PREVENTING CHILD DEATHS IN THE FIRST STATE

CHILD DEATH, NEAR DEATH AND STILLBIRTH COMMISSION
ANNUAL REPORT FOR FISCAL YEAR 2011

State of Delaware
Child Death, Near Death and Stillbirth Commission
900 King Street, Suite 220
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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: April 2, 2012

SUBJECT: Fiscal Year 2011 Child Death, Near Death and Stillbirth Commission Annual Report

I am pleased to present to you the ninth 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 2011. 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.

This report not only reflects opportunities for system improvement, but also highlights evidenced based models that have been implemented by the Child Death, Near Death and Stillbirth Commission and collaborative partners. The Commission will always remember that each "number" reflected in this report symbolizes the loss or near loss of a precious child. This loss detracts from our families, our community and our state as a whole. The Commission will continue to serve and develop strategies for the State of Delaware to reduce the number of deaths.

GHCC/amp
Enclosure

"The moral test of a government is how it treats those who are at the dawn of life, the children; those who are in the twilight of life, the aged: and those who are in the shadow of life, the sick and the needy, and the handicapped."
Hubert Humphrey

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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.

Multi-disciplinary Child Death Review Panels and Multi-disciplinary Fetal Infant Mortality Review (FIMR) Case Review Teams (CRTs) met from September to May to conduct 91retrospective reviews of the history and circumstances surrounding each fetal or infant death in Delaware. During this period, 48 death cases were reviewed by the Child Death Panels. The work of the dedicated Child Death Panels and CRTs can best be reflected in the recommendations and prevention initiative portion of this annual report. Since becoming fully staffed in 2006, the Commission has become a fully integrated partner with other agencies and community non-profits. The Commission believes that every child deserves a tomorrow and that mission statement has become the driving force behind the Commission's passion and efforts.

From this report, the Commission has drawn the following conclusions from FIMR and Child Death Review:

- Of the 91 FIMR cases reviewed in FY11, 56 (62%) were fetal deaths or stillbirths, and 35 (38%) were infant deaths. In FY11, 23 out of the 91 cases (25%) reviewed by the CRTs included a maternal interview. The leading primary cause of death among FIMR infant cases was prematurity, accounting for 17 of the 35 cases (Table 4). A higher proportion of Black infant deaths were ascribed primarily to prematurity (61% or 14 cases) compared to White infant deaths (three cases), and this difference is statistically significant (p=0.04). This disparity is highlighted in the FIMR Table 4 for primary cause of death, see page 29.
- All five of these issues have been identified in prior FIMR reports, but there are some variations in the proportion of cases affected from year to year.

The five key issues are:

1. Mothers' pre-existing medical conditions

2. Medical and social services and community resources available but not used

3. Identification of and referral for mothers' social stressors

4. Family planning and birth spacing

5. Grief support and bereavement services for families

- The following recommendation is an example of the deliberations at the FIMR case review teams: The Commission recommends that the Delaware Healthy Mother and Infant Consortium review the definition of a stillbirth versus a live birth. Federal guidelines concerning non-issuance of a birth/death certificate should be followed if the fetus is less than 350 grams or less than 20 weeks gestation. In lieu of a birth/death certificate, some type of certificate should be issued to the grieving parents.
- African Americans make up 21.4% of Delaware's population[1]. However, African American children disproportionately represent 33% (16 out of 48) of all deaths that were reviewed by the child death review panels during FY11. This percentage has decreased by 26% from FY10 and by 7% from FY09.
- The Kent/Sussex child death panel reviewed 28 deaths and the New Castle

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

"There are risks and costs to a program of action. But they are far less than the long-range risks and costs of comfortable inaction." John F. Kennedy

County child death panel reviewed 18 deaths during FY11. The two leading causes of death in cases reviewed during FY11 were motor vehicle collisions (16) and infant unsafe sleeping (11).

- The Commission reviewed two deaths due to drowning. Of those two deaths both were in a residential pool where the child was not properly supervised. Proper supervision of children is the best way to prevent a child from drowning.
- The Commission reviewed a total of three deaths due to poisoning, overdose or acute intoxication. In all three deaths, the child was a male between the ages of 15-17. One death resulted from a suicide. The other two 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).
- The Commission reviewed 16 child deaths due to motor vehicle collisions. Motor vehicle crashes are the leading cause of death for teenagers in the United States and also in Delaware. Risk factors involving the 16 cases include one case of inadequate lighting, three cases where the teenager was responsible for the motor vehicle crash and two cases where the graduated licensing rules were not followed in that there were more than two teen passengers. In one motor vehicle collision, the teen was under the influence of alcohol and in another case the teen was driving without a license.

- In FY11, eleven 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 11 cases are only reflective of the cases reviewed by the Panels; not vital statistics data. Of these 11 deaths, five infants were white and six were black. In 82% of the cases (9 out of 11) cases, the infant was NOT sleeping in a crib or bassinette. In 64% (7 out of 11) of the cases, the infant was bed-sharing with another individual. See page 24 for the continued work surrounding this concerning cause of death.
- The Child Abuse and Neglect (CAN) Panel reviewed two child deaths that resulted from abuse and neglect. In addition, 11 CAPTA[2] reports were completed which reflected the extensive work of the CAN panel through 16 recommendations that were put forth in support of system change in order to prevent future child deaths and child near deaths due to abuse and neglect. These CAPTA reports are available on the website.[3]

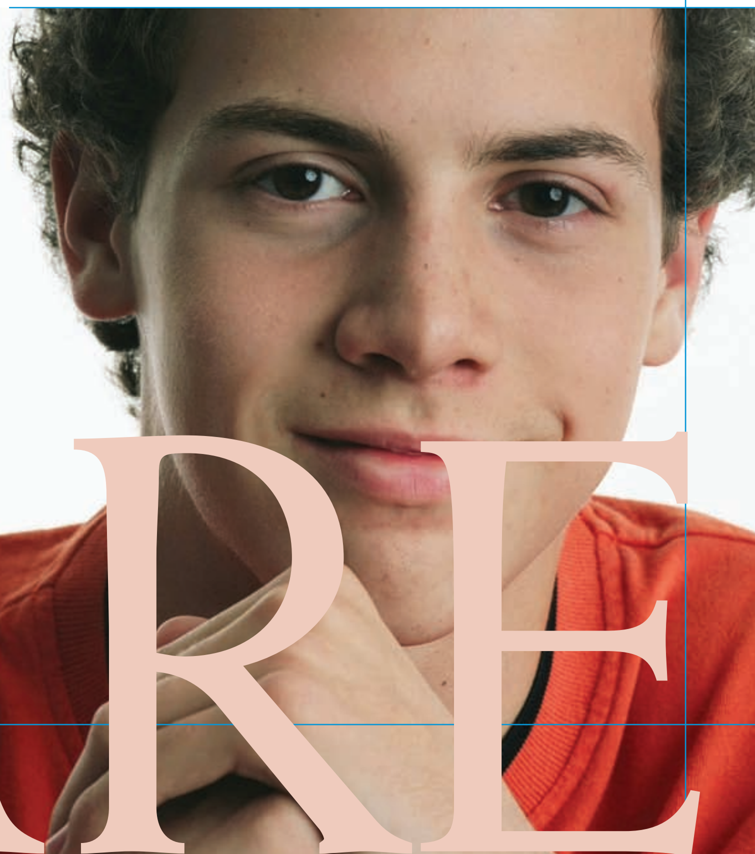
A few examples of Child Abuse and Neglect recommendations made in FY11:

- As recommended in two case reviews and previous annual reports, law enforcement shall adhere to 16 Del. C. §§§ 903, 904, and 905, Department of Services for Children, Youth and their Families (DSCYF) policy, and the Memorandum of Understanding between DSCYF, the Children's Advocacy Center, the Department of Justice (DOJ),and Delaware Police Departments when reporting child abuse and neglect via the report line.
- As stated in previous recommendations, CDNDSC recommends that DSCYF no longer accept any hand-delivered reports of child abuse and/or neglect from law enforcement. Instead all reports of child abuse and/or neglect shall be reported via the report line in accordance with the law (16 Del. C. § 903, 904, and 905), DSCYF policy, and the Memorandum of Understanding between DSCYF, the Children's Advocacy Center, the DOJ, and Delaware Police Departments.

◆ DSCYF shall review and modify its policies and procedures to give greater weight to criminal history for any individuals responsible for the care of children, including biological parents, when making decisions regarding the risk to and safety of children receiving services from the Division of Family Services (DFS).

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



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"Every baby's first breath on earth could be one of peace and love. Every mother should be healthy and strong. Every birth could be safe and loving. But our world is not there yet." Robin Lim

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Glossary...

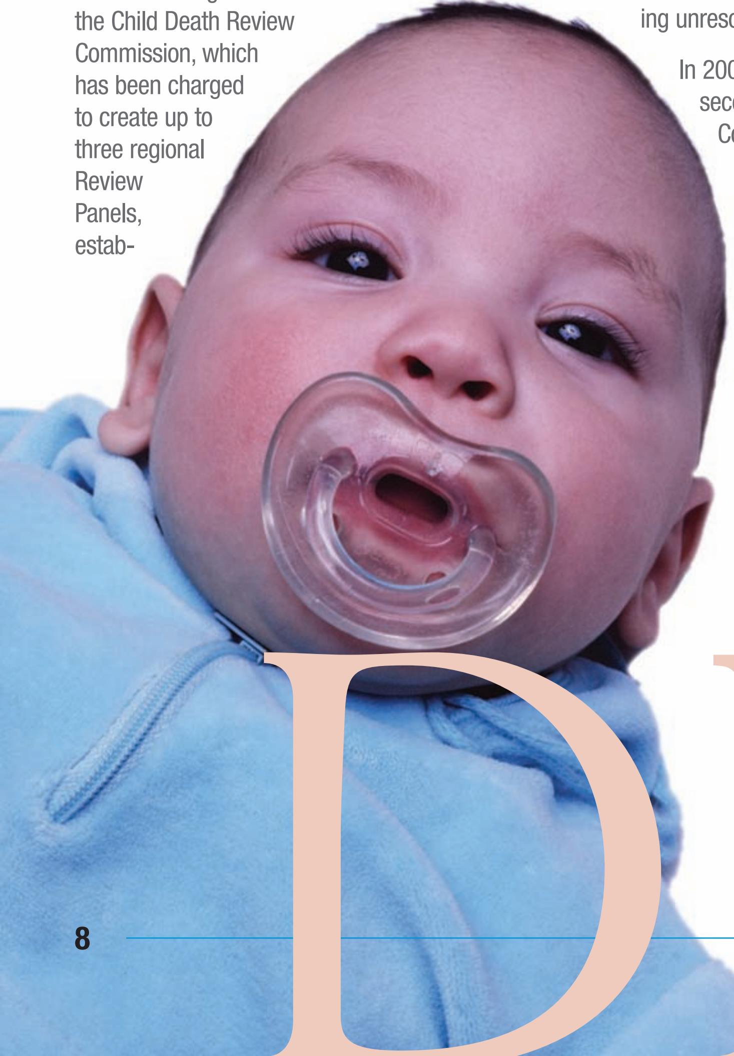
Commonly Used Terms...

Term	Definition
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)
CPAC:	Child Protection Accountability Commission
CPR:	Cardiopulmonary Resuscitation
CPS:	Child Protective Services (in Delaware known as DFS)
CRT:	FIMR Case Review Team
Delaware Juvenile Justice Advisory Group:	Established by Executive order on 7/19/04. More information can be found at http://cjc.delaware.gov/juvjustice/index.shtml
DFS:	Division of Family Services
DHMIC:	Delaware Healthy Mother and Infant Consortium
Disparity:	A lack of equality between people or things.
DPH:	Division of Public Health
DSCYF:	Department of Services for Children, Youth, and their Families
DTI:	Department of Technology and Information
DV:	Domestic Violence
Failure to thrive:	A pronounced lack of growth in a child because of inadequate absorption of nutrients or a serious heart or kidney condition, resulting in below-average height and weight.
Fetal Death:	Death before the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy; the death is indicated by the fact that after such separation, the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.
FIMR:	Fetal and Infant Mortality Review
Graduated Driver Licensing Law:	A method of licensing used for granting individuals the privilege to perform a task that takes skill and may put other individuals at risk of harm if not done properly, notably driving. Graduated drivers' 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 drivers' 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 Commisions:	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
NFP:	Nurse Family Partnership
NICU:	Neonatal Intensive Care Unit
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.

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 from a variety of disciplines together 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 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 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 FY05, 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 FY06, 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 FY07 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.

[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.

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During FY08, 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 neglect, after prosecution, to fulfill the federal CAPTA statute mandate.[5]

Abusive Head Trauma Program

After the Commission reviewed 13 deaths and near deaths involving abusive head trauma, the need for preventive parent education on abusive head trauma 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[6] 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 has 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 stating that they watched the DVD and understand its content. They 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 baby is born. If the parent needs additional support at the time of the phone call, appropriate referrals and resources will be given to the parent. 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 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 FY10 at all birthing hospitals throughout the State.

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*

As seen above, the Commission received 20 cases of child near death or child 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, not all hospitals were trained and fully implemented 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. As evidenced by these numbers, this prevention education program works. However, more work needs to be done with the hospitals to ensure that education continues and that such education remains effective.

[5] The first meeting of the Maternal Death Review was held on November 16, 2011 and will be discussed in the FY12 Annual Report.

[6] 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).

"UNLESS someone like you cares a whole awful lot, nothing is going to get better. It's not." The Lorax, Dr. Seuss

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Child Abuse Identification and Reporting Guidelines for Delaware Medical Providers

In FY09, CPAC's Abuse Intervention Subcommittee, through its Medical Workgroup, finalized the development of and launched its training program *Child Abuse Identification and Reporting Guidelines* for *Delaware Medical Providers*. This training was developed as a direct result of 11 cases of death and near death in which medical providers saw the child with injuries prior to the death or near death and failed to diagnose and/or report child abuse and neglect.

The inaugural training was co-presented by a local physician and a Division of Family Services staff member with great success on March 24, 2009, at Kent General Hospital to doctors, nurses, and social workers. CDNDSC, the training facilitator at the time, received monies through the Children's Justice Act Grant to facilitate ongoing training throughout the state.

Dr. Cindy Christian was the keynote speaker for the Delaware Child Abuse Recognition and Reporting Summit.

From April 2010 through December 2010, CDNDSC acted as the facilitator for the training for medical personnel. In January 2011, the Office of the Child Advocate (OCA) began facilitating the training on behalf of CPAC. Further, the same presentation was used to train over 800 medical, legal, social service, and law enforcement professionals at the Delaware Child Abuse Recognition and Reporting Summit on February 1, 2011, which was hosted and organized by the Delaware Department of State Division of Professional Regulation. Not only was the training a collaborative effort during its planning stage, but the combined expertise of three women, Dr. Danielle Giddins, Deputy Attorney General Patricia Dailey Lewis, and Stacy Northam-Smith from DFS, contributed to the success of the event.[7]

[7] CPAC Fiscal Year 2011 Annual Report

"Human progress is neither automatic nor inevitable... Every step toward the goal of justice requires sacrifice, suffering, and struggle; the tireless exertions and passionate concern of dedicated individuals."
Martin Luther King, Jr

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Protecting Delaware's Children Conference

At the start of the fiscal year, planning was underway by CPAC's Training Subcommittee to pinpoint national and local experts on emerging issues in child welfare. The Subcommittee worked to develop workshops with a wide array of learning opportunities for various professionals, who investigate and prosecute child abuse cases or who provide services to this population. With significant funding garnered for the training from the Federal Court Improvement Project under Family Court, the date was set for October 19-20, 2011. More information regarding the success of this conference will be provided in the FY12 annual report.

Child Protection Accountability Commission

CPAC and CDNDSC continued their collaborative affiliation through Fiscal Year 2011. In addition to semiannual Joint Commission Meetings and planning the Protecting Delaware's Children Conference, they also engaged in joint committees to develop a mandatory reporting outreach campaign, research a more effective risk assessment tool, and evaluate the current health care structure for children in foster care.

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:

- Mandatory Reporting Outreach Committee
- Risk Assessment Committee[8]
- Medical Committee
- The Infant Safe Sleeping Practice Community Action Team

Mandatory Reporting Outreach Campaign

To complement the training endeavors in the State, CPAC and CDNDSC's Mandatory Reporting Outreach Committee created an action plan to develop and/or coordinate two core initiatives: media activities and community education. As an immediate priority, the Committee set out to educate the general public about reporting child abuse in Delaware. First, the Committee established a logo, "Stop Child Abuse: See the Signs, Make the Call", with the support of Children's Justice Act funds. Simultaneously, the Committee prioritized the creation of the website, iseethesigns.org, which provides resources for reporting child abuse and neglect in Delaware. In addition, the website was unveiled concurrently with the Delaware Child Abuse Recognition and Reporting Summit, so professionals could access the resources. Public service announcements (PSA) were also recorded by the DSCYF Cabinet Secretary, Vivian Rapposelli, and Attorney General Joseph R. Biden, III. These PSAs were played regularly on local radio stations and during a promotional night at the Wilmington Blue Rocks, which took place on June 7, 2011. T-shirts advertising the Stop Child Abuse logo were distributed at the game, but more importantly, the Committee partnered with the Blue Rocks to advertise on a billboard in the stadium for the entire season. To sponsor this event, the Department of Justice secured funding through the Delaware Criminal Justice Council and the Federal FY10 Victims of Crime Act grant program.

