STATE OF DELAWARE
CHILD DEATH, NEAR DEATH AND STILLBIRTH COMMISSION

Annual Report
Calendar Year
2003

Florence M. Alberque, MPA
Executive Director

March 2005

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

Executive Summary

"CHILDREN ARE NOT SUPPOSED TO DIE."
Coleen Kivlahan, MD, MSPH
2004 National Symposium on Child Fatalities, August 2004

Between 1996 and 2000, the Child Death Rate for children through age 14 was 24.2 per 100,000 children in the United States and 22.1 per 100,000 children in the State of Delaware. In these same years, 7.1 of every 1,000 infants died nationally; Delaware exceeded National Infant Mortality Rates with a rate of 8.4 deaths per 1000 births (Kids Count in Delaware, Families Count in Delaware, Fact Book, 2003).

Every child death is a tragedy, especially when the death could have been averted. Child death review processes have been implemented throughout the United States to help understand how and why children die, and to implement changes to prevent future deaths of our most vulnerable citizens.

Delaware's child death review legislation enacted by the General Assembly strives to prevent child mortality in this State. The Child Death, Near Death, and Stillbirth Commission, and its Regional Panels, conduct retrospective reviews of all child deaths occurring in the State of Delaware to make meaningful and timely system-wide recommendations to support this goal. The process brings professionals and experts from a variety of disciplines together to form multi-faceted recommendations and encourage interagency collaboration to end child deaths in Delaware.

Deaths which are determined to have been "preventable" lead to multidisciplinary discussion and development of recommendations to prevent future child deaths. Cases which involve abuse and/or neglect of a child are expedited, in order to make and implement recommendations as quickly as possible. The Commission reports its recommendations to the Governor, General Assembly and Child Protection Accountability Commission.

In the calendar year 2003, the Commission and Regional Panels completed reviews of 174 child deaths in Delaware. Nearly three percent of the child deaths reviewed were determined to be preventable deaths, meaning one or more interventions by medical, community, legal and/or psychological systems might reasonably have averted the death of the child. Recommendations for system improvements are made even in cases where the death of a child was not deemed preventable.

In November, 2004, the Commission hired an Executive Director and hopes to have three staff by Summer, 2005. In 2005, with staff on board, the Commission will implement a third Regional Panel, whose focus will be expedited reviews of both deaths and near deaths of children due to abuse and/or neglect. It will also continue to explore ways to complete reviews of stillbirths in Delaware, including taking a leadership role in the implementation of a statewide Fetal Infant Mortality Review (FIMR) process in collaboration with the Governor's Infant Mortality Task Force and the Division of Public Health.

In 2005, the Commission will participate in a national pilot study of child death review data, improving the Commission's ability to collect and analyze quantifiable data and make effective recommendations for system change to alleviate child deaths. The Commission is committed to continued growth to make improving the care and safety of Delaware's children a top priority.

Special Note

The members of the Child Death, Near Death and Stillbirth Commission extend their special thanks to citizens who have served on the Commission and its Regional Panels from the inception of the Commission until present.

The Commission recognizes the significant time, energy and sacrifice made by the volunteer members of the Regional Panels, and their commitment to the future of the children of Delaware.

Without the hard work, expertise and dedication of panel members, the Commission could not carry out its duty to prevent the deaths of children in the State of Delaware.

The Commission would also like to thank Attorney M. General Jane Brady and Secretary Cari DeSantis for providing support staff to the Commission, and the staff of the Office of the Child Advocate for their work on previous annual reports. Your dedication to Delaware's children is appreciated.

Table of Contents

I. Mission/Purpose

The 142nd General Assembly of the State of Delaware declared:

> "...the health and safety of the children of the State will be safeguarded if deaths of children under the age of 18, near deaths of abused and/or neglected children, and stillbirths occurring after at least 27 weeks of gestation are reviewed, in order to provide recommendations to alleviate those practices or conditions which impact the mortality of children." (Title 31, Part I, Ch.3, Subch. II, § 320).

The Child Death, Near Death and Stillbirth Commission (formerly the Child Death Review Commission), and its Regional Panels, conduct retrospective reviews of every child death in Delaware, in order to provide meaningful, prompt, system-wide recommendations to alleviate the mortality of children and improve services to the children of Delaware.

