Delaware

Preventing Child Deaths in the First State

Child Death, Near Death and Stillbirth Commission
2003, 2004, 2005, 2006, 2007
Consolidated Annual Report

This report is dedicated to Jackie Howard, who passed away April 10, 2004. Jackie served faithfully on the Kent/Sussex Child Death Review Panel for eight years. She brought with her the experiences and background of having worked at Family Court for many years. Most of all, she brought her concern for the welfare of people, especially the children of Delaware. As a member of the Child Death Review Panel, Jackie reviewed the most challenging of events in human life – the deaths of children. With her fellow panel members from varying disciplines, she sifted through the details, looking for lessons to be learned and making recommendations that could prevent another child from suffering the same fate.

A special thank you goes to the Department of Services for Children, Youth and their Families, specifically Donna Knotts, Stuart Mast, and Karen Triolo for all of their support and dedication to CDNDSC prior to staff being hired.

Special thanks to Dr. Meena Ramakrishnan and Susan Greenstein who served as consultants to CDNDSC and conducted the FIMR Pilot Study and Lessons Learned. They helped to provide the framework for implementing a statewide FIMR Program in the State of Delaware.

Also, CDNDSC would like to thank the Division of Pubic Health for their assistance and dedication in making FIMR a reality in Delaware.

STATE OF DELAWARE

CHILD DEATH, NEAR DEATH AND STILLBIRTH COMMISSION

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TO: The Honorable Ruth Ann Minner
Members of the General Assembly

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

DATE: May 1, 2008

SUBJECT: FY03 through FY07 Child Death,
Near Death and Stillbirth Commission Annual Report

I am pleased to present to you the Sixth 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 years 2003, 2004, 2005, 2006, and 2007. The Commission would like to thank you for your continued support to reducing infant mortality and child deaths in Delaware.

As a result of the statutory changes in 2004 and 2006, the Child Death, Near Death and Stillbirth Commission now reviews all near deaths of children due to abuse and neglect and has implemented the Fetal Infant Mortality Review Program. It is the Commission's goal that the multi-disciplinary reviews and recommendations will lead to implementation strategies that will reduce child deaths in Delaware. With the assistance of the Commission's dedicated staff, the recommendations are now being translated into measurable action steps and prevention initiatives. The work of the Commission, Panels, and staff truly reflect the spirit for which this Commission was created.

GHCC/amp
Enclosure

"Our lives begin to end; the day we become silent about things that matter"
(Reverend Martin Luther King, Jr.)

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Executive Summary

The Child Death, Near Death and Stillbirth Commission ("CDNDSC" or "Commission") was established in 1995. Its mission is to safeguard the health and safety of all Delaware children as set forth in 31 Del. C. § 320-324.

Multi-disciplinary Review Panels met from September to May each year between FY 2003 and FY 2007 to conduct a retrospective review of the history and circumstances surrounding each child's death or near death in Delaware. During this period, 556 child deaths were reviewed. Out of these 556 deaths, 35 were voted preventable by the Panels. The remaining 521 deaths were voted not preventable, undecided or were deaths caused by Sudden Infant Death Syndrome ("SIDS")/Sudden Unexplained Infant Death Syndrome ("SUIDS"), for which risk factors are identified but no vote is taken.

The work of the dedicated panels can best be reflected in the Recommendation portion of this annual report. Many of these recommendations were implemented by system partners over the past four years and have improved the ability of systems in Delaware to prevent child deaths. Some examples include: the development of a Safe Sleeping Subcommittee to address the prevalence of unsafe sleeping deaths, a warning sign posted at a dangerous area for swimming, and support of legislation regarding increased regulations for teenage drivers.

Based on the recommendations from five years of child death and near death reviews, the Commission has drawn the following conclusions:

- Delaware's infant mortality rate remains the sixth worst infant mortality rate in the nation.
- Forty-seven percent of all natural deaths reviewed were attributed to prematurity. Fifty-nine percent of all infant deaths were due to prematurity.
- African Americans make up nineteen percent of Delaware's population. However, African American children disproportionately represent forty percent of all deaths CDNDSC reviewed.
- Sixty-seven percent of all non-natural deaths reviewed can be attributed to motor-vehicle crashes. This is an increase of nineteen percent from the period covered by the 2000-2002 annual report.
- The adolescent drivers accounted for fifty-nine percent of deaths due to motor vehicle crashes.
- Forty-one percent of all homicides involved teenagers. Ninety-one percent of these deaths involved use of a firearm.
- Firearms were used in sixty-two percent of the adolescent suicides.
- The risk factors that were most prevalent in SIDS/SUIDS cases were infants not sleeping in a crib, sleeping with other people, and not sleeping on their backs.

Mission

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

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. According to Commission policies and procedures, a child death or near-death is considered to be preventable if one or more interventions (medical, community, legal, and/or psychological) might reasonably have averted the child's death or near-death. The reasonableness of the intervention is defined by the conditions and circumstances of the death and available resources. 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 and Accomplishments

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 the power to create up to three regional Review Panels, establishes confidentiality for the reviews, and provides the Commission with the ability to secure pertinent records. In addition, it provides protection to members of the Commission and regional Review Panels from claims, suits, liability and damages, or any other recourse, civil or criminal.

The Commission has established three panels. The New Castle and Kent/Sussex panels review all non-child abuse or neglect deaths. The Child Abuse/Neglect panel reviews deaths and near deaths due to child abuse/neglect statewide. Each of the three panels conducted monthly child death reviews (except during the summer months). The Commission has met at least quarterly to review and approve the work of the Panels.

The 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 three months of a report to the Commission not withstanding 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[1] of an abused and/or neglected child within three months of notification of said child. The amended statute also required that system-wide recommendations arising from an expedited review of a death or near death due to child abuse or neglect be made to the Governor and General Assembly, as well as any members of the public requesting the recommendations, within 20 days of the completion of such investigation and review.

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

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Future goals:

- A report card on action and implementation of recommendations
- Joint Conference with CPAC (Spring 2008)
- Full Implementation of the National Data Tool (expanded annual report demographics) and BASINET (FIMR database)
- Continued Safe Sleeping Media campaigns
- Develop or partner with an existing group to address teenage motor vehicle crashes.

MISSION *(continued from page 5)*

In addition, the Chair of the Child Protection Accountability Commission ("CPAC") was added as a member of the 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 Fiscal Year 2005, 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. This pilot included the review of 50 infant deaths occurring in 2003 using Commission case information and maternal interviews conducted by DPH social workers.

In Fiscal Year 2006, FIMR's budgetary positions were placed with the CDNDSC. These three positions include a Registered Nurse III FIMR Program Coordinator, Senior Medical Social Worker and an Administrative Specialist. Collaboration and joint training also began with CPAC during Fiscal Year 2006. These meetings occur semi-annually and have resulted in the development of joint subcommittees: Safe Sleeping Practice Subcommittee, Caseload/Workload Subcommittee, Multi-disciplinary Use of History in Decision-Making, and Delaware Code Changes/Standardized Definitions of Abuse/Neglect Subcommittee. During Fiscal Year 2006, the Child Abuse/Neglect Panel was developed, trained and started to review all cases of death or near death due to abuse/neglect.

The most significant accomplishment for Fiscal Year 2007 was the full implementation of the Fetal Infant Mortality Review Process. FIMR is now fully staffed and operational. FIMR case reviews include information gathered through a clinical review and summary of records and maternal interviews. 110 Fetal and Infant deaths were referred to CDNDSC. Of those, 14 were not appropriate per the statutory mandate. Seven cases were reviewed by the FIMR case review teams during the period of April to June 2007. And five of the 110 deaths were reviewed by the Child Death Panels due to cause and manner of death.

The search for an appropriate database for FIMR has resulted in the adoption of the BASINET (Baby Abstracting System and Information Network) program that was developed by the Florida Healthy Start Coalition to track fetal and infant deaths. This program has been successfully implemented by several states and appears to meet the needs of the Commission. This program will also be used to provide information to the national database on child deaths. The Commission has agreed to work with the Delaware Healthy Mothers and Infant Consortium, and its subcommittees will act as the Community Action Team for the FIMR 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/near deaths with domestic violence as a significant risk factor in the death or near death.

Abuse/Neglect

The Child Welfare League of America documented that 1,177 children died in the year 2003 from abuse and neglect. Nationally, it is estimated that about half of child abuse and neglect deaths are not coded consistently on death certificates (Pediatrics, 2002). In reviewing the number of "homicides" due to abuse/neglect in Delaware, one could make the assumption that these types of deaths are decreasing. However, as noted from the work of the Panels, neglect is an issue that continues to impact the mortality of children. From FY03 to FY07, 15 cases of death or near death due to abuse/neglect, were reviewed by the CDNDSC.

Recommendation:

Before the Division of Family Services ("DFS") closes a case, a second check should be made with Delaware Criminal Justice Information System ("DELJIS"). The DSCYF representative will review with DFS the project to obtain PREMIS checks and she will report back to the panel. The Office of the Child Advocate ("OCA") is to work with DFS to determine the definition for adequate care. (FY04)

DSCYF response: The Division is currently exploring revisions to the policy regarding the frequency of criminal background checks. This recommendation will be taken into account.
The definition of adequate care has been addressed by the CPAC Legislative Subcommittee and codified by Senate Bill #266 during the 2007 legislative session.

OCA response: CPAC's Definitions subgroup standardized the definitions of child abuse, neglect, and dependency through HB266 and as now reflected in 10 Del.C. §901. The term, "adequate care" has been replaced with the term, "necessary care".

Recommendation:

The panel supports the DSCYF[2] plan. (FY04)

Recommendation:

Delacare Regulations are currently under revision through the Child Placing Agency Rule Revision Task Force. Since this process is lengthy, the Commission recommends that Child Placing Agencies are noticed that it is best practice to conduct criminal background and child protection registry checks on all prospective adoptive parents prior to finalization of an adoption. It is recommended that these agencies are encouraged to immediately begin conducting such background checks, pending rule revision. (CDNDSC Expedited Review, Letter to the Governor, 4/19/2005).

DSCYF response: Rule revision is in process for Requirements covering Child Placing Agencies. The Task Force reconvened and this issue was addressed. Child Placing Agency's ("CPA") are conducting checks prior to the completion of a home study.

Recommendation:

Current practices and procedures for investigating complaints regarding childcare providers and addressing identified deficiencies need to be well defined.

Therefore, the Commission recommends the following changes in policy and practice:

a.) Senate Amendment 1 to House Bill 528 prohibited the retroactive termination of employment for childcare providers who had a substantiated history of abuse and/or neglect. As a result, an undetermined number of family childcare homes continue to operate despite the placement of

[2]DSCYF Safety Council has reviewed and recommended an interagency group including the Office of the Child Advocate (" OCA"), the Department of Justice ("DOJ"), and Family Court be formed to study how the system responds to cases of chronic neglect. *Child Placing Agencies are now being advised that it is a best practice to conduct background checks on all perspective adoptive parents prior to finalization.*

Case Review Recommendations and Discussion FY03-FY07

The Commission shall make recommendations to the Governor and the General Assembly, at least annually, regarding those practices or conditions, which 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. (31 Del. C. § 322.)

DFS is developing a Chronological History Summary that would succinctly capture a person's history. The FACTS functionality and event was developed and advanced as a budget initiative for the Department for FY09.

CDNDSC wrote a letter of support to the Governor and the Office of Management and Budget in support of this budget initiative.

ABUSE/NEGLECT *(continued from page 7)*

employees/operators at Level III or IV of the Child Protection Registry. It is imperative that the OCCL complete comprehensive, timely safety, assessments for all licensed daycare providers placed on the Child Protection Registry prior to February 1, 2003. This assessment should include but not be limited to a review of the provider's DSCYF history, progress on any corrective action plans entered, and home inspections to ensure that safety exists in those homes.

DSCYF response: Complete. A crosswalk of child care providers and Registry findings was completed in December 2004. Each individual was reviewed by licensing staff. This issue has been discussed with the Office of the Attorney General. It was their opinion that the OCCL could not enforce the requirements under HB 528 against those individuals that were substantiated prior to enactment of that legislation. For all of those cases that occurred prior to the enactment OCCL took appropriate actions.

b.) Quality assurance mechanisms should be implemented to ensure that regulations and procedures established to protect children in childcare settings are consistently applied and followed, and that corrective action plans are formally implemented.

DSCYF response: An internal review occurs to assess the circumstances of each situation of a complaint/violation/abuse allegation that includes the OCCL Administrator. Recommendations are made for any corrective action plan or other action. CQI is under development.

c.) Create an independent investigative unit within the Department to thoroughly investigate DELACARE requirement violation complaints similar to the procedure for investigation of institutional abuse/neglect complaints. Investigation of DELACARE requirement violations and institutional abuse/neglect complaints should utilize all available investigative resources, including but not limited to the Children's Advocacy Center, DSCYF history and, in the case of abuse and neglect complaints, criminal history as well.

DSCYF response: This recommendation has been reviewed by DFS and it has been determined that the practice of Office of Child Care Licensing (OCCL) investigating complaints concerning alleged violations/ non-compliances with Delacare Rules/ Requirements would continue. In 2006-2007 OCCL has received training in investigative techniques from Institutional Abuse (IA) and DFS trainers to enhance competencies in investigative techniques. OCCL uses all resources available to assist in investigating standards complaints. Joint investigations have been conducted with Audit Recovery and Management Services of the Department of Health and Social Services, Division of Social Services monitors, Child and Adult Care Food Program monitors, Division of Public Health officials, City/town building/codes authorities, and Fire Marshals. IA is utilized as a resource frequently to obtain guidance. When there is an IA investigations, these allegations also would be potential violations of Delacare Rules/Requirements. The common practice is to conduct a joint investigation with IA in those cases with IA focused on the abuse/neglect elements and OCCL on the standards elements. Licensing Specialists are frequently present during interviews conducted by IA and law enforcement.

d.) Policies and procedures should require that responses to reported childcare complaints are timely, consistent, and include a uniform reporting mechanism. A specific timeframe in which the investigation will occur and close supervision of the process to ensure compliance should be implemented. Deficiencies should be

addressed through a specific corrective action plan with timeframes and follow-up. (CDNDSC Expedited Review, Letter to the Governor, 12/17/2004).

DSCYF response: Policies set forth time frames for initiation and completion of complaint investigations. Supervisors and the OCCL Administrator receive a monthly report on complaints and each complaint is "work listed" by Licensing Specialist. There is a template for complaint investigation reports. OCCL policies are under revision to bring the timelines for completion of investigation in line with IA timelines. Whenever a standards complaint is "substantiated" or "unsubstantiated with concern" recommendations and corrective actions are issued and monitored. Such findings may lead to increased monitoring and unannounced visits.

Recommendation:

It is recommended that the Department of Services for Children, Youth and Their Families review the caseloads and responsibilities of Office of Child Care Licensing (OCCL) and submit caseload and resource proposals for improving compliance with this area of regulation in accordance with the above recommendations. 29 Del. C. § 9015(b)(5) requires an adequate number of licensing specialists for child care centers and family child care homes so that caseloads do not exceed 150 per specialist. (CDNDSC Expedited Review, Letter to the Governor, 12/17/2004).

DSCYF response: Caseload reports are monitored on a monthly basis. OCCL reviews the overall caseload and individual caseloads. Reports quantify the number of cases assigned, number of complaints assigned and resolved, and number of enforcement actions. All caseloads for family child care homes and child care centers are currently under 150 and have been so for over two years. The average caseload now stands at 130 cases.

Recommendation:

Specifically, the items listed below should be reviewed:

a.) Completion of comprehensive safety assessments for all licensed childcare providers placed on the Child Protection Registry prior to February 1, 2003. Assessments should include but not be limited to a review of the provider's DSCYF history, progress on any corrective action plans entered by OCCL, and unannounced home inspections. *See #3a below for further details;*

b.) Use of substitute caregivers;

c.) 24-hour care;

d.) Safe infant sleeping practices;

e.) Mandated time frames for center/family child care home inspections keyed to licensure renewal;

f.) Institution of a quality assurance mechanism to ensure that regulations and procedures established to protect children in child care settings are followed; and

Education on and appropriate application of 16 Del. C., Ch. 9, Subch. II (§§ 921-929) (Child Protection Registry) by OCCL regarding the operation of family child care homes and persons working in centers. (CDNDSC Expedited Review, Letter to the Governor, 12/17/2004).

DSCYF response: The Rules for Family and Large Family Child Care Homes are currently out for public comment. (1/12/07-1/16/08). In developing these revised Rules extensive research was completed and the recommendations of CDNDSC were shared with the Task Force that was established to help write new Rules.

The following are currently being put forward to address recommendations a-d:

a. FACTS is regularly used to check on the status of providers for any involvement with other Offices within DSCYF. At least one unannounced visit is made to each Family Child Care Provider on an annual basis. All Providers must submit an application for licensure annually. On that application, which is a notarized document, are questions relating to convictions, criminal activity, child abuse or neglect, and other issues. These applications are carefully reviewed and compared with previous applications and cross checked in FACTS.

b. Rules 133-140 (Family Homes) and Rules 170-177 (Large Family Homes) added/clarified regarding the use of substitute.

c. Rule 132 (Family Homes) added which limits the consecutive hours of care to 17 hours within any 24 hour period.

d. Rules 221-227 (Family Homes) and Rules (Large Family Homes) specifies Sleep: Napping Accommodations which include Safe Sleeping Practices.

e. OCCL has reviewed this recommendation and feels that having a random time associated with unannounced visits on Family Home Providers will do more to advance the safety of children in care. In some cases it may coincide with license renewal. To coincide with all visits with license renewal would provide a limited "window" timeframe when the Licensee would know a visit was imminent.

f. A quality assurance mechanism is under revision at this time.

OCCL Staff have been educated on the appropriate application of Delaware Code. Enforcement actions have been taken against Providers in which the primary reason for enforcement was based on a provider or household member's status on the Child Protection Registry.

ABUSE/NEGLECT *(continued from page 9)*

Police should orally notify DFS on reports of suspected child abuse and neglect as required by Title16 Del. C. § 904. The Memorandum of Understanding between DFS, Police, and the Attorney General's Office provides additional guidance to law enforcement officers on how to make a report of suspected child abuse and neglect.

