Delaware CDNDSC

REVIEW & PREVENTION OF CHILD DEATHS

Annual Report for Fiscal Year 2012
and Calendar Year 2012

CDNDSC

Child Death, Near Death
and Stillbirth Commission

REVIEW & PREVENTION OF CHILD DEATHS

State of Delaware
Child Death, Near Death and Stillbirth Commission
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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: MAY 10, 2013

SUBJECT: Fiscal Year 2012 & Calander Year 2012 Child Death, Near Death and Stillbirth Commission Annual Report

I am pleased to present to you the tenth Annual Report of the Delaware Child Death, Near Death and Stillbirth Commission. The Report provides a summary of the work of the Panels and Commission during fiscal year and calendar year 2012.

Many of the deaths reflected in this report are preventable and they are often the result of predictable events. As the facts and story of a child's life are compiled and analyzed, certain risk factors for Delaware's children emerge. The challenge is to apply our knowledge of these risk factors and work together as a state to prevent these unnecessary deaths that impact our families and communities. This report reflects opportunities for system improvement and areas where we could do a better job to protect our future, the children of Delaware. The report also highlights the initiatives of many system partners and state agencies. The work we do is serious and necessary because we never forget that a child death is a sentinel event for every community.

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

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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 Fiscal Year (FY) 2012 (July 1, 2011 through June 30, 2012) and Calendar Year (CY) 2012. These reviews were conducted by multi-disciplinary Child Death Review Panels (CDR) and multi-disciplinary Fetal Infant Mortality Review (FIMR) Case Review Teams (CRTs). FIMR conducted 101 retrospective reviews of the history and circumstances surrounding each fetal or infant death in Delaware. During this period, 82 death cases and 16 child abuse/neglect near death cases were reviewed by the Child Death Panels. In addition, one out of state case was reviewed internally for possible identification of Delaware systems issues. The work of the dedicated CDR panels and CRTs can best be reflected in the recommendations and prevention initiative portion of this annual report. The Commission continues to fine-tune the response to child death with an increased focus on prevention as reflected in the new logo on the cover page.

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 FIMR and CDR:

FIMR

- From September 2011 through December 2012, FIMR CRTs deliberated on 101 cases of fetal and infant deaths. Seventy-nine of those cases were reviewed during the FY 2012 period by the New Castle and the Kent/Sussex CRTs (an average of 4.4 cases per meeting), and 70 cases were reviewed during CY 2012 (an average of 4.1 cases per meeting). Forty-eight cases, those deliberated between January and June 2012, are represented in both the FY 2012 and CY 2012 count. The 101 deaths reviewed occurred to 93 mothers, with 8 mothers experiencing more than one loss.
- Over the 18-month period, 26 FIMR cases had a maternal interview, yielding a maternal interview acceptance rate of 26%. Thirty-four percent of FIMR cases (15 out of 44) involving White mothers had a maternal interview, this is a higher proportion than those cases involving Black mothers, among whom 18% had a maternal interview (10 out of 56 cases). In FY 2012, the maternal interview acceptance rate was 24% (19 out of 79 cases), and in CY 2012, the maternal interview acceptance rate was 27% (19 out of 70 cases).

The FIMR recommendations are grouped into three larger categories:

1. Improve the quality of prenatal care and enhance service coordination and systems integration.
2. Provide quality bereavement support and interconception care to women with prior adverse pregnancy outcomes.
3. Provide education to obstetrical practitioners to support best practices in perinatal care and public health.

- There was a higher proportion of FIMR Black mothers among FIMR infant deaths (68% and 70%), while White mothers made up the majority of FIMR fetal deaths (58% and 60%). In FY 2012, 9% of cases involved mothers who did not receive prenatal care, and in CY 2012 this percentage was 17%. Slightly higher proportions of White mothers did not receive prenatal care compared to Black mothers in both the FY 2012 and CY 2012 groups.

CDR

- Blacks make up 21.9% of Delaware's population.[1] However, black children disproportionately represent 34% (28 out of 82) of all deaths that were reviewed by the CDR panels during FY 2012 and CY 2012.
- The Kent/Sussex CDR panel reviewed 26 deaths and the New Castle County CDR panel reviewed 51 deaths during FY 2012 and CY 2012. The two leading causes of death in cases reviewed during FY 2012 and CY 2012 were motor vehicle crashes (15) and infant unsafe sleeping environments (24). These two panels put forth 13 case recommendations and one supportive statement.
- The Commission reviewed three deaths due to drowning. Of those three deaths, two were in a residential pool and one occurred in a river. Two cases were Black males and one case was a White male child. In one case, a child between the ages of 5 to 9 was not properly supervised. Proper supervision of children is the best way to prevent a child from drowning.
- The Commission reviewed a total of four deaths due to poisoning, overdose or acute intoxication, of these four deaths (two were

[1] Available at: http://quickfacts.census.gov/qfd/states/10000.html

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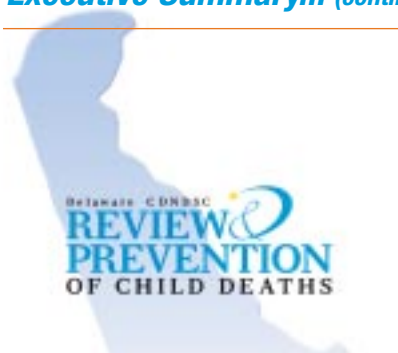

female, two were male), the children were between the ages of 15 to 17. Of these, one death resulted from a suicide. The other deaths were accidental overdoses as a result of substance abuse (this is defined as including alcohol, prescription drugs, over the counter medication, or herbal medicines from the Internet). Two deaths involved prescription drugs. Two near death cases were reviewed by the Child Abuse and Neglect (CAN) Panel for accidental overdose. They involved prescription drugs, over the counter drugs and a cleaning substance. In each of these cases, the child was unsupervised and had access to the substances. Both of these children were under the age of nine.

- The Commission reviewed two homicide cases not due to abuse or neglect. The deaths involved one Black and one Multiracial child. They were in the age range of 15 to 17 years and involved handguns. One of these cases may have been caused by a possible retaliation and gang involvement. The other case involved a robbery. Both males had juvenile criminal history and possible drug involvement. Both victims knew their perpetrator as an acquaintance.
- The Commission reviewed 15 child deaths due to motor vehicle crashes. Twelve children were White and three were Black. Motor vehicle crashes are the leading cause of death for teenagers in the United States and also in Delaware. Risk factors involving the 15 cases include one case of wet roads, four cases where the teenager was responsible for the motor vehicle crash, one case where the child had a suspended license, and one case where the graduated licensing rules were not followed, in as more than two teen passengers were present in the vehicle. Of the 15 deaths, four were pedestrians, one was a bicyclist and one child was on a motorcycle. In the case involving the bicyclist, a helmet was not worn. Additionally, in four cases, a seatbelt was not worn by the child, nor was a booster or car seat used as a protective measure.
- In FY 2012 and CY 2012, 24 deaths were reviewed in Delaware due to infant unsafe sleeping. The Commission continues to see approximately one to two referrals every month due to this type of death. The 24 cases are only reflective of the cases reviewed by the CDR panels; not actual calendar year infant unsafe sleeping data collected through Delaware's Office of Vital Statistics. Of the 24 unsafe sleeping deaths, two were Hispanic, eight were Black and 14 were White. Ten of the infants were females and 14 were males. In 79% of the cases (19 out of 24), the infant was **NOT** sleeping in a crib or bassinette. Moreover, in 71% (17 out of 24) of the cases, the infant was bed-sharing with another individual. Among the 24 cases reviewed, ten of the infants were not sleeping on their back. Three of these cases involved a parent and/or caretaker who had consumed alcohol or was drug impaired 24 hours prior to the infant's death.
- The Child Abuse and Neglect (CAN) Panel reviewed five child deaths and 16 near deaths that resulted from abuse and neglect. Twenty-one cases were initial reviews. Of those initial reviews, three were finalized as CAPTA[2] reports. In addition, 13 near death CAPTA reports were finalized. These cases were initially reviewed in a prior year and reflected in a prior report. All CAPTA reports are available on the CDNDSC website.[3]
- The CAN Panel put forth 62 Commission approved recommendations, 20 ancillary recommendations and four supportive statements. This is a significant recommendation increase from 16 recommendations approved during FY 2011.

[2] 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).

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

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THERE IS NO TRUST MORE SACRED THAN THE ONE THE WORLD HOLDS WITH CHILDREN. THERE IS NO DUTY MORE IMPORTANT THAN ENSURING THAT THEIR RIGHTS ARE RESPECTED, THAT THEIR WELFARE IS PROTECTED, THAT THEIR LIVES ARE FREE FROM FEAR AND WANT AND THAT THEY CAN GROW UP IN PEACE. – KOFI ANNAN

CDNDSC

Child Death, Near Death and Stillbirth Commission

AHT: Abusive Head Trauma: Formerly called Shaken Baby Syndrome

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.

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

DELJIS: Delaware Criminal Justice Information System

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

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's 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

Maternal Interview: 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

NAS: Neonatal Abstinence Syndrome

NFP: Nurse Family Partnership

NICU: Neonatal Intensive Care Unit

NCRPCD: National Center for the Review and Prevention of Child Deaths

OB: Obstetrician

OCCL: Office of Child Care Licensing

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

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...

Delaware CDNDSC
REVIEW & PREVENTION OF CHILD DEATHS

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. The Child Abuse and Neglect (CAN) Panel reviews 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[4] 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 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.

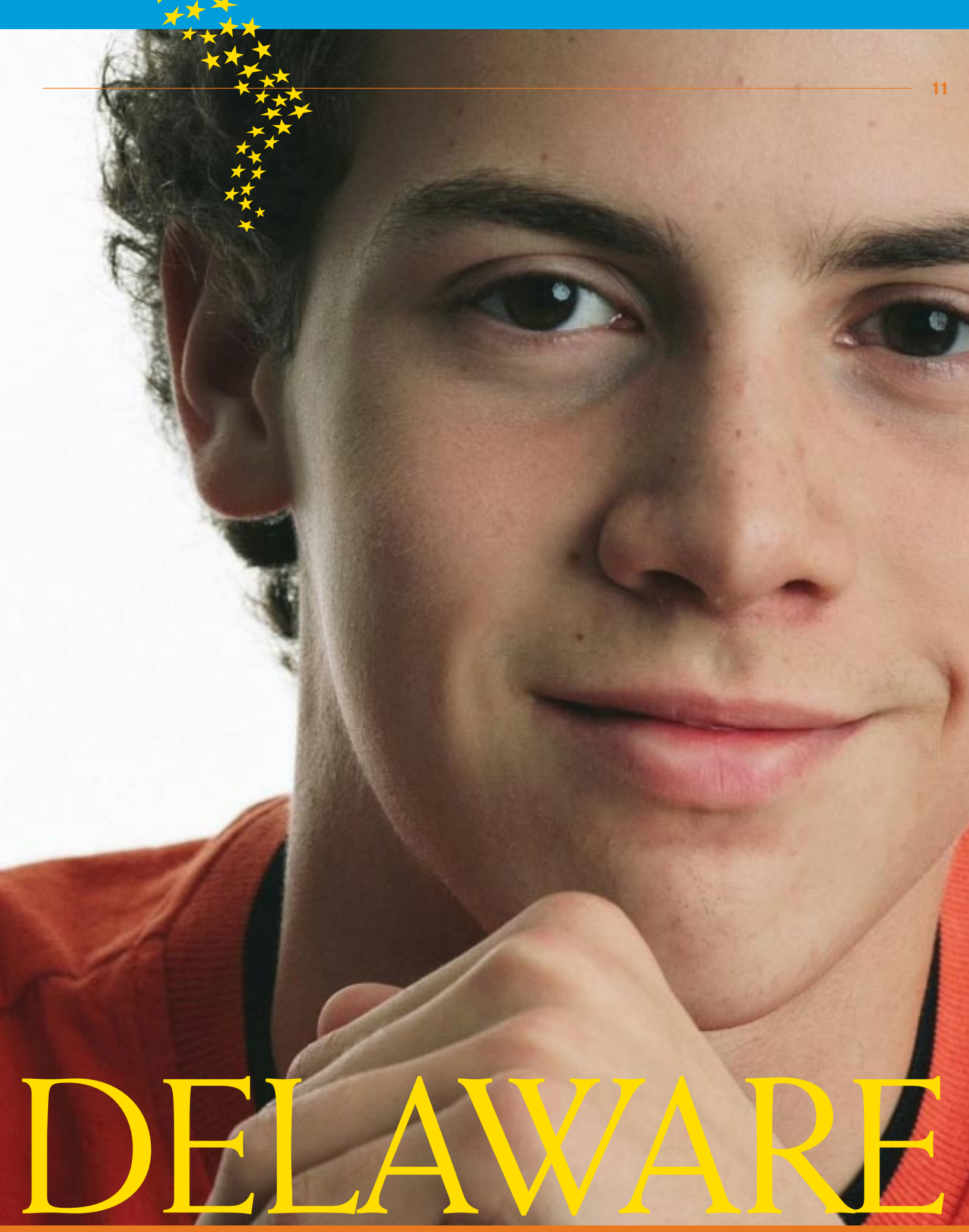
The most significant accomplishment for FY 2007 was the full implementation of the Fetal Infant Mortality Review Process. The bi-annual joint reviews with the Domestic Violence Coordinating Council's Fatal Incident Review Team began in April 2007. The cases reviewed involved child deaths and near deaths 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 first two meetings of the Maternal Death review occurred in FY 2012.

[4] 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.

CDNDSC

Child Death, Near Death and Stillbirth Commission



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Prevention Initiatives and Education...

How can you help prevent future child deaths?

- Empower individuals to intervene in situations where child abuse, neglect and other violence harm children. This includes reporting abuse or neglect to the Child Abuse Report Line, 1-800-292-9582.
- Educate children, families, organizations and community groups on preventable child deaths.
- Encourage community and individual involvement in recognizing and preventing risk factors that contribute to child deaths.
- Assist and support families to achieve healthy parenting practices through education and resources.
- Improve systems of care initiatives so that all children receive optimal health care before and after birth and throughout their lives.

ABUSIVE HEAD TRAUMA PROGRAM

After the Commission reviewed 13 deaths and near deaths involving Abusive Head Trauma (AHT), the need for preventive parent education on AHT was demonstrated. The Commission partnered with Prevent Child Abuse Delaware (PCAD) to form a comprehensive Parent Education Abusive Head Trauma Program. After review of nationwide parent education programs, Delaware selected an evidence-based model[5] from Pennsylvania. When replicated in other states, this program has demonstrated a reduction in the number of infant Abusive Head Trauma cases. The Delaware program was made possible by a grant through AstraZeneca and Barclay Card US.

The Delaware Parent Education Abusive Head Trauma program had a nurse educator train all of the nursing staff in the birthing hospitals within the state. After training, the hospital nursing staff will show each mother and father or caregiver a 10-minute DVD before they are discharged from the hospital. The DVD shows three families who have experienced the tragedy of Abusive Head Trauma. The possible injuries from shaking are identified as well as the outcome of the three families. After watching the DVD, the parents sign a consent form (commitment statement) stating that they watched the DVD and understand its content. (To date, 23,825 commitment statements have been collected.) Parents then have the opportunity to list their phone number for a follow-up phone call, which is made by a social worker six to seven weeks after the infant's birth. (This six to seven week period has been shown to be the peak of an infant's crying and, by extension, the timeframe of greatest risk for Abusive Head Trauma.)

If the parent needs additional support at the time of the phone call, appropriate referrals and resources will be given to the parent. If a child has been abused after education on Abusive Head Trauma, this will be reflected through medical record abstraction by the Commission at the Child Abuse and Neglect Panel. The training for this program was completed in FY 2010 at all birthing hospitals throughout the State, resulting in 167 nurses being trained.

Infant Severe Physical Abuse/Abusive Head Trauma

	CASES
September 2006-December 2009 (Approximately 6-7 per year)	*20*
December 2009 to September 2011 (Approximately 3 per year)	*7*
July 1, 2011 to June 30, 2012	*8*

As seen in the chart, the Commission received 20 cases of child death or child near death due to Abusive Head Trauma and/or severe physical abuse from September 2006 to December 2009. These cases were received prior to the hospital prevention program being implemented. However, the program was not fully implemented with all hospitals receiving such training until October 2010. Even with the delay in all hospitals participating; only seven cases have been reported to the CDNDSC from December 2009 to September 2011. However, there is reason to be concerned due to a dramatic increase in FY 2012 (July 1, 2011 – June 30, 2012). During this short 12 month period, eight cases of AHT occurred. The rate of AHT cases during this time period increased by almost 50%. It is an alarming trend and may be due to outdated educational materials and the lack of funds to secure current, accurate information, in particular the DVD "Portrait of Promise" which is outdated and not breast feeding friendly. Major birthing hospitals in Delaware will no longer use material that is not breast feeding friendly and have informed the program they will not be showing the DVD, which is an important component of the program. Without the compliance of all birthing hospitals in Delaware, the program is in jeopardy of failing to reach the initial goals proposed.

As a result of this feedback from birthing hospitals, a parent focus group was conducted in the summer of 2012 to determine which DVD

[5] Awareness, education, and prevention programs shall be offered in all birthing centers and hospitals to every parent, upon the birth of a child. Consideration should be given to the outreach education program developed by Dr. Mark Dias, a pediatric neurosurgeon in Pennsylvania. The Pennsylvania Shaken Baby Syndrome Prevention and Awareness program provides consistent Shaken Baby Syndrome education to parents upon the birth of their child in 100% of Pennsylvania's birthing hospitals. (Recommendation from the Steve and Karen Green CPAC Near Death Report)

would appeal to parents as well as provide the essential prevention message on AHT. Five DVD's were shown and parents felt that "Portrait of a Promise" was outdated and gave a negative message. They wanted more information on how to calm a crying baby. After this focus group, the planning committee determined that the "All Babies Cry" program would be appropriate for Delaware's needs. Therefore in November 2012, CDNDSC applied for a grant through Prevent Child Abuse Delaware from the Federal Community Based Child Abuse Prevention Program (CBCAP) to purchase and implement this program state-wide.

"All Babies Cry" is a new evidence-based program designed to promote healthy parental behaviors and prevent child abuse in the first year of life. Funded by the Eunice Kennedy Shriver National Institute of Child Health and Human Development, the program incorporates the protective factors of the Strengthening Families initiative.[6] This model has been adopted nationally by child welfare organizations, states (over 60%) and federal partners, and empowers new mothers and fathers with practical demonstrations of infant soothing and clear strategies for managing normal stress in parenting. The DVD is an 11 minute video that comes with a 28-page, four color booklet with checklists, activities, hotline numbers and other resources. All materials are in English and Spanish with closed captioning.

The CBCAP grant was awarded to the Child Death, Near Death and Stillbirth Commission by Prevent Child Abuse Delaware, but is currently awaiting Office of Management and Budget Clearinghouse approval. If approved, the new prevention education program will begin in fall 2013. The "All Babies Cry" program would be offered to all birthing hospitals state-wide. CDNDSC would oversee the program and ensure its continuation if funded through this grant.

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

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Prevention Initiatives and Education... (continued from page 13)

Cribs for Kids®
Helping every baby sleep safer

Delaware Cribs for Kids

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.[7]

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 six 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.

Among the 506 cribs that were delivered state-wide in FY 2012 and CY 2012 through the Delaware Cribs for Kids program, only one infant of a parent or caretaker that received a crib and the mandatory infant safe sleep education has died due to unsafe sleeping. From the inception of the program in the fall of 2009 through December 31, 2012, 780 cribs have been distributed.

Delaware Cribs for Kids partners/educators:

- A. I. duPont Hospital for Children
- Division of Public Health State-wide
- 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 U of D)
- Westside Health (all four locations)

[7] Through compelling research by SIDS of Pennsylvania's Cribs for Kids® Program, a safe-sleep environment has been identified as a key factor in reducing the rates of infant death. Babies, who sleep in unsafe sleep environments, including adult beds, are at a 40 times greater risk of dying. (www.CribsforKids.org)

DELAWARE

CHILD PROTECTION ACCOUNTABILITY COMMISSION

CPAC and the Child Death, Near Death, and Stillbirth Commission (CDNDSC) continued their collaborative affiliation through FY 2012 and CY 2012. In addition to semi-annual Joint Commission Meetings, CPAC and CDNDSC hosted 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.

These committees were established based upon recommendations developed as a result of child deaths or child near deaths due to abuse and/or neglect. The recommendation must be recurring and the issue of utmost necessity to keep children safe in order to warrant a newly formed committee.

Joint CPAC and CDNDSC Commission committees include the following:

- Investigation and Prosecution
- Mandatory Reporting Outreach Campaign
- Foster Care Medical Committee
- The Infant Safe Sleeping Practice Community Action Team

INVESTIGATION AND PROSECUTION

In December 2011, CPAC and CDNDSC held their semi-annual joint meeting and approved the creation of the Joint Committee on the Investigation and Prosecution of Child Abuse. The charge of this Committee is to research and develop 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. The Committee is led by co-chairs, Malcolm C. Cochran IV, Esquire and Senator Patricia Blevins, and the membership includes representatives from the following agencies: A.I. duPont Hospital, Child Development Watch, CDNDSC, CPAC, Delaware State Police (DSP), Department of Justice (DOJ), Division of Family Services (DFS), Family Court, New Castle County Police Department (NCCPD), Office of the Child Advocate (OCA), and Wilmington Police Department (WPD). The Committee began meeting in February 2012, and the priority was to collect and analyze Delaware data on child abuse death and near deaths and best practices nationwide. The group began by analyzing the trends in a total of 96 cases referred to the CAN Panel between 2001 and 2011. Of those 95 cases, the criminal dispositions predominantly resulted in convictions for Assault and/or Endangering the Welfare of a Child. The Joint Committee has used this data to determine opportunities for improvement, including drafting legislation, developing a Best Practices for Investigation and Prosecution Handbook, and ongoing multidisciplinary training. A report is expected to be released from this committee in the spring 2013.[8]

MANDATORY REPORTING OUTREACH CAMPAIGN

In addition to training, educating the community on recognizing the signs of child abuse and raising awareness about Delaware's mandatory reporting obligations continued to be a priority for the fiscal year. In fact, CPAC and CDNDSC's Mandatory Reporting Outreach Committee, co-chaired by Anne Pedrick and Randy Williams, Executive Director of the Children's Advocacy Center (CAC), followed through with its action plan to develop and/or coordinate two core initiatives: media activities and community education. In the prior fiscal year, the Committee's efforts included developing a brand identity, securing a website, and establishing the Protecting Delaware's Children Fund at the Delaware Community Foundation. After concluding these initial activities, the Committee was able to focus its efforts on developing an outreach campaign for the month of April, which is Child Abuse Prevention and Awareness Month. Funding received from CDNDSC and the Children's Justice Act Federal Grant enabled the group to unveil its media activities and broadly disseminate its message, "See the Signs, Make the Call", through the distribution of posters and magnets and the release of public service announcements and statewide billboards in English and Spanish. In the future, the Committee hopes to demonstrate significant progress and garner additional funding to support the media outreach annually.[9] Once again in 2013, an outreach campaign has been scheduled for the month of April.