II. General Background

A. Introduction

Delaware's initiative to prevent mortality of its children began in 1988 with the Office of the Attorney General's Abuse Intervention Committee. Delaware Code first established its Child Death Review Commission in July, 1995, after a pilot project demonstrated the importance of a child death review process to prevent future deaths of children in the State. Legislation has evolved to amend the name of the Commission to the Child Death, Near Death and Stillbirth Commission, include reviews of stillbirths and near deaths of children 0 – 17 years old due to abuse and/or neglect, and include expedited reviews. In July 2004, SB 279 also funded the Commission and added an Executive Director, further emphasizing the need to prevent child deaths in Delaware.

The death of a child is a community problem. Often, circumstances involved in the deaths of children are unknown. When risk factors are determined, they are multidimensional. Prevention of child deaths is complex and requires a multi-disciplinary, public-private approach.

The Delaware Child Death, Near Death and Stillbirth Commission is a statewide consortium of experts and leaders from multiple systems, disciplines, and agencies, both private and public, joined together to help identify the complex factors related to child deaths in Delaware. As these factors are identified, recommendations are made for systemic improvements in the future, with the goal of ending the deaths of children in this State.

B. Structure and Membership

The Commission is mandated to meet at least semi-annually, and conduct one joint meeting per year with the Child Protection Accountability Commission. Legislation allows for at least one, but no more than three, regional Child Death, Near Death and Stillbirth Panels. Panel members are appointed by the Commission.

The Commission will be meeting bi-monthly in Calendar Year 2005. Two Regional Panels meet monthly. These Panels review in detail all child deaths occurring in the State. One Panel represents New Castle County; the second Panel represents both Kent and Sussex County. Legislation provides for the creation of a third Panel, whose primary purpose is to review deaths and near deaths due to abuse and/or neglect. This panel will be established in 2005.

The Child Death, Near Death and Stillbirth Commission and regional Panel members are designated in Title 31, Part I, Ch. 3, Subch. II, § 321(Appendix A). Appendix B includes a table of Commissioners, Panel Members and legislative roles.

C. Duties and Responsibilities

Title 31, Part I, Ch.3, Subch. II, §323 (Appendix A) gives the Child Death, Near Death and Stillbirth Commission the power to investigate and review all deaths and near deaths of children, and stillbirths which occur in Delaware. In the event that a child death or near death occurs as a result of abuse and/or neglect, the Commission must conduct an expedited review within 3 months of notice of such a death or near death. Notice must come from the Attorney General, the Department of Services for Children, Youth and their Families, or any other agency responsible for investigating child deaths. These reviews may be extended to 6 months for good cause.

At least annually, the Commission is responsible to make recommendations to the Governor, General Assembly and Child Protection Accountability Commission regarding practices impacting the mortality of children. Recommendations based on expedited review findings are reported within 20 days of the completion of such review.

D. Review Process – Update

The Child Death, Near Death and Stillbirth Commission utilizes retrospective reviews of child deaths to make recommendations with the goal of preventing future deaths of children in Delaware. In 2003, the Commission approved formalized procedures for case reviews. These procedures were based on those created in the past by the Abuse Intervention Committee of the Attorney General's Office. In 2004, Regional Panels began developing action steps in instances where recommendations are made. In the future, these action steps will be monitored by Commission staff in order to track progress toward implementation of recommendations.

Reviews of child deaths due to abuse/neglect are expedited, and completed within 3 to 6 months. Recommendations from expedited reviews are submitted to the Governor, the General Assembly and the Child Protection Accountability Commission in a letter within 20 days of completion of the review. In 2005, reviews of near deaths will be conducted in an expedited time frame. All other recommendations are submitted to the Governor, General Assembly and Child Protection Accountability Commission in an annual report completed by staff and reviewed and approved by the Commission. All recommendations of the Commission are available to the public.

To maintain compliance with the Freedom of Information Act, the Commission and Regional Panels discuss all confidential information in executive session during meetings.

III. Child Death Reviews in Delaware – 2003

A. Overview

The following table depicts the number of child death cases reviewed by both Regional Panels and the Commission in calendar year 2003. Three percent (3%) of all child deaths reviewed were determined to be preventable by the panels and commission.