Recommendation:

Delaware citizens should easily be able to obtain access to information regarding licensed childcare, including access to history of substantiated complaints of abuse and/or neglect against a particular employee, home and/or center. The Department of Services for Children, Youth and Their Families, Division of Family Services, Office of Child Care Licensing is the State entity charged with licensing childcare, investigating violations, and maintaining information regarding complaints against day care facilities and employees in Delaware. 31 Del. C., Ch. 3, Subch. III. Current practice requires a citizen to schedule an appointment with the Office of Child Care Licensing ("OCCL") at which time they must be physically present to review the OCCL file pertaining to a particular childcare provider. The intent of Delaware's Parents Right to Know Act (31 Del. C. § 398) is to increase a parent's access to information about licensed child care facilities. OCCL should develop a comprehensive database on all licensed childcare homes and centers, including enforcement actions and substantiated complaints. This information needs to be easily accessed via the Internet, telephone and in person. The Commission also notes that the Parents Right to Know Act requires OCCL to make certain child care information, including enforcement actions, available on the website of the Department of Services for Children, Youth, and Their Families. Enforcement actions do not appear to be available online. The Commission recommends that OCCL come into compliance with and review the scope of the Act's mandate. (CDNDSC Expedited Review, Letter to the Governor, 12/17/2004).

DSCYF response: It is anticipated that the OCCL website will have available within two months (March 2008), a comprehensive database on all licensed child care homes and centers, including enforcement actions, substantiated complaints, and non-compliance history. Initially this will show a history of three years and eventually five years. Enforcement actions, however, because of programming issues will only show current events. Continuous research is being done to see how this historical information can be added. This is a very user friendly format. We envision revision will be made to this site as technology allows. A survey will be on the site to obtain input from users that will assist in guiding changes to the format. The on-site file review process will remain an option for individuals who still want a more in depth view of a file. Licensing Specialists conduct the file review to be available to answer questions.

Recommendation:

Through the work of the Caseload/ Workload Subcommittee, DFS should explore ways to assure that their staff has the time needed to consult with experts that can provide consultation on issues such as substance abuse, mental health, and domestic violence. These experts must be available to all DFS staff and DFS staff must have adequate time to consult these experts during an investigation. These experts give valuable information regarding the parent's ability to keep the children safe. (CDNDSC Final Review, Letter to the Governor, 3/2/2007).

DSCYF response: New guidelines have been reissued to allow Investigators access to the Substance Abuse Liaisons. A request for mental health consultants has been included in the Department's recommended budget for DFS.

Recommendation:

CDNDSC remains in support of the ongoing CPAC/CDNDSC Caseload/Workload Subcommittee. (CDNDSC Final Review, Letter to the Governor, 3/2/2007).

DSCYF response: DFS continues to work as a participant in the Caseload/Workload Subcommittee and is supporting the recommendations from that group.

OCA response: CPAC's Caseloads/ Workload Subcommittee researched, drafted, and advocated for the passage of SB113, which lowered DFS investigation caseload standards from 14 to 11. SB180 *was introduced which addresses caseload standard reduction for DFS treatment caseworkers. The Subcommittee continues to research and advocate for caseload/workload management strategies.*

Recommendation:

The Division should immediately fill all 15 over hire ("trainee") positions and keep those positions filled pursuant to 29 Del. C. § 9015(b)(4) so that fully trained staff are always available to fill vacancies. While the Department has indicated that filling the over hire positions will not alleviate the high caseloads that they experience on a regular basis, the Subcommittee believes that a commitment to use of the over hire positions will assist in providing the needed resources when dealing with positions of high-turnover and burnout. (CDNDSC Expedited Review, Letter to the Governor, 3/31/2006).

DSCYF response: DSCYF had already been reporting over-hire details to CPAC on a quarterly basis (filled and vacant). Because of ongoing movement; it is not possible to have all trainee positions filled continuously. However, the regions do ongoing interviews and maintain a hiring waitlist to bring on new trainees quickly.

Recommendation:

DFS should manage caseload distribution so that cases with a chronic risk of recurring abuse/neglect/dependency and/or presenting with multiple complicating factors are counted, or weighted to reflect their complexity. This theoretically would allow case managers more time to devote to the family who presents with more intensive needs. (CDNDSC Expedited Review, Letter to the Governor, 3/31/2006).

DSCYF response: DFS will explore the feasibility of enhancing or building upon our current case weight system in our FACTS information system. The DFS will need to consider the current data structure and financial implications. It may prove more effective to design the needed case weight data structure in our next generation information system – FACTS II. The FACTS II project has case weighting as a requirement of the new information system.

Recommendation:

DSCYF should monitor the following quality assurance issues that were identified during the review of this case:

- ✔ How case histories are reviewed, weighted and incorporated into decision making by DFS
- ✔ DFS workers visiting children within stated guidelines
- ✔ Not viewing each event as an individual incident but looking at the totality of a child's history
- ✔ Assuring that new allegations of abuse and/or neglect in a case already open for DFS investigation or treatment are treated as a new hotline report (this will ensure that all available history presented to DFS will be available to workers in the future)
- ✔ Determine what qualifies a case as complex and requiring a more intense level of intervention
- ✔ Reflecting on how many risk factors must be present within a family before DFS brings a child into care (CDNDSC Final review, Letter to the Governor, 3/2/2007).

DSCYF response: DFS' QA case review system provides monitoring of safety assessment throughout the life of a case. The contacts are measured and monitored through management reports. QA specifically measures safety and removal decisions; DFS policy is clear regarding criteria for accepting new reports on investigation and treatment cases. The CPAC Caseload/Workload Subcommittee's recommendations do not address case weighting as a strategy for workload management.

(Pending Action) DFS is developing a Chronological History Summary that would succinctly capture a person's history. The FACTS functionality and event was developed and advanced as a budget initiative for the Department for FY09.

CDNDSC action taken or next steps: CDNDSC wrote a letter of support to the Governor and the Office of Management and Budget in support of this budget initiative.

CDNDSC should send a letter to the Delaware Chapter of the American Academy of Pediatrics, the Medical Society of Delaware and nursing affiliate groups requesting their assistance on providing training on the issue of mandatory reporting of child abuse/ neglect and additional training on child abuse and neglect issues. This training would be consistent with the latest information regarding abuse /neglect.

CDNDSC supports home visiting services that replicate successful national models such as the "David Olds" model.

ABUSE/NEGLECT *(continued from page 11)*

Recommendation:

DFS should develop a process to conduct interagency meetings, particularly in complex cases, including those cases of chronic neglect. This would enable all service providers to discuss the family's progress and identify any additional needs. This would apply to families that do not have Family Court oversight. At this meeting, case plans can be reviewed to assure services match the level of risk. As risk increases, so should the intensity of services to the family. If the family is uncooperative, the interagency meeting could decide if it is best to terminate the services or file for custody of the child.16 Del. C. § 906(b)(7). (CDNDSC Final Review, Letter to the Governor, 3/2/2007).

DSCYF response: DFS participates in interagency meetings and has policy and procedures for multi-divisional cases and high risk hospitalized infants pending discharge. System of care initiatives and Integrated Service Planning encourages multidisciplinary meetings and planning.

Recommendation:

DFS should review current practice and policy with regard to case planning to ensure services are meeting the identified need(s) and are monitored to measure progress and influence case decisions. (CDNDSC Expedited Review, Letter to the Governor, same recommendation was put forth again in the final letter, 3/31/2006).

DSCYF response: The agency reviews and updates its policies on an annual basis. Supervisory training and expectations include routine case conferences with staff and coaching towards improved outcomes for children and families aligned with Federal outcomes, national standards and DSCYF objectives. Our quality assurance review system monitors case planning activities such as identified needs and selection of service. The Department's Quality Improvement Unit (OCM) also conducts reviews to examine the quality of DFS work through effective case planning, service provision and management. The Court reviews our work associated with provision of service to children and families that are in care.

Recommendation:

DFS should explore ways to access experts that can provide consultation on issues like substance abuse, mental health, and domestic violence. These experts must be available to all DFS staff and DFS must have adequate time to consult these experts during an investigation. These experts give valuable information regarding the parent's ability to keep the children safe. (CDNDSC Expedited Review, Letter to the Governor, 3/31/2006).

DSCYF response: January 2008, DFS revised the scope of services for the AOD liaisons. All staff statewide will now be able to utilize the expertise of this AOD liaison. The agency has policy pertaining to the use of collateral corroboration. The Department has Memorandums of Understanding with regards to working in a seamless approach across and within organizations to include: DOJ/Police, Public Schools, DSAMH, Public Health, DOC, and DDDS.

Recommendation:

DFS caseworkers need a user-friendly process, including automated computer access, to identify and link cases where a single person may be involved with more than one family. The current participant listing search process may be cumbersome and difficult to navigate for caseworkers. (CDNDSC Expedited Review, Letter to the Governor, 4/19/2005).

DSCYF response: Proposed changes are being included in FACTS II requirements/development project.

Recommendation:

DFS needs to better utilize the legal option of compelling cooperation during an investigation and the legal ability to include judicial enforcement. (CDNDSC Expedited Review, Letter to the Governor, 10/6/2006).

DSCYF response: DFS policy outlines this expectation and the expected coordination with the DAGs.

Recommendation:

DFS should explore what information can be legally obtained and legally shared with other professionals working with the family so that they can determine the most appropriate intervention for the family. Collateral collaboration needs to be improved. (CDNDSC Expedited Review, Letter to the Governor, 3/31/2006).

DSCYF response: The agency has policy and procedures pertaining to collateral collaboration. The Department has Memorandums of Understanding with regards to working in a seamless approach across and within organizations. DSCYF is in the process of reviewing and updating its Confidentiality policy, coordinating with the Department of Justice and other partners to update the Law Enforcement MOU, and we are finalizing a revised MOU with the schools, Division of Developmental Disabilities and others. Federal oversight of our policy and practice is conducted through Child and Family Service Reviews and annual grant reports.

Recommendation:

Five years ago, the Children's Department implemented a drug and alcohol-screening tool for use in child abuse investigations in response to an Independent Review of a child death. The Department has since been utilizing this tool, and is currently reviewing the screening instrument for validity. The Commission supports the Department's efforts to revisit the utilization of the current screening instrument. The Commission recommends the Department research the use of newer empirically valid screening instruments, and/or drug/alcohol abuse screening tools recommended by the Child Welfare League of America or other nationally recognized child welfare agencies. (CDNDSC Expedited Review, Letter to the Governor, 4/4/2005).

DSCYF response: January 2008, DFS revised the scope of services for the AOD liaisons. The AOD liaisons will be completing initial screenings on all clients if substance abuse is NOT obvious.

Recommendation:

Require child abuse investigators to routinely contact primary care physicians to assess prior care and risks for future abuse of other children. (CDNDSC Expedited Review, Letter to the Governor, 10/23/2002).

DSCYF response: DFS policies are consistent with this recommendation.

Recommendation:

DFS must establish a tracking mechanism and policy for treatment workers recording the contact schedule for children in the 0-6 age group to assess and assure their safety. These children must be seen on a regular basis. (CDNDSC Expedited Review, Letter to the Governor, 3/31/2006).

DSCYF response: Current policy does not require case manager-child contact for all children in an open treatment case. Contact schedules are established by supervisors and are based on risk factors affecting child safety. The agency participates in the CPAC Workload/Caseload Subcommittee to study workload standards.

Recommendation:

Delaware Code (Title 13, Ch.7, Subch. 2) states that in accordance with the best interests of the child, the criminal history of any party or resident of the household should be considered in custody proceedings. The Commission recommends that the Courts explore development of a process to ensure that Family Court Judges have access to all relevant civil and criminal records pertaining to all parties involved in civil custody cases. (CDNDSC Expedited Review, Letter to the Governor, 4/19/2005).

Family Court response: Judges are strongly urged pursuant to Internal Policy to review relevant related files prior to making a civil decision.

Recommendation:

The Child Death and Stillbirth Review Commission supports House Bill #78 (regarding use of DELJIS at Family Court). (CDNDSC Expedited Review, Letter to the Governor, 7/3/2003).

DSCYF response: In place HB 78 as of FY 05 passed the General Assembly June 2004 and requires criminal history of any party and/or household members be considered in determining child's best interests.

Family Court response: Judges are strongly urged pursuant to Internal Policy to review relevant related files prior to making a civil decision.

Recommendation:

Police should orally notify DFS on reports of suspected child abuse and neglect as required by Title16 Del. C. § 904. The Memorandum of Understanding between DFS, Police, and the Attorney General's Office provides additional guidance to law enforcement officers on how to make a report of suspected child abuse and neglect. (CDNDSC Final Review, Letter to the Governor, 3/2/2007).

DOJ response: Final comments have been received. The MOU is ready for signature.

DSCYF response: MOU under revision; support the signing with finalization as soon as possible, with training provided to all involved agencies.

The CDNDSC supports recommendation #8 from the report; Reducing Infant Mortality in Delaware – The Task Force Report – May 2005. "Implement a comprehensive (holistic) Family Practice Team Model to provide continuous comprehensive case management service to pregnant women and their infants up to two years post partum. Services will include comprehensive case management, trained resource mothers, outreach workers, nurses, social workers, and nutritionists."

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Recommendation:

The hearsay exception (Title II, 2513) should be re-evaluated. The Commission suggests a collaborative effort to evaluate the statute among the Department of Justice, the Department of Services for Children, Youth, and Their Families, the Office of the Child Advocate, and an independent advocate for children. (CDNDSC Expedited Review, Letter to the Governor, 11/7/2003).

DOJ response: No longer constitutional under the Crawford decision.

Recommendation:

CDNDSC should send a letter to the Delaware Chapter of the American Academy of Pediatrics, the Medical Society of Delaware and nursing affiliate groups requesting their assistance on providing training on the issue of mandatory reporting of child abuse/neglect and additional training on child abuse and neglect issues. This training would be consistent with the latest information regarding abuse/neglect. (CDNDSC FINAL Review, Letter to the Governor, 3/2/2007).

DSCYF response: Agree and support.

CDNDSC action taken or next steps: The Medical Society of Delaware has agreed to partner and assist CDNDSC in providing mandatory reporting training of child abuse/neglect. CDNDSC will be working with the Abuse Intervention Committee's medical subcommittee to coordinate a statewide onsite training with medical providers.

Recommendation:

CDNDSC supports home visiting services that replicate successful national models such as the "David Olds" model. (CDNDSC Expedited Review, Letter to the Governor, 10/6/2006).

Recommendation:

The CDNDSC will send a letter to the emergency room and radiology directors of Delaware hospitals requesting that they follow standards on how to properly examine a child for child abuse using skeletal surveys. The letter should specifically include a copy of the three-year study from the American Academy of Pediatrics. (CDNDSC Expedited Review, Letter to the Governor, 10/6/2006).

CDNDSC action taken or next steps: Letter was sent on 6/7/06.

Recommendation:

CDNDSC will send a letter of concern to the Medical Director of the child's clinic and/or hospital that clearly states that high risk moms and babies should have follow up mechanism in place so follow up is enacted when an appointment is not kept. (CDNDSC Expedited Review, Letter to the Governor, 3/31/2006).

CDNDSC action taken or next steps: Letter was sent on 10/6/06.

Recommendation:

Make referrals to the appropriate medical/nursing licensing organizations regarding a particular case if there is evidence that the standard of medical or nursing care may have been breeched. (CDNDSC Expedited Review, Letter to the Governor, 10/24/2002).

CDNDSC action taken or next steps: The Commission referred a case to the Board of Medical Practice on 2/1/07.

Recommendation:

Require state funded medical insurance providers to routinely screen for domestic violence during well child visits, and encourage private insurers to accept the same standards. (CDNDSC Expedited Review, Letter to the Governor, 10/24/2002).

Recommendation:

The CDNDSC supports hospitals in developing some type of internal system that alerts physicians when a child's family has a history of violence and/or abuse. (CDNDSC Expedited Review, Letter to the Governor, 10/24/2002).

Recommendation:
The CPAC/CDNDSC Information Sharing Subcommittee should continue to explore what information can be obtained and shared with other professionals working with the family to keep children safe. This subcommittee's exploration of this issue should include discussion about the ability of DFS to engage in a two-sided dialogue that provides feedback and information to professionals who can help to enhance the safety of the child. Professionals working with children need on-going critical information from the Division of Family Services to better detect abuse/neglect in the children they serve. (CDNDSC Final Review, Letter to the Governor, 3/2/2007).

DSCYF response: The Information Sharing Subgroup of the CPAC Multi Disciplinary Use of History Decision-Making Subcommittee issued a report in October 2007. The report's results and recommendations were presented to the Joint Commission of CPAC and CDNDSC by Carlyse Giddins, DFS Director, on October 12, 2007. The results indicated that there are sufficient statutes and processes (e.g., memoranda of understanding-MOU) in place to share information among professionals. It was recommended, however, that information sharing procedures within existing MOU such as the Department of Education – Local Education Agencies and Charter Schools or the Division of Public Health be enforced. The Joint Commission accepted the Subgroup's final report and recommendations.

Recommendation:
Child Development Watch and other Public Health officials need to communicate more effectively. (CDNDSC Expedited Review, Letter to the Governor, 10/6/2006).

DSCYF response: There is a DSCYF Administrator supervising 2 DFS staff who serve as CDW/DFS liaisons. These resources facilitate communication and exchange of vital information across systems. In addition to systemic issues, professionals from CDW and DFS share information such as family whereabouts, worker identity, and information aiding the treatment of the child. CDW staff, along with Public Health nurses, advise frontline investigation and treatment staff of critical issues in the home and make child abuse and neglect referrals.

Recommendation:
The CDNDSC supports recommendation #8 from the report; Reducing Infant Mortality in Delaware – The Task Force Report – May 2005. "Implement a comprehensive (holistic) Family Practice Team Model to provide continuous comprehensive case management service to pregnant women and their infants up to two years post partum. Services will include comprehensive case management, trained resource mothers, outreach workers, nurses, social workers, and nutritionists." (CDNDSC Expedited Review, Letter to the Governor, 10/6/2006).

Recommendation:
Exploration by the DSCYF of CAPTA provisions that describe who is entitled to information about cases is needed. The results of this review should be utilized to create policies and procedures that help to enhance communication between partners. (CDNDSC Expedited Review, Letter to the Governor, 10/6/2006).

DSCYF response: DFS policy is in compliance with CAPTA requirements for confidentiality.

Recommendation:
Utilization of the Children's Advocacy Center is highly recommended whenever possible during the investigation of physical and/or sexual abuse. (CDNDSC Final Review, Letter to the Governor, 5/5/2006).

DSCYF response: We concur that the CAC should be utilized when the case circumstances meets the established criteria.