FOSTER CARE MEDICAL COMMITTEE

CPAC and CDNDSC's Foster Care Medical Committee is focused on improving the provision of health care to children and teens in foster care. In order to do so, the Committee plans to review and evaluate the current medical

[8] CPAC Fiscal Year 2012 Annual Report http://courts.delaware.gov/childadvocate/cpacreports.stm

[9] CPAC Fiscal Year 2012 Annual Report

health care structure within the foster care system by reviewing individual cases, conducting research on various model systems, and making recommendations on how medical care delivery within the foster care system can better meet the needs of children and teens. The Committee has reviewed 40 case records representing individual children in foster care to evaluate how these children are currently receiving medical care. In collaboration with DFS, the Subcommittee conducted reviews in each county with the help of DFS staff. A report is anticipated to be submitted to the Joint Commissions in the Spring of 2013 detailing the recommendations that reflect compliance with the American Academy of Pediatrics' standards of care for children and teens in foster care.

THE INFANT SAFE SLEEPING PRACTICE COMMUNITY ACTION TEAM

The Infant Safe Sleeping Practice Committee was created in FY 2006 after the Commission reviewed 57 infant and child sleep-related deaths during FY 2003-FY 2007. In 2012, the Committee switched its focus and became an action committee. Therefore, the name was changed from the Infant Safe Sleeping Practice Subcommittee to the Infant Safe Sleeping Practice Community Action Team (TISSPCAT). The new mission is to reduce the number of SIDS (Sudden Infant Death Syndrome) and SUID (Sudden Unexplained Infant Death) deaths in the State of Delaware through educational awareness campaigns around safe sleeping practice. The goals of the action team include: to expand the message from "Back to Sleep" to "Safe Sleep Environment" that will include all of the American Academy of Pediatrics task-force 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.

On November 15, 2011, CDNDSC partnered with the March of Dimes for their Summit on Safe Sleep at Christiana Care Hospital. Dr. Rachel Moon, chair of the American Academy of Pediatrics Task Force on SIDS and Unsafe Sleep Environments presented along with Marjorie Hershberger, CDNDSC infant safe sleep expert. They spoke at Pediatric Grand Rounds, a morning session for Neonatal Intensive Care Unit (NICU) nurses and an afternoon session for all professionals.

In addition to on-going numerous activities of the TISSPCAT, the chair, Marjorie Hershberger had the honor of becoming Delaware's Safe to Sleep Champion for the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD). A call went out to 20 states with the highest percentage of unsafe sleep deaths to nominate individuals for Safe Sleep Champions for their state. Training in Atlanta occurred in September 2012 for all "champions." As part of the expectations, champions were to reach out to media outlets about the NICHD Safe to Sleep expansion.

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

- Bayhealth Baby Fair
- Beautiful Gate Outreach Program
- Christiana Care Health Services
- 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 Public Health
- "I love Smyrna Day"- Smyrna School District
- Head Start Association Conference
- Lighthouse Program
- Office of Child Care Licensing
- Second Chance Resale and Website
- The Bridge Program under the Career TEAM
- Wilmington University

Collaborative Initiatives... (continued from page 17)

The efforts resulted in interviews with Marjorie Hershberger on WDEL, and Marjorie and Anne Pedrick on WHYY radio (which later went on National NPR). B101 ran public service announcements for the month of October, which is SIDS awareness month. The NICHD Safe to Sleep campaign launched in October 2012 expands upon the successful efforts of the former Back to Sleep campaign to educate parents and caregivers about ways to reduce the risk of SIDS. The expanded campaign educates the public on safe infant sleep practices based on the most recent recommendations from the American Academy of Pediatrics. The Safe to Sleep campaign not only addresses ways to reduce the risk of SIDS, but also ways to reduce the risk of other sleep-related causes of infant death, such as Accidental Suffocation and Strangulation in Bed (ASSB).

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. The development of this state-wide campaign will incorporate 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 is currently working on this campaign. The public launch date is scheduled for April 17, 2013 at the Delaware Healthy Mother and Infant Consortium.

PROTECTING DELAWARE'S CHILDREN CONFERENCE

Supporting and enhancing current practice in investigations and prosecutions of child abuse cases was also a goal shared by CPAC and CDNDSC in planning the Protecting Delaware's Children Conference. With significant funding garnered from the Federal Court Improvement Program under Family Court, the statewide conference was held on October 16-17, 2011, and nearly 500 child welfare professionals convened in Dover, DE for the two-day event. To address emerging issues in child welfare, the Training Committee identified advanced workshops from national and local subject matter experts. In fact, the conference began with an innovative approach to using works of art to help enhance the skills of child welfare professionals. Through the Art of Perception ®, Amy Herman, JD, invoked participants to reconsider how we observe and communicate case specific information. Equally as inspiring, plenary speakers, Dr. Cindy Christian from the Children's Hospital of Philadelphia and Chris Newlin from the National Children's Advocacy Center, emphasized working in multidisciplinary teams to protect children. Additionally, several key speakers from the National Child Protection Training Center were invited to speak on topics such as Family Violence and Child Abuse, Allegations of Sexual Abuse in High Conflict Divorcing Parents, Non-Verbal Children and Evidence Based Prosecution, and Uses and Misuses of Expert Testimony. Several of these experts were also presenters at the When Words Matter Conference.[10] The conference was a success due to the collaborative efforts of the various agencies involved. The next Protecting Delaware's Children Conference will be held on May 22 and 23, 2013.

[10] CPAC Fiscal Year 2012 Annual Report

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 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 Death
- 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

SAFE TO SLEEP

Other Partnerships

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

- Coalition for Injury Prevention
- CPAC Committees
- Training Committee
- Abuse Intervention Committee
- Delaware Healthy Mother and Infant Consortium
  - * 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 (NCRPCD)
  - * Mid-Atlantic CDR Coalition
  - * Data Dissemination Subcommittee
- Nurse Family Partnership Advisory Board
- Suicide Prevention Taskforce
  - * Youth Suicide Subcommittee
- Wilmington Consortium

CDNDSC National Collaboration...

National Meetings

CDNDSC was invited to attend the *"National Conversation on Maternal Mortality and Pregnancy-related Deaths,"* which occurred on Wednesday, October 17, 2012. The goal of this summit was to review the scope of causes for maternal deaths in the perinatal period and develop a national agenda to reduce pregnancy-related deaths from a multidisciplinary perspective. The summit was sponsored by the National Perinatal Association.

In December 2011, CPAC and CDNDSC were invited to attend a national meeting in Washington, D.C. that focused on the collaboration between citizen review panels, child fatality and maternal death, fetal infant mortality reviews, domestic violence reviews, and elder abuse reviews. Representatives from the Commissions spoke on the collaborative initiatives between the Joint Commission and the system changes that have resulted from the joint efforts. The report of this meeting can be located at the following link: The Coordination & Integration of Fatality Reviews: Improving Health & Safety Outcomes Across the Life Course.

As a result of this meeting, a year-long review was conducted by Walter R. McDonald under the Children's Bureau to highlight the promising practices within fatality reviews. Delaware was selected as one of the states for their report. As such, CPAC, CDNDSC and Domestic Violence Coordinating Council representatives were asked to return for a follow up meeting in August 2012, in Washington, D.C. entitled *"Preventing Child Fatalities: Promising Strategies for Improving the Outcomes of Fatality Reviews."* CDNDSC presented on the *"Recommendations for Change: Processes, Types, and Targets."*

In addition, CDNDSC participates and chairs the Mid-Atlantic National Center for the Review and Prevention of Child Deaths Coalition (NCRPCD). 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 June 2012 in Gettysburg, PA. The focus of that meeting was to create a solid coalition and learn what each state is currently doing.

National Data Tool Research

Health Resources and Services Administration Information Center (HRSA) awarded a one year secondary data analysis grant to Dr. Victoria Vetter at the Children's Hospital of Philadelphia (CHOP) to better understand cardiovascular deaths in children using de-identified data reported from the National Data Tool. Delaware was a participating data state for this project. Future data projects are currently in the review stage with the NCRPCD Data Dissemination Subcommittee for which CDNDSC participates. ■

FY 2012 and CY 2012 Delaware Child Deaths Reviewed

Demographics (Ethnicity/Race and Age Group by Sex) Statewide

Ethnicity	Age Group	Male	Female	Total
Hispanic /Latino (any race)	< 1 Year	1	1	2
	1-4 Years	2	1	3
	5-9 Years	1	0	1
	10-14 Years	0	1	1
	15-17 Years	0	1	1
	Subtotal	**4**	**4**	**8**
Race				
White	< 1 Year	8	8	16
	1-4 Years	3	4	7
	5-9 Years	4	3	7
	10-14 Years	5	3	8
	15-17 Years	7	6	13
	Subtotal	**27**	**24**	**51**
Black, African American	< 1 Year	5	4	9
	1-4 Years	0	3	3
	5-9 Years	3	1	4
	10-14 Years	5	1	6
	15-17 Years	3	3	6
	Subtotal	**16**	**12**	**28**
Multi-racial	< 1 Year	1	0	1
	1-4 Years	0	1	1
	15-17 Years	1	0	1
	Subtotal	**2**	**1**	**3**
Unknown	< 1 Year	0	1	1
	Subtotal	**0**	**1**	**1**
All Races	< 1 Year	14	13	27
	1-4 Years	3	8	11
	5-9 Years	7	4	11
	10-14 Years	10	4	14
	15-17 Years	11	9	20
	Subtotal	**45**	**38**	**83**

FY 2012 and CY 2012 Delaware Child Deaths Reviewed

Manner and Cause of Death by Age Group-Statewide

	Age Group					
Manner	**<1**	**1-4**	**5-9**	**10-14**	**15-17**	**Total**
Natural	8	6	6	10	6	36
Accident	3	4	5	4	9	25
Suicide	0	0	0	0	3	3
Homicide	1	1	0	0	2	4
Undetermined	14	0	0	0	0	14
Unknown	1	0	0	0	0	1
Total	**27**	**11**	**11**	**14**	**20**	**83**

Manner and Cause of Death by Age Group-Statewide

		Age Group					
Manner	Cause	<1	1-4	5-9	10-14	15-17	Total
Natural							
	Any Injury	1	0	0	0	0	1
	Asthma	0	0	0	2	0	2
	Cancer	0	1	1	6	2	10
	Cardiovascular	0	1	1	1	1	4
	Congenital anomaly	0	1	0	0	0	1
	Influenza	0	1	0	0	0	1
	Neurological/seizure disorder	0	0	1	0	0	1
	Pneumonia	1	0	1	0	0	2
	SIDS	4	0	0	0	0	4
	Other medical condition	2	2	2	1	3	10
	Sub Total	**8**	**6**	**6**	**10**	**6**	**36**
Accident							
	Any Medical Cause	0	1	0	0	0	1
	Motor Vehicle	0	1	3	3	8	15
	Fire, Burn, or Electrocution	0	1	0	0	0	1
	Drowning	0	0	2	1	0	3
	Asphyxia	3	1	0	0	0	4
	Poisoning, Overdose or Acute Intoxication	0	0	0	0	1	1
	Sub Total	**3**	**4**	**5**	**4**	**9**	**25**
Suicide							
	Asphyxia	0	0	0	0	2	2
	Poisoning, Overdose or Acute Intoxication	0	0	0	0	1	1
	Sub Total	**0**	**0**	**0**	**0**	**3**	**3**
Homicide							
	Weapon	1	1	0	0	2	4
	Sub Total	**1**	**1**	**0**	**0**	**2**	**4**
Undetermined							
	Any Medical Cause	1	0	0	0	0	1
	Undertermined Injury	9	0	0	0	0	9
	Unknown	4	0	0	0	0	4
	Sub Total	**14**	**0**	**0**	**0**	**0**	**14**

FY 2012 and CY 2012 Delaware Child Deaths Reviewed

Demographics (Ethnicity/Race and Age Group by Sex) New Castle County

Ethnicity	Age Group	Male	Female	Total
All Races	< 1 Year	10	7	17
	1-4 Years	2	5	7
	5-9 Years	4	1	5
	10-14 Years	4	3	7
	15-17 Years	10	5	15
	Subtotal	30	21	51

Demographics (Ethnicity/Race and Age Group by Sex) Kent/Sussex County

Ethnicity	Age Group	Male	Female	Total
All Races	< 1 Year	3	3	6
	1-4 Years	1	2	3
	5-9 Years	3	3	6
	10-14 Years	6	1	7
	15-17 Years	1	3	4
	Subtotal	14	12	26

ABUSE/NEGLECT DEATHS OR NEAR DEATHS

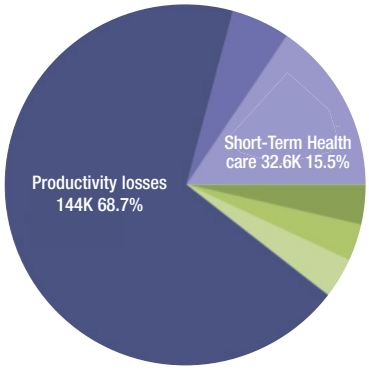
The Child Abuse and Neglect (CAN) Panel reviewed five child deaths and 16 near deaths that resulted from abuse and neglect. Twenty-one cases were initial reviews. Of those initial reviews, three were finalized as CAPTA reports. In addition, 13 near death CAPTA reports were finalized. These cases were initially reviewed in a prior year and reflected in a prior report. All CAPTA[11] reports are available on the CDNDSC website.[12]

It is estimated that Americans pay $124 billion per year for the cost of child abuse. The effects of child abuse impact health care costs, education costs, criminal justice fees and welfare systems. Each victim may cost over $200,000 depending upon the severity of the injuries.

The Cost of Child Abuse

Description: The average lifetime cost of nonfatal child abuse per victim. Discounted at 3 percent, the CDC estimated the average lifetime cost per victim of nonfatal child abuse to be $210,012 in 2010 dollars.[14]

Average lifetime cost per victim (in 2010 dollars). Total=210K



- Short-Term Health care 36.2K
- Long-Term Health care 10.5K
- Productivity losses 144K
- Child welfare cost 7.7 K
- Criminal justice cost 6.7K
- Special education cost 8K

INITIAL REVIEWS

	Deaths	Near Deaths
Abusive Head Trauma	2 (one was also a CAPTA)[13]	5
Burns/Scalds		1
Extreme Physical Abuse		7
Homicide	1	
Ingestion Prescription Meds-Lack of Supervision		2 (one was also a CAPTA)
Near Drowning-Lack of Supervision		1
Unsafe Infant Sleeping practice and Founded for Neglect due to egregious circumstances	2	
TOTAL	5	16

FINAL CAPTA REPORTS

	Death	Near Death
Abusive Head Trauma	1 (See footnote 13)	6
Burns/Scalds		3
Drowning	1	
Extreme Physical Abuse		1
Homicide	1	
Ingestion of Prescription Meds-Lack of Supervision		2 (See footnote 13)
Motor Vehicle Crash-child injured due to Alcohol/Drug Usage by Parent		1
Near Drowning-Lack of Supervision		1
Unsafe Infant Sleeping practice and Founded for Neglect due to egregious circumstances	1	
TOTAL	3 (See footnote 13)	13 (See footnote 13)

[11] 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).

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

[13] One case due to AHT and one near death case of ingestion prescription medicine received both initial reviews and final CAPTA reports within the FY12 and CY12.

[14] Americans Paying a High Price for Child Abuse: $124 Billion. http://www-958.ibm.com/software/data/cognos/manyeyes/visualizations/cost-of-child-abuse-2

Child abuse casts a shadow the length of a lifetime.

--Herbert Ward

Smyrna Police Sgt. Torrie James is seen with Lizzie Birney, who had the idea to reward children who wear helmets when biking, and Cindy Jung, owner of Rita's in Smyrna.[17]

BICYCLE/MOTOR VEHICLE/ PEDESTRIAN DEATHS

The leading cause of death in Delaware for teenagers is motor vehicle crashes. Teenage drivers (age 16 and 17) are involved in seven times as many crashes per mile as compared with adults in their 40's and beyond. In the United States, during 2011, 1,150 motor vehicle crashes occurred within the 16 and 17 year old group.[15]

The Commission reviewed 15 child deaths due to motor vehicle crashes. Twelve children were White and three were Black. Motor vehicle crashes are the leading cause of death for teenagers in the United States and also in Delaware. There were two male drivers and two female drivers that were responsible for the motor vehicle crashes. Risk factors involving the 15 cases include one case of wet roads, four cases where the teenager was responsible for the motor vehicle crash, one case where the child had a suspended license and one case where the graduated licensing rules were not followed in as more than two teen passengers were present in the vehicle. Of the 15 deaths, four were pedestrians, one was a bicyclist and one child was on a motorcycle. In the case involving the bicyclist, a helmet was not worn. Additionally, in four cases, a seatbelt was not worn by the child, nor was a booster or car seat used as a protective measure. The following recommendation was submitted to and approved by the Commission from the child death panels: CDNDSC supports current laws regarding child placement and correct seating in motor vehicles.

Bicycle

The proper use of a helmet while bicycle riding has been shown to mitigate the severity of traumatic brain injury in children.[16] Between 2003 and June 2010, eight children (all White male) died on their bicycle while not wearing their helmet. In response to this concern, CDNDSC partnered with a Girl Scout (Lizzie Birney) earning her Silver Award, Smyrna Police Department, and Smyrna's Rita's Water Ice to send a preventive message to the community. Lizzie made 250 coupons, redeemable at Rita's for a free water ice or custard. The Smyrna police officers distributed the coupons to children who were wearing a helmet while bicycling. Approximately 25 families redeemed the coupons that summer. Delaware requires all kids younger than 18 years of age to wear a helmet when cycling. Parents of kids who violate the law can be fined $25 for the first offense and $50 for each subsequent offense.

"I figured kids would feel better about wearing a helmet if they were rewarded for doing it. Kids my age care about how they look and they think it will look silly to wear a helmet, but I'm hoping I can get more kids to wear helmets by rewarding them." - Lizzie Birney

Motor Vehicle Car Seat/Booster Seat usage

Delaware law requires children to be in a car seat or booster seat until age eight or 65 pounds, whichever comes first. It also prohibits children under the age of 12 from sitting in the front seat when an air bag is present. The fine for violating the law is $25 plus court costs. In the last two years, three dozen Delaware children have been injured or killed in car crashes in which seat belts or child seats were missing or used incorrectly, according to Delaware's Office of Highway Safety. Improperly secured child seats in vehicles are surprisingly common. The Office of Highway Safety estimates that four out of five are not used correctly. As a result of two deaths (reflected in this report), the New Castle County Head Start program renewed its focus to educate parents on child safety car seats and booster seats. Head Start also provided a limited number of booster seats to the community and conducted a booster seat donation drive with the deceased children's grandmother.[18]

[15] The News Journal, Putting brakes on teen crashes, October 17, 2012

[16] Tobias A. Mattei, M.D., Brandon J. Bond, B.A., Carlos R. Goulart, B.S., Chris A. Sloffer, M.D., M.B.A., Martin J. Morris, Ph.D, and Julian J. Lin, M.D. Performance analysis of the protective effects of bicycle helmets during impact and crush tests in pediatric skull models. Journal of Neurosurgery: Pediatrics Dec 2012 / Vol. 10 / No. 6 / Pages 490-497. Available at: http://thejns.org/doi/abs/10.3171/2012.8.PEDS12116

[17] The News Journal, Safety is Sweet, September 5, 2011

[18] The News Journal, Keeping Kids Safe with Car Seats, November 20, 2012

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.

DELAWARE

Delaware Child Death Review Section... (continued from page 27)

Bicycle / Motor Vehicle / Pedestrian Deaths

What you need to know regarding seat belt safety [19]

- *Wearing a seat belt decreases your risk of being seriously injured or killed in a crash by 50%.*
- *Unbelted occupants in crashes are three times more likely to require a hospital stay.*
- *On average, hospital costs for an unbelted crash victim is 55% higher than those of a belted victim.*
- *Strong seat belt laws protect families. When parents are buckled up, 90% of the time their children are too.*

What you can do

- *Follow the seat belt law every time you get in the car and remind others to do the same. Not only could it save your life, but help you avoid needless fines.*
- *Everyone in the vehicle, including back seat passengers and children, must wear seat belts properly. Shoulder and lap belts must be worn across the chest and low on the hips.*
- *The driver will receive a ticket for anyone in the vehicle who does not buckle up. Fines are $25 plus court costs, which can total more than $70.*
- *Support changes to our current system such as raising the minimum required hours of supervised driving time from 50 hours to 65 hours and prohibit all passengers (aside from the supervising driver) when teenagers have their learner's permit. Delaware currently allows one passenger, excluding family members.*

Pedestrian

Of the four pedestrian deaths, two were female and two were male. Three child deaths occurred in a suburban area and one in a rural area. Many were not supervised, due to developmental age appropriateness, at the time of death.

Safety 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 systems. 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.

[19] Delaware Office of Highway Safety, May 2012 Newsletter, Available at: www.ohs.delaware.gov/

Bicycle / Motor Vehicle / Pedestrian Deaths (continued)

Motor Vehicle and Other Transport Death Demographics

Position of Child	Driver	Passenger	On Bicycle	Pedestrian	Total
Age Group					
<-1	0	0	0	0	0
1-4 Years	0	1	0	0	1
5-9 Years	0	2	0	1	3
10-14 Years	1	1	0	1	3
15-17 Years	3	2	1	2	8
Total	**4**	**6**	**1**	**4**	**15**
Sex					
Male	2	2	1	2	7
Female	2	4	0	2	8
Total	**4**	**6**	**1**	**4**	**15**
Ethnicity					
Hispanic (Any Race)	0	2	0	1	3
Race					
White	4	5	1	2	12
Black, African American	0	1	0	2	3
Total	**4**	**6**	**1**	**4**	**15**
Area Where Incident Occurred					
Urban	0	2	0	0	2
Suburban	3	1	1	3	8
Rural	1	3	0	1	5
Total	**4**	**6**	**1**	**4**	**15**

Delaware Child Death Review Section... (continued from page 29)

Risk Factors of Young Drivers (Ages 14-18) Involved in the Crash

	Drivers Involved in Incident Ages 14-18		
Risk Factors	Child was Driving	Driver of Childs Vehicle	Driver of Other Primary Vehicle
Deaths Reviewed	4	1	3
Responsible for causing incident	4	1	3
Alcohol/drug impaired	0	0	0
No license	0	0	0
Suspended license	1	0	0
Violating graduated licensing rules	0	0	0
Two or more teen passengers (ages 14-21)	1	1	0

Driving Conditions	All Deaths Involving Drivers Ages 14-18
Deaths Reviewed	7
Loose gravel	0
Muddy roads	0
Ice/Snow	0
Fog	0
Wet roads	1
Construction zone	0
Inadequate Lighting	0

Footnote: Columns do not add up to total because the factors are not mutually exclusive.

