DELAWARE

PREVENTING CHILD DEATHS IN THE FIRST STATE

CHILD DEATH, NEAR DEATH AND STILLBIRTH COMMISSION

ANNUAL REPORT FOR FISCAL YEAR 2010

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How Are The Children?

Among the most accomplished and fabled tribes of Africa, no tribe was considered to have warriors more fearsome or more intelligent than the mighty Masai. It is perhaps surprising then to learn the traditional greeting that passed between Masai warriors. "Kasserian ingera," one would always say to another. It means, "And how are the children?"

It is still the traditional greeting among the Masai, acknowledging the high value that the Masai always place on their children's well-being. Even warriors with no children of their own would always give the traditional answer. "All the children are well." Meaning, of course, that peace and safety prevail, that the priorities of protecting the young, the powerless, are in place, that Masai society has not forgotten its reason for being, its proper functions and responsibilities. "All the children are well" means that life is good. It means that the daily struggles of existence, even among a poor people; do not preclude proper caring for its young.

I wonder how it might affect our consciousness of our own children's welfare if in our culture we took to greeting each other with this same daily question: "And how are the children?" I wonder if we heard that question and passed it along to each other a dozen times a day, if it would begin to make a difference in the reality of how children are thought of or cared for in this country.

I wonder if every adult among us, parent and non-parent alike felt an equal weight for the daily care and protection of all the children in our town, in our state, in our country . . . I wonder if we could truly say without any hesitation. "The children are well, yes, all the children are well." What would it be like . . . if the President began every press conference, every public appearance, by answering the question, "And how are the children, Mr. President?" If every governor of every state had to answer the same question at every press conference: "And how are the children, Governor? Are they all well?" Wouldn't it be interesting to hear their answers?

Excerpted from a speech by the Rev. Dr. Patrick T. O'Neill, First Parish Unitarian Universalist Church in Framingham, MA.

Due to fiscal constraints in the State of Delaware, the Fiscal Year 2010 Child Death, Near Death and Stillbirth Commission ("CDNDSC") Annual Report has been distributed through electronic email and computer disc distribution. This effort will save taxpayer dollars and help reduce the State's environmental footprint.

State of Delaware...

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

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

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

DATE: April 4, 2011

SUBJECT: Fiscal Year 2010 Child Death, Near Death and Stillbirth Commission Annual Report

I am pleased to present to you the Eighth 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 2010. This report is a useful vehicle to share Child Death and Child Near Death findings with the wider community to engage others to implement policies, programs and practices that can have a positive impact on the lives of Delaware's children.

The Commission has been able to reach out to other community organizations and develop the critical public and private partnerships needed to implement the recommendations contained in this report. The Commission continues to thank you for your support of the Commission's work in making every effort to reduce child deaths in the State of Delaware.

GHCC/amp
Enclosure

"We must not, in trying to think about how we can make a big difference ignore the small daily differences we can make which over time, add up to big differences that we often cannot foresee."

Marian Wright Edelman

Executive Summary...

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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 retrospective reviews of the history and circumstances surrounding each child's death or near death in Delaware. During this period, 44 death cases and one near death case 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 seen positive action and outcomes in a relatively short interval. CDNDSC 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:

- FIMR CRTs reviewed 104 cases in FY (Fiscal Year) 10: 48 fetal deaths and 56 infant deaths. One-third of these cases had a maternal interview. A higher percentage of African American infant deaths (47%, 8 out of 17) were primarily due to prematurity compared to Caucasian infant deaths (25%, or 9 out of 36). This disparity is highlighted in the FIMR Table 3 for cause of death *(see page 24).*
- Eight key issues emerged from FIMR Case Review Team (CRT) deliberations in FY10, five of which were also found in FY08-09 (issues 1-5 below). Three new issues have been identified in FY10 (issues 6-8).

1. Pre-existing medical conditions
2. Medical and social services/community resources available but not used
3. Obesity/nutrition
4. Preterm labor
5. Bereavement counseling/support
6. Family planning/birth spacing
7. Socioeconomic stressors
8. Fetal deaths later in pregnancy

- African Americans make up 21% of Delaware's population. However, African American children disproportionately represent 59% (26 out of 44) of all deaths that were reviewed by CDNDSC during FY10. This percentage has increased from the 40% noted in previous years.
- Thirty-eight percent (5 out of 13 deaths) of all child deaths due to motor-vehicle crashes occurred in the 15 to 17 year old range. This number has decreased by 60% as compared with the previous annual report.

African Americans make up 21% of Delaware's population. However, African American children disproportionately represent 59% (26 out of 44) of all deaths that were reviewed by CDNDSC during FY10. This percentage has increased from the 40% noted in previous years.

MISSION... Safeguard the health and safety of all Delaware children as set forth in 31 Del. C., § 320

- Three child deaths occurring in the 15 to 17 age range were due to the use of firearms. All three were adolescents, African American, and determined to be homicides by the Medical Examiner. In these particular cases, one adolescent was a bystander victim and the other two adolescents were victims of random violence. The perpetrators in these cases were identified as a friend or acquaintance.

- The review of unsafe infant sleeping deaths has dramatically increased to 18 deaths reviewed in FY10. Statistically speaking, a significant disparity has been noted with 83% (15 of the 18 reviewed) among African Americans. Among the 18 deaths, only one infant was sleeping in a crib. In 77% (14 of 18) of the infant unsafe sleeping death cases, the child was bed-sharing with another person.

- The Child Abuse and Neglect (CAN) Panel reviewed two child deaths and one child near death that resulted from abuse and neglect. These cases had numerous systems issues and resulted in lengthy comprehensive reviews. In addition, eight CAPTA[1] reports were completed which reflected the extensive work of the CAN panel through twenty-five 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. However, with that said there is still much work to accomplish within FY11. Currently, the CAN panel has 20 pending cases of child deaths or near deaths due to abuse or neglect. A few examples of Child Abuse and Neglect recommendations made in FY10:

  ▲ 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.

  ▲ CDNDSC recommends that the Child Protection Accountability Commission (CPAC) Risk Assessment Subcommittee research more effective and efficient risk assessment tools that will objectively evaluate risk and history and appropriately incorporate criminal, multigenerational and individual DSCYF history.

  ▲ CDNDSC supports the efforts of the Child Protection Accountability Commission's Abuse Intervention Subcommittee in developing and offering training on the updated 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.

  ▲ CDNDSC supports the ongoing efforts to educate the entire medical community concerning their responsibilities for mandatory reporting of child abuse and neglect.

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

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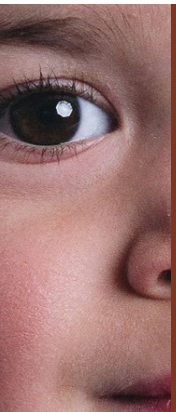

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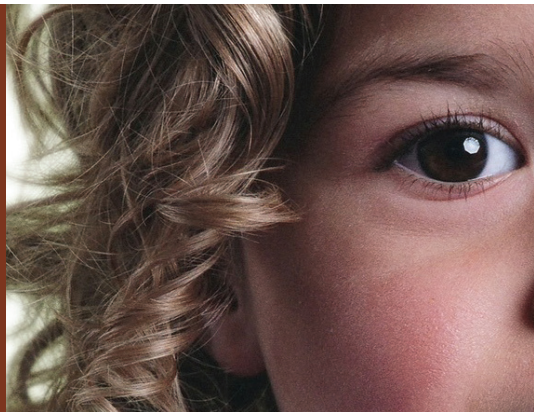

Glossary...

Commonly Used Terms

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 dis turbances in the level of consciousness, cog nition, perception, judgment, affect, or behav ior, 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 Mothers and Infants 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 seri ous 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, irre-spective 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 evi-dence of life, such as beating of the heart, pulsa-tion 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 individ-uals at risk of harm if not done properly, notably driving. Graduated drivers' licens-ing generally restricts nighttime, express-way, and unsupervised driving during ini-tial 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 experi-ences 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
Z-test:	Compares sample and population means to determine if there is a significant difference.

CDNDSC supports the efforts of the Child Protection Accountability Commission's Abuse Intervention Subcommittee in developing and offering training on the updated 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.

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Purpose of Child Death Reviews
The Commission provides meaningful system-wide recommendations to prevent the deaths and/or near deaths of children and improve the systems that provide services to children. The process brings professionals and experts 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 established by legislation passed 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 Review Panels review all non-child abuse or neglect deaths. The Child Abuse and Neglect Review (CAN) Panel reviews deaths and near deaths due to child abuse and neglect statewide. Each of the three panels conduct reviews on a monthly basis. The Commission meets at least quarterly to review and approve the work of the Panels.

CDNDSC 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. For instance, the scope of infant review was changed 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 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[2] 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, CDNDSC worked in collaboration with the Division of Public Health (DPH) to implement a Fetal Infant Mortality Review (FIMR) pilot project under the leadership of the Governor's Infant Mortality Task Force. In FY06, FIMR's budgetary positions were placed with CDNDSC. 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.

During FY2008, the CDNDSC statute was altered 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.

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

CDNDSC supports the ongoing efforts to educate the entire medical community concerning their responsibilities for mandatory reporting of abuse and neglect.

Prevention Initiatives and Education...

Abusive Head Trauma Program
After CDNDSC reviewed 13 deaths and near deaths involving abusive head trauma, the need for preventive parent education on abusive head trauma was demonstrated. CDNDSC 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[3] 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 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 voluntary 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 follow-up 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.

Prevent Child Abuse Delaware will complete the research gathered from the initial follow-up phone calls to determine the efficacy of the program during FY11. If a child has been abused after education on abusive head trauma, this will be reflected through medical record abstraction by CDNDSC at the Child Abuse and Neglect Panel. The training for this program was completed in FY10 at all birthing hospitals throughout the State. A full report on this program can be found at http://courts.delaware.gov/childdeath/reports.htm

Child Abuse Identification and Reporting Guidelines for Delaware Medical Providers
In FY09, CPAC's Abuse Intervention Subcommittee, through its Medical Subcommittee, 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 (DFS) staff member with great success on March 24, 2009, at Kent General Hospital to doctors, nurses, and social workers. CDNDSC, the training facilitator, has received a small grant from the Childrens' Justice Act Grant to facilitate ongoing training throughout the state.

By the end of FY10, 102 medical professionals and staff were trained by a local physician and DFS representative. Trainings have already been scheduled for FY11. Additionally, recent legislation increased the need for the Child Abuse Identification and Reporting Guidelines for Delaware Medical Providers training statewide. The legislation clarified that the mandatory duty to report child abuse or neglect applies to all persons, as well as agencies, organizations, and entities. Additionally, the law eliminated any confusion as to where to report and specified that all reports of abuse or neglect against children are to be made to DSCYF. Finally, the potential civil penalties were also increased for persons or entities who fail to report with the added provision that DOJ will be notified of any violations.[4]

[3]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)

[4]CPAC Fiscal Year 2010 Annual Report

CDNDSC supports continued infant safe sleeping education for state agencies, community agencies, and the public.

Partnerships...

Protecting Delaware's Children Conference
In June 2010, CPAC and CDNDSC, along with significant funding from the Federal Court Improvement Project under Family Court, and contributions from Prevent Child Abuse Delaware, Children and Families First, Office of Juvenile Justice and Delinquency Prevention, and the Criminal Justice Council, jointly sponsored the second Protecting Delaware's Children Conference. Five hundred child welfare professionals committed their time to further their knowledge and insight on improving the health, safety, and well-being of Delaware's most vulnerable population of children. From techniques on enhancing documentation and observation skills for first responders, to the investigation and prosecution of child abuse involving developmentally disabled and nonverbal children, to developing multi-disciplinary teams, to internet crimes involving children, to the impact of trauma on children, this conference featured a wide array of learning opportunities for professionals from many disciplines. In addition to local experts, several national experts presented workshops with a focus on the investigation and prosecution of child physical and sexual abuse. The conference will be offered again in the fall of 2011.[5]

Collaborative Initiatives
Child Protection Accountability Commission (CPAC) CDNDSC and CPAC continued their collaborative affiliation throughout FY10.

Meetings with CPAC occur semi-annually, however partnership occurs throughout the year at several subcommittees. These subcommittees are formed from recommendations developed as a result of child deaths or child near deaths due to abuse and/or neglect. The recommendation must be a recurring theme and of utmost necessity to keep children safe in order to warrant a newly formed subcommittee.

Joint CPAC and CDNDSC Commission subcommittees include the following:

- Mandatory Reporting Media Subcommittee
- Risk Assessment Subcommittee[6]
- Healthcare of Children in Foster Care
- Infant Safe Sleeping Practices

To complement the Mandatory Reporting Training, CPAC and CDNDSC partnered to develop a Mandatory Reporting Media Campaign which will primarily focus on the problem of child abuse, the duty to report, and individuals likely to be a perpetrator of abuse and/or neglect within the community.

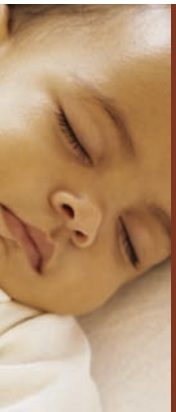
The Subcommittee had its initial meeting at the close of the fiscal year, and endeavors to raise community awareness will continue into the next fiscal year.

An additional joint Commission initiative is the development of the Risk Assessment Subcommittee after 20 recommendations involved re-evaluating the current risk assessment model being utilized by the Division of Family Services. The mission of this subcommittee is to research various risk assessment tools and make recommendations on the most appropriate tool for Delaware to adopt and use. The work of this subcommittee should conclude in FY11.

The Healthcare of Children in Foster Care Subcommittee will evaluate whether children in foster care are being adequately served under the current medical care system.

[5]CPAC Fiscal Year 2010 Annual Report

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



Office of Child Care Licensing and its advisory board should review best practices nationwide and implement enforcement and sanctioned procedure which increases child safety in daycares.

Representatives from CDNDSC and CPAC will begin meeting in FY11 to establish a mission and begin identifying opportunities for improvement to health care services for children in foster care.[7]

The Infant Safe Sleeping Practice Subcommittee was created in FY06 after the Commission reviewed 57 infant and child sleep-related deaths during FY03-FY07. The subcommittee, a community action team, immediately went to work to address this significant problem in Delaware. The Commission continues to educate the community at a local, grassroots level. The training for professionals continues as often as possible throughout the state to physicians, nurses, social workers, and day-care workers. CDNDSC has also partnered with the Delaware Ecumenical Council to develop a brochure on infant safe sleeping practices. This will be a guide for clergy and others to utilize within their faith community. A full comprehensive report on the work of the subcommittee can be found at: http://courts.delaware.gov/childdeath/reports.htm

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 (Sudden Infant Death Syndrome) 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.[8]

CRIBS FOR KIDS®
...it's for the babies

In June 2009, a partnership was developed between the Delaware Division of Public Health, Nemours Health and Prevention Services of the Nemours Foundation (Nemours), and CDNDSC to implement the first Cribs for Kids® program in Delaware. Any Delaware mother is entitled to a free crib 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.

Nemours has been designated as the nonprofit organization that will be the gatekeeper for the donated funds from the community. CDNDSC will house cribs for distribution and will continue to partner on events to secure funds for the program. The education will be provided to the family by a Division of Public Health nurse. 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. The training and full implementation of this program started in November 2009. Please see the Delaware Cribs for Kids website® [9] for more information.

[7]CPAC Fiscal Year 2010 Annual Report

[8]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)

[9]www.cribsforkidsde.org

Among the 120 cribs that were delivered in FY10 through the Delaware Cribs for Kids program, not one death occurred in those families due to unsafe infant sleeping.

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

- April Child Abuse Blue Ribbon Campaign
- Bayhealth Child Advocacy Subcommittee
- CPAC Subcommittees
  - Training Subcommittee
  - Abuse Intervention Committee
  - Legislative Subcommittee
- Delaware Healthy Mother Infant Consortium
  - Data and Science Committee
  - Education and Prevention Committee
  - Disparities Committee
  - Standards of Care Committee
  - Systems of Care Committee
- Nurse Family Partnership Advisory Board
- Suicide Prevention Taskforce

CDNDSC PREVENTION PARTNERS

- 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 Ecumenical Council
- Delaware Healthy Mother Infant Consortium
- Delaware SIDS Affiliate
- Delaware Suicide Prevention Coalition
- Department of Services for Children, Youth and their Families (DSCYF)
- Department of Justice
- Division of Family Services
- 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

Left hand side: Michael Brown (Office Manager), Center: Ashlee Starratt (Child Death Specialist)

Continue to support the Delaware Healthy Mother Infant Consortium (DHMIC) and the Division of Public Health's (DPH) initiative Healthy Women, Healthy Babies (HWHB) that takes a life course perspective and considers preconception and inter-conception health to optimize women's pregnancy outcomes. Better pregnancy outcomes begin with preventive health visits for women.

Recommendations for Cases Reviewed During FY2010

Abuse/Neglect Deaths or Near Deaths

Cause of Death-Most Recent National Data	Total Deaths
U.S. Soldiers killed in Iraq and Afghanistan	479
H1N1 Pediatric fatalities	281
Food Borne Illnesses	74
Toyota Accelerator Malfunction	34
Coal Mining Accidents	33
Total Other Causes of Death	901
Total Child Abuse and Neglect Fatalities	1740

Child Abuse and Neglect Fatalities vs. Other Causes of Death

Nationally, the above total number of child abuse and neglect fatalities occurred from July 2007 to June 2008.[10] Experts believe that this number is significantly undercounted and there may be more deaths not acknowledged as caused by abuse and neglect. This is due, in part, to how the cause of death is coded for child maltreatment deaths.[11]

During FY10, the CAN Panel reviewed two child deaths and one child near death that resulted from abuse and neglect. These cases had numerous systems issues and the child near death encompassed a six month comprehensive review. In addition, eight CAPTA reports were completed.