Recommendation:
DFS should develop a process to conduct interagency meetings, in particular complex cases, including those cases of chronic neglect. This would enable all service providers to discuss the family's progress and identify any additional needs. This would apply to

Training regarding the reporting of abuse and neglect as required by 16 Del. C. §903 should be implemented. The CDNDSC shall request that the Abuse Intervention Committee review the current mandatory reported laws of this State and other states to ensure Delaware's statutes are adequately protecting children

Expand education and training on child abuse, child neglect and domestic violence to health care providers.

ABUSE/NEGLECT *(continued from page 15)*

families that do not have Family Court oversight. At this meeting, case plans can be reviewed to assure services match the level of risk. As risk increases, so should the services to the family. If the family is uncooperative, the interagency meeting could decide if it is best to terminate the services or file for custody of the child. 16 Del. C. § 906 (b)(7). (CDNDSC Expedited Review, Letter to the Governor, 3/31/2006).

DSCYF response: While multi-disciplinary approaches are beneficial, current workloads do not provide for extensive collaborative consultation. Case plans and case plan reviews are approved by supervisors. Case plan progress and changes in risk are reviewed in this process. The Department's Integrated Service Planning Policy #201 requires a multi-disciplinary approach to case planning for youth open to more than one division.

Recommendation:

The Commission supports the Children's Department in its leadership role to develop and implement a system of care for children and families in Delaware. In particular, the Commission recognizes the value of information sharing and enhanced communication within and between public agencies serving the State's children. (CDNDSC Expedited Review, Letter to the Governor, 4/04/2005).

DSCYF response: In place, see above, department appreciates support for SOC.

DOE response: Again, here is a reference to "Lack of multi-disciplinary collaboration and communication". This case was a school-age child. The System of Care Initiative should address this issue.

Recommendation:

Review the Memorandum of Understanding among the Department of Justice, the Department of Services for Children, Youth, and Their Families, and the Delaware Police agencies for clarification of roles, and for the addition of the Children's Advocacy Center of Delaware, Inc. and the medical community. (CDNDSC Expedited Review, Letter to the Governor, 10/24/2002).

DSCYF response: In place; see above, in process.

Recommendation:

Training regarding the reporting of abuse and neglect as required by 16 Del. C. §903 should be implemented. The CDNDSC shall request that the Abuse Intervention Committee review the current mandatory reported laws of this State and other states to ensure Delaware's statutes are adequately protecting children. (CDNDSC Expedited Review, Letter to the Governor, 10/6/2006).

CDNDSC action taken or next steps: Request was submitted to the Abuse Intervention Committee.

DOJ response: The Abuse Intervention Medical Subcommittee is currently working on this issue as it relates to medical professionals. A second AIC subcommittee, Mandatory Reporting, was formed to review Delaware's statute. Drafted recommendations to improve reporter accountability have been developed.

Recommendation:

CDNDSC will send a letter to the hospital (highlighting the emergency services and radiology departments) involved with this child informing them of the failure of the emergency room personnel to make a report of suspected child abuse on 12/23/05. This letter shall include prior letters and request that a response with an action plan be sent to the CDNDSC. (CDNDSC Expedited Review, Letter to the Governor, 10/6/2006).

CDNDSC action taken or next steps: Letter was sent on 10/30/06.

Recommendation:

The CDNDSC shall request that the Abuse Intervention Committee review the current mandatory reporter laws of this State and other states to ensure Delaware's statutes are adequately protecting children. (CDNDSC Expedited Review, Letter to the Governor, 6/2/2006).

DOJ response: The AIC Mandatory Reporting subcommittee was formed to review DE's statute. Drafted recommendations to improve reporter accountability have been developed. These recommendations will be formally presented at the Joint Commission meeting on 10/12/07.

Recommendation:

DFS should establish a quality assurance process for reviewing rejected hotline reports given the repeated failures to adhere to established policies in this and other cases and the volume of reports that are rejected. (CDNDSC Expedited Review, Letter to the Governor, 6/2/2006).

DSCYF response: July 2007, DFS implemented quality assurance reviews for rejected hotline reports.

Recommendation:

DFS must ensure that employees are strictly following all policies and procedures during the hotline intake process, with particular attention to all risk factors, including family history, age of the child, emotional state of the caregiver and the status of the reporter with greater credibility assigned to professionals. The CDNDSC notes that this recommendation has been made previously on several occasions by this Commission and other review bodies. (CDNDSC Expedited Review, Letter to the Governor, 6/2/2006).

DSCYF response: DFS uses the case review quality assurance system to monitor the intake process and consideration of all risk factors; in July 2007, DFS implemented quality assurance reviews for rejected hotline reports as well. Reports on reviewer findings are circulated to regional administrators and program managers.

Recommendation:

DFS should review compliance with current DFS policies regarding new allegations of abuse and/or neglect in a case already open for DFS investigations or treatment. It is once again recommended, that when new allegations of abuse and/or neglect are called in to the child abuse report line, that a new hotline report be written. This will ensure that all available history presented to DFS will be available to the future possible worker. (CDNDSC Expedited Review, Letter to the Governor, 3/31/2006).

DSCYF response: Policies are in place to make a report when new allegations of abuse and neglect are made in an open treatment case. Our quality assurance case review system is used to monitor compliance with this policy. DFS produces and reviews monthly hotline report data which includes new abuse and neglect reports on open cases.

Recommendation:

DFS should stop accepting written Police bin reports in lieu of statutorily mandated oral reports. All reports of suspected child abuse and neglect are required to be made orally to DFS pursuant to Title 16 Del. C. § 904. The Memorandum of Understanding between DFS, Police, and the Attorney General's Office provides additional guidance to law enforcement officers on how to make a report of suspected child abuse and neglect. (CDNDSC Expedited Review, Letter to the Governor, 3/31/2006).

DSCYF response: DFS does not accept abuse and neglect reports via the police bin reports. These bin reports are used as collaborative information on open cases. Abuse and neglect reports are accepted orally or in person per Code. We agree the Law Enforcement MOU provides guidance to police reporting child abuse and neglect. DFS participates on the DOJ/Police MOU revision process.

Recommendation:

The Commission recommends that DFS review compliance with its current policy regarding new allegations of abuse and/or neglect in a case already opened for treatment or investigation. It is recommended that when new allegations of abuse and/or neglect are called in to the Child Abuse Report Line, that a Hotline Report be written. This will ensure that child safety is fully addressed. (CDNDSC Expedited Review, Letter to the Governor, 4/19/2005).

DSCYF response: In place Current policy requires a new report to be written regarding a new allegation of abuse or neglect. If the case is active in Investigation, the issues in the new report must be addressed. If the case is active in Treatment, the case will be assigned to an Investigation worker.

Recommendation:

Expand education and training on child abuse, child neglect and domestic violence to health care providers. (CDNDSC Expedited Review, Letter to the Governor, 10/24/2002).

DSCYF response: In place, See above, The AG's Abuse Intervention Committee has formed subcommittees to focus on 2 primary report sources: education and the medical community.

Recommendation:

Ensure compliance with 16 Del.C. Section 906 (b)(3) through training and supervision of all appropriate personnel in the child welfare community. (CDNDSC Expedited Review, Letter to the Governor, 10/24/2002).

DSCYF response: In place , See above.

Recommendation:

CDNDSC remains in support of the ongoing CPAC/CDNDSC multi- disciplinary use of history subcommittee. This subcommittee should continue to research a data management and retrieval system that would allow DFS and other partners to view history in a timeline or summary format. (CDNDSC Final Review, Letter to the Governor, 3/2/2007).

DSCYF response: DFS chaired the subcommittee workgroup on history. A chronological history summary event was approved by the CPAC subcommittee on history. DSCYF has recommended this initiative for FY09 funding.

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.

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Recommendation:

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. (CDNDSC Expedited Review, Letter to the Governor, 10/6/2006).

DSCYF response: DFS is in agreement.

Recommendation:

DFS should review current policy and practices regarding how case histories are reviewed and incorporated into decision-making and develop a standardized protocol regarding how case histories are used. (CDNDSC Expedited Review, Letter to the Governor, 3/31/2006).

DSCYF response: DFS chaired the subcommittee workgroup on history. A chronological history summary event was approved by the CPAC subcommittee on history. DSCYF has recommended this initiative for FY09 funding.

Recommendation:

DFS should create a data management and retrieval system that would allow DFS staff to view history in a timeline or summary format. (CDNDSC Expedited Review, Letter to the Governor, 3/31/2006).

DSCYF response: The sub-group developed a Chronological Historical Information function for FACTS. The Department and CPAC approved this function. As a result, funding for this initiative will be requested for FY09.

Recommendation:

Pursue development of policy and procedure that would enable appropriate and necessary utilization of DELJIS and PREMIS history by Division of Family Services' workers. (CDNDSC Expedited Review, Letter to the Governor, 10/24/2002).

DSCYF response: In place. See above.

Recommendation:

Even though item 6a of regulation # 3 of the Interstate Compact regulations exist, if a Delaware State agency is involved in any way, that agency should assure that the receiving guardian is not listed on the child protection registry or any other relevant registry. (CDNDSC Expedited Review, Letter to the Governor; 11/7/2003; Final Report to the Governor; same recommendation submitted, 5/5/2006).

DSCYF response: DFS is complying with the 2006 ICPC, Safe and Timely Interstate Placement Act, and the Adam Walsh Act to ensure that the background history and registry checks are completed prior to placement of DFS children.

Recommendation:

At the next national meeting at which the compact agreement is discussed, representatives from Delaware should state the Delaware agencies have adopted this suggestion as best practice and recommend that other states in the compact do the same. (CDNDSC Final Report to the Governor, same recommendation submitted, 5/5/2006).

DSCYF response: DFS is complying with the 2006 ICPC, Safe and Timely Interstate Placement Act, and the Adam Walsh Act to ensure that the background history and registry checks are completed prior to placement of DFS children. This issue has been presented to the AAICPC Executive Board and is under discussion for adoption as a best practice in interstate work across the country.

Recommendation:

The CDNDSC is also interested in exploring collaboration with the DVCC in reviewing child abuse deaths and promulgating system change when the child's death was not the direct result of domestic violence, but a significant domestic violence component was present in the family. (CDNDSC Expedited Review, Letter to the Governor, 10/24/2002).

CDNDSC action taken or next steps: The bi-annual joint review with the Domestic Violence Coordinating Council's Fatal Incident Review Team began in April 2007. ✤

Fire Prevention

Deaths Caused by Fire

In the United States, an estimated 2,500 children age 14 or younger are injured or killed in residential fires every year. (U.S. Fire Administration, 2002).

- Children make up 20% of all fire deaths.
- Every year children set over 100,000 fires. About 20,000 of those are set in homes.
- Children as young as age two can strike a match and start a fire.
- Over 30% of the fires that kill children are set by children playing with fire.
- Most child fire-play incidents involve matches or lighters. (www.med.umich.edu).

Recommendation:

The panel recommends the Commission to encourage support of, and participation of DE citizens in "Wake Up Delaware". The panel also recommends a letter be written to the schools in the fall reinforcing the need for mandatory fire safety education in grades K-6 as written in HB 57. The panel encourages primary care physicians to be more diligent in their fire safety education when undertaking anticipatory guidance as part of the routine physical exam. (FY04).

CDNDSC action taken or next steps: Articles in the DNA reporter and DE AAP newsletter can carry out the action step. The DOE representative and emergency room physician representative agreed to pursue the action plan.

Recommendation:

CDNDSC should contact a specific municipality to determine what responsibilities the building inspectors have when receiving smoke detector complaints. DFS should add smoke detectors to their DFS home environment safety screening guidelines. (FY05).

CDNDSC action taken or next steps: A letter was sent to the specific municipality.

DSCYF response: DFS' home environment safety screening guidelines includes fire related hazards. DFS does not access the presence of smoke detectors as an independent factor but may be considered with other fire hazards such as free standing kerosene heaters. ✤

Injury Related Deaths

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. Each year, approximately 140 children in the United States are killed as bicyclists. (National Center for Injury Prevention, WISQARS Fatal Injuries: Mortality Reports, 2005).

Recommendation:

Panel reinforces use of helmets in high-risk behaviors as well as the need for adult supervision. (FY03).

Recommendation:

DELDOT should reinstitute the State Bureau of Aeronautics to oversee the safety and operations of private airports and airstrips. (FY06).

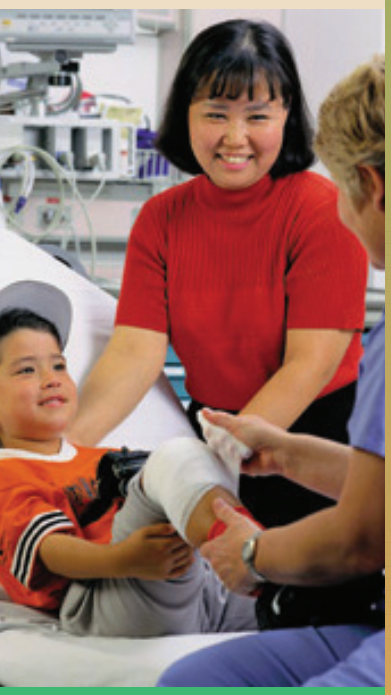
CDNDSC action taken or next steps: The National Transportation Safety Board sent a letter to the Delaware Department of Transportation copying the Commission and Dr. Fran Franklin who is the K/S Panel Chair.

The letter asked:

- *What types of inspections have been conducted or plan to be conducted of private take off and landing areas?*
- *What actions, if any, has the State of Delaware made to modify the Delaware State Code?*
- *What plans, if any, require standards and needs for reinforcement of regulations for licensing, construction, establishment, realignment, alteration, activation and deactivation of all private takeoff and landing areas?* ✤

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.

Panel strongly supports that all infants have the right to a medical home visit and suggest exploration be made to investigate how all infants can be assured of a 2 week after delivery visit. Public Health referral only occurs if concern is raised.



Medical Concerns

Recommendation:

1. Affirmed the DSCYF recommendation of the development of a transfer of information form.

2. Recommend to CDNDSC that a letter be sent to hospital emergency rooms to make them aware of the need for children in placement to have new prescription if the dosage is changed.

   CDNDSC action taken or next steps: CDNDSC sent a letter to the emergency rooms regarding the need to write new prescriptions when a dosage is changed.

3. Recommend DSCYF send a letter to placement contractors re: the need for new prescriptions if dosage is changed and to educate department and contractor staff on this practice. (FY03).

   DSCYF response: The Department implemented the Transfer Instruction Sheet effective August 2004 – revised July 2006. Placement contractors were trained on the use and provided Copies of the Transfer Instruction Sheet. The Transfer Instruction Sheet is designed to provide the most accurate and current information regarding a child's school, medication, and other medical, emotional, or behavioral information. The Transfer Instruction Sheet would accompany a child/youth when: (1) entering contracted residential placement or foster care; (2) moving from one residential program to another; (3) returning to the community from residential placement; or (4) going on a home pass or visit or respite care.

Recommendation:

Documentation should follow the standards/protocol outlined in the EDIN Manual to ensure consistency and detail in describing actions taken. Recommendation to be presented to the CDNDSC and if approved requested the Commission Chair send a letter to the EMS Director addressing this recommendation. (FY03).

The Division of Public Health response: The letter was received by the Director of EMS, and an EMS representative has been serving on each of the panels. Marie Renzi, EMSC, and Dr. Megargel sit on NCC and Dr. Bristowe sits on Kent/Sussex panel.

As for the EDIN reference, there was a case over a year ago that was reviewed where Medics did not follow protocol properly, so the documentation in the report was not sufficient. The EDIN manual is a technical data manual and doesn't contain protocols that deal with documentation. There is a general statement in the Paramedic Protocols about proper documentation, not in the EDIN manual. The recommendation should be modified to replace the EDIN manual reference with Paramedic Protocols but as noted, this is already included in said protocols.

Recommendation:

1. Continued support of incentive programs and recommends increased public awareness of career opportunities within nursing and support for financial assistance for nursing educational programs.

   CDNDSC action taken or next steps: Take recommendation to the Health Care Commission.

2. Panel recommends consideration of the expansion of the Child Watch (or similar) program to provide services for older children with special medical needs.

   CDNDSC action taken or next steps: The Emergency Room Physician Representative will present the recommendation to and request some funding from the Emergency Medical Services for Children Coalition. The Public Health representative will review within DPH.

The Division of Public Health response: DPH has not received this request. This requires more specificity. Delaware Health and Social Services Division of Management Services owns this grant. Request to expand the program should be addressed directly to the Division Director. DMS receives the federal grant for CDW (Birth to Three Program). DPH receives a portion of the grant from them. DPH has the responsibility to assess children and determine eligibility. This is done through our own staff as well as through contractual agreements with CCHS and other agencies. DPH and several other agencies (DOE, DDDS, DFS) who collaborate with us provide the service coordination for each child from program entry to age 2.5 years when they are transitioned to the school districts. DMS contracts with providers in the community to provide the needed developmental services through age 3 years. There is a long standing interagency agreement that established CDW.

3. Recommend an internal review of the quality assurance system within Medicaid to verify actual service provision versus service authorized. Action plan: The Public Health representative will present recommendation to Delaware Health and Social Services. (FY03).

The Division of Public Health response: Medicaid has a Quality Improvement Initiative (QII) and hosts monthly meeting to which DPH sends a representative. The request should be made by Executive Director of Commission directly to Director of Division Medicaid and Medical Service, Mr. Harry Hill.

Recommendation:

Continue to support sex education in schools and programs that teach and encourage parents how to talk with their children. (FY03).

Recommendation:

Public Health should educate the community on hypothermia and dehydration in infants. (FY03).

Recommendation:

Panel strongly supports that all infants have the right to a medical home visit and suggest exploration be made to investigate how all infants can be assured of a 2 week after delivery visit. Public Health referral only occurs if concern is raised. (FY03).

The Division of Public Health response: The Home Visiting Program for First Time Parents supports a home visit to first infant in a family. This nursing visit is covered by Medicaid, by private insurance or by a visit by a Public Health Nurse, if uninsured or not covered. Infants that are considered high-risk medically can be visited by a nurse either through private insurance, Medicaid or through Public Health. Public Health also accepts referrals for infants at risk due to psycho-social family issues or home environment issues. There are not sufficient resources to provide a post–delivery visit to all 10,000 births annually. Infants should be seen by a physician or medical provider at appropriate intervals. Recently, BCBS of DE decided that they will only pay for those with medical risks. Medicaid contractors pay for these services currently. This has been in place since the inception of the program. Again, coverage depends on the insurance, but several of the large ones are only covering the medically at risk now.

