substance abuse, suicide or homicide; and
3. Cases that do not have pending litigation.

Delaware is unique in offering a family member of the deceased mother an interview as part of the case review process. The information from a family interview helps uncover insights into the mother's life course perspective, her perception of her health, access to medical, social support and community services, and events leading to her death.

In 2013, the MMR panel reviewed one maternal death dating from 2009, four cases of deaths occurring in 2010 and one case from 2012. The panel classified three deaths as pregnancy-related, two cases as pregnancy-unrelated—a cause of death not related or aggravated by the woman's pregnancy or its management—and one case as undetermined. One case included a family interview in which the CDNDSC senior medical social worker had spoken with the father of a deceased woman.



Maternal Mortality Review (MMR) in Delaware... *(continued from page 73)*

The Every Mother Initiative Grant: A Learning Collaborative and Action Planning

In June 2013, the Delaware CDNDSC staff applied for the Every Mother Initiative sponsored by the Association of Maternal and Child Health Programs (AMCHP). The goal of this initiative is to help states address maternal health issues through strengthening and enhancing the maternal mortality surveillance system and using the data from maternal mortality reviews to implement action plans and strategies to improve maternal health outcomes. Delaware was one of six states awarded the Every Mother Initiative grant and as such is participating in a 15-month Action Learning Collaborative. The Action Learning Collaborative kicked off with an on-site meeting in Atlanta which brought together three emerging MMR programs, including Delaware, and three established reviews. Five representatives from Delaware attended the AMCHP kick-off meeting. The Delaware team, headed by Anne Pedrick of the CDNDSC and Crystal Sherman of DPH, drafted an action plan for the implementation of the grant and its $30,000 translational sub-award. Elements of the Delaware action plan include:

- Develop and implement provider and community education based upon findings from Delaware MMR reviews;
- Ensure communication with in-state stakeholders such as the Delaware chapter of the American Congress of Obstetricians and Gynecologists (ACOG) and the Association of Women's Health, Obstetrics and Neonatal Nurses (AWHONN) and the Perinatal Collaborative;
- Beta-test a new computerized MMR database for case abstraction provided by the Centers for Disease Control and Prevention (CDC) and assess the utility of this program for regular case review in Delaware;
- Explore the feasibility of linking fetal death certificates and birth certificates to maternal death certificates to ensure better case ascertainment; and
- Explore the possibility of conducting a pilot study looking at data on "near misses," cases involving serious maternal morbidity, in Delaware.

The Delaware team is working to move this action agenda forward and partnering with groups such as the Medical Society of Delaware and the Office of Vital Statistics at DPH.

MMR Recommendations

Five recommendations were approved by the CDNDSC based on the review of the six maternal death cases in 2013.

Recommendation 1: Delaware's Maternal Mortality Review Team recommends that depression screenings and domestic violence screenings be conducted upon the initial prenatal assessment/appointment for all pregnant women within Delaware.

- **Rationale:** Such screening did not occur during a mother's initial prenatal visit. It was made known that the mother was a victim of domestic violence. However, such information was made known after the mother's death. As a result of there being no depression or domestic violence screenings, the review team was unable to determine if the mother's death was pregnancy related or not.
- **Anticipated Result:** ACOG supports depression and domestic violence screening.
- **Responsible Agency:** DE chapter of ACOG
- **Response:** ACOG supports depression and domestic violence screening.

Maternal Mortality Review (MMR) in Delaware... *(continued from page 74)*

Recommendation 2: CDNDSC recommends improved communication between the Emergency Department and Primary Care Physician as well as the prenatal care provider to ensure follow up and better management of patients.

- **Rationale:** There was a lack of communication between the obstetrician, maternal fetal medicine specialist, and endocrinologist. The mother had documented low blood sugar levels but there was no follow up with her or between her providers to coordinate care for insulin dosing. The mother missed appointments with her endocrinologist and there was no documented evidence that she was contacted to assess her blood sugar levels.
- **Anticipated result:** Mothers with poorly controlled chronic diseases and issues with medical compliance will have improved management of care if feedback communications are in place.
- **Responsible agency:** All Delaware birthing hospitals
- **Response:** No response received.