Lastly, a Protecting Delaware's Children Fund was established at the Delaware Community Foundation thanks in part to the generous donation by the Ellen and Alan Levin Family Foundation. Despite these initial actions, the Committee hopes to demonstrate significant progress and garner additional funding to support the media activities in the upcoming fiscal year. As a second priority, the Committee is charged with coordinating the community education and prevention activities to ensure that the private and public sectors have knowledge of the child abuse prevention programs available across the State. For instance, the Committee supports the implementation plan for Darkness to Light's Stewards of Children prevention program. Specifically, multiple organizations have embarked on a collaborative initiative to bring a nationally utilized, evidence-based training program to Delaware. Prevent Child Abuse Delaware and the YMCA of Delaware are leading the effort with the Stewards of Children program, which uses an adult-based training curriculum to help adults prevent, recognize and react to child sexual abuse. Other lead partners in this endeavor include: the YMCA of Delaware, which is the designated fiscal agent for the program, and the Office of the Attorney General, which has championed it with press conferences, training of its staff, and the development of trainers to take the program into the community. In addition, multiple government and nonprofit child-serving agencies have also pledged ongoing support, including the Arsht Cannon Fund, Family Court, the Latin American Community Center, Child Inc., DFS, DOJ, Children's Advocacy Center, and OCA. In five years, the goal is to train 5% of Delaware's adult population or 35,000 Delawareans. Currently, facilitators, many of whom are from the agencies listed above, are being trained in each county to assist with the effort. In addition to training facilitators, a press conference and other events are being scheduled to bring recognition to the

[8] The Risk Assessment Committee was developed after 27 recommendations from child deaths citing Delaware's current risk assessment tool as being inadequate for protecting children from abuse/neglect.

program and to identify potential training audiences. PCAD will also be providing the three-hour Stewards of Children training to a group of participants at the Protecting Delaware's Children Conference on October 19, 2011.[9]

Risk Assessment Committee

An additional joint Commission initiative was the development of the Risk Assessment Committee after 20 recommendations involved re-evaluating the risk assessment model being utilized by the Division of Family Services. The mission of this Committee was to research various risk assessment tools and make recommendations on the most appropriate tool for Delaware to adopt and use. The CPAC and CDNDSC Risk Assessment Committee was created in FY10 and began to meet regularly on August 3, 2010. It was then that the members prioritized a goal of identifying the most effective risk assessment tool available for use within Delaware's child welfare system. It was determined that an ideal risk assessment tool is one that is objective, unbiased, and that cannot be manipulated by opinion or human emotion. Such a tool can then be used to determine, for example, whether or not an incident of suspected child abuse or neglect will be substantiated, whether or not risk of future harm to a child exists, and whether or not a case will be transferred to treatment. In researching best practices of risk assessment tools used by other states, it was determined that over 20 states are utilizing the Structured Decision Making Model (SDM) developed by the Children's Research Center (CRC). After contacting the CRC, the Committee attended a full day presentation on the SDM Model on December 20, 2010. Following further research, re-evaluation of Delaware's current tool, and a subsequent presentation by the Philadelphia Department of Human Services on its Safety Assessment and Management Process, the Committee recommended that DSCYF adopt the Structured Decision Making Model in its entirety and as properly tailored for our state. Further, the creation of a separate subcommittee on Differential Response[10] was recommended as well. With the Committee's final recommendations[11] approved by the Joint Commissions and embraced by DSCYF, the Committee's work concluded. Meanwhile, DFS has led the charge and negotiated a contract with the CRC to first adapt the SDM model at the child abuse and neglect report line and then into the rest of the Family and Child Tracking System (FACTS), which is the DFS computerized case management system. In the near future, the other components of the SDM model, including the safety assessment, risk assessment and case planning components, will be phased into FACTS. DSCYF should be highly praised not only for its participation on the committee, but also for fervently pursuing the implementation of the SDM Model and overcoming fiscal challenges to realize the importance of this tool.[12]

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 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 had its first meeting on January 14, 2011; however, since then, the Committee has prioritized the review of 40 case records representing individual children in foster care to evaluate how these children are currently receiving medical care. In collaboration with DFS, the Committee has been diligently conducting reviews in each county with the help of DFS staff. Upon completion of the reviews, a report will be submitted to the Joint Commissions detailing the recommendations that reflect compliance with the American Academy of Pediatrics' standards of care for children and teens in foster care.[13]

The Infant Safe Sleeping Practice Community Action Team

The Infant Safe Sleeping Practice Committee was created in FY06 after the Commission reviewed 57 infant and child sleep-related deaths during FY03-FY07. The Committee over the last four years has switched its focus and it has become more of 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).

[9] CPAC Fiscal Year 2011 Annual Report

[10] Differential response is a CPS practice that allows for more than one method of initial response to reports of child abuse and neglect. http://www.childwelfare.gov/pubs/issue_briefs/differential_response/differential_response.pdf

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

[12] CPAC Fiscal Year 2011 Annual Report

[13] CPAC Fiscal Year 2011 Annual Report

Exploring a Co-bedding Practice Change to Increase Safety from NICU to Home

Tracy Bell BSN, RNC-NIC and Karen Davis MSN, RNC-NIC

Abstract

Why was a Visual Model Chosen for Education?

How Might this Change Affect My Nursing Routines/Practices?

Ongoing Obstacles After Discharge From the NICU

Evaluation of Education

How Can We Model the AAP Recommendations For Safe Sleep for our Families?

Rationale for Evidence Based Practice Change:

Why Change Our Practice of Co-bedding to Single Bedding of Multiples?

Keep soft objects and loose bedding out of the crib. Avoid heavy quilts and comforters as blankets when in crib.

Christiana Hospital

Another TISSPCAT team member (Tracy Bell) from CCHS had a poster accepted to National Association of Neonatal Nurses on co-bedding multiples in the NICU. This idea was discussed at the TISSPCAT meetings.

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 practices. The goals of the action team will include: to expand the message from “Back to Sleep” to “Safe Sleep Environment” that will include all of the American Academy of Pediatrics taskforce recommendations on safe sleep practices; to reinforce the message whenever and wherever possible; to provide a consistent message that makes sense to the lay public; to address parental desires to keep the baby safe and comfortable; and to emphasize parent self-efficacy and the preventability of infant unsafe sleeping deaths.

As such, training and community education is critical for prevention efforts. Examples of preventive education involve the following:

- Nurse Family Partnership staff
- Division of Public Health staff
- Westside Health staff
- Bayhealth Baby Fair 2011, 600 adults and 885 children attended this event
- I Love Smyrna School District Day
- Delaware Adolescent Prevention Initiative (DAPI)
- 2nd Chance Resales and Website
- Bridge Program

Furthermore, CDNDSC will be working closely with the Education Subcommittee of the Delaware Healthy Mother and Infant Consortium (DHMIC) to develop a three year media campaign on infant safe sleeping in FY12. Other activities of the Community Action Team involve CCHS representatives (Pam Jimenez and Kathy Lefebvre) exploring the use of Halo Sleep sacks in the hospital instead of blankets.

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Among the 259 cribs that were delivered in FY11 through the Delaware Cribs for Kids program, not one death occurred in those families due to unsafe infant sleeping.

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 260 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.[14]

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. 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 in six weeks or less; or has an infant who is younger than six months of age. The first crib was distributed in November 2009. This program is one of the biggest accomplishments from the TISSPCAT.

January 7, 2011, Family receiving a "Pack n Play" from DPH. Since the program started in the fall of 2009, 379 cribs have been distributed as of June 30, 2011. Not one infant of a family that received the mandatory infant safe sleep education has died.

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. This 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. Please see the Delaware Cribs for Kids website® for more information.[15]

In an effort to continue to make this program self-sustaining, the "Delicious Delaware" cookbook was developed to benefit the Delaware Cribs for Kids program. Thus far, over $5,000 has been raised through this fundraiser to purchase cribs. In addition, the Pediatric Department at Christiana Care Health Services donated to Delaware Cribs for Kids program. Fundraising efforts will continue as the program has become better known in the community and the request for cribs exceeds each previous year.

One such example of community publicity was on January 7, 2011 when Cribs for Kids advocates Marjorie Hershberger, Anne Pedrick, Dr. Kate Cronan (Nemours), Judith Ann Moore (Division of Public Health), and a family receiving a "Pack n Play" were interviewed by WHYY for the "First" program. Infant safe sleeping and the Cribs for Kids Program were discussed.

[14] 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)

[15] www.cribsforkidsde.org

Other Partnerships...

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

- CPAC Subcommittees
  - 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
- Grief Awareness Consortium
- Nurse Family Partnership Advisory Board
- Suicide Prevention Taskforce
- Wilmington Consortium

CDNDSC Prevention Partners...

- 2nd Chance Resale & Consignment
- Bayhealth Medical Center
- Child Protection Accountability Commission
- Children and Families First
- Christiana Care Health System
- Delaware American Academy of Pediatrics
- Delaware Birth Defects Registry
- Delaware 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 Child Death Review
- 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

During FY11, the CAN Panel reviewed two child deaths that resulted from abuse and neglect. In addition, 11 (near death and death due to abuse/neglect) CAPTA reports were completed. The following recommendations were submitted to and approved by the Commission from the CAN panel. They reflect the recommendations from the two initial reviews and the 11 final reviews.

Child Protection Accountability Commission

1. **CDNDSC recommends that the Child Protection Accountability Commission's Risk Assessment Committee research more effective and efficient risk assessment tools that will objectively evaluate risk and history and appropriately incorporate and assess criminal, multigenerational and individual DSCYF history. (Final)**

   Rationale: Although a risk assessment was completed, the criminal, individual, and multigenerational histories were not given the appropriate weight.

   Anticipated Result: A more objective tool will be researched and implemented resulting in a more reliable assessment.

   Responsible Agency: Child Protection Accountability Commission's Risk Assessment Subcommittee and Child Death, Near Death and Stillbirth Commission

2. **CDNDSC supports the efforts of the Child Protection Accountability Commission's Abuse Intervention Subcommittee in developing and offering training on Mandatory Reporting of Child Abuse and Neglect for the general public.**

   Rationale: If the neighbor had reported the suspected abuse of the child, then the appropriate agencies would have been notified and earlier intervention would have been provided. Since the neighbor failed to report the suspected abuse, the child continued to reside in an unsafe environment which eventually led to the child sustaining life threatening injuries.

   Anticipated Result: To create awareness and raise the level of responsibility among agencies and the lay public for reporting cases of child abuse and/or neglect.

   Responsible Agency: Child Protection Accountability Commission's Abuse Intervention Subcommittee and the Child Death, Near Death and Stillbirth Commission

For an update on the two aforementioned recommendations, please see pages 11-12.

Department of Services for Children, Youth and their Families

3. **DSCYF shall review and modify its policies and procedures to give greater weight to criminal history for any individuals responsible for the care of children, including biological parents, when making decisions regarding the risk to and safety of children receiving services from the Division of Family Services. (Final)**

   Rationale: The Division reviewed the criminal history of the father but determined that he was not a threat. The father's criminal history included multiple charges of assault (both felony and misdemeanor), endangering the welfare of a child, and possession of a deadly weapon during the commission of a felony, all of which show a proclivity toward violent behavior. Even with the history, the Division determined that it did not meet a level of significance to disrupt placement that the mother had arranged.

   Anticipated Result: A more thorough review and more consideration will be given to the criminal history, which relates specifically

Recommendations for cases reviewed during FY11

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.)

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to crimes against persons, the nature of charges, premise checks, domestic complaint inquiries, child endangerment, treatment, and arrest history.

Responsible Agency: Department of Services for Children, Youth and Their Families

4. **DSCYF shall implement training for all supervisors and caseworkers on Delaware's criminal justice processes including, but not limited to, charges, pleas, prosecution, dismissals and definitions, and how understanding the criminal system can impact DSCYF risk assessment and decision making. (Final)**

   Rationale: DSCYF's lack of knowledge on criminal justice processes resulted in improper weight being given to the father's habitual civil and criminal activity when assessing the child's safety and placement with his father.

   Anticipated Result: DSCYF supervisors and caseworkers will have a better understanding of the criminal legal system and will be better able to effectively utilize this information in assessing the safety of a child.

   Responsible Agency: Department of Services for Children, Youth and Their Families

5. **DSCYF shall review and modify its policies, procedures, and training to clarify how caseworkers and supervisors can appropriately incorporate an individual's and individual family's multigenerational and chronic DSCYF history into their decision making. (Final)**

   Rationale: The extensive DSCYF history for both mother and father demonstrated a pattern of poor decision making, multigenerational history of abuse and neglect, domestic violence, substance abuse, and mental health issues which were not given appropriate weight when assessing the safety of a child.

   Anticipated Results:
   - A higher level of scrutiny for cases with extensive DSCYF history.
   - Earlier intervention in the life of an at risk child.
   - The development of guidelines created with a lower, more meaningful threshold for intervention and with a higher level of significance placed on multigenerational and chronic DSCYF history.

   Responsible Agency: Department of Services for Children, Youth and Their Families

6. **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. (Final)**

   Rationale: If such oversight had been provided, then the child would have been seen by a caseworker to continually assess safety. In this specific instance, the child was not seen for a period of ninety days. If contact had been made sooner and more frequently, the child may have disclosed the abuse that was occurring within the home prior to his near death, or the dramatic weight loss may have been noted and an investigation of this begun. Additionally, there is extensive history alleging physical and sexual abuse of this child which dates back to 2002. History of abuse and neglect, pertaining to the mother is also reflected in the Division records thus creating a pattern of multigenerational and chronic abuse and/or neglect.

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

   Responsible Agency: Department of Services for Children, Youth and Their Families.

7. **DSCYF should apply its frequency of contact requirements to the population based upon a thorough safety assessment of each child known to DSCYF, even if the child is not within DSCYF custody. (Final)**

   Rationale: The child was not seen by a DFS caseworker for over ninety days. The last time the child was seen was the day after the mother's attempted suicide, when a home evaluation was conducted by DSCYF. Since the mother arranged for the child to stay in the home of the father, the child was not defined as a child to be seen by DSCYF treatment

policy. DSCYF treatment policy states that, "a child's safety is assessed at the time of the initial face-to-face contact with the identified victim and household caregivers. A child is deemed safe when consideration of available information leads to the conclusion that the child in his or her current living arrangement is not in immediate danger or harm, and no safety interventions are necessary." The child's father was never made part of the original safety plan and the focus shifted to the two younger half-siblings who were residing with a non-relative caregiver. Therefore, the child was not made part of the treatment visitation schedule.

Anticipated Result: To ensure the safety of a child through at least monthly contact with the child in person, and more frequently when case circumstances merit.

Responsible Agency: Department of Services for Children, Youth and Their Families

8. **DSCYF shall review its policy of and further define "family" and "case." (Final)**

   Rationale: The child was not viewed as a child to be seen per policy by the Division due to the fact that the child was residing in the home of his father. However, if the child was considered part of the "case" and therefore part of the "family," then the immediate focus of the caseworker would have not only been the child's two younger half-siblings, but the child himself. The only time the child had been seen by a caseworker was after the mother's attempted suicide when a home evaluation was conducted and the child, father, and father's paramour were interviewed.

   Anticipated Result: To ensure the safety and well-being of all children known to the Division.

   Responsible Agency: Department of Services for Children, Youth and Their Families

9. **DSCYF shall update and/or develop policy delineating the steps and the difference between evaluating risk and safety when considering placement, via safety planning or DSCYF custody, with relative and non-custodial parents. (Final)**

   Rationale: Failure to view, assess and incorporate all known information about this family led to the child being placed in a high risk, unsafe home.

   Anticipated Result: Greater scrutiny by DSCYF of risk and safety assessments in order to ensure the safety of children.

   Responsible Agency: Department of Services for Children, Youth and Their Families

10. **As stated in previous recommendations, CDNDSC recommends that DSCYF no longer accept any hand-delivered reports of child abuse and/or neglect from law enforcement. Instead all reports of child abuse and/or neglect shall be reported via the report line in accordance with the law (16 Del. C. § 903, 904, and 905), DSCYF policy, and the Memorandum of Understanding between the Department of Services for Children, Youth, and Their Families, the Children's Advocacy Center, the Department of Justice, and Delaware Police Departments. (Final)**

    Rationale: A prior domestic violence incident in 2005, involving father, another paramour and their infant which was not called into DFS, but rather only left in a bin at the DFS hotline as indicated by a police report. No hotline report was ever entered into the DFS computer system.

    Anticipated Result: Better documentation of history within the DSCYF computer system which will lead to a better assessment of risk to the child(ren).

Responsible Agency: Department of Services for Children, Youth and Their Families

11. **CDNDSC asks that the Department of Services for Children, Youth, and Their Families ("Department") investigate the number of cases that are being assigned to investigative caseworkers to ensure that each caseworker is not exceeding the caseload set by the statutory standard as put forth in 29 Del.C. § 9012 (b) (1). In addition, CDNDSC asks that the Department report these numbers as a raw figure rather than an average. (Final)**

    Rationale: The Commission is aware that the number of cases assigned to the investigative caseworkers exceeds the statutory requirement and therefore raises concerns as to the caseworker's ability to adequately assess cases in a timely and thorough manner. In reference to this particular case, a complex set of factors exist, such as the multigenerational and chronic DFS history and the father's criminal history, that were not given proper weight which may have led to misjudgments by the caseworker.

    Anticipated Result: Compliance with the Delaware statute.

    Responsible Agency: Department of Services for Children, Youth and Their Families

Law Enforcement Agencies

12. **As recommended in two case reviews and previous annual reports, Law enforcement shall adhere to 16 Del. C. §§§ 903, 904, and 905, DSCYF policy, and the Memorandum of Understanding between the Department of Services for Children, Youth, and Their Families, the Children's Advocacy Center, the Department of Justice, and Delaware Police Departments when reporting child abuse and neglect via the report line. (Initial and Final)**

    Rationale: A prior domestic violence incident in 2005, involving the father, another paramour and their infant which was not called into DFS, but rather only left in a bin at the DFS hotline as indicated by a police report. No hotline report was ever entered into the DFS computer system. According to the Child Welfare Compilation this issue was originally made as a recommendation in 2006 as part of an expedited case review.