Recommendation:

Broader well baby care education to incorporate family members, such as siblings who will be participating in infants care. (FY04).

Recommendation:

CDNDSC recommends that the pathology be sent to the emergency room (of this case) for their review (to see if there is anything different, they could do in the future). (FY04).

CDNDSC action taken or next steps: CDNDSC sent a letter to the Chief of the Department of Pediatrics of the hospital outlining panel concerns but without containing case identifying information.

The panel recommends that upon a child's admission to a mental health facility, as part of their discharge planning the parent or Caregiver be requested to sign a release form for information for the child's discharge plan to go to the child's school wellness center or school's health care agent. In addition, if the school has a wellness center the parents are requested to sign permission for participation in the wellness center, so the child can be assessed following discharge.

A system should be put in place that allows physicians timely access to their patients Hospital and Emergency Room Records.

MEDICAL CONCERNS *(continued from page 21)*

Recommendation:

The panel recommends that upon a child's admission to a mental health facility, as part of their discharge planning the parent or Caregiver be requested to sign a release form for information for the child's discharge plan to go to the child's school wellness center or school's health care agent. In addition, if the school has a wellness center the parents are requested to sign permission for participation in the wellness center, so the child can be assessed following discharge. (FY04).

The Division of Public Health response: Hospitals must ensure that patients receive proper post-hospital care within the constraints of the hospital's authority under State law and within the limits of a patient's right to refuse discharge-planning services. While this recommendation is an attempt to coordinate care across organizations, without legislative action, this would have to be a voluntary procedure by the mental health facility. In addition to requesting a signature on a form, the facility would have to provide information, explanations, consequences and options in order for the parent to make an informed decision. Since this recommendation involves protected health information, and since the rules regarding Individually Identifiable Health Information would apply, it would need to be made clear to the parents that they have a choice whether to sign the release or not. It is not clear within the recommendation whether the mental health facility would be responsible for requesting that the parents sign permission for participation in the wellness center or whether this would be a wellness center responsibility.

Recommendation:

Support improved education related to asthma and risks and the need for treatment. (FY04).

Recommendation:

1) Children with multiple chronic issues should be covered by an insurance that streamlines their attainment of having medical needs met in a prompt fashion.

2) Institutions caring for children with serious, chronic medical conditions should have action plan for the care of changes in the child's condition. (FY05).

Recommendation:

The CDNDSC should send a letter to all hospitals recommending that when a child has surgery in one hospital and dies within 30 days in another hospital, the hospital where the surgery was done be notified so their Morbidity and Mortality committee can review the case. (FY05).

CDNDSC action taken or next steps: A Morbidity and Mortality review was completed on this case.

Recommendation:

A public health system needs to be in place to ensure that required vaccines, such as recommended by CDC, are available for distribution and to dispense. Panel Action Plan: The Public Health Representative will see if the "Growing Together" packet for parents of infants includes information about the need for the Prevnar vaccination. (FY05).

The Division of Public Health response: The immunization program has determined that the entire immunization piece is outdated and requires a complete re-write. What little immunization information is in the packet, is not current and does not reflect ACIP guidelines. The small journal (Growing Together - Health Journal copyright 1986 - 2004) has only a single 3 in X 5 in page which discusses immunizations and the information is not a reflection of

current immunization recommendations. Additionally, the journal provides a chart that can be filled out when immunizations are received but the chart does not contain a list of current recommended vaccines.

The immunization program will work on revising the presentation of the entire vaccine info within the package. The immunization program director will work with the birth to three programs to revise the presentation of the entire vaccine info within the package by January 30th 2009.

Recommendation:

Earlier intervention in pregnancies is an issue. The CDNDSC should track cases where this is an issue. (FY05).

CDNDSC action taken or next steps: The FIMR program will be capturing all of this data through the new database (BASINET).

Recommendation:

Institutions caring for children with serious, chronic medical conditions should have an action plan for the care of changes in the child's condition. (FY05).

Recommendation:

The New Castle County Panel will compose a letter for AI duPont Hospital for the children's internal review board to request review of this case. (FY06).

CDNDSC action taken or next steps: The New Castle County Panel chair completed this letter.

Recommendation:

The CDNDSC should send a letter to AI duPont hospital for the Children's Medical Director, suggesting that for future cases when questions arise in regards to the neurological status or withdrawal of life support that the Ethics Committee of the hospital be consulted. (FY06).

Recommendation:

A system should be put in place that allows physicians timely access to their patients Hospital and Emergency Room Records. (FY06).

Recommendation:

1. Delaware licensing and Certification Survey Team or some other designated group of surveyors must monitor and review all care given to super skilled children whether they are financially covered by Delaware Medicaid or another state's Medicaid. Surveys need to be conducted on a regular basis.
2. Facilities must provide properly trained staff in sufficient volume. Mandatory staff should include Advance Cardiac Life Support Pediatric Certified Nurses and a respiratory therapist.
3. Facilities must provide sufficient numbers of supervisors on staff to oversee direct care for at risk children to prevent problems.
4. Facilities must provide adequate administrative oversight, including analysis of accidents and plan to prevent reoccurrences.
5. Facilities must provide proper equipment including well stocked pediatric emergency drugs, pediatric defibrillators, and cardiac monitors.
6. Facilities must have an emergency plan to implement a full code and plan to transport the child to an appropriate hospital for emergency care as necessary.
7. Facilities must provide regular maintenance for all equipment involved in caring for children and able to supply a backup if necessary in a timely manner.
8. Treatment plans should be visible at all times to medical professionals involved in patient care. This acute care life plan should be very detailed and properly displayed.
9. Delaware Health and Social Services should develop a pediatric long term care regulatory body of regulations. (FY07). (Recommended in four cases).

The Division of Public Health response: Pediatric LTC regulations do exist & are under the authority of the Division of Long Term Care Residents Protection (DLTCRP), not the Division of Public Health, Office of Health Licensing and Certification. The OHLC does not conduct surveys in pediatric LTC facilities. ✤

Miscellaneous Recommendations

Recommendation:

Recommend gun safety be given at school (two separate cases). (FY03).

The Department of Education response: Gun Safety is a part of Risk Watch, our recommended and prevalently used curriculum.

Recommendation:

Develop a central database or other tracking mechanism to record Delaware child death trends. (FY03).

CDNDSC action taken or next steps: The CDNDSC now utilizes the national child death data tool database available through the National Maternal Child Health Center for Child Death Review.

Recommendation:

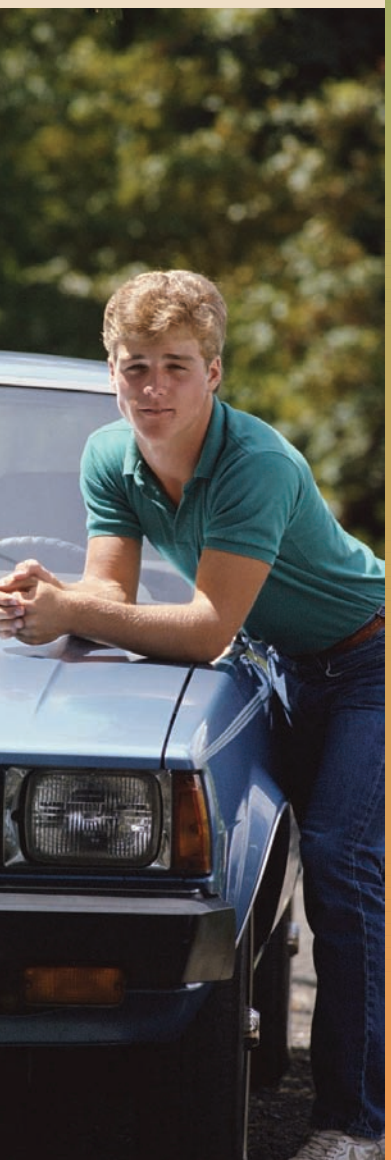
The Department of Agriculture should be approached to mandate that stores selling cold blooded reptiles, or food for same, post warning signs about the dangers of Salmonella. (FY03).

CDNDSC action taken or next steps: The CDNDSC sent a letter to the Department of Agriculture supporting more requirements for establishments selling reptiles to present warnings on exposure to Salmonella.

Recommendation:

It is recommended that an ordinance be implemented for dangerous dogs. A special fine should be enacted if the dangerous dog is involved in injury. There is also a need for owners of dangerous dogs to carry insurance to cover potential injuries. Schools should provide animal safety training to children. (FY04). ✤

Each year in the United States, an estimated 2,446 children age 14 years and under die in a motor vehicle incident.



Motor Vehicle Crash Prevention

Deaths Caused by Motor Vehicle Injury

Each year in the United States, an estimated 2,446 children age 14 years and under die in a motor vehicle incident. (National Center for Health Statistics, 2007).

In 2007, traffic deaths fell to the lowest level in eight years following a 20% decline from the previous year (Del. Traffic deaths at lowest level since '99', the Delaware News Journal article, January 3, 2008). However, the Panels continued to review adolescent motor vehicle crashes where speed and aggressive driving were contributing factors in the deaths.

In a focus group, teens mentioned the following issues as impairments for safe driving: (Teen Unsafe Driving Behaviors, U.S Department of Transportation, September 2006).

- Driving drunk (or impaired by drugs)
- Talking on cell phones
- Fooling with radio or CD player or getting caught up in the music
- Road rage
- Drowsy driving
- Speeding
- Driving "old"
- Talking to friends in the back seat
- Failure to signal lane changes
- Street racing (different from driving over the speed limit)
- Putting on makeup (mentioned by more males than females)
- Other distractions such as eating and flirting with girls

Recommendation:

The panel encourages the continuation of aggressive defensive driving education to all high school age children, such as the SLAM (former New Castle County program) that have a proven efficacy. (Recommended in two separate cases). (FY03).

Recommendation:

Continued support of driver's education in high schools and consideration of inclusion of defensive driving course components if not already in place. Panel also recommended that DOE consider incorporating simulators in driver's education curriculum. Possible funding resources included insurance companies, automotive companies, and public funding through tobacco monies. (FY03).

Recommendation:

Continued support for education for street safety. (FY03).

Recommendation:

Panel continues to emphasize the importance of seat belt use, graduated license, and driver's education including use of drugs being in conflict with driving. (Recommended in two separate cases). (FY03).

Recommendation:

Panel encourages the continuation of funding of programs that are designed to keep kids safe, i.e., how to properly install car seats. *Panel Action plan:* to encourage various groups involved in outreach programs to focus on car seat safety such as church outreach, University of Delaware, Safe Kids coalition and State Police. (FY03).

Recommendation:

The panel recommends continued driver education and awareness. Adolescents should be encouraged to follow the law and wear seat belts. (FY03). (Recommended in two separate cases).

Recommendation:

1. Children should be taught to "Look, listen: Cross at appropriate place".
2. Parents and children should be provided safety information when they go back to school in the fall and throughout the year. (FY03).

Recommendation:

1. There should be stiffer penalties for habitual DUI.
2. Evaluate rehab programs for substance abusers.
3. Stacking penalties should be questioned that occur during probationary period. (FY03).

Recommendation:

Consider stiffer penalties for 2nd offenses for improper restraint of a child. (FY04).

CDNDSC action taken or next steps: Legislation for stiffer penalties for a 2nd offense of improper restraint of a child was being drafted by the Attorney General's office for increased penalties for the first offense. This legislation did not pass the legislature and will be reintroduced in the future.

Recommendation:

The Commission should continue to support the new legislation that is enhancing the graduate licensing. It was also suggested that a course might be developed that would involve some type of virtual driving skills for the defendant/driver to participate in as well as community service involving contact with victims from auto accidents. (FY04).

Recommendation:

Increase the public's knowledge and awareness of the need to have child car seats assessed for correct installation, as well as availability of where these services are available. (FY04).

CDNDSC action taken or next steps: Ask the Delaware Safe Kids Coalition to present information on what is available for the community. A future public awareness campaign may be needed. The Director of the Office of Highway Safety presented information on child safety seat programs as part of the action plan. These are 4 areas the program addresses:

1. *Certification of Technicians: This is a National course that began in 1996 and consists of 4 days of training with an exam at the end. This certification must be maintained on a yearly basis. Delaware currently has 250 technicians.*
2. *Fitting stations: There are currently 4 permanent fitting stations located at NCC EMS, NCC PD, CCHS, and Wilmington DMV. There is also one at the Dover DMV. Anyone can call and schedule a time for a car seat check. Car seat checks find that 86% are improperly installed.*
3. *Educational: Information is provided to community groups, parents, daycare providers, childbirth classes, health and safety fairs, etc.*
4. *Partnerships with other state agencies: A loaner car seat program is available through the State Service Centers (pay $20 for 1 year and return seat and get $10 back). Some free seats are available for special cases. Also are partnering with WIC and Head Start to provide booster seats.*

Information regarding the proposed changes with HB 365 and SB 244 were also presented to the New Castle County Panel. HB 365 was currently being revised to take out the clause that would dismiss charges if the violator presents a car seat at the court appearance. The director also updated the panel on teen driving and 4 major changes being proposed in SB 244 including:

1. Besides supervisor with driver, only - **1** passenger allowed.
2. Restricted use of cell phone.
3. When license is suspended or revoked that period of time will be extended to the GDL.
4. All passengers must be belted.

The Division of Public Health response: The last WIC car seat giveaway was done in 2004 in coordination with the Office of Highway Safety. There are no funds or plans at this time to continue this initiative.

Consider stiffer penalties for 2nd offenses for improper restraint of a child.

MOTOR VEHICLE CRASH *(continued from page 25)*

Passengers in the car are an issue with teen drivers. The CDNDSC should develop a workgroup to look into adolescent motor vehicle collisions and demographics related to graduated licenses.

Recommendation:
Support HB 365. In addition recommend the fine be increased to $100 from $28.75 for violation of child safety seat and such revenue is directed back into the car seat program. (FY04).

CDNDSC action taken or next steps: The Commission sent a letter to the legislature supporting HB 365. The bill passed the House of Representatives on 5/6/04. However, it was assigned to the Senate Public Safety Committee and reported out on 5/12/04, but did not proceed to a vote in the Senate.

Recommendation:
Continue to support education related to teenage driving; determine if there is any pending legislation to increase the restrictions on graduated driving privileges for teen drivers and support if there is legislation; review how motor vehicle violations of drivers under age 18 are handled by courts and the number of points that can be accumulated as a minor and still maintain a license; recommend DMV identify a subdivision to monitor teenage drivers with violations. (FY04).

CDNDSC action taken or next steps: HB 363 and SB 244 increasing restrictions on young drivers did not pass the legislature and a separate bill passed giving more freedom to young drivers. The letter from the Commission to support the bills was not sent by the Commission chair because when received the session had ended. The Commission agreed to keep the issue of supporting legislation for increased restrictions on graduated licenses on the agenda. There was discussion that letters supporting legislation should be sent out promptly and the new executive director will review legislation and report legislation of interest to the Commission.

Recommendation:
The CDNDSC should support SB 244 and HB 363. (FY04).

CDNDSC action taken or next steps: See above response.

Recommendation:
Passengers in the car are an issue with teen drivers. The CDNDSC should develop a workgroup to look into adolescent motor vehicle collisions and demographics related to graduated licenses. (FY05). (Recommendation put forth in two separate cases).

Recommendation:
The CDNDSC supports SB 117 restricting the number of passengers in car with a driver with a permit. (FY05).

Recommendation:
The CDNDSC should explore statistics and best practices regarding testing for driver's licenses. (FY05).

CDNDSC action taken or next steps: This along with other issues regarding teenage driving will be evaluated and researched at the proposed CDNDSC teenage driving subcommittee.

Recommendation:
DELDOT should assess the intersection at Owls Nest Road and Fox Run Circle for the possibility of a four way stop. (FY06).

Recommendation:
The CDNDSC should continue support of national safety programs such as "Safe Kids" and the need for public awareness of these programs through media coverage such as the News Journal, the radio, etc. (FY06).

Recommendation:
The CDNDSC should revisit and discuss the pending six legislative bills regarding teenage driving. (FY06). (Recommendation put forth in three separate cases).

Pool and Water Safety

Deaths Caused by Drowning

Approximately 830 children ages 14 and under, die as a result of unintentional drowning every year in the United States (National Center for Health Statistics, 2007). A drowning can be quick and silent. In ten seconds, a child can be submerged, in two minutes a child can lose consciousness and in four to six minutes, a child who is submerged can suffer permanent brain damage. (National Safe Kids Campaign).

Drowning Prevention Suggestions:

- NEVER leave a baby alone in a bathtub even for a second. Always keep the baby in arm's reach.
- NEVER leave young children alone or with young siblings in a bathtub even if you are using a bath seat or ring. Children can drown quickly and silently.
- Keep the toilet lid down, and keep young children out of the bathroom when unsupervised. Consider placing a latch on the bathroom door out of reach of young children.
- Be sure all containers of liquids are emptied immediately after use. Do not leave empty containers in yards or around the house where they may accumulate water and attract young children.
- Always secure the safety cover on your spa or hot tub.

Recommendation:

CDNDSC should explore guidelines governing public pools: staffing requirements and configurations of staff. (FY03).

CDNDSC action taken or next steps: This is currently being reviewed by the CDNDSC staff during FY08.

Recommendation:

The Panel supports ongoing recommendation for appropriate configuration for safety practices of swimming pools in the public domain. (FY03).

Recommendation:

1. The Division of Public Health should review the public pool requirements and consider opportunities to reinforce appropriate signage requirements.
2. Periodically, there should be public notice to inform parents of their responsibility of supervising their children and the consequences of leaving them unattended.
3. The Attorney General's office in collaboration with the Delaware Children's Department and Department of Health and Social Services will draft the language of the notice.
4. There should be seasonal public notification of the importance of adult supervision and water safety. (CDNDSC Expedited Review, Letter to the Governor, 7/3/2003).

DSCYF response: In process, The Attorney General's office in collaboration with the Department of Services for Children, Youth and Their Families and Department of Health and Social Services will draft the language of the notice.

The Division of Public Health response: State Law exempts lifeguards at hotels/motels; not the DPH regulations. In response to that exemption, the current pool regulations in Section 7.8 require signage to be posted at these exempt pools. This signage is inspected as part of the post-construction inspection of every pool (as applicable) that is made prior to any pool given a permit to operate and during each operational inspection. The current public pool and spa regulations already address this concern, and meet this recommendation.

Recommendation:

Assess public safety and the need for posting of warning signs in the town of Blades. (FY04).