For the purpose of Delaware's Child Death Review Process, preventable death is defined as:

> "One or more interventions (medical, community, legal, psychological) might reasonably have averted the child's death."

2003 Child Deaths – Number of Completed Reviews

Number of Deaths Reviewed	174
Number of Preventable Deaths	5
Percentage of Deaths deemed Preventable	3%

B. Commission and Panel Activity – 2003

1. New Castle County Panel

The following table depicts the activities of the New Castle County Panel and the physician review of deaths of infants less than 28 days old in New Castle County. These child death cases were reviewed by this panel because the death occurred in New Castle County. Overall, 115 child deaths occurring in New Castle County were reviewed by the New Castle County Panel and its physician members in 2003. This constitutes **66% of all statewide child death reviews** completed during the year.

New Castle County Panel – 2003 Child Death Reviews Completed

Number of Times Panel Met	9
Number of Child Deaths Reviewed by Panel	43
Percent of all Deaths Reviewed Statewide	24.7%
Number of Deaths Reviewed by Panel (child<1 yr old)	13
Number of Deaths Reviewed (child 1 yr – 17 yrs old)	30
Number of Male Deaths Reviewed	32
Number of Female Deaths Reviewed	11
Number of Deaths - Black	20
Number of Deaths - Caucasian	16
Number of Deaths - Hispanic	4
Number of Deaths – Other Race	3
Percent of Deaths Reviewed - Preventable	1
Number of Physician Reviews of Infants	**72**

Of the child deaths reviewed by the panel, 30% were deaths of infants between 28 days old and one year old. **62.6%** of all deaths reviewed by the panel and physician were infants under 1 year. The majority (46.5%) of deaths of children over 28 days old reviewed were black children. Males accounted for 74.4% of child deaths (over 28 days old) reviewed.

2. Kent/Sussex County Panel

The following table depicts the activities of the Kent/Sussex Regional Panel and the physician review of deaths of infants less than 28 days old in both Kent and Sussex Counties. These child death cases were reviewed by this panel because the death occurred in either Kent or Sussex County. Overall, 59 child deaths occurring in both counties were reviewed by the Kent/Sussex Regional Panel and its physician members in 2003. This represents **34% of all child death reviews** conducted statewide during the calendar year.

Kent/Sussex County Panel – 2003 Child Death Reviews

Number of Times Panel Met	6
Number of Child Deaths Reviewed	24
Percent of all Deaths Reviewed Statewide	13.8%
Number of Deaths Reviewed by Panel (child<1 yr old)	11
Number of Deaths Reviewed (child 1 yr – 17 yrs old)	13
Number of Male Deaths Reviewed	15
Number of Female Deaths Reviewed	9
Number of Deaths - Black	11
Number of Deaths - Caucasian	12
Number of Deaths - Hispanic	1
Number of Deaths – Other Race	0
Percent of Deaths Reviewed - Preventable	4
Number of Physician Reviews of Infants	35

Of the child deaths reviewed by the panel, 45.8% were deaths of infants between 28 days old and one year old. **59.3%** of all deaths reviewed by the panel and physician were infants under 1 year. The majority (50%) of deaths of children over 28 days old reviewed were Caucasian children. Males accounted for 62.5% of child deaths (over 28 days old) reviewed.

3. Commission

Child Death, Near Death and Stillbirth Commission – 2003 Activity

Number of Commission Meetings	4
Number of Panel Reports Reviewed/Approved	7

4. Accomplishments and Challenges - 2003

Accomplishments:

- 100% of all deaths referred via copy of death certificate from DPH were reviewed, unless deferred.
- A "tracking tool" was developed to monitor recurring factors in death over time, such as sleeping position of infants.
- A process subcommittee was developed and a handbook of review processes was created.
- The Commission supported HB 106, increasing penalties for youth not wearing seatbelts.

Challenges:

- Issues needed to be addressed related to the right of parents to release educational records of a child, even after the child's death (FERPA).
- A Regional Panel member was identified as a potential witness in a criminal case related to a child death.

C. Cause/Manner of Death for Delaware Children Ages 0 – 17

The following data describes causes of death, and manner of death in child death cases reviewed by Regional Panels in 2003 in relation to the age, gender, and race of the child.