    Anticipated Result: For law enforcement agencies to be in compliance with law and policy and to reemphasize the role of DFS and police when reporting child abuse and/or neglect.

    Responsible Agency: Delaware Police Departments

13. **CDNDSC recommends that Law Enforcement Officers be educated on the effects of Shaken Baby Syndrome/ Abusive Head Trauma. Law Enforcement Officers should know their role in identifying and reporting cases of suspected abuse due to Shaken Baby Syndrome/Abusive Head Trauma and that physical injury might not be noticeable but internal injury may be present. (Initial Review)**

    Rationale: Law Enforcement received a report that a child had been shaken violently and upon arrival, law enforcement looked the child over and determined that the child was fine. However, because law enforcement officers are undereducated on the issue of Shaken Baby Syndrome/ Abusive Head Trauma, their inability and expertise to identify such injuries is limited.

    Anticipated Result: Law Enforcement will have a better understanding of the effects of Shaken Baby Syndrome/Abusive Head Trauma.

    Responsible Agency: Child Protection Accountability Commission's Abuse Intervention Subcommittee.

14. **CDNDSC continues to support the training of Law Enforcement Officers on the "Identification and Recognition of Child Abuse and Neglect Training." (Initial Review)**

    Rationale: Law Enforcement received a report that a child had been shaken violently, however no reports were made by law enforcement to the Child Abuse and Neglect Report Line regarding this incident.

    Anticipated Result: Law Enforcement will report abuse/neglect to the Child Abuse and Neglect Report Line.

    Responsible Agency: Child Protection Accountability Commission's Abuse Intervention Subcommittee

Office of Highway Safety

15. **CDNDSC will contact the Office of Highway Safety for further information and statistics regarding pedestrian jay walking.**

    Rationale: To look at the trends relating to death and or injuries resulting from jay walking at this location in order to see if further action needs to be taken.

    Anticipated Result: To affirm that all markings and signage are appropriately placed in order to prevent pedestrians from jay walking.

    Responsible Agency: CDNDSC

Drowning/Pool Safety

During FY11, the Commission reviewed two deaths due to drowning. Of those two deaths (ages 1-4) both were in a residential pool where the child was not supervised and supervision was needed. Proper supervision of children is the best way to prevent a child from drowning. Both of these cases occurred in Kent/Sussex counties.

Pool Safety Tips[16]:

- *Good pool supervision means scanning the area every 20 seconds when children are in the water, with an adult no more than ten seconds away.*
- *Good pool supervision is NOT telling the 12-year old to keep an eye on the little ones, no matter how strong a swimmer the older child might be.*
- *A four-foot fence around a pool with a self-closing, self-latching gate and locks beyond a child's reach are recommended.*
- *Do not stack chairs, other furniture or pool equipment near a fence to prevent children from climbing. The same goes for leaving toys in the pool that can entice kids back into the pool after water playtime is over.*
- *Cut back tree limbs extending over a pool fence to discourage climbing.*
- *Pool deaths are called the silent killer. Sometimes kids just slide under the water with hardly a splash and they never come out again.*
- *If a child goes missing and there is a pool around, head there first.*

Homicides (not due to child abuse and neglect)

The Commission reviewed one case of homicide not due to abuse or neglect. This death involved one African American child in the range of 15 to 17 years and involved a handgun. In this particular case, one adolescent was a bystander victim as a result of random violence that stemmed from an argument not involving this child. The perpetrator in this case was identified as a stranger.

"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 four times the number of American combat fatalities in Afghanistan to date." [17]

Injury Prevention

1. **CDNDSC recommends that the Office of Child Care Licensing (OCCL) distribute educational information to all child care facilities regarding the signs and symptoms of head trauma.**

   Rationale: In this particular case, the staff members at a child care facility were unaware of the signs and symptoms of head trauma.

   Anticipated Result: That all licensed child care facilities will know how to respond to a head injury occurring in their facility and prevent a future death or near death of a child.

   Responsible Agency: OCCL

[16] Don't let summertime fun end in tragedy, www.Delawareonline.com, 5/26/11.

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

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2. **Based on community behaviors that could minimize and/or prevent another near death, the Panel recommends a community outreach effort to educate parents on keeping their child safe while in the care of a babysitter. Specifically, parents should thoroughly investigate the homes in which they are leaving their children to ensure a safe environment that is free of hazards, where medications and toxins are out of reach and should always ensure that any caregiver can reach a parent easily by phone in case of emergency.**

   Rationale: A child had access to prescription medicine which led to their death.

   Anticipated Result: Parents will cover safety factors and hazards with all babysitters with whom they interact for the care of their children.

   Responsible Agency: OCCL

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.**[18]

   Rationale: If stove had been properly secured to the wall then it would have prevented the stove from tipping upon the child standing on the oven door.

   Anticipated Result: Creating a safer environment for children by child proofing appliances.

   Responsible Agency: Delaware Housing Authority

The International residential code series requires ranges to be listed and labeled and installed per manufacturer's instructions. Since 1991, all instructions have required anti-tip brackets. The entire State of Delaware is in this code series, some in the 2003 edition, some in the 2006 edition, and some in the 2009 edition.

Medical Prevention

1. **CDNDSC recommends that the standard of care as set forth by the American Academy of Pediatrics be followed when prescribing proper dosage and the administration of such dosage.**

   Rationale: A child died as a result of improper medicine dosage.

   Anticipated Result: To prevent future deaths or serious injury to children through the further education of this improper practice.

   Responsible Agency: CDNDSC will send a letter to the Medical Society of Delaware

2. **CDNDSC recommends that the use of Electronic Information Sharing and further enhancements of such systems be implemented and used by all medical professionals in order to help track hospital re-admission rates for premature babies who are discharged prior to weighing five pounds.**

   Rationale: The infant was discharged weighing less than five pounds to two cognitively delayed parents. Although this infant only presented to the emergency room once after birth, the child presented to his primary care physician several times within a matter of days. Standard of care would suggest that the child be seen more frequently given the diagnosis of non-organic failure to thrive, and the fact that the child continued to lose weight after each visit with the primary care physician. Furthermore, it is evident that the child's parents had limitations and therefore it is questionable as to whether further assistance was needed by the parents in order for them to adequately care for their child. If proper tracking and assessment of the child's history had been conducted, necessary intervention might have been provided and the child's diagnosis of failure to thrive might have been prevented. Additionally, current practice allows for discharge after four pounds. Statistics should be collected to ensure that this discharge protocol is not increasing the risk of serious injury or failure to thrive of premature infants.

   Anticipated Result: To establish a uniform medical tracking system so that all medical personnel are aware of the child's history upon admission

   Responsible Agency: Delaware Health Care Commission

[18] M1901.2 Cooking appliances. Household cooking appliances shall be listed and labeled and shall be installed in accordance with the manufacturer's installation instructions. The installation shall not interfere with combustion air or accessibility for operation and servicing.

DELAWARE
PREVENTING CHILD DEATHS IN THE FIRST STATE

CHILD DEATH, NEAR DEATH AND STILLBIRTH COMMISSION
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Motor Vehicle Collisions

The Commission reviewed 16 child deaths due to motor vehicle collisions. Motor Vehicle Collisions are the leading cause of death for teenagers in the United States and also in Delaware. Risk factors involving the 16 cases include one case of inadequate lighting, three cases where the teenager was responsible for the motor vehicle collision and two cases where the graduated licensing rules were not followed in which there were more than two teen passengers. In one case, the teen was under the influence of alcohol. In another case, the teen was driving without a license.

Of the deaths reviewed in FY11, female deaths occurred in ten out of the 16 motor vehicle collisions, and 12 of the children were Caucasian. Fifteen of the motor vehicle collisions occurred in a rural or suburban setting. Three children did not use seat belts. Two cases did not have a child/booster seat present when one was required by the Statute. One case involved a child on an ATV on a public roadway, and another child on a motorcycle with no helmet present.

Two of the 16 cases resulted in a child without a helmet being struck while riding a bicycle. Between 2003 and June 2010, eight children (all Caucasian male) have died on their bicycle while not wearing their helmet. In response to this concern, CDNDSC partnered with a Girl Scout earning her Silver Award, Smyrna Police Department, and Smyrna Rita's Water Ice to send a preventive message to the community. This prevention program started at the beginning of FY12 and will be featured in our next annual report.

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

1. **The Commission continues to support the community outreach efforts to high school students on the dangers of alcohol use and driving.**

   Rationale: A child died as a result of a motor vehicle collision, in which the child was under the influence of alcohol.

   Anticipated Result: To prevent future deaths or serious injury to children through the awareness and education on driving while under the influence of alcohol and drugs.

   Responsible Agency: CDNDSC

2. **The Commission recommends that DelDOT evaluate the shrubbery at the location of the collision and if deemed hazardous, the shrubbery be removed.**

   Rationale: A child died as a result of poor line of sight involving usage of an ATV.

   Anticipated Result: To prevent future deaths by establishing if the shrubbery poses a threat to all motorists or others.

   Responsible Agency: DelDOT

3. **The Commission shall refer to the Safe Kids Coalition to assess appropriate safety regulations for the use of off-road motorized vehicles for children.**

   Rationale: A child died as a result of improper ATV usage, in which the child was using the ATV on a roadway.

   Anticipated Result: To prevent future deaths or serious injury to children through the awareness and education of the dangers regarding ATV usage by children.

   Responsible Agency: Safe Kids

On January 2, 2011, Delaware's hand held cell phone ban went into effect. This law bans texting while driving and talking while driving unless using hands free equipment.

4. **As stated in previous annual reports, the Commission shall support the Safe Kids program in the continuation of education for car seat safety and safety seat checkpoints.**

   Rationale: A child died as a result of a motor vehicle collision, in which the child was not properly restrained in a car seat.

   Anticipated Result: To prevent future deaths or serious injury to children through the awareness and education on car seat safety.

   Responsible Agency: Safe Kids

Delaware law requires children to be in a car seat or booster seat until age eight or 65 lbs. 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 April 2011, the American Academy of Pediatrics released new recommendations on car seats, confirming that children should ride rear-facing to age two and use a booster seat until at least age eight. (Pediatrics. 2011 April;127(4):788-793)

Poisoning, Overdose or Acute Intoxication Deaths

The Commission reviewed a total of three[19] deaths due to poisoning, overdose or acute intoxication deaths. All three male Caucasian children were between the ages of 15-17. One death was intentional as part of a suicide. The rest were accidental overdoses as a result of substance usage (this may include alcohol, prescription drugs, over the counter medication, or herbal medicines from the internet).

On July 15, 2010, Governor Jack Markell signed into law Senate Bill 235.[20] This legislation authorizes the State's Office of Controlled Substances to establish a database of prescription information from pharmacies to prevent prescription drug abuse. This database gives the doctors the ability to check the database before giving prescriptions for controlled substances. Since 1999, deaths from drug use have more than doubled. This rate surpasses suicides, homicides and gunshot wounds in causes of death. This increase is largely because of prescription opiod painkillers.[21]

1. **CDNDSC recommends that the Department of Education take steps to assure proper interaction and communication between adults and their children with regard to alcohol and other drugs (AOD).**

   Rationale: If more education had been provided on the behaviors and preventive measures that could have been taken to help those suffering from addictions, then the child's death may have been prevented by means of earlier intervention.

   Anticipated Result: To assist those who are suffering from AOD through further education, specifically education geared toward interaction and communication with adolescents.

   Responsible Agency: Department of Education

[19] One case did not list this as the Medical Examiner "Cause of Death", however the circumstances from the case warrant inclusion under this category.

[20] http://delcode.delaware.gov/sessionlaws/ga145/chp396.shtml

[21] http://governor.delaware.gov/news/2010/1007july/20100715-prescription.shtml

Suicide

The Commission reviewed one child death due to suicide during this time period. The child had a history of substance abuse and was drug impaired at the time of the suicide. The child left a note but the suicide was completely unexpected.

Delaware continues to address this issue in a preventive manner. The Department of Services for Children, Youth and Their Families' Division of Prevention and Behavioral Health Services (DPBHS) is leading a grant (SAMHSA's Garrett Lee Smith Youth Suicide Prevention) program entitled Project LIFE (Living Is for Everyone). This program has been funded for three years, focusing on reducing negative behaviors and enhancing resiliency in youth most at risk for suicide. The goals are to prevent suicidal behaviors, reduce the impact of suicide and suicidal behaviors on individuals, families and communities and improve access to and availability of prevention services for vulnerable individuals. Strategies include: Gatekeeper trainings, social marketing campaigns, peer-to-peer support, a Crisis Hotline and website, Toolkits, funding two crisis workers and providing materials to parents and professionals. DPBHS has received a new round of funding for three more years to focus on middle school students and their families.

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

In FY11, eleven 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 11 cases are only reflective of the cases reviewed by the panels; not vital statistics data. Of these 11 deaths, five infants were white and six were black. In 82% of the cases (9 out of 11) cases, the infant was NOT sleeping in a crib or bassinette. In 64% (7 out of 11) of the cases, the infant was bed-sharing with another individual.

Among the 11 cases reviewed, six of the infants were not sleeping on their back. Three of these cases had unsafe bedding for the infant's sleep.

After review of the 11 unsafe infant sleeping deaths, the Commission has made the following recommendations:

1. **CDNDSC is in support of the recommendation that was put forth by the DSCYF Safety Council regarding the revision of policy to include the assessment of safe sleeping practices in cases involving infants as well as the provision of information pertaining to safe sleeping practices to the parents/care providers involved in such cases.**[22]

The DSCYF Delaware Safety Council (DSC) Chair will inform the DFS Director of the DSC recommendation that DFS consider revising policy to include assessing safe sleeping practices in cases involving infants as well as the provision of information pertaining to safe sleeping practices to the parents/care providers involved.

Rationale: An infant died as a result of unsafe sleeping practices. DFS was involved with this family and may have had the opportunity to educate the parents on infant safe sleeping deaths.

Anticipated Result: Families will have one more professional educating them on infant safe sleeping and possibly referring them to the Delaware Cribs for Kids Program.

Responsible Agency: DFS

2. **As stated in previous annual reports, CDNDSC supports the continued infant safe sleeping education for agencies such as Cribs for Kids, Prevent Child Abuse Delaware, Delaware SIDS Affiliate and other like initiatives.**

Rationale: The more attention that is brought to the issue of unsafe sleeping within the community, the more likely the public is to perceive it as a problem.

Anticipated Result: To increase awareness among agencies and families about programs that provide education on safe sleeping in order to prevent deaths that result from inappropriate sleeping accommodations.

Responsible Agency: CDNDSC

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," *(Click on link for statement: http://pediatrics.aappublications.org/content/128/5/1030*

[22] This case was a final child abuse/neglect case review, thus the reason the recommendation is appearing in subsequent annual reports.

On June 28, 2011, The Consumer Products Safety commission banned the manufacture and sale of drop-side cribs, which have been blamed for dozens of deaths. (Credit: U.S. Consumer Products Safety Commission)

These types of 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 have made this one of their top priorities for FY12.

The Infant Safe Sleeping Recommendations Include:[23]

- *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 percent.*
- *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 woman 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.*
- *Infants should receive all recommended vaccinations.*
- *Supervised, awake tummy time is recommended daily to facilitate development and minimize the occurrence of positional plagiocephaly (flat heads).*

[23] www.healthychildren.org

DELAWARE
PREVENTING CHILD DEATHS
IN THE FIRST STATE

CHILD DEATH, NEAR DEATH AND
STILLBIRTH COMMISSION
ANNUAL REPORT FOR FISCAL YEAR 2011

Part I: FIMR Background

The Fetal and Infant Mortality Review is a nationally recognized model to investigate the systems of care that affect the well-being of pregnant women and infants. Delaware piloted the FIMR process in 2004-2005. During that time period, the infant mortality rate in Delaware—the number of infant deaths per 1000 live births—was among the highest in the nation at 9.3 and significantly higher than the U.S. rate of 6.9. Governor Minner established the Infant Mortality Task Force in 2004 to make recommendations of strategies to reduce the infant mortality rate and improve health for women and infants. One of the recommendations from the task force was the on-going, in-depth review of fetal and infant deaths using the FIMR model. Since 2006 the Child Death, Near Death and Stillbirth Commission (CDNDSC) has conducted the FIMR program to review the majority of infant deaths and fetal deaths occurring after 20 weeks gestation in Delaware. The goal of the FIMR review is to identify and implement action steps that improve services for women and infants and optimize pregnancy outcomes. The Delaware infant mortality rate for 2005-2009 has decreased to 8.3 deaths per 1000 live births but is still significantly higher than the national average of 6.6.

As depicted in Figure 1, there are several steps in the FIMR process:

1. Data gathering: The Office of Vital Statistics reports infant deaths and fetal deaths to the CDNDSC on a regular basis. Infant deaths that do not involve abuse, neglect, or SIDS (sudden infant death syndrome) and all fetal deaths after 20 weeks gestation are grouped as potential FIMR cases. Infant deaths due to the aforementioned causes are triaged to the child death review process, which is also conducted by CDNDSC.

   The mothers of all potential FIMR cases are invited to participate in a maternal interview conducted by the FIMR senior medical social worker. Medical records are requested from clinics and hospitals.

2. Case review: All cases in which a mother gives an interview are discussed by a Case Review Team (CRT). Cases in which the mother was not interviewed are randomly selected for CRT discussion based on date of death: even dates of death are selected for one six-month period in the year, and the odd dates of death are selected for the other six-month period.

   CRTs are multidisciplinary groups including health care providers, public health professionals, social workers, community group representatives and health administrators. CRTs discuss each FIMR case to identify positive factors that worked in the mother's favor, risk factors that may have contributed to the poor pregnancy outcome and recommendations that would improve the systems of care that touched the mother and infant's lives.