[10] Retrieved from: http://www.acf.hhs.gov/programs/cb/pubs/cm08/

[11] We Can Do Better, Child Abuse and Neglect Deaths in America (2010) www.everychildmatters.org

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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The following recommendations were submitted to and approved by the Commission from the CAN panel.

Department of Services for Children, Youth and their Families

(1) 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.

(2) 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.

(3) 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.

(4) 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.

(5) 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.

(6) DSCYF shall review its policy and further define "family" and "case."

(7) 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.

(8) CDNDSC recommends that the Child Protection Accountability Commission (CPAC) Risk Assessment Subcommittee research more effective and efficient risk assessment tools that will objectively evaluate risk and history and appropriately incorporate criminal, multigenerational and individual DSCYF history.

(9) CDNDSC supports the efforts of the Child Protection Accountability Commission's Abuse Intervention Subcommittee in developing and offering training on the updated 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.

(10) As stated in previous recommendations, CDNDSC recommends that DSCYF no longer accepts 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.

(11) CDNDSC asks that the Department of Services for Children, Youth, and Their Families investigate the number of cases that are being assigned to investigative caseworkers to ensure that each caseworker is meeting 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.

Multidisciplinary use of child welfare history in decision-making should be a system-wide priority for all those entities involved in child protection. CDNDSC and CPAC should continue its work with their subcommittee developed to address this issue.

(12) CDNDSC recommends that DFS reassess how each case is handled, with specific attention to safety plans.

(13) OCCL and its advisory board should review best practices nationwide and implement enforcement and sanctioned procedure which increases child safety in daycares.

(14) CDNDSC recommends that OCCL distribute educational information to all child care facilities regarding the signs and symptoms of head trauma.

Law Enforcement Agencies

(1) As recommended in two case reviews, 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.

Medical Community

(1) CDNDSC shall send a letter to the medical facility in this case requesting a review of policy and procedure for children who are diagnosed as medically fragile; providing them also with patient support and information on contacting the Division of Family Services.

(2) CDNDSC shall refer the physician involved in the present case to the Board of Medical Practice to review the physician's treatment as it pertained to this case.

(3) CDNDSC recommends that Neonatal Intensive Care Units (NICU), as a team, review their policies and procedures with regard to the assessment and evaluation of the family and home situation to ensure each child's safety upon discharge.

(4) CDNDSC recommends that the 2008 American Academy of Pediatric's recommendations for discharge be reviewed and followed by medical personnel caring for premature infants.

(5) CDNDSC recommends that the Delaware Chapter of the American Academy of Family Practitioners be updated on the management of Failure to Thrive and the care of low birth weight and premature infants.

(6) CDNDSC recommends that the Family Practitioner be referred to the Board of Medical Licensure and Discipline for further review concerning the care or lack of care this child received since the treatment does not appear to meet the current standard of care.

(7) CDNDSC recommends that the Visiting Nurse be referred to the Board of Nursing due to her failure to report child abuse and neglect.

Multi-Disciplinary Reporting and Investigation of Child Abuse and Neglect

(1) CDNDSC shall support the continued education on mandatory reporting of child abuse and neglect.

(2) CDNDSC supports the ongoing efforts to educate the entire medical community concerning their responsibilities for mandatory reporting.

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.

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Drowning/Pool Safety
During FY10, the Commission reviewed two deaths due to drowning. Of those two deaths both occurred in an in-ground pool where the child was not supervised and supervision was needed due to child's developmental age. Proper supervision of children is the best way to prevent a child from drowning.

The Commission has made the following recommendation to prevent children from drowning:

(1) CDNDSC supports the initiative of the Safe Kids Pool Watcher Program.[12]

(2) CDNDSC supports the efforts of the Delaware Drowning Prevention Coalition.[13]

[12]The Pool Watcher Program designates one individual at each private gathering to be the designated "pool watcher". This is often denoted by a lanyard name tag being worn by this individual. These tags are available through www.safekids.org

[13]The Drowning Prevention Coalition of Delaware has begun to work on making public pools and spas safe across the state. The Consumer Product Safety Commission is approaching the Attorney General's office to support the Coalition by amending Delaware's law to reflect that of the Federal Pool and Spa Safety Act as passed in 2008.

BASIC PRECAUTIONS FOR PARENTS:[14]

- Teach your child to swim. Most children can learn by age five.
- Learn CPR and teach children to call 911.
- Always keep a fence around a swimming pool, lock the gate and install a pool alarm.
- Be prepared for an emergency by keeping a cell phone, flotation devices, lifesavers, life jackets and other rescue equipment near the pool.
- Don't leave pool toys in the water.
- Remove above-ground pool steps when the pool isn't in use.
- Strictly enforce pool rules-no running, no horseplay, no diving-and never swim alone.
- Never let children play or sit near a drain in a pool or hot tub. Hair and body parts may become entrapped by the strong suction.

Homicides (not due to child abuse and neglect)
The Commission reviewed three cases of homicide. These cases involved three African American children, in the range of 15 to 17 years and the use of firearms. In these particular cases, one adolescent was a bystander victim and the other two adolescents were victims of random violence. The perpetrators in these cases were identified as a friend or acquaintance. From 1994 to 2009, children made up 19% of people charged with weapon-related offenses.[15]

[14]Great day for a swim? Watch the young ones, Delawareonline, 7/4/10.

[15]Delaware Criminal Justice Information Center

The following recommendation was put forth in two of these deaths due to gun violence:
(1) CDNDSC supports the efforts of the Delaware Juvenile Justice Advisory Group and will make available relevant data regarding juvenile violence resulting in death.

http://www.dhss.delaware.gov/dhss/dph/ems/safekids.html

CDNDSC supports the initiative of the Safe Kids Pool Watch Program.

Motor Vehicle Crashes

The Commission reviewed 13 child deaths due to motor vehicle collisions. Thirty-eight percent (five out of 13 deaths) of all child deaths due to motor-vehicle collisions occurred in the 15 to 17 age range. This number has decreased by 60% from the previous annual report. Unique factors involving the teen populations include three cases of wet roadways, four cases where the teenager was responsible for the motor vehicle crash and one case where the graduated licensing requirements were not followed by allowing more than two teen passengers. The good news is that the efforts of the legislature and Office of Highway Safety have started to show a reduction in teenage motor vehicle crashes. According to a federal report, fatal car crashes involving teen drivers fell by about a third over the past five years.[16] This is attributed to the Graduated Driver Licensing Law that went into effect in 1999.

Of the deaths reviewed in FY10, male deaths occurred in 10 out of the 13 motor vehicle collisions, and eight of the children were Caucasian. Eleven of the motor vehicle collisions occurred in a rural or suburban setting. Three cases were the result of not being properly restrained by a seatbelt. Two cases involved a child safety seat that was used incorrectly. Two of the thirteen cases resulted in a child without a helmet being struck on a bicycle and another as a pedestrian.

The Commission has made the following recommendations to prevent motor vehicle deaths:

(1) CDNDSC shall support the Safe Kids program in the continuation of education for car seat safety and safety seat checkpoints.

With regard to the dangerous practice of using a cell phone while driving a vehicle, the Commission put forth the following recommendations:

(2) The Commission will support the legislation banning cell phone use while driving.

(3) The Commission shall ask the Department of Technology and Information (DTI) to add a field box (check box) for cell phone use to police investigation and incident reports to indicate whether or not an electronic communication devise was in use while operating a vehicle.

In July 2008, the Delaware child restraint law was changed. All children must be properly restrained in a federally approved child safety seat appropriate for the child's age, weight, and height up through seven years of age or 65 pounds. Additionally, children eight through 15 years old must be properly secured in a seatbelt. All children less than 12 years old or 65 inches in height are still required to sit in the back seat if there are active airbags in the front passenger seating position. The fine for violating this law is $25 plus court costs.

[16] Laws restricting teenagers' driving have been lifesavers, Delaware News Journal, 10/23/10.

On January 2, 2011, Delaware's hand held cell phone ban went into effect. This law bans texting and talking while driving unless using a hands-free device. (http://www.ohs.delaware.gov/)

Drivers who use hand-held devices are four times more likely to get into crashes serious enough to injure themselves. (Office of Highway Safety, 2010)

In Delaware, all children under the age of 16 must wear a helmet while riding a bike. The first offense is punished with a $25 fine; all subsequent offenses are $50.

Well-Being and Prevention... (Continued)

Poisoning, Overdose or Acute Intoxication Deaths

The Commission reviewed a total of four deaths due to poisoning, overdose, or acute intoxication. All four 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, or over the counter medication). Three of the four cases were male. Three of the four children were white, with one African American child.

(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.

Suicide

Delaware has taken a step forward in addressing adolescent suicide. The Division of Public Health Wellness Centers have had advanced training on this issue and they continue to work with CDNDSC after the death of a child due to suicide. The Department of Services for Children, Youth and Their Families' Office of Prevention and Early Intervention is leading a grant program entitled Project LIFE (Living Is for Everyone). This is a comprehensive, statewide suicide prevention initiative targeting youth ages 10 to 24. This project is supported by the Delaware Suicide Prevention Coalition (DSPC), of which CDNDSC is a member. By creating new programming and leveraging existing sources, the DSPC aims to reduce negative behaviors and enhance resiliency in youth most at risk for suicide. Project LIFE takes a public health and community-based approach to suicide prevention by identifying the broader patterns of suicidal behavior through groups and populations. Following the Guiding Principles of the National Strategy for Suicide Prevention, DSPC is designed to be a catalyst for social change, with the power to transform attitudes, policies and services. The goals of Project LIFE are to prevent suicidal behaviors by enhancing resiliency; reduce the impact of suicide and suicidal behaviors on individuals, families, and communities; and improve access to available prevention services for vulnerable, high-risk individuals.[17]

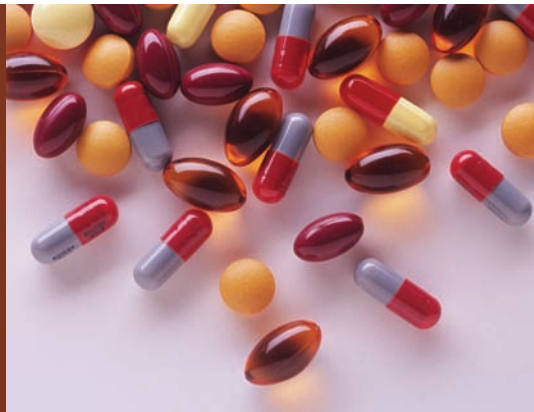
The Commission reviewed one child death due to suicide during this time period. The child had a history of substance abuse and was impaired at the time of the suicide.

The following recommendation was put forth by the Commission as a result of this death:

(1) CDNDSC recommends that the Suicide Prevention Coalition identify any potential barriers or opportunities to improve communication and coordination among health care providers.

[17] http://www.delteenspace.org/life.html

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.



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

The unsafe infant sleeping practice deaths have dramatically increased to 18 deaths reviewed in FY10. Statistically speaking, a significant disparity has been found for the cause of death among the African American population of 83% (15 of those 18 reviewed). Among the 18 deaths, only one infant was sleeping in a crib. In 77% (14 of 18) of the unsafe infant sleeping death cases, the child was bed-sharing with another person.

Among the 18 cases reviewed, six of the infants were not sleeping on their back. Four of these cases had unsafe bedding for the infant's sleep including two "boppy" (feeding and support) pillows. Two of these cases involved a mother who fell asleep while breastfeeding the infant. These deaths were 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) have made this one of their top priorities.

After review of the 18 unsafe infant sleeping deaths, the Commission has made the following recommendations:

(1) CDNDSC supports the efforts to prosecute individuals who disregard education on safe sleeping practices. In this particular case, the mother was educated on safe sleeping practices more than once, but chose to ignore these risk factors and continued sleeping with the child. The child died as a result of the overlay by mother. The anticipated result of this recommendation is that harsher penalties will be sought for parents who blatantly disregard the information that they have learned from programs; such as, Cribs for Kids and other safe sleeping initiatives. If parents are aware of these penalties, it might prohibit them from endangering their child by bed-sharing. The Attorney General's office will take the lead in implementing this recommendation.

(2) The following recommendation was made after review of three separate deaths: CDNDSC supports continued infant safe sleeping education for state agencies, community agencies, and the public.

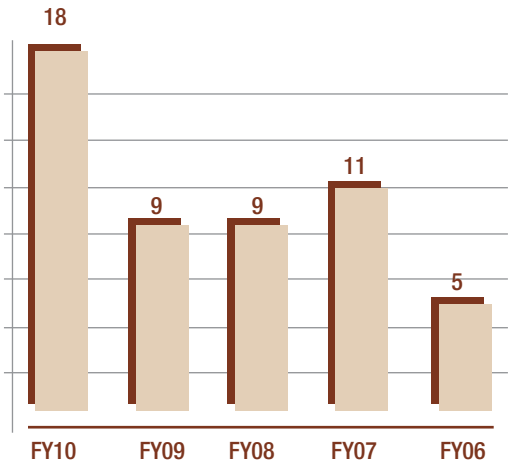
(3) The following recommendation was made after review of four separate deaths: CDNDSC shall support the continued education for agencies on Cribs for Kids and other safe sleeping initiatives.

(4) The following recommendation was made after review of two separate deaths: CDNDSC recommends that the Department of Services for Children, Youth, and Their Families' (DSCYF) safe sleeping practices education become formal DSCYF policy.

(5) CDNDSC shall send a letter to home visiting programs to educate all nurses on the Cribs for Kids initiative.

(6) CDNDSC shall send a letter to the social service agency in this case offering their nurses continuing education on this issue for their licensing requirements.

Figure 1: Unsafe Infant Sleeping Deaths Reviewed



10 Steps to Promote Infant Sleep Safety

1. *Place babies to sleep on their backs for naps and at nighttime, not on their tummies or sides. Remember "stomach to play, back to sleep" for baby's healthy development and to lower SIDS risks.*
2. *Give the protection of a crib and make sure babies do not sleep on sofas or in beds with others. Let the infant sleep in a crib or bassinet near the parent's bed.*
3. *Use a firm mattress that fits and has no gap between it and the frame of the crib.*
4. *Use a fitted sheet that is the right size for the mattress and tuck blankets in.*
5. *Do not use bumper pads, sleep position wedges, or pillows in the crib.*
6. *Keep toys and fluffy blankets out of the crib while baby sleeps.*
7. *Make sure the baby's room is in the safe temperature range of 68°F to 75°F; using a thermometer in the baby's room can help.*
8. *Position the crib away from the heat vent.*
9. *Prevent overheating by layering the baby's clothes and not overdressing them.*
10. *Keep all cigarette smoke away from pregnant women and all babies.*

Outdoor Campaign
Fall 2009

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Part I: Progress to Date

Case Reviews

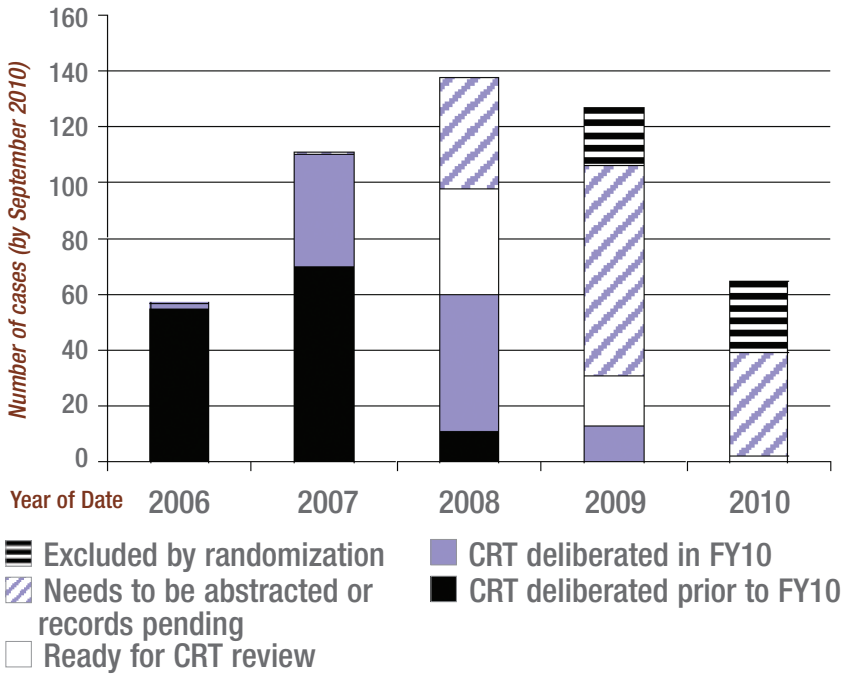
Three Case Review Teams (CRTs) met from September 2009 through May 2010 to review a total of 104 Fetal and Infant Mortality Review (FIMR) cases in FY10. This was the first year in which the monthly CRT meetings increased in length from two to three hours. Consequently, in FY10, an average of 4.3 cases were reviewed at each CRT meeting, which is an increase from the FY09 average of 2.9 cases per meeting and the FY08 average of 2.1 cases per meeting. The three CRT groups had similar average caseloads per meeting: Wilmington (4.1 cases per meeting), New Castle County (4 cases per meeting), and Kent/Sussex County (4.6 cases per meeting). This suggests that between four and five cases per meeting is the number that can be optimally reviewed. Assuming that three CRT groups continue to function for nine months every year, up to 135 FIMR cases can be reviewed in a fiscal year. However, there are about 95-110 infant deaths and 50-60 fetal deaths that occur annually in Delaware.[18] Thus the total annual number of infant and fetal deaths in Delaware exceeds the review capacity of the FIMR CRTs.

FY10 marked the beginning of a randomized case selection process based on date of death in order to make the FIMR caseload more manageable based on the number of cases that can be optimally reviewed by the CRTs each year. In order to provide the same opportunity for grief support and referrals, the FIMR medical social worker attempted to contact all mothers with a fetal or infant death and offered a maternal interview. If the mother accepted and a maternal interview was conducted, her case was automatically included for a full CRT review. Among the remaining cases without a maternal interview, beginning on July 1, 2009, cases were randomly selected for a full CRT review if the death occurred on an odd date between July 1 and December 31, 2009, or if the death occurred on an even date between January 1 and June 30, 2010. The only exception to this randomization process by date of death was if the mother experienced multiple losses; in that case, if one loss met the inclusion criteria for full CRT review, all the mother's other fetal or infant losses were also reviewed, regardless of date of death, and presented together for CRT discussion.