CDNDSC action taken or next steps: CDNDSC sent a letter to the Mayor of Blades regarding the posting of warning signs. The Mayor of Blades responded to the letter sent by the CDNDSC reporting the efforts made to post warning signs and advising of other jurisdictions involved. The CDNDSC sent similar letters to the other jurisdictions involved in this area where the drowning occurred and also a letter to Blades thanking them for their response. The Norfolk Southern Corporation will cooperate with the involved towns to allow them to post warning signs.

Recommendation:

Manufacturers should include pool alarms in all pool kits. Pools should not be filled until required fencing, locks, and alarms are in place. CDNDSC should continue to support education about pool safety, including at places selling pools. (FY05). ✤

The CDNDSC should track co-sleeping and couch sleeping cases. The CDNDSC should develop a workgroup to develop a plan for addressing the issue of co-sleeping.

SIDS[3] And Infant Safe Sleeping

SIDS rates have declined by more than 50% since 1990, due to the national Back to Sleep campaign focused on reducing prone sleeping. However, studies have shown that since 1999, some deaths previously classified as SIDS are now classified as "accidental suffocation or undetermined". This finding suggests that changes in the reporting of cause of death may account for part of the recent decrease in SIDS rates (Department of Health and Human Services, Centers for Disease Control/CDC). Nationally, the CDC will classify all of these deaths as "SIDS" if the following are written on a death certificate;

- Cot Death
- Crib Death
- Sudden Death in Infancy or SDII
- Sudden Infant Death or SID
- Sudden Infant Death Syndrome or SIDS
- Sudden Unexplained Death or SUD
- Sudden Unexplained (Unexpected) Death in Infancy or SUDI
- Sudden Unexplained Infant Death or SUID
- Sudden + (unexpected) or (unattended) or (unexplained)
- Death + (cause unknown) or (in infancy) or (syndrome)
- Infant Death + (syndrome)
- Presumed SIDS
- Probable SIDS
- Consistent with SIDS

Risk Factors Associated with SIDS

The Panels no longer determine preventability in these cases, but risk factors continue to be tracked since the etiology of SIDS is still unknown.

Some of the risk factors or common denominators that are tracked by the CDNDSC include the following:

- Smoking in the household
- Sleeping on side/stomach
- Co-Sleeping
- Co-Sleeping with an obese adult
- Soft bedding
- Fever infection/cold
- Late or no prenatal care
- Prematurity
- Animal in the home
- Drug/Alcohol usage by adult caretaker
- Race
- Teen mom

[3]SIDS is a medical definition to describe an infant under 12 months, (over 12 months the death would be classified as SUDS/Sudden Unexplained Death Syndrome) whose unexplained cause of death has been carefully evaluated by death scene investigation, autopsy, and medical history review.

Safe Sleeping for Your Infant

It is not surprising that many parents are confused regarding safe sleeping practices for their infant. Guidelines continue to evolve and have even changed since the last CDNDSC annual report. Providing a safe sleeping environment for your infant is extremely important for the safety of your baby. In January 2006, the American Academy of Pediatrics issued updated guidelines regarding safe sleeping.

Recommendation:

The CDNDSC should ensure that there is easy access to cribs for a home that does not have a crib. (FY05).

CDNDSC action taken or next steps:
Through case reviews, access to cribs has not been the problem but utilization of the crib by the parent or caretaker.

Recommendation:

The CDNDSC should track co-sleeping and couch sleeping cases. The CDNDSC should develop a workgroup to develop a plan for addressing the issue of co-sleeping. (FY05).

CDNDSC action taken or next steps: At the May 2006 Joint CPAC/CDNDSC meeting a community action team was charged with the following mission: To evaluate programs, task forces and educational awareness campaigns around safe sleeping practices education in Delaware and make a recommendation for creation, improvement or merging of initiatives to address the current number of SIDS deaths with sleeping practices factors.

The following recommendations were submitted to the Commissions:

1. The Office of Child Care Licensing and the Division of Family Services should continue to include the most updated information available on safe sleeping practices as part of the Department's core curriculum for foster care training and childcare providers.

   DSCYF response: Revised Rules for Early Care and Education and School Age Centers became effective January 1, 2007. Proposed revised Rules for Family Child Care Homes and Large Family Child Care Homes have been put forth for public comment. It is anticipated that these proposed Rules will be adopted and will become effective July 1, 2008. All three sets of Rules include Safe Sleeping Practices based on the recommendations of the American Academy of Pediatrics and "Caring for Our Children". Consultation on wording and content of these Rules was held with The Safe Sleeping Practices Subcommittee. Adherence to these Rules is monitored through Compliance Visits that occur no less than annually.

   At all orientation meetings for individuals/organizations interested in conducting child care, the importance of safe sleep practices is emphasized and all are provided brochures on this topic, produced by the National Institute of Child Health and Human Development.

   Family Services is an active participant in the joint CPAC/CDNDSC Subcommittee on safe sleeping practices and supports distribution and promotion of pertinent information.

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.

SIDS *(continued from page 29)*

The Center for Maternal and Child Health Excellence and the Delaware Healthy Mother Infant Consortium should include, as part of its statewide educational campaign on improving birth outcomes, safe sleeping practices information, and specifically target that information to minority communities.

2. The Child Death, Near Death, and Still Birth Commission (CDNDSC), the Delaware SIDS Coordinator, and the Delaware SIDS Affiliate, should jointly develop a Safe Sleeping Practices website or link under the CDNDSC website. This website should include a preventive message as well as links to other state and national organizations that promote the health and well-being of infants.

   CDNDSC action taken or next steps: The CDNDSC website has been created and CDNDSC will continue to monitor the Safe Sleeping Practices section in collaboration with the Delaware SIDS Affiliate, the Delaware SIDS Coordinator.

   The Division of Public Health response: Delaware SIDS Coordinator, from the DPH, is participating on committee to address Safe Sleeping Practice.

3. The Joint Commissions should identify an organization/program to develop and coordinate a statewide hospital education campaign on safe sleeping practices. This campaign should include guidelines for safe sleeping practices for use by pediatric healthcare providers.

   CDNDSC action taken or next steps: In process.

4. The Center for Maternal and Child Health Excellence and the Delaware Healthy Mother Infant Consortium should include, as part of its statewide educational campaign on improving birth outcomes, safe sleeping practices information, and specifically target that information to minority communities. To achieve this goal, the Center should coordinate outreach efforts with community organizations such as, but not limited to, the DE SIDS Affiliate, SIDS Alliance of the Mid-Atlantic, the Resources Mothers Program, Nemours Health and Preventive Services, Christiana Care Health Systems and other hospitals, the Bayard House, Ministry of Caring, Delaware Ecumenical Council, and other similar organizations.

   The Division of Public Health response: DHMIC and Center for Maternal and Child Health Excellence are working on a contract to transfer $10,000 to CDNDSC to fund this campaign.

5. The Fetal Infant Mortality Review (FIMR) Community Action Teams are directed to research national outcome studies on "Campaign for Cribs" programs and, if national data recommends this strategy, the Community Action Teams should develop and implement a Delaware Campaign for Cribs program, modeled after a similar initiative from SIDS of Pennsylvania called, "Cribs for Kids".

   CDNDSC action taken or next steps: The "Campaign for Cribs" was researched by the Safe Sleeping Practice Subcommittee and it does not appear to be efficacious for Delaware's population at this time. In most of these cases reviewed by the Child Death Panels, the family owned a bassinet or crib but decided not to use it.

6. The CDNDSC legislative subcommittee should research state SIDS/Safe Sleeping Practices legislation and, if necessary, report to the CDNDSC by April 2007 or earlier with proposed legislation to be implemented in Delaware.

   CDNDSC action taken or next steps: National research was conducted by this subcommittee. However, proposed legislation has not yet been discussed. ✣

Suicide

The Delaware Child Death Review Panels continue to review cases where suicide was predominantly by means of a firearm. Some of the risk factors seen in these cases involve: school troubles, mental health issues, and a recent significant relationship ending.

Recommendation:

1. A formal means of communication between agencies and identification of a lead agency to prevent gaps in information is needed. Panel Action plan: DSCYF will take lead with their Systems of Care initiative.
2. Panel concurred with recommendations resulting from DSCYF/RCA[4] . Memorandum of Understanding with the schools could build on this. Panel Action plan: DSCYF is implementing the Root Cause Analysis as outlined in the Lessons Learned document.
3. If a child is being referred to an emergency room by either school or wellness center personnel, for either suicidal ideation or attempt, the following is recommended: School personnel should contact 911; and the referring agency must speak to the ER physician or psychiatric professional to inform them of the referral and any pertinent issues. Panel Action plan: The DOE representative will present recommendation to the Department of Education and develop an action plan. The Public Health representative will present the recommendation to the Division of Public Health and develop an action plan.
4. Children's Justice Act is looking at a mass media campaign regarding mandatory reporting. The Panel recommends the CDNDSC support this effort. Panel Action plan: To be presented to CDNDSC with request for support.
5. Review and determine if all school staff (including volunteers and contractors) are aware of the mandatory reporting law. Panel Action plan: The DOE representative will review and present at next meeting.
6. Sexual abuse training is needed for all DFS staff and then more extensive training for treatment workers. Panel Action plan: Included in the DSCYF Root Cause Analysis recommendations see recommendations # 2 above.
7. Education regarding suicide precautions is needed for all. Panel Action plan: Each agency represented on the K/S CDR panel will bring to the table what training currently exists-bring to the next panel meeting.

DSCYF response: Sexual abuse training for all staff was provided in 2005 by a licensed clinical therapist whose practice includes children who have been victims of sexual abuse. Additionally, an overview to sexual abuse is given in DFS new worker core training. A day of treatment training was added to new worker training in 2005.

8. Information on the McKinney Homeless Act and its implication on Foster Care placement will be shared with education staff and case workers. Panel Action plan: The DOE representative will work with DOE staff to disseminate information re: the McKinney Homeless Act and its implications to the school districts. The DOE representative will provide information to the DSCYF representative. The DSCYF representative will present information to DSCYF.

DSCYF response: Joanne Miro (former Educational Associate for School Improvement) did a PowerPoint presentation at an April 2006 statewide management meeting. McKinney-Vento has also been discussed in the Investigation Work Group. A distinct section detailing McKinney-Vento has been added to the pending revisions of the DSCYF – DOE - Local Education and Charter School MOU.

9. Issues of lack of case management follow up, need for suicide precautions during and at time of discharge, changing workers related to county lines once assigned and the lack of outpatient follow up by Rockford Center after an acute suicidal attempt will be addressed. Panel Action plan: The DSCYF representative will review the issue of case assignment with DSCYF. The Public Health representative will consult with the Office of Facility health licensing regarding requirements for discharge planning. (FY03).

The Division of Public Health response: See prior comment on discharge planning.

[4]DSCYF Recommendations & Improvement Plan:

1. Emphasis should be placed on matching workers' skills and competencies with the needs of the individual case. This would require advanced training in specialized areas e.g. sexual abuse, depression/suicide in addition to reasonable caseload sizes.
2. Emphasis should be placed in/on implementing existing policy on Interdivisional Planning/Case management and breaking down the barriers i.e. high case load, competing priorities, divisional barriers etc… that are impediments to policy implementation.
3. Explore the possibility of developing a MOU with wellness centers and incorporating them in our treatment continuum.
4. Continued support of the MOU developed regarding utilization of the CAC.

Summary of Improvement Plan:

- Revise Department Policy addressing Integrated Service Planning
- Provide Departmental Training
- Explore FACTS upgrade to provide tickler to divisions already active when the child/family becomes active with a sister division
- Develop CAC protocol
- Explore current agreements/MOU between Wellness Centers/DPH/DOE

Criteria for Cases to be Reviewed FY03-FY07

- 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 not withstanding 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.

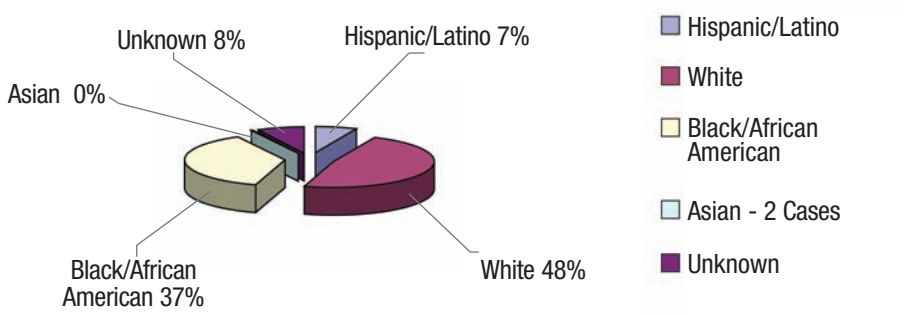
Data From Cases Reviewed During FY03-FY07

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.)

Demographics (Ethnicity/Race and Age Group by Sex)
Fiscal Review Year Range: 2003 to 2007 All Cases Reviewed

Ethnicity	Age Group	Male	Female	Unknown	Total
Hispanic /Latino (any race)	< 1 Year	15	12	0	27
	1-4 Years	1	4	0	5
	5-9 Years	1	1	0	2
	10-14 Years	0	1	0	1
	15-17 Years	4	1	0	5
	Unknown	0	0	0	0
	Subtotal	**21**	**19**	**0**	**40**
Race					
White	< 1 Year	94	69	4	167
	1-4 Years	14	12	0	26
	5-9 Years	11	11	0	22
	10-14 Years	13	7	0	20
	15-17 Years	32	18	0	50
	Unknown	1	0	0	1
	Subtotal	**165**	**117**	**4**	**286**
Black, African American	< 1 Year	93	68	1	162
	1-4 Years	11	12	0	23
	5-9 Years	6	4	0	10
	10-14 Years	7	3	0	10
	15-17 Years	12	5	0	17
	Unknown	1	0	0	1
	Subtotal	**130**	**92**	**1**	**223**
Asian	< 1 Year	0	2	0	2
	1-4 Years	0	0	0	0
	5-9 Years	0	0	0	0
	10-14 Years	0	0	0	0
	15-17 Years	0	0	0	0
	Unknown	0	0	0	0
	Subtotal	**0**	**2**	**0**	**2**
Unknown	< 1 Year	13	13	0	26
	1-4 Years	2	4	0	6
	5-9 Years	2	1	0	3
	10-14 Years	0	2	0	2
	15-17 Years	4	3	0	7
	Unknown	0	0	1	1
	Subtotal	**21**	**23**	**1**	**45**
All Races	< 1 Year	200	152	5	357
	1-4 Years	27	28	0	55
	5-9 Years	19	16	0	35
	10-14 Years	20	12	0	32
	15-17 Years	48	26	0	74
	Unknown	2	0	1	3
	Subtotal	**316**	**234**	**6**	**556**

Demographics Fiscal Review Year Range: 2003-2007



Demographics (Ethnicity/Race and Age Group by Sex)
Fiscal Review Year Range: 2003 to 2003 All Cases Reviewed

Ethnicity	Age Group	Male	Female	Unknown	Total
Hispanic /Latino (any race)	< 1 Year	3	1	0	4
	1-4 Years	0	1	0	1
	5-9 Years	0	0	0	0
	10-14 Years	0	0	0	0
	15-17 Years	1	0	0	1
	Unknown	0	0	0	0
	Subtotal	**4**	**2**	**0**	**6**
Race					
White	< 1 Year	34	22	0	56
	1-4 Years	3	2	0	5
	5-9 Years	2	1	0	3
	10-14 Years	4	1	0	5
	15-17 Years	9	1	0	10
	Unknown	0	0	0	0
	Subtotal	**52**	**27**	**0**	**79**
Black, African American	< 1 Year	22	13	0	35
	1-4 Years	3	0	0	3
	5-9 Years	3	0	0	3
	10-14 Years	2	1	0	3
	15-17 Years	5	0	0	5
	Unknown	0	0	0	0
	Subtotal	**35**	**14**	**0**	**49**
Unknown	< 1 Year	7	4	0	11
	1-4 Years	1	1	0	2
	5-9 Years	0	0	0	0
	10-14 Years	0	1	0	1
	15-17 Years	1	1	0	2
	Unknown	0	0	0	0
	Subtotal	**9**	**7**	**0**	**16**
All Races	< 1 Year	63	39	0	102
	1-4 Years	7	3	0	10
	5-9 Years	5	1	0	6
	10-14 Years	6	3	0	9
	15-17 Years	15	2	0	17
	Unknown	0	0	0	0
	Subtotal	**96**	**48**	**0**	**144**

Data From Cases Reviewed During FY03-FY07
(continued)

Demographics (Ethnicity/Race and Age Group by Sex)
Fiscal Review Year Range: 2004 to 2004 All Cases Reviewed

Ethnicity	Age Group	Male	Female	Unknown	Total
Hispanic /Latino (any race)	< 1 Year	7	4	0	11
	1-4 Years	0	0	0	0
	5-9 Years	0	0	0	0
	10-14 Years	0	0	0	0
	15-17 Years	0	0	0	0
	Unknown	0	0	0	0
	Subtotal	**7**	**4**	**0**	**11**
Race					
White	< 1 Year	28	17	3	48
	1-4 Years	5	4	0	9
	5-9 Years	5	3	0	8
	10-14 Years	4	2	0	6
	15-17 Years	9	3	0	12
	Unknown	1	0	0	1
	Subtotal	**52**	**29**	**3**	**84**
Black, African American	< 1 Year	33	22	0	55
	1-4 Years	4	2	0	6
	5-9 Years	1	0	0	1
	10-14 Years	1	1	0	2
	15-17 Years	2	1	0	3
	Unknown	1	0	0	1
	Subtotal	**42**	**26**	**0**	**68**
Unknown	< 1 Year	2	2	0	4
	1-4 Years	0	0	0	0
	5-9 Years	0	0	0	0
	10-14 Years	0	0	0	0
	15-17 Years	0	0	0	0
	Unknown	0	0	0	0
	Subtotal	**2**	**2**	**0**	**4**
All Races	< 1 Year	63	41	3	107
	1-4 Years	9	6	0	15
	5-9 Years	6	3	0	9
	10-14 Years	5	3	0	8
	15-17 Years	11	4	0	15
	Unknown	2	0	0	2
	Subtotal	**96**	**57**	**3**	**156**

Demographics (Ethnicity/Race and Age Group by Sex)
Fiscal Review Year Range: 2005 to 2005 All Cases Reviewed