3. Community action: FIMR recommendations are presented to the CDNDSC for review and approval. Once approved, FIMR recommendations are disseminated to community action groups including state agencies, community groups and the Delaware Healthy Mother and Infant Consortium (DHMIC).

4. Changes in community systems: Through the efforts of various community and state partners, several programmatic changes and educational initiatives have been made that affect women's care and knowledge in the perinatal period. The Division of Public Health and Subcommittees of the DHMIC are particularly important partners that have taken up recommendations and insights from the FIMR data. Specific action steps are documented in Part III of this report.

Case Reviews

FIMR CRTs reviewed 91 cases in fiscal year 2011 (FY11). Three CRTs met regularly from September 2010 to May 2011 and represented the City of Wilmington (n=26 cases), the balance of New Castle County (n=35 cases) and Kent/Sussex Counties combined (n=30 cases). The three CRTs reviewed the following average number of cases per meeting: Wilmington 4.3 cases, New Castle County 5.0 cases, and Kent/Sussex 4.3 cases.

Figure 1: Key steps in the FIMR process

The 91 FIMR cases that were reviewed in FY11 represent fetal and infant deaths that occurred over four calendar years: two cases from 2007, 50 cases from 2008, 27 cases from 2009, and 12 cases from 2010. (See Figure 2.) There was about a two year lag time between the occurrence of the fetal or infant death and CRT discussion of the case. Meanwhile, the Office of Vital Statistics continued to send monthly reports of more current cases of fetal and infant deaths to the CDNDSC office. These cases are added to the FIMR potential case list. Of the 131 cases reported to the CDNDSC between July 1, 2010 and June 30, 2011, nine cases did not meet FIMR criteria: three cases were elective terminations of pregnancy, two cases were fetal deaths under 20 weeks gestation and four cases were infant deaths under 20 weeks gestation.[24] The latter four cases involved deliveries where a live birth certificate was issued despite the fetus being previable; such cases are reported every year to the CDNDSC.

[24] Infant deaths differ from fetal deaths in that the former involves a live birth as determined by the birth attendants who accordingly issue a birth certificate. However, infants born before 20 weeks gestation are previable: because of their severe prematurity they cannot survive. Based on the National FIMR model, only fetal and infant deaths after 20 weeks are reviewed in the Delaware FIMR program. The definition of live birth in Del Code (title 16, section 3101) does not give a gestational age cutoff, which is problematic because it leads to variations in tracking for vital stats.

In light of this situation, the CDNDSC made the following recommendation in FY11:

- The CDNDSC recommends that the Delaware Healthy Mother and Infant Consortium review the definition of a still-birth versus a live birth. If possible, based upon federal guidelines a birth/death certificate should not be issued if the fetus is less than 350 grams or less than 20 weeks gestation. In lieu of a birth/death certificate, some type of certificate should be issued for the grieving parents.

Maternal Interviews

In FY11, 23 out of the 91 cases (25%) reviewed by the CRTs included a maternal interview: there was a maternal interview for 23% of the cases involving Black mothers and 30% involving White mothers. The maternal interview adds a richness of detail to the case summary presented to the CRTs as it gives the mother's perspective on her experiences, her interactions with systems of care and her decisions. In seven cases (8%), the FIMR social worker contacted the mother and she declined participating in the interview. In 57 cases (63%), the FIMR social worker attempted at least three times to contact the mother but was unable to do so.

Ten mothers who were interviewed in FY11 completed an evaluation about their experience participating in the FIMR process. Reasons given by mothers for participating in the FIMR interview included: they wanted to provide information that might help other mothers and infants (80%), they wanted to talk about their experience (50%), and they were looking for services in the community that may be beneficial for them (30%). 90% of mothers felt they could openly share their feelings during the interview, and 70% felt they benefited from their participation. 40% of mothers felt they gained some insight about their loss through participating in the interview, and 40% felt they did not: as one mother said, "we have accepted there are no answers."

Mothers completing an evaluation had varied responses as to when would have been the optimal time for initial contact with the FIMR program and participation in the interview. Three mothers (30%) felt between four to six weeks after their loss would have been optimal, two mothers (20%) would have preferred between two to four weeks after their loss. One mother felt that the initial contact should have been made in the hospital right after the delivery:

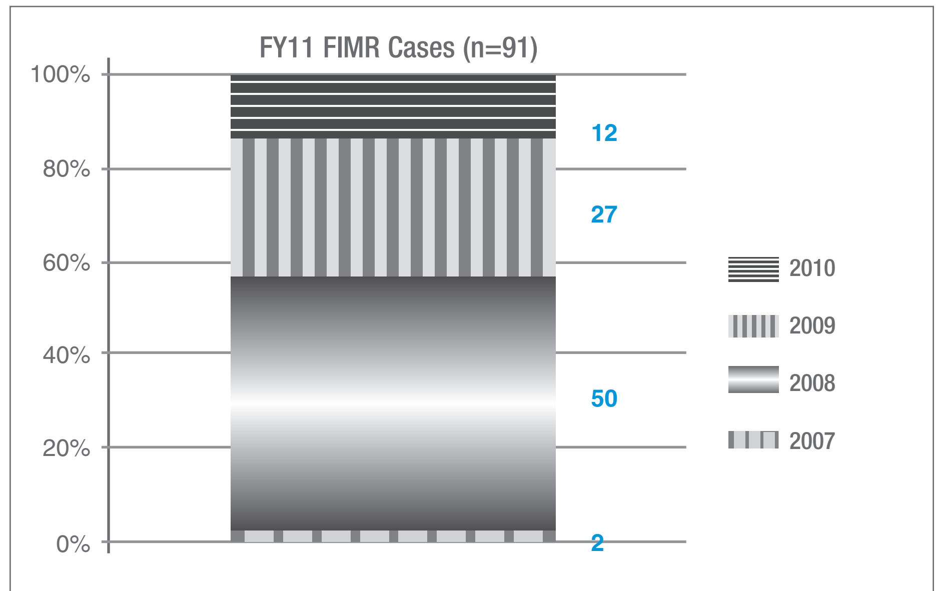

Figure 2: The number of FY11 FIMR infant or fetal death cases by calendar year of death

"It would have been better to know and talk about it in the hospital. All of the (information) given to us would have been useful in the beginning not 17 weeks after. . . I know it would have been harder to answer the questions as it was all so new but all of the resources and places to go to for help would have been a great resource."

Overall, mothers felt the maternal interview provided a safe venue for telling their story and that their interaction with the FIMR social worker was positive:

"(The FIMR social worker) was great and took all the time needed for me to explain some of (the) medical background which was great because many professionals never showed as much interest as she did! She was very interested in learning more about a rare medical problem I had, and letting me explain about it."

"(The social worker) was thorough with her line of questions. She was considerate about our loss and experience."

Annual Bereavement Conference

CDNDSC and FIMR hosted the fourth annual Delaware Bereavement Conference in October 2010. The bereavement conference provided resources, continuing education and support for professionals working directly with families grieving a fetal or infant loss. The conference addressed the topics of fathers' grief, sibling grief, and caregivers' working through their own experiences of loss and grief. The invited guest speaker was Tim Nelson, a certified grief facilitator/trainer from the Grief Recovery Institute. The FIMR social worker presented findings from FIMR maternal interviews relating to women's needs and experiences with grief and bereavement support. 55 attendees represented hospitals, community and outreach programs, private offices, health insurers and DPH.

Description of FY11 FIMR Cases

Of the 91 cases reviewed in FY11, 56 (62%) were fetal deaths or stillbirths, and 35 (38%) were infant deaths. The 91 FIMR cases involved 88 mothers, with three mothers experiencing multiple losses. Table 1 summarizes key maternal characteristics for the total 91 cases, the fetal death cases and the infant death cases. Cases are also separated by maternal race. Comparable proportions are provided for a comparison group of either all infant deaths or all live births in Delaware. Among FIMR infant deaths, there were a higher proportion of Black mothers (66%); this is comparable to the proportion of 2009 infant deaths that occurred to Black mothers (59%). In contrast, among FIMR fetal death cases, White mothers were more frequent, accounting for 50% of fetal cases. 40% of FIMR cases involved mothers who were receiving Medicaid, while 45% had private insurance. In 12% of FIMR cases the mother did not receive prenatal care, and this proportion was higher among Black mothers at 18%.

Table 2 provides key infant/fetal characteristics of the FY11 FIMR cases. As noted in previous FIMR findings, there was a higher proportion of FIMR fetal deaths during the 28-36 week gestation period (34%) compared to FIMR infant deaths from that same gestational period (14%). Over two-thirds of FIMR infant deaths occurred prior to 28 weeks gestation, while only about half of fetal deaths occurred in that period.

About three-quarters of the 35 FIMR infant deaths (77%) occurred in the neonatal period, before 28 days of life (Table 3). Of these 27 deaths, 17 of them (63%) occurred in the first 24 hours after birth. The remaining 23% (n=8) of FIMR infant deaths are classified as post-neonatal, occurring between 29 and 364 days of age. The proportion of FIMR infant deaths

Table 1: Maternal Characteristics of FIMR Cases

	% total FIMR cases (n=91)	% fetal deaths (n=56)	% infant deaths (n=35))	% White mothers (n=40)	% Black mothers (n=44)	% total DE infant deaths or live births
Maternal race[1]						
White	44%	50%	34%	0%	0%	33%
Black	48%	38%	66%	0%	0%	59%
Other	8%	13%	0%	0%	0%	8%
County of residence[1]						
New Castle	68%	68%	69%	63%	73%	63%
Kent	16%	13%	23%	20%	16%	20%
Sussex	15%	20%	9%	18%	11%	18%
Maternal age (years)[2]						
<20	12%	14%	9%	10%	16%	10%
20-29	55%	54%	57%	53%	55%	54%
30-39	27%	29%	26%	28%	27%	34%
40+	4%	4%	6%	8%	2%	3%
Maternal education[2]						
<12 years	25%	30%	17%	18%	32%	22%
High school diploma or GED	34%	32%	37%	43%	27%	25%
1+ years college	27%	23%	34%	23%	32%	25%
Postgraduate	3%	5%	0%	8%	0%	27%
No information	10%	9%	11%	10%	9%	1%
Marital status[2]						
Single	38%	41%	34%	35%	45%	48%
Married	43%	43%	43%	43%	36%	52%
Other	0%	0%	0%	0%	0%	0%
No information	19%	16%	23%	23%	18%	0%
Entry into prenatal care[2]						
1st trimester	68%	68%	69%	75%	64%	76%
2nd trimester	13%	18%	6%	13%	9%	16%
3rd trimester	0%	0%	0%	0%	0%	4%
No prenatal care	12%	11%	14%	8%	18%	4%
Method of payment[2]						
Medicaid	40%	36%	46%	33%	45%	49%
Private	45%	45%	46%	50%	39%	45%
Self	5%	9%	0%	8%	5%	2%
Other	8%	9%	6%	10%	7%	3%
No information	2%	2%	3%	0%	5%	2%

[1] Comparison group is 2009 total DE infant deaths (n=91). Delaware Health Statistics Center. Accessed at http://dhss.delaware.gov/dph/hp/2009.html on November 30, 2011.

[2] Comparison group is 2009 DE live birth cohort (n=11,369). Delaware Health Statistics Center. http://dhss.delaware.gov/dph/hp/2009.html. Accessed November 30, 2011.

Table 2: Fetal/Infant Characteristics of FIMR Cases

	% total FIMR cases (n=91)	% fetal deaths (n=56)	% infant deaths (n=35))	% White mothers (n=40)	% Black mothers (n=44)	% total DE infant deaths or live births
Sex of fetus or infant[1]						
Male	56%	55%	57%	58%	57%	54%
Female	44%	45%	43%	43%	43%	46%
Plurality[1]						
Single	93%	95%	91%	95%	93%	82%
Multiple gestation	7%	5%	9%	5%	7%	18%
Gestational age (weeks)[2]						
<28	56%	48%	69%	50%	66%	57%
28-36	26%	34%	14%	23%	25%	20%
37+	18%	18%	17%	28%	9%	23%
Birth weight (grams)[1]						
<500	24%	20%	31%	13%	36%	32%
500-1499	43%	41%	46%	45%	39%	34%
1500-2499	14%	20%	6%	15%	14%	13%
2500+	19%	20%	17%	28%	11%	22%

[1] Comparison group is 2004-2008 DE infant death cohort (n=474). Delaware Health Statistics Center. Delaware Vital Statistics Annual Report, 2008.

[2] Comparison group is 2003-2007 DE infant death cohort. Delaware Health Statistics Center. Delaware Vital Statistics Annual Report, 2008. http://dhss.delaware.gov/dph/hp/files/infant_mortality08.pdf. Accessed on November 30, 2011.

Table 4: Primary Cause of Infant Death

Primary cause of death	% FIMR infant deaths (n=35)	% White infant deaths (n=12)	% Black infant deaths (n=23
Prematurity	49%	25%	61%
Respiratory distress/failure	11%	17%	9%
Congenital malformations & chromosomal abnormalities	11%	17%	9%
Renal failure	6%	0%	9%
Shock	3%	8%	0%
Intraventricular hemorrhage	3%	8%	0%
Other	14%	33%	4%

Table 3: Age of infant death

Age at death[1]	FIMR FY11 infant deaths (n=35)	2004-2008 DE infant deaths (n=474)
<24 hours	49%	41%
0-28 days	77%	70%
29-364 days	23%	30%

that occurred in the first 24 hours after birth is slightly higher compared to all infant deaths in Delaware over the period 2004-2008.

The leading primary cause of death among FIMR infant cases was prematurity, accounting for 17 of the 35 cases (Table 4). A higher proportion of Black infant deaths were ascribed primarily to prematurity (61% or 14 cases) compared to White infant deaths (three cases), and this difference is statistically significant ($p=0.04$). Respiratory distress/failure was the second leading cause of death (n=4) among all FIMR infant deaths. Other primary causes of death, representing one case each, included cardiac dysrhythmia, cardio respiratory failure and placental abruption. During CRT discussion, a higher proportion of cases involving White mothers were noted to have a diagnosis of a congenital anomaly incompatible with life (15%) compared to cases involving Black mothers (7%).

Among all infant deaths in Delaware between 2004 and 2008, 24.7% were due to prematurity and low birth weight. Congenital anomalies accounted for 12.9% of deaths, and maternal complications of pregnancy—primarily incompetent cervix and premature rupture of membranes—accounted for 8.4% of deaths.

Every FIMR case is reviewed in depth by a multidisciplinary CRT. The CRT members discuss the case to identify pertinent positive factors, or "strengths" that may have protected the mother and worked in her favor. CRTs also identify negative risk factors, which are "contributing factors", associated with the poor pregnancy outcome. Finally, CRTs identify recommendations, or "suggestions" for individual, medical, social and community level changes that may improve women's perinatal services or pregnancy outcomes in the future. The findings from the CRT's discussion is recorded in the electronic database BASINET (Baby Abstracting System and Information NETwork) developed by Go Beyond, L.L.C.

In this section, the proportion of all 91 FIMR cases reviewed in FY11 with each strength, contributing factor and suggestion listed in BASINET is summarized. For a full list of all the strengths, contributing factors and suggestions identified in FY11 cases, please refer to appendices 1-3. Based on the frequency of the enumerated strengths, contributing factors and suggestions, the FIMR staff identified five key issues that continue to be important in impacting women's health and services in the perinatal period. All five of these issues have been identified in prior FIMR reports, but there are some variations in the proportion of cases affected from year to year.

The five key issues are:

1. Mothers' pre-existing medical conditions
2. Medical and social services and community resources available but not used
3. Identification of and referral for mothers' social stressors
4. Family planning and birth spacing
5. Grief support and bereavement services for families

Below, the proportion of affected cases in which the relevant strengths, contributing factors and suggestions were identified by the CRT are given for the fiscal years 2008 and 2009 combined, 2010 as well as 2011. For FY11 cases, the frequency is also presented separately for White and Black mothers.

In addition to the five key issues, three tracking issues are presented in this section:

1. Preterm labor
2. Fetal deaths later in pregnancy
3. Obesity/nutrition

These issues were included in prior FIMR annual reports, and so data on their prevalence in FY11 cases is highlighted for ongoing consideration while programs and educational campaigns have been implemented to address these issues. As action steps are implemented, changes in the FIMR data, if any, will take time to become evident as there is on average a two-year time lag between the occurrence of a death and its FIMR CRT review.

Besides actual changes in the number of cases affected by factors that come to light in the FIMR process, there are other reasons that may contribute to a FIMR issue's changing prevalence from year to year that should be kept in mind. Changes to the BASINET list of strengths, contributing factors and suggestions have affected the ease of capturing some of

Medical Issues Affecting FIMR Mothers in FY11

Strengths	% FY11 cases (n=91))	% FY10 cases (n=104))	% FY08-09 (n=136)	% FY11 Black mothers (n=44)	% FY11 White mothers (n=40)
Quality prenatal care with appropriate referrals	75%	71%	59%	73%	73%
High risk obstetric consultation	64%	53%	26%	61%	70%
Mental health referral	20%	15%	10%	16%	23%
Timely transfer to a more appropriate level of care	18%	26%	12%	18%	18%
Medication compliance	43%	26%	22%	34%	50%
Contributing Factors					
Pre-existing medical conditions such as asthma, hypertension, diabetes, mental health disorders, etc.	86%	80%	71%	89%	88%
Gestational diabetes	10%	6%	1%	5%	15%
Sexually transmitted disease (STD)	13%	19%	19%	18%	10%
Maternal infection other than STD's	34%	26%	20%	32%	33%
Noncompliance with plan of care	13%	12%	11%	14%	13%
Suggestions					
Importance of being healthy before pregnancy	79%	68%	71%	86%	75%
Home visits during pregnancy to monitor clinical status in high risk patients and provide education	46%	39%	43%	45%	48%
More intensive services/follow up to address patient education and non-compliance issues	19%	17%	18%	18%	20%
Better communication among healthcare providers, especially with high risk patients	5%	6%	2%	9%	3%

the data on cases. Changes in the BASINET database are made to better capture specific data on issues of interest, for example the provision of fetal kick counts education by providers. As the database changes and CRT members become more familiar with the list of potential factors to identify, certain strengths, contributing factors and suggestions are more likely to be regularly recorded. This may introduce an ascertainment bias that contributes to some of the changes in prevalence over the different years. The difference between an issue's frequency among Black and White mothers was tested for statistical significance using a Z-test for the comparison of two proportions. Differences associated with a p-value of less than 0.05 are noted in the following tables.