Recommendation 3: CDNDSC recommends an increased awareness among private prenatal providers about available home visitation services and a need to establish a feedback mechanism to healthcare providers about what services/referral the patients are receiving.

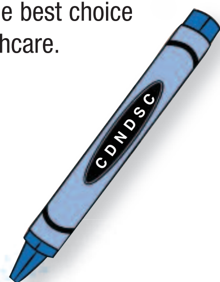
- **Rationale:** Although a patient had private insurance, she may have benefited from home-based nursing visits as she had a poorly controlled chronic disease and compliance was an issue.
- **Anticipated Result:** Those mothers with poorly controlled chronic diseases and issues with medical compliance may benefit from a referral for home nurse visiting for assistance in management of poorly controlled disease and increase compliance.
- **Responsible Agency:** DHMIC
- **Response:** No response received.

Recommendation 4: CDNDSC recommends that healthcare providers express consistent explanations regarding the risks and benefits when diagnostic radiological procedures are necessary for pregnant patients in an effort to avoid confusion and allow them to make the best choice for their healthcare.

- **Rationale:** At 31 weeks, a patient complained of chest pain and dyspnea. A pulmonary embolism was suspected and a CT scan was recommended but declined by the patient. Four weeks later, she presented with similar complaints and admitted to having the same pain two weeks prior. Several hours later, she decompensated and the baby was delivered via stat Cesarean section and an emergency thoracotomy was performed and massive bleeding was noted. The cause of death was aortic dissection.
- **Anticipated Result:** Obstetricians and radiologists will consult and provide consistent messages regarding the risks and benefits when diagnostic radiological procedures for pregnant patients need to be performed so she can make the best choice for her healthcare.
- **Responsible Agency:** Delaware chapter of ACOG, Medical Society of Delaware and radiological services
- **Response:** No response received.

Recommendation 5: CDNDSC recommends improved communication between the Emergency Department (ED) and primary care physicians (PCP) as well as the prenatal care provider to ensure follow up and better management of patients.

- **Rationale:** At 31 weeks, a patient complained of chest pain and dyspnea. A pulmonary embolism was suspected and a CT scan was recommended but declined by the patient. Four weeks later, she presented with similar complaints and admitted to having the same pain two weeks prior. Several hours later, she decompensated and the baby was delivered via stat Cesarean section and an emergency thoracotomy was performed and massive bleeding was noted.
- **Anticipated Result:** For those mothers with repeat visits to the ED, there will be an improved communication between the ED and PCP as well as the prenatal care provider to ensure follow up care.
- **Responsible Agency:** All Delaware birthing hospitals
- **Response:** No response received.



Commissioners and Panel Members...

Commissioners

Margaret-Rose Agostino, DNP, MSW, RN-BC (MMR Chair)

Rodney Brittingham (DSCYF)

Aleks Casper (NCC FIMR Chair)

Patricia Ciranni, RN (K/S FIMR Chair)

C. Malcolm Cochran, Esq. (CPAC)

Dr. Garrett Colmorgen (Chair, MS/Perinatology)

Mary Ann Crosley (Child Advocate, statewide nonprofit organization)

Tania Culley, Esq. (OCA)

Patricia Dailey Lewis, Esq. (DOJ)

Dr. Gerard Gallucci (DHSS)

Mawuna Gardesey (DPH)

Marjorie Hershberger, MSN, APN (NCC Panel Chair)

Judge Joelle Hitch (Family Court)

Dr. Kathy Janvier (DE Nurses Association)

Dr. Amanda Kay (Medical Society of DE~Pediatrician)

Rebecca Laster, LCSW (CAN Panel Chair)

Mary Ann Mieczkowski (DOE)

Deborah Miller, LCSW (NASW)

Leslie Newman (Child Advocate, statewide nonprofit organization)

CPL Adrienne Owen (DSP)

Michael Price (Office of the Chief Medical Examiner)

Dr. David Paul (MS/Neonatology)

Dr. Philip Shlossman (K/S Panel Chair, MS/Obstetrics)

Chief Henry Tobin (Police Chief's Council)

Lt. Teresa Williams (NCCPD)

CAN Panel Members

AnnaMarie Breland (Nonprofit Child Advocate)

Sandra Carter (DPH)