Ethnicity	Age Group	Male	Female	Unknown	Total
Hispanic /Latino (any race)	< 1 Year	1	5	0	6
	1-4 Years	0	1	0	1
	5-9 Years	0	1	0	1
	10-14 Years	0	0	0	0
	15-17 Years	1	1	0	2
	Unknown	0	0	0	0
	Subtotal	**2**	**8**	**0**	**10**
Race					
White	< 1 Year	18	17	0	35
	1-4 Years	3	1	0	4
	5-9 Years	2	6	0	8
	10-14 Years	1	1	0	2
	15-17 Years	4	5	0	9
	Unknown	0	0	0	0
	Subtotal	**28**	**30**	**0**	**58**
Black, African American	< 1 Year	23	12	0	35
	1-4 Years	4	4	0	8
	5-9 Years	1	3	0	4
	10-14 Years	0	0	0	0
	15-17 Years	4	4	0	8
	Unknown	0	0	0	0
	Subtotal	**32**	**23**	**0**	**55**
Asian	< 1 Year	0	1	0	1
	1-4 Years	0	0	0	0
	5-9 Years	0	0	0	0
	10-14 Years	0	0	0	0
	15-17 Years	0	0	0	0
	Unknown	0	0	0	0
	Subtotal	**0**	**1**	**0**	**1**
Unknown	< 1 Year	1	3	0	4
	1-4 Years	0	1	0	1
	5-9 Years	0	1	0	1
	10-14 Years	0	0	0	0
	15-17 Years	1	1	0	2
	Unknown	0	0	0	0
	Subtotal	**2**	**6**	**0**	**8**
All Races	< 1 Year	42	33	0	75
	1-4 Years	7	6	0	13
	5-9 Years	3	10	0	13
	10-14 Years	1	1	0	2
	15-17 Years	9	10	0	19
	Unknown	0	0	0	0
	Subtotal	**62**	**60**	**0**	**122**

Data From Cases Reviewed During FY03-FY07
(continued)

Demographics (Ethnicity/Race and Age Group by Sex)
Fiscal Review Year Range: 2006 to 2006 All Cases Reviewed

Ethnicity	Age Group	Male	Female	Unknown	Total
Hispanic /Latino (any race)	< 1 Year	4	1	0	5
	1-4 Years	1	1	0	2
	5-9 Years	0	0	0	0
	10-14 Years	0	0	0	0
	15-17 Years	1	0	0	1
	Unknown	0	0	0	0
	Subtotal	**6**	**2**	**0**	**8**
Race					
White	< 1 Year	8	8	1	17
	1-4 Years	1	1	0	2
	5-9 Years	1	1	0	2
	10-14 Years	1	1	0	2
	15-17 Years	6	2	0	8
	Unknown	0	0	0	0
	Subtotal	**17**	**13**	**1**	**31**
Black, African American	< 1 Year	8	8	1	17
	1-4 Years	0	2	0	2
	5-9 Years	1	0	0	1
	10-14 Years	1	1	0	2
	15-17 Years	0	0	0	0
	Unknown	0	0	0	0
	Subtotal	**10**	**11**	**1**	**22**
Asian	< 1 Year	0	1	0	1
	1-4 Years	0	0	0	0
	5-9 Years	0	0	0	0
	10-14 Years	0	0	0	0
	15-17 Years	0	0	0	0
	Unknown	0	0	0	0
	Subtotal	**0**	**1**	**0**	**1**
Unknown	< 1 Year	3	2	0	5
	1-4 Years	1	1	0	2
	5-9 Years	0	0	0	0
	10-14 Years	0	0	0	0
	15-17 Years	1	0	0	1
	Unknown	0	0	0	0
	Subtotal	**5**	**3**	**0**	**8**
All Races	< 1 Year	19	19	2	40
	1-4 Years	2	4	0	6
	5-9 Years	2	1	0	3
	10-14 Years	2	2	0	4
	15-17 Years	7	2	0	9
	Unknown	0	0	0	0
	Subtotal	**32**	**28**	**2**	**62**

Demographics (Ethnicity/Race and Age Group by Sex)
Fiscal Review Year Range: 2007 to 2007 All Cases Reviewed

Ethnicity	Age Group	Male	Female	Unknown	Total
Hispanic /Latino (any race)	< 1 Year	0	1	0	1
	1-4 Years	0	1	0	1
	5-9 Years	1	0	0	1
	10-14 Years	0	1	0	1
	15-17 Years	1	0	0	1
	Unknown	0	0	0	0
	Subtotal	**2**	**3**	**0**	**5**
Race					
White	< 1 Year	6	5	0	11
	1-4 Years	2	4	0	6
	5-9 Years	1	0	0	1
	10-14 Years	3	2	0	5
	15-17 Years	4	7	0	11
	Unknown	0	0	0	0
	Subtotal	**16**	**18**	**0**	**34**
Black, African American	< 1 Year	7	13	0	20
	1-4 Years	0	4	0	4
	5-9 Years	0	1	0	1
	10-14 Years	3	0	0	3
	15-17 Years	1	0	0	1
	Unknown	0	0	0	0
	Subtotal	**11**	**18**	**0**	**29**
Unknown	< 1 Year	0	2	0	2
	1-4 Years	0	1	0	1
	5-9 Years	2	0	0	2
	10-14 Years	0	1	0	1
	15-17 Years	1	1	0	2
	Unknown	0	0	1	1
	Subtotal	**3**	**5**	**1**	**9**
All Races	< 1 Year	13	20	0	33
	1-4 Years	2	9	0	11
	5-9 Years	3	1	0	4
	10-14 Years	6	3	0	9
	15-17 Years	6	8	0	14
	Unknown	0	0	1	1
	Subtotal	**30**	**41**	**1**	**72**

Manner and Cause of Death, Near Death
Fiscal Review Year Range: 2003 to 2007 All Cases Reviewed

		Age Group						
		<1	1-4	5-9	10-14	15-17	Unk	Total
Manner								
	Natural	316	31	23	13	11	2	396
	Accident	6	14	9	11	46	0	86
	Suicide	0	0	0	3	9	0	12
	Homicide	3	5	2	4	7	0	21
	Undetermined	26	4	1	0	1	0	32
	Unknown	6	1	0	1	0	1	9
Total		**357**	**55**	**35**	**32**	**74**	**3**	**556**

		Age Group						
Manner	**Cause**	<1	1-4	5-9	10-14	15-17	Unk	Total
Natural	Any Injury	2	0	0	0	1	0	3
	Asthma	0	0	1	0	1	0	2
	Cancer	0	0	1	1	1	0	3
	Cardiovascular	4	0	0	2	1	0	7
	Congenital anomaly	10	1	0	0	1	0	12
	Malnutrition/ dehydration	1	0	0	0	0	0	1
	Pneumonia	4	1	1	0	0	0	6
	Prematurity	186	0	0	0	0	2	188
	SIDS*	17	1	0	0	0	0	18
	Other infection	1	0	0	0	0	0	1
	Other medical condition	91	28	19	10	6	0	154
	Unknown	0	0	1	0	0	0	1
	Subtotal	**316**	**31**	**23**	**13**	**11**	**2**	**396**
Accident	Any Medical Cause	0	0	1	0	0	0	1
	Motor Vehicle	0	7	0	6	45	0	58
	Fire, Burn, or Electrocution	0	2	2	1	0	0	5
	Drowning	1	2	2	2	0	0	7
	Suffocation or Strangulation	4	1	3	1	0	0	9
	Weapon	0	0	0	1	1	0	2
	Fall or Crush	0	0	1	0	0	0	1
	Exposure	1	0	0	0	0	0	1
	Other Injury	0	1	0	0	0	0	1
	Unknown	0	1	0	0	0	0	1
	Subtotal	**6**	**14**	**9**	**11**	**46**	**0**	**86**
Suicide								
	Suffocation or Strangulation	0	0	0	0	2	0	2
	Weapon	0	0	0	2	5	0	7
	Poisoning	0	0	0	0	2	0	2
	Exposure	0	0	0	0	0	0	0
	Other Injury	0	0	0	1	0	0	1
	Subtotal	**0**	**0**	**0**	**3**	**9**	**0**	**12**

*Other sleep related deaths listed as Asphyxia or Undetermined are not counted in this category *(see page 62)*.

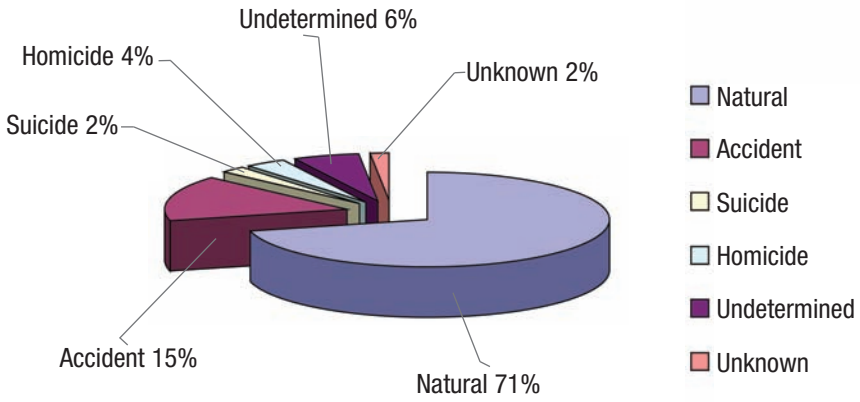
Manner and Cause of Death, Near Death
Fiscal Review Year Range: 2003 to 2007 All Cases Reviewed *(continued)*

	Age Group						
	<1	1-4	5-9	10-14	15-17	Unk	Total
Homicide							
Fire, Burn, or Electrocution	0	1	0	0	0	0	1
Drowning	0	0	0	1	0	0	1
Suffocation or Strangulation	0	0	0	0	1	0	1
Weapon	1	3	2	2	6	0	14
Other Injury	2	1	0	0	0	0	3
Unknown	0	0	0	1	0	0	1
Subtotal	**3**	**5**	**2**	**4**	**7**	**0**	**21**

	Age Group					
	<1	1-4	5-9	15-17	Unk	Total
Undetermined						
Any Medical Cause	23	4	0	0	0	27
Drowning	0	0	1	0	0	1
Suffocation or Strangulation	3	0	0	0	0	3
Weapon	0	0	0	1	0	1
Subtotal	**26**	**4**	**1**	**1**	**0**	**32**

	Age Group						
All Cases	<1	1-4	5-9	10-14	15-17	Unk	Total
Unknown	6	1	0	1	0	1	9

Manner and Cause



Deaths by Manner and Cause by Preventability
Fiscal Review Year Range: 2003 to 2007 All Cases Reviewed

		Could the death have been prevented?				
Manner		**No, Probably**	**Yes, Probably**	**Could Not Determine**	**Unknown**	**Total**
	Natural	341	4	50	1	396
	Accident	50	21	10	5	86
	Suicide	6	1	4	1	12
	Homicide	12	7	2	0	21
	Undetermined	2	1	29	0	32
	Unknown	2	1	3	3	9
	Total	**413**	**35**	**98**	**10**	**556**

		Could the death have been prevented?				
		No, Probably	**Yes, Probably**	**Could Not Determine**	**Unknown**	**Total**
Manner	**Cause**					
Natural	Any Injury	2	0	1	0	3
	Asthma	2	0	0	0	2
	Cancer	3	0	0	0	3
	Cardiovascular	5	1	1	0	7
	Congenital anomaly	9	0	3	0	12
	Malnutrition/ dehydration	0	0	1	0	1
	Pneumonia	3	0	3	0	6
	Prematurity	180	1	7	0	188
	SIDS	0	0	18	0	18
	Other infection	1	0	0	0	1
	Other medical condition	136	2	15	1	154
	Unknown	0	0	1	0	1
	Subtotal	**341**	**4**	**50**	**1**	**396**
Accident (unintentional)						
	Any Medical Cause	0	1	0	0	1
	Motor Vehicle	40	7	7	4	58
	Fire, Burn, or Electrocution	0	5	0	0	5
	Drowning	3	3	1	0	7
	Suffocation or Strangulation	5	2	2	0	9
	Weapon	0	1	0	1	2
	Fall or Crush	1	0	0	0	1
	Exposure	0	1	0	0	1
	Other Injury	0	1	0	0	1
	Unknown	1	0	0	0	1
	Subtotal	**50**	**21**	**10**	**5**	**86**

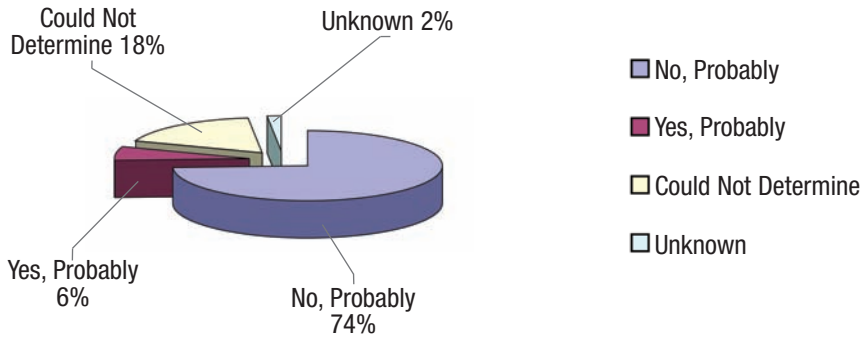
Deaths by Manner and Cause by Preventability
Fiscal Review Year Range: 2003 to 2007 All Cases Reviewed *(continued)*

	Could the death have been prevented?				
	No, Probably	Yes, Probably	Could Not Determine	Unknown	Total
Suicide					
Suffocation or Strangulation	0	1	1	0	2
Weapon	5	0	1	1	7
Poisoning	1	0	1	0	2
Other Injury	0	0	1	0	1
Subtotal	**6**	**1**	**4**	**1**	**12**

	Could the death have been prevented?			
	No, Probably	Yes, Probably	Could Not Determine	Total
Homicide				
Fire, Burn, or Electrocution	1	0	0	1
Drowning	0	1	0	1
Suffocation or Strangulation	0	0	1	1
Weapon	8	5	1	14
Other Injury	2	1	0	3
Unknown	1	0	0	1
Subtotal	**12**	**7**	**2**	**21**
Undetermined				
Any Medical Cause	1	0	26	27
Drowning	0	0	1	1
Suffocation or Strangulation	1	1	1	3
Weapon	0	0	1	1
Subtotal	**2**	**1**	**29**	**32**

All Cases	No, Probably	Yes, Probably	Could Not Determine	Unknown	Total
Unknown	2	1	3	3	9

Death by Manner and Cause by Preventability

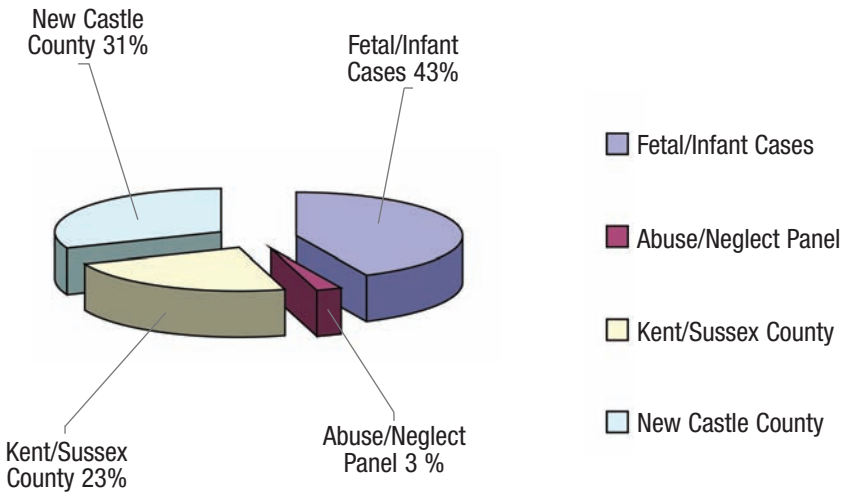


Data From Cases Reviewed During FY03-FY07
(continued)

County/Panel Numbers
Fiscal Review Year Range: 2003 to 2007All Cases Reviewed

	# of cases reviewed
Fetal/Infant Cases[1]	239
Abuse/Neglect Panel	15
Kent/Sussex County	129
New Castle County	173
Total	**556**

Fetal/Infant Cases / County Breakout



[1]These cases were primarily reviewed by Medical doctors. However seven of these cases were reviewed by the newly formed FIMR Case review teams. Five of these cases were reviewed by the child death review panels. In the future, it is anticipated that the majority of these cases will be reviewed by FIMR.