Among the 104 cases reviewed in FY10, CRTs deliberated two cases of deaths occurring in calendar year 2006, 40 cases from 2007, 49 cases from 2008 and 13 cases from 2009. An additional 59 cases were fully abstracted and were ready for CRT review. Of the fetal and infant death cases reported to the CDNDSC and occurring after July 1, 2009, 47 were excluded from full CRT review by the date of death random selection process. Four cases that would have been excluded based on date of death were added back to the CRT list because the mother accepted a maternal interview. Additionally, four cases were added back to the CRT list because they involved women with multiple losses. Figure 1 presents a summary of the progress to date on fetal and infant deaths by calendar year.

[18]Kroelinger CD, Gladders B. Using scientific evidence to shape research, intervention programs, and policy in a statewide effort to reduce infant mortality, 2004-2009. Delaware Medical Journal 2010;82 (8):273-84.

Figure 2: Progress to date on fetal and infant death cases reported to the CDNDSC



FY10 marked the beginning of a randomized case selection process based on date of death in order to make the FIMR caseload more manageable based on the number of cases that can be optimally reviewed by the CRTs each year.

Except for one, fetal/infant deaths through 2007 have been completely reviewed. Forty-three percent of 2008 deaths have been reviewed by CRTs (60 out of 138), and another 28% are ready for review (38 out of 138 cases). Among the 2009 deaths, 10% (13 out of 127 cases) have been reviewed by CRTs, 14% (18 out of 127) are ready for review, 59% of deaths (75 out of 127) need to be abstracted and 17% (21 out of 127) were excluded by the date of death randomization process. Among the 2010 deaths through June 30, 2010 and reported as of September 2010, 3% of deaths were ready for CRT review (2 out of 65), 57% need to be abstracted (37 out of 65) and 40% were excluded by their date of death (26 out of 65).

Every year, the CDNDSC staff receives reports of fetal deaths that do not meet FIMR eligibility criteria because they occur prior to 20 weeks gestation. In FY10 there were three such cases reported to the CDNDSC by the Office of Vital Statistics, in FY09 and FY08 there were five cases each year, and in FY07 there were eight cases. Terminations of pregnancy are also excluded from FIMR review; in FY10 there was one such case reported to the CDNDSC.

Maternal Interviews

In selecting cases for CRT deliberation, the FIMR staff prioritized cases in which a maternal interview was completed. In FY10, 34 (33%) of the 104 FIMR cases deliberated included a maternal interview. This acceptance rate for the maternal interview, based on cases deliberated, has increased from a rate of 24% for the prior two years. The acceptance rates among White mothers (37%, 22 out of 59 cases) and Black mothers (29%, 11 out of 38 cases) have also increased from their corresponding rates in the prior two years of 29% and 20%, respectively.

The FIMR medical social worker conducts the maternal interviews and sends out an evaluation form to all mothers who participated in the maternal interview process. Eleven evaluations were completed in FY10, including two in Spanish. Eighty-one percent of mothers participated in the interview because they wanted the opportunity to provide information that may help other mothers and infants, 55% wanted to talk about their experience and 27% wanted assistance identifying beneficial community services. All the mothers responding to the evaluation felt they had the opportunity to openly share their feelings. Ninety-one percent of women felt it was beneficial to answer questions about their loss, and about two-thirds of women responding felt that they gained some insight about their loss through their participation in the interview. These women felt that the FIMR medical social worker was caring and professional, thus making the interview experience overall a positive one. Two women expressed the importance of connecting with other women going through similar experiences either to receive or extend help. Women had varied opinions regarding the best time to make contact with them about an interview: a little over half the women (6 out of 11) felt the optimal time was between two and six weeks after their loss. In practice, only one of the 32 women interviewed in FY10 had her interview conducted within ten weeks of her loss; about half of the women interviewed (15 out of 32 or 47%) were 21 to 30 weeks out from their fetal or infant loss. The median time between the death and the maternal interview for the 32 women interviewed was 23.5 weeks, or almost six months.

FIMR Bereavment Conference

CDNDSC and FIMR hosted the third annual Delaware Bereavement Conference in September 2009 to provide resources, continuing education and support for professionals working directly with grieving families who have experienced a fetal or infant loss. Thirty-seven attendees represented hospitals, community and outreach programs, health insurers and public health agencies. Conference topics included: funeral arrangements when a baby dies, working through grief, miscarriage outreach and bereavement photography. Attendees also had the opportunity to provide an update on what they or their agency are doing to support families and to hear the feedback from FIMR maternal interviews about mothers' perspectives on bereavement support.

Quotes from the maternal interview evaluations:

"(The interviewer) was very warm and very professional at the same time, and I felt like she sincerely cared about my experience. While I was reluctant to talk with a state agency about such a personal experience, I'm very glad that I did."

"I would like to let you know that (the interviewer) has been keeping in touch with me through e-mail. She has been sending me information that she thinks will benefit me. She goes above and beyond!"

"Muy bien. Persona super especiales que saben como hacer su trabajo."

Descriptive Summary of FIMR Cases Deliberated in FY10

FIMR CRTS reviewed 104 cases in FY10, 48 deaths were fetal deaths and 56 deaths were infant deaths. These 104 cases involved 97 mothers. Six mothers experienced more than one fetal or infant death. Five mothers had twins that died: three sets of twins were infant deaths, one set was counted as fetal deaths, and one set included one infant and one fetal death. The sixth mother had three separate infant deaths over three separate pregnancies.

Table 1 summarizes the proportion of certain key variables and maternal characteristics among the total FY10 FIMR cases, FIMR fetal death cases, and FIMR infant death cases. Cases are also separated out by maternal race, with the proportion of key variables reported for FIMR cases—both fetal and infant deaths--involving White mothers (n=59) and cases involving Black mothers (n=38).

The breakdown of FIMR fetal and infant death cases by gestational age is shown in Figure 3. The proportion of FIMR infant deaths under 28 weeks, 28-36 weeks and over 37 weeks is similar to the comparison group of all Delaware infant deaths between 2002 and 2006. However, among FIMR fetal deaths, a higher proportion of cases (38%) occurred between 28 and 36 weeks gestation.

Figure 4 depicts the birth weight distribution of FIMR fetal deaths and FIMR infant deaths. The comparison group is the total Delaware infant deaths from 2002 through 2006. Among FIMR fetal deaths, there is a higher proportion of cases weighing less than 500 grams (39%) and weighing between 1500 and 2499 grams (27%) compared to FIMR infant deaths.

Table 1: Characteristics of FIMR cases

	% total FIMR cases (n=104)	% FIMR fetal deaths (n=48)	%FIMR infant deaths (n=56)	% White mothers (n=59)	% Black mothers (n=38)	% total Delaware infant deaths or live births[19]
Maternal race						
White	57%	48%	64%			58%*
Black	37%	44%	30%			41%
Other	6%	6%	5%			1%
County of residence						
New Castle	65%	63%	68%	66%	61%	66%*
Kent	16%	21%	13%	19%	13%	10%
Sussex	18%	17%	20%	15%	24%	24%
Maternal age (years)						
<20	13%	15%	13%	12%	13%	10%**
20-29	48%	42%	54%	49%	53%	53%
30-39	35%	38%	32%	36%	32%	34%
40+	4%	6%	2%	3%	3%	2%
Maternal education						
<12 years	32%	23%	39%	37%	21%	24%**
High school diploma or GED	34%	40%	29%	25%	50%	24%
1+ years college	29%	29%	29%	31%	26%	
Postgraduate	3%	2%	4%	3%	3%	
No information	3%	6%	0%	3%	0%	1%
Entry into prenatal care						
1st trimester	73%	65%	80%	75%	71%	67%**
2nd trimester	17%	23%	13%	15%	18%	18%
3rd trimester	3%	4%	2%	2%	5%	5%
No prenatal care	6%	8%	4%	7%	5%	3%
Method of payment						
Medicaid	40%	40%	41%	36%	50%	46%**
Private	35%	35%	34%	37%	29%	47%
Self	5%	6%	4%	3%	5%	2%
Other	12%	6%	16%	15%	5%	2%
No information	9%	13%	5%	8%	11%	2%
Sex of fetus or infant						
Male	54%	58%	50%	56%	50%	54%***
Female	46%	42%	50%	44%	50%	46%
Plurality						
Single	88%	94%	84%	85%	92%	80%***
Multiple gestation	12%	6%	16%	15%	8%	20%

* For this category, the comparison group is all Delaware infant deaths in 2007, n=90.

** For this category, the comparison group is all Delaware live births in 2007, n=12,097.

***For this category, the comparison group is all Delaware infant deaths between 2002 and 2006, n=485.

[19]Delaware Health Statistics Center (DHSC). Delaware Vital Statistics Annual Report, 2007: Delaware Department of Health and Social Services, Division of Public Health 2010.

Table 1: Characteristics of FIMR cases

Figure 3: Gestational age distribution (in weeks) [20]

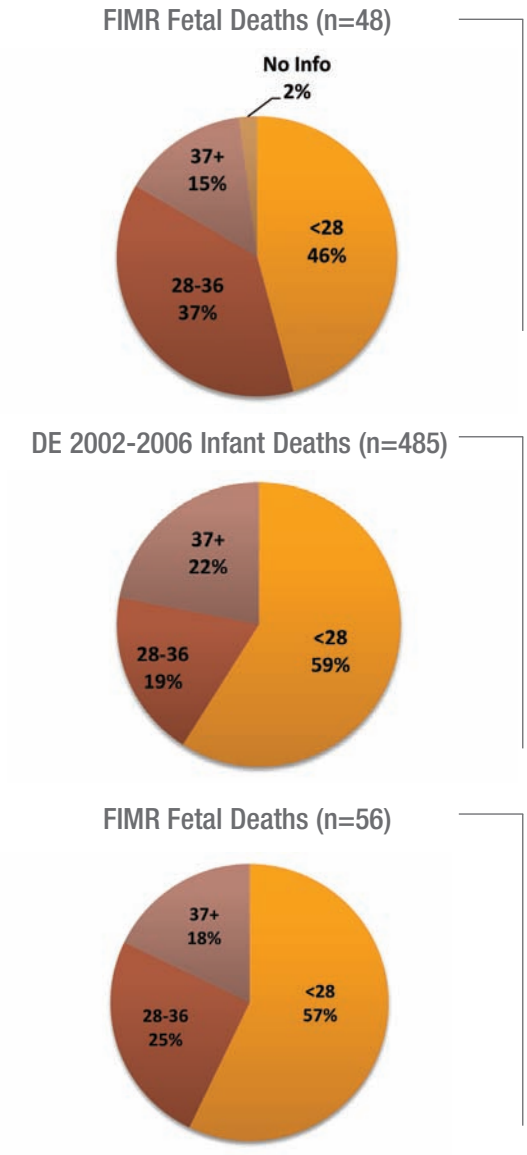
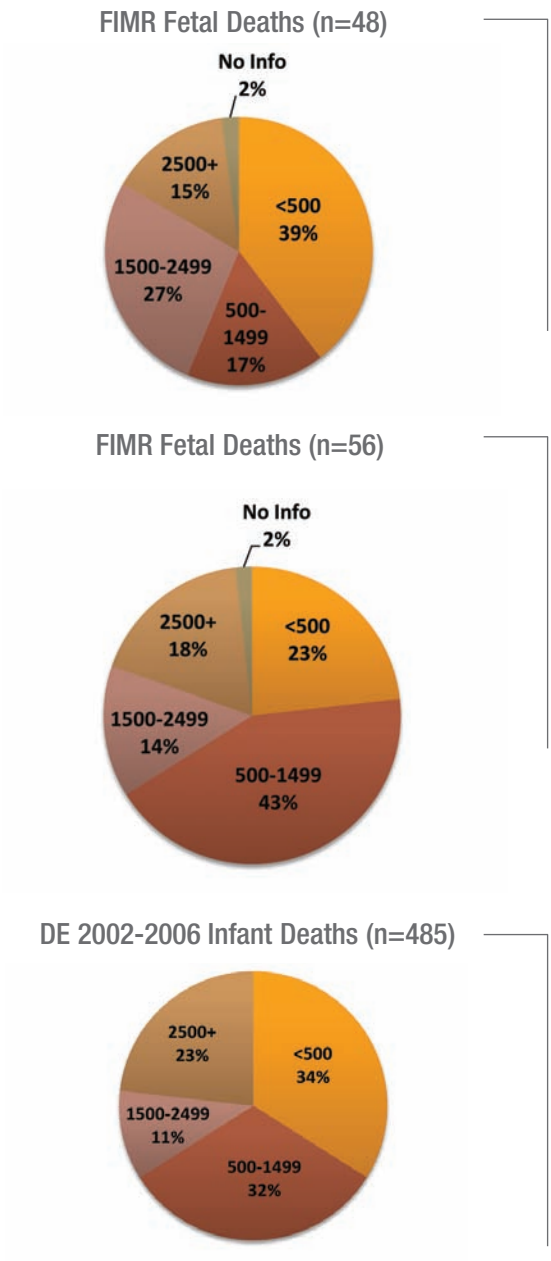


Figure 4: Birth weight distribution (in grams) [21]



[20] DHSC. Delaware Vital Statistics Annual Report, 2007: Delaware Department of Health and Social Services, Division of Public Health 2010.

[21] DHSC. Delaware Vital Statistics Annual Report, 2007: Delaware Department of Health and Social Services, Division of Public Health 2010.

Descriptive Summary of FIMR Cases Deliberated in FY10 (Continued)

Three-quarters of the 56 FIMR infant death cases occurred in the neonatal period, between 0 and 28 days of age (n=42). Of these, about 70% (n=29) occurred in the first 24 hours after birth, representing 52% of all FIMR infant deaths. One-quarter of FIMR infant deaths (n=14) are classified as post-neonatal, occurring between 29 and 364 days of age. The proportion of neonatal and post-neonatal deaths among FIMR infant cases and among all 2003-07 Delaware infant deaths is comparable (Table 2). However, more FIMR infant deaths occurred in the first 24 hours compared to the 2003-07 Delaware infant death group.

The leading primary cause of death among FIMR infant cases was prematurity, accounting for 18 of the 56 cases (Table 3). Congenital malformations and chromosomal abnormalities was the second leading cause of death and included the diagnoses of diaphragmatic hernia (n=2), spinal muscular atrophy (n=2), congenital heart disease (n=1), osteogenesis imperfecta (n=1), anencephaly (n=1) and Trisomy 18 (n=1). Respiratory distress/failure accounted for 10 of 56 deaths. "Other" causes of deaths included such diagnoses as bowel perforation (n=1), metabolic disorder (n=1), placental abruption (n=1) and perinatal asphyxia (n=1).

A higher percentage of Black infant deaths (47%, 8 out of 17) were due to prematurity compared to White infant deaths (25%, or 9 out of 36). Among all infant deaths in Delaware between 2003 and 2007, prematurity and low birth weight accounted for 22.3% of deaths, congenital anomalies accounted for 12.5%, and maternal complications of pregnancy—primarily incompetent cervix and premature rupture of membranes—accounted for 8.7% of deaths because such complications essentially result in preterm delivery.[23]

Highlights of FIMR FY10 Progress to Date and Descriptive Case Summary

- Under the present program structure, FIMR CRTs can review a maximum of 135 cases per fiscal year. However, an average of 95-110 infant deaths and 50-60 fetal deaths occur annually in Delaware.[24] Thus the total annual number of infant and fetal deaths in Delaware exceeds the review capacity of the FIMR CRTs. Consequently, a random case selection process, based on date of death, was implemented in July 2009 for those cases without a maternal interview in order to bring the Delaware fetal and infant death caseload down to a more feasible number for timely CRT review.
- CRTs reviewed 104 cases in FY10: 48 fetal deaths and 56 infant deaths. One-third of these cases had a maternal interview.
- A higher proportion of FIMR fetal deaths occurred between 28 and 36 weeks gestation (38%) compared to FIMR infant deaths (25%) and all 2002-06 Delaware infant deaths (19%).

[22]DHSC. Delaware Vital Statistics Annual Report, 2007: Delaware Department of Health and Social Services, Division of Public Health 2010

[23]DHSC. Delaware Vital Statistics Annual Report, 2007: Delaware Department of Health and Social Services, Division of Public Health 2010.

[24]Kroelinger CD, Gladders B. Using scientific evidence to shape research, intervention programs, and policy in a statewide effort to reduce infant mortality, 2004-2009. Delaware Medical Journal 2010; 82(8): 273-84.

Table 2: Age of infant death

	FIMR infant FY10 deaths (n=56)	DE 2003-07 infant deaths (n=497)[22]
<24 hrs	52%	39%
0-28 days	75%	71%
29-364 days	25%	29%

Table 3: Primary cause of death

Cause of death	% FIMR infant deaths (n=56)	%White infant deaths (n=36)	%Black infant deaths (n=17)
Prematurity	32%	25%	47%
Congenital malformations & chromosomal abnormalities	14%	14%	12%
Respiratory distress/failure	18%	19%	18%
Sepsis	9%	11%	6%
Encephalopathy	4%	6%	0%
Renal failure	2%	0%	6%
Necrotizing enterocolitis	2%	0%	6%
Other	20%	25%	6%

Part II: FIMR Recommendations & Action Steps

FIMR CRTs are a multidisciplinary group who represent medical, public health and community organizations. The FIMR Program Coordinator helps facilitate CRT meetings, and the FIMR medical social worker provides insight to the mothers' experiences in those cases with a maternal interview. FIMR staff use the electronic database, BASINET (Baby Abstracting System and Information NETwork) supported by Go Beyond, L.L.C., to generate case summaries of each fetal/infant death. CRT members receive the case summaries one week prior to each meeting. During the CRT meeting, the FIMR Program Coordinator uses a BASINET checklist to capture the key factors of each case and the recommendations to improve future pregnancy outcomes as identified by the CRT's discussion.