Vehicle Type Involved in Incident and Position of Child

Position of Child	Driver	Passenger	Not in a Vehicle	Total
Vehicle Type Child In/On				
Car	2	4	0	6
SUV	0	1	0	1
Truck	1	1	0	2
Pedestrian	0	0	4	4
Motorcycle	1	0	0	1
Bicycle	0	0	1	1
Total	4	6	5	15

Motor Vehicle Protective Measures

Position of Child	Driver	Passenger	On Bicycle	Pedestrian	Total
Deaths Reviewed	4	6	1	4	15
Protective Measure Present and Used Correctly					
Airbag	1	4	0	0	5
Lap Belt	1	2	0	0	3
Shoulder belt	1	2	0	0	3
Helmet	1	0	0	0	1
Protective Measure Present and Not Used					
Lap Belt	1	3	0	0	4
Shoulder belt	1	3	0	0	4
Booster seat	0	2	0	0	2
Protective Measure Needed But None Present					
Child seat	0	1	0	0	1
Helmet	0	0	1	0	1

Footnote: Columns do not add up to total because more than one protective measure could have been used.

DELAWARE

Fire / Drowning / Homicide Deaths

FIRE DEATHS

One death reviewed was due to fire. The female child was less than four years old. The child was not supervised but supervision was needed given the circumstances. The child was playing with a lighter at the time of the fire erupting.

DROWNING DEATHS

Drowning is a leading cause of death worldwide for boys ages 5 to 14, and in the United States it is the second-leading cause of injury-related death for children 1 to 4.[20] More than one in five fatal drowning victims are children age 14 and younger. For every child who dies from drowning, another four receive emergency department care for nonfatal submersion injuries.[21]

The Commission reviewed three deaths due to drowning. Of those three deaths, two were in a residential pool and one occurred in a river. Two cases were Black males and one case was a White male child. In one case, a child between the ages of 5 to 9 was not properly supervised. Proper supervision of children is the best way to prevent a child from drowning. Two near drowning incidents and one homicidal drowning are not included in these figures as they are reflected in the abuse/neglect section. The homicidal drowning was reflected upon in an earlier annual report as this statistic is part of the final CAPTA cases.

"The CDC reports that a total of 3,042 children and teens died by gunfire in 2010-a number nearly equal to the total number of U.S. combat deaths in Iraq and 4x the number of American combat fatalities in Afghanistan to date." [23]

HOMICIDE DEATHS (NOT DUE TO ABUSE/NEGLECT)

The Commission reviewed two homicide cases not due to abuse or neglect. The deaths involved one Black and one Multi-racial child. They were in the age ranges of 15 to 17 years and involved handguns. One of these cases may have been caused by a possible retaliation and gang involvement. The other case involved a robbery. Both males had juvenile criminal history and possible drug involvement. Both victims knew their perpetrator as an acquaintance. One child had history with DFS as a child.

As a result of the tragedy in Newtown, Connecticut, The American Academy of Pediatrics reaffirmed their 1992 position that guns being absent in a child's home and community is the most reliable and effective measure to prevent future firearm related injuries in children and adolescents. In 2010, there were 6,570 deaths due to gun violence for children and young people (1 to 24 years of age). That equates to seven deaths per day. Gun injuries occur five times more often than heart disease, twice as many times as cancer, and 15 times as many as infections. Specific measures of support to reduce these tragedies include the regulation of the manufacture, sale, purchase, ownership, and use of firearms; a ban on semi-automatic assault weapons; and expanded regulations of handguns for personal use.[24]

In 2010, firearm injuries in this country cost $174 billion and the government's firearm injury bill exceeded $12 billion. It is estimated that firearm injury costs approximately $645 per gun in this country. These costs include medical and mental health care costs; criminal justice associated costs, wage losses, and lost quality of life.[25]

[20] David Szpilman, M.D., Joost J.L.M. Bierens, M.D., Ph.D., Anthony J. Handley, M.D., and James P. Orlowski, M.D. Drowning Is a Leading Cause of Death for Boys Worldwide , N Engl J Med 2012; 366:2102-2110, May 31, 2012DOI: 10.1056/NEJMra1013317 Available at: http://www.nejm.org/doi/full/10.1056/NEJ Mra1013317

[21] Available at: http://www.cdc.gov/HomeandRecreational Safety/Water-Safety/waterinjuries-factsheet.html

[22] Available at the following link: Protect the Ones You Love from Drowning

[23] Children's Defense Fund, Protect Children, Not Guns, Available at: http://www.childrensdefense.org/child-research-data-publications/data/protect-children-not-guns.html

[24] Firearm-Related Injuries Affecting the Pediatric Population Committee on Injury and Poison Prevention, Pediatrics Vol. 105 No. 4, April 1, 2000, pp. 888 -895 Available at: http://pediatrics.aappublications.org/content/105/4/888.full

[25] Miller T.R., The Cost of Firearm violence, Children's Safety Network Economics and Data Analysis Resource Center, at Pacific Institute for Research and Evaluation, December 2012, Available at: http://www.childrenssafetynetwork.org/cost-gun-violence

Prevention Tips[22]

Learn life-saving skills. Everyone should know the basics of swimming (floating, moving through the water) and cardiopulmonary resuscitation (CPR).

Fence it off. Install a four–sided isolation fence, with self–closing and self–latching gates, around backyard swimming pools. This can help keep children away from the area when they aren't supposed to be swimming. Pool fences should completely separate the house and play area from the pool.

Make life jackets a "must." Make sure kids wear life jackets in and around natural bodies of water, such as lakes or the ocean, even if they know how to swim. Life jackets can be used in and around pools for weaker swimmers too.

Be on the look out. When kids are in or near water (including bathtubs), closely supervise them at all times. Adults watching kids in or near water should avoid distracting activities like playing cards, reading books, talking on the phone, and using alcohol or drugs.

POISONING, OVERDOSE OR ACUTE INTOXICATION DEATHS

The Commission reviewed a total of four deaths due to poisoning, overdose or acute intoxication. In four of the deaths (two were female, two were male), the children were between the ages of 15 to 17. Of these, one death resulted from a suicide. The other deaths were accidental overdoses as a result of substance abuse (this is defined as including alcohol, prescription drugs, over the counter medication, or herbal medicines from the internet). Two deaths involved prescription drugs. Two near death cases were reviewed by the Child Abuse and Neglect (CAN) Panel for accidental overdose. They involved prescription drugs, over the counter drugs and a cleaning substance. In each of these cases, the child was unsupervised and had access to the substances. Both of these children were under the age of nine.

Poisoning deaths continue to increase among 15 to 19 year olds, largely due to prescription drug overdoses. According to other Centers for Disease Control (CDC) research, appropriate prescribing, discouraging medication sharing, proper storage and disposal, and state-based prescription drug monitoring (such as implemented by Governor Markell on July 15, 2010)[26] programs could reduce these deaths.[27]

SUICIDE

Suicide has surpassed motor vehicle crashs as the leading cause of injury-related deaths in this country. It is estimated that suicides have risen by 15% in the last decade, while motor vehicle deaths have decreased by 25% during the same period.[28] Delaware and surrounding states are starting to see that increase in teen suicides. Between January 1 and May 4, 2012, 11 teen deaths by suicide occurred in Kent and Sussex counties. 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 to 21 years in the same counties during this time period.[29] 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. They also commented on how well Delaware responded with cooperation among the Department of Education, the affected schools, law enforcement, The Division of Prevention and Behavioral Health Services (DPBHS), Delaware Health and Social Services, and many other organizations.

DPBHS offered onsite assistance to each of the individual schools that were affected and accelerated a suicide prevention program[30] 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 and an additional 3,200 teachers and other school staff in an adult module. For 2013, DPBHS will again be aggressive in offering this program to any Delaware middle or high school. In addition to schools, this campaign has been extended to community youth organizations such as sports, scouting, summer camps, etc. In addition, several community events occurred as a result of these tragedies. CDNDSC participated in the Dover Teen Suicide Prevention Expo on May 3, 2012 along with Contact Lifeline, Mental Health Association of Delaware and DPBHS.

The CDNDSC review of these deaths started in October 2012 at an all day Kent/Sussex Child Death Panel. However, the reviews are not yet complete as the panel felt they needed additional information to fully review the deaths. The system recommendations and risk factors will be fully addressed in the CY 2013 CDNDSC Annual Report.

The Commission completed three child death reviews due to suicide during the time period of this report. This number does not reflect the 2012 suicide cluster in Kent/Sussex counties. Those deaths will be reflected in the CY 2013 annual report. ■

...it is possible to detect risk factors for suicide in youth, and prevent suicidal behaviors in vulnerable young persons."

- CDC Epi-Aid Delaware Investigative Report

[26] Senate Bill 235 as amended by Senate Amendment No. 2 Available at: http://delcode.delaware.gov/session-laws/ga145/chp396.shtml

[27] The CDC National Action Plan for Child Injury Prevention: Protecting Our Nation's future, Available at: http://www.cdc.gov/safechild/nap/index.html

[28] Ian R. H. Rockett, PhD, MPH, Michael D. Regier, PhD, Nestor D. Kapusta, MD, Jeffrey H. Coben, MD, Ted R. Miller, PhD, Randy L. Hanzlick, MD, Leading Causes of Unintentional and Intentional InjuryMortality: United States, 2000–2009 Available at: http://ajph.aphapublications.org/doi/pdf/ 10.2105/AJPH.2012.300960

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

[30] 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 re-sources 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, and parents, and students.

WHAT SHOULD PARENTS DO?

1. Educate yourselves – drugfree.org offers support, tools, resources and answers.
2. Communicate the risks of prescription drug abuse to your kids. Children who learn a lot about the risks of drugs are up to 50% less likely to use drugs.
3. Safeguard your own medicines. Keep prescription medicine in a secure place, count and monitor the number of pills you have. Learn more at: www.drugfree.org

Delaware Child Death Review Section... (continued from page 33)

Acts of Omission/Commission Suicide Information

	SUICIDE		
	Caused	Contributed	Total
Death Reviewed	3	0	3
Child History			
History of substance abuse	1	0	1
Drug/alcohol impaired at time of accident	1	0	1
Criminal history on delinquency	1	0	1
Spent time in juvenile detention	1	0	1
CPS Involvement			
Open CPS at the time of death	0	0	0
Investigation found evidence of prior abuse	2	0	2
Child had history of maltreatment as victim	2	0	2
Child placed outside of home	2	0	2
Circumstances			
Child talked about suicide	2	0	2
Prior suicide threats were made	1	0	1
Suicide was completely unexpected	2	0	2
Child had received prior mental health services	1	0	1
Child was receiving mental health services at time of death	1	0	1
Leading Reason that may have contributed to Child's Death			
Family discord	3	0	3
Argument with parent	2	0	2
School Failure	1	0	1
Rape/Sexual abuse	1	0	1
Problems with law	1	0	1
Breakup with boyfriend/girlfriend	1	0	1

Footnote: Includes all cases where actions of omission/commission caused or contributed to the death was reported by team as Yes or Probable (Section I, Question 1 in CDR Case Reporting System). Child placed outside of home refers to placement in foster care including licensed and relative/kinship foster homes.

Unsafe Slepping Practice Deaths (Undetermined, SUID, and SIDS)

In FY 2012 and CY 2012, 24 deaths were reviewed in Delaware due to infant unsafe sleeping. The Commission continues to see approximately one to two referrals every month due to this type of death. The 24 cases are only reflective of the cases reviewed by the CDR panels; not actual calendar year infant unsafe sleeping data collected through Delaware's Office of Vital Statistics. Of the 24 unsafe sleeping deaths, two were Hispanic, eight were Black and 14 were White. Ten of the infants were females and 14 were males. In 79% of the cases (19 out of 24), the infant was **NOT** sleeping in a crib or bassinet. Moreover, in 71% (17 out of 24) of the cases, the infant was bed-sharing with another individual. Among the 24 cases reviewed, ten of the infants were not sleeping on their back. In one case, the infant was sleeping on a "boppy" (feeding and support pillow.) Of the 24 infant safe sleeping deaths, not one infant was being breastfed when discharged from the birthing hospital. Three of these cases involved a parent and/or caretaker who had consumed alcohol or was drug impaired 24 hours prior to the infant's death.

One initiative CDNDSC has undertaken during CY 2012 is utilizing the maternal interviewer from FIMR to offer bereavement, referrals and correct information to families who may have lost an infant to unsafe sleeping. This new practice is cutting-edge for child death review and this country. Research was conducted internationally on countries that already conduct maternal interviews patterned after the FIMR practice. These interviews will only occur if there is no litigation in the case.

Among the 506 cribs that were delivered state-wide in FY 2012 and CY 2012 through the Delaware Cribs for Kids program, only one infant of a parent or caretaker that received a crib and the mandatory infant safe sleep education has died due to unsafe sleeping. From the inception of the program in the fall of 2009 through December 31, 2012, 780 cribs have been distributed.

Delaware Child Death Review Section... (continued from page 35)

Unsafe Slepping Practice Deaths (Undetermined, SUID, and SIDS)

Unsafe Sleeping deaths are often preventable and it is critical that the public education on the risks of unsafe infant sleeping continue within the State of Delaware. As mentioned earlier, the Joint Commissions (CPAC and CDNDSC) along with the DHMIC continue to make this one of their top priorities.

I feel frustrated that I know so little about what caused my baby's death. I do not feel that SIDS is the true answer.

- Maternal Interview for an unsafe sleeping death.

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."

CDNDSC collaborated with the Office of Child Care Licensing to provide a child care facility with training regarding Infant Safe Sleeping Practices since unsafe sleeping practices were noted during the review.

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).*

Sleep-Related Death Demographics-Statewide

	Age Group	Male	Female	Total
Race				
Hispanic/Latino (any race)	4-5 Months	0	1	1
	6-7 Months	1	0	1
	Subtotal	**1**	**1**	**2**
White	0-1 Months	2	1	3
	2-3 Months	6	3	9
	4-5 Months	0	1	1
	8-11 Months	0	1	1
	Subtotal	**8**	**6**	**14**
Black, African American	0-1 Months	0	2	2
	2-3 Months	2	0	2
	4-5 Months	1	0	1
	6-7 Months	2	1	3
	Subtotal	**5**	**3**	**8**
Multi-racial	2-3 Months	1	0	1
	Subtotal	**1**	**0**	**1**
Unknown	2-3 Months	0	1	1
	Subtotal	**0**	**1**	**1**
All Races	0-1 Months	2	3	5
	2-3 Months	9	4	13
	4-5 Months	1	1	2
	6-7 Months	2	1	3
	8-11 Months	0	1	1
	Subtotal	**14**	**10**	**24**

Sleep-Related Deaths by Cause

	Cause of Death					
	SIDS	Asphyxia	Medical Condition	Undetermined	All Other Causes	Total
0-1 Months	1	1	0	2	1	5
2-3 Months	2	1	3	5	2	13
4-5 Months	0	0	0	1	1	2
6-7 Months	1	1	0	1	0	3
8-11 Months	0	0	0	1	0	1
Total	4	3	3	10	4	24

Footnote: Medical conditions including unknown medical causes. Undetermined included undetermined deaths from both medical and injury causes. All others causes included deaths from other unknown causes and undetermined if injury or medical casuses and cases where the cause was left blank.

Circumstances Involved in Sleep-Related Deaths

	Age Group					
	0-1 Mos	2-3 Mos	4-5 Mos	6-7 Mos	8-11 Mos	Total
Unobstructed by person or object	0	1	0	1	0	2
On top of person	0	1	0	0	0	1
On top of object	0	3	0	2	0	5
Under person	1	2	0	0	0	3
Between person	0	0	0	0	1	1
Wedged	1	1	0	0	0	2
Unknown	3	5	2	0	0	10
Total	5	13	2	3	1	24

Factors Involved in Sleep-Related Deaths

	Age Group					
	0-1 Mos	2-3 Mos	4-5 Mos	6-7 Mos	8-11 Mos	Total
Deaths Reviewed	5	13	2	3	1	24
Not in a crib or bassinet	4	10	2	2	1	19
Not sleeping on back	1	6	1	1	1	10
Unsafe bedding or toys	2	3	0	1	0	6
Sleeping with other people	4	8	2	2	1	17
Obese adult sleeping with child	1	0	0	1	0	2
Adult was alcohol impaired	1	0	0	0	0	1
Adult was drug impaired	1	1	0	0	0	2
Caregiver/Supervisor fell asleep while bottle feeding	2	0	0	0	0	2

Footnote: Columns do not add up to total deaths because the factors are not mutually exclusive. If factor is unknown, it is not included in these counts. Portable cribs may inadvertently be counted as not in a crib or bassinet since they are typically coded as "other". Unsafe bedding or toys include pillow, comforter, or stuffed toy.

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.)

Within the last year, CDNDSC along with CPAC representatives have taken a closer look at improving the recommendation process. One of those changes is to include the rationale, anticipated result and responsible agency for each recommendation. Many of the recommendations contained in this annual report are in that format; however, some were voted upon prior to this change.

In total, 75 recommendations were made by the Child Death Review (CDR) Panels, and the Child Abuse and Neglect (CAN) Panel was responsible for the majority of these recommendations. These recommendations are tracked and identified through the following categories: Administrative, Best Practices, Child Well Being, Compliance, Legal, and Training. In fact, within the last year, eight administrative, 37 best practices, one child well being, 20 compliance, four legal, and five training recommendations were made. These totals do not include the ancillary and supportive statements that were also made for several cases.

Although this categorical structure was recently implemented, CDNDSC has been able to glean several trends. First, the prevalent findings related to best practices and compliance suggested that existing policies were either not accomplishing the goal of keeping children safe or were not being followed by agency representatives. As a result, several recommendations proposed ways to improve the investigative practices used in cases of child abuse and neglect. For instance, it was recommended that DFS and law enforcement seek immediate medical care for a child when allegations are received that a child was shaken. Also, CDNDSC noted the common theme in these reviews was that professionals investigating child abuse and neglect must work together as a multidisciplinary team and utilize the Memorandum of Understanding as a guide for best practices.

In terms of agency specific recommendations, 34 pertained to the Department of Services for Children, Youth and Their Families and 24 pertained to the medical community. The remaining 17 recommendations were relevant to the Child Protection Accountability Commission, Department of Education, Department of Justice, Family Court, law enforcement, Mental Health Association, and other agencies.

In the future, CDNDSC will continue to work with CPAC to identify ways to address concerns with best practices and compliance with agency specific policies, procedures, and standards of care. Additionally, CDNDSC and CPAC plan to implement a protocol to ensure recommendations from these reviews are implemented. As such, in next year's annual report, CDNDSC hopes to include the responses submitted by our child welfare partners in response to the recommendations.

These recommendations will continue to influence CDNDSC and CPAC's priorities for the next year. In fact, supporting and enhancing current practice in investigations and prosecutions of child abuse is the focus of the 2013 Protecting Delaware's Children Conference. Through national and local subject matter experts, CDNDSC and CPAC hope to provide resources and/or model practices to support Delaware's child welfare partners in the implementation of these recommendations.

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

ACKNOWLEDGEMENTS[31]

1. CDNDSC shall send a letter to the Department of Services for Children, Youth, and Their Families applauding the exquisite investigative efforts that were put forth by the DFS' caseworker and Family Crisis Therapist. (Ancillary[32] Recommendation)

AGENCY SPECIFIC RECOMMENDATIONS

I. CHILD PROTECTION ACCOUNTABILITY COMMISSION

ADMINISTRATIVE[33]

No recommendations were put forth.

BEST PRACTICES[34]

1. CDNDSC recommends that research be conducted to review national standards as to what other Child Protection Services are doing with regard to families that present with multigenerational histories of child abuse and neglect. (Ancillary Recommendation)
   a. Rationale: To establish best practice in the State of Delaware for cases of child abuse and neglect.
   b. Anticipated Result: Best practices in Delaware.
   c. Responsible Agency: Child Protection Accountability Commission

CHILD WELL BEING[35]

No recommendations were put forth.

COMPLIANCE[36]

No recommendations were put forth.

LEGAL[37]

No recommendations were put forth.

TRAINING[38]

1. CDNDSC recommends that the Child Protection Accountability Commission develop training for first responders regarding abusers of prescription drugs and best practices through potential funds secured by the Children's Justice Act.

II. DEPARTMENT OF EDUCATION

ADMINISTRATIVE

No recommendations were put forth.

BEST PRACTICES

1. CDNDSC recommends that school districts develop policy for when a suicide or suicide attempt occurs on how the school will not only handle such an event, but also if a child presents with suicidal ideations when and how to contact the parent/caregiver.
   a. Rationale: Caregiver was not informed that the child was threatening to harm himself and that an intervention had occurred on school grounds. If a caregiver had been contacted and informed of the circumstances a heightened sense of supervision might have been placed on the child and additional resources may have been provided.
   b. Anticipated Result: To establish school policy and procedure for crisis events.
   c. Responsible Agency: Department of Education

[31] 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.

[32] In some cases there may be no system practices or conditions that impacted the death or near death of the child; however if the Panel determines that there are ancillary factors which impact the safety or mortality of children, those factors are compiled by CDNDSC staff and presented at least annually to the Commission for possible action.

[33] Administrative recommendations may suggest an internal review by an agency, report employee performance issues or refer to any other finding that requires an administrative response or action.

[34] Best practice recommendations may suggest revisions to existing methods, techniques or policies/procedures or implementation of new methods, techniques or policies/procedures, which are superior to those currently used by the agency and/or which may be currently used by other jurisdictions.

[35] Child well being recommendations may suggest practices that will enhance the physical, psychological, cognitive, or social health and development of children or practices which consider the impact of trauma and avoid re-traumatization of abused and neglected children.

[36] Compliance recommendations may identify agency or organization specific policies, procedures or standards of care, which were not followed by agencies involved in investigating and overseeing the welfare of children.