Demographics (Ethnicity/Race and Age Group by Sex)
Fiscal Review Year Range: 2003 to 2007 New Castle County All Cases Reviewed

Ethnicity	Age Group	Male	Female	Unknown	Total
Hispanic /Latino (any race)	< 1 Year	4	7	0	11
	1-4 Years	0	3	0	3
	5-9 Years	0	1	0	1
	10-14 Years	0	0	0	0
	15-17 Years	3	0	0	3
	Unknown	0	0	0	0
	Subtotal	**7**	**11**	**0**	**18**
Race					
White	< 1 Year	11	12	0	23
	1-4 Years	4	9	0	13
	5-9 Years	9	8	0	17
	10-14 Years	4	2	0	6
	15-17 Years	22	8	0	30
	Unknown	0	0	0	0
	Subtotal	**50**	**39**	**0**	**89**
Black, African American	< 1 Year	15	13	0	28
	1-4 Years	6	6	0	12
	5-9 Years	5	4	0	9
	10-14 Years	6	2	0	8
	15-17 Years	8	4	0	12
	Unknown	0	0	0	0
	Subtotal	**40**	**29**	**0**	**69**
Unknown	< 1 Year	1	6	0	7
	1-4 Years	1	3	0	4
	5-9 Years	0	1	0	1
	10-14 Years	0	0	0	0
	15-17 Years	3	0	0	3
	Unknown	0	0	0	0
	Subtotal	**5**	**10**	**0**	**15**
All Races	< 1 Year	27	31	0	58
	1-4 Years	11	18	0	29
	5-9 Years	14	13	0	27
	10-14 Years	10	4	0	14
	15-17 Years	33	12	0	45
	Unknown	0	0	0	0
	Subtotal	**95**	**78**	**0**	**173**

Data From Cases Reviewed During FY03-FY07
(continued)

Manner and Cause of Death by Age Group
Fiscal Review Year Range: 2003 to 2007 New Castle County All Cases Reviewed

		Age Group						
		<1	1-4	5-9	10-14	15-17	Unk	Total
Manner								
	Natural	44	16	21	8	6	0	95
	Accident	3	8	4	3	26	0	44
	Suicide	0	0	0	1	7	0	8
	Homicide	2	2	1	2	5	0	12
	Undetermined	9	3	1	0	1	0	14
	Total	**58**	**29**	**27**	**14**	**45**	**0**	**173**

		Age Group						
		<1	1-4	5-9	10-14	15-17	Unk	Total
Manner	Cause							
Natural	Any Injury	2	0	0	0	1	0	3
	Asthma	0	0	1	0	0	0	1
	Cancer	0	0	1	1	1	0	3
	Cardiovascular	2	0	0	1	0	0	3
	Congenital anomaly	1	0	0	0	0	0	1
	Malnutrition/ dehydration	1	0	0	0	0	0	1
	Pneumonia	1	0	1	0	0	0	2
	Prematurity	6	0	0	0	0	0	6
	SIDS	8	0	0	0	0	0	8
	Other medical condition	23	16	17	6	4	0	66
	Unknown	0	0	1	0	0	0	1
	Subtotal	**44**	**16**	**21**	**8**	**6**	**0**	**95**
Accident	Motor Vehicle	0	3	0	1	26	0	30
	Fire, Burn, or Electrocution	0	2	1	0	0	0	3
	Drowning	0	0	0	1	0	0	1
	Suffocation or Strangulation	2	1	3	1	0	0	7
	Exposure	1	0	0	0	0	0	1
	Other Injury	0	1	0	0	0	0	1
	Unknown	0	1	0	0	0	0	1
	Subtotal	**3**	**8**	**4**	**3**	**26**	**0**	**44**

Manner and Cause of Death by Age Group
Fiscal Review Year Range: 2003 to 2007 New Castle County All Cases Reviewed *(continued)*

	Age Group						
	<1	1-4	5-9	10-14	15-17	Unk	Total
Suicide							
Suffocation or Strangulation	0	0	0	0	2	0	2
Weapon	0	0	0	1	4	0	5
Poisoning	0	0	0	0	2	0	2
Subtotal	**0**	**0**	**0**	**1**	**8**	**0**	**9**
Homicide							
Weapon	1	2	1	2	5	0	11
Other Injury	1	0	0	0	0	0	1
Subtotal	**2**	**2**	**1**	**2**	**5**	**0**	**12**

	Age Group					
	<1	1-4	5-9	15-17	Unk	Total
Undetermined						
Any Medical Cause	7	3	0	0	0	10
Drowning	0	0	1	0	0	1
Suffocation or Strangulation	2	0	0	0	0	2
Weapon	0	0	0	1	0	1
Subtotal	**9**	**3**	**1**	**1**	**0**	**14**

Data From Cases Reviewed During FY03-FY07
(continued)

Demographics (Ethnicity/Race and Age Group by Sex)
Fiscal Review Year Range: 2003 to 2007 Kent/Sussex County
All Cases Reviewed

Ethnicity	Age Group	Male	Female	Unknown	Total
Hispanic /Latino (any race)	< 1 Year	2	0	0	2
	1-4 Years	0	1	0	1
	5-9 Years	1	0	0	1
	10-14 Years	0	1	0	1
	15-17 Years	1	1	0	2
	Unknown	0	0	0	0
	Subtotal	**4**	**3**	**0**	**7**
Race					
White	< 1 Year	18	10	0	28
	1-4 Years	7	3	0	10
	5-9 Years	2	2	0	4
	10-14 Years	9	5	0	14
	15-17 Years	10	10	0	20
	Unknown	0	0	0	0
	Subtotal	**46**	**30**	**0**	**76**
Black, African American	< 1 Year	13	11	0	24
	1-4 Years	5	6	0	11
	5-9 Years	1	0	0	1
	10-14 Years	1	1	0	2
	15-17 Years	4	1	0	5
	Unknown	0	0	0	0
	Subtotal	**24**	**19**	**0**	**43**
Unknown	< 1 Year	1	0	0	1
	1-4 Years	0	1	0	1
	5-9 Years	2	0	0	2
	10-14 Years	0	2	0	2
	15-17 Years	1	3	0	4
	Unknown	0	0	0	0
	Subtotal	**4**	**6**	**0**	**10**
All Races	< 1 Year	32	21	0	53
	1-4 Years	12	10	0	22
	5-9 Years	5	2	0	7
	10-14 Years	10	8	0	18
	15-17 Years	15	14	0	29
	Unknown	0	0	0	0
	Subtotal	**74**	**55**	**0**	**129**

Manner and Cause of Death by Age Group
Fiscal Review Year Range: 2003 to 2007 Kent/Sussex County
All Cases Reviewed

		Age Group						
		<1	1-4	5-9	10-14	15-17	Unk	Total
Manner								
	Natural	35	15	2	5	5	0	62
	Accident	2	5	5	8	20	0	40
	Suicide	0	0	0	2	2	0	4
	Homicide	0	1	0	2	2	0	5
	Undetermined	16	1	0	0	0	0	17
	Unknown	0	0	0	1	0	0	1
	Total	53	22	7	18	29	0	129

		Age Group						
		<1	1-4	5-9	10-14	15-17	Unk	Total
Manner	Cause							
Natural								
	Asthma	0	0	0	0	1	0	1
	Cardiovascular	1	0	0	1	1	0	3
	Congenital anomaly	0	1	0	0	1	0	2
	Pneumonia	3	1	0	0	0	0	4
	Prematurity	5	0	0	0	0	0	5
	SIDS	9	1	0	0	0	0	10
	Other infection	1	0	0	0	0	0	1
	Other medical condition	16	12	2	4	2	0	36
	Subtotal	35	15	2	5	5	0	62
Accident								
	Any Medical Cause	0	0	1	0	0	0	1
	Motor Vehicle	0	4	0	5	19	0	28
	Fire, Burn, or Electrocution	0	0	1	1	0	0	2
	Drowning	1	1	2	1	0	0	5
	Suffocation or Strangulation	1	0	0	0	0	0	1
	Weapon	0	0	0	1	1	0	2
	Animal Bite or Attack	0	0	0	0	0	0	0
	Fall or Crush	0	0	1	0	0	0	1
	Subtotal	2	5	5	8	20	0	40
Suicide								
	Suffocation or Strangulation	0	0	0	0	1	0	1
	Weapon	0	0	0	1	1	0	2
	Other Injury	0	0	0	1	0	0	1
	Subtotal	0	0	0	2	2	0	4

Manner and Cause of Death by Age Group
Fiscal Review Year Range: 2003 to 2007 Kent/Sussex County
All Cases Reviewed *(continued from page 47)*

	Age Group						
	<1	1-4	5-9	10-14	15-17	Unk	Total
Homicide							
Drowning	0	0	0	1	0	0	1
Suffocation or Strangulation	0	0	0	0	1	0	1
Weapon	0	0	0	0	1	0	1
Other Injury	0	1	0	0	0	0	1
Unknown	0	0	0	1	0	0	1
Subtotal	**0**	**1**	**0**	**2**	**2**	**0**	**5**

	Age Group			
	<1	1-4	Unk	Total
Undetermined				
Any Medical Cause	16	1	0	17
Subtotal	**16**	**1**	**0**	**17**

	Age Group						
All Cases	<1	1-4	5-9	10-14	15-17	Unk	Total
Unknown	0	0	0	1	0	0	1

Demographics (Ethnicity/Race and Age Group by Sex)
Fiscal Review Year Range: 2003 to 2007
Abuse/Neglect Panel All Cases Reviewed

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

Manner and Cause of Death by Age Group
Fiscal Review Year Range: 2003 to 2007 Abuse/Neglect Panel
All Cases Reviewed

		Age Group						
		<1	1-4	5-9	10-14	15-17	Unk	Total
Manner								
	Natural	0	0	0	0	0	0	0
	Accident	1	1	0	0	0	0	2
	Suicide	0	0	0	0	0	0	0
	Homicide	1	2	1	0	0	0	4
	Undetermined	1	0	0	0	0	0	1
	Unknown	6	1	0	0	0	1	8
Total		**9**	**4**	**1**	**0**	**0**	**1**	**15**

		Age Group						
		<1	1-4	5-9	10-14	15-17	Unk	Total
Manner	Cause							
Accident	Drowning	0	1	0	0	0	0	1
	Suffocation or Strangulation	1	0	0	0	0	0	1
	Subtotal	**1**	**1**	**0**	**0**	**0**	**0**	**2**
Homicide								
	Fire, Burn or Electrocution	0	1	0	0	0	0	1
	Weapon	0	1	1	0	0	0	2
	Other Injury	1	0	0	0	0	0	1
	Subtotal	**1**	**2**	**1**	**0**	**0**	**0**	**4**

	Age Group		
	<1	Unk	Total
Undetermined			
Suffocation or Strangulation	1	0	1
Subtotal	**1**	**0**	**1**

All Cases	<1	1-4	5-9	10-14	15-17	Unk	Total
Unknown	6	1	0	0	0	1	8

Demographics (Ethnicity/Race and Age Group by Sex)
Fiscal Review Year Range: 2003 to 2007 Fetal/Infant Cases
All Cases Reviewed

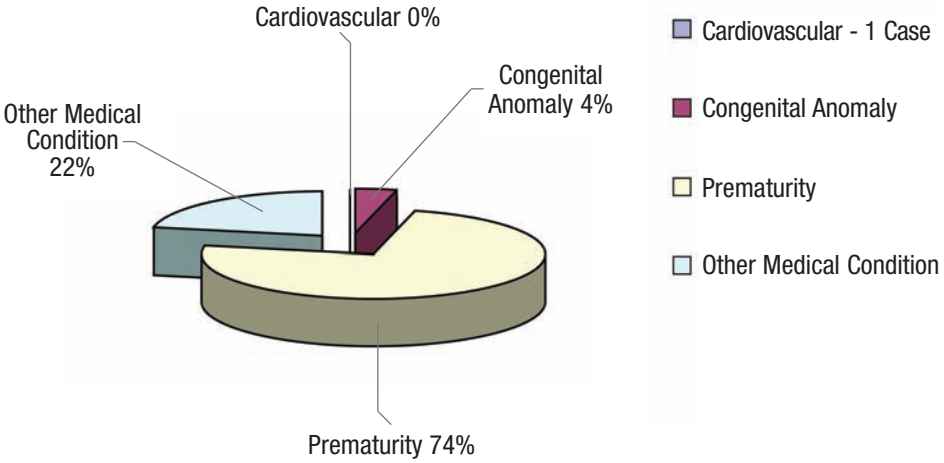
Ethnicity	Age Group	Male	Female	Unknown	Total
Hispanic /Latino (any race)	< 1 Year	7	5	0	12
	1-4 Years	0	0	0	0
	5-9 Years	0	0	0	0
	10-14 Years	0	0	0	0
	15-17 Years	0	0	0	0
	Unknown	0	0	0	0
	Subtotal	**7**	**5**	**0**	**12**
Race					
White	< 1 Year	62	47	4	113
	1-4 Years	0	0	0	0
	5-9 Years	0	0	0	0
	10-14 Years	0	0	0	0
	15-17 Years	0	0	0	0
	Unknown	1	0	0	1
	Subtotal	**63**	**47**	**4**	**114**
Black, African American	< 1 Year	63	42	1	106
	1-4 Years	0	0	0	0
	5-9 Years	0	0	0	0
	10-14 Years	0	0	0	0
	15-17 Years	0	0	0	0
	Unknown	1	0	0	1
	Subtotal	**64**	**42**	**1**	**107**
Asian	< 1 Year	0	2	0	2
	1-4 Years	0	0	0	0
	5-9 Years	0	0	0	0
	10-14 Years	0	0	0	0
	15-17 Years	0	0	0	0
	Unknown	0	0	0	0
	Subtotal	**0**	**2**	**0**	**2**
Unknown	< 1 Year	9	7	0	16
	1-4 Years	0	0	0	0
	5-9 Years	0	0	0	0
	10-14 Years	0	0	0	0
	15-17 Years	0	0	0	0
	Unknown	0	0	0	0
	Subtotal	**9**	**7**	**0**	**16**
All Races	< 1 Year	134	98	5	237
	1-4 Years	0	0	0	0
	5-9 Years	0	0	0	0
	10-14 Years	0	0	0	0
	15-17 Years	0	0	0	0
	Unknown	2	0	0	2
	Subtotal	**136**	**98**	**5**	**239**

Manner and Cause of Death by Age Group
Fiscal Review Year Range: 2003 to 2007 Fetal/Infant cases
All Cases Reviewed

	Age Group		
	<1	Unk	Total
Manner			
Natural	237	2	239
Total	**237**	**2**	**239**

	Age Group		
	<1	Unk	Total
Manner			
Cause			
Natural			
Cardiovascular	1	0	1
Congenital anomaly	9	0	9
Prematurity	175	2	177
Other medical condition	52	0	52
Subtotal	**237**	**2**	**239**

Fetal/Infant Cases



Infant Death Information
Fiscal Review Year Range: 2003 to 2007
All Cases Reviewed

	Manner of Death					
	Natural	Accident	Homicide	Undeter	Unknown	Total
Deaths Reviewed	316	6	3	26	6	**357**
Premature (<37 weeks)	10	0	0	0	0	**10**
Low Birth Weight (<2500 grams)	7	0	0	0	0	**7**
Intrauterine Smoke Exposure	4	1	0	2	0	**7**
Intrauterine Alcohol Exposure	1	0	0	0	0	**1**
Intrauterine Drug Exposure	7	0	0	2	0	**9**
Late (>6 wks) or No Prenatal Care	6	1	0	0	0	**7**

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

Data From Cases Reviewed During FY03-FY07 *(continued)*

Acts of Omission/Commission Demographics
Fiscal Review Year Range: 2003 to 2007 All Cases Reviewed

		Acts of Omission/Commision							
	Deaths Reviewed	Poor/Absent Supervision	Child Abuse	Child Neglect	Other Negligence	Assault (not child abuse)	Suicide	Other	Unknown
Age Group									
<1 Year	12	3	5	2	0	0	0	1	1
1-4 Years	6	1	2	0	1	0	0	2	0
5-9 Years	3	1	0	0	0	0	0	2	0
10-14 Years	1	0	1	0	0	0	0	0	0
15-17 Years	5	1	1	0	1	1	0	1	0
Total	**27**	**6**	**9**	**2**	**2**	**1**	**0**	**6**	**1**
Sex									
Male	19	5	8	1	1	0	0	3	1
Female	8	1	1	1	1	1	0	3	0
Unknown	1	0	1	0	0	0	0	0	0
Total	**28**	**6**	**10**	**2**	**2**	**1**	**0**	**6**	**1**
Ethnicity									
Hispanic (any race)	3	0	3	0	0	0	0	0	0
Race									
White	14	4	3	1	1	1	0	3	1
Black, African American	11	2	4	1	1	0	0	3	0
Unknown	3	0	3	0	0	0	0	0	0
Total	**28**	**6**	**10**	**2**	**2**	**1**	**0**	**6**	**1**
Manner of Death									
Accident (Unintentional)	8	4	0	0	2	0	0	2	0
Suicide	3	1	2	0	0	0	0	0	0
Homicide	9	0	3	0	0	1	0	4	1
Undetermined	2	1	0	1	0	0	0	0	0
Unknown	6	0	5	1	0	0	0	0	0
Total	**28**	**6**	**10**	**2**	**2**	**1**	**0**	**6**	**1**
Primary Cause of Death									
Motor vehicle	4	0	0	0	2	0	0	2	0
Fire, Burn or Electrocution	1	0	0	0	0	0	0	1	0
Drowning	3	3	0	0	0	0	0	0	0
Suffocation or Strangulation	5	2	1	1	0	1	0	0	0
Weapon	10	1	7	0	0	0	0	2	0
Other Injury	2	0	0	0	0	0	0	1	1
Unknown Cause	3	0	2	1	0	0	0	0	0
Total	**28**	**6**	**10**	**2**	**2**	**1**	**0**	**6**	**1**

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
Fiscal Review Year Range: 2003 to 2007
All Cases Reviewed

	Acts of Omission/Commision Intent							
	Poor/Absent Supervision	Child Abuse	Child Neglect	Other Negligence	Assault (not child abuse)	Suicide	Other	Unknown
Deaths Reviewed	6	10	2	2	1	0	6	1
Cause								
Intentional	0	3	0	0	1	0	1	0
Unintentional	0	0	0	0	0	0	2	0
Unknown	0	0	0	0	0	0	1	0
Contributed								
Intentional	0	0	0	0	0	0	1	1
Unintentional	5	7	2	2	0	0	1	0
Unknown	1	0	0	0	0	0	0	0

Drowning Death Demographics
Fiscal Review Year Range: 2003 to 2007
All Cases Reviewed

	Place of Drowning									
	Lake/River/ Pond/Creek	Ocean	Quarry/Gravel Pit	Canal	Pool/Hot Tub/Spa	Well/Cistern/ Septic	Bathtub	Other	Unknown	Total
Age Group										
<1 Year	0	0	0	0	0	0	1	0	0	1
1-4 Years	0	0	0	0	1	0	0	1	0	2
5-9 Years	0	0	0	0	1	0	2	0	0	3
10-14 Years	1	0	0	0	2	0	0	0	0	3
15-17 Years	0	0	0	0	0	0	0	0	0	0
Unknown	0	0	0	0	0	0	0	0	0	0
Total	**1**	**0**	**0**	**0**	**4**	**0**	**3**	**1**	**0**	**9**
Sex										
Male	1	0	0	0	4	0	1	1	0	7
Female	0	0	0	0	0	0	2	0	0	2
Unknown	0	0	0	0	0	0	0	0	0	0
Total	**1**	**0**	**0**	**0**	**4**	**0**	**3**	**1**	**0**	**9**
Race										
White	0	0	0	0	2	0	2	1	0	5
Black, African American	1	0	0	0	2	0	1	0	0	4
Total	**1**	**0**	**0**	**0**	**4**	**0**	**3**	**1**	**0**	**9**

Data From Cases Reviewed During FY03-FY07 *(continued)*

Factors Involved in Drowning Deaths
Fiscal Review Year Range: 2003 to 2007
Delaware
Child Deaths Reviewed All Cases

	Place of Drowning									
	Lake/River/ Pond/Creek	Ocean	Quarry/Gravel Pit	Canal	Pool/Hot Tub/Spa	Well/Cistern/ Septic	Bathtub	Other	Unknown	Total
Deaths Reviewed	1	0	0	0	4	0	3	1	0	**9**
Child could swim	0	0	0	0	1	0	0	0	0	**1**
No barriers to water	1	0	0	0	0	0	0	1	0	**2**
Child not supervised, but needed	0	0	0	0	1	0	0	1	0	**2**
Supervisor impaired by alcohol/drugs	0	0	0	0	0	0	1	0	0	**1**