Causes of Child Deaths Reviewed

Cause of Death	# of Child Deaths	% of all Child Deaths Reviewed
Non-natural Causes of Death		
Drowning	2	1.1%
Fire	0	0%
Homicide	3	1.7%
Machinery	0	0%
Other	2	1.1%
Suicide	4	2.3%
Vehicular Crashes	**15**	**8.6%**
Subtotal Non-natural	**26**	**14.8%**
Natural Causes of Death		
Asthma	1	0.6%
Congenital Defects	9	5.2%
Dehydration	2	1.1%
Heart Failure/ Heart Disease	12	6.9%
Pneumonia	2	1.1%
Prematurity	**85**	**48.9%**
Renal Failure	3	1.8%
Respiratory Failure	5	2.9%
SIDS/SUDI	6	3.5%
Sepsis	4	2.3%
Other Natural/Unknown	19	10.9%
Subtotal Natural	**148**	**85.2%**
Total	**174**	**100%**

It is worthy to note that 48.9% of all deaths reviewed were related to prematurity. This is the highest natural cause of death in children. Vehicular crashes accounted for the majority of non-natural deaths of children.

D. Death Reviews Completed by Age, Gender and Race

Manner of Death Reviewed by Age

Manner of Death	<1 yr	1-4 yrs	5-9 yrs	10-14 yrs	15-17yrs	Total
Natural	124	6	5	3	2	140
Accidental	1	2	1	4	11	19
Suicide	0	0	0	1	3	4
Homicide	0	0	0	2	1	3
Pending	0	0	0	0	0	0
Undetermined	6	2	0	0	0	8
Total	131	10	6	10	17	174

Of the 174 cases of child death reviewed in 2003, the majority were due to natural causes. However, 88.6% of natural child deaths were infant deaths (under 1 year of age.) The majority of accidental child deaths (57.9%) involved a child 15 – 17 years old. This age group also accounted for 75% of all suicides.

Manner of Death Reviewed by Gender

Manner of Death	Male	Female	Unknown	Total
Natural	89	50	1	140
Accidental	14	5	0	19
Suicide	4	0	0	4
Homicide	3	0	0	3
Pending	0	0	0	0
Undetermined	6	2	0	8
Total	116	57	1	174

Of all child deaths reviewed, 63.6% involved a male child. The majority of accidental deaths (73.7%) involved males, and 100% of child suicides and homicides involved males.

Manner of Death Reviewed by Race

Manner of Death	Black	Caucasian	Hispanic	Other/Unknown	Total
Natural	67	61	6	6	140
Accidental	6	12	0	1	19
Suicide	1	3	0	0	4
Homicide	1	2	0	0	3
Pending	0	0	0	0	0
Undetermined	6	2	0	0	8
Total	81	80	6	7	174

Of the 2003 child deaths reviewed, deaths by accident and suicide involved primarily Caucasian children (63.2% and 75%), and Caucasians represented 2/3 of all homicides reviewed. The majority of natural deaths **(47.8%) occurred in black children.**

E. Deaths Reviewed by County

The following data describes child deaths reviewed by county of death in relation to the age and manner of death of the child.

Deaths Reviewed by Age and County

County	# Deaths <1 yr	# Deaths 1 -17 yrs	Total Deaths	% of Statewide Deaths
New Castle	85	30	115	66.09%
Kent	30	4	34	19.54%
Sussex	16	9	25	14.37%

Manner of Death Reviewed by County

Manner of Death	# NCC	%NCC*	#Kent	%Kent*	# Sussex	%Sussex*
Natural	96	83.5%	28	82.4%	16	64.0%
Accidental	12	10.5%	3	8.8%	4	16.0%
Suicide	3	2.6%	1	2.9%	0	0.0%
Homicide	1	0.9%	0	0.0%	2	8.0%
Pending	0	0.0%	0	0.0%	0	0.0%
Undetermined	3	2.6%	2	5.9%	3	12.0%
Total	115	100.0%	34	100.0%	25	100.0%

*Percentage of all child deaths reviewed in that county due to a particular manner of death

IV. Summary

Of 174 child deaths reviewed in 2003, 124 (or 95%) were deaths by natural causes of infants less than one-year old. Adolescents (15-17 y/o) comprised the majority (57.8%) of accidental deaths reviewed. 75% of child suicides reviewed were by adolescents; one child suicide was a child between 10 and 14 years old. Seventy-five percent of suicides were by Caucasian children.