[37] Legal recommendations may document a failure to comply with state or federal laws/regulations, advocate for new legislation or revise existing legislation.

[38] Training recommendations may suggest that agencies access, develop or provide specific education or training on the various standards, criteria, or investigative practices used in cases of child abuse and neglect.

2. CDNDSC recommends that all school educators and staff participate in the Lifelines training as provided by the Delaware Suicide Prevention Coalition.

   a. Rationale: Education/training will prepare anyone over the age of 15 to identify persons with thoughts of suicide and connect them to suicide first aid resources. The training also addresses how to respond to threats or signs of suicide and intervene - before it's too late, and how to successfully address and respond to not only suicide, but any type of traumatic death that profoundly affects the school population.

   b. Anticipated Result: To offer help and resources to children who pose a threat to themselves and others.

   c. Responsible Agency: Mental Health Association, Suicide Prevention Coalition

CHILD WELL BEING

No recommendations were put forth.

COMPLIANCE

No recommendations were put forth.

LEGAL

No recommendations were put forth.

TRAINING

No recommendations were put forth.

III. DEPARTMENT OF JUSTICE

ADMINISTRATIVE

No recommendations were put forth.

BEST PRACTICES

1. CDNSDC recommends that during the investigation or prior to case closure, the DFS worker (supervisor and/or caseworker) should consider whether or not verbiage pertaining to the custody of the child was discussed and whether or not a consult with the Attorney General's Office was completed as it pertains to the custody of the child. (Repeated within the DSCYF section)

   a. Rationale: During review of this case, it was determined that custody of the child should have been sought by DFS due to the history of the parent and current circumstances which allowed DFS to become involved with the child and family once again. Custody was not sought, nor did discussion occur between DFS and the Deputy Attorney General (DAG) even though concern was raised as to whether or not the child should come into care.

   b. Anticipated Result: Improved communication between DFS and the DAG as it pertains to the custody of the child.

   c. Responsible Agency: DOJ and DSCYF

CHILD WELL BEING

No recommendations were put forth.

COMPLIANCE

1. CDNDSC recommends that there be compliance with the Memorandum of Understanding between the Department of Services for Children, Youth and Their Families, the Children's Advocacy Center, the Department of Justice (DOJ), and Delaware Police Departments as it pertains to the use of multidisciplinary teams and information sharing for both civil and criminal proceedings. (Ancillary Recommendation)
2. CDNDSC recognizes that the goal for every child is permanency. Therefore, CDNDSC urges that the criminal procedures of a case follow a more definitive timeline with regard to the investigation resulting in charging, trial/plea, and/or sentencing. Furthermore, CDNDSC urges that the criminal investigation be more thorough and expedited by Delaware law enforcement agencies and the Department of Justice. (Ancillary Recommendation, Repeated in Law Enforcement section)
3. CDNDSC recommends that DFS review policy as it pertains to consults with the Department of Justice's Deputy Attorney Generals (DAG). (Repeated within the DSCYF section)
    a. Rationale: The children were considered to be safe because their father was in the home and as available through his extended family and daycare service. However, mother's history of non-compliance and unsuccessful completion of treatment services combined with the concerns noted in previous investigations, as well as the father's work schedule did not appear to be considered when assessing the safety of the children. Prior to case closure, the DAG should have been contacted in order to determine if there were grounds to take custody of the children.
    b. Anticipated Result: Proper consultation with the DAG by DFS in cases where family has extensive history and noncompliant.
    c.Responsible Agency: DOJ and DSCYF

LEGAL

No recommendations were put forth.

TRAINING

1. CDNDSC recommends that the Department of Justice and the DSCYF review its legal training for caseworkers to ensure adequacy, efficiency, and uniformity is being offered in each county. (Ancillary Recommendation, Repeated within the DSCYF section)
2. CDNDSC supports the use of multi-disciplinary team trainings for each county as provided by the Children's Advocacy Center and the Child Protection Accountability Commission. (Supportive Statement,[39] Repeated within the DSCYF and Law Enforcement section)
3. CDNDSC recommends that the medical profession educate the DFS, the Department of Justice and law enforcement on all substance abuse screening within Delaware hospitals. It is further recommended that cross training occur among these professions as to the treatment received for such substances and the impact that such substances have on the abuser's ability to care for their children. (Repeated within the Medical section)
    a. Rationale: Mother took a Percocet right before she went into labor and didn't realize it would show up in her system. Mother states she was experiencing severe back labor pain, was dehydrated, and could not walk. She says the baby had already started to come out before she had reached the hospital and she had to be carried in. Mother denies taking any other drugs or having issues with them.

[39] A supportive statement will be set forth by the panels when there is no role for a specific agency/entity to act upon. However, for tracking and documentation purposes the panel would like to support and acknowledge exceptional work, evidenced based programs or laws that would protect children.

b. Anticipated Result: It was reported to the Panel that certain hospitals only test for certain drugs during a urine drug screen. This allows a parent to manipulate the system if they are aware what hospitals test for what substances. It was also made known that certain hospitals do not test for the synthetic drug and therefore if used, the drug will not appear on the test. Cross education is important because it will create a greater awareness of what to look for in a drug screen as well as the impact that these drugs can have on the early development of a child.

c. Responsible Agency: Medical Society of Delaware

IV. DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH, AND THEIR FAMILIES

ADMINISTRATIVE

1. CDNDSC recommends that the DFS establish a point of contact and develop a systems protocol so that when outside committees and/or agencies have concerns regarding egregious cases, such cases can be brought before the point of contact in order to address said concerns.

   a. Rationale: Review of this case resulted in continued concerns of the well-being and safety of the children currently residing in the home. The panel determined that contact needed to be made with DFS to ensure that the children are safe with parent/caregiver.

   b. Anticipated Result: To ensure the safety and well-being of a child.

   c. Responsible Agency: DSCYF

2. CDNDSC recommends that a letter be sent to the Director of the DFS, informing the Director of the issues surrounding the caseworker's job performance and the caseworker's ability to follow DFS policy and procedure and the supervisory oversight or lack thereof that was given to said caseworker. CDNDSC recognizes that the caseworker's performance was reviewed in this case.

   a. Rationale: The caseworker in this case displayed poor performance during the investigation of this case placing the child at continued risk. Although the caseworker's performance was reviewed, the panel deemed it necessary to highlight the lack of supervisory oversight and worker's ability to comply with policy.

   b. Anticipated Result: Acknowledgement of the performance issues within this case in order to ensure that they do not continue by either caseworker or supervisor.

   c. Responsible Agency: CDNDSC

BEST PRACTICES

1. CDNDSC recommends that DSCYF shall establish policy that states prior to closing any case as unsubstantiated, where a death or near death occurs, the case must be signed off by a senior Deputy Attorney General. (Ancillary Recommendation)

2. CDNDSC recommends that in addition to the child's medical records, growth charts be included and made available to DSCYF and Family Court so that proper tracking of the child's growth can be reviewed by all agencies involved. (Repeated within the Family Court section)

   a. Rationale: To ensure that proper tracking of the child's growth can be reviewed by all agencies involved in order to ensure the child's well-being.

3. CDNDSC supports the DFS review of the Hospital High Risk Medical Discharge Protocol for children and youth with special medical needs.

a. Rationale: To ensure that appropriate care of the child will be provided prior to and after discharge.

b. Anticipated Result: Appropriate communication among DFS and Delaware hospitals as it pertains to child's care management and concerns by hospital.

c. Responsible Agency: DSCYF

4. CDNDSC supports the use of the Hospital High Risk Medical Discharge Protocol. (Repeated within the Medical section)

   a. Rationale: The purpose of this protocol is to ensure that children are discharged into an environment that is safe and supportive of their medical needs. In the above mentioned case, DFS was not notified of the child's positive urine drug screen until the day of discharge. If the Hospital High Risk Medical Discharge Planning Meeting had been utilized then DFS and the birthing hospital would have had more time to appropriately plan for the child's discharge as a meeting would have been called utilizing a team approach which would have included family, social worker/nurse case manager, and DFS.

   b. Anticipated Result: To ensure the safety of a child upon discharge

   c. Responsible Agency: Delaware Hospitals and DSCYF

5. CDNDSC recommends that the DFS clarify and better define how cases shall be abridged or administratively discontinued. CDNDSC further requests, that such cases be tracked and a comparison drawn against the number of cases received by the DFS versus the number of cases being abridged and/or administratively discontinued.

   a. Rationale: To establish a guide for cases that qualify for administrative discontinuance or abridgement and track cases in which this is occurring.

   b. Anticipated Result: To provide a better understanding and/or explanation for cases that meet the criteria for being administratively discontinued and/or abridged.

   c. Responsible Agency: DSCYF

6. CDNDSC recommends that the DFS develop policy regarding verification of medical, mental health, and substance abuse issues by a medical professional instead of relying on the word of the parent(s) and/or suspected abuser(s).

   a. Rationale: In this case, the caseworker did not follow up with medical, mental health and/or substance abuse providers in order to ensure that the information provided by the parent(s) was accurate.

   b. Anticipated Result: To ensure proper collateral contacts within a case in order to support or oppose the information provided by the parent(s).

   c. Responsible Agency: DSCYF

7. CDNDSC recommends that during the investigation or prior to case closure, the DFS worker (supervisor and/or caseworker) should consider whether or not verbiage pertaining to the custody of the child was discussed and whether or not a consult with the Attorney General's Office was completed as it pertains to the custody of the child. (Repeated within the DOJ section)

a. Rationale: During review of this case, it was determined that custody of the child should have been sought by DFS due to the history of the parent and current circumstances which allowed DFS to become involved with the child and family once again. Custody was not sought, nor did discussion occur between DFS and the Deputy Attorney General (DAG), even though concern was raised as to whether or not the child should come into care.

b. Anticipated Result: Improved communication between DFS and the DAG as it pertains to the custody of the child.

c. Responsible Agency: DSCYF and DOJ

8. CDNDSC recommends that the DFS review policy and procedure for when a worker is to transfer a case from investigation to treatment, that policy and procedure should reinforce the importance of verbal communication between caseworkers and that such communication should also be documented within Family and Child Tracking System (FACTS).

a. Rationale: The investigation was closed and the case was transferred to treatment. Although case facts were properly documented within the FACTS, there was not direct communication between the investigation worker and treatment worker as to the current concerns for the child and family.

b. Anticipated Result: Better communication among investigation and treatment workers as it pertains to the facts, issues and continued concerns within a case.

c. Responsible Agency: DSCYF

9. CDNDSC recommends that DSCYF redefine case findings/dispositions to terminology that is logical, consistent, factual, and uniform. (Ancillary Recommendation)

a. Rationale: The Child Abuse and Neglect Panel has reviewed numerous cases in which there is conflict with the findings/dispositions of a case.

b. Anticipated Result: To create more clarity in the disposition of cases and allow for more uniform terminology.

c. Responsible Agency: DSCYF and CPAC

10. 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. (Ancillary Recommendation)

a. Rationale: A pattern of abuse/neglect has been identified by the CAN Panel along with a multigenerational history of abuse and these cases require more in-depth support and investigative services.

b. Anticipated Result: To ensure the safety of all children known to DFS and provide earlier intervention where needed for families with multigenerational and chronic patterns of child abuse and/or neglect.

c. Responsible Agency: CPAC

11. CDNDSC recommends that the DFS consider a way to track all changes made by caseworkers in the FACTS system in order to prevent the falsification/alteration of documents.

a. Rationale: It was noted that documentation was not written within FACTS according to policy which states that documentation must occur within 48 hours.

b. Anticipated Result: Compliance with policy and better documentation.

c. Responsible Agency: DSCYF

12. CDNDSC recommends that when the DFS and law enforcement receive a report alleging Abusive Head Trauma (AHT), that the child be brought to the Emergency Department for evaluation as injuries are often internal and not visible upon first impression. (Repeated within Law Enforcement section)

    a. Rationale: A DFS caseworker and police officer were called to the residence to investigate allegations of abuse; specifically, AHT, possible near drowning and beatings. The DFS caseworker and police officer removed child's clothing and observed the child. Alleged father reported that child was seen earlier that day at a hospital and was given a clean bill of health. Neither the caseworker nor the police officer followed up with the hospital to ensure such statements and the child was not transported to the Emergency Department for further evaluation.

    b. Anticipated Result: Thorough examination of the child in order to rule out internal injuries that could be caused as a result of AHT.

    c. Responsible Agencies: DSCYF

13. CDNDSC recommends that the DFS' Collateral Contact Information Sheet be amended to include questions pertaining to Neonatal Abstinence Syndrome (NAS), as well as if DFS has concern of substance abuse, physical abuse, sexual abuse, emotional maltreatment, and neglect.

    a. Rationale: Collateral contacts are not descriptive enough as to why the child(ren) and/or family is involved with the DFS. If parents have signed consent forms then information should be made readily available to the DFS, the PCP and other parties involved in the care of the child. Information that the DFS may not deem relevant may be of significance to other parties involved.

    b. Anticipated Result: The medical community and other community partners are able to identify high risk problems that could put the child at risk of harm.

    c. Responsible Agency: DSCYF

14. CDNDSC recommends that when there is an active investigation and a child leaves the State during the investigation, that the State in which the child is going, be contacted and informed of the allegations of the investigation and a home assessment be requested concerning the residence in which the child will be residing.

    a. Rationale: Child was immediately sent to another state during an active investigation. Follow up did not occur with this state's CPS; therefore, safety of child was unable to be assessed. Follow up did occur with the family.

    b. Anticipated Result: Child will continue to be monitored by a Child Protection Agency upon leaving the State.

    c. Responsible Agency: DSCYF

15. CDNDSC recommends that post discharge services be included in the Safety Plan for appropriate follow up by the DFS.

    a. Rationale: Christiana Care's Visiting Nurse Association was offered to family, but at the date of initial review it was unknown if such services were used by the family.

    b. Anticipated Result: Documentation of services to be received by child and/or family in order for appropriate follow up to occur by necessary parties.

    c. Responsible Agency: DSCYF

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16. CDNDSC recommends that the DFS re-evaluate the DFS Foster Care training and assessment of potential foster care placement families.

    a. Rationale: In this case, after the death of the child, the child's siblings were placed in a foster home and then had to be replaced as the foster parents were unable to provide appropriate care to the children. In order to avoid multiple placements, a thorough assessment of placement and education of foster care parents should be performed. Foster families should be made aware of supports that can be utilized as a resource.

    b. Anticipated Result: To prevent multiple placements within foster care.

    c. Responsible Agency: DSCYF

17. CDNDSC recommends that DFS review policy and further define what is meant by "family" and "case" when assessing the safety of a child.

    a. Rationale: During the previous DFS investigations, the DFS caseworker went out to the home in order to assess the safety of the newborn. However, the safety of the other children residing in the home was not assessed nor included in the safety plan that was implemented by DFS.

    b. Anticipated Result: To ensure the safety of all children residing in the home when a family becomes active with the DFS.

    c. Responsible Agency: DSCYF

18. CDNDSC recommends that the DSCYF reconsider the ability to substantiate a case for physical abuse and/or neglect with perpetrator unknown.

    a. Rationale: Grave concern was raised by panel members about the closure of cases. Specifically, cases that are unsubstantiated because the perpetrator is unknown, but it is clear that abuse is occurring within the child's residence.

    b. Anticipated Result: To ensure the safety and well being of Delaware's children.

    c. Responsible Agency: DSCYF

19. CDNDSC recommends that confirmation occur immediately with medical personnel if the DFS receives a report of abuse AND if parents or caregivers state that the child was seen that day and medically cleared.

    a. Rationale: A DFS caseworker and a police officer were called to the residence to investigate allegations of abuse; specifically, AHT, possible near drowning and beatings. The DFS caseworker and police officer removed child's clothing and observed the child. Mother reported that child was seen earlier that day at the hospital and was given a clean bill of health.

    b. Anticipated Result: To ensure the well being of the child.

    c. Responsible Agency: DSCYF

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

    a. Rationale: Documentation did not reflect that safe sleeping practices were discussed with the parents. Bed-sharing is a factor noted at the time of death.

    b. Anticipated Result: To reduce the number of deaths associated with unsafe sleep environments.

    c. Responsible Agency: DSCYF

21. CDNDSC supports the DFS implementation of Structured Decision Making (SDM).

    a. Rationale: This evidence and research based system uses structured assessments to improve the consistency and validity of each case decision. The system consists of several assessments that help agencies work to reduce subsequent harm to children and to expedite permanency; such as, the intake assessment, the safety assessment, the risk assessment, family strengths and needs assessment, risk reassessment, and reunification assessment. The use of SDM in this case would have taken into consideration mother's history, lack of compliance, domestic violence issues, drug exposed infants, drug and substance abuse, and lack of protective factors, thus maybe changing the overall decision of the caseworker and allowing for consistent findings in cases where neglect is alleged due to the birth of drug positive infants.

    b. Anticipated Result: Ensure the safety and well being of the child and reduce future risk of harm to the child.

    c. Responsible Agency: DSCYF

22. CDNDSC recommends that the DFS revisit the job description of the Family Services Assistant (FSA), which is outlined within the Office of Management and Budget, in order to clarify that a FSA should not be able to conduct initial home assessments during an investigation.

    a. Rationale: In this case, the FSA conducted the initial home assessment for mother and paternal grandmother. FSA's are not trained to conduct investigations nor are they trained on assessing the safety of a child in the home. Therefore, it was noted that the home of mother and paternal grandmother was not properly assessed during the investigation AND the conditions of both father and paternal grandmother's home did not change prior to case closure.

    b. Anticipated Result: To ensure that during an investigation, a home assessment is completed by the investigation caseworker, so that a proper assessment can be conducted using the skills, training, and experience that have been provided to the investigation caseworker.

    c. Responsible Agency: DSCYF

CHILD WELL BEING

No recommendations were put forth.

COMPLIANCE

1. CDNDSC is to write a letter to the DFS addressing the agency's failure to comply with policy as it pertains to the investigation of case 9-03-12-00011.

    a. Rationale: After discharge child was not seen by caseworker for 28 days. On 6/02 a safety plan was put in place with requirements but 17days later, on 6/19, it is documented that the safety plan is not being followed and no action is taken by DFS to correct the matter. There is no indication of a home assessment with maternal great grandmother. On 7/16, a Hotline Report is made alleging possible AHT, near drowning and physical abuse. DFS second shift caseworker and DSP respond. Child is observed and determined to be okay. Due to the implications within the report to the Hotline, the child should have been examined at the hospital. Worker and Trooper did not attempt to verify parent's statements regarding the child's clean bill of health given by medical professionals that morning. There is also a failure on behalf of DFS to address mother's substance abuse issues and properly evaluate mother for such issues. It is also noted that documentation is not written within FACTS according to policy which states that it must be entered within 48 hours. Furthermore, it appears that the caseworker did not make objective

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observation of interactions with parent and child; instead statements were of the caseworker's opinion. On 6/30, a home visit was conducted by the caseworker and the child was observed to be asleep. This again is not consistent with the home visit policy, child must be awake. Lastly, there is no follow up with mental health to ensure the receipt of treatment.

b. Anticipated Result: Compliance with policy.

c. Responsible Agency: CDNDSC

2. CDNDSC shall send a letter to the DFS outlining the policy issues in the case of 9-03-2012-00018.
   a. Rationale: To inform the DFS where policy was not adhered to by the caseworker.
   b. Anticipated Result: To ensure compliance with DFS policy and procedure.
   c. Responsible Agency: CDNDSC
3. CDNDSC recommends that the DFS and the investigating law enforcement agency comply with the existing Memorandum of Understanding (MOU) between the DSCYF, the CAC, the DOJ, and Delaware Police Departments when conducting forensic interviews with a child who presents with serious mental and/or emotional disabilities. (Repeated within the Law Enforcement section)
   a. Rationale: To conduct a joint investigation using a multidisciplinary team when investigating cases of child abuse/neglect especially when a child presents with serious mental and/or emotional disabilities.
   b. Anticipated Result: Compliance with the MOU.
   c. Responsible Agency: DFS and Delaware Police Departments
4. The DFS and Law Enforcement shall comply with the MOU between the DSCYF, the Delaware CAC, the DOJ, and Delaware Police Departments as it pertains to joint investigations of child abuse and/or neglect. (Repeated within the Law Enforcement section)
   a. Rationale: To conduct a joint investigation using a multidisciplinary team when investigating cases of child abuse/neglect.
   b. Anticipated Result: Compliance with the MOU.
   c. Responsible Agency: DFS and Delaware Police Departments
5. CDNDSC shall recommend that DSCYF monitor and comply with the standard temperature of water for foster homes, daycares and contracted foster homes per the Delacare rules. In addition to childcare centers, CDNDSC recommends that DSCYF require DFS foster homes and contracted foster homes to comply with the requirements similar to rule 270 of Delacare prohibiting water temperatures higher than 120 degrees Fahrenheit.
   a. Rationale: Child was placed in a foster home where the standard water temperature exceeded 120 degrees, thus allowing the child to receive substantial burns to her body surface area while bathing. Child was unsupervised at the time of this incident.
   b. Anticipated Result: To ensure compliance of DFS foster home with Delacare Rules.
   c. Responsible Agency: DSCYF
6. CDNDSC recommends that the DFS follow policy as it pertains to the oversight of caseworkers by supervisors.

a. Rationale: During review of this case, it was noted by the panel that there was a lack of supervisory oversight.

b. Anticipated Result: To ensure compliance with policy as it pertains to oversight of caseworkers by supervisors.

c. Responsible Agency: DSCYF

7. CDNDSC recommends that the DFS follow policy as it pertains to the medical examination or medical screening of a child, under the age of nine, "based on the Medical Examination Protocol in the Investigation User Manual. Medical examinations shall be conducted by qualified medical staff."

a. Rationale: DFS did not have child examined by "qualified medical staff." Therefore, policy was not followed.

b. Anticipated Result: To ensure compliance with policy as outlined in the Investigation User Manual Protocol.

c. Responsible Agency: DSCYF

8. CDNDSC recommends that when a case is made known to the DFS and when a family has recently moved to Delaware from another state, that the caseworker follow policy and request information from that state's Child Protective Services and Criminal Justice Information System (CJIS) in order to rule out multigenerational or chronic patterns of child abuse and/or neglect and/or criminal offenses that may serve as a risk factor in assessing the safety of a child.

a. Rationale: During review of this case, it was noted that contact was not made with out-of-state CPS agencies by the caseworker. Therefore, history of the child and family was unknown.

b. Anticipated Result: To ensure the safety and well-being of the child.

c. Responsible Agency: DSCYF

9. CDNDSC recommends that the DFS follow policy as it pertains to interviewing or observing, within 24 hours, all other children not identified as victims, when the reported victim is determined to not be safe.

a. Rationale: Child was not seen until 48 hours after the death of her sibling. This delay caused the assault charge to be dropped as it could not be determined when the injuries occurred.

b. Anticipated Result: Siblings will be kept safe from possible safety threats.

c. Responsible Agency: DSCYF

10. CDNDSC recommends that DFS caseworkers comply with policy as it pertains to collateral contacts.

a. Rationale: After the child was born and the case was accepted for investigation, collateral contacts were not made with mother's methadone clinic or the child's Primary Care Physician (PCP).

b. Anticipated Result: To ensure that what mother is self reporting is accurate and to follow up with such clinic or PCP in order to see if there are further concerns of abuse and/or neglect.

c. Responsible Agency: DSCYF

11. CDNDSC recommends that when a child, who is active with the Division of Youth Rehabilitative Services (YRS) and under the supervision of a probation officer, violates their probation that sanctions be increased in accordance with policy.

a. Rationale: Child tested positive for substances, a violation of probation. Sanctions were not increased and the standard response was not followed.

b. Anticipated Result: Compliance with probation and if probation is violated then an increase of sanctions by probation officer.

c. Responsible Agency: DSCYF

12. CDNDSC recommends that DFS review policy as it pertains to consults with the DOJ Deputy Attorney Generals (DAG). (Repeated within the DOJ section)

a. Rationale: The children were considered to be safe because their father was in the home and as available through his extended family and daycare service. However, mother's history of non-compliance and unsuccessful completion of treatment services combined with the concerns noted in previous investigations, as well as the father's work schedule, did not appear to be considered when assessing the safety of the children. Prior to case closure, the DAG should have been contacted in order to determine if there were grounds to take custody of the children.

b. Anticipated Result: Proper consultation with the DAG by DFS in cases where family has extensive history and noncompliance.

c. Responsible Agency: DSCYF

LEGAL

1. CDNDSC recommends that the DFS caseworkers comply with Delaware's child restraint law when providing transportation. "All children must be properly restrained in a federally approved child safety seat appropriate for the child's age, weight, and height up to eight years of age or 65 lbs whichever comes first."

a. Rationale: The law was not followed by caseworker as a child was under the age and weight requirement and was not placed in a proper child restraint seat. Child was placed in the back seat and buckled.

b. Anticipated Result: Compliance with state statute.

c. Responsible Agency: DSCYF

TRAINING

1. CDNDSC recommends that the DOJ and the DSCYF review its legal training for caseworkers to ensure adequacy, efficiency, and uniformity is being offered in each county. (Ancillary Recommendation, Repeated within the DOJ section)

2. CDNDSC supports the use of multi-disciplinary team trainings for each county as provided by the CAC and the CPAC. (Supportive Statement, Repeated within the DOJ and Law Enforcement sections)

V. FAMILY COURT

ADMINISTRATIVE

No recommendations were put forth.