Mothers with Pre-existing Medical Conditions

Among the FIMR cases in FY11, eighty-six percent of mothers with a fetal or infant loss (n=78) had a significant and perhaps contributory history of pre-existing medical conditions. Almost two-thirds of mothers had a high risk obstetric consultation during pregnancy. Among Black mothers, a significantly higher proportion had inadequate nutrition, including anemia during pregnancy, compared to White mothers, 34% and 10% respectively. Several years of FIMR data show a continuing high proportion of mothers with significant medical history that may increase their risk for pregnancy complications and poor outcomes. Table 5 provides a breakdown of some of the types of medical issues affecting FIMR mothers in FY11.

Recommendations

- FIMR CRTs continue to support preconception, interconception and prenatal teaching of the importance of the mother's health with optimal management of medical conditions (79% of cases). In 46% of cases CRTs deemed that home visitation services may help monitor clinical status in high risk women and provide education. While 43% of mothers were considered compliant with their plan of care, in 19% of cases CRT members recommended more intensive follow up and education to improve compliance.
- With about 20% of mothers having a history of mental health issues—particularly depression and anxiety--FIMR supports the efforts of the DHMIC's Systems of Care subcommittee as it examines the impact of mental health and behavioral health disorders on maternal and child health.

Action Steps

- The DHMIC and DPH are promoting Reproductive Life Plan toolkits to help women set and follow personal goals and, when desired, achieve healthy pregnancies. These toolkits were developed in 2009 and are available online at http://dhmic.healthywomende.com/Resources/Marketing-Materials

The DHMIC is coordinating the Healthy Women Healthy Babies (HWHB) care model that recognizes the importance of healthy behaviors and preventive services on a woman's well-being. Based on a life course perspective, the HWHB program provides health care, mental health and nutrition services for women before, during and after pregnancy. HWHB clinics are located throughout the State and in FY09 served over 11,000 women.

Table 5: Frequency of Pre-existing Medical Issues Among FIMR Mothers

Medical or obstetric issue	Percent of mothers affected (n=88)	Comments
Acute or chronic respiratory problem	26%	
Asthma	22%	
Bronchitis	5%	
Mental health issue	22%	Most frequently depression and anxiety
Cardiovascular	7%	Includes history of murmurs, arrhythmia
Hypertension	13%	
Musculoskeletal problem	10%	Includes injuries and arthritis
Neurological issue	13%	Most frequently diagnosis of migraines
Endocrine issue	10%	
Urinary infections	15%	
Anemia	9%	
Gastrointestinal issue	20%	Includes history of reflux and gallstones
Gynecological issue	43%	Other diagnoses include uterine fibroids and polycystic ovaries
Abnormal Pap smear	15%	
Infertility	5%	

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Medical and Social Services and Community Resources Available but Not Used

FIMR data over the last several years shows the continued importance of women accessing appropriate medical, social service and community resources. The first step in access to services is identifying a woman's needs based on her social, economic and medical history. In 36% of FIMR FY11 cases, there was no documentation in the medical record for providers' screening the mother for her possible eligibility to benefit from such services as Smart Start, Nurse Family Partnership or Resource Mothers. 45% of cases involving White mothers lacked documentation of such screening compared to 25% of cases involving Black mothers, and this difference was almost statistically significant (p=0.54). In 47% of cases, the CRTs felt that a mother may have benefited from available support services in her area, but such services were not used. Of note, a significantly higher proportion of Black mothers (20%) were felt to have fear of or dissatisfaction with systems of care, and this may reduce their acceptance of medical or social services. In only one case did CRTs determine that services were unavailable: this case involved trying to access prenatal care and social services for a homeless mother.

Recommendations

- CRTs recommend early screening for services such as Smart Start and Nurse Family Partnership at the first prenatal visit (31% of cases) and early referral to social services (46% of cases).
- With 14% of mothers dissatisfied or fearful of the health care or social service system– particularly Black mothers–efforts should be taken to educate the public as well as prenatal providers on the importance and benefits of such support services.

(continued)

Medical and Social Services and Community Resources Available But Not Used

Strengths	% FY11 cases (n=91))	% FY10 cases (n=104))	% FY08-09 (n=136)	% FY11 Black mothers (n=44)	% FY11 White mothers (n=40)
SS (Smart Start)/NFP (Nurse Family Partnership)/RM (Resource Mothers) involvement	4%	4%	NR	5%	3%
Screened for SS (Smart Start)/NFP (Nurse Family Partnership)/RM (Resource Mothers)	8%	3%	NR	11%	3%
Referral for SS (Smart Start)/NFP (Nurse Family Partnership)/RM (Resource Mothers) involvement	7%	5%	NR	9%	3%
Contributing Factors					
No SS (Smart Start)/NFP (Nurse Family Partnership)/RM (Resource Mothers) screening	36%	27%	1%	25%	45%
Medical and social services/ community resources unavailable in area	1%	1%	1%	2%	0%
Medical and social services/ community resources available, but not used	47%	32%	40%	50%	43%
Quality of medical and social services/community resources inadequate to meet needs	4%	2%	3%	5%	3%
Patient fear of or dissatisfaction with system	14%	12%	7%	20%*	5%
Suggestions					
Home visits during pregnancy to monitor clinical status in high risk patients and provide education	46%	39%	43%	45%	48%
SS/NFP/RM prenatal screening on initial prenatal visit	31%	24%	NR	30%	33%
Education on the importance of SS/NFP/RM services	25%	13%	NR	27%	25%
Understanding benefits of SS/NFP/RM services as evidenced by referrals	20%	5%	1%	16%	25%
Knowledge of community services available as evidenced by referrals	10%	12%	26%	2%	18%*
Timely entry of risk assessment scores and/or referrals so care can be initiated promptly	11%	7%	2%	7%	15%
Better follow up when patients that are referred do not keep appointment	4%	6%	7%	2%	8%
SS/NFP/RM postnatal screening after delivery before baby is discharged	2%	NR	NR	5%	0%
Enhance communication between providers, hospitals and community services such as SS/NFP/RM, clinics, etc.	2%	6%	1%	5%	0%
Accurate scoring of SS/NFP/RM risk factors	3%	NR	NR	0%	8%

NR=not reported **statistically significant difference between Black and White mother ($p<0.05$)*

Identification of and Referral for Social Stressors in Mothers' Lives

Strengths	% FY11 cases (n=91))	% FY10 cases (n=104))	% FY08-09 (n=136)	% FY11 Black mothers (n=44)	% FY11 White mothers (n=40)
Church support	19%	14%	3%	18%	23%
Family support	63%	63%	17%	73%	58%
Father of baby involved/supportive	65%	61%	26%	59%	68%
Parents in a stable marriage	34%	28%	20%	30%	33%
Stable financial situation	21%	24%	18%	18%	25%
Supportive friends	25%	20%	12%	16%	40%*
Mother demonstrated self-advocacy	32%	23%	4%	30%	38%
Mother had a positive attitude despite multiple hardships and challenges in her life	19%	16%	7%	11%	25%
Past Social Services involvement	40%	57%	34%	45%	35%
Active Social Services involvement	26%	29%	NR	32%	20%
Referrals to needed community resources such as Women, Infants and Children (WIC) program, food stamps, shelter, etc.	21%	28%	9%	25%	15%
Contributing Factors					
Presence of life course perspective risk factors (stressors in childhood, history of abuse, poverty, lack of support, etc.)	41%	40%	24%	50%	30%
Domestic abuse (during pregnancy or infant's life)	4%	7%	3%	5%	5%
Lack of support systems (during pregnancy or infant's life)	18%	16%	15%	14%	20%
Poverty (during pregnancy or infant's life)	21%	33%	13%	23%	15%
Other emotional stressors during pregnancy (such as loss of job, loss of loved one, incarceration, divorce, natural disaster, etc.)	43%	38%	20%	39%	53%
Father of baby involved but not supportive	9%	14%	NR	7%	13%
No domestic abuse screening documented	52%	40%	7%	34%	68%*
Suggestions					
Better assessment of family's home/ socioeconomic situation	45%	38%	40%	36%	48%
Consistent/ongoing domestic violence (DV) screening	60%	43%	9%	52%	70%
Early referrals to social services	46%	35%	37%	41%	48%
Referral for financial assistance, WIC, food stamps, emergency shelter, etc.	18%	18%	7%	16%	23%
Use open ended questions on initial contact to solicit more info from parent	5%	4%	28%	7%	3%

NR=not reported **statistically significant difference between Black and White mother (p<0.05)*

- To help coordinate the needs of high risk women with private insurance, FIMR supports the role of the perinatal case manager as a resource for mothers as they navigate the health system.

- FIMR continues to support the establishment of a central point of entry for integrated family and early child services through the Delaware "Help Me Grow" program. DPH is working to establish a telephone-based information and referral service that can help families access appropriate services. Such a single point of entry will also facilitate the care coordination of resources between state agencies, programs, and providers.

Action Steps

- The Delaware Maternal, Infant, and Early Childhood Home Visiting program has received a competitive grant to better coordinate and increase capacity for services provided through evidence-based home visiting programs such as Smart Start, Nurse Family Partnership, Parents as Teachers and Early Head Start. The grant provides an additional $2.9 million for home visiting services in Delaware.
- DPH is restructuring Smart Start to incorporate an evidence-based model of home visits, the Healthy Families America (HFA) model. The HFA model involves intensive home visits that are initiated prenatally or up to 90 days after birth and focuses on at-risk geographical areas in the State.

Identification of and Referral for Social Stressors in Mothers' Lives

41% of FIMR mothers (n=37) had a life course perspective risk factor as determined by CRT review. The life course perspective takes into account a woman's life-long history including major stressors from childhood or her environment. Half of Black mothers had such a risk factor. A high proportion of FIMR mothers (43%) also had an emotional stressor during pregnancy, including slightly over half of White mothers. Of the 23 women who were interviewed by the FIMR social worker, nine (39%) disclosed a

(continued from page 33)

history of childhood abuse, eight (35%) reported experiencing job-related stress during their pregnancy and seven (30%) were worried about having enough money. Women with life course risk factors and/or socioeconomic stressors may benefit from social services. About one-fourth of the FIMR mothers were actively involved with social services, and 21% were referred to community resources such as public assistance programs.

The prevalence of social stressors among the larger group of all women with a live birth in Delaware is assessed through the Delaware Pregnancy Risk Assessment Monitoring System (PRAMS). According to this survey, 14% of women who had a live birth in 2008 were on some type of public assistance program such as Temporary Assistance for Needy Families (TANF), food stamps or Supplemental Security Income (SSI). 48% were enrolled in WIC (Special Supplemental Nutrition Program for Women, Infants and Children.)

Upon CRT review, 52% of FIMR cases did not have documentation of domestic violence screening in any part of the medical record, and this proportion was significantly higher among cases involving White mothers (68%) compared to Black mothers (34%). Only 13% of cases specifically noted domestic violence screening by health care providers. 4% of FIMR mothers experienced domestic abuse. As reported through PRAMS, 54% of women who had a live birth in 2008 were asked by a health care provider about domestic violence and 3% were physically hurt by their partner during the pregnancy.

Case Study:

A 26 year old mother suffered a fetal demise at 35 weeks. She has multiple psychosocial issues including mental illness–bipolar disorder and depression–homelessness, domestic violence, substance abuse and significant Division of Family Services (DFS) history. She relies on income from Social Security Disability. She entered into prenatal care between 19-21 weeks gestation and subsequently had infrequent prenatal care. The mother reported her partner, the father of the baby, was hitting her, and she was fearful of him. Psychiatry and social work were consulted. Later in the second trimester, the mother came to the hospital with abdominal pain and diarrhea. She admitted to still being with her partner and experiencing ongoing physical abuse. She was afraid to go home. A social worker assisted her in getting a life phone. She declined police or SANE intervention and was ambivalent about leaving her partner. She said she planned to leave him next month when she received her next SSI check.

The mother presented again a week later with depression stating she had no place to live, no job and did not know where to go with the baby. She stated she had been homeless for two months. She smokes marijuana daily: her urine drug screens were positive for cannabis and/or cocaine/barbiturates. She was followed by psychiatry and was in the hospital for two weeks.

Her last admission was at 35 5/7 weeks after having fallen backwards, hitting her head and losing consciousness. She suffered a fetal demise. She was induced and delivered uneventfully via repeat C-section. A maternal interview was conducted and the mother denied any domestic violence history as documented in the medical records.

Recommendations

- There should be more consistent documented ongoing domestic violence screening, as noted by CRTs in 60% of FIMR cases.
- In 45% of cases, CRTs recommended better assessment of a woman's home and socioeconomic situation. In order to do this, an effective screening tool is needed. The screening should be done in an appropriate, confidential manner. Part of the screening should be to inquire about the social services and types of assistance with which the mother/family are already involved.

Action Steps

- The Delaware 211 "Help Me Grow" telephone-based referral system will help link families to social services such as TANF, WIC and housing assistance.
- The Standards of Care Subcommittee of the DHMIC is looking into screening for domestic violence and intimate partner violence. The subcommittee is working with Delaware State University and the Delaware Coalition against Domestic Violence to evaluate the screening resources available and possible educational initiatives for healthcare workers and/or the public to raise awareness around the importance of this issue.

Family Planning and Birth Spacing

About equal proportions of FY11 FIMR cases were planned pregnancies (26%) and unplanned pregnancies (27%). The length of the interpregnancy interval, the number of months between the end of one pregnancy and the start of the next, has been associated with pregnancy outcome. The lowest risk for preterm birth, low birth weight or fetal growth restriction is associated with an interpregnancy interval of 18-23 months. Among FY11 FIMR cases, 37% had an interpregnancy interval of at least 24 months. There continues to be

scant documentation of what birth spacing education is provided to women at their postpartum visit. Of the 78 women who had a postpartum visit, 58 women (74%) did not have any birth spacing education documented in their record. Five women (6%) were counseled to wait less than six months before trying to conceive again. Five women (6%) were counseled to wait 6-12 months, three women (4%) were counseled to wait 12-24 months, and four women (5%) were counseled to wait at least 24 months or two years.

From maternal interviews, it is also evident that the message on appropriate birth spacing has been delivered inconsistently; leading to confusion and frustration for parents who are trying to plan for their next baby and who have already suffered a terrible loss. During some of the FIMR interviews, the FIMR social worker noted the following regarding birth spacing education:

- The mother of the baby said her doctor did not talk to her about waiting to get pregnant or birth control during the postpartum visit.
- The mother said that her doctor is encouraging her to get pregnant now and does not believe in waiting two years between pregnancies, and said if you get ten doctors in a room they will all give you a different opinion on how long a woman should wait.
- The mother said she was told by her doctor to wait three months. The father of the baby said that the hospital told them to wait 18 months.
- The parents were told to wait three to six months to try again, but the father is concerned that that is not enough time and wonders how the mother's body could possibly be ready to maintain a pregnancy after such a short amount of time.

Family Planning and Birth Spacing in FY11

Strengths	% FY11 cases (n=91))	% FY10 cases (n=104))	% FY08-09 (n=136)	% FY11 Black mothers (n=44)	% FY11 White mothers (n=40)
Planned pregnancy	26%	23%	21%	25%	23%
Interpregnancy interval of at least 24 months	37%	37%	27%	34%	38%
Unintended pregnancy, but parent(s) happy	18%	12%	6%	16%	20%
Family planning counseling done	49%	34%	17%	55%	45%
Contraceptives or script given postpartum at hospital discharge	26%	17%	13%	34%	23%
Mother offered contraception but declined	7%	26%	NR	5%	8%
Contributing Factors					
Unplanned pregnancy (parental compliance/knowledge)	27%	24%	17%	27%	33%
Undesired pregnancy (parental compliance/knowledge)	4%	2%	2%	9%	0%
Lack of or inadequate family planning education (per provider)	9%	12%	2%	7%	10%
Inadequate birth spacing	16%	17%	16%	20%	10%
Ambivalent feelings toward pregnancy	3%	6%	NR	5%	5%
Suggestions					
Importance of family planning/preconceptional/interconceptional care	75%	53%	54%	80%	68%
Education on appropriate birth spacing	79%	67%	40%	82%	75%
Birth control in the immediate postpartum period and compliance with chosen contraceptive method	40%	39%	21%	41%	35%
Family planning counseling with contraception dose/script or tubal ligation prior to discharge	24%	26%	14%	25%	18%
Persistent follow up for contraception/family planning when patients initially refuse services in hospital or at postpartum visit	9%	30%	14%	9%	10%

NR=not reported

Recommendations

- CRTs recommended better documentation and more consistent education regarding appropriate birth spacing in 79% of FIMR cases. Early discussion of options for family planning is important in the postpartum period as determined in 40% of cases.
- FIMR supports the birth spacing awareness initiative as a statewide education campaign.