CRT members discuss each case in depth to identify pertinent positive factors–recorded as "strengths" on the BASINET checklist–that may be considered protective or may have ameliorated the mother's experience. CRTs also identify negative or risk factors--recorded as "contributing factors"--that may have contributed to the poor pregnancy outcome in the case reviewed. In addition, CRTs iterate recommendations for changes at the individual, medical, social and community levels that may serve to improve women's perinatal experiences or pregnancy outcomes in the future. These recommendations are recorded as "suggestions" in the BASINET database.

A benefit of using a computerized database is that BASINET summarizes the proportion of cases that were marked on the checklist as having each listed strength, contributing factor or suggestion (see appendices 2 and 3.) Based on a review of the strengths, contributing factors and suggestions recorded for the 104 cases reviewed in FY10, eight key issues emerge that are important in improving maternal and infant health in Delaware.

1. Pre-existing medical conditions
2. Medical and social services/community resources available but not used
3. Obesity/nutrition
4. Preterm labor
5. Bereavement counseling/support
6. Family planning/birth spacing
7. Socioeconomic stressors
8. Fetal deaths later in pregnancy

Five of these key issues were also found in FY08-09 based on the 136 cases reviewed during that period (issues 1-5). Three new issues were identified in FY10 (issues 6-8). In this section, recommendations and action steps for each key issue are presented as well as the proportion of cases for which CRTs noted a relevant strength, contributing factor or suggestion in FY08-09 compared to FY10. FY10 cases are also separated out by maternal race. Changes in the BASINET CRT checklist were made in FY10 to better reflect programs and issues specific to Delaware. These changes to the checklist may, in part, account for some of the differences seen between FY08-09 and FY10. In addition, there may be some ascertainment bias that contributes to the different numbers reported for FY08-09 and FY10, as CRTs learned to better use the BASINET checklist and more regularly and efficiently capture case strengths, contributing factors and suggestions. Differences between FY08-09 findings and FY10, as well as differences between White mothers and Black mothers in FY10, were tested for statistical significance using a Z-test for comparisons of two proportions. Differences associated with a p-value less than 0.05 are noted in the following tables.

1. Pre-existing Medical Conditions

CATEGORY	FY08-09 (n=136)	FY10 (n=104)	White mothers FY10 (n=59)	Black mothers FY10 (n=38)
Strengths				
High risk consultation	26%	53%*	53%	53%
Mental health referral	10%	15%	20%	8%
Medication compliance	22%	26%	29%	18%
Contributing Factors				
Pre-existing medical conditions such as asthma, hypertension, diabetes, mental health disorders, etc.	71%	80%	85%	76%
History of sexually transmitted disease (STD) or other genitourinary infection	12%	33%*	29%	45%
Mother taking prescription drugs for medical condition(s)	-	33%	32%	34%
Suggestions				
Home visits during pregnancy to monitor clinical status in high risk patients and provide education	43%	39%	31%	50%
Importance of being healthy before pregnancy	71%	68%	66%	76%
Importance of protected sex, STD/HIV prevention	15%	26%*	19%	42%**

**statistically significant difference between FY08-09 and FY10 ($p<0.05$)*
***statistically significant difference between White mothers FY10 and Black mothers FY10 ($p<0.05$)*

Eighty percent of FY10 FIMR cases involved mothers who were dealing with pre-existing medical conditions. Many of the factors related to infant mortality are related to the health of the mother not only during pregnancy but even before she becomes pregnant. Some medical conditions put the mother at risk for pregnancy complications or poor pregnancy outcome. Maternal complications accounted for 8.7% of infant deaths in Delaware between 2003 and 2007.[27]

[27]DHSC. Delaware Vital Statistics Annual Report, 2007: Delaware Department of Health and Social Services, Division of Public Health 2010.

Table 4: Pre-existing medical conditions

	% of mothers affected (n=97)
Gynecological issue	40%
Abnormal Pap smear	11%
History of Chlamydia infection	4%
History of herpes simplex virus infection	5%
History of Gonorrheal infection	3%
Polycystic ovarian syndrome	3%
Structural abnormalities of the uterus	6%
Fertility problems	6%
Mental health issues	21%
Depression	18%
Musculoskeletal problems	20%
Chronic hypertension	8%
Cardiovascular disease	2%
Respiratory issues	10%
History of asthma	7%
Bronchitis	2%
Sleep apnea	1%
Tuberculosis exposure	1%
Neurological issues	9%

Of the 97 mothers who had fetal or infant death cases reviewed in FY10, the proportion with pre-existing medical conditions was high for both White mothers and Black mothers. The following table specifies the frequency of certain, significant medical history noted among the FY10 cases overall.

Among the 32 women who were interviewed by the FIMR medical social worker in FY10, about one-third (11 out of 32) reported having mental health issues before or during their pregnancy. Three mothers (9%) felt they were not treated appropriately like a high risk pregnancy and their risks were not clearly explained to them.

FIMR CRTs found that 53% of mothers accessed high risk obstetric (OB) services. Such access has been improved with the provision of maternal fetal medicine services based in Dover to care for women in Kent and Sussex Counties. Chronic diseases need to be followed closely during pregnancy, and some of the follow up can and should be provided outside a specialist's clinic or a prenatal clinic. Home-based services--such as those provided by Smart Start, the Visiting Nurse Association (VNA), Nurse Family Partnership (NFP) or the Resource Mothers Program (RM)--should be accessed to ensure women with medical issues are getting the care they need and monitoring their health status appropriately.

Recommendations:

- Continue to support the Delaware Healthy Mother Infant Consortium (DHMIC) and the Division of Public Health's (DPH) initiative Healthy Women, Healthy Babies (HWHB) that takes a life course perspective and considers preconception and inter-conception health to optimize women's pregnancy outcomes. Better pregnancy outcomes begin with preventive health visits for women.

- Encourage providers and home visiting agencies to consider a woman's medical history when planning her care or referrals. In addi-

Case study: pre-existing medical conditions, socioeconomic stressors & preterm labor

This is a 24 year old woman who has a history of a 20 week loss due to preterm labor. Her history is also notable for chronic hypertension, nephrotic syndrome, bipolar disorder, sexual abuse, uterine fibroids and obesity. She attempted suicide at the age of 20, not knowing at the time she was seven weeks pregnant; she went on to miscarry. Not long after that, her brother attempted to kill her, and he was imprisoned. During the recent pregnancy, he was released and her mother allowed him to move into their home. The woman was very nervous and fearful about living with her brother again.

The woman worked and had private insurance, and she also had Medicaid. She had smoked cigarettes since the age of 10 years and was able to cut back to seven cigarettes a day while pregnant. This was an unplanned pregnancy. The father of the baby was 48 years old and not supportive. He gave the woman a sexually transmitted disease while she was pregnant. She is certain that this contributed to her loss.

tion to eligibility criteria based on income or insurance status, home visiting service agencies should be aware of a pregnant woman's medical issues that place her at increased risk for a poor pregnancy outcome. All home visit providers should be aware of the importance of chronic disease management and encourage women to take care of themselves, keep scheduled appointments, comply with medical care plans, and act on early warning signs of a worsening condition.

- Support the Reproductive Life Plans created by DHMIC and DPH that encourage women to actively plan for a healthy pregnancy and achieving life goals. In addition to targeting teens and young women, older women may warrant special consideration in reproductive life plans to help them plan for optimizing their health before trying to get pregnant.
- Support efforts by the Medical Society of Delaware and the DHMIC Systems of Care Committee to provide continuing medical education on the use of psychotropic medicine during and after pregnancy.

Action Steps:

- DHMIC and DPH are implementing Healthy Women Healty Babies (HWHB), a program to provide services to women deemed at higher risk for poor birth outcomes. The program provides services to women before they are pregnant (preconception) as well as during pregnancy. Services include nutrition counseling, weight management, chronic disease management and promoting the physical and mental well-being of at-risk women in Delaware. HWHB is being offered through six contractors throughout the state, including through the Healthy Beginnings program at Christiana Care Health System (CCHS), Westside Health, Planned Parenthood, St. Francis Hospital and La Red Health Center.
- DHMIC and DPH are designing a website that promotes and facilitates a healthy lifestyle among Delaware women of childbearing age. The website will be integrated with the Reproductive Life Plans and text messaging reminders to help provide women the tools and information they need to make healthy choices.
- The DHMIC's Systems of Care Committee is focusing on addressing mental health issues in the perinatal period. The committee has gathered information on the screening efforts used in Delaware, the capacity issues that exist in addressing mental health and the models that integrate mental health services in a primary care setting. The committee recruited Dr. Jennifer Payne, the Director of the Women's Mood Disorders Center at the Johns Hopkins School of Medicine, to speak at the DHMIC annual summit in April 2010 on medications for depression and mood disorders in the perinatal period.
- FIMR staff will work more closely with CCHS to obtain records from the Healthy Beginnings program on FIMR cases that may have been referred. Healthy Beginnings offers prenatal and preventive care for women who are pregnant, planning for a pregnancy or are in their childbearing years. FIMR subpoenas now specifically request such records in addition to outpatient and hospital records. Better record review will provide a more complete picture of the type of referrals, education and services women are receiving in the preconception and interconception periods.
- The CDNDSC will share its annual report and findings with home visitation agencies to encourage continued focus on chronic disease management as a priority for counseling clients.

2. Medical and Social Services/Community Resources Available But Not Used

CATEGORY	FY08-09 (n=136)	FY10 (n=104)	White mothers FY10 (n=59)	Black mothers FY10 (n=38)
Strengths				
Smart Start, Nurse Family Partnership (NFP), or Resource Mothers' (RM) involvement	-	4%	7%	0%
Screened for Smart Start, NFP or RM programs	-	3%	2%	5%
Referral for Smart Start, NFP or RM	-	5%	3%	8%
Enrolled in Healthy Beginnings at CCHS	-	1%	0%	3%
Contributing Factors				
No Smart Start, NFP or RM screening	1%	27%*	29%	24%
Medical and social services/community resources available, but not used	40%	32%	25%	37%
Noncompliance with plan of care	11%	12%	12%	13%
Suggestions				
Home visits during pregnancy to monitor clinical status in high risk patients and provide education	43%	39%	31%	50%
More intensive services/follow-up to address patient education and non-compliance issues	18%	17%	10%	26%**
Smart Start/NFP/RM prenatal screening on initial prenatal care visit	-	24%	24%	26%
Knowledge of community services available as evidenced by referrals	26%	12%*	15%	5%

**statistically significant difference between FY08-09 and FY10 ($p<0.05$)*
***statistically significant difference between White mothers FY10 and Black mothers FY10 ($p<0.05$)*

Part II: FIMR Recommendations & Action Steps *(Continued)*

With revised discussion forms tailored to include Delaware prenatal program offerings, FIMR CRTs are better capturing the numbers of cases screened, referred to or using the services provided by Smart Start, Nurse Family Partnership (NFP) or The Resource Mothers Program (RM). This improvement in CRT tracking, in part, explains the FY10 jump in reporting 27% of cases in which screening was not done but in which services may have been helpful. Enrollment in such programs as Smart Start, NFP or RM is very low among FIMR cases reviewed: in only 4% of cases overall were women participating in such programs. In part, this low proportion may be due to the fact that most FY10 cases date back to deaths that occurred in calendar years 2007 and 2008, when NFP was not yet available in Delaware.

There is a group of mothers who are high risk for poor pregnancy outcomes, either because of their pre-existing medical conditions or history of preterm labor, fetal or infant loss. These women need to be targeted for referral and follow up by case management, HWHB and/or home visitation services. In one-third of FY10 FIMR cases (32%), CRTs reported that available medical and social/community services were not used. Particularly among Black mothers, home visits and more intensive follow up is needed to monitor high risk women, provide education and improve compliance to optimize their health during pregnancy.

Recommendations:

- Improve and facilitate the screening and referral of high risk pregnant women to increase access to case management, mental health and public assistance programs as needed.

- Continue to provide funding for programs in places such as Smart Start, NFP, RM, Parents as Teachers and CCHS Healthy Beginnings.

- Continue to support statewide education for all obstetricians, obstetric triage units, hospital discharge planners and hospital social workers on community programs available throughout Delaware and on how to refer women to these programs. Support the establishment of an easy to refer toll free 800 number and website for providers who wish to access additional home-based services for high risk pregnant women.

- Continue to support the development and distribution of a comprehensive community resource list to all obstetric and family practice clinics. This resource list should be given to all pregnant women regardless of their socioeconomic or insurance status and should include information on social and community programs, warning signs during pregnancy, and when to call their provider for further help.

Action Steps:

- DHMIC and DPH is implementing HWHB, a program to provide services to women deemed at higher risk for poor birth outcomes. The goals of HWHB include reducing infant mortality and low birth weight/prematurity among high risk women. HWHB contractors will provide services to address healthy lifestyle, nutrition and chronic disease management in the preconception, prenatal and inter-conception periods.

- Delaware Children and Families First is implementing the NFP program to provide home-based support for first-time mothers who meet income eligibility requirements. This program, in addition to other existing programs such as Smart Start and RM, will add to the capacity to provide home visit services to pregnant women.

- CDNDSC/FIMR staff will work on establishing a memorandum of understanding to obtain records from Delaware Children and Families First when mothers with a fetal or infant loss were enrolled in NFP or RM. This will help capture better information on cases in which mothers were referred to or receiving services.

Case study: pre-existing medical conditions & social services/community resources available but not used

This 26 year old woman has a history of depression, seizure disorder, asthma, acid reflux, anemia and hypertension with pregnancy. She is obese and smoked cigarettes and marijuana during the pregnancy. She was a Medicaid recipient. A letter was sent to her obstetrician by her insurance company identifying her as someone eligible for case management; however, no such services were utilized. The woman had no family in the area, but she did have her boyfriend and his family for support. She did not have a car and relied on her boyfriend to take her to her appointments. She was working in a fast food restaurant before she became too sick to work any longer. She said she was sick every day with hyperemesis, and she lost 44 pounds during the pregnancy. She was hospitalized several times for nausea.

The woman was at home when she started to feel "weird." She contacted the doctor and was told that her symptoms were normal. She began to feel worse, however, so she called an ambulance. She was taken to one hospital and then transferred to another. Labor could not be stopped and her water broke the next day. She delivered stillborn twins at 24 weeks.

She said she received good support in the hospital. She used a mental health outpatient program to try to cope with her loss. Her doctor told her to wait five to six months before trying to get pregnant again.

Nutrition should be part of preconception care counseling as unhealthy weight can be identified early and behavior change takes time. Wide spread use of BMI to screen women and quantify changes in weight can help track a woman's progress towards a healthier weight. During prenatal visits, providers, who are already dealing with a busy caseload and limited time per patient, may hesitate to take on the issue of overweight without access to nutrition referral. At some prenatal clinics such as CCHS, Westside Health, and Henrietta Johnson Medical Center, nutritionists are available to meet with women during regular prenatal checkups. However, access to nutrition referrals is limited in the setting of private obstetric clinics. With weight issues, the real challenge is going from providing nutrition education—which most mothers are receiving—to actually making lifestyle changes. To facilitate real change may need to delve into deeper, life course issues surrounding a woman's body image, self-esteem, stress, coping resources and finances. Such behavior modification requires time for counseling, follow up and support.

Recommendations:

- Nutritional counseling services should be widely available and reimbursable as a standard of care in pregnancy especially for high risk women. Nutritional counseling should also be available and reimbursable during a preconception care visit so that women are closer to their ideal weight before getting pregnant.

- Reinforce education and outreach in Delaware schools to promote healthy lifestyle choices to include avoidance of substance abuse, healthier food choices and weight management as well as exercise and methods to decrease stress. Such efforts are being undertaken by the Nemours Health and Prevention Services and can help turn the tide of the rising obesity epidemic by starting with children and young people to prevent and reduce the occurrence of behaviors that are linked to obesity.

- Discuss small, feasible action steps at every well visit and at the preconception care visit to encourage women and reduce behaviors that are linked with obesity.

- Educate providers on completing nutritional histories as a standard of practice in prenatal care.

- Educate women on the importance of proper nutrition and weight gain during pregnancy at every prenatal visit.

- Refer women at high risk to social services for WIC, food stamps and consultation with a nutritionist.

- Expand nutrition counseling services for those women at high risk and who are privately insured.

- Address mental health, stress and life course issues that may underlie a mother's issues with body weight.

Action Steps:

- DHMIC and DPH are rolling out Reproductive Life Plans and a website that cover the topics of proper nutrition and exercise as part of a healthy lifestyle and maintaining a healthy weight.

- DHMIC and DPH is implementing HWHB, with one specific program aim being to decrease obesity among women of childbearing age. Nutrition counseling and tools to maintain a healthy weight are part of the package of services offered to women.

3. Obesity/Nutrition

CATEGORY	FY08-09 (n=136)	FY10 (n=104)	White mothers FY10 (n=59)	Black mothers FY10 (n=38)
Strengths				
Nutritional education	44%	54%	56%	50%
Weight loss as directed per physician	1%	3%	2%	5%
Medication compliance	22%	26%	29%	18%
Contributing Factors				
Obesity	36%	40%	36%	55%
Inadequate weight gain	-	22%	24%	18%
Inadequate nutrition (includes anemia at first trimester prenatal visit)	24%	23%	17%	29%
Suggestions				
Closer evaluation of dietary habits and evaluation of diet content/nutritional counseling	17%	36%*	32%	45%
Patient education on risks of obesity	39%	41%	37%	55%
Patient education on importance of proper nutrition and weight gain during pregnancy.	35%	55%*	58%	53%
Referral for financial assistance, WIC, food stamps, emergency shelter, etc	7%	18%*	17%	18%

**statistically significant difference between FY08-09 and FY10 ($p<0.05$)*

Almost one-quarter of mothers had a prior history of delivering a preterm and/or low birth weight infant. One-third of mothers had a prior history of a fetal or infant loss. This is a group of high risk women who should be identified and followed for future pregnancies with additional support. Services in the inter-conception period such as genetic counseling, medical evaluation and optimal management of pre-existing medical conditions will be especially important for these high risk women. Also during the pregnancy, if women experience preterm labor, they may need additional case management, community or social support services in addition to specialized medical care. For example, being on bed rest can present challenges for women and their ability to support themselves or care for their family. Among the 32 women interviewed by the FIMR social worker, five women (16%) found it difficult to comply with bed rest at home.