BEST PRACTICES

1. CDNDSC recommends that in addition to the child's medical records, growth charts be included and made available to DSCYF and Family Court so that proper tracking of the child's growth can be reviewed by all agencies involved. (Repeated within the DSCYF section)
   a. Rationale: To ensure that proper tracking of the child's growth can be reviewed by all agencies involved in order to ensure the child's well being.

CHILD WELL BEING

No recommendations were put forth.

COMPLIANCE

No recommendations were put forth.

LEGAL

No recommendations were put forth.

TRAINING

1. CDNDSC recommends that further education be offered to judicial officers, such as the development of a bench book, pertaining to the psychological, developmental, and/or physical impacts of abuse and neglect on nonverbal children who sustain serious, life threatening injuries. (Ancillary Recommendation)

VI. LAW ENFORCEMENT AGENCIES

ADMINISTRATIVE

No recommendations were put forth.

BEST PRACTICES

1. CDNDSC recommends that when the DFS and law enforcement receive a report alleging AHT that the child be brought to the Emergency Department for evaluation as injuries are often internal and not visible upon first impression. (Repeated within the DSCYF section)
   a. Rationale: A DFS caseworker and police officer were called to the residence to investigate allegations of abuse; specifically, AHT, possible near drowning and beatings. The DFS caseworker and police officer removed child's clothing and observed the child. Alleged father reported that child was seen earlier that day at a hospital and was given a clean bill of health. Neither the caseworker nor the police officer followed up with the hospital to ensure such statements and the child was not transported to the Emergency Department for further evaluation.
   b. Anticipated Result: Thorough examination of the child in order to rule out internal injuries that could be caused as a result of AHT.
   c. Responsible Agencies: DFS and Delaware Police Departments
2. CDNDSC recommends that if law enforcement is to respond to a residence for allegations of abuse that a report be submitted for said incident so that such claims can be tracked within DELJIS and reported to additional parties if necessary.
   a. Rationale: A DFS caseworker and police officer were called to the residence to investigate allegations of abuse; specifically, AHT, possible near drowning and beatings. An incident report was

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not found at the time of the panel's initial review. The panel requested what these reports are coded as? Do they differ according to agency? Was this coded as a miscellaneous report?

b. Anticipated Result: Proper tracking and history of individuals involved with law enforcement.

c. Responsible Agency: Delaware Police Departments

3. CDNDSC recommends that the investigating police agency revise policy and procedure as it pertains to the investigation of child abuse and neglect cases, with specific focus on securing and maintaining a crime scene, interviews of key witnesses, and communication among lead detectives and subordinates. (Ancillary Recommendation)

CHILD WELL BEING

No recommendations were put forth.

COMPLIANCE

1. The DFS and Law Enforcement shall comply with the MOU between the DSCYF, the Delaware CAC, the DOJ, and Delaware Police Departments as it pertains to joint investigations of child abuse and/or neglect. (Repeated within the DSCYF section)

   a. Rationale: To conduct a joint investigation using a multidisciplinary team when investigating cases of child abuse/neglect.

   b. Anticipated Result: Compliance with the MOU.

   c. Responsible Agency: DFS and Delaware Police Departments

2. CDNDSC recommends that the DFS and the investigating law enforcement agency comply with the existing MOU between the DSCYF, the CAC, the DOJ, and Delaware Police Departments when conducting forensic interviews with a child who presents with serious mental and/or emotional disabilities. (Repeated within the DSCYF section)

   a. Rationale: To conduct a joint investigation using a multidisciplinary team when investigating cases of child abuse/neglect especially when a child presents with serious mental and/or emotional disabilities.

   b. Anticipated Result: Compliance with the MOU.

   c. Responsible Agency: DFS and Delaware Police Departments

3. CDNDSC recognizes that the goal for every child is permanency. Therefore, CDNDSC urges that the criminal procedures of a case follow a more definitive timeline with regard to the investigation resulting in charging, trial/plea, and/or sentencing. Furthermore, CDNDSC urges that that criminal investigation be more thorough and expedited by Delaware law enforcement agencies and the DOJ. (Ancillary Recommendation, Repeated in the DOJ section)

4. CDNDSC recommends that the investigative police agency follow the MOU between the DSCYF, the CAC, the DOJ, and Delaware Police Departments when placing a child with a relative. Prior to such placement, the DFS shall be notified in order to determine if placement is appropriate.

   a. Rationale: In this particular case, the MOU was not followed and DFS was not notified prior to child being placed with a relative.

   b. Anticipated Result: Compliance with the MOU.

   c. Responsible Agency: Delaware Police Departments

LEGAL

1. Law enforcement shall adhere to 16 Del. C. § 903, 904, and 905, DSCYF policy, and the MOU between the DSCYF, the CAC, the DOJ, and Delaware Police Departments when reporting child abuse and neglect via the report line.
   a. Rationale: This incident is a failure to report on behalf of law enforcement as officers did not adhere to the statute after responding to a call that alleged that father was abusing his daughter.
   b. Anticipated Result: Adherence to the statute and policy.
   c. Responsible Agency: Law Enforcement

TRAINING

1. CDNDSC recommends that all law enforcement who respond to such an investigation receive training in best practices for maintaining and securing a crime scene with specific regard to the preservation of evidence.
   a. Rationale: In this case, the collection of evidence and the preservation of the crime scene was not appropriate.
   b. Anticipated Result: Best practice will be followed as it pertains to the collection of evidence and the preservation of the crime scene when child abuse and/or foul play is suspected.
   c. Responsible Agency: Delaware Police Departments
2. CDNDSC recommends that law enforcement officers be educated on the effects of AHT. Law enforcement officers should know their role in identifying and reporting cases of suspected abuse due to AHT and that physical injury might not be noticeable but internal injury may be present.
   a. Rationale: Law enforcement responded after 911 received a call from the bowling alley that father had been abusing his child for twenty minutes. Upon arrival, law enforcement looked the child over and determined that the child had sustained no injuries. However, because law enforcement is undereducated on the issue of AHT, their ability and expertise to identify such injuries is limited.
   b. Anticipated Result: Law enforcement will have a better understanding of the effects of AHT.
   c. Responsible Agency: CPAC
3. CDNDSC recommends that education on child abuse and neglect be added into the police academy curriculum, so that cases regarding serious injury and the elements needed to effectively prosecute such cases can be understood and reciprocated in the field during such an investigation. (Ancillary Recommendation)
4. CDNDSC recommends that law enforcement officers continue to be trained in the "Identification and Reporting of Child Abuse and Neglect" as created by the CPAC and enforced by the DOJ. It is further recommended that this training be revised to incorporate proper protocol and procedure when investigating a serious injury case of a non-verbal child. (Ancillary Recommendation)
5. CDNDSC supports the use of multi-disciplinary team trainings for each county as provided by the CAC and the CPAC. (Supportive Statement, Repeated within the DSCYF and DOJ sections)

VII. MEDICAL

ADMINISTRATIVE

1. CDNDSC recommends that the hospital in which the child received a tonsillectomy/adenoidectomy conduct an internal review on policy and procedure of children who present with complaints of large tonsils and where obstructive sleep apnea is present requiring tonsillectomy/adenoidectomy. This review should include consideration of and determination as to whether (1) professionals complied with the standard of care, (2) whether all professionals were properly referred to licensure and disciplinary proceedings, and (3) whether all pertinent policies of the hospital were followed.
   a. Rationale: To conduct an internal review of policy and procedure to ensure that such policy and procedure was followed.
   b. Anticipated Result: Compliance with hospital policy.
   c. Responsible Agency: CDNDSC shall send a letter to the hospital in this case.
2. CDNDSC recommends that the hospital in this case conduct a Sentinel Review of all professionals involved in this case; including but not limited to, the Pediatric Otolaryngologist, the Anesthesiologist, and the Nursing Staff.
   a. Rationale: To conduct an internal review of policy and procedure to ensure that such policy and procedure was followed.
   b. Anticipated Result: Compliance with hospital policy.
   c. Responsible Agency: CDNDSC shall send a letter to the hospital in this case.
3. CDNDSC shall send a letter to the hospital requesting that a medical review be conducted regarding the medical care and treatment provided to this child, with specific attention to the apnea download or lack thereof.
   a. Rationale: During the review of this case, medical documentation did not indicate whether or not the apnea monitor had been downloaded. Due to this child's cause of death, such download was necessary.
   b. Anticipated Result: A review of the medical care and treatment of this child.
   c. Responsible Agency: CDNDSC shall send a letter to the hospital in this case.
4. CDNDSC shall send a letter requesting that the inpatient facility complete an internal case review in order to evaluate the assessment and documentation of patient's presenting with Post Partum Depression, as well as their policy and procedure pertaining to mandatory reporting and whether it falls into compliance with Delaware's mandatory reporting statute, 16 Del. C. § 903.
   a. Rationale: Proper assessment and documentation of mother's post partum depression was not properly documented and therefore the risk that mother posed to her child(ren) was not properly assessed.
   b. Anticipated Result: To evaluate the risk of the child(ren) within the home.
   c. Responsible Agency: CDNDSC

BEST PRACTICES

1. CDNDSC supports the inception and establishment of the Child Protection Team at the Christiana Care Hospital. (Supportive Statement)

2. CDNDSC recommends and supports the establishment of a multidisciplinary team within Delaware hospitals as modeled after facilities that provide the same service, such as Bayhealth's Child Advocacy Committee.
   a. Rationale: The establishment and inception of such teams will enable hospitals and DFS to discuss cases where policy issues arise while treating a child for abuse and/or neglect.
   b. Anticipated Result: To ensure the safety and well being of a child prior to hospital discharge.
   c. Responsible Agency: CDNDSC shall send a letter with this recommendation to all hospitals.
3. CDNDSC recommends that the treating emergency room hospital implement policy and/or procedure to ensure that discharge summaries of children who are seen/examined in the Emergency Room be sent to said child's PCP in order to ensure or create awareness by the child's PCP that follow up is to occur and/or recommended. (Ancillary Recommendation)
4. CDNDSC recommends that children under three months of age not be solely evaluated by a Physician's Assistant. (Ancillary Recommendation)
   a. Rationale for recommendation 3 and 4: The child, who was two months and one day of age, was taken to the emergency room by mother and father. Child was evaluated by a Physician's Assistant and diagnosed with what appeared to be a soft tissue subcutaneous mass on the left upper back, approximately 2.5 by 1 centimeters in size. It was documented that this mass was a "spider bite," however, there was no indication of mass mobility, color, or tenderness and no further physical findings were noted. Parents noted that the mark had appeared on the child within the last 48 hours. It was further documented that child would cry upon wakening and had a flat anterior fontanelle (soft spot). Child was discharged home to the care of her mother and father. The Physician's Assistant recommended immediate follow up with the PCP. However, follow up did not occur.
   b. Anticipated Result: To ensure the safety and well being of the child.
   c. Responsible Agency: CDNDSC shall send a letter to all Delaware Hospitals.
5. CDNDSC recommends that children two years of age and under should receive physical examinations where clothing is removed in order to observe the child's body so that abuse, whether or not it is suspected, can be ruled out.
6. CDNDSC recommends that the hospital in this particular case review its policy entitled Care of Patients Recovering from General Anesthesia or Deep Sedation and address the amount of time necessary for a child who has received narcotics and general anesthesia to be recovered before being discharged from Phase I and Phase II of Post Anesthesia Recovery and Discharge.
   a. Rationale: To conduct an internal review of policy and procedure to ensure that such policy and procedure was followed.
   b. Anticipated Result: Compliance with hospital policy.
   c. Responsible Agency: CDNDSC shall send a letter to the hospital in this case.
7. CDNDSC recommends that all medical professionals and staff abide by the guidelines established for questioning a child when suspicion of abuse or neglect is raised. If a child is to be questioned about a specific event for purposes of information gathering, it is recommended, as best practice, that such questioning not occur within the presence of a parent(s) and/or caregiver(s).

Recommendations for Cases Reviewed... (continued from page 57)

a. Rationale: On the day of the child's near death incident, child was questioned by Emergency Department personnel in front of mother.

b. Anticipated Result: Compliance with guidelines established for questioning children when abuse/neglect is suspected.

c. Responsible Agency: CDNDSC shall send a letter to all Delaware Hospitals.

8. CDNDSC recommends that when a child presents to the Emergency Department with the chief complaint of being "limp with a vigorous cry," that the child be fully evaluated including the documentation of appropriate history.

   a. Rationale: Child presented to the Emergency Department with the chief complaint of being "limp" as reported by mother. The Emergency Department performed a chest x-ray and determined that the child was suffering from colic/formula intolerance in which it was recommended that the child's formula be changed. Child was discharged.

   b. Anticipated Result: To ensure the well being of the child.

   c. Responsible Agency: Delaware Emergency Departments

9. CDNDSC supports the use of the Hospital High Risk Medical Discharge Protocol. (Repeated within the DSCYF section)

   a. Rationale: The purpose of this protocol is to ensure that children are discharged into an environment that is safe and supportive of their medical needs. In the above mentioned case, DFS was not notified of the child's positive urine drug screen until the day of discharge. If the Hospital High Risk Medical Discharge Planning Meeting had been utilized then DFS and the birthing hospital would have had more time to appropriately plan for the child's discharge as a meeting would have been called utilizing a team approach which would have included family, social worker/nurse case manager, and DFS.

   b. Anticipated Result: To ensure the safety of a child upon discharge.

   c. Responsible Agency: Delaware Hospitals and DSCYF

10. CDNDSC recommends that all Delaware hospitals implement the Hospital High Risk Medical Discharge Protocol when concern is raised regarding the safety of a child upon discharge.

    a. Rationale: Child tested positive for opiates. During his stay in the hospital, parents repeatedly showed their inability to care for the child. The hospital contacted DFS numerous times to voice their concerns regarding mother's and father's inability to appropriately parent a newborn. If the hospital were to request a meeting with DFS, then a meeting would have been called and allowed for more time to appropriately plan for the child's discharge. The meeting would have utilized a team approach which would have included family, social worker/nurse case manager, and DFS.

    b. Anticipated Result: To ensure the safety and well being of a child upon hospital discharge.

    c. Responsible Agency: CDNDSC shall send a letter with this recommendation to all hospitals.

11. CDNDSC strongly supports the use of standard developmental screening as consistent with the Help Me Grow Delaware program.

    a. Rationale: Help Me Grow is a bridge that connects at-risk children and their families to existing resources statewide through Delaware 2-1-1. It helps coordinate early childhood services, including screening for conditions that might impact development.

b. Anticipated Result: Standard developmental screenings.

c. Responsible Agency: This will be included in the Annual Report.

12. CDNDSC encourages Delaware State Hospitals, under the guidance of the Delaware Healthy Mother and Infant Consortium (DHMIC), to explore and assess patients who present with post partum depression through techniques such as screening tools, referrals, and additional resources and services.

    a. Rationale: To give medical and mental health facilities the proper resources and tools to appropriately screen for and provide services for patients who present with post partum depression.

    b. Anticipated Result: Increased safety for mothers and infants

    c. Responsible Agency: DHMIC

CHILD WELL BEING

1. CDNDSC encourages the development of chronic care services for children with complex medical conditions in Sussex County.

    a. Rationale: Child had to be transported to the hospital for services due to a lack of chronic care services in Sussex County.

    b. Anticipated Results: Better services to children in Sussex County.

    c. Responsible Agency: This will be a general recommendation in CDNDSC annual report.

COMPLIANCE

1. CDNDSC recommends that a letter be sent to the on-call medical service proposing that medical documentation be time and date stamped and that follow up regarding the recommended care for the child occur when advised by the PCP. (Ancillary Recommendation)

    a. Rationale: The on-call medical service recommended that the child be taken to the Emergency Department; however, there was no follow up to ensure that this occurred.

    b. Anticipated Result: Follow up by medical practitioners.

    c. Responsible Agency: CDNDSC

2. CDNDSC shall send a letter to the PCP requesting that the practice adhere to the American Academy of Pediatrics' (AAP) guidelines on back to sleep.

    a. Rationale: In this case the child's PCP was not educating parents of the proper guidelines for infant safe sleeping. As a result, child was placed prone by parents.

    b. Anticipated Result: Adherence by this practice with AAP guidelines.

    c. Responsible Agency: CDNDSC

3. CDNDSC shall send a letter to the PCP requesting that the practice adhere to the AAP guidelines on back to sleep as the practice is currently educating parents that sleeping on "back or side will reduce risk of SIDS."

    a. Rationale: In this case the child's PCP was not educating parents on the proper guidelines for infant safe sleeping.

    b. Anticipated Result: Adherence by this practice with AAP guidelines.

    c. Responsible Agency: CDNDSC

Recommendations for Cases Reviewed... (continued from page 59)

4. CDNDSC shall send a letter to the medical aid unit that performed the initial physical examination of the child expressing their concern regarding the transportation of the child by the parents to the children's hospital for further examination and treatment when suspicion of child abuse and/or neglect is suspected and when the perpetrator is believed to be the child's parent(s).
   a. Rationale: The child was transported to the children's hospital by the parents, who at the time were the alleged perpetrators.
   b. Anticipated Result: To inform the medical aid unit that when there is a suspicion of abuse regarding a child, said child should not be transported by parents and/or caregiver. Instead, alternative transportation should be sought.
   c. Responsible Agency: CDNDSC
5. CDNDSC shall send a letter to the child's PCP stating the panel's concerns regarding the lack of attention to the child's lack of growth, with particular attention to the lack of dietary, environmental, family, and social history, as is recommended by the AAP and is considered standard of care.
   a. Rationale: The medical standard of care was not followed in this case as it pertained to the child's growth, with particular attention to the lack of dietary, environmental, family, and social history.
   b. Anticipated Result: Compliance with the medical standard of care.
   c. Responsible Agency: CDNDSC
6. CDNDSC recommends that a letter be sent to Delaware Long Term Care informing this regulatory body that the long term care facility in this case did not abide by policy for the placement/reinsertion of g-tubes. Furthermore, this institution did not follow best practice in accordance with the American Society of Gastroenterology.
   a. Rationale: Policy was not followed by this particular long-term care facility as it pertains to the reinsertion of g-tubes.
   b. Anticipated Result: Compliance with policy.
   c. Responsible Agency: CDNDSC shall send a letter to Delaware Long Term Care.
7. CDNDSC recommends that Delaware Hospitals follow policy (and develop one if not in place) for when a mother's urine drug screen is positive, upon admission to the hospital, that the infant receive a newborn drug screen and be followed for NAS.
   a. Rationale: Mother's urine drug screen was positive and the initial physician refused to order a newborn drug screen or institute NAS scoring. A newborn drug screen was ordered and NAS instituted by the oncoming physician.
   b. Anticipated Result: Compliance with hospital policy.
   c. Responsible Agency: Delaware Hospitals
8. CDNDSC shall send a letter to the outpatient facility expressing concern as to their policy regarding record keeping of patients and the length of time that must pass prior to records being destroyed.
   a. Rationale: An effective review of this case was unable to be performed because CDNDSC was unable to obtain the appropriate records from this facility and other mental health facilities pertaining to services and treatment received by mother.
   b. Anticipated Result: To ensure that records are properly kept and archived in order to efficiently and effectively review a patient's history.
   c. Responsible Agency: CDNDSC