Action Steps

- The Systems of Care subcommittee of the DHMIC is promoting awareness of the Medicaid family planning waiver among women and health care providers. Under the Medicaid family planning waiver, women are eligible for family planning services for up to 24 months after their Medicaid closing.

(continued)

Grief Support and Bereavement Services for Families

Grief support for families experiencing a fetal or infant loss is an important aspect of their care. Grief support may begin in the prenatal period itself if a life-limiting fetal anomaly is diagnosed. 97% of FIMR mothers received in-hospital grief support. While 69% of mothers were referred to community grief support services after hospital discharge, only 10% had documented receipt of such services. Healthy Beginnings, Parents as Teachers, Smart Start, Compassionate Friends, Loving Arms support groups and hospice are among the community resources that provided assistance to families. There are also services to take professional photographs of the deceased infant or fetus prior to funeral arrangements. In eight out of the 23 maternal interviews (35%), women said they were not offered this service; one mother had received professional photography services with a previous loss, and "would have loved to have had that available to me for this loss" as she "cherishes" the photos of her deceased baby.

The importance of quality, unhurried grief support in the hospital setting is reinforced by mothers' comments during the FIMR interview. From maternal interviews:

- The mother was "disappointed" in her interaction with the hospital social worker. She said she came in and talked to her "real quick" just an hour before being discharged.
- The parents were offered social work services at the hospital, but the social worker did not come until they were getting ready to leave. The mother was disappointed that they were not offered more support in a timely manner. The social worker also called the mother by the wrong name.
- The mother said she was waiting for someone to reach out to her from the hospital after she was discharged. She saw a social worker in the hospital who gave her a packet. The mother was not happy with this level of support and said "reading a packet is not the same as support." She never received a follow up call and finally called the social work department herself, and no one returned her call.

Grief Support and Bereavement Services for Families in FY11

Strengths	% FY11 cases (n=91))	% FY10 cases (n=104))	% FY08-09 (n=136)	% FY11 Black mothers (n=44)	% FY11 White mothers (n=40)
Professional staff respectful of parents' wishes to continue pregnancy despite poor prognosis	14%	20%	10%	18%	13%
Lethal anomaly diagnosed with discussion of options	7%	8%	7%	2%	15%*
Autopsy offered	78%	57%	NR	70%	83%
Chaplain, pastor, nurse, Smart Start (SS), Nurse Family Partnership (NFP), Resource Mothers (RM) or social work grief support	97%	97%	82%	95%	95%
Family requested to see baby to bond	60%	54%	21%	66%	53%
Referral to community grief support services after discharge	69%	58%	62%	68%	65%
Follow up per hospital bereavement team	10%	15%	58%	9%	10%
Suggestions					
Prenatal providers to take an active part in addressing grief and denial issues	92%	94%	96%	95%	85%
Referral to community agency for grief counseling	91%	90%	92%	93%	85%
Debrief parents 2-3 months after loss to assess understanding of cause(s)/ circumstances of death	33%	45%	27%	36%	30%
Grief counseling/support at delivery and/or pediatric care facility	22%	9%	5%	20%	20%
Follow up with patients that initially decline grief support services	13%	16%	2%	16%	8%
Have Chaplain see patient to assess needs	10%	12%	3%	5%	13%
Postpartum depression screening and assessment of grieving status with appropriate referrals	34%	38%	12%	34%	33%

NR=not reported **statistically significant difference between Black and White mother ($p<0.05$)*

Other Issues to Track for Families in FY11

Strengths	% FY11 cases (n=91))	% FY10 cases (n=104))	% FY08-09 (n=136)	% FY11 Black mothers (n=44)	% FY11 White mothers (n=40)
Good obstetric management of preterm labor	24%	27%	10%	25%	28%
Compliance with bedrest, activity limitations and/or no intercourse orders	24%	11%	6%	27%	23%
Mom recognized signs/symptoms of preterm labor, premature rupture of membranes (PROM), etc. and sought immediate medical care	32%	31%	15%	34%	30%
Contributing Factors					
History of previous preterm and/or low birth weight baby	14%	23%	12%	20%	8%
History of preterm labor	15%	15%	7%	20%	10%
PROM/Preterm PROM	18%	25%	21%	23%	15%
Preterm labor	41%	31%	32%	48%	33%
Suspected clinical chorioamnionitis	12%	21%	NR	16%	5%
Histological chorioamnionitis **	41%	14%	NR	45%	35%
Signs and symptoms of labor or rupture of membranes and when to call health care provider	7%	16%	7%	5%	10%
Previability of fetus	22%	27%	25%	32%*	13%
Prematurity	32%	56%	45%	41%	25%

NR=not reported

**statistically significant difference between Black and White mother (p<0.05)*

***Note: chorioamnionitis indicates the presence of inflammation which may or may not be due to infection.*

Recommendations

- CDNDSC recommends that hospital nurses/social workers should make it standard practice to offer a professional photography service to parents when there is a fetal/infant demise.
- When a mother is diagnosed with a fetal demise and/or poor pregnancy outcome; healthcare providers/staff should increase awareness and sensitivity and offer immediate emotional support. Bereavement support should be offered by the healthcare personnel at the point of impact and referrals initiated for persons trained in bereavement support and/or hospital chaplains to continue support as the family proceeds through labor, delivery and the postpartum period.

Action Steps

- The CDNDSC staff will continue to support professional development opportunities for family grief counselors by coordinating future bereavement training sessions in conjunction with the Grief Awareness Consortium Conference and/or the Protecting Delaware's Children Conference.

Christiana Care Health System and A.I. duPont Hospital for Children have established a neonatal intensive care unit (NICU) palliative care program. This program brings a multidisciplinary approach to caring for the family as a whole and addressing quality of life and comfort goals.

Other Issues to Track

Review of the FIMR data indicates there are additional important issues that occur in a high proportion of FIMR cases. These issues have been highlighted in past FIMR annual reports. In the adjacent and following tables, these issues are tracked by presenting the data for FY11 cases affected. To address some of these issues, specific programs and efforts have been undertaken in Delaware. It may take a few years to see the effects, if any, of such programmatic changes in FIMR data as there is a one to two year lag time between the calendar date of a fetal or infant death and the FIMR CRT review.

Preterm Labor

Preterm labor affected 41% of FY11 FIMR cases, and in 15% of cases the mother had a history of preterm labor. FIMR data also shows a high proportion of cases affected by histologically proven chorioamnionitis (41%). Significantly more Black cases involved previability of the fetus (32%) compared to White cases (13%). These data support the need for the Prematurity Prevention Program, an effort underway in Delaware to increase the availability of progesterone to women at risk for preterm labor.

Fetal Deaths Later in Pregnancy

Over half of the 56 FIMR fetal deaths (52%) occurred in the third trimester of pregnancy, at or after 28 weeks gestation. As a result of this previously reported trend, DPH and DHMIC implemented the Fetal Kick Counts campaign to increase education of women on the importance of fetal movement tracking later in pregnancy. Social marketing materials such as fetal kick counts tool kits are available and have been distributed throughout the State to prenatal care providers in 2011.

Obesity/Nutrition

Thirty-five percent of FIMR mothers were obese. A significantly higher proportion of Black mothers had inadequate nutrition, including anemia in the first trimester (34%), and anemia after the first trimester of pregnancy (20%) compared to White mothers. In 63% of cases, CRTs recommended education on the importance of proper nutrition and weight gain during pregnancy. CRTs were also likely to recommend closer evaluation of dietary habits and nutritional counseling (40% of cases.) Obesity/nutrition has been a key issue in previous FIMR annual reports, and the prevalence of these issues in FIMR cases should be followed over time.

Fetal Deaths Later in Pregnancy in FY11

Strengths	% FY11 cases (n=91))	% FY10 cases (n=104))	% FY08-09 (n=136)	% FY11 Black mothers (n=44)	% FY11 White mothers (n=40)
Fetal kick count teaching done	16%	9%	NR	20%	13%
Contributing Factors					
No documented teaching on fetal kick counts, signs of decreased fetal movement and when to call provider	33%	14%	18%	25%	35%
Suggestions					
Continuing "Kick counts" education; signs and symptoms of decreased fetal movement and when to call provider	35%	19%	19%	27%	38%

NR=not reported

Obesity/Nutrition in FY11

Strengths	% FY11 cases (n=91))	% FY10 cases (n=104))	% FY08-09 (n=136)	% FY11 Black mothers (n=44)	% FY11 White mothers (n=40)
Nutritional education documented	60%	54%	44%	59%	63%
Contributing Factors					
Obesity	35%	40%	36%	34%	40%
Inadequate nutrition (includes anemia at first trimester prenatal visit)	21%	23%	24%	34%*	10%
Inadequate weight gain	16%	22%	NR	18%	15%
Anemia (diagnosed after first trimester)	12%	10%	6%	20%*	3%
Suggestions					
Closer evaluation of dietary habits and evaluation of diet content/ nutritional counseling	40%	36%	17%	43%	38%
Risks of obesity	36%	41%	39%	36%	40%
Importance of proper nutrition and weight gain during pregnancy	63%	55%	35%	70%	60%

NR=not reported

**statistically significant difference between Black and White mother ($p<0.05$)*

Appendix 1: Strengths Identified by Case Review Teams

Category	% FY11 cases (n=91	% FY11 Black mothers (n=44)	% FY11 White mothers (n=40)
Socioeconomic			
Church support	19%	18%	23%
Patient with private insurance	45%	39%	50%
Patient with timely Medicaid	42%	48%	40%
Family support	63%	73%	58%
Father of baby involved/supportive	65%	59%	68%
Parents in stable marriage	34%	30%	33%
Stable financial situation	21%	18%	25%
Supportive friends	25%	16%	40%
Maternal Character			
Teen mom stayed in school during pregnancy	4%	7%	3%
Patient with strong family history of abuse, yet she has not abused her children	7%	2%	10%
Mother demonstrated self-advocacy	32%	30%	38%
Mom's positive attitude despite multiple hardships and challenges in her life	19%	11%	25%
Mom furthering her education	7%	11%	3%
Mom with college or an advanced degree	29%	23%	35%
Social Support Services			
Past Social Services involvement	40%	45%	35%
Active Social Services involvement	26%	32%	20%
Referrals to needed community resources such as Special Supplemental Nutrition Program for Women, Infants and Children (WIC), food stamps, shelter, etc.	21%	25%	15%
SS (Smart Start)/NFP (Nurse Family Partnership)/RM (Resource Mothers) involvement	4%	5%	3%
Child protective services involvement	3%	2%	5%
School nurse involvement	1%	2%	0%
Medical Care			
Quality prenatal care with appropriate referrals	75%	73%	73%
High risk obstetric consultation	64%	61%	70%
Good obstetric management of preterm labor	24%	25%	28%
Good obstetric management of incompetent cervix	9%	9%	8%
Timely transfer to more appropriate level of care	18%	18%	18%
Comprehensive medical care for critically ill mom	2%	2%	0%
Mental health referral	20%	16%	23%
Comprehensive neonatal intensive care	21%	25%	20%
Neonatology consult (prenatally)	35%	39%	35%
Perinatology (MFM) consult (during labor)	30%	39%	20%

Appendix 1: Strengths Identified by Case Review Teams (continued from page 39)

Category	% FY11 cases (n=91	% FY11 Black mothers (n=44)	% FY11 White mothers (n=40)
Provider Positives			
Screened for SS (Smart Start)/NFP (Nurse Family Partnership) /RM (Resource Mothers)	8%	11%	3%
Referral for SS (Smart Start)/NFP (Nurse Family Partnership) /RM (Resource Mothers) involvement	7%	9%	3%
Patient/provider communication regarding pregnancy and plan of care	60%	55%	70%
Provider allowed co-management with patient and respected patient's wishes	54%	48%	60%
Multiple attempts by prenatal provider to get patient back into care	8%	9%	8%
Good communication between providers	45%	45%	48%
Professional staff respectful of parents' wishes to continue pregnancy despite poor prognosis	14%	18%	13%
Rapid 911 response	2%	2%	3%
Mom reported hospital staff very helpful and supportive	19%	11%	28%
Interpreter/written translation information given	5%	0%	8%
Progesterone offered/given	13%	14%	15%
Antenatal steroids offered/given	11%	11%	13%
Prenatal care follow up after triage visit	1%	2%	0%
Domestic violence screening done	13%	16%	8%
Patient Education			
Nutritional education	60%	59%	63%
Risks of substance abuse	34%	32%	40%
Risks of unprotected sex	12%	23%	5%
Need for compliance with care plan	10%	9%	13%
Lethal anomaly with discussion of options	7%	2%	15%
Genetic counseling	14%	9%	23%
Well baby care	2%	2%	3%
Safe Sleep/SIDS risk reduction	14%	25%	5%
Shaken baby syndrome	14%	23%	8%
Car seat safety	48%	45%	53%
Comprehensive prenatal teaching	57%	59%	55%
Autopsy offered	78%	70%	83%
Fetal kick count teaching	16%	20%	13%
Compliance/Knowledge			
Early prenatal care (1st trimester)	74%	75%	75%
Compliance with prenatal care/kept appointments	65%	55%	73%
Compliance with bed rest, activity limitations and/or no intercourse orders	24%	27%	23%

Appendix 1: Strengths Identified by Case Review Teams *(continued)*

Category	% FY11 cases (n=91	% FY11 Black mothers (n=44)	% FY11 White mothers (n=40)
Medication compliance	43%	34%	50%
Mom recognized signs/symptoms of preterm labor, premature rupture of membranes, etc. and sought immediate medical care	32%	34%	30%
Compliance with postpartum care/kept appointments	64%	59%	63%
Compliance with pediatric care	5%	5%	8%
Restricted second hand smoke exposure for baby	3%	2%	3%
Caregiver sought medical attention for the baby in a timely manner after identifying signs of illness	7%	2%	13%
Caregiver knowledge regarding baby's illness and treatment	9%	7%	13%
Caregiver knowledge of CPR	1%	2%	0%
Family Planning			
Planned pregnancy	26%	25%	23%
Pregnancy interval (at least 24 months)	37%	34%	38%
Unintended pregnancy, but parent(s) happy	18%	16%	20%
Family planning counseling	49%	55%	45%
Contraceptives or script given postpartum at discharge	26%	34%	23%
Sterilization after pregnancy	8%	14%	3%
Offered contraception but declined	7%	5%	8%
Substance Abuse			
Drug screening done	24%	34%	18%
Smoking cessation referral	3%	2%	5%
Reduction of substance abuse during pregnancy	9%	7%	13%
Cessation of substance abuse during pregnancy	8%	9%	8%
Grief Support			
Chaplain, pastor, nurse, Smart Start (SS), Nurse Family Partnership (NFP), Resource Mothers (RM) or social work grief support	97%	95%	95%
Family requested to see baby to bond	60%	66%	53%
Referral to community grief support services after discharge	69%	68%	65%
Follow up per hospital bereavement team	10%	9%	10%
Services Infrastructure			
No gaps (medical or social services unavailable, not used or lacking in quality)	9%	9%	10%

Appendix 2: Contributing Factors Identified by Case Review Teams

Category	% FY11 cases (n=91	% FY11 Black mothers (n=44)	% FY11 White mothers (n=40)
Mother's Medical/OB History			
Pre-existing medical conditions such as asthma, hypertension, diabetes, mental health disorders, etc.	86%	89%	88%
Obesity	35%	34%	40%
Inadequate nutrition (includes anemia at first trimester prenatal visit)	21%	34%	10%
Inadequate weight gain	16%	18%	15%
History of previous preterm and/or low birth weight baby	14%	20%	8%
History of preterm labor	15%	20%	10%
History of fetal or infant loss	24%	27%	20%
History of fetal loss greater than 20 weeks but less than 23 weeks gestation (previable)	4%	5%	5%
History of spontaneous abortion (SAB) less than 13 weeks gestation	13%	16%	15%
History of spontaneous abortion (SAB) between 13 and 20 weeks gestation	9%	11%	5%
History of incompetent cervix	5%	7%	3%
History of sexually transmitted disease (STD)	22%	25%	23%
History of genitourinary infection (GU)	27%	30%	28%
History of cervical conization	5%	2%	10%
History of elective termination	27%	34%	23%
History of uterine surgery	7%	9%	3%
Mother taking prescription drugs including prenatal vitamins	60%	57%	63%
Mother taking over the counter drugs	31%	23%	43%
Socioeconomic			
Presence of life course perspective risk factors (stressors in childhood, history of abuse, poverty, lack of support, etc.)	41%	50%	30%
Maternal age less than 21 years	16%	20%	15%
Maternal age over 35 years	9%	9%	8%
Domestic abuse (during pregnancy or infant's life)	4%	5%	5%
Sexual abuse (during pregnancy or infant's life)	1%	0%	3%
Lack of support systems (during pregnancy or infant's life)	18%	14%	20%
Poverty (during pregnancy or infant's life)	21%	23%	15%
Other emotional stressors during pregnancy such as loss of job, loss of loved one, incarceration, divorce, natural disaster, etc.)	43%	39%	53%
Father of baby involved but not supportive	9%	7%	13%

Appendix 2: Contributing Factors Identified by Case Review Teams (continued)