Recommendations:

- Part of the inter-conception and postpartum care of women with a preterm delivery should include their experience of symptoms of labor or premature rupture of membranes (PROM). Such a discussion may present an important teachable moment so that in the future high risk women may be more informed and empowered.
- Early identification of those pregnant women at a high risk for preterm labor, regardless of socioeconomic status, and refer these women to home-based services--such as Smart Start—or to perinatal case managers through their private health insurers or Medicaid HMO. Some women will benefit from telephone follow up, monitoring or surveillance. However, home-based services are particularly important for those mothers who are placed on bed rest or have significant psychosocial issues.

Action Steps:

Through the creation of a statewide Perinatal Collaborative, the DHMIC will work in partnership with birth hospitals and community partners to ensure best practice standards for perinatal care.

In almost all FIMR cases, there was someone providing grief support to the mother at some point after her loss. There still remains a great need for continued and multiple contacts for grief support. Physicians and nurses as well as chaplains, social workers and home-based visi-

4. Preterm Labor

	FY08-09 (n=136)	FY10 (n=104)	White mothers FY10 (n=59)	Black mothers FY10 (n=38)
CATEGORY				
Strengths				
Early prenatal care (1st trimester)	70%	73%	75%	71%
Good obstetric management of preterm labor	10%	27%*	24%	32%
Good obstetric management of incompetent cervix	-	12%	10%	16%
Compliance with prenatal care/kept appointments	43%	62%*	61%	61%
Compliance with bed rest, activity limitations and/or abstinence orders	6%	11%	12%	8%
Mother recognized signs/symptoms of preterm labor, premature rupture of membranes and sought immediate medical care	15%	31%*	32%	29%
Contributing Factors				
History of previous preterm and/or low birth weight baby	12%	23%*	19%	34%
History of preterm labor	7%	15%*	10%	26%**
Preterm labor (in most recent pregnancy)	32%	31%	34%	29%
Newly diagnosed incompetent cervix	6%	8%	7%	8%
Signs and symptoms of labor or rupture of membranes and when to call provider	7%	16%*	19%	13%
Prematurity	45%	56%	59%	50%
Infection	21%	26%	29%	21%
Genetic/congenital anomaly incompatible with life	10%	10%	12%	5%

**statistically significant difference between FY08-09 and FY10 ($p<0.05$)*
***statistically significant difference between White mothers FY10 and Black mothers FY10 ($p<0.05$)*

tors all need special training to be equipped to appropriately and sympathetically handle the family grieving a loss. The need for follow up contact with the family is important. Only 15% of mothers had follow up with bereavement support after leaving the hospital, and this proportion was significantly lower for Black women (5%). The postpartum visit is an opportunity for the prenatal care provider to address grief and mental health issues. The provider should feel comfortable screening for depression and identify and refer women who need additional support services.

During the maternal interviews, 12 out of 32 women (38%) felt there was a need for better awareness and sensitivity among providers and hospital staff when dealing with a family who was preparing for or had experienced a loss. Five women (16%) said they wanted better counseling referrals in addition to support group information following a loss. One mother felt that hospice services would have been helpful during her pregnancy after her fetus was diagnosed with a terminal condition.

From maternal interviews:

- *The mother regrets that she never looked at her baby. She never undressed him and really looked at his body. She said everything about him including his deformities were "precious" and "valued".*
- *Regarding peer support, women said they would like a resource that could connect them with other mothers who have had similar experiences.*
- *One mother said that the day after she delivered some people came in to talk to her, but she has very little memory of who they were or what they said.*

5. Bereavement Counseling/Support

	FY08-09 (n=136)	FY10 (n=104)	White mothers FY10 (n=59)	Black mothers FY10 (n=38)
CATEGORY				
Strengths				
Chaplain, pastor, nurse, Smart Start, NFP, RM or social work grief support in hospital	82%	97%*	97%	97%
Referral to community grief support services after hospital discharge	62%	58%	63%	53%
Follow up with bereavement support post-discharge	-	15%	24%	5%**
Hospice support	-	2%	-	-
Contributing Factors				
History of fetal or infant loss	35%	35%	29%	42%
Suggestions				
History of fetal or infant loss	35%	35%	29%	42%
Sensitivity training for providers	4%	18%*	20%	11%
Debrief parents two to three months after loss to assess understanding of cause(s)/ circumstances of death	27%	45%*	42%	47%
Grief counseling/support at delivery and/or pediatric care facility	5%	9%	8%	11%
Follow up with patients that initially decline grief support services	2%	16%*	12%	24%
Have chaplain see patient to assess needs	3%	12%*	10%	18%
Referral to community agency for grief counseling	92%	90%	90%	89%
Prenatal care providers to take an active part in addressing grief and denial issues	96%	94%	98%	87%**
Postpartum depression screening & assessment of grieving status with appropriate referrals	12%	38%*	37%	34%

**statistically significant difference between FY08-09 and FY10 ($p<0.05$)*
***statistically significant difference between White mothers FY10 and Black mothers FY10 ($p<0.05$)*

Recommendations:

- In the hospital, families may need a staff member to sit down with them and help them navigate the key decisions they need to make prior to discharge on such issues as creating memories of their baby and funeral arrangements. Families may not be able to read through a full packet of bereavement materials in the hospital when they have a brief window of time to make certain important decisions.
- Continue to support nurses, social work and pastoral care in the hospital to allow for full staffing and trainings so that families may be seen in person by someone who is comfortable with providing support in the circumstance of a fetal or infant loss.
- All mothers who have suffered a fetal/infant loss should receive a follow up telephone call from a bereavement counselor after discharge to allow another opportunity to ask questions and receive counseling or referral for services.
- A woman's primary obstetric or family care provider should be notified when she experiences a fetal or infant loss so that she may follow up with them.
- Obstetricians should take a more active role in referring and supporting those mothers who suffered a fetal/infant loss; they should have a resource list available to them that is accurate, up to date and contains contact information of groups and counselors specializing in bereavement support.
- Enhance and provide funding for public programs in place such as Smart Start and NFP to provide additional bereavement support either by a home nursing visit and/or telephone follow up.
- Ensure that community resources are culturally appropriate to address the unique needs of all mothers who have suffered a loss.
- Continue to support the Delaware annual bereavement conference as a venue for further training and professional development of the persons supporting grieving families.

Action Steps:

- CCHS and A.I. duPont Hospital for Children are working to create a NICU palliative care team to promote comfort and quality of life as goals for all NICU patients in complement to curative care. The palliative care team is a multidisciplinary team that is addressing training and research needs to make the culture of the NICU more family-focused and holistic.
- The Delaware Grief Awareness Consortium is spearheading a statewide effort to create a standardized grief resource packet for families and professionals due out in November 2010. More information is available at www.degac.org.

6. Family Planning/Birth Spacing

CATEGORY	FY08-09 (n=136)	FY10 (n=104)	White mothers FY10 (n=59)	Black mothers FY10 (n=38)
Strengths				
Compliance with postpartum care/kept appointments	60%	64%	73%	50%**
Planned pregnancy	21%	23%	29%	11%**
Pregnancy interval at least 24 months	27%	37%	37%	34%
Family planning counseling	17%	34%*	34%	32%
Contraceptives or prescription given postpartum at hospital discharge	13%	17%	20%	13%
Offered contraception but declined	-	26%	27%	21%
Contributing Factors				
Unplanned pregnancy (parental compliance /knowledge)	17%	24%	20%	29%
Undesired pregnancy (parental compliance/knowledge)	2%	2%	2%	3%
Lack of or inadequate family planning education (per provider)	2%	12%*	17%	5%
Inadequate birth spacing	16%	17%	15%	18%
Suggestions				
Importance of being healthy before pregnancy	71%	68%	66%	76%
Importance of family planning, preconception or inter-conception care	54%	53%	51%	63%
Appropriate birth spacing	40%	67%*	71%	61%
Birth control in the immediate postpartum period and compliance with chosen contraceptive method	21%	39%*	36%	47%
Family planning counseling with contraception dose, prescription or bilateral tubal ligation prior to discharge	14%	26%*	20%	37%
Persistent follow up regarding contraception and family planning when patients initially refuse services in hospital or at a postpartum visit	14%	30%*	25%	34%

*statistically significant difference between FY08-09 and FY10 ($p<0.05$)
**statistically significant difference between White mothers FY10 and Black mothers FY10 ($p<0.05$)

Among FIMR cases reviewed in FY10, about one-quarter were unplanned pregnancies and the same proportion were planned pregnancies. There were significantly fewer planned pregnancies noted among Black mothers (11%) compared to White mothers (29%). Thirty-seven percent of all cases had at least a 24 month inter-pregnancy interval (the time between the end of the last pregnancy and the start of the next pregnancy.) In two-thirds of cases, the CRTs felt that the birth spacing was not optimal. Among maternal interviewees, 22% (7 out of 32) of mothers were pregnant or had recently given birth at the time of the interview.

The postpartum visit is an important opportunity to discuss family planning and optimal birth spacing. Seventy-one percent of FIMR mothers had a postpartum visit within eight weeks of delivery (74 out of 104). Eleven percent of mothers (11 out of 104) did not keep their postpartum visit, and there was no information about the postpartum visit in 18% of the FIMR cases (19 out of 104). Appropriate birth spacing is an issue that was actively tracked by CRTs this past year. During CRT review, it was noted that among the 74 FIMR cases with a postpartum visit, 65% (48 out of 74) had no documentation of birth spacing education at the time of the visit. Among the documented counseling at the time of the postpartum visit, 12% (9 out of 74) of mothers were counseled to wait four or fewer months prior to getting pregnant again, 12% were counseled to wait between 4 months and one year, 5% (four out of 74) were counseled to wait between one and two years, and 5% were counseled to wait two or more years.

Recommendations:

- There is a need for more consistent interconception education on the importance of appropriate birth spacing.
- Continue tracking provider education on birth spacing as this information may help inform the consistency of perinatal teaching and be a targeted provider education effort in the future.
- There is a need to increase awareness and utilization of the Medicaid family planning waiver so that those with Medicaid can continue family planning benefits after traditional Medicaid services expire.

Action Steps:

- The DHMIC, through the Systems of Care subcommittee, is examining ways to expand the utilization of the Medicaid family planning waiver.

The DHMIC and DPH have created consumer-friendly teen and young adult Reproductive Life Plans. Using print, text messaging and web-based tools, these life plans encourage women and men to achieve the best possible health and proactively plan to have or not have children. The teen life plans have been approved by the Department of Education for use in high school health classes statewide.

7. Socioeconomic Stressors

	FY08-09 (n=136)	FY10 (n=104)	White mothers FY10 (n=59)	Black mothers FY10 (n=38)
CATEGORY				
Strengths				
Referrals to needed community resources such as WIC, food stamps, shelter, etc.	9%	28%*	36%	21%
Church support	3%	14%*	17%	8%
Family support	17%	63%*	69%	55%
Father of baby involved/supportive	26%	61%*	66%	47%
Parents in stable marriage	20%	28%	32%	13%**
Stable financial situation	18%	24%	32%	13%**
Contributing Factors				
Socioeconomic	60%	76%*	75%	82%
Presence of life course perspective risk factors (stressors in childhood, history of abuse, poverty, lack of support, etc.)	24%	40%*	36%	53%
Lack of support systems (during pregnancy or infant's life)	-	16%	17%	18%
Poverty (during pregnancy or infant's life)	13%	33%*	34%	34%
Other emotional stressors during pregnancy (such as loss of job, loss of a loved one, incarceration, divorce, natural disaster, etc.)	20%	38%*	36%	45%
Suggestions				
Better assessment of family's home/ socioeconomic situation	40%	38%	34%	45%
Early referrals to social services	37%	35%	27%	45%
Referral for financial assistance, WIC, food stamps, emergency shelter, etc.	7%	18%*	17%	18%

**statistically significant difference between FY08-09 and FY10 ($p<0.05$)*
***statistically significant difference between White mothers FY10 and Black mothers FY10 ($p<0.05$)*

Part II: FIMR Recommendations & Action Steps *(Continued)*

Case study: Socioeconomic stressors, preterm labor & birth spacing

A 19-year old pregnant woman was left by the father of her baby. She worked a physically demanding night job and attended school during the day. The woman was living at home with her family until she told her mother about the pregnancy. Her mother was very upset and gave her one week to move out of the home and told her not to expect any support from the family. The woman was able to find a low-income apartment, with the help of a support agency, however the area had a reputation for criminal activity. She was very worried about paying her bills. She had very little support, even though she found a new boyfriend during the pregnancy. She was late starting prenatal care at seventeen weeks gestation.

The woman went into preterm labor, was evaluated and was sent home from the hospital. A few hours later she was in a lot of pain and she needed to get back to the hospital, but she did not have transportation. Finally she convinced a neighbor to take her. She delivered her baby that night at 25 weeks and six days gestation, and the baby died shortly after birth. She said she was discharged from the hospital "like nothing happened". Her doctor told her that she could start trying to get pregnant again in three months. She is taking birth control and would like to get pregnant soon with the new boyfriend, but she is a little afraid after what she went through.

The increased proportion of FIMR cases with socioeconomic risk factors among those reviewed in FY10 may reflect the impact of the 2008 recession and financial crisis in the lives of women. About half of FY10 FIMR cases (47% or 49 out of 104) date back to a death that occurred in calendar year 2008. For this issue, the disparity between Black and White mothers is notable. About half of Black mothers had the presence of life course perspective risk factors and other emotional stressors during pregnancy, compared to about one-third of White mothers. Significantly fewer Black mothers were in a stable marriage or financial situation. For all women, the family and father of the baby are important in their support network.

Among the 32 women who were interviewed in FY10, two-thirds (21 women) reported having stress in her life that affected her pregnancy. Eight (25%) had a job that made them stressed or tense. Five women (16%) worried about affording food during their pregnancy; and four (13%) women did not feel safe in their neighborhood.

Recommendations:

- FIMR data supports the need for early, standardized screening for socioeconomic risk factors that may be a source of stress for the pregnant woman. This includes a review of the mother's access to safe housing, food, transportation and financial stability. Prenatal clinics would be the first point of contact to make a socioeconomic assessment, and this should be done at the first visit and periodically updated thereafter.
- Support use of the 211 Delaware Helpline or an easy to refer toll free number so that providers or case managers may access social support services for pregnant women.
- Assess women's capacity to handle stress and provide tools to mitigate the mental and physical effects of stress.
- Support efforts by the DHMIC Systems of Care Subcommittee and the Medical Society of Delaware to provide continuing medical education on the use of psychotropic medicine during and after pregnancy.
- Continue to support the development and distribution of a comprehensive community resource list to all obstetric and family practice clinics. This resource list should be given to all pregnant women regardless of their socioeconomic or insurance status and would include information on social and community programs, warning signs during pregnancy, and when to call their provider for further help.

Action Steps:

- Socioeconomic stressors may exacerbate a woman's mental health problem, or vice versa. Being able to screen a woman's socioeconomic risk factors as well as her stress, methods of coping and overall mental health is key to formulating a supportive plan of care during the perinatal period. The DHMIC's Systems of Care Subcommittee is focusing on addressing mental health issues in the perinatal period. The committee has gathered information on the screening efforts

8. Fetal Deaths Later in Pregnancy

CATEGORY	FY08-09 (n=136)	FY10 (n=104)	White mothers FY10 (n=59)	Black mothers FY10 (n=38)
Strengths				
Patient education on fetal kick counts	-	9%	10%	8%
Contributing Factors				
Kick counts; signs of decreased fetal movement and when to call health provider	18%	14%	14%	16%
Suggestions				
Continue "Kick counts" education; signs and symptoms of decreased fetal movement and when to call health provider	19%	19%	20%	18%

used in Delaware, the capacity issues that exist in addressing mental health and the models that integrate mental health services in a primary care setting.

The Delaware Child Poverty Task Force, convened in 2007, is charged with developing a ten-year plan to reduce the number of children living in poverty by 50% and to promote the health, safety and well-being of Delaware's families. For more information, see kids.delaware.gov/cptf/about.html.

Fetal deaths comprised 46% of the cases reviewed in FY10 (48 out of 104). Of these fetal deaths, 63% (30 out of 48) occurred at or above 24 weeks gestation. As shown in Figure 3 for FY10 FIMR cases, over half (53%) of fetal deaths occurred after 28 weeks gestation; while among infant deaths, the proportion over 28 weeks was only 43%. Fetal deaths, also known as stillbirths, affect approximately one out of every 150 pregnancies nationwide. Recognizing decreased fetal movements early and seeking immediate medical attention can help reduce the occurrence of stillbirths. Thus the American Congress of Obstetricians and Gynecologists recommends that pregnant women count fetal movements at the same time everyday. A woman should feel at least ten fetal kicks in two hours.

Among the cases reviewed, only 9% of women had education on tracking fetal movements documented in their prenatal record or reported during an interview. Of the 32 women interviewed in FY10, 8 women (25%) reported feeling reduced fetal movements prior to their loss. Since FIMR began, 26 maternal interviews have been conducted with women who have had a fetal death after 24 weeks gestation. Only five of these women (19%) went to the hospital or doctor's office the same day that they noted decreased fetal movement. Five women did not notice that their baby's movements had decreased. Eleven women (42%) waited one or two days after they noticed decreased fetal movements before contacting their obstetric provider or going to the hospital.