LEGAL

1. CDNDSC supports the statute for centralizing prescription medication scripts in order to establish greater quality assurance and prevent abuse of such drugs. (Supportive Statement)
2. CDNDSC shall refer the PCP to the Division of Professional Regulation (DPR) for lack of attention to the child's lack of growth, with particular attention to the lack of dietary, environmental, family, and social history, as is recommended by the AAP and is considered standard of care.
   a. Rationale: Standard of care was not followed in this case as it pertained to the child's growth, with particular attention to the lack of dietary, environmental, family, and social history.
   b. Anticipated Result: Compliance with the medical standard of care.
   c. Responsible Agency: CDNDSC
3. CDNDSC shall refer the child's PCP to the Department of State, DPR as the PCP failed to appropriately refer the child and family to medical specialists, services and/or resources for the child's diagnosis of, treatment of, and understanding of Tuberous Sclerosis. Furthermore, the documentation by this physician within the child's medical chart was conflicting and refuted medical records obtained from neurology at the children's hospital which were consistent with the child's diagnosis.
   a. Rationale: The PCP failed to appropriately refer the child and family to medical specialists, services and/or resources for the child's diagnosis of, treatment of, and understanding of Tuberous Sclerosis. In addition, documentation by this physician within the child's medical chart was conflicting and refuted medical records obtained from neurology at the children's hospital which was consistent with the child's diagnosis.
   b. Anticipated Result: Referral to DPR.
   c. Responsible Agency: CDNDSC

TRAINING

1. CDNDSC supports the continued training of medical professionals on the "Identification and Reporting of Child Abuse and Neglect." (Supportive Statement)
2. CDNDSC recommends that there be education/training of Family Practitioners/Pediatrics for NAS (Ancillary Recommendation)
3. CDNDSC recommends that there be education/training of Obstetrics and Family Practitioners on the recognition and prevalence of maternal drug use and/or abuse. (Ancillary Recommendation)
4. CDNDSC recommends that education be offered to physicians on resources regarding home visiting programs. (Ancillary Recommendation)
5. CDNDSC recommends that health care professionals be trained and educated on how to identify, refer, and educate parents about services and/or resources that are available for children who present as medically fragile and developmentally and/or physically delayed. (Ancillary Recommendation)
6. CDNDSC recommends that the medical profession educate the DFS, the DOJ and law enforcement on all substance abuse screening within Delaware hospitals. It is further recommended that cross training occur among these professions as to the treatment received for such substances and the impact that such substances have on the abuser's ability to care for their children. (Repeated within the DOJ section)
   a. Rationale: Mother took a Percocet right before she went into labor and didn't realize it would show up in her system. Mother states she was experiencing severe back labor pain, was dehydrated, and could not

walk. She says the baby had already started to come out before she had reached the hospital and she had to be carried in. Mother denies taking any other drugs or having issues with them.

b. Anticipated Result: It was reported to the Panel that certain hospitals only test for certain drugs during a urine drug screen. This allows a parent to manipulate the system if they are aware what hospitals test for what substances. It was also made known that certain hospitals do not test for the synthetic drug and therefore if used, the drug will not appear on the test. Cross education is important because it will create a greater awareness of what to look for in a drug screen as well as the impact that these drugs can have on the early development of a child.

c. Responsible Agency: Medical Society of Delaware

7. CDNDSC recommends that training/education be offered to all Emergency Department hospitals on the treatment of children who present with head trauma and the reporting of suspected abuse to the DFS' Child Abuse Report line.

a. Rationale: Child was taken to the Emergency Department with the chief complaint that he had fallen from a bed onto a car seat causing a laceration of the head. Injury required a computed tomography (CT) scan of the head which revealed a small linear lucency (clear spot) on one image possibly representing a non-displaced fracture under the site of the laceration. The child also received six staples in order to close the laceration and was transferred to another hospital for further evaluation and treatment. The original hospital did not report this incident to the Child Abuse Report line as it is believed that the treating physician did not think the child's injury rose to a level of abuse, and that such injury could have been sustained given mother's initial explanation of events. However, upon further inquiry with mother, at the transfer hospital, mother clarified that the bed in which the child fell from was an air mattress. Also, further examination of the child revealed a healing fracture of the left arm. Documentation further suggests that the Emergency Department nurses heard child state that mother's paramour threw him off the bed and that mother told child to say he fell off the bed.

b. Anticipated Result: Better identification of child abuse/neglect by medical professionals, so that children are not placed at continued risk.

c. Responsible Agency: CPAC

VIII. MENTAL HEALTH ASSOCIATION

ADMINISTRATIVE

1. CDNDSC recommends that a letter be sent to the Mental Health Association requesting that resources be made available to patients who lose insurance or do not have the financial means to continue receiving treatment.

a. Rationale: Child was under the care of a psychologist until April when family insurance policy lapsed. Child was given a one month supply of medication. There is no documentation that child was referred to another provider or resources on how the child could continue treatment. Child died the following year.

b. Anticipated Result: Continued treatment.

c. Responsible Agency: Mental Health Association, Suicide Prevention Coalition

BEST PRACTICES

1. CDNDSC recommends that mental health facilities communicate more often between inpatient and outpatient programs.

a. Rationale: If better communication occurred between outpatient and inpatient facilities, mother may have received better services, treatment, and overall care.

b. Anticipated Result: Appropriate care for patient.

c. Responsible Agency: Mental Health Community

2. CDNDSC recommends that the Mental Health community revise patient's checklist/assessment if encountering clients for routine medication and distribution of medicine. Revised checklist/assessment should include a more in depth assessment of the client's current social environment and circumstances.

a. Rationale: Mother's current mental health assessments were only inquiring about mother's history. Records did not include mother's present history of mental health issues.

b. Anticipated Result: A more comprehensive assessment of mother and her ability to function.

c. Responsible Agency: Mental Health Community

CHILD WELL BEING

No recommendations were put forth.

COMPLIANCE

No recommendations were put forth.

LEGAL

No recommendations were put forth.

TRAINING

No recommendations were put forth.

IX. OTHER AGENCIES OR COMMITTEES

ADMINISTRATIVE

1. CDNDSC recommends that Child Development Watch (CDW) reassess their mission statement and that part of their assessment for discharge incorporate if other services provided by the DPH can be utilized and appropriate referrals be made.

a. Rationale: The DPH and CDW were active with this child. The case was closed when child's developmental screening, done at three months of age, was normal. It was noted that the child could have been followed by other services implemented by DPH such as Smart Start and a home visiting nurse that were not utilized at that time.

b. Anticipated Result: To ensure that appropriate referrals are made for children.

c. Responsible Agency: DHSS

BEST PRACTICES

1. CDNDSC and the CPAC shall continue to support the Joint Commission Foster Care Medical Committee.
2. CDNDSC shall continue to support the DHMIC System of Care Subcommittee in their work surrounding mothers and post partum depression.

a. Rationale: More awareness and understanding as to the effects and symptoms of post partum depression is needed in order for mothers to be properly diagnosed.

b. Anticipated Result: Community awareness.

c. Responsible Agency: DHMIC

Recommendations for Cases Reviewed... (continued from page 63)

3. CDNDSC recommends that the Delaware Housing Authority require all Section 8 housing appliances to be securely fastened to the wall and accompanied with safety locks.
   a. Rationale: If stove had been properly secured to the wall then it would have prevented the stove from tipping when child stood on the oven door.
   b. Anticipated Result: To ensure the safety of children through child safety initiatives and preventative measures.
   c. Responsible Agency: Delaware Housing Authority
4. CDNDSC recommends that a protocol be developed for emergency phone call operators regarding child abuse and neglect calls to include a standard line of questioning which would identify more about the perpetrator(s) and a description of the incident.
   a. Rationale: More information will be given to first responders, so that first responders will be able to make a better assessment on how to proceed and handle cases where child abuse and/or neglect is suspected.
   b. Anticipated Result: Better intake and dissemination of information to appropriate agencies.
   c. Responsible Agency: Emergency Medical Services
5. CDNDSC recommends that the Steering Council for Home Visiting, under Leslie Newman and Vicky Kelly, evaluate current statewide policy and practice for drug exposed infants within the medical community. Such subcommittee shall take into consideration mother's substance abuse history, prenatal care, delivery, and infant care management in regards to NAS. This council shall also take into account the DFS policy and procedure as it pertains to the acceptance and investigations of infants who are born drug exposed. This task shall be piloted for six months and then a report shall be submitted to the Commission on the council's progress.
   a. Rationale: Upon delivery, child presented as cocaine and opiate addicted. This was mother's second drug positive newborn. Mother presented with a history of alcohol and substance abuse issues. However, the case was not substantiated by DFS as policy indicates that such substances must impair a parent's ability to properly care for their child. In this particular case, DFS found that mother would be able to meet her child's needs as she was under the treatment of a methadone clinic and was receiving support from paternal grandmother and father.
   b. Anticipated Result: Cross education regarding the care of drug exposed infants from prenatal care, to delivery, to further infant care management. Such education should be supported by the Medical Society of Delaware, AAP and ACOG guidelines and other agencies that have collaborated on this topic. Furthermore, education should be provided to medical professionals as well as parents in order to inform them of the importance of testing during prenatal care and the risk of prenatal drug exposure.
   c. Responsible Agency: CPAC/CDNDSC

CHILD WELL BEING

No recommendations were put forth.

COMPLIANCE

No recommendations were put forth.

LEGAL

1. CDNDSC supports current laws regarding child placement and correct seating in motor vehicles. (Supportive Statement)

TRAINING

No recommendations were put forth. ■

FIMR Program Update

FIMR grew out of a statewide effort to address the unacceptably high infant mortality rate (IMR). From its peak in 2000-2004, the Delaware five-year average IMR has declined 11% from 9.3 deaths per 1,000 live births to 8.3 per 1,000 live births in 2005-2009. While improved, Delaware's IMR is still significantly higher than the national rate of 6.6 deaths per 1,000 live births.[40]

FIMR is an action-oriented, community process that takes a public health perspective to assess, monitor and improve the quality of perinatal care and pregnancy outcomes.[41] Data is gathered from extensive medical record reviews and, whenever possible, maternal interviews. This data is put together in a de-identified case summary that is discussed by a multidisciplinary case review team (CRT). The CRT drafts recommendations which are subsequently reviewed by the CDNDSC. Once approved, FIMR recommendations are then disseminated to the DHMIC, state agencies – including the DPH – and community groups. These key partners are the community action teams in the Delaware FIMR model.

The criteria for FIMR case selection is based on the type of death, the cause of death and date of death. Only fetal and infant deaths occurring after 20 weeks gestation are eligible for possible review. A fetal death is also known as a stillbirth; an infant death occurs in those cases involving a live birth. Certain causes of death are reviewed by a CDR panel in Delaware and not by FIMR; these causes include: deaths due to suspected or proven abuse, neglect, Sudden Infant Death Syndrome (SIDS) or a sleep-related condition. The remaining fetal and infant death cases are deemed potential FIMR cases, and the FIMR senior medical social worker invites mothers to participate in a maternal interview. If the mother accepts, her case is fully reviewed. If the mother does not accept, cases are selected by a random process based on the date of death: cases with even dates of death are selected for FIMR review over one six-month period in the year, and odd dates of death are selected for the other six-month period. This randomization process was implemented in 2009 to better align the number of FIMR cases for review with the capacity of CRTs to accomplish reviews.

There have been notable changes to refine and improve the FIMR process over FY 2012 and CY 2012.

- Case Review Teams: Beginning in September 2011, the Wilmington and New Castle CRTs were combined into one CRT. This was done to promote the number of attendees and the diversity of represented groups at the CRT meeting. Kent and Sussex Counties continued to have one combined CRT.
- Data Collection: The web-based BASINET data system was updated in December 2011 to include more current, Delaware-specific options in the standard list of case strengths, contributing factors and suggestions. CRTs use this standard list to select those factors pertinent in each case. Refining the list to better suit Delaware's needs and programs enables CRTs to identify pertinent factors in a more standardized way.
- Incorporation of Life Course Perspective (LCP) into FIMR activities: Growing out of their participation in the National FIMR conference in

[40] Delaware Health Statistics Center. Delaware Vital Statistics Annual Report, 2009. Delaware Department of Health and Social Services, Division of Public Health: 2011. Available at: http://dhss.delaware.gov/dph/hp/files/infant_mortality09.pdf. Accessed on January 8, 2013.

[41] National Fetal and Infant Mortality Review Program. Available at: http://www.nfimr.org/. Accessed on January 10, 2013.

Delaware Fetal and Infant Mortality Review.. (continued from page 65)

June 2012, FIMR staff worked closely with the Perinatal Cooperative nurse educator to submit a proposal for incorporating the LCP into the FIMR process. LCP takes a temporal and social view on health, looking back across an individual's life experiences, across generations, and the wider social, economic and cultural context for clues to current patterns of health and disease.[42] Delaware was one of seven programs selected to receive a grant from the National FIMR program. As a result, beginning in September 2012, Delaware FIMR has undertaken specific changes to the maternal interview and CRT processes:

- To encourage maternal interviews and to thank mothers for their time in providing valuable information that adds depth to the review process, the maternal interview gift card incentives were increased in value.
- Questions were added to the FIMR maternal interview to better capture and explore important experiences that impact the mother and her health trajectory.
- A maternal interview summary checklist was developed as a quick way to convey information about key risk and protective factors in the mother's life course. This checklist is distributed during the CRT meeting and informs the CRT discussion of the case.
- A new CRT discussion guide was developed that includes questions and headings to capture the LCP. Delaware CRTs had not used a discussion guide for several years, and the re-introduction of this tool is intended to help summarize important points in a case as they relate to a mother's history, environment and equity issues.
- CRTs were trained on the LCP in September and October, 2012. The teams played the Life Course Game developed by CityMatCH.[43] Discussion of the LCP and brief presentations accompanied the game.

DESCRIPTION OF FIMR CASES REVIEWED

Between July 1, 2011 and December 31, 2012, the Office of Vital Statistics reported 213 potential cases of fetal deaths (n=107) and infant deaths (n=106) to the CDNDSC. Of these reported deaths, nine cases did not meet FIMR criteria: seven reported fetal deaths were before 20 weeks gestation—the cutoff in Delaware statute based on National FIMR recommendations—and two were elective terminations. Those cases meeting FIMR criteria but that were not deliberated by CRTs, because they lacked a maternal interview and had a date of death outside the selection parameters, were triaged by a FIMR staff member based on a brief review of delivery records. The triage process is intended to look for any glaring gaps in services or care among cases that do not get a full review. If any case raises a concern in the triage process, it is investigated further by the FIMR staff. Between July 1, 2011 and December 31, 2012, 98 fetal and infant cases were triaged by a FIMR staff member.

From September 2011 through December 2012, FIMR CRTs deliberated on 101 cases of fetal and infant deaths. Seventy-nine of those cases were reviewed during the FY 2012 period by the New Castle and the Kent/Sussex CRTs (an average of 4.4 cases per meeting), and 70 cases were reviewed during CY 2012 (an average of 4.1 cases per meeting). Forty-eight cases, those deliberated between January and June 2012, are represented in both the FY 2012 and CY 2012 count. The 101 deaths reviewed occurred to 93 mothers, with eight mothers experiencing more than one loss. Over the 18-month period, 26 cases had a maternal interview, yielding a maternal interview acceptance rate of 26%. Thirty-four percent of FIMR cases (15 out of 44) involving White mothers had a maternal interview, this is a higher proportion than those cases involving Black mothers, among which 18% had a maternal interview (10 out of 56 cases). In FY 2012, the maternal interview acceptance rate was 24% (19 out of 79 cases), and in CY 2012, the maternal interview acceptance rate was 27% (19 out of 70 cases).

[42] World Health Organization. The implications for training of embracing a life course approach to health. 2000. Available at: http://www.who.int/ageing/publications/life-course/alc_lif course_training_en.pdf. Accessed on August 28, 2012.

[43] City Match. Life Course Game. Available at: http://www.citymatch.org/sidewide-keywords/life-course-game Accessed on January 10, 2013.

The 101 cases reviewed in FY 2012 and CY 2012 represent fetal and infant deaths that occurred over five years, from 2008 through 2012. FIMR CRTs deliberated cases, on average, about 29 months after the occurrence of a death. Among the FY 2012 cases, 23 (29%) occurred in 2008, 24 (30%) in 2009, 19 (24%) in 2010, and 13 (16%) in 2011 [Figure 1].

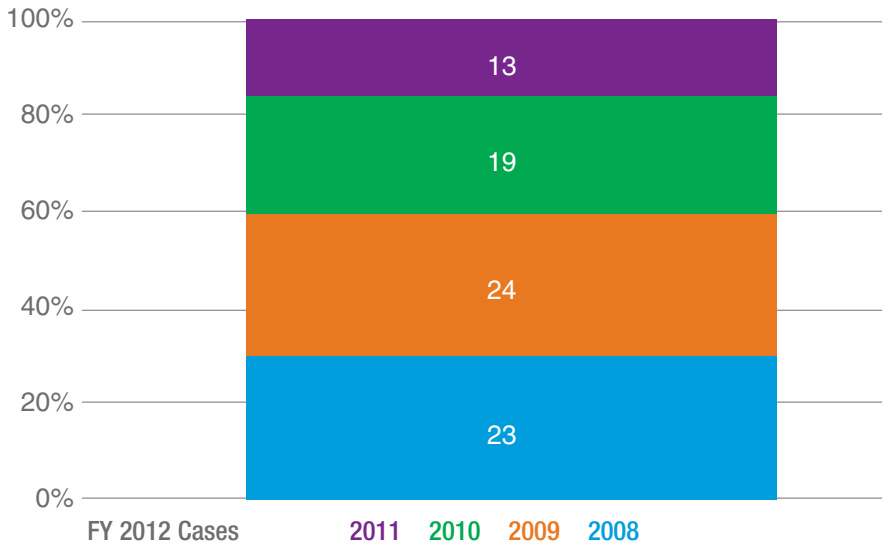
Quotes from mothers participating in FIMR maternal interviews:

"(I) just want to thank the State of Delaware for funding this program. Infant death is so taboo in our society."

"Initially I felt any contact (by the program) was too soon . . . the letter felt impersonal. (When the social worker) contacted me over the phone and I felt more inclined to participate in the interview."

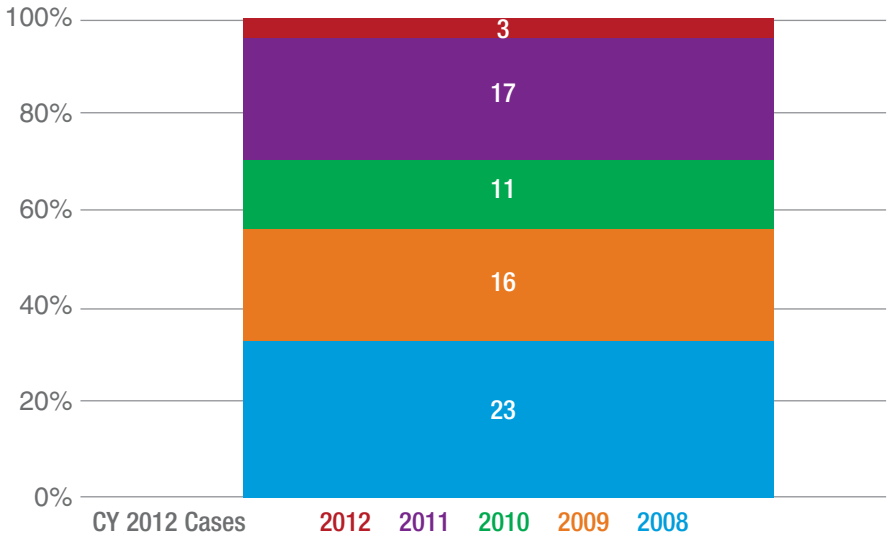
"I am so happy there is an organization trying to make this process better for parents. In some ways sharing my experience and knowing it can help other parents ensures that my (child's) death was not in vain."

Figure 1: Number and percent of FY 2012 cases by year of death



Among the CY 2012 cases, 23 deaths (33%) occurred in 2008, 16 (23%) in 2009, 11 (16%) in 2010, 17 (24%) in 2011 and 3 (4%) in 2012 [Figure 2].

Figure 2: Number and percent of CY 2012 cases by year of death



Delaware Fetal and Infant Mortality Review... (continued from page 67)

Tables 1 and 2 summarize key maternal characteristics for the FY 2012 and CY 2012 cases, respectively. Cases are separated by maternal race (White or Black), and death type (infant or fetal). Demographic information is provided for statewide comparison groups of infant deaths, live births or fetal deaths as reported by the Office of Vital Statistics. There was a higher proportion of Black mothers among FIMR infant deaths (68% and 70%), while White mothers made up the majority of FIMR fetal deaths (58% and 60%). In FY 2012, 9% of cases involved mothers who did not receive prenatal care, and in CY 2012 this percentage was 17%. Slightly higher proportions of White mothers did not receive prenatal care compared to Black mothers in both the FY 2012 and CY 2012 groups. Among FIMR cases, 40% and 48% of mothers were on Medicaid during their prenatal period.

[1] Comparison group is 2009 total DE infant deaths (n=91). Delaware Health Statistics Center. Delaware Vital Statistics Annual Report, 2009. Delaware Department of Health and Social Services; Division of Public Health: 2011. Available at: http://dhss.delaware.gov/dph/hp/files/infant_mortality09.pdf. Accessed on January 8, 2013.

[2] Comparison group is 2009 DE live births (n=11,369). Delaware Health Statistics Center. Delaware Vital Statistics Annual Report, 2009. Delaware Department of Health and Social Services; Division of Public Health: 2011. http://dhss.delaware.gov/dph/hp/files/lb09.pdf Accessed on January 8, 2013.

[3] Delaware Health Statistics Center. Delaware Vital Statistics Annual Report, 2009. Delaware Department of Health and Social Services; Division of Public Health: 2011. Available at: http://dhss.delaware.gov/dph/hp/files/fp09.pdf Accessed on January 9, 2013.