Category	% FY11 cases (n=91	% FY11 Black mothers (n=44)	% FY11 White mothers (n=40)
Medical Conditions During This Pregnancy/Labor			
In vitro fertilization or assisted reproductive technology (IVF/ART)	4%	7%	3%
Multiple gestation	8%	11%	3%
Anemia (diagnosed after first trimester)	12%	20%	3%
Gestational diabetes	10%	5%	15%
Hyperemesis	1%	2%	0%
Sexually transmitted disease (STD)	13%	18%	10%
Maternal infection other than STD's	34%	32%	33%
Pre-eclampsia/eclampsia/HELLP (hemolysis, elevated liver enzymes, low platelets) syndrome	7%	7%	5%
Placenta previa	8%	9%	8%
Premature rupture of membranes (ROM)/Preterm premature ROM	18%	23%	15%
Prolonged ROM	4%	5%	5%
Preterm labor	41%	48%	33%
Placental abruption	15%	20%	8%
Subchorionic bleed	7%	11%	3%
Newly diagnosed incompetent cervix	13%	11%	18%
GBS (group B streptococcus) positive	10%	11%	8%
Suspected clinical chorioamnionitis	12%	16%	5%
Histological chorioamnionitis	41%	45%	35%
Funisitis	24%	27%	23%
Provider Issues			
No SS (Smart Start)/NFP (Nurse Family Partnership)/RM (Resource Mothers) screening	36%	25%	45%
SS (Smart Start)/NFP (Nurse Family Partnership)/RM (Resource Mothers) screening done with score indicating risk, but no referral given	1%	0%	0%
No domestic abuse screening	52%	34%	68%
Poor communication between provider and patient	15%	18%	13%
Poor communication between providers	4%	9%	0%
Lack of Safe Sleep/SIDS risk reduction education	1%	0%	3%
Misdiagnosis of mother or child	1%	2%	0%
Poor follow up for patient with obstetric complications	1%	0%	0%
Appropriate triage questions not elicited	2%	2%	3%
Parental Knowledge/Compliance Issues			
Late entry into prenatal care after 13th week	14%	11%	13%
Inconsistent prenatal care (missed visits)	14%	18%	13%
No prenatal care	12%	18%	5%

Appendix 2: Contributing Factors Identified by Case Review Teams *(continued from page 43)*

Category	% FY11 cases (n=91	% FY11 Black mothers (n=44)	% FY11 White mothers (n=40)
Parental Knowledge/Compliance Issues *(continued)*			
Signs and symptoms of labor or rupture of membranes and when to call provider	7%	5%	10%
Fetal kick counts; signs of decreased fetal movement and when to call provider	33%	25%	35%
Safe Sleep/SIDS risk reduction	1%	0%	3%
Signs and symptoms of illness in children and when to call provider	2%	2%	3%
Child safety (car restraint, medication administration, shaken baby syndrome, childproofing household, etc.)	2%	0%	5%
Noncompliance with plan of care	13%	14%	13%
Family Planning			
Unplanned pregnancy (parental compliance/knowledge)	27%	27%	33%
Undesired pregnancy (parental compliance/knowledge)	4%	9%	0%
Lack of or inadequate family planning education (per provider)	9%	7%	10%
Inadequate birth spacing	16%	20%	10%
Ambivalent feelings toward pregnancy	3%	5%	5%
Substance Abuse			
Substance abuse (medical issue)	23%	25%	23%
Substance abuse lifestyle (social issue)	3%	5%	3%
Exposure to second hand smoke	11%	11%	13%
No substance abuse screening	7%	7%	3%
No referral to smoking cessation program	7%	2%	13%
No referral to drug/alcohol rehab/treatment	7%	11%	3%
Fetal/Infant Medical Issues			
Genetic/congenital anomaly incompatible with life	11%	7%	15%
Cord problem	23%	11%	28%
Previability	22%	32%	13%
Pre-existing medical condition (includes nonlethal anomalies, metabolic disorders, etc.)	19%	11%	28%
Prematurity	32%	41%	25%
Infection	9%	9%	10%
Service Issues			
Medical and social services/community resources unavailable in area	1%	2%	0%
Medical and social services/community resources available, but not used	47%	50%	43%
Quality of medical and social services/community resources inadequate to meet needs	4%	5%	3%
Patient fear of/dissatisfaction with system	14%	20%	5%

Appendix 3: Suggestions Made by Case Review Teams

Category	% FY11 cases (n=91	% FY11 Black mothers (n=44)	% FY11 White mothers (n=40)
Socioeconomic			
Better assessment of family's home/socioeconomic situation	45%	36%	48%
Low cost/subsidized quality daycare	1%	0%	0%
Early referrals to social services	46%	41%	48%
Referral for financial assistance, WIC, food stamps, emergency shelter, etc.	18%	16%	23%
Easier access to care for those without insurance	5%	2%	5%
Child Protective Services involvement (CPS)	1%	0%	3%
SS/NFP/RM or Case Management (CM) Services			
Timely entry of risk assessment scores and/or referrals so care can be initiated promptly	11%	7%	15%
Use open ended questions on initial contact to solicit more info from parent	5%	7%	3%
Better follow up when patients that are referred do not keep appointment	4%	2%	8%
Home visits during pregnancy to monitor clinical status in high risk patients and provide education	46%	45%	48%
More intensive services/follow up to address patient education and non-compliance issues	19%	18%	20%
Enhance communication between providers, hospitals and community services such as SS/NFP/RM, clinics, etc.	2%	5%	0%
Medical Care/Provider Opportunities			
SS/NFP/RM prenatal screening on initial prenatal visit	31%	30%	33%
SS/NFP/RM postnatal screening after delivery before baby is discharged	2%	5%	0%
Accurate scoring of SS/NFP/RM risk factors	3%	0%	8%
Understanding benefits of SS/NFP/RM services as evidenced by referrals	20%	16%	25%
Consistent/ongoing domestic violence (DV) screening	60%	52%	70%
Referral for DV/rape counseling services	3%	5%	3%
Knowledge of community services available as evidenced by referrals	10%	2%	18%
Cultural competence	14%	11%	8%
Sensitivity training for providers	11%	9%	15%
Better network of interpreters for translation	8%	5%	3%
Timely referral to local STD centers for all patients seen with STD's	1%	2%	0%
Closer evaluation of dietary habits and evaluation of diet content/nutritional counseling	40%	43%	38%

Appendix 3: Suggestions Made by Case Review Teams *(continued from page 45)*

Category	% FY11 cases (n=91	% FY11 Black mothers (n=44)	% FY11 White mothers (n=40)
Medical Care/Provider Opportunities *(continued)*			
Better management of multiple genitourinary infections	1%	0%	3%
More intensive management/follow up for mothers with pregnancy complications	4%	2%	8%
Completion of placental pathology/histology	4%	5%	3%
Better management of incompetent cervix	2%	2%	3%
Follow up with patients when appointments missed to reschedule; documentation of attempts/patients' responses	7%	7%	8%
Accurate diagnosis	5%	9%	3%
Better communication by provider of issues during pregnancy or infant's care, and evaluation of patient's/caregiver's understanding	9%	9%	10%
Better communication among providers, especially with high risk patients	5%	9%	3%
Better follow up from provider when they refer a patient to another provider to ensure patient did not have lapse in care	2%	2%	0%
Appropriate genetic testing/autopsy in babies with documented dysmorphic features	5%	7%	3%
Better assessment of patient's/caregiver's understanding of discharge instructions prior to discharge	5%	9%	3%
Death certificate completion (death type/cause of death)	2%	2%	3%
Debrief parents 2-3 months after loss to assess understanding of cause(s)/circumstances of death	33%	36%	30%
Patient/Caregiver/Community Education			
Importance of protected sex, STD/HIV prevention	23%	36%	13%
Risks of obesity	36%	36%	40%
Importance of compliance with plan of care	24%	27%	23%
Importance of early and consistent prenatal care	44%	45%	40%
Importance of proper nutrition and weight gain during pregnancy	63%	70%	60%
Importance of SS/NFP/RM services	25%	27%	25%
Importance of receiving care from an appropriate prenatal care provider instead of friends/family in the medical field	2%	0%	3%
Continuing "fetal kick counts" education; signs and symptoms of decreased fetal movement and when to call provider	35%	27%	38%
Signs and symptoms of premature ROM and when to call provider	3%	0%	5%
Signs and symptoms of preterm labor and when to call provider	2%	0%	5%
Breastfeeding/lactation consultant	1%	0%	3%
Child safety education (car restraint, medication administration, shaken baby syndrome, child proofing, etc.)	1%	0%	3%
Incompetent cervix; cerclage, etc. prior to next pregnancy	10%	11%	10%

Appendix 3: Suggestions Made by Case Review Teams (continued)

Category	% FY11 cases (n=91	% FY11 Black mothers (n=44)	% FY11 White mothers (n=40)
Grief Support			
Grief counseling/support at delivery and/or pediatric care facility	22%	20%	20%
Follow up with patients that initially decline grief support services	13%	16%	8%
Have Chaplain see patient to assess needs	10%	5%	13%
Referral to community agency for grief counseling	91%	93%	85%
Prenatal providers to take an active part in addressing grief and denial issues	92%	95%	85%
Postpartum depression screening and assessment of grieving status with appropriate referrals	34%	34%	33%
Family Planning			
Importance of being healthy before pregnancy	79%	86%	75%
Importance of family planning/preconceptional/ interconceptional care	75%	80%	68%
Appropriate birth spacing	79%	82%	75%
Birth control in the immediate postpartum period and compliance with chosen contraceptive method (i.e. no missed doses)	40%	41%	35%
Family planning counseling with contraception dose/script or bilateral tubal ligation prior to discharge	24%	25%	18%
Community service agency to see patients in hospital after delivery to give contraceptives before discharge	5%	7%	3%
Genetic counseling prior to next pregnancy	35%	25%	48%
Persistent follow-up regarding contraception/family planning when patients initially refuse services in hospital or at postpartum visit	9%	9%	10%
Substance Abuse			
Patient/community education regarding importance of not using drugs anytime, especially when pregnant	16%	23%	13%
Consistent/ongoing drug screening	12%	14%	13%
Substance abuse (including smoking cessation) referral for treatment	23%	25%	23%
Closer following of patients in drug rehabilitation and attempt to contact patients when they do not follow their treatment plan	1%	0%	0%
Medical Record/Documentation			
Improve completeness of prenatal records	3%	2%	3%
Improve completeness/consistency of medical record	9%	11%	3%

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DELAWARE
PREVENTING CHILD DEATHS IN THE FIRST STATE

CHILD DEATH, NEAR DEATH AND STILLBIRTH COMMISSION
ANNUAL REPORT FOR FISCAL YEAR 2011

Criteria for Cases to be Reviewed FY11

- All State of Delaware residents under the age of 18 whose deaths occurred within the state.
- Deaths involving criminal investigations (with the exception of abuse/neglect cases) are delayed contingent upon authorization of the Attorney General's Office.
- Deaths involving abuse and/or neglect shall be reviewed within six months of a report to the Commission notwithstanding unresolved criminal charges.
- Special requests to review a case that did not meet the review criteria are considered from agencies and professionals affiliated with the Child Death Review Panels and are approved or denied by the Panel chairperson.
- Authority: Review, in a confidential manner, the deaths of children under the age of 18, near deaths of abused and/or neglected children, and stillbirths occurring after at least 20 weeks of gestation. (31 Del. C. § 323.)

Cases Reviewed and Finalized[25] in FY11

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

Ethnicity	Age Group	Male	Female	Total
Hispanic /Latino (any race)	1-4 Years	1	1	2
	10-14 Years	0	1	1
	15-17 Years	1	0	1
	Subtotal	**2**	**2**	**4**
Race				
White	< 1 Year	4	0	4
	1-4 Years	3	3	6
	5-9 Years	2	5	7
	10-14 Years	3	2	5
	15-17 Years	4	4	8
	Subtotal	**16**	**14**	**30**
Black, African American	< 1 Year	1	5	6
	1-4 Years	0	3	3
	5-9 Years	1	0	1
	10-14 Years	0	2	2
	15-17 Years	3	1	4
	Subtotal	**5**	**11**	**16**
Asian	5-9 Years	1	0	1
	Subtotal	**1**	**0**	**1**
Unknown	15-17 Years	0	1	1
	Subtotal	**0**	**1**	**1**
All Races	< 1 Year	5	5	10
	1-4 Years	3	6	9
	5-9 Years	4	5	9
	10-14 Years	3	4	7
	15-17 Years	7	6	13
	Subtotal	**22**	**26**	**48**

[25] Approved by the Commission with a 60% quorum vote.

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

Ethnicity	Age Group	Male	Female	Total
Hispanic /Latino (any race)	1-4 Years	1	0	1
	10-14 Years	0	1	1
	15-17 Years	1	0	1
	Subtotal	**2**	**1**	**3**
Race				
White	< 1 Year	1	0	1
	1-4 Years	2	0	2
	5-9 Years	1	0	1
	10-14 Years	2	1	3
	15-17 Years	2	0	2
	Subtotal	**8**	**1**	**9**
Black, African American	< 1 Year	0	4	4
	1-4 Years	0	1	1
	5-9 Years	1	0	1
	15-17 Years	2	0	2
	Subtotal	**3**	**5**	**8**
Asian	5-9 Years	1	0	1
	Subtotal	**1**	**0**	**1**
All Races	< 1 Year	1	4	5
	1-4 Years	2	1	3
	5-9 Years	3	0	3
	10-14 Years	2	1	3
	15-17 Years	4	0	4
	Subtotal	**12**	**6**	**18**

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

Ethnicity	Age Group	Male	Female	Total
Hispanic /Latino (any race)	1-4 Years	0	1	1
	Subtotal	**0**	**1**	**1**
Race				
White	< 1 Year	3	0	3
	1-4 Years	1	3	4
	5-9 Years	1	5	6
	10-14 Years	1	1	2
	15-17 Years	2	4	6
	Subtotal	**8**	**13**	**21**
Black, African American	< 1 Year	0	1	1
	1-4 Years	0	1	1
	10-14 Years	0	2	2
	15-17 Years	1	1	2
	Subtotal	**1**	**5**	**6**
Unknown	15-17 Years	0	1	1
	Subtotal	**0**	**1**	**1**
All Races	< 1 Year	3	1	4
	1-4 Years	1	4	5
	5-9 Years	1	5	6
	10-14 Years	1	3	4
	15-17 Years	3	6	9
	Subtotal	**9**	**19**	**28**

[25] *Approved by the Commission with a 60% quorum vote.*

Data From Child Death Cases Reviewed During FY11

Demographics (Ethnicity/Race and Age Group by Sex)

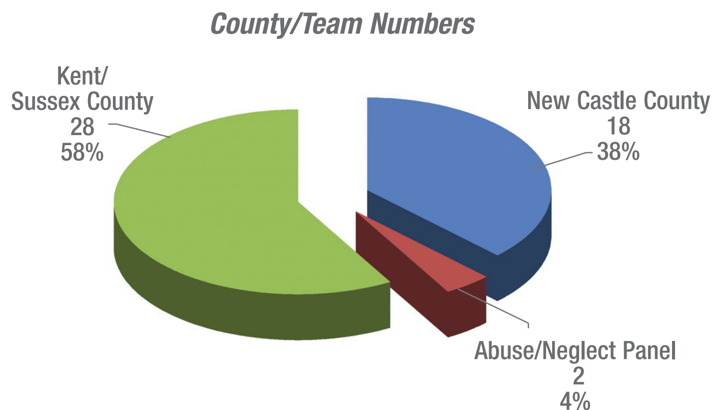
Abuse/Neglect Panel - The cases below reflect child deaths that were reviewed due to abuse/neglect. Of these cases, one was an initial/final case review and the other case was an initial review which will be finalized in FY12.

	Age Group	Male	Female	Total
Race				
Black, African American	< 1 Year	1	0	1
	1-4 Years	0	1	1
	Subtotal	1	1	2

Cases Reviewed and Finalized[25] in FY11

County/Team Numbers

	# of Cases Reviewed
Abuse/Neglect Panel	2
Kent/Sussex County	28
New Castle County	18
Total	**48**



Infant Death Information-Statewide

Due to cause of death (infant unsafe sleeping and injuries), these cases were not reviewed and statistically counted by FIMR.