From a maternal interview:

"I am on the fence on whether I want to try and have a baby again. I think that doctors should talk about the risks more openly and do better teaching on kick counts. I feel I should have been monitored more closely".

Case study: Fetal death later in pregnancy

A 24 year old woman suffered a fetal demise at 30 weeks. She has a history of two live premature births. She entered into prenatal care at eight weeks. She had a maternal fetal medicine (MFM) consult at 15 weeks gestation (due to her history of preterm births) and the woman agreed to start Progesterone at 16 weeks. She continued to see MFM regularly. She presented to the hospital at 30 weeks with decreased fetal movement and back pain. Fetal demise was confirmed. According to the physician, the woman had decreased fetal movement for two weeks and no fetal movement for two days with accompanying back pain prior to coming to the hospital. She was hypertensive and had confirmed pre-eclampsia and magnesium sulfate was started. She was induced and delivered vaginally. An autopsy was done and the fetus measured at 30 weeks, the placenta was small with meconium deposition; chromosomes were normal.

Recommendations:

- Support prenatal education on fetal movement tracking as a standard of obstetric care.
- The establishment of an educational campaign aimed at both mothers and prenatal healthcare providers on the techniques of fetal movement counting, the recognition of abnormal/decreased fetal movement patterns, and the importance of notifying a healthcare provider of abnormal/decreased fetal movements.

Action Steps:

- DPH and DHMIC, as encouraged by FIMR, are implementing Fetal Kicks Count, a social marketing campaign that targets health care providers and pregnant women with the message that fetal movement tracking, beginning at 24 weeks gestation, is an important indicator of fetal health. Women are encouraged to immediately contact their health care provider and go to the labor and delivery unit if they do not feel ten fetal movements in two hours. The Fetal Kicks Count kits will be delivered to health care providers in early 2011. This program was developed and implemented in less than six months after a discussion and a recommendation made at a FIMR CRT meeting.

Appendix 1: Issues brought up in FIMR maternal interviews

Issue	Number of cases involved	% of total cases interviewed (n=32)
Provider and care received		
Better awareness and sensitivity of providers and staff in the hospital when they are dealing with a woman who has experienced a loss	12	38%
Mother dissatisfied with wait time to see a doctor	5	16%
Mother felt she was not treated like she was a high risk pregnancy when she should have been and the risks were not explained to her clearly	3	9%
Mother did not feel she was provided with enough information/ education from her doctor about the pregnancy	5	16%
Mother was not heard/believed when she told medical professionals that something was wrong	7	22%
Mother went to OB triage on an emergency basis and had to wait to be treated	4	13%
Mother saw different providers at the doctor's office and felt it impacted the quality of her care	5	16%
Mother felt that she did not receive quality care in the hospital	7	22%
Mother felt that she received inconsistent information on the condition of her baby	4	13%
Mother felt that she was a burden when she asked the doctor questions or called the office	0	0%
Mother wanted better communication between providers and hospitals when the death occurred	2	6%
Mother was dissatisfied with the amount of time the doctor spent with her	5	16%
Mother never got to see her baby before the baby was transported to another hospital and died	1	3%
Mother was dissatisfied with the advice the doctor gave her	7	22%
Mother felt she should have been hospitalized and not sent home	4	13%
Mother missed an appointment and could not afford to pay the fee for missed appointments and therefore she had to switch providers	1	3%
Mother would like education on possible "bad outcomes" of pregnancy	0	0%
Mother wanted to start prenatal care sooner but could not get an appointment	0	0%

Appendix 1: Issues brought up in FIMR maternal interviews (Continued)

Issue	Number of cases involved	% of total cases interviewed (n=32)
Mother's health during pregnancy		
Mother called the doctor's office with concerns and was reassured that things were fine	5	16%
Mother would have aborted pregnancy if the money was available	0	0%
Mother was not taught about fetal kicks count	4	13%
Mother found it difficult to comply with bed rest at home	5	16%
Mother had a large medical bill after the pregnancy	7	22%
Mother had stress in her life that could have affected her pregnancy	21	66%
Mother had mental health issues before or during her pregnancy	11	34%
Mother smoked cigarettes during part of her pregnancy	7	22%
Mother had a preconceptual care visit for the lost pregnancy or the new, subsequent pregnancy	1	3%
Mother was extremely sick during her pregnancy and lost weight	3	9%
Mother drank alcohol during some part of her pregnancy	3	9%
Mother smoked marijuana during her pregnancy	3	9%
Mother exposed to second hand smoke during her pregnancy	5	16%
Mother had a job that made her stressed	5	16%
Mother worried about being able to afford food during her pregnancy	5	16%
Mother did not feel safe in her neighborhood	5	16%
Mother noticed reduced fetal movement prior to her loss	8	25%
Mother had a fall or injury during her pregnancy	3	9%
Bereavement issues		
Mother would like better counseling referrals not just support group information	5	16%
Mother found that planning a funeral for the baby was overwhelming	0	0%
Mother sought treatment at a mental health facility after loss of baby	1	3%
Mother would have liked follow up contact from the hospital	0	0%
Mother would like to see a fund set up for burial expenses	1	3%
Mother did not receive hospital grief packet	1	3%
Mother felt she did not receive adequate bereavement support in the hospital	6	19%
Other		
Mother is pregnant or has recently given birth at time of interview	7	22%
Mother would like a support group for women who have had a loss and who are pregnant again	0	0%

Appendix 2: Contributing factors identified by Case Review Teams

Category	FY10 (n=104)	White mothers FY10 (n=59)	Black mothers FY10 (n=38)
Mother's Medical/OB History	**96%**	**95%**	**97%**
Pre-existing medical conditions such as asthma, hypertension, diabetes, mental health disorders, etc.	80%	85%	76%
Obesity	40%	36%	55%
Inadequate nutrition (includes anemia at first trimester prenatal visit)	23%	17%	29%
History of previous preterm and/or low birth weight baby	23%	19%	34%
History of preterm labor	15%	10%	26%
History of fetal or infant loss	35%	29%	42%
History of incompetent cervix	4%	2%	8%
History of sexually transmitted disease (STD) or other genitourinary infection	33%	29%	45%
History of elective termination	20%	10%	39%
Other	16%	14%	21%
Socioeconomic	**76%**	**75%**	**82%**
Presence of life course perspective risk factors (stressors in childhood, history of abuse, poverty, lack of support, etc.)	40%	36%	53%
Maternal age < 21 years	18%	17%	18%
Maternal age > 35 years	11%	10%	11%
Domestic abuse (during pregnancy or infant's life)	7%	5%	11%
Lack of support systems (during pregnancy or infant's life)	16%	17%	18%
Poverty (during pregnancy or infant's life)	33%	34%	34%
Other emotional stressors during pregnancy (such as loss of job, loss of loved one, incarceration, divorce, natural disaster, etc.)	38%	36%	45%
Medical conditions during this pregnancy/labor	**81%**	**78%**	**87%**
In vitro fertilization/assisted reproductive technology	10%	12%	5%
Multiple gestation	12%	17%	8%
Anemia (diagnosed after first trimester)	10%	8%	13%
Gestational diabetes	6%	10%	0%
Hyperemesis	3%	5%	0%
STD	19%	14%	32%
Maternal infection other than STDs	26%	19%	42%
Pre-eclampsia/eclampsia/HELLP (hemolysis, elevated liver enzymes, low platelets) syndrome	4%	3%	5%
Placenta previa	6%	7%	3%
Premature rupture of membranes (ROM)/Preterm premature ROM	25%	25%	24%
Prolonged ROM	12%	19%	3%
Preterm labor	31%	34%	29%
Placental abruption	10%	8%	11%
Subchorionic bleed	6%	7%	5%
Newly diagnosed incompetent cervix	8%	7%	8%
Other	14%	17%	13%
Provider Issues	**61%**	**68%**	**47%**
No Smart Start (SS) screening/ Nurse Family Partnership (NFP)/Resource Mothers (RM) screening	27%	29%	24%
No domestic abuse screening	40%	46%	26%

Appendix 2: Contributing factors identified by Case Review Teams (Continued)

Category	FY10 (n=104)	White mothers FY10 (n=59)	Black mothers FY10 (n=38)
Provider Issues *(continued)*	**61%**	**68%**	**47%**
Poor communication between provider and patient	11%	8%	11%
Poor communication between providers	3%	3%	-
Referral to appropriate level of care not given	2%	2%	3%
Misdiagnosis of mother or child	1%	2%	0%
Poor management of labor	1%	0%	3%
Poor follow up for patient with obstetric complications	2%	3%	0%
Other	15%	20%	5%
Maternal Knowledge/Compliance Issues	**62%**	**61%**	**63%**
Late entry into prenatal care after 13th week	19%	17%	21%
Inconsistent prenatal care (missed visits)	13%	10%	21%
No prenatal care	6%	7%	5%
Signs and symptoms of labor or ROM and when to call provider	16%	19%	13%
Kick counts; signs of decreased fetal movement and when to call provider	14%	14%	16%
Noncompliance with plan of care	12%	3%	13%
Other	3%	0%	3%
Family Planning	**46%**	**42%**	**50%**
Unplanned pregnancy (parental compliance/knowledge)	24%	20%	29%
Undesired pregnancy (parental compliance/knowledge)	2%	2%	3%
Lack of or inadequate family planning education (per provider)	12%	17%	5%
Inadequate birth spacing	17%	15%	18%
Other	1%	2%	0%
Substance Abuse	**33%**	**32%**	**39%**
Substance abuse (medical issue)	28%	27%	34%
Substance abuse lifestyle (social issue)	11%	7%	18%
No substance abuse screening	4%	3%	5%
No referral to smoking cessation/drug/alcohol rehabilitation /treatment	9%	8%	11%
Referral to smoking cessation/drug/alcohol rehabilitation/ treatment not timely	1%	2%	3%
Fetal/Infant Medical Issues	**84%**	**85%**	**79%**
Genetic/congenital anomaly incompatible with life	10%	12%	5%
Cord problem	26%	25%	24%
Previability	27%	19%	39%
Pre-existing medical condition (includes non-lethal anomalies, metabolic disorders, etc.)	12%	15%	8%
Prematurity	56%	59%	50%
Infection	26%	29%	21%
Other	4%	5%	3%
Service Issues	**41%**	**36%**	**47%**
Medical and social services/community resources unavailable in area	1%	2%	0%
Medical and social services/community resources available, but not used	32%	25%	37%
Quality of medical and social services/community resources inadequate to meet needs	2%	2%	3%
Patient fear of/dissatisfaction with health care system	12%	15%	11%

Appendix 3: Suggestions made by Case Review Teams

Category	FY10 (n=104)	White mothers FY10 (n=59)	Black mothers FY10 (n=38)
Socioeconomic	**54%**	**47%**	**63%**
Better assessment of family's home/socioeconomic situation	38%	34%	45%
Early referrals to social services	35%	27%	45%
Referral for financial assistance, WIC, NICA, food stamps, emergency shelter, etc.	18%	17%	18%
Easier access to care for those without insurance	5%	7%	-
Medicaid health maintenance organizations (HMO) that are more user friendly and offer more provider choices for patients	2%	2%	3%
Child Protective Services involvement (CPS)	2%	2%	-
Other	2%	2%	3%
SS/NFP/RM or Case Management (CM) Services	**49%**	**42%**	**58%**
Timely entry of risk assessment scores and/or referrals so care can be initiated promptly	7%	5%	11%
Use open ended questions on initial contact to solicit more info from parent	4%	-	5%
Work aggressively for at least one month to find high risk patients for services	1%	2%	-
Better follow up when patients that are referred do not keep appointments	6%	5%	8%
Home visits during pregnancy to monitor clinical status in high risk patients and provide education	39%	31%	50%
More intensive services/follow up to address patient education and non-compliance issues	17%	10%	26%
Enhance communication between providers, hospitals and community services such as SS/NFP/RM, clinics, etc.	6%	7%	3%
Medical care/Provider Opportunities	**95%**	**92%**	**100%**
ISS/NFP/RM screening on initial prenatal visit	24%	24%	26%
Understanding benefits of SS/NFP/RM services as evidenced by referrals	5%	2%	8%
Consistent/ongoing domestic violence (DV) screening	43%	47%	34%
Referral for DV/rape counseling services	1%	2%	0%
Knowledge of community services available as evidenced by referrals	12%	15%	5%
Cultural competence	10%	7%	8%
Sensitivity training for providers	18%	20%	11%
Better network of interpreters for translation	12%	15%	-
More aggressive education by emergency room staff regarding importance of prenatal care	3%	2%	5%
Timely referral to local STD centers for all patients seen with STDs	2%	0%	5%
Closer evaluation of dietary habits and evaluation of diet content/nutritional counseling	36%	32%	45%
Better management of multiple genitourinary infections	2%	0%	5%
More intensive management/follow up for mothers with pregnancy complications	12%	10%	13%

Appendix 3: Suggestions made by Case Review Teams (Continued)

Category	FY10 (n=104)	White mothers FY10 (n=59)	Black mothers FY10 (n=38)
Medical care/Provider Opportunities *(continued)*	**95%**	**92%**	**100%**
Completion of placental pathology/histology	3%	2%	5%
Better management of incompetent cervix	1%	2%	0%
Better management of labor	4%	5%	3%
Follow up with patients when appointments missed and need to reschedule; documentation of attempts and patient responses	12%	5%	18%
Timely transfer to appropriate level of care	1%	0%	3%
Better communication by provider of issues during pregnancy or infant's care, and evaluation of patient's/caregiver's understanding	12%	10%	13%
Better communication among providers, especially with high risk patients	6%	7%	3%
Better follow up from provider when they refer a patient to another provider to ensure there is no lapse in care	3%	3%	3%
Appropriate genetic testing/autopsy for infants with documented dysmorphic features	1%	2%	0%
Better assessment of patient's/caregiver's understanding of instructions prior to discharge	4%	2%	8%
Debrief parents two to three months after loss to assess understanding of cause(s)/circumstances of death	45%	42%	47%
Other	16%	20%	11%
Patient/Caregiver/Community Education	**89%**	**86%**	**97%**
Importance of protected sex, STD/HIV prevention	26%	19%	42%
Risks of obesity	41%	37%	55%
Importance of compliance with plan of care	16%	19%	16%
Importance of early and consistent prenatal care	34%	32%	37%
Importance of proper nutrition and weight gain during pregnancy	55%	58%	53%
Continuing "Kick counts" education; signs and symptoms of decreased fetal movement and when to call provider	19%	20%	18%
Signs and symptoms of premature ROM and when to call provider	11%	12%	11%
Importance of proper hydration to prevent preterm labor	7%	5%	8%
Signs and symptoms of preterm labor & when to call provider	10%	12%	8%
Incompetent cervix; cerclage, etc. prior to next pregnancy	9%	7%	13%
Other	6%	3%	11%
Grief Support	**98%**	**100%**	**95%**
Grief counseling/support at delivery and/or pediatric care facility	9%	8%	11%
Follow up with patients that initially decline grief support services	16%	12%	24%
Have chaplain see patient to assess needs	12%	10%	18%
Referral to community agency for grief counseling	90%	90%	89%
Prenatal care providers to take an active part in addressing grief and denial issues	94%	98%	87%
Postpartum depression screening & assessment of grieving status with appropriate referrals	38%	37%	34%
Other	3%	2%	5%

Appendix 3: Suggestions made by Case Review Teams (Continued)

Category	FY10 (n=104)	White mothers FY10 (n=59)	Black mothers FY10 (n=38)
Family Planning	**96%**	**97%**	**95%**
Importance of being healthy before pregnancy	68%	66%	76%
Importance of family planning/preconception/inter-conception care	53%	51%	63%
Appropriate birth spacing	67%	71%	61%
Birth control in the immediate postpartum period and compliance with chosen contraceptive method	39%	36%	47%
Family planning counseling with contraception dose/prescription or bilateral tubal ligation prior to discharge	26%	20%	37%
Community service agency to see patients in hospital postpartum to give contraceptives before discharge	4%	5%	3%
Genetic counseling prior to next pregnancy	22%	31%	8%
Persistent follow up regarding contraception/family planning when patients initially refuse services in hospital or at postpartum visit	30%	25%	34%
Other	4%	2%	8%
Substance Abuse	**36%**	**36%**	**42%**
Patient/community education regarding importance of not using drugs, especially when pregnant	15%	14%	21%
Consistent/ongoing drug screening	12%	8%	18%
Substance abuse (including smoking cessation) referral for treatment	30%	31%	34%
Closer following of patients in drug rehabilitation & attempt to contact patients when they do not follow their treatment plan	1%	0%	3%
Medical Record/Documentation	**11%**	**3%**	**16%**
Improve accuracy/quality/completeness of vital statistics records	1%	0%	3%
Improve completeness of prenatal records	2%	0%	5%
Improve completeness/consistency of medical records	4%	3%	3%
Other	4%	-	5%

Data From Child Death Cases Reviewed During FY2010

County/Team Numbers

	Reviewed
Abuse/Neglect Panel	2
Kent/Sussex County	22
New Castle County	20
Total	***44***

Demographics (Ethnicity/Race and Age Group by Sex)

Ethnicity	Age Group	Male	Female	Total
Hispanic /Latino (any race)	1-4 Years	1	0	1
	5-9 Years	1	0	1
	10-14 Years	0	1	1
	15-17 Years	1	0	1
	Subtotal	3	1	4
Race				
White	< 1 Year	3	0	3
	1-4 Years	1	1	2
	5-9 Years	4	1	5
	10-14 Years	0	2	2
	15-17 Years	2	2	4
	Subtotal	10	6	16
Black, African American	< 1 Year	6	7	13
	1-4 Years	1	4	5
	5-9 Years	2	0	2
	15-17 Years	6	0	6
	Subtotal	15	11	26
Asian	10-14 Years	1	0	1
	Subtotal	1	0	1
All Races	< 1 Year	9	7	16
	1-4 Years	2	5	7
	5-9 Years	6	1	7
	10-14 Years	1	2	3
	15-17 Years	8	2	10
	Subtotal	26	17	43

Data From Case Reviewed During FY10

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.)