Karen DeRasmo (Nonprofit Child Advocate)

Jennifer Donahue (DSCYF)

Marjorie Hershberger, MSN, APN (Delaware Nurses Association)

Tynisa Howell (Nonprofit Child Advocate)

Carrie Hyla (Family Court)

Dr. Amanda Kay (Chair)

Lt. Michael Kelly (Middletown PD)

Diane Klecan (Nonprofit Child Advocate)

Rebecca Laster, LCSW (Chair)

Mary Ann Mieczkowski / Linda Smith (DOE)

Janice Mink (CPAC)

Rosalie Morales (OCA)

Reese Parker (DSCYF)

Julia Pillsbury (Pediatrician)

Det. Gary Potts (DSP)

Bridget Poulle / Cara Sawyer (DVCC)

Helen Shallow (DHSS)

Janice Tigani (DOJ)

Cheri Will (Beebe Hospital)

NCC CDR Panel Members

Ann Altemus (Child Advocate, statewide non-profit organization)

Det. Cecilia Ashe / Det. Ron Mullin (WPD)

Veronica Blackston (DOJ)

Det. Joseph Bloch (NCCPD)

Renee Ciconte (Family Court)

Alice Coleman, LCSW

Dr. Kate Cronan (A.I. duPont)

Sue Graham (DPH)

Marjorie Hershberger, MSN, APN

Dr. Richard Leader (Obstetrics, St Francis Hospital)

Cindy Mercer (DVCC)

Ross Megargel (Emergency Medical Services)

Mary Ann Mieczkowski / Linda Smith (DOE)

Rosalie Morales (OCA)

Anita Muir (DPH)

SGT Daniel Oliphant (DSP)

Michael Price (OME)

Cara Sawyer (DVCC)

Karen Triolo / Belvie Herbert-Perry (DSCYF)

Kent/Sussex CDR Panel Members

Kevin Bristowe

Det. Kenneth Brown (Milford PD)

Helene Diskau / Maureen Ewadinger(Child Development Watch)

Margaret Foor (DHSS)

Frances Franklin (NASW, Children and Families First)

Belvie Herbert-Perry (DSCYF)

Cherelyn Homlish (Child Advocate)

Capt. Melissa Hukill (DSP)

Jim Lesko (DOE)

Dr. Edward McDonough (OME)

Lt. Daniel McKeown (Dover PD)

Rosalie Morales (OCA)

Christopher Parker (DOJ)

Joseph Richardson (Dover PD)

Dr. Phillip Shlossman (Chair / Christiana Care)

Aimee String (DVCC)

Karen Triolo / Belvie Herbert-Perry (DSCYF)

Ophelia Wallace

FIMR: Caring Communities/ Sharing Hope

NCC CRT Members

Linda Brittingham, SW

Aleks Casper, BA (Chair)

Danielle Cooper (Health Ambassador)

Sandy Elliott, CNM, MSN

Barbara Hobbs, BSN (co-Chair)

Shirley Ibrahimovic (Health Ambassador)

Cortney Jones, LCSW (former co-Chair)

Venus Jones (Health Ambassador)

Moonyeen Klopfenstein, MS, RN

Margaret Lynch, BSN, MBA

Kristin Maiden, BA, MA, PhD

Katie McCarthy, D.O., M.S.

Nancy O'Brien, BSN

Virginia Phillips, BS, MSW

Commissioners and Panel Members... (continued from page 76)

FIMR: Caring Communities/Sharing Hope… (continued from page 76)

Stephanie Rogers, RN, BS
Kathleen Russell, BSN
Tamika Sales, RN
Miriam Sigler, BA, MBA
Angelica Sineni (Health Ambassador)
Nikki Stryker, LCSW
Clare Szymanski, BSN, MSN
Gayla Walker, RN
Courtney Watson, BSN, MSN

Kent and Sussex County CRT Members

Margaret-Rose Agostino, DNP, MSW, RN-BC
Bridget Buckaloo, MSN, RNC-OB (co-Chair)
Linda Brauchler, BSN, MSN
Candice Carbone, BSN, MSN
Patricia Ciranni, MSN, WHNP-BC (Chair)
Freda Collins, BA
Garrett Colmorgen, MD
Maureen Ewadinger, MSN
Nanette Holmes, RN
Beth Keena, BA, MS
Karen Kelly, BSN
Pamela Laymon, BSN
Jennifer Lilge, RNC, SANE, FNE
Rosemarie Pomilla, RN, NNP
Melody Wireman, RNC, MSN