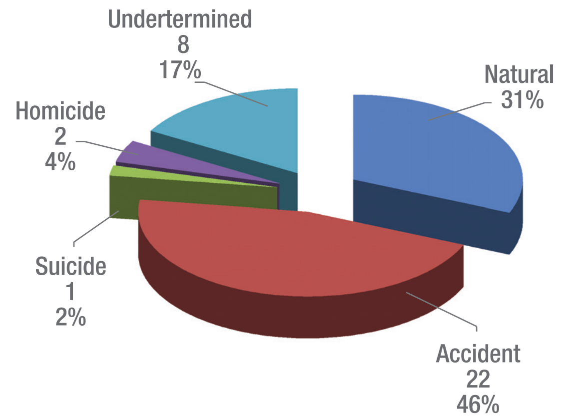
Manner of Death

	Natural	Accident	Undetermined	Total
Deaths Reviewed	2	2	6	**10**
Premature (<37 weeks)	0	0	1	**1**
Low Birth Weight (<2500 grams)	0	0	1	**1**
Intrauterine Smoke Exposure	1	0	4	**5**
Intrauterine Drug Exposure	0	0	1	**1**
Late (>6 months) or No Prenatal Care	2	0	1	**3**

Manner and Cause of Death by Age Group-Statewide

	Age Group					
Manner	**<1**	**1-4**	**5-9**	**10-14**	**15-17**	**Total**
Natural	2	2	6	1	4	15
Accident	2	4	3	6	7	22
Suicide	0	0	0	0	1	1
Homicide	0	1	0	0	1	2
Undetermined	6	2	0	0	0	8
Total	**10**	**9**	**9**	**7**	**13**	**48**

Manner and Cause of Death-Statewide



Manner and Cause of Death by Age Group-Statewide

Manner	Cause	<1	1-4	5-9	10-14	15-17	Total
		Age Group					
Natural							
	Cancer	0	1	1	0	1	3
	Congenital anomaly	0	1	0	0	0	1
	Neurological/seizure disorder	0	0	0	0	1	1
	SIDS	2	0	0	0	0	2
	Other infection	0	0	1	1	1	3
	Other medical condition	0	0	4	0	1	5
	Sub Total	**2**	**2**	**6**	**1**	**4**	**15**

Manner	Cause	<1	1-4	5-9	10-14	15-17	Total
		Age Group					
Accident							
	Motor Vehicle	0	2	2	6	6	16
	Fire, Burn, or Electrocution	0	0	1	0	0	1
	Drowning	0	2	0	0	0	2
	Asphyxia	2	0	0	0	0	2
	Poisoning, Overdose or Acute Intoxication	0	0	0	0	1	1
	Sub Total	**2**	**4**	**3**	**6**	**7**	**22**
Suicide							
	Poisoning, Overdose or Acute Intoxication	0	0	0	0	1	1
	Sub Total	**0**	**0**	**0**	**0**	**1**	**1**
Homicide							
	Weapon	0	1	0	0	1	2
	Sub Total	**0**	**1**	**0**	**0**	**1**	**2**

Manner	Cause	<1	1-4	Total
		Age Group		
Undetermined				
	Any Medical Cause	5	2	7
	Unknown	1	0	1
	Sub Total	**6**	**2**	**8**

Manner and Cause of Death by Age Group-New Castle County

	Age Group					
Manner	**<1**	**1-4**	**5-9**	**10-14**	**15-17**	**Total**
Natural	1	2	2	1	1	7
Accident	1	0	1	2	2	6
Suicide	0	0	0	0	1	1
Undetermined	3	1	0	0	0	4
Total	**5**	**3**	**3**	**3**	**4**	**18**

Manner and Cause of Death by Age Group-New Castle County

		Age Group					
Manner	**Cause**	<1	1-4	5-9	10-14	15-17	Total
Natural							
	Cancer	0	1	0	0	0	1
	Congenital anomaly	0	1	0	0	0	1
	SIDS	1	0	0	0	0	1
	Other infection	0	0	1	1	1	3
	Other medical condition	0	0	1	0	0	1
	Sub Total	**1**	**2**	**2**	**1**	**1**	**7**

		Age Group					
Manner	**Cause**	<1	1-4	5-9	10-14	15-17	Total
Accident							
	Motor Vehicle	0	0	0	2	2	4
	Fire, Burn, or Electrocution	0	0	1	0	0	1
	Asphyxia	1	0	0	0	0	1
	Sub Total	**1**	**0**	**1**	**2**	**2**	**6**
Suicide							
	Poisoning, Overdose or Acute Intoxication	0	0	0	0	1	1
	Sub Total	**0**	**0**	**0**	**0**	**1**	**1**

		Age Group		
Manner	**Cause**	<1	1-4	Total
Undetermined				
	Any Medical Cause	3	1	4
	Sub Total	**3**	**1**	**4**

Data From Child Death Cases Reviewed During FY11

Manner and Cause of Death by Age Group-Kent/Sussex County

	Age Group					
Manner	**<1**	**1-4**	**5-9**	**10-14**	**15-17**	**Total**
Natural	1	0	4	0	3	8
Accident	1	4	2	4	5	16
Homicide	0	0	0	0	1	1
Undetermined	2	1	0	0	0	3
Total	**4**	**5**	**6**	**4**	**9**	**28**

Manner and Cause of Death by Age Group-Kent/Sussex County

		Age Group					
		<1	1-4	5-9	10-14	15-17	Total
Manner	**Cause**						
Natural							
	Cancer	0	0	1	0	1	2
	Neurological/seizure disorder	0	0	0	0	1	1
	SIDS	1	0	0	0	0	1
	Other medical condition	0	0	3	0	1	4
	Sub Total	**1**	**0**	**4**	**0**	**3**	**8**
Manner	**Cause**						
Accident							
	Motor Vehicle	0	2	2	4	4	12
	Drowning	0	2	0	0	0	2
	Asphyxia	1	0	0	0	0	1
	Poisoning, Overdose or Acute Intoxication	0	0	0	0	1	1
	Sub Total	**1**	**4**	**2**	**4**	**5**	**16**
Manner	**Cause**						
Homicide							
	Weapon	0	0	0	0	1	1
	Sub Total	**0**	**0**	**0**	**0**	**1**	**1**
Manner	**Cause**						
Undetermined							
	Any Medical Cause	2	1	0	0	0	3
	Sub Total	**2**	**1**	**0**	**0**	**0**	**3**

Data From Motor Vehicle Crashes Reviewed During FY11

Motor Vehicle and Other Transport Death Demographics

Position of Child	Driver	Passenger	On Bicycle	Total
Age Group				
1-4 Years	0	2	0	2
5-9 Years	0	2	0	2
10-14 Years	0	4	2	6
15-17 Years	4	2	0	6
Total	4	10	2	16
Sex				
Male	2	2	2	6
Female	2	8	0	10
Total	4	10	2	16
Ethnicity				
Hispanic (Any Race)	1	0	0	1
Race				
White	3	7	2	12
Black, African American	1	3	0	4
Total	4	10	2	16
Area Where Incident Occurred				
Urban	0	0	1	1
Suburban	3	0	1	4
Rural	1	10	0	11
Total	4	10	2	16

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	5	0	7
Van	0	2	0	2
SUV	0	3	0	3
Motorcycle	1	0	0	1
All terrain vehicle (ATV)	1	0	0	1
Bicycle	0	0	2	2
Total	4	10	2	16

Data From Motor Vehicle Crashes Reviewed During FY11

Risk Factors of Young Drivers (Ages 14-21) Involved in the Crash

	Drivers Involved in Incident Ages 14-21		
Risk Factors	Child was Driving	Driver of Childs Vehicle	Driver of Other Primary Vehicle
Deaths Reviewed	4	2	1
Responsible for causing incident	3	2	1
Alcohol/drug impaired	1	0	0
No license	1	0	0
Violating graduated licensing rules	0	2	0
Two or more teen passengers (ages 14-21)	0	2	0

Motor Vehicle Protective Measures

Position of Child	Driver	Passenger	On Bicycle	Total
Deaths Reviewed	4	10	2	16
Protective Measure Present and Used Correctly				
Airbag	2	1	0	3
Lap Belt	1	3	0	4
Shoulder belt	1	3	0	4
Helmet	1	0	0	1
Lap Belt	0	2	0	2
Shoulder belt	0	2	0	2
Booster seat	0	1	0	1
Protective Measure Present and Not Used				
Lap Belt	1	2	0	3
Shoulder belt	1	2	0	3
Protective Measure Needed But None Present				
Airbag	0	2	0	2
Child seat	0	1	0	1
Booster seat	1	0	0	1
Helmet	1	0	2	3

Motor Vehicle and Other Transport Death Demographics-New Castle County

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

Motor Vehicle and Other Transport Death Demographics-Kent/Sussex County

Position of Child		Driver	Passenger	Total
Age Group				
	1-4 Years	0	2	2
	5-9 Years	0	2	2
	10-14 Years	0	4	4
	15-17 Years	2	2	4
	Total	**2**	**10**	**12**
Sex				
	Male	0	2	2
	Female	2	8	10
	Total	**2**	**10**	**12**
Race				
	White	2	7	9
	Black, African American	0	3	3
	Total	**2**	**10**	**12**
Area Where Incident Occurred				
	Suburban	1	0	1
	Rural	1	10	11
	Total	**2**	**10**	**12**

Homicide Death Demographics

		Firearm	Person's Body Part	Total
Age Group				
	1-4 Years	0	1	1
	15-17 Years	1	0	1
	Total	**1**	**1**	**2**
Sex				
	Female	1	1	2
Race				
	Black, African American	1	1	2

Type of Weapon		Firearm	Person's Body Part	Total
Leading Uses of Weapon at Time of Incident	Argument	1	1	2
	Random Violence	1	0	1
	Jealousy	0	1	1
	Intimate Partner Violence	0	1	1

Acts of Omission/Commission Intent

	Acts of Omission/Commision Intent						
	Poor/Absent Supervision	Child Abuse	Child Neglect	Other Negligence	Assault (not child abuse)	Suicide	Other
Deaths Reviewed	4	1	6	14	1	1	3
Cause							
Intentional	0	1	1	0	0	1	0
Unintentional	0	0	2	10	1	0	0
Undetermined	0	0	0	1	0	0	0
Contributed							
Unintentional	4	0	3	3	0	0	3
Person Responsible for Act							
Parent's partner	0	1	0	1	0	0	0
Other	0	1	0	1	0	0	0
Male	0	1	0	1	0	0	0

Footnote: Acts of omission or commission are defined as any act or failure to act which causes or contributes to the death.

Acts of Omission/Commission Demographics

	Acts of Omission/Commision							
	Deaths Reviewed	Poor/Absent Supervision	Child Abuse	Child Neglect	Other Negligence	Assault (not child abuse)	Suicide	Other
Age Group								
<1 Year	10	0	0	5	4	0	0	1
1-4 Years	5	2	1	0	1	0	0	1
5-9 Years	2	0	0	0	2	0	0	0
10-14 Years	5	2	0	0	3	0	0	0
15-17 Years	8	0	0	1	4	1	1	1
Total	**30**	**4**	**1**	**6**	**14**	**1**	**1**	**3**
Sex								
Male	13	3	0	3	5	0	1	1
Female	17	1	1	3	9	1	0	2
Total	**30**	**4**	**1**	**6**	**14**	**1**	**1**	**3**
Ethnicity								
Hispanic (any race)	1	0	0	0	0	0	0	1
Race								
White	17	4	0	1	10	0	1	1
Black, African American	13	0	1	5	4	1	0	2
Total	**30**	**4**	**1**	**6**	**14**	**1**	**1**	**3**
Manner of Death								
Natural	3	0	0	1	2	0	0	0
Accident	18	4	0	1	11	0	0	2
(Unintentional)								
Suicide	1	0	0	0	0	0	1	0
Homicide	2	0	1	0	0	1	0	0
Undetermined	6	0	0	4	1	0	0	1
Total	**30**	**4**	**1**	**6**	**14**	**1**	**1**	**3**
Primary Cause of Death								
Motor vehicle	14	2	0	0	10	0	0	2
Drowning	2	2	0	0	0	0	0	0
Suffocation or strangulation	2	0	0	1	1	0	0	0
Weapon	2	0	1	0	0	1	0	0
Poisoning	1	0	0	0	0	0	1	0
Medical condition	8	0	0	4	3	0	0	1
Unknown Cause	1	0	0	1	0	0	0	0
Total	**30**	**4**	**1**	**6**	**14**	**1**	**1**	**3**

Suffocation/Asphyxia Death Demographics[26]

	Action Causing Suffocation/Asphyxia	
	Sleep Related	Total
Age Group		
<1 Year	2	2
Total	2	2
Sex		
Male	1	1
Female	1	1
Total	2	2
Race		
White	1	1
Black, African American	1	1
Total	2	2
Manner of Death		
Accident	2	2
Total	2	2

[26] As labeled by the Medical Examiner's Cause of Death on the death certificate.

Sleep-Related Deaths by Cause

	Cause of Death			
	SIDS	Asphyxia	All Other Causes	Total
0-1 Months	0	0	0	0
2-3 Months	4	1	0	5
4-5 Months	2	0	0	2
6-7 Months	0	0	0	0
8-11 Months	1	1	1	3
1-4 Years	1	0	0	1
Total	8	2	1	11[27]

[27] One case was reviewed by the child abuse/neglect panel due to the circumstances of the death.

Sleep-Related Death Demographics-Statewide

	Age Group	Male	Female	Total
Race				
White	2-3 Months	2	0	2
	4-5 Months	1	0	1
	8-11 Months	1	0	1
	1-4 Years	1	0	1
	Subtotal	5	0	5
Black, African American	2-3 Months	0	3	3
	4-5 Months	0	1	1
	8-11 Months	1	1	2
	Subtotal	1	5	6
All Races	2-3 Months	2	3	5
	4-5 Months	1	1	2
	8-11 Months	2	1	3
	1-4 Years	1	0	1
	Subtotal	6	5	11

Sleep-Related Death Demographics-New Castle County

	Age Group	Male	Female	Total
Race				
White	4-5 Months	1	0	1
	1-4 Years	1	0	1
	Subtotal	2	0	2
Black, African American	2-3 Months	0	2	2
	4-5 Months	0	1	1
	8-11 Months	0	1	1
	Subtotal	0	4	4
All Races	2-3 Months	0	2	2
	4-5 Months	1	1	2
	8-11 Months	0	1	1
	1-4 Years	1	0	1
	Subtotal	2	4	6

Sleep-Related Death Demographics- Kent/Sussex County

	Age Group	Male	Female	Total
Race				
White	2-3 Months	2	0	2
	8-11 Months	1	0	1
	Subtotal	3	0	3
Black, African American	2-3 Months	0	1	1
	Subtotal	0	1	1
All Races	2-3 Months	2	1	3
	8-11 Months	1	0	1
	Subtotal	3	1	4

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IN THE FIRST STATE

CHILD DEATH, NEAR DEATH AND
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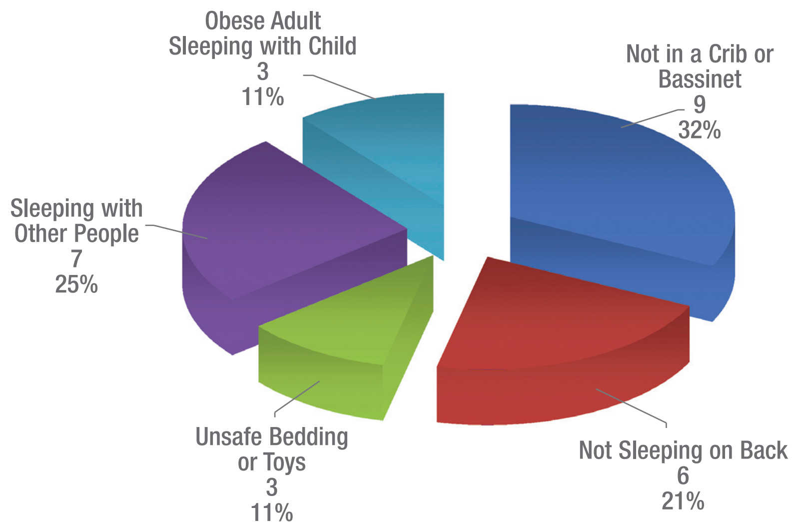
Circumstances Involved in Sleep-Related Deaths

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

Factors Involved in Sleep-Related Deaths



Factors Involved in Sleep-Related Deaths

	Age Group						
	0-1 Mos	2-3 Mos	4-5 Mos	6-7 Mos	8-11 Mos	1-4 Yrs	Total
Deaths Reviewed	0	5	2	0	3	1	11
Not in a crib or bassinet	0	4	2	0	3	0	9
Not sleeping on back	0	1	2	0	2	1	6
Unsafe bedding or toys	0	1	0	0	2	0	3
Sleeping with other people	0	3	1	0	3	0	7
Obese adult sleeping with child	0	1	0	0	2	0	3
Adult was alcohol impaired	0	0	0	0	0	0	0
Adult was drug impaired	0	0	0	0	0	0	0
Caregiver/Supervisor fell asleep while bottle feeding	0	0	0	0	0	0	0
Caregiver/Supervisor fell asleep while breast feeding	0	0	0	0	0	0	0

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 bassinette since they are typically coded as "other". Unsafe bedding or toys include pillow, comforter, or stuffed toy.

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Ms. Mariann Kenville-Moore	Department of Justice

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Dr. Philip Shlossman, Chair	Obstetrician
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Ms. Cara Sawyer	Domestic Violence Coordinating Council
Ms. Jill Rosen	Child Advocate
Ms. Janice Tigani, Esquire	Department of Justice
Ms. Anita Symonds	Child Advocate

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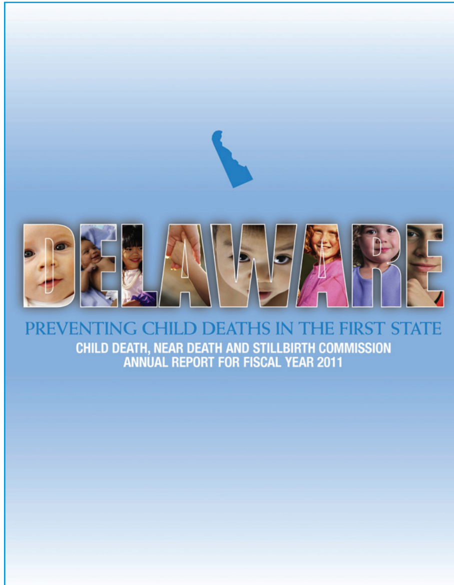

This annual report is dedicated to every child who leaves the earth too soon and for the loved ones who remain with their memories and sadness.

I want to thank the Child Death Review Panel members, the FIMR Case Review Team members, and the Panel Chairs who volunteer numerous hours to this cause. To serve on a panel or case review team takes great courage, stamina, and self-care skills. Due to confidentiality, the professionals cannot discuss the work that is done at the panels/teams and therefore they contain the horrors, tragedies, and sadness within. May they never forget that they are making a difference one case review at a time.

In addition, the CDNDSC staff (Kristin, Joan, Angela, Ashlee, and Elaine) are the backbone to the CDNDSC and without their dedication, the Commission could not succeed at its mission. A special thanks to Dr. Meena Ramakrishnan (for her work on FIMR and Maternal Death Review), Marjorie L. Hershberger (NCC Panel Chair and infant safe sleep expert), and Sharon Larson (medical abstractor for FY11) for their service, passion and collaboration with the CDNDSC in this work.

Anne Pedrick
CDNDSC Executive Director

Every Child Deserves A Tomorrow

STATE OF DELAWARE
Child Death, Near Death and Stillbirth Commission

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Wilmington, DE 19801-3341

Due to fiscal constraints in the State of Delaware, the Fiscal Year 2011 Child Death, Near Death and Stillbirth Commission ("CDNDSC") 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[28].

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