Criteria for Cases to Be Reviewed FY10

- *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 three 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.*

Manner of Death
Infant Death Information

	Natural	Accident	Undetermined	Total
Deaths Reviewed	3	4	9	16
Premature (<37 weeks)	1	2	4	7
Low Birth Weight (<2500 grams)	1	3	4	8
Intrauterine Smoke Exposure	2	4	3	9
Intrauterine Drug Exposure	0	1	2	3
Late (>6 months) or No Prenatal Care	0	0	1	1

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

Manner and Cause of Death by Age Group

	Age Group					
Manner	<1	1-4	5-9	10-14	15-17	Total
Natural	3	2	1	2	0	8
Accident	4	4	6	1	6	21
Suicide	0	0	0	0	1	1
Homicide	0	1	0	0	3	4
Undetermined	9	0	0	0	0	9
Total	16	7	7	3	10	43

Manner and Cause of Death by Age Group

		Age Group					
		<1	1-4	5-9	10-14	15-17	Total
Manner	**Cause**						
Natural							
	Cancer	0	0	0	1	0	1
	Cardiovascular	0	0	1	0	0	1
	SIDS	3	1	0	0	0	4
	Other medical condition	0	1	0	1	0	2
	Sub Total	3	2	1	2	0	8

		Age Group					
		<1	1-4	5-9	10-14	15-17	Total
Manner	**Cause**						
Accident	Any Medical Cause	1	0	0	0	0	1
	Motor Vehicle	0	3	4	1	5	13
	Drowning	0	1	1	0	0	2
	Asphyxia	3	0	1	0	0	4
	Poisoning, Overdose or Acute Intoxication	0	0	0	0	1	1
	Sub Total	4	4	6	1	6	21
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	3	4
	Sub Total	0	1	0	0	3	4

		Age Group	
		<1	Total
Manner	**Cause**		
Undetermined			
	Any Medical Cause	8	8
	Asphyxia	1	1
	Sub Total	9	9

Investigation Information

Cause of Death

	Motor Vehicle	Drowning	Asphyxia	Weapon	Poisoning, Overdose or Acute Intoxication	Exposure	Any Medical condition	Unknown	Total
DEATH WAS REFERRED TO MEDICAL EXAMINER OR CORONER	12	2	5	4	2	0	15	0	40
DEATH WAS NOT REFERRED TO MEDICAL EXAMINER OR CORONER	1	0	0	0	0	1	2	0	4
AUTOPSY WAS PERFORMED	8	2	5	4	2	0	13	0	34
SCENE INVESTIGATION WAS CONDUCTED	13	2	5	4	2	1	15	0	42
TOXICOLOGY SCREEN WAS CONDUCTED	4	0	4	3	2	0	14	0	27
X-RAYS WERE TAKEN	0	0	1	4	0	1	4	0	10
CPS RECORD CHECK WAS CONDUCTED AS RESULT OF DEATH	13	2	5	4	2	1	15	0	42
INVESTIGATION FOUND PRIOR EVIDENCE OF ABUSE	3	0	1	0	1	1	3	0	9
CPS ACTION TAKEN BECAUSE OF DEATH	1	0	0	0	1	0	2	0	4

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

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

	Age Group					
Manner	<1	1-4	5-9	10-14	15-17	Total
Natural	0	2	0	1	0	3
Accident	2	2	2	1	1	8
Homicide	0	0	0	0	2	2
Undetermined	7	0	0	0	0	7
Total	9	4	2	2	3	20

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

		Age Group					
Manner	**Cause**	**<1**	**1-4**	**5-9**	**10-14**	**15-17**	**Total**
Accident							
	Any Medical Cause	1	0	0	0	0	1
	Motor Vehicle	0	1	0	1	5	2
	Drowning	0	1	1	0	0	2
	Asphyxia	1	0	1	0	0	2
	Poisoning, Overdose or	0	0	0	0	0	1
	Acute Intoxication	0	0	0	0	1	0
	Sub Total	4	2	2	1	1	8
Homicide							
	Weapon	0	0	0	0	2	2
	Sub Total	0	0	0	0	2	2

		Age Group	
Manner	**Cause**	**<1**	**Total**
Undetermined			
	Any Medical Cause	6	6
	Asphyxia	1	1
	Sub Total	7	7

Data From Child Death Cases Reviewed During FY2010 (continued)

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

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

		Age Group					
Manner	Cause	<1	1-4	5-9	10-14	15-17	Total
Natural							
	Cancer	0	0	0	1	0	1
	Cardiovascular	0	0	1	0	0	1
	SIDS	3	0	0	0	0	3
	Sub Total	3	0	1	1	0	5

		Age Group					
Manner	Cause	<1	1-4	5-9	10-14	15-17	Total
Accident	Motor Vehicle	0	2	4	0	5	11
	Acute Intoxication	2	0	0	0	0	2
	Sub Total	2	2	4	0	5	13
Suicide							
	Poisoning, Overdose or	0	0	0	0	1	1
	Acute Intoxication	0	0	0	0	0	0
	Sub Total	0	0	0	0	1	1
Homicide							
	Weapon	0	0	0	0	1	1
	Sub Total	0	0	0	0	1	1

		Age Group	
Manner	Cause	<1	Total
Undetermined			
	Any Medical Cause	2	2
	Sub Total	2	92

Manner and Cause of Death by Age Group
Abuse/Neglect Panel

	Age Group					
Manner	<1	1-4	5-9	10-14	15-17	Total
Homicide	0	1	0	0	0	1
Unknown	0	0	0	1	0	1
Total	0	1	0	1	0	2

		Age Group					
Manner	Cause	<1	1-4	5-9	10-14	15-17	Total
Homicide							
	Weapon	0	1	0	0	0	1
	Sub Total	0	1	0	0	0	1
All Cases							
	Unknown	0	0	0	1	0	1
	Sub Total	0	1	0	1	0	1

Motor Vehicle and Other Transport Death Demographics

	Position of Child					
Age Group	Driver	Passenger	On Bicycle	Pedestrian	Unknown	Total
1-4 Years	0	3	0	0	0	3
5-9 Years	0	3	1	0	0	4
10-14 Years	0	0	0	0	1	1
15-17 Years	3	2	1	1	0	1
Total	3	8	1	1	1	13
Sex						
Male	2	6	1	1	4	10
Female	1	2	0	0	0	3
Total	3	8	1	0	1	13
Ethnicity						
Hispanic (any race)	0	1	0	0	0	1
Race						
White	2	5	1	0	0	8
Black, African American	1	3	0	0	0	4
Asian	1	0	0	1	1	1
Total	3	8	1	1	1	13
Area Where Incident Occurred						
Urban	1	1	0	0	0	2
Suburb	0	0	1	1	1	2
Rural	2	7	0	0	0	9
Total	3	8	1	1	1	13

Data From Motor Vehicle Crashes During FY2010

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	2	0	4
SUV	1	6	0	7
Bicycle	0	0	0	1
Pedestrian	0	0	1	1
Other	0	0	1	1
Total	3	8	2	13

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

	Drivers Involved in Incident Ages 14-18	
	Child was Driving	Driver of Other Primary Vehicle
Risk Factors		
Deaths Reviewed	3	1
Responsible for causing incident	3	1
Violating graduated licensing rules	1	1
Two or more teen passengers (ages 14-21)	1	1

Driving Conditions

	Drivers Involved in Incident Ages 14-18
Deaths Reviewed	4
Wet roads	3

Motor Vehicle Protective Measures

	Position Of Child					
	Driver	Passenger	On Bicycle	Pedestrian	Unknown	Total
Deaths Reviewed	3	8	1	1	0	**3**
Protective Measure Present and Used Correctly						
Airbag	2	2	0	0	0	4
Lap Belt	1	1	0	0	0	2
Shoulder Belt	1	1	0	0	2	
Child Seat	0	2	0	0	0	2
Protective Measure Present and Used Incorrectly						
Lap Belt	0	1	0	0	0	1
Shoulder belt	0	1	0	0	0	1
Child Seat	0	1	0	0	0	1
Booster	0	1	0	0	0	1
Protective Measure Present and Not Used						
Lap Belt	2	1	0	0	0	3
Shoulder Belt	2	1	0	0	0	3
Protective Measure Needed But None Present						
Helmet	0	0	1	0	0	1

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

Drowning Death Demographics

	Position Of Child									
	Lake/River/ Pond/Creek	Ocean	Quarry/Gravel Pit	Canal	Pool/Hot Tub/Spa	Well/Cistern/ Septic	Bathtub	Other	Unknown	Total
Age Group										
1-4 Years	0	0	0	0	1	0	0	0	0	1
5-9 Years	0	0	0	0	1	0	0	0	0	1
Total	0	0	0	0	2	0	0	0	0	2
Sex										
Male	1	0	0	0	1	0	1	1	0	1
Female	0	0	0	0	1	0	0	0	0	1
Total	0	0	0	0	2	0	0	0	0	2
Race										
White	0	0	0	0	1	0	0	0	0	1
Black, African American	0	0	0	0	1	0	0	0	0	1
Total	**0**	**0**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**0**

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Factors Involved in Drowning Deaths

	Place Of Drowning	
Risk Factors	Child was Driving	Driver of Other Primary Vehicle
Child could not swim	1	1
No barriers to water	1	1
Child not supervised, but needed	2	2

Weapon Death Demographics

	Type of Weapon									
	Firearm	Sharp	Blunt	Body Part	Explosive	Rope	Biological	Other	Unknown	Total
Age Group										
<1 Year	0	0	0	0	0	0	0	0	0	0
1-4 Years	0	0	0	1	0	0	0	0	0	1
5-9 Years	0	0	0	0	0	0	0	0	0	0
10-14 Years	0	0	0	0	0	0	0	0	0	0
15-17 Years	3	0	0	0	0	0	0	0	0	3
Unknown	0	0	0	0	0	0	0	0	0	0
Total	3	0	0	3	0	0	0	0	0	4
Sex										
Male	3	0	0	0	0	0	0	0	0	3
Female	0	0	0	1	0	0	0	0	0	1
Unknown	0	0	0	0	0	0	0	0	0	0
Total	3	0	0	1	0	0	0	0	0	4
Ethnicity										
Hispanic (any race)	1	0	0	0	0	0	0	0	0	1
Race										
White	3	0	0	1	0	0	0	0	0	4
Black, African American	3	0	0	1	0	0	0	0	0	4
Unknown	0	0	0	0	0	0	0	0	0	0
Total	6	0	0	0	0	0	0	0	0	8

Weapon Death Demographics

	Type of Weapon									
Manner of Death	Firearm	Sharp	Blunt	Body Part	Explosive	Rope	Biological	Other	Unknown	Total
Accident (Unintentional)	0	0	0	0	0	0	0	0	0	0
Suicide	0	0	0	0	0	0	0	0	0	0
Homicide	3	0	0	1	0	0	0	0	0	4
Undetermined	0	0	0	0	0	0	0	0	0	0
Unknown	0	0	0	0	0	0	0	0	0	0
Total	3	0	0	1	0	0	0	0	0	4
Action Omission/ Commission Contributed to Death	1	0	0	1	0	0	0	0	0	2

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

Safety Features and Storage of Firearms Used in Incident

	Type of Firearm		
Safety Features	Hand Gun	Unknown	Total
Deaths Reviewed	3	0	3
Unknown safety	3	0	3
Where Firearm Stored	**Not Stored**	**Unknown**	**Total**
Deaths Reviewed	1	2	3
Unknown safety	1	2	3

Owner and Use of Weapon at Time of Incident

	Firearm Licensed		
Owner of Fatal Firearm	Yes	Unknown	Total
Self	0	0	0
Parent	0	0	0
Friend/Acquaintance	2	0	2
Other	1	0	2
Unknown	0	0	0
Total	3	0	3

Owner and Use of Weapon at Time of Incident

	Type of Weapon									
Leading Uses of Weapon at Time of Incident	Firearm	Sharp	Body Part	Blunt	Explosive	Rope	Biological	Other	Unknown	Total
Self Injury	0	0	0	0	0	0	0	0	0	0
Argument	0	0	1	0	0	0	0	0	0	1
Other Use	0	0	0	0	0	0	0	0	0	0
Commission of Crime	0	0	0	0	0	0	0	0	0	0
Intimate Partner Violence	0	0	1	0	0	0	0	0	0	1
Bystander	1	0	0	0	0	0	0	0	0	0
Self Defense	0	0	0	0	0	0	0	0	0	0
Russian Roulette	0	0	0	0	0	0	0	0	0	0
Random Violence	2	0	0	0	0	0	0	0	0	2
Drive By	0	0	0	0	0	0	0	0	0	0

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

DELAWARE
PREVENTING CHILD DEATHS
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Poisoning, Overdose, or Acute Intoxication Death Demographics

		Type of Poison				
	Deaths Reviewed	Prescription Drug	Over the Counter Drug	Cleaning Substance	Other	Unknown
Age Group						
<1 Year	0	0	0	0	0	0
1-4 Years	0	0	0	0	0	0
5-9 Years	0	0	0	0	0	0
10-14 Years	0	0	0	0	0	0
15-17 Years	4	1	1	0	1	0
Unknown	0	0	0	0	0	0
Total	**4**	**1**	**1**	**0**	**1**	**0**
Sex						
Male	3	1	0	0	1	0
Female	1	0	1	0	0	0
Total	**4**	**1**	**1**	**0**	**1**	**0**
Race						
White	3	0	1	0	0	0
Black, African American	1	1	0	0	1	0
Native Hawaiian	0	0	0	0	0	0
Total	**4**	**1**	**1**	**0**	**1**	**0**

Footnote: Rows do not add up to totals because more than one type of poison could have been involved

Factors Involved in Poisoning, Overdose or Acute Intoxication Deaths

		Type of Poison				
	Deaths Reviewed	Prescription Drug	Over the Counter Drug	Cleaning Substance	Other	Unknown
Poisoning Resulted from:						
Accidental Overdose	2	1	0	0	1	0
Deliberate Poisoning	1	0	1	0	0	0
Total	**3**	**1**	**1**	**0**	**1**	**0**
Where was poison stored?						
Open Area	1	1	0	0	1	0
Unknown	3	0	1	0	0	0
Total	**4**	**1**	**1**	**0**	**1**	**0**
Child not supervised, but needed	0	0	0	0	0	0
Supervisor Speaks English	0	0	0	0	0	0

Footnote: Rows do not add up to totals because more than one type of poison could have been involved.

Suffocation /Asphyxia Death Demographics

	Action Causing Suffocation/Asphyxia									
	Bed, Product, or Overlay	Strangled by Person or	Covered in or Fell into Object	Confined in Tight Space	Choked on Object	Swaddled in Tight Blanket	Wedged into Tight Place (Not Sleep)	Sleep Related	Unknown	Total
Age Group										
<1 Year	0	0	0	0	0	0	0	4	0	4
1-4 Years	0	0	0	0	0	0	0	0	0	0
5-9 Years	0	0	0	0	0	0	0	0	0	0
10-14 Years	0	0	0	0	0	0	0	0	0	0
15-17 Years	0	2	0	0	0	0	0	0	0	0
Unknown	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	4
Sex										
Male	0	0	0	0	0	0	0	2	0	2
Female	0	0	0	0	0	0	0	2	0	2
Unknown	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	4	0	4
Ethnicity										
Hispanic (any race)	0	0	0	0	0	0	0	0	0	0
Race										
White,	0	0	0	0	0	0	0	0	0	0
Black, African American	0	0	0	0	0	0	0	4	0	4
Unknown	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	4	0	4
Manner of Death										
Natural	0	0	0	0	0	0	0	0	0	0
Accident (Unintentional)	0	0	0	0	0	0	0	3	0	3
Suicide	0	0	0	0	0	0	0	0	0	0
Homicide	0	0	0	0	0	0	0	0	0	0
Undetermined	0	0	0	0	1	0	0	0	0	0
Total	0	0	0	0	0	0	0	4	0	4
Supervisor Impaired by Drugs	0	0	0	0	0	0	0	0	0	0

Sleep-Related Death Demographics

Ethnicity	Age Group	Male	Female	Unknown	Total
White	0-1 Months	1	0	0	1
	2-3 Months	1	0	0	1
	8-11 Months	1	0	0	1
	Subtotal	1	0	0	3
Race					
Black, African American	0-1 Months	2	3	0	5
	2-3 Months	1	3	0	4
	4-5 Months	1	0	0	1
	6-7 Months	1	1	0	2
	8-11 Months	1	0	0	1
	1-4 Years	0	2	0	2
	Subtotal	6	9	0	15
All Races	0-1 Months	3	3	0	6
	2-3 Months	2	3	0	5
	4-5 Months	1	0	0	1
	6-7 Months	1	1	0	2
	8-11 Months	2	0	0	2
	1-4 Years	0	2	0	2
	Subtotal	9	9	0	18

Sleep-Related Deaths by Cause

	Cause of Death				
	SIDS	Asphyxia	Medical Condition	All Other	Total Causes
0-1 Months	5	1	0	0	6
2-3 Months	4	1	0	0	5
4-5 Months	1	0	0	0	1
6-7 Months	0	2	0	0	2
8-11 Months	2	0	0	0	2
1-4 Years	1	0	1	0	2
Total	13	4	1	0	18