**Categories not comparable.*

Table 1: Maternal characteristics of FY 2012 cases compared to Delaware infant deaths, live births or fetal deaths

	% Total cases (n=79)	% White mothers (n=35)	% Black mothers (n=43)	% Infant deaths (n=44)	% Total DE infant deaths or live births	% Fetal deaths (n=35)	% Total DE 2009 fetal deaths (n=66)[3]
Maternal race[1]							
White	44%			32%	33%	60%	53%
Black	54%			68%	59%	37%	42%
Other	1%			0%	8%	3%	5%
County of residence[1]							
New Castle	71%	60%	79%	80%	63%	60%	68%
Kent	13%	14%	12%	11%	20%	14%	11%
Sussex	16%	26%	9%	9%	18%	26%	21%
Maternal age (years)[2]							
<20	11%	9%	14%	16%	10%	6%	12%
20-29	48%	43%	51%	48%	54%	49%	*
30-39	32%	40%	26%	30%	34%	34%	*
40+	9%	9%	9%	7%	3%	11%	*
Maternal education[2]							
<12 years	15%	23%	9%	20%	22%	9%	23%
High school diploma or GED	37%	29%	42%	39%	25%	34%	41%
College 1-3 years	29%	26%	33%	20%	25%	40%	15%
College 4+ years	14%	17%	12%	18%	27%	9%	14%
No information	5%	6%	5%	2%	1%	9%	8%
Marital status[2]							
Single	47%	43%	51%	41%	48%	54%	55%
Married	42%	54%	30%	41%	52%	43%	45%
No information	11%	3%	19%	18%	0%	3%	0%
Entry into prenatal care[2]							
1st trimester	65%	63%	65%	73%	75%	54%	
2nd trimester	20%	17%	23%	14%	16%	29%	
3rd trimester	1%	3%	0%	0%	4%	3%	
No prenatal care	9%	14%	5%	9%	4%	9%	
No information	5%	3%	7%	5%	1%	6%	
Method of payment[2]							
Medicaid	48%	49%	49%	43%	49%	54%	
Private	47%	46%	47%	52%	45%	40%	
Self-pay	0%	0%	0%	0%	2%	0%	
Other	0%	0%	0%	0%	3%	0%	
No information	5%	6%	5%	5%	2%	6%	

Table 2: Maternal characteristics of CY 2012 cases compared to Delaware infant deaths, live births or fetal deaths

	% Total cases (n=70)	% White mothers (n=28)	% Black mothers (n=42)	% Infant deaths (n=44)	% Total DE infant deaths or live births	% Fetal deaths (n=26)	% Total DE 2009 fetal deaths (n=66)[3]
Maternal race[1]							
White	40%			30%	33%	58%	53%
Black	60%			70%	59%	42%	42%
Other	0%			0%	8%	0%	5%
County of residence[1]							
New Castle	81%	75%	86%	84%	63%	77%	68%
Kent	11%	14%	10%	11%	20%	12%	11%
Sussex	7%	11%	5%	5%	18%	12%	21%
Maternal age (years)[2]							
<20	10%	7%	12%	11%	10%	8%	12%
20-29	50%	46%	52%	48%	54%	54%	*
30-39	34%	43%	29%	36%	34%	31%	*
40+	6%	4%	7%	5%	3%	8%	*
Maternal education[2]							
<12 years	13%	21%	7%	11%	22%	15%	23%
High school diploma or GED	36%	32%	38%	34%	25%	38%	41%
College 1-3 years	31%	21%	38%	32%	25%	31%	15%
College 4+ years	19%	25%	14%	20%	27%	15%	14%
No information	1%	0%	2%	2%	1%	0%	8%
Marital status[2]							
Single	50%	46%	52%	43%	48%	62%	55%
Married	39%	50%	31%	41%	52%	35%	45%
No information	11%	4%	17%	16%	0%	4%	0%
Entry into prenatal care[2]							
1st trimester	60%	61%	60%	64%	75%	54%	
2nd trimester	20%	18%	21%	11%	16%	35%	
3rd trimester	0%	0%	0%	0%	4%	0%	
No prenatal care	17%	21%	14%	20%	4%	12%	
No information	3%	0%	5%	5%	1%	0%	
Method of payment[2]							
Medicaid	40%	36%	43%	43%	49%	35%	
Private	51%	54%	50%	52%	45%	50%	
Self-pay	1%	0%	2%	2%	2%	0%	
Other	3%	7%	0%	0%	3%	8%	
No information	4%	4%	5%	2%	2%	8%	

[1] Comparison group is 2009 total DE infant deaths (n=91). Delaware Health Statistics Center. Delaware Vital Statistics Annual Report, 2009. Delaware Department of Health and Social Services; Division of Public Health: 2011.

[2] Comparison group is 2009 DE live births (n=11,369). Delaware Health Statistics Center. Delaware Vital Statistics Annual Report, 2009. Delaware Department of Health and Social Services; Division of Public Health: 2011.

[3] Delaware Health Statistics Center. Delaware Vital Statistics Annual Report, 2009. Delaware Department of Health and Social Services; Division of Public Health: 2011.

**Categories not comparable.*

Infant and fetal characteristics of FIMR cases are presented in Tables 3 and 4 for the FY 2012 and CY 2012 groups, respectively. As noted in previous FIMR findings, there was a higher proportion of FIMR fetal deaths during the 28-36 week gestation period (27% and 31%) compared to FIMR infant deaths from that same gestational period (7% and 11%). At least three-quarters of FIMR infant deaths occurred prior to 28 weeks gestation, while only about half of fetal deaths occurred in that period.

Table 3: Infant and fetal characteristics of FIMR cases for FY 2012

	% Total cases (n=79)	% White infants (n=35)	% Black infants (n=43)	% Infant deaths (n=44)	% Total DE infant deaths 2004-2008 (n=474)[1]	% Fetal deaths (n=35)	% Total DE 2009 fetal deaths (n=66)[1]
Sex of fetus or infant							
Male	47%	40%	53%	50%	54%	43%	
Female	53%	60%	47%	50%	46%	57%	
Plurality							
Single	81%	86%	77%	73%	82%	91%	
Multiple gestation	19%	14%	23%	27%	18%	9%	
Gestational age (weeks)							
<28	65%	49%	79%	80%	58%	46%	*
28-36	18%	23%	12%	7%	20%	31%	*
37+	18%	29%	9%	14%	21%	23%	*
Birth weight (grams)							
<500	28%	23%	33%	30%	32%	26%	32%
500-1499	46%	34%	56%	52%	34%	37%	39%
1500-2499	13%	17%	9%	9%	13%	17%	14%
2500+	14%	26%	2%	9%	22%	20%	15%

Table 4: Infant and fetal characteristics of FIMR cases for CY 2012

	% Total cases (n=70)	% White infants (n=28)	% Black infants (n=42)	% Infant deaths (n=44)	% Total DE infant deaths 2004-2008 (n=474)[1]	% Fetal deaths (n=26)	% Total DE 2009 fetal deaths (n=66)[1]
Sex of fetus or infant							
Male	43%	36%	48%	43%	54%	42%	
Female	57%	64%	52%	57%	46%	58%	
Plurality							
Single	81%	75%	86%	73%	82%	96%	
Multiple gestation	19%	25%	14%	27%	18%	4%	
Gestational age (weeks)							
<28	67%	57%	74%	75%	58%	54%	*
28-36	17%	21%	14%	11%	20%	27%	*
37+	16%	21%	12%	14%	21%	19%	*
Birth weight (grams)							
<500	24%	21%	26%	20%	32%	31%	32%
500-1499	51%	46%	55%	59%	34%	38%	39%
1500-2499	14%	14%	14%	11%	13%	19%	14%
2500+	10%	18%	5%	9%	22%	12%	15%

[1] Delaware Health Statistics Center. Delaware Vital Statistics Annual Report, 2009. Delaware Department of Health and Social Services; Division of Public Health: 2011. Available at: http://dhss.delaware.gov/dph/hp/files/infant_mortality09.pdf Accessed on January 8, 2013.

Categories not comparable.

Neonatal deaths (before 28 days of age) accounted for about 80% of all FIMR infant deaths reviewed [Table 5]. The majority of neonatal deaths occurred within the first 24 hours after birth: 61% and 52% of FY 2012 and CY 2012 infant death cases, respectively. This proportion reviewed is slightly higher than the total Delaware infant deaths between 2005 and 2009 occurring within the first 24 hours. Conversely, the proportion of postneonatal deaths, occurring between 29 and 365 days of age, is lower in the FIMR groups (18% and 20%) compared to the five-year cohort of all infant deaths in the State. These differences may be partly due to the fact that some causes of deaths are reviewed by the CDR panels instead of FIMR CRTs.

Prematurity accounted for 50% and 41% of the FIMR cases in FY 2012 and CY 2012, respectively [Table 6]. The proportions of Black infant deaths with prematurity as the primary cause (48% and 60%) were higher than the proportions among White infant deaths (23% and 29%). Among all Delaware infant deaths between 2005 and 2009, 24.8% were attributed to prematurity and low birth weight, 12.7% to congenital anomalies (birth defects), and 9.8% to maternal complications of pregnancy, such as incompetent cervix and premature rupture of membranes.[44]

[44] Delaware Health Statistics Center. Delaware Vital Statistics Annual Report, 2009. Delaware Department of Health and Social Services, Division of Public Health: 2011. Available at: http://dhss.delaware.gov/dph/hp/files/infant_mortality09.pdf. Accessed on January 8, 2013.

Table 5: Age at infant death

Age at death	FY 2012 infant deaths (n=44)	CY 2012 infant deaths (n=44)	% Total DE infant deaths 2005-2009 (n=488)[1]
<24 hours	61%	52%	43%
0-28 days	82%	80%	72%
29-364 days	18%	20%	28%

1 Delaware Health Statistics Center. Delaware Vital Statistics Annual Report, 2009. Delaware Department of Health and Social Services; Division of Public Health: 2011.

Table 6: Primary cause of infant death in FIMR cases, FY 2012 and CY 2012

	% Infant deaths FY 2012 (n=44)	% Infant deaths CY 2012 (n=44)	% White infant deaths FY 2012 (n=14)	% White infant deaths CY 2012 (n=13)	% Black infant deaths FY 2012 (n= 30)	% Black infant deaths CY 2012 (n=31)
Prematurity	50%	41%	29%	23%	60%	48%
Respiratory distress/failure	9%	11%	14%	8%	7%	13%
Congenital malformations & chromosomal abnormalities	2%	2%	0%	0%	3%	3%
Renal failure	2%	2%	0%	0%	3%	3%
Other	27%	39%	57%	69%	13%	26%

IMPROVE THE QUALITY OF PRENATAL CARE AND ENHANCE SERVICE COORDINATION AND SYSTEMS INTEGRATION

FIMR RECOMMENDATIONS

FIMR CRTs draft and vote on recommendations based on findings from one or several cases. These recommendations are then reviewed and voted upon by the CDNDSC. When approved, the recommendations are shared with the DHMIC and other partners for action planning and implementation. Below are the 12 recommendations that came out of CRT discussions in FY 2012 and CY 2012. The recommendations are grouped into three larger categories:

- Improve the quality of prenatal care and enhance service coordination and systems integration.
- Provide quality bereavement support and interconception care to women with prior adverse pregnancy outcomes.
- Provide education to obstetrical practitioners to support best practices in perinatal care and public health.

Accompanying each recommendation is the rationale behind it, which provides some more case-specific context, as well as pertinent aggregate findings from the total 101 FIMR cases reviewed in FY 2012 and CY 2012. The aggregate findings are based on the BASINET deliberation tool that CRTs complete for each case reviewed. The deliberation tool lists possible "Strengths," factors that may have helped the mother, "Contributing factors," possible risk factors that may have contributed to the poor pregnancy outcome, and "Suggestions," recommendations to improve the quality of perinatal care based on the case findings.

Recommendation 1: A perinatal self-risk assessment form should be developed that can be presented to each patient at the first prenatal visit. The intent is that the patient will complete the form at the first visit and the obstetrical healthcare provider will review the assessment with the mother and sign the assessment acknowledging the mother's history.

Recommendation 2: FIMR recommends that the DHMIC develop a standardized assessment tool for use by all obstetrical healthcare providers in the State of Delaware to initiate a plan of care early in the pregnancy.

Rationale: These recommendations are based on a case in which the mother experienced a previous twin loss that was also reviewed by the CRT. The mother had multiple psychosocial issues. The CRT believed that if a standardized assessment were completed and reviewed at the first prenatal visit, this would have aided the healthcare provider in developing a plan of care with the mother to address her multiple risk factors early on in the pregnancy.

Aggregate CRT findings: In 50% of FIMR cases deliberated there was no documented screening of mothers for their eligibility to enroll in Smart Start, Nurse Family Partnership (NFP) or Resource Mothers. CRTs found that 35% of mothers did not use available medical, social or community services that may have been beneficial. In 60% of cases CRTs suggested better assessment of the family's home and socioeconomic situation was needed. Table 7 lists some other findings that underscore the importance of early screening and initiation of referrals for mothers identified as having multiple risk factors.

Case in point

The mother did not care for the doctor she was seeing at the high-risk clinic. The doctor told her at each appointment that things were getting worse for the baby, and the doctor seemed angry with the mother for wanting to continue the pregnancy. The mother felt alone during this process. She said (the doctors) "kept pushing termination down my throat." The mother was very angry with the providers, saying they just tell you the bad news and send you out the door and offer "no support."

– from a maternal interview

Recommendation 3: After all medical options and risks and benefits have been discussed with the patient and her family, parental decisions will be respected and supported as it relates to the continuation of a pregnancy or its termination.

Rationale: A FIMR CRT reviewed a case in which the mother perceived a conflict in management concerning her fetus that was expected to have a poor outcome due to a life-limiting diagnosis. The standard of care, as endorsed by the American Congress of Obstetricians and Gynecologists, is to permit the mother and family to have the ultimate decision to manage

Table 7: CRT findings among FIMR cases relating to screening and referrals for risk factors

	% cases (n=101)	% White mothers (n=44)	% Black mothers (n=56)
Contributing factors			
No Smart Start, NFP or Resource Mother screening	50%	45%	52%
No domestic abuse screening	44%	45%	39%
Medical and social services, community resources available but not used	35%	36%	34%
Lack of support systems for mother during pregnancy or infant's life	17%	18%	13%
No referral to smoking cessation program	9%	14%	5%
No referral to drug or alcohol rehabilitation	4%	2%	5%
Suggestions			
Better assessment of family's home and socioeconomic situation	60%	57%	64%
Early referrals to social services	28%	7%	45%
Smart Start, NFP, Resource Mother prenatal screening on initial prenatal visit	40%	39%	41%
Provider education on benefits of Smart Start, NFP and Resource Mothers	43%	32%	52%
Provider education on community services available	22%	25%	20%
Referral for financial assistance, WIC, food stamps, emergency shelter, etc.	17%	16%	18%
Consistent and ongoing drug screening	11%	11%	11%

the pregnancy. Health care providers should be reminded that their responsibility is to inform patients of appropriate treatment options and the associated risks and benefits. The patient then makes her decision on whether to continue the pregnancy. Providers should respect and follow the patient's wish or, in cases where they cannot do so, arrange for the referral of the patient to a provider who can.

Aggregate CRT findings: In many FIMR cases reviewed, CRTs noted strengths in providers' communicating with patients about their plan of care (67% of cases), and allowing co-management decisions and respecting patients' wishes (50%). Such decisions may be more complicated when a life-limiting diagnosis is made prenatally. In 8% of deliberated cases there was a lethal anomaly diagnosed that resulted in a discussion of options with the family. In 24% of FIMR cases, the CRTs felt professional staff were respectful of parents' wishes to continue a pregnancy despite a poor prognosis. While in 16% of cases overall, CRTs felt sensitivity training for providers was needed.

Recommendation 4: If the parents choose to continue a pregnancy with a life-limiting fetal diagnosis, information regarding end-of-life care should be made available to all providers involved with the patient and appropriate referrals should be initiated. Examples include referrals to hospice programs, hospital-based palliative care programs, social work consultations and referrals to perinatal insurance case managers.

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Aggregate CRT findings: In 23% of FIMR cases, CRTs noted poor communication between the provider and patient, this may have been in part due to the lack of: case management, hospice referral, social work referral or interpretation services. Some cases exemplify good provider communication around end-of-life decisions: one case had documentation of discussing the infant's "do not resuscitate" (DNR) status, and in another case providers helped formulate a birth plan with a mother whose fetus had a life-limiting diagnosis. Hospice care was noted in one case. In another case, the parents had a hospital memorial service for their deceased child.

Other FIMR cases, however, serve as reminders that there are still gaps in services and underutilized services for families making end-of-life decisions. In two cases, CRTs noted that the family was not offered hospice services that may have been of help; and in another case, the mother felt obstetrical triage staff were insensitive to her needs when delivering a previable fetus.

Recommendation 5: FIMR recommends that the DHMIC develop a mechanism for those mothers who have had no established prenatal care and present to the hospital for delivery; the obstetrical hospital personnel will refer the mother to an obstetrical clinic or other comparable perinatal care provider and make an appointment for her postpartum care. If she fails to keep the appointment, the obstetrical clinic or other comparable perinatal care provider will call the mother to follow up on the missed appointment.

Rationale: This recommendation follows a case in which the mother presented with no prenatal care and had multiple psychosocial issues, as well as complex medical issues. She did not keep her postpartum appointment. If the postpartum appointment were made prior to discharge from the hospital, a responsible provider would be identified who has the mother's records and can follow up with the mother after the missed appointment to get her back into care.

Aggregate CRT findings: In 53% of FIMR cases deliberated, the mother kept her postpartum appointment. In 14% of cases, CRTs felt there should be better efforts to locate mothers who have missed a postpartum visit. Twelve percent of FIMR mothers (11 out of 94 mothers) did not have prenatal care. Among just the FY 2012 cases, seven mothers did not have prenatal care, and four of them (57%) did not keep their postpartum visit. Among mothers who initiated prenatal care in the first trimester of pregnancy, 33% of them did not keep their postpartum appointment. Review of five years' worth of FIMR data showed a similar result: a much lower proportion of mothers with early prenatal care missed their postpartum visit (27%) compared to mothers with no prenatal care (69%) [Personal communication, email from V. Vishnubhakta, APS Healthcare, January 25, 2013].

Case in point

The mother wished someone had prepared her for what the baby would look like before she saw the baby. The baby was very swollen. The mother did not want to treat her baby like the doctors were treating her. She wanted to treat her like any other baby deserves to be treated.

The nurse brought the baby to the mother without any diaper or clothes on. The mother asked why they did not dress the baby, and the nurse said there was "no sense in that." Now I Lay Me Down to Sleep was called, and the photographer put a diaper on the baby and dressed him for the mother. He then took the pictures and gave all the clothes and diaper back to the mother to keep. She really appreciated that.

– from maternal interviews

PROVIDE QUALITY BEREAVEMENT SUPPORT AND INTERCONCEPTION CARE TO WOMEN WITH PRIOR ADVERSE PREGNANCY OUTCOMES

Recommendation 6: In the event of a sudden perinatal death, families will be offered access to a patient advocate/ombudsman to offer a formal debriefing, an opportunity to review the circumstances around the death and follow up as needed.

Rationale: This recommendation is based on a case in which the family felt that the medical personnel did not adequately explain the circumstances surrounding their baby's death. This case adds to the CRTs' experience over several years of review in which they have found that there was not adequate explanation of debriefing provided to families so they may understand the circumstances of the death.

Aggregate CRT findings: In 43% of cases, CRTs recommended that parents be debriefed two to three months after a loss to assess their understanding of the cause of death of their fetus or infant. Only in two cases (2%) did CRTs specifically note that providers debriefed families as to the reason(s) for the loss. From information gathering during maternal interviews, it

was noted in a few cases that families need particular support in the delivery and immediate postpartum hospital stay. Some families were not prepared adequately to see their baby who had died in utero.

Recommendation 7: Establish a standard for hospital bereavement personnel to offer an appropriate and comprehensive bereavement follow up call to the family (after discharge) and document the follow up conversation in the medical record.

Recommendation 8: A mechanism should be established to notify the obstetrical healthcare provider that contact efforts were made.

Rationale: These recommendations follow from a case in which no bereavement follow up call was initiated. The FIMR CRT has noted a trend over the years that no follow up calls are noted in the medical record. Similarly, when maternal interviews are offered to the family, the maternal interviewer has found that few parents are offered a follow up call from the hospital bereavement team. Such follow up would help support the family through their loss and provide an opportunity to offer additional referrals if appropriate.

Aggregate CRT findings: In most FIMR cases (86%), there is documented inpatient bereavement support provided by a social worker, chaplain, pastor, nurse or other staff. However, only 9% of cases have documentation of follow up by the hospital bereavement team. CRTs have felt that involvement of the obstetrical care provider is important as reflected by the suggestion in 87% of cases that the provider take an active part in addressing grief issues.

Recommendation 9: FIMR recommends that the DHMIC develop a mechanism to follow up with women experiencing perinatal/infant loss for bereavement support, depression screening and referral for appropriate services.

Table 8: CRT findings among FIMR cases relating to follow up after a loss and the interconception period

	% cases (n=101)	% White mothers (n=44)	% Black mothers (n=56)
Strengths			
Referral made to community grief support services after hospital discharge	69%	75%	64%
Hospital staff, social work, Smart Start, NFP or Resource Mother support provided as an outpatient	1%	0%	2%
Contributing factors			
History of fetal or infant loss	36%	25%	45%
Suggestions			
Refer mother to community agency for grief counseling	80%	82%	79%
Provide postpartum depression screening and education with appropriate referrals	38%	32%	43%
Follow up with mothers who initially decline grief support services	12%	5%	18%
Provide grief counseling/support at delivery and/or pediatric care facility	21%	18%	23%

Rationale: A CRT reviewed a case in which an infant with multiple congenital anomalies suffered extensive medical complications and ultimately succumbed to the illness. If a comprehensive depression screening and referral system were in place for mothers experiencing a loss, this would enable the mother and her family to receive services in a timelier manner.

Aggregate CRT findings: In 80% of FIMR cases, CRTs recommended that mothers be referred to community agencies for grief counseling after a loss. Mothers who have experienced a fetal or infant loss are at high risk for recurrent losses—36% of FIMR cases occurred to mothers with a history of a prior loss--and the interconception period is an important time to provide adequate follow up for bereavement, medical care and genetic counseling, if appropriate. All these services are needed to optimize the mother's health prior to her becoming pregnant again. Table 8 compiles other factors identified at the time of CRT review that relate to follow up after a fetal or infant loss.

Case in point

The mother made an effort to schedule her postpartum appointments with her own doctor, but she was not able to get him. None of the three doctors she saw after her loss were aware of what she had been through and how hard it had been on her.

– from a maternal interview

PROVIDE EDUCATION TO OBSTETRICAL PRACTITIONERS TO SUPPORT BEST PRACTICES IN PERINATAL CARE AND PUBLIC HEALTH.

Recommendation 10: FIMR recommends that the DHMIC develop a plan to conduct provider-based education on appropriate birth spacing education to women after a fetal/infant loss. The education should be congruent with the American Congress of Obstetricians and Gynecologists, the World Health Organization and the State of Delaware's endorsement that women wait 18 months to two years before attempting to achieve a pregnancy after a fetal/infant loss. This education will occur at hospital discharge and then again at the postpartum appointment and should be documented by the healthcare provider in the medical record.

Rationale: CRTs continue to see lack of appropriate birth spacing education or incorrect information provided at the postpartum visit to mothers who have suffered a fetal loss of 20 weeks or more or an infant loss.