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

Fire Death Demographics
Fiscal Review Year Range: 2003 to 2007 All Cases Reviewed

	Building on Fire						
	Single Home	Duplex	Apartment	Trailer/Mobile Home	Other	Unknown/NA	Total
Age Group							
<1 Year	0	0	0	0	0	0	0
1-4 Years	1	0	0	0	0	2	3
5-9 Years	2	0	0	0	0	0	2
10-14 Years	1	0	0	0	0	0	1
15-17 Years	0	0	0	0	0	0	0
Unknown	0	0	0	0	0	0	0
Total	**4**	**0**	**0**	**0**	**0**	**2**	**6**
Sex							
Male	3	0	0	0	0	1	4
Female	1	0	0	0	0	1	2
Unknown	0	0	0	0	0	0	0
Total	**4**	**0**	**0**	**0**	**0**	**2**	**6**
Ethnicity							
Hispanic (any race)	0	0	0	0	0	0	0
Race							
White	4	0	0	0	0	0	4
Black, African American	0	0	0	0	0	2	2
Total	**4**	**0**	**0**	**0**	**0**	**2**	**6**

Factors Involved in Fire Deaths
Fiscal Review Year Range: 2003 to 2007 All Cases Reviewed

	Building on Fire						
	Single Home	Duplex	Apartment	Trailer/Mobile Home	Other	Unknown/NA	Total
Deaths Reviewed	4	0	0	0	0	2	6
Factors delayed Fire Department arrival	1	0	0	0	0	0	1
Fire was suspected arson	1	0	0	0	0	0	1
Child not supervised, but needed	1	0	0	0	0	0	1

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

Motor Vehicle and Other Transport Death Demographics
Fiscal Review Year Range: 2003 to 2007 All Cases Reviewed

	Position of Child					
Age Group	Driver	Passenger	On Bicycle	Pedestrian	Unknown	Total
<1 Year	0	0	0	0	0	0
1-4 Years	0	3	0	1	3	7
5-9 Years	0	0	0	0	0	0
10-14 Years	2	3	0	0	1	6
15-17 Years	11	16	1	1	17	46
Unknown	0	0	0	0	0	0
Total	**13**	**22**	**1**	**2**	**21**	**59**
Sex						
Male	6	9	1	1	16	33
Female	7	13	0	1	5	26
Unknown	0	0	0	0	0	0
Total	**13**	**22**	**1**	**2**	**21**	**59**
Ethnicity						
Hispanic (any race)	0	1	0	0	3	4
Race						
White	10	15	1	1	16	43
Black, African American	2	5	0	1	1	9
Unknown	1	2	0	0	4	7
Total	**13**	**22**	**1**	**2**	**21**	**59**
Area Where Incident Occurred						
Urban	0	0	0	1	0	1
Suburb	2	2	0	0	0	4
Rural	0	6	0	0	0	6
Unknown	11	14	1	1	21	48
Total	**13**	**22**	**1**	**2**	**21**	**59**

Data From Cases Reviewed During FY03-FY07 *(continued)*

Vehicle Type Involved in Incident and Position of Child
Fiscal Review Year Range: 2003 to 2007
All Cases Reviewed

	Position of Child				
	Driver	Passenger	Not in a Vehicle	Unknown	Total
Vehicle Type Child In/On					
Car	10	14	1	1	**26**
Van	0	1	0	0	**1**
SUV	0	1	0	0	**1**
Bicycle	0	0	1	0	**1**
Pedestrian	0	1	0	0	**1**
Other	1	0	0	0	**1**
Unknown	2	5	1	20	**28**
Total	**13**	**22**	**3**	**21**	**59**

Risk Factors of Young Drivers (Ages 14-18) Involved in the Crash
Fiscal Review Year Range: 2003 to 2007
All Cases Reviewed

	Drivers Involved in Incident Ages 14-18		
	Child was Driving	Driver of Childs Vehicle	Driver of Other Primary Vehicle
Risk Factors			
Deaths Reviewed	12	0	1
Responsible for causing incident	8	0	1
Alcohol/drug impaired	1	0	0
No license	6	0	0
Suspended license	0	0	0
Violating graduated licensing rules	0	0	0
Two or more teen passengers (ages 14-21)	2	0	0

Motor Vehicle Protective Measures
Fiscal Review Year Range: 2003 to 2007
All Cases Reviewed

	Position Of Child					
	Driver	Passenger	On Bicycle	Pedestrian	Unknown	Total
Deaths Reviewed	13	22	1	2	21	59
Protective Measure Present and Used Correctly						
Airbag	0	1	0	0	0	1
Lap Belt	0	5	0	0	0	5
Shoulder Belt	0	5	0	0	0	5
Protective Measure Present and Used Incorrectly						
Airbag	0	1	0	0	0	1
Lap Belt	0	1	0	0	0	1
Shoulder Belt	0	1	0	0	0	1
Protective Measure Present and Not Used						
Lap Belt	7	7	0	0	2	16
Shoulder Belt	7	7	0	0	2	16
Protective Measure Needed But None Present						
Rear-facing Child Seat	0	1	0	0	0	1
Front-facing Child Seat	0	3	0	0	0	3
Helmet	1	0	1	0	0	2

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

Data From Cases Reviewed During FY03-FY07 *(continued)*

Poisoning Death Demographics
Fiscal Review Year Range: 2003 to 2007 All Cases Reviewed

		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	1	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	2	0	2	0	0	0
Unknown	0	0	0	0	0	0
Total	**3**	**1**	**2**	**0**	**0**	**0**
Sex						
Male	0	0	0	0	0	0
Female	3	1	2	0	0	0
Total	**3**	**0**	**2**	**0**	**0**	**0**
Race						
White	2	1	1	0	0	0
Black, African American	1	0	1	0	0	0
Native Hawaiian	0	0	0	0	0	0
Total	**2**	**0**	**2**	**0**	**0**	**0**

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

Factors Involved in Poisoning Deaths
Fiscal Review Year Range: 2003 to 2007 All Cases Reviewed

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

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

Sleep-Related Death Demographics
Fiscal Review Year Range: 2003 to 2007
All Cases Reviewed

Ethnicity	Age Group	Male	Female	Unknown	Total
Hispanic /Latino (any race)	0-1 Months	0	1	0	1
	2-3 Months	0	0	0	0
	4-5 Months	0	1	0	1
	6-7 Months	1	0	0	1
	8-11 Months	0	1	0	1
	1-4 Years	0	0	0	0
	5 Years and Up	1	0	0	1
	Subtotal	**2**	**3**	**0**	**5**
Race					
White	0-1 Months	7	1	0	8
	2-3 Months	4	6	0	10
	4-5 Months	2	0	0	2
	6-7 Months	0	0	0	0
	8-11 Months	0	0	0	0
	1-4 Years	0	1	0	1
	5 Years and Up	1	1	0	2
	Unknown	0	0	0	0
	Subtotal	**14**	**9**	**0**	**23**
Black, African American	0-1 Months	6	7	0	13
	2-3 Months	5	5	0	10
	4-5 Months	0	2	0	2
	6-7 Months	1	1	0	2
	8-11 Months	0	1	0	1
	1-4 Years	2	0	0	2
	5 Years and Up	1	0	0	1
	Unknown	0	0	0	0
	Subtotal	**15**	**16**	**0**	**31**
Unknown	0-1 Months	0	1	0	1
	2-3 Months	0	0	0	0
	4-5 Months	0	1	0	1
	6-7 Months	0	0	0	0
	8-11 Months	0	1	0	1
	1-4 Years	0	0	0	0
	5 Years and Up	0	0	0	0
	Unknown	0	0	0	0
	Subtotal	**0**	**3**	**0**	**3**
All Races	0-1 Months	13	9	0	22
	2-3 Months	9	11	0	20
	4-5 Months	2	3	0	5
	6-7 Months	1	1	0	2
	8-11 Months	0	2	0	2
	1-4 Years	2	1	0	3
	5 Years and Up	2	1	0	3
	Unknown	0	0	0	0
	Subtotal	**29**	**28**	**0**	**57**

Data From Cases Reviewed During FY03-FY07 *(continued)*

Sleep-Related Deaths by Cause
Fiscal Review Year Range: 2003 to 2007
Delaware
All Cases Reviewed

	Cause of Death				
	SIDS	Suffocation	Medical Condition	All Other	Total Causes
0-1 Months	20	0	2	0	**22**
2-3 Months	15	4	1	0	**20**
4-5 Months	4	1	0	0	**5**
6-7 Months	0	2	0	0	**2**
8-11 Months	0	1	1	0	**2**
1-4 Years	1	1	0	1	**3**
5 Years and Up	0	2	1	0	**3**
Unknown	0	0	0	0	**0**
Total	**40**	**11**	**5**	**1**	**57**

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.

Circumstances Involved in Sleep-Related Deaths
Fiscal Review Year Range: 2003 to 2007
All Cases Reviewed

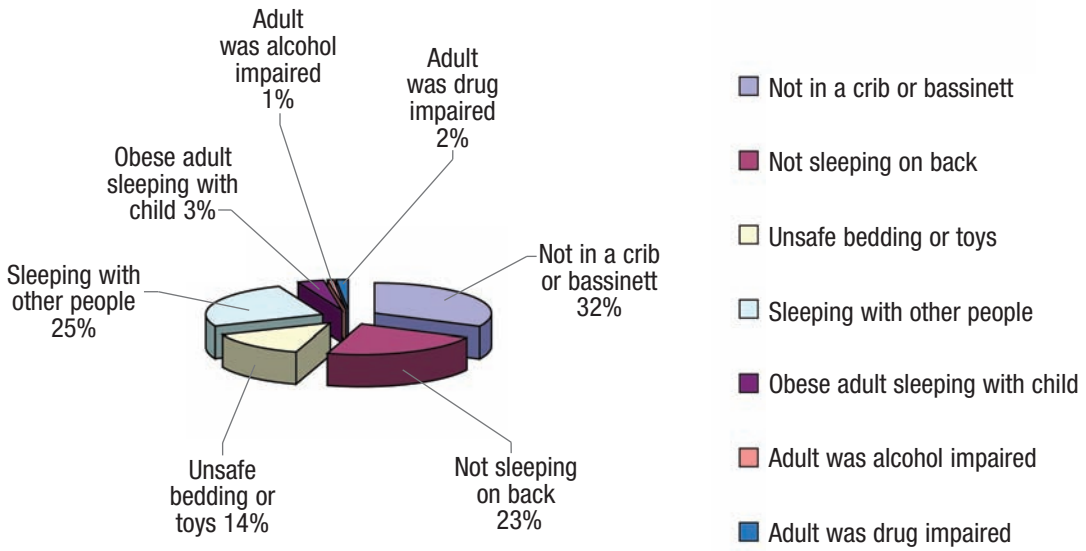
	Age Group							
	0-1 Mos	2-3 Mos	4-5 Mos	6-7 Mos	8-11 Mos	1-4 Yrs	5 Yrs Up	Total
Face and Body Unobstructed	0	0	1	0	0	0	0	**1**
Under Person	0	1	0	1	0	2	0	**4**
Between Person	0	1	0	0	0	0	0	**1**
Between Object	0	0	0	0	1	0	0	**1**
Wedged	0	1	0	0	0	0	2	**3**
Pressed	0	3	2	0	0	0	0	**5**
Fell or Rolled onto Object	1	1	0	0	0	0	0	**2**
Other	2	0	0	0	0	0	1	**3**
Unknown	19	13	2	1	1	1	0	**37**
Total	**22**	**20**	**5**	**2**	**2**	**3**	**3**	**57**

Factors Involved in Sleep-Related Deaths
Fiscal Review Year Range: 2003 to 2007
All Cases Reviewed

	Age Group							
	0-1 Mos	2-3 Mos	4-5 Mos	6-7 Mos	8-11 Mos	1-4 Yrs	5 Yrs Up	Total
Deaths Reviewed	22	20	5	2	2	3	3	**57**
Not in a Crib or Bassinette	11	14	3	2	1	3	3	**37**
Not Sleeping on Back	8	10	4	0	1	1	2	**26**
Unsafe Bedding or Toys	9	4	3	0	0	0	0	**16**
Sleeping with Other People	11	11	2	2	1	2	0	**29**
Obese Adult Sleeping with Child	1	1	0	1	0	1	0	**4**
Adult was Alcohol Impaired	0	0	0	1	0	0	0	**1**
Adult was Drug Impaired	0	1	0	1	0	0	0	**2**

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

Sleep Related Death Factors



Data From Cases Reviewed During FY03-FY07 *(continued)*

Suffocation or Strangulation Death Demographics
Fiscal Review Year Range: 2003 to 2007
All Cases Reviewed

	Action Causing Suffocation									
	Bed, Product, or Overlay (Sleep)	Strangled by Person or Object	Covered in or Fell into Object	Confined in Tight Space	Choked on Object	Swaddled in Tight Blanket	Wedged into Tight Place (Not Sleep)	Other	Unknown	Total
Age Group										
<1 Year	8	0	0	0	0	0	0	0	1	**9**
1-4 Years	1	0	0	0	0	0	0	0	0	**1**
5-9 Years	2	0	0	0	1	0	0	0	0	**3**
10-14 Years	0	0	0	0	1	0	0	0	0	**1**
15-17 Years	0	2	0	0	0	1	0	0	0	**3**
Unknown	0	0	0	0	0	0	0	0	0	**0**
Total	**11**	**2**	**0**	**0**	**2**	**1**	**0**	**0**	**1**	**17**
Sex										
Male	4	1	0	0	1	0	0	0	1	**7**
Female	7	1	0	0	1	1	0	0	0	**10**
Total	**11**	**2**	**0**	**0**	**2**	**1**	**0**	**0**	**1**	**17**
Ethnicity										
Hispanic (any race)	1	0	0	0	1	0	0	0	0	**2**
Race										
White	4	2	0	0	1	1	0	0	0	**8**
Black, African American	7	0	0	0	0	0	0	0	1	**8**
Unknown	0	0	0	0	1	0	0	0	0	**1**
Total	**11**	**2**	**0**	**0**	**2**	**1**	**0**	**0**	**1**	**17**
Manner of Death										
Natural	1	0	0	0	0	0	0	0	1	**2**
Accident (Unintentional)	7	0	0	0	2	0	0	0	0	**9**
Suicide	0	2	0	0	0	0	0	0	0	**2**
Homicide	0	0	0	0	0	1	0	0	0	**1**
Undetermined	3	0	0	0	0	0	0	0	0	**3**
Total	**11**	**2**	**0**	**0**	**2**	**1**	**0**	**0**	**1**	**17**
Supervisor Impaired by Drugs	2	0	0	0	0	0	0	0	0	**2**

Weapon Death Demographics
Fiscal Review Year Range: 2003 to 2007
Delaware
All Cases Reviewed

	Type of Weapon									
Age Group	**Firearm**	**Sharp**	**Blunt**	**Body Part**	**Explosive**	**Rope**	**Biological**	**Other**	**Unknown**	**Total**
<1 Year	0	0	0	4	0	0	0	0	0	4
1-4 Years	0	0	0	3	0	0	0	0	0	3
5-9 Years	1	1	0	0	0	0	0	0	0	2
10-14 Years	5	0	0	0	0	0	0	0	0	5
15-17 Years	12	1	0	0	0	0	0	0	0	13
Unknown	0	0	0	1	0	0	0	0	0	1
Total	**18**	**2**	**0**	**8**	**0**	**0**	**0**	**0**	**0**	**28**
Sex										
Male	16	1	0	5	0	0	0	0	0	22
Female	2	1	0	2	0	0	0	0	0	5
Unknown	0	0	0	1	0	0	0	0	0	1
Total	**18**	**2**	**0**	**8**	**0**	**0**	**0**	**0**	**0**	**28**
Ethnicity										
Hispanic (any race)	0	1	0	2	0	0	0	0	0	3
Race										
White	9	1	0	2	0	0	0	0	0	12
Black, African American	9	0	0	4	0	0	0	0	0	13
Unknown	0	1	0	2	0	0	0	0	0	3
Total	**18**	**2**	**0**	**8**	**0**	**0**	**0**	**0**	**0**	**28**

Factors Involved in Weapon Deaths
Fiscal Review Year Range: 2003 to 2007, Delaware
All Cases Reviewed

	Type of Weapon									
Manner of Death	**Firearm**	**Sharp**	**Blunt**	**Body Part**	**Explosive**	**Rope**	**Biological**	**Other**	**Unknown**	**Total**
Accident (Unintentional)	2	0	0	0	0	0	0	0	0	2
Suicide	7	0	0	0	0	0	0	0	0	7
Homicide	8	2	0	4	0	0	0	0	0	14
Undetermined	1	0	0	0	0	0	0	0	0	1
Unknown	0	0	0	3	0	0	0	0	0	3
Total	**18**	**2**	**0**	**7**	**0**	**0**	**0**	**0**	**0**	**27**
Action Omission/ Commission Contributed to Death	3	1	0	6	0	0	0	0	0	10

Owner and Use of Weapon at Time of Incident
Fiscal Review Year Range: 2003 to 2007
All Cases Reviewed

	Firearm Licensed		
Owner of Fatal Firearm	Yes	Unknown	Total
Self	0	1	1
Parent	2	1	3
Friend/Acquaintance	0	1	1
Other	0	5	5
Unknown	0	8	8
Total	2	16	18

	Type of Weapon									
Leading Uses of Weapon at Time of Incident	Firearm	Sharp	Body Part	Blunt	Explosive	Rope	Biological	Other	Unknown	Total
Self Injury	7	0	0	0	0	0	0	0	0	7
Unknown Use	4	0	0	0	0	0	0	0	0	4
Other Use	1	0	2	0	0	0	0	0	0	3
Commission of Crime	1	2	0	0	0	0	0	0	0	3
Intimate Partner Violence	0	0	2	0	0	0	0	0	0	2
Bystander	2	0	0	0	0	0	0	0	0	2
Self Defense	1	0	0	0	0	0	0	0	0	1
Russian Roulette	1	0	0	0	0	0	0	0	0	1
Random Violence	0	0	1	0	0	0	0	0	0	1
Drive By	1	0	0	0	0	0	0	0	0	1

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

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FY 2005

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New Castle County Panel

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FY 2007

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Every Child Deserves A Tomorrow

STATE OF DELAWARE

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