MMR Members

Margaret-Rose Agostino, DNP, MSW, RN-BC
Scott Bovelsky, MD (co-Chair)
Bridget Buckaloo MSN, RNC-OB
Melanie Chichester, RN
Patricia Ciranni, MSN, WHNP-BC
Garrett Colmorgen, MD
Mary Ann Crosley, RN
Anna D'Amico, MD
Terry Dombrowski, RN
Deborah Ehrenthal, MD
Sandy Elliott, CNM, MSN
Lamar Ekbladh, MD
Susan Kelly, MD
Susan Kline, BSN
Veronica Kopec, RN
Pamela Laymon, RN
Meena Ramakrishnan, MD
Kirsten M. Smith, MD
Megan O'Hara, LCSW
Crystal Sherman
Phillip Shlossman, MD
Clare Symanski, BSN, MSN
Michael Vest, MD

CDNDSC Interns

Administrative Office of the Courts
Summer Foster Care Youth Program

CDNDSC Location and Staff

Child Death, Near Death and Stillbirth Commission
900 King Street, Suite 220
Wilmington, DE 19801
Main # 302-255-1760
Fax # 302-577-1129
http://courts.delaware.gov/childdeath/

Anne Pedrick, MS
Executive Director
302-255-1761
Email: anne.pedrick@state.de.us

Joan Kelley, RN
FIMR Program Coordinator
302-255-1766
Email: joan.kelley@state.de.us

Ashlee Starratt, BA
Child Death Review Specialist until September 2013
302-255-1762
Email: ashlee.starratt@state.de.us

Kristin Joyce, BA
Senior Medical Social Worker
302-255-1765
Email: Kristin.joyce@state.de.us

Angela Birney, AAS
Promoted to Child Death Review Specialist October 2013, Office Manager
302-255-1760
Email: angela.birney@state.de.us

Elaine O'Neill, BS
Promoted to Office Manager November 2013 until August 2014, Administrative Specialist
302-255-1763
Email: elaine.oneill@state.de.us

Christine Purnell
Administrative Specialist I, started February 2014
302-255-1760
Email: Christine.purnell@state.de.us

This annual report is dedicated to Scarlett Alexandra Donovan*

8/1/11-11/19/11

"I NEVER thought it could happen to my children. I always thought, "SIDS is something that happens to other people and not me or my family... I know how to take care of an infant; on top of that, I'm a nurse!" In 2011 the unthinkable happened. My daughter Scarlett was stolen in her sleep by SIDS at 15 weeks old. It CAN happen to you! None of us are immune from SIDS since it is an unexplained death; a diagnosis of exclusion. Since we cannot PREVENT SIDS, why not practice reducing the risk by following the four simple sleep practices: SLEEP ALONE, ON BACK, EMPTY CRIB, SMOKE FREE. WE need to protect our children until they are old enough to protect themselves. "
Sarah Cantoni, RN, ARC Counselor

A special thanks to Dr. Meena Ramakrishnan (for her work on FIMR and Maternal Death Review), Dr. Anna D'Amico (Maternal Mortality Review), and Marjorie L. Hershberger (NCC Panel Chair, Specialist on Safe Sleep and SIDS and Abusive Head Trauma Coordinator and infant safe sleep expert) and their contributions to the CDNDSC.

* This picture and quote were used with permission from Scarlett's mother.

Delaware CDNDSC
REVIEW & PREVENTION
OF CHILD DEATHS

State of Delaware
Child Death, Near Death and Stillborn Commission
900 North King Street, Suite 220
Wilmington, DE 19801-3341

Due to continued fiscal constraints in the State of Delaware, the Calendar Year 2013 Child Death, Near Death and Stillbirth Commission Annual Report has been distributed through electronic distribution. This effort will both save taxpayer dollars and help reduce the State's environmental footprint.

Copies of the Annual Report are available online at the CDNDSC website.[31]

[31] *http://courts.delaware.gov/childdeath/reports.htm*