Aggregate CRT findings: In the FY 2012 and CY 2012 period, 35% of FIMR cases had a pregnancy interval of at least two years, and 14% had inadequate birth spacing noted on CRT deliberation. Based on documentation in 87 cases, CRTs recorded what mothers were told about birth spacing. In 65 cases (75% of the 87 records), there was no documented discussion of optimal birth spacing. Among the remaining 22 records reviewed that did have documentation of providers' discussing this issue with mothers, only 36% of providers (n=8) counseled mothers to wait at least one year prior to becoming pregnant again.

Related to the discussion of birth spacing, the postpartum period offers an important opportunity to discuss contraception choices. Eleven percent of FIMR mothers were given contraceptives or a prescription prior to hospital discharge following delivery, and 23% were offered contraception at the postpartum visit. CRTs recommended education on appropriate birth spacing in 70% of cases and birth control in the immediate postpartum period in 46%. CRTs also noted that persistent follow up is needed on family planning choices when mothers initially refuse services (10% of cases).

Recommendation 11: FIMR recommends that the DHMIC support the current Centers for Disease Control and Prevention (CDC) recommendation for the evaluation and treatment of symptomatic vaginal discharges during pregnancy.

Rationale: This recommendation followed review of a case in which a mother called her obstetrical provider complaining of a vaginal discharge. The provider did not examine the patient but called in an antibiotic prescription to the pharmacy. The CRT recommends that an evaluation be performed prior to treating with antibiotics and that obstetrical providers follow current CDC recommendations for the evaluation and treatment of vaginal discharge in pregnancy.

Aggregate CRT findings: Fourteen percent of FIMR cases had documentation of a sexually transmitted disease during the pregnancy, and 21% had a urinary tract infection while pregnant.

Recommendation 12: FIMR 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.

Rationale: A FIMR CRT reviewed a case in which an infant less than 22 weeks gestation was delivered at home. The EMS team detected a heartbeat and began resuscitation efforts but was unsuccessful. The infant's death was erroneously classified as a fetal death. The event should have been reported as an infant death because there were signs of life at birth.[45] There have been numerous cases over the years reported to FIMR with errors in the type of death (fetal or infant). In a small state such as Delaware, such errors can have a larger impact by leading to inaccurate fetal and infant mortality rates.

Aggregate CRT findings: In 5% of records reviewed, CRTs recommended improved accuracy and/or completeness of vital statistic records.

FIMR ACTION STEPS

In Delaware, the DHMIC and its committees, the Perinatal Cooperative, DPH and community groups are key partners for implementing FIMR recommendations. There is a conscientious effort on the part of the CDNDSC and FIMR staff to maintain overlap and close working relationships with the committees of the DHMIC. The Executive Director of the CDNDSC is a member of the Data and Science Committee and the Infant Safe Sleep Media

[45] Kowaleski J. State definitions and reporting requirements for live births, fetal deaths, and induced terminations of pregnancy (1997 revision). Hyattsville, Maryland: National Center for Health Statistics. 1997.

Committee; the FIMR program coordinator is a member of the Prevention and Education Committee, Standards of Care Committee and the Wilmington Consortium; and the FIMR senior medical social worker is a member of the Health Equity Systems Committee.

Fetal Kicks Count

In January 2010, the CDNDSC approved the following recommendation from a FIMR CRT:

The CDNDSC recommends establishment of an educational campaign aimed at both mothers and prenatal healthcare providers concerning the techniques of fetal movement counting, the recognition of abnormal/decreased fetal movement patterns and the importance of notifying a healthcare provider of abnormal/decreased fetal movement.

Six months later, the Fetal Kicks Count program was developed to increase women's tracking fetal movements in pregnancy. Working closely with the DHMIC and DPH, the Perinatal Cooperative has supported provider education on the program, helped distribute Fetal Kicks Count tool kits and conducted a provider survey capturing feedback on the program and the materials developed. Results from the provider survey indicate that 75% of respondents use the Fetal Kicks Count materials in their practice (the response rate was 68%) and 61% distribute the tool kits in the 24-28 weeks gestation period as recommended.[46]

From FIMR CRT deliberations, in FY 2012 and CY 2012, 31% of cases were found to have documented fetal kicks count teaching; this is increased from FY 2011 when 16% of reviewed cases had documented teaching. Conversely, the percent of mothers with no documented fetal movement teaching noted as a contributing factor decreased in FY 2012-CY 2012 to 15% from 33% in FY 2011. In 23% of FY 2012-CY 2012 cases, CRTs suggested that kick counts education continue with teaching on the signs of decreased fetal movement and when to call the provider.

Dissemination of FIMR findings

There have been efforts to present the findings from the Delaware FIMR program and related work of the DHMIC and DPH. Posters on the Fetal Kicks Count program were presented at the National Perinatal Association annual conference in October 2012 and the Seventh National FIMR Conference in June 2012. One poster entitled "Fetal deaths later in pregnancy: the conception and roll-out of Fetal Kicks Count in Delaware" presented the disproportionately high rate of late-term fetal deaths and maternal interview findings that spurred action on fetal movement tracking. The second poster, "Implementation and evaluation of the Fetal Kicks Count program in Delaware," presented the key partners and their role in implementation as well as findings from the provider survey. There was much interest in the Fetal Kicks Count materials developed, and samples of the provider packets and tool kits were distributed.

With the support of the DHMIC's Data and Science Committee and DPH, APS Healthcare did a multi-year analysis of FIMR data and deliberation findings.[47] The report covers data from infant and fetal deaths occurring in FY 2007 through FY 2012 and that were deliberated by CRTs. Trends in CRT-defined strengths, contributing factors and suggestions by maternal characteristics are reported in detail. The report has been approved by the CDNDSC and findings will be presented before the DHMIC in 2013.

CDNDSC staff are also committed to continuing the Delaware annual bereavement conference. This conference was last held in October 2010 and brings together professionals working directly with families who have experienced a fetal or infant loss. As many current and past FIMR recommendations pertain to bereavement support, this conference can help work towards ensuring more consistent access to high quality in-hospital and outpatient services for families.

Another mechanism for spreading findings from FIMR is the development of a Perinatal Cooperative newsletter. FIMR issues, trends and mothers' perspectives will be highlighted in the newsletter. The newsletter is set to come out quarterly beginning in fall 2013 and will be distributed to obstetrical providers and birthing hospitals statewide.

Life Course Perspective: NFIMR grant activities and reporting

FIMR findings from FY 2012 and CY 2012 revealed that in 45 out of 101 cases (45%), CRTs noted the presence of a life course perspective (LCP) risk factor as a contributing factor during case review. Similar proportions of

[46] Colmorgen G, Buckaloo B, Jones A, Kelley JM, Joyce K, Ramakrishnan M and Pedrick A. Implementation and evaluation of the Kicks Count program in Delaware. Poster presented at: The 7th National Fetal and Infant Mortality Review Conference; 2012 Jun 7-9; Arlington, VA.

[47] Delaware Health and Social Services, Division of Public Health, Delaware Fetal and Infant Mortality Review FY 2007-2012. November 2012.

Delaware Fetal and Infant Mortality Review.. (continued from page 77)

White mothers (48%) and Black mothers (43%) had an LCP risk factor. Table 9 lists some associated deliberation findings for those cases with an LCP risk factor and those without an LCP risk factor (n=56), as identified by CRTs. Notably, cases with an LCP risk factor had a higher prevalence of lack of social supports during pregnancy or the infant's life (31%) and emotional stressors during pregnancy (69%) compared to cases without an identified LCP (11% and 30%, respectively).

In an effort to further explore and address findings associated with LCP risk factors, CRTs will be conducting targeted case reviews focusing on high-risk communities in the May and June 2013 meetings. Recognizing the impact of environmental and socioeconomic factors on the lives and health trajectories of women is an important aspect of the LCP. As part of a 2011 needs assessment, the Delaware Maternal and Child Health Bureau identified six at-risk communities that would be the priority areas for the Delaware Maternal, Infant and Early Childhood Home Visiting Program.[48] FIMR CRTs and staff will use these pre-identified zones as the basis of conducting focused, in-depth reviews of women living in these communities: the New Castle County CRT will review cases from three zones in the City of Wilmington, and the Kent/Sussex CRT will cover cases from three zones in the southern part of the State. By conducting targeted reviews over two consecutive months, CRTs will be better positioned to identify community-specific themes and factors that may prompt more targeted recommendations.

CRTs will be asked to give their feedback on the changes to the review process undertaken in 2012-2013 based on the efforts to incorporate the LCP. This feedback will help inform what ongoing changes and refinements are made to the FIMR data gathering and case review processes for FY 2014. A formal report will be written up from the Delaware FIMR grant activities and presented to NFIMR and key partners such as the DHMIC and DPH.

Table 9: CRT findings among cases with and without a life course perspective (LCP) risk factor identified[1]

	% cases with LCP risk factor present (n=45)	% cases with LCP risk factor not present (n=56)
Strengths		
Church support	16%	23%
Patient with private insurance	38%	57%
Patient with timely Medicaid	60%	43%
Family support	82%	88%
Father of baby involved/supportive	84%	66%
Parents in stable marriage	29%	41%
Stable financial situation	13%	34%
Supportive friends	31%	41%
Contributing Factors		
Maternal age less than 21 years	16%	13%
Maternal age over 35 years	13%	20%
Father of baby involved but not supportive	16%	7%
Domestic abuse during pregnancy or infant's life	7%	0%
Sexual abuse during pregnancy or infant's life	2%	5%
Lack of support systems during pregnancy or infant's life	31%	11%
Poverty	40%	23%
Other emotional stressors during pregnancy such as loss of job, loss of loved one, incarceration, divorce	69%	30%
Strengths		
Better assessment of family's home/socioeconomic situation	69%	41%
Low cost/subsidized quality daycare	7%	2%
Early referrals to social services	62%	20%
Referral for financial assistance, WIC, food stamps, emergency shelter, etc.	29%	5%
Easier access to care for those without insurance	2%	2%
Medicaid HMO's that are more user friendly and offer more provider choices for patients	2%	2%
Child Protective Services (CPS) involvement	4%	0%

[1] Personal communication, email from V. Vishnubhakta, APS Healthcare, February 9, 2013

[48] State of Delaware. Delaware Health and Social Services. Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Updated State Plan. June 2011. Award No: 6 X02MC19404-01-01.

MMR Policies and Procedures

Case selection

The Delaware Maternal Mortality Review (MMR) program was implemented in 2011 by statutory authority granted to the CDNDSC. The goal of MMR is to conduct in-depth, multidisciplinary reviews of pregnancy-related deaths and some pregnancy-associated deaths to achieve the following objectives:

- Describe and track factors associated with maternal deaths in Delaware;
- Identify system-wide issues that may have contributed to the deaths;
- Develop and disseminate recommendations for change;
- Assist in the implementation of action steps that will improve the health of mothers in Delaware.

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. A pregnancy-associated death, also called 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.[49]

Maternal mortality reviews are conducted on selected maternal deaths occurring after July 1, 2008. Annually, Delaware has anywhere between zero and four maternal deaths per year as reported by the Office of Vital Statistics.[50]

The Office of Vital Statistics sends qualifying death certificates to the CDNDSC office on a monthly basis. These death certificates are identified by the pregnancy check box. 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;
3. Cases that do not have pending litigation.

In the latter instance, cases are set aside for review once litigation is complete if they meet one of the first two criteria. Basic demographic information is recorded in a database on cases that are not selected for MMR review.

Medical record review

CDNDSC staff subpoena pertinent medical records up to two years preceding the death on the cases selected for MMR. Delivery records, hospitalizations, primary care records, prenatal records and records relating to the terminal event are possible sources of information. Staff also request a Division of Public Health (DPH) case summary based on any relevant visit records that the mother may have had in the two years preceding her death. An obstetrician reviews the medical records and fills out a detailed data abstraction form. This form was adapted for Delaware use based on examples provided by MMR programs in Florida and New Jersey.

Family interview

One of the unique aspects of the Delaware MMR is that it is the only statewide program of its type seeking to gain the input of family members about the mother's experiences leading up to her death. This family interview is conducted by the CDNDSC senior medical social worker based on the next of kin or emergency contact identified in the death certificate or the initial medical record review. Depending on the year of death, the social worker makes contact with the identified family member by letter (for deaths prior to 2009) or letter and phone follow up (for deaths that occurred in 2010 or later). The social worker uses a family interview questionnaire, adapted from a tool used in New York, as the basis of topics to be covered in the interview. The social worker also gathers the deceased mother's history on the circumstances of her life, such as the presence of domestic violence, history of assault or drug use.

Maternal mortality review panels

Information from the medical records and family interview, if available, are put together to present to a multidisciplinary MMR panel. MMR panel meetings are held semiannually and bring together stakeholders across the State: representatives from the Office of the

[49] Berg C, Danel I, Atrash H, Zane S, Bartlett L (Editors). Strategies to reduce pregnancy-related deaths: from identification and review to action. Atlanta: Centers for Disease Control and Prevention; 2001.

[50] Delaware Health Statistics Center. Delaware Vital Statistics Annual Report, 2009.

Delaware Maternal Mortality Review... (continued from page 79)

Medical Examiner, DPH, the DHMIC and the Perinatal Cooperative, as well as practitioners with expertise in obstetrics, midwifery, nursing, internal medicine, maternal fetal medicine and licensed clinical social work. The obstetrician reviewing the medical records writes a case summary, which is given to panel members for their review and discussion at each meeting. In addition, the CDNDSC senior medical social worker presents a written summary of the findings from the family interview. The panel members deliberate the case to identify key factors that contributed to the outcome and possible changes to community behaviors, technologies, agency systems, service provision and/or regulations that could mitigate these risk factors and, perhaps, prevent another death. A case discussion guide is used to help capture salient points and record any recommendations put forth by the MMR panel for CDNDSC review. The MMR panel also discusses whether or not the death was pregnancy-related, pregnancy-associated or undetermined.

MMR Progress to Date

In 2011 and 2012, 17 potential maternal deaths were reported to or identified by CDNDSC staff through passive surveillance. Of these 17, one case was found to have an error on the death certificate that marked it as a maternal death, but review of the medical records did not reveal any recent pregnancy. Through the end of CY 2012, two family interviews have been conducted: one with the husband of the deceased, and the other with the mother of the deceased. After meeting these families, the CDNDSC senior medical social worker provided information and referral contacts for grief counseling and supporting children after the loss of a parent: information she identified that may be of benefit to the families based on their experiences. MMR panels met in November 2011 and April 2012. Four cases were deliberated at the two meetings; MMR panel members deemed all four cases to be pregnancy-related deaths. Two cases included the information available through the family interview.

MMR Recommendations

MMR panels have written and the CDNDSC has approved the following eight recommendations based on the four pregnancy-related deaths reviewed in FY 2012 and CY 2012:

Recommendation 1: CDNDSC recognizes the need for further education for obstetrical providers on the importance of assessing psychosocial risk factors and understanding the criteria that would trigger a referral to Social Services.

Recommendation 2: CDNDSC recommends that education should be provided to obstetrical providers and consumers on what Social Services are available and how to increase referrals and utilization of existing services.

Recommendation 3: CDNDSC recommends improved care coordination between pain management clinics and primary or mental health providers for patients with complex medical and/or psychological issues.

Recommendation 4: CDNDSC recommends that for patients seen with a drug overdose, routine standard of care should include a psychosocial evaluation (i.e. social work or psychiatry consult) and attempts to communicate directly with the physician prescribing the drug involved.

Recommendation 5: CDNDSC recommends that DPH query what protocols the hospital emergency rooms follow when a patient presents with drug overdose and identify what those protocols are.

Recommendation 6: CDNDSC recommends in cases of maternal cardiac death, surviving children and maternal relatives should be evaluated for potential early cardiovascular risk factors.

Recommendation 7: CDNDSC recommends that primary care providers and obstetrician/gynecologists serving as primary medical doctors perform a thorough and regular history and physical examination with patients who have a strong family history of early cardiac death.

Recommendation 8: CDNDSC recommends that all off-site medical facilities ascertain pregnancy status when treating women of reproductive age. This may be done by documented history of last menstrual period, urine or blood human chorionic gonadotropin (HCG) testing. If patient history is unclear or in doubt, then a documented urine or blood HCG test is preferable to determine pregnancy status.

Action Item: It is recommended that DPH query off-site medical facilities, such as walk-in or urgent care clinics, to determine how and when they are documenting pregnancy status in women of reproductive age.

MMR Next Steps

Recommendations from the MMR process will be shared with CDNDSC partners including DPH and the DHMIC for implementation and consideration in their action plans. MMR reviews will continue on a semiannual basis, and when at least 20 cases have been reviewed, additional findings on contributing risk factors and protective factors associated with the deaths will be analyzed. Until that time and due to the small number of maternal deaths in Delaware, the case count is too small for quantitative analysis. ■

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Rodney Brittingham (DSCYF)
Dr. Richard Callery (OME)
Aleks Casper (NCC FIMR Chair)
Patricia Ciranni, RN (K/S FIMR Chair)
C. Malcolm Cochran, Esq. (CPAC)
Dr. Garrett Colmorgen (Chair, MS/Perinatology)
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Patricia Dailey Lewis, Esq. (DOJ)
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Mary Kate McLaughlin (DHSS/DSCYF)
Mary Ann Mieczkowski (DOE)
Deborah Miller, LCSW (NASW)
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Dr. David Paul (MS/Neonatology)
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Commissioners and Panel Members... (continued from page 81)

Caring Communities/Sharing Hope: (continued from page 81)

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CDNDSC

Child Death, Near Death and Stillbirth Commission

Every Child Deserves a Tomorrow...

This annual report is dedicated to every loved one, family, and community who is grieving the loss of a child.

This past year, has seen many national and local tragedies affecting children. Every day there are infant and child tragedies that occur within our Delaware communities. Following, you will find a letter from Theresa Covington, the Director for the National Center for the Review and Prevention of Child Deaths. It echoes the passion and drive that all of us at CDNDSC must rely upon to continue this difficult work.

The work of CDNDSC could not be accomplished without the CDNDSC staff, the CDNDSC Commissioners, the CDR Panel members, the FIMR CRT members, and the Chairs who volunteer numerous hours to this cause. This work is often difficult to qualitatively assess for system improvement and yet the ripple effects of prevention are life changing.

With this same passion and drive, CDNDSC has wonderful, dedicated partners who assist in the day to day operations. 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 and infant safe sleep expert), who has been a champion for this cause since 1995 when the Commission began. A special thanks goes to Rosalie Morales and Tania Culley (staff to CPAC) for their assistance in revising the recommendation section.

We must continue to learn from the past to protect the children of tomorrow.

Anne Pedrick
CDNDSC Executive Director

DELAWARE

Dear Santa,

I know you are busy making childhood dreams come true. But I have a few wishes for you too Santa. Over 100 years ago, a little girl named Virginia doubted your existence. In a reply to her letter, an editor wrote that "how dreary would be the world if there were no Santa Claus. It would be as dreary as if there were no Virginias." Well Santa, there are 20 fewer Virginias in Connecticut for you to deliver toys to this holiday. And across the United States, there are tens of thousands fewer children on your list because they too died this year. On average, almost 150 children died each day in the U.S. this year from natural causes, accidents, homicides, suicides and undetermined causes. Children died because they are born too small or too early or with birth defects. They died in car crashes or while crossing streets. Children drowned in pools, ponds, and tubs. They died in house fires. They suffered fatal organ failures, cancers, and died from often-treatable infections. Far too many teenagers died when they killed themselves or were murdered by peers. Over 2,700 children died when the adults who were supposed to love them killed them instead. Then the tragedy in Newtown: an indescribable senseless act of violence to children that has so rightfully torn our hearts apart and galvanized national attention to mass shootings.

Santa, we can work much harder and smarter in this country to keep children from dying. Already, across this country, people in every state come together to try to prevent child deaths. These health professionals, mental health workers, law enforcement officers, judges, prosecutors, educators, social workers and others meet as child death review teams. They meet to understand what caused child deaths; and they then act to prevent other children from dying. Many decide not to wait until there is a perfect solution. Many make recommendations known to prevent deaths even though they may not be popular with some policy makers, civic leaders or the public. Teams know they can't wait.

Santa, I have a few things on my wish list. I wish that we hurry it up and act as a nation to stop mass shootings, other violence and all the other preventable deaths of children. I wish that we put in place national and state policies and laws that we already know can prevent deaths. I wish we stop making excuses. And I wish that our policy makers will decide that children's' lives are worth some costs to adults. We might not get it perfect Santa, and we surely won't make all the adults happy. But I'd rather that more children are able to celebrate the joy you bring each and every year. Santa, please work your magic to keep children alive because I'm afraid magic is what is needed. ■

Sincerely,

Theresa Covington, MPH

Director, National Center for the Review and Prevention of Child Deaths

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President Obama's speech at prayer vigil for Newtown shooting victims (Partial transcript)

By Washington Post Staff,
Published: December 16, 2012

You know, someone once described the joy and anxiety of parenthood as the equivalent of having your heart outside of your body all the time, walking around.

With their very first cry, this most precious, vital part of ourselves, our child, is suddenly exposed to the world, to possible mishap or malice, and every parent knows there's nothing we will not do to shield our children from harm. And yet we also know that with that child's very first step and each step after that, they are separating from us, that we won't -- that we can't always be there for them.

They will suffer sickness and setbacks and broken hearts and disappointments, and we learn that our most important job is to give them what they need to become self-reliant and capable and resilient, ready to face the world without fear. And we know we can't do this by ourselves.

It comes as a shock at a certain point where you realize no matter how much you love these kids, you can't do it by yourself, that this job of keeping our children safe and teaching them well is something we can only do together, with the help of friends and neighbors, the help of a community and the help of a nation.

And in that way we come to realize that we bear responsibility for every child, because we're counting on everybody else to help look after ours, that we're all parents, that they are all our children.

This is our first task, caring for our children. It's our first job. If we don't get that right, we don't get anything right. That's how, as a society, we will be judged.

And by that measure, can we truly say, as a nation, that we're meeting our obligations?

Can we honestly say that we're doing enough to keep our children, all of them, safe from harm?

Can we claim, as a nation, that we're all together there, letting them know they are loved and teaching them to love in return?

Can we say that we're truly doing enough to give all the children of this country the chance they deserve to live out their lives in happiness and with purpose?

I've been reflecting on this the last few days, and if we're honest with ourselves, the answer's no. We're not doing enough. And we will have to change. ■

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

Due to fiscal constraints in the State of Delaware, the Fiscal Year and Calendar Year 2012 Child Death, Near Death and Stillbirth Commission Annual Report has been distributed through electronic email and computer disc 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.[51]

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