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

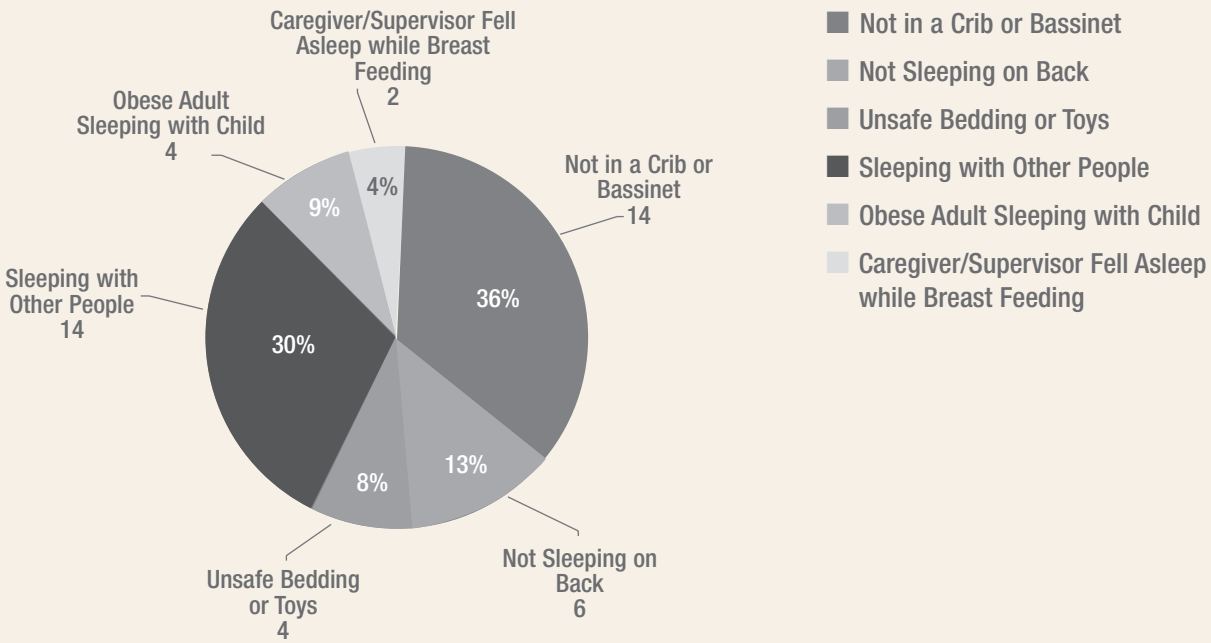
Circumstances Involved in Sleep-Related Deaths

	Age Group						
	0-1 Mos	2-3 Mos	4-5 Mos	6-7 Mos	8-11 Mos	1-4 Yrs	Total
Unobstructed by person or object	0	1	0	0	1	1	3
On top of oerson	0	0	1	0	0	0	1
On top of object	0	1	0	0	0	0	1
Under person	1	1	0	1	0	0	3
Under object	0	1	0	0	0	1	2
Wedged	0	0	0	1	0	0	1
Pressed	1	0	0	0	1	0	2
Fell or Rolled onto Object	1	0	0	0	0	0	1
Unknow	3	1	0	0	0	0	4
Total	6	5	1	2	2	2	18

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	6	5	1	2	2	2	18
Not in a Crib or Bassinet	6	5	1	2	2	1	17
Not Sleeping on Back	2	2	0	1	0	1	6
Unsafe Bedding or Toys	0	2	1	1	0	0	4
Sleeping with Other People	5	4	1	1	2	1	14
Obese Adult Sleeping with Child	2	2	0	0	0	0	4
Caregiver/Supervisor Fell Asleep while Breast Feeding	1	1	0	0	0	0	2

Footnote: Columns do not add up to total deaths because the factors are not mutually exclusive. If factor is unknown, it is not included in these counts. Unsafe bedding or toys include pillow, comforter, stuffed toy, and other toy.



Sleep-Related Deaths by Acts that Caused or Contributed to Death

	Cause of Death				
	SIDS	Asphyxia	Medical Condition	All Other	Total Causes
Deaths Reviewed	13	4	1	0	18
Other negligence	12	4	1	0	17
Unknown	13	4	1	0	18

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

Acts of Omission/Commission Demographics

	Deaths Reviewed	Acts of Omission/Commision: Poor/Absent Supervision	Child Abuse	Child Neglect	Other Negligence	Assault (not child abuse)	Suicide	Other	Unknown
Age Group									
<1 Year	16	0	0	0	15	0	0	1	0
1-4 Years	6	1	1	0	3	0	0	1	0
5-9 Years	5	2	0	3	0	0	0	0	0
10-14 Years	2	0	1	0	1	0	0	0	0
15-17 Years	6	1	0	0	3	1	1	0	0
Total	**35**	**4**	**2**	**3**	**22**	**1**	**1**	**2**	**0**
Sex									
Male	20	3	1	2	13	1	0	0	0
Female	15	1	1	1	9	0	1	2	0
Unknown	0	0	0	0	0	0	0	0	0
Total	**35**	**4**	**2**	**3**	**22**	**1**	**1**	**2**	**0**
Ethnicity									
Hispanic (any race)	3	0	1	0	1	1	0	0	0
Race									
White	14	2	1	3	7	0	1	0	0
Black, African American	21	2	1	0	15	1	0	2	0
Unknown	0	0	0	0	0	0	0	0	0
Total	**35**	**4**	**2**	**3**	**22**	**1**	**1**	**2**	**0**
Manner of Death									
Natural	6	0	0	0	6	0	0	0	0
Accident (Unintentional)	16	4	0	3	8	0	0	1	0
Suicide	1	0	0	0	0	0	1	0	0
Homicide	2	0	1	0	0	1	0	0	0
Undetermined	9	0	0	0	8	0	0	1	0
Unknown	1	0	1	0	0	0	0	0	0
Total	**35**	**4**	**2**	**3**	**22**	**1**	**1**	**2**	**0**
Primary Cause of Death									
Motor vehicle	9	1	0	3	4	0	0	1	0
Drowning	2	2	0	0	0	0	0	0	0
Suffocation or Strangulation	4	0	0	0	4	0	0	0	0
Weapon	2	0	1	0	0	1	0	0	0
Poisoning	2	1	0	0	0	0	1	0	0
Other injury	1	0	1	0	0	0	0	0	0
Medical Conditions	15	0	0	0	14	0	0	1	0
Total	**35**	**4**	**2**	**3**	**22**	**1**	**1**	**2**	**0**

Footnote: Rows do not add up to totals because more than one type of act could have been involved. "Other" acts include religious/cultural practices, medical misadventure, and other. Other injury includes animal bite or attack, exposure, undetermined injury, other injury, or unknown injury.

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	Unknown
Deaths Reviewed	4	2	3	22	1	1	2	0
Cause								
Intentional	0	1	0	0	1	0	0	0
Unintentional	2	0	0	2	0	0	0	0
Undetermined	0	1	0	0	0	0	0	0
Contributed								
Intentional	0	0	0	0	0	1	0	0
Unintentional	2	0	3	20	0	0	2	0
Undetermined	0	0	0	0	0	0	0	0

Acts of Omission/Commission Suicide Information

	Cause of Death		
Suicide	**Caused**	**Contributed**	**Total**
Deaths Reviewed	0	1	1
Child History			
Drug/alcohol impaired at time of incident	0	1	1
Circumstances			
Child talked about suicide	0	1	1
Prior suicide threats were made	0	1	1
Child had received prior mental health services	0	1	1
Issues prevented child from receiving mental health services	0	1	1
Leading Reasons that may have contributed to Child's Death			
Argument with parent	0	1	1

Deaths by Manner and Cause by Preventability

		Could the death have been prevented?				
Manner	Cause	No, Probably	Yes, Probably	Could Not Determine	Unknown	Total
	Natural	2	6	0	0	8
	Accident	3	17	1	0	21
	Suicide	0	1	0	0	1
	Homicide	3	1	0	0	4
	Undetermined	0	9	0	0	9
	Unknown	0	1	0	0	1
	Total	**8**	**35**	**1**	**0**	**44**
Natural						
	Any Injury	0	0	0	0	0
	Asthma	0	0	0	0	0
	Cancer	1	0	0	0	1
	Cardiovascular	1	0	0	0	1
	Congenital anomaly	0	0	0	0	0
	Malnutrition/ dehydration	0	0	0	0	0
	Pneumonia	0	0	0	0	0
	Prematurity	0	0	0	0	0
	SIDS	0	4	0	0	4
	Other infection	0	0	0	0	0
	Other medical condition	0	2	0	0	2
	Unknown	0	0	0	0	0
	Subtotal	**2**	**6**	**50**	**1**	**8**
Accident (unintentional)						
	Any Medical Cause	0	1	0	0	1
	Motor Vehicle	2	10	1	0	13
	Fire, Burn, or Electrocution	0	0	0	0	0
	Drowning	0	2	0	0	2
	Asphyxia	1	3	0	0	4
	Poisoning, Overdose, or Acute Intoxication	0	1	0	0	1
	Weapon	0	0	0	0	0
	Fall or Crush	0	0	0	0	0
	Exposure	0	0	0	0	0
	Other Injury	0	0	0	0	0
	Unknown	0	0	0	0	0
	Subtotal	**0**	**1**	**0**	**0**	**1**
Suicide						
	Poisoning, Overdose, or Acute Intoxication	0	1	0	0	1
	Subtotal	**0**	**1**	**0**	**0**	**1**
Homicide						
	Weapon	3	1	0	0	4
	Subtotal	**3**	**1**	**0**	**0**	**4**
Undetermined						
	Any Medical Cause	0	8	0	0	8
	Asphyxia	0	9	0	0	9
	Subtotal	**0**	**9**	**0**	**0**	**9**

Commissioners and Panel Members...

COMMISSIONERS FY2010	STATUTORY ROLE
The Honorable Joseph R. Biden III	State Attorney General
Dr. Richard T. Callery	State Medical Examiner
Ms. Aleks Casper	Wilmington Chair Fetal Infant Mortality Review
Ms. Patricia Ciranni	Kent/Sussex Chair Fetal Infant Mortality Review
C. Malcolm Cochran, IV, Esquire	Chair of the Child Protection Accountability Commission
Dr. Garrett H. C. Colmorgen, Chair	Perinatologist
Ms. Tania M. Culley, Esquire	Child Advocate
The Honorable Vivian L. Rapposelli	Secretary of the Department of Services for Children, Youth and Their Families
Ms. Marjorie Lynn Hershberger	Chair of the CAN Panel and NCC Panel
Dr. Kathy A. Janvier	Delaware Nurses Association
Dr. Amanda Kay	Chair of the CAN Panel
The Honorable Chandlee Johnson Kuhn	Chief Judge of the Family Court
Colonel Robert M. Coupe	Superintendent of the Delaware State Police
The Honorable Rita Landgraf	Secretary of the State Department of Health and Social Services
Chief Kevin McDerby	New Castle County City Police
Dr. Lani L. Nelson-Zlupko	National Association of Social Workers
Ms. Leslie Newman	Child Advocate from statewide nonprofit organization
Dr. David Paul	Neonatologist
Ms. Marie E. Renzi	Child Advocate from statewide nonprofit organization
Dr. Karyl Rattay	Director of the Division of Public Health
Dr. Kevin Sheahan	Pediatrician
Dr. Philip Shlossman	Obstetrician
Dr. Wendy Sturtz and Ms. Cortney Jones	New Castle County Chair, Fetal Infant Mortality Review
Chief Michael J. Szczerba	Police Chief's Council of Delaware
The Honorable Lillian M. Lowery	State Secretary of Department of Education

COMMISSIONER PROXIES FY10
Ms. Patricia Dailey Lewis, Esquire
The Honorable Joelle Hitch
Sgt. Scott McCarthy
Ms. Mary Kate McLaughlin
Ms. Alisa Olshefsky
Cpl. Adrienne Owen

NEW CASTLE COUNTY PANEL	STATUTORY ROLE
Ms. Ann Altemus	Child, Inc.
Ms. Alice Coleman	Delaware Health and Social Services
Sgt. Matthew Cox	Delaware State Police
Dr. Kate Cronan	Emergency Room Physician
Sgt. Patricia Davies	New Castle County Police Department
Ms. Karen DeRasmo	Child Advocate
Det. Donna DiClemente	City of Wilmington Police
Ms. Kathy Goldsmith	Department of Education
Ms. Patricia Hearn	Family Court
Ms. Marjorie Hershberger, Chair	Delaware Nurses Association
Ms. Sue Poley	Child Advocate
Ms. Bridget Poulle	Domestic Violence Coordinating Council
Ms. Mariann Kenville-Moore	Department of Justice

Commissioners and Panel Members... (continued)

NEW CASTLE COUNTY PANEL (CONTINUED)	STATUTORY ROLE (CONTINUED)
Dr. Richard Leader	OB/GYN
Mr. Stuart Mast	Dept. of Services for Children, Youth and Their Families
Ms. Rosalie Morales	Office of the Child Advocate
Ms. Barbara Mengers	Delaware Health and Social Services
Ms. Janice Mink	Child Protection and Accountability Commission
Ms. Anita Muir	Division of Public Health
Ms. Angela Stancil	Dept. of Services for Children, Youth and Their Families
Ms. Karen Triolo	Dept. of Services for Children, Youth and Their Families
Dr. Jennie Vershvovsky	Office of the Medical Examiner

KENT/SUSSEX PANEL	
Mrs. Cindy Boehmer	Domestic Violence Coordinating Council
Det. Kenneth Brown	Milford Police Dept.
Capt. Ralph Davis	Delaware State Police
Ms. Helene Diskau	Child Development Watch
Ms. Maureen Ewadinger	Child Development Watch
Ms. Margaret Foor	Delaware Health and Social Services
Dr. Fran Franklin	Children and Families First
Ms. Patricia Hearn	Family Court
Ms. Cherelyn Homlish	Child Advocate
Ms. Diane Klecan	Child Advocate
Mr. Jim Lesko	Department of Education
Mr. Stuart Mast	Dept. of Services for Children, Youth and Their Families
Dr. Edward McDonough	Office of the Medical Examiner
Det. Daniel McKeown	Dover Police Department
Ms. Rosalie Morales	Office of the Child Advocate
Mr. Christopher Parker, Esquire	Department of Justice
Mr. Reese Parker	Dept. of Services for Children, Youth and Their Families
Mr. Ralph Richardson III	Child Advocate
Det. Steve Rust	Milford Police Department
Dr. Philip Shlossman	Obstetrician
Ms. Angela Stancil	Dept. of Services for Children, Youth and Their Families

ABUSE/NEGLECT PANEL	
Ms. Barbara Akenhead	Division of Public Health
Det. Mary Lou Bartkowski	Delaware State Police
Ms. Karen DeRasmo	Child Advocate
Ms. Kathy Goldsmith	Department of Education
Ms. Marjorie Hershberger	Delaware Nurses Association
Dr. Amanda Kay, Chair	Pediatric Hospitalist
Ms. Diane Klecan	Children's Advocacy Center
Ms. Rebecca Laster	National Association of Social Workers
Ms. Rosalie Morales	Office of the Child Advocate
Ms. Janice Mink	Child Advocate
Mr. Reese Parker	Dept. of Services for Children, Youth and Their Families
Ms. Bridget Poulle	Domestic Violence Coordinating Council
Ms. Jill Rosen	Child Advocate
Ms. Phyllis Scully, Esquire	Department of Justice
Ms. Anita Symonds	Child Advocate
Ms. Janice Tigani, Esquire	Department of Justice

FIMR Case Review Teams:

FY10 New Castle County Case Review Team:

Bridget Casar
Maryann Crosley
Terry Dombrowski
Vonna Drayton
Katherine Esterly
Cathie Frost
Sue Graham
Madeline Clark-Harris
Barbara Hobbs
Cortney Jones (co-Chair)
Virginia Phillips
Nikki Stryker
Wendy Sturtz (Chair)
Elizabeth Sushereba
Clare Szymanski
Catherine Townsend

FY10 Wilmington Case Review Team:

Aleks Casper (Chair)
Pat Caulk
Susan Greenstein
David Hack
Richard Henderson
Moonyeen Klopfenstein
Judith Ann Moore (co-Chair)
Anita Muir
Stephanie Rogers
Kathleen Russell
Miriam Sigler

FY10 Kent and Sussex Case Review Team:

Margaret Rose Agostino
Prue Albright
Michael Antunes
Sandra Bibb
Linda Brauchler
Bridget Buckaloo (co-Chair)
Jacqueline Christman
Patricia Ciranni (Chair)
Freda Collins
Garrett Colmorgen
Sandra Elliott
Maureen Ewadinger
Arlana Harriford
Nanette Holmes
Beth Keena
Karen Kelly
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Robert Locke
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Stephen Pearlman
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This annual report is dedicated to the children whose lives were extinguished too soon and the families that must endure this pain.

I want to thank the Child Death Review Panel members and the FIMR case review team members. They are the dedicated professionals who make this report happen due to their commitment in preventing future deaths and near deaths. In addition, the CDNDSC staff (Michael, Kristin, Joan, Angela, and Ashlee) deserves praise for their continued passion and service to this critical yet very difficult service to the State of Delaware. A special thanks to Dr. Meena Ramakrishnan, Marjorie L. Hershberger, and Sharon Larson, for their continued efforts and creative talents in supporting the mission of CDNDSC.

Once again, I would like to acknowledge Bryan Martin, whose torture and death started Delaware on a path of continual self-improvement in the child protection community. His tragic death continues to encourage my service and dedication to child protection on a daily basis.

Anne Pedrick
CDNDSC Executive Director

A statue stands in a shaded place,
An angel girl with an upturned face,
A name is written on a polished rock,
A broken heart that the world forgot

Martina McBride, "Concrete Angel," Greatest Hits, RCA Records, 2001, written by Stephanie Bentley and Rob Crosby, produced by Martina McBride and Paul Worley.

Design & Production by:
Mooney Marketing, 267-210-5878 and calabrocommunications

Every Child Deserves A Tomorrow

STATE OF DELAWARE

Child Death, Near Death and Stillbirth Commission

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Wilmington, DE 19801-3341

Copies of the Annual Report are available online at the CDNDSC website at
http://courts.delaware.gov/childdeath/reports.htm