The majority of child deaths reviewed involved the death of a male child (66.7%). This rate is higher than the percentage of male children in Delaware in 2000 (51% per Families Count in Delaware Fact Book, 2003). Black children accounted for 46.6% of all child deaths reviewed.

V. Recommendations

A. Preventable Deaths

For the purpose of Delaware's Child Death Review Process, preventable death is defined as:

> "One or more interventions (medical, community, legal, psychological) might reasonably have averted the child's death."

This definition has been adopted by the Commission in an effort to maintain a focus on systems issues vs. individual responsibility. Recommendations are made by panels and approved by the Commission based on systems challenges/needs identified, particularly in cases of preventable death.

Statewide Child Deaths Reviewed and found Preventable

Total Number Cases Reviewed	# Preventable	# Not Preventable	# Unknown/Split Vote	% Preventable
174	5	142	27	2.9%

New Castle County Preventable Deaths Reviewed

Number of Cases Reviewed	115
Number Preventable Child Death	1
% Cases Preventable	0.87%

Kent County Preventable Deaths Reviewed

Number of Cases Reviewed	34
Number Preventable Child Death	2
% Cases Preventable	5.9%

Sussex County Preventable Deaths Reviewed

Number of Cases Reviewed	25
Number Preventable Child Death	2
% Cases Preventable	8.0%

In 2003, nearly 3% of all child deaths reviewed were determined to have been preventable. While the majority (66%) of child deaths reviewed were residents of New Castle County, the number of preventable deaths in each of Kent and Sussex Counties was twice that in New Castle County.

Although not defined as preventable from a system-perspective, premature birth was a factor in nearly half of all child deaths reviewed.

The Child Death, Near Death and Stillbirth Commission hopes that the recommendations put forth in this report may alleviate preventable deaths of children in all of Delaware's counties in the future.

B. Recommendations

The Commission makes the following recommendations based on reviews completed in 2003:

- The Division of Public Health should review public pool safety requirements and consider opportunities to reinforce appropriate signage requirements.
- Implement seasonal public notification of the importance of adult supervision of children in pools, and water safety.
- Provide periodic public notice to parents of their responsibilities to supervise their children and the consequences of leaving children unattended.
- Provide support for nursing education, including support for financial assistance for nursing education programs and increased public awareness of professional opportunities in the nursing field.
- Expand public programs, such as weekend daycare and respite programs, for children with special medical needs.
- Develop and implement an internal review process within Medicaid to verify actual service provision versus authorized services.
- Provide continued funding for programs designed to keep kids safe, such as Safe Kids Coalition.
- Encourage groups involved in outreach to address car seat safety.
- Support Sex Education in schools, and programs that teach and encourage parents how to communicate with their children about sex.
- DSCYF should develop and implement a transfer of information form, and should send a letter to contracted providers regarding the need for new prescriptions if a dosage is changed. Training regarding the process for when medications have changed should also be provided to department and contractor staff.
- Consider stiffer penalties for a second offense of improper restraint of a child.

VI. Plans for the Future

A. Implementation of Legislation

Thanks to the dedication of Governor Minner and the 142nd General Assembly to prevent child mortality in Delaware, the Commission evolved into a State Agency, housed in the Administrative Offices of the Courts in July 2004. In November, 2004, the Commission hired an Executive Director [Title 31, Part I, Ch.3, Subch. II, §321(a)]. As of January, 2005, two support staff positions are being developed in the State Personnel Office, and office space for the Commission staff has been identified by the Administrative Offices of the Court.

Once all three positions are established, and staff are hired, the Commission will prioritize the implementation of a third Regional Panel, whose focus will be on expedited reviews of child deaths and near deaths due to abuse and/or neglect. This panel should be fully operational by Spring, 2005. Staff are studying models in order to create the most effective expedited review process possible. As mandated by Delaware Code [Title 31, Part I, Ch. 3, Subch. II, § 321(c)], the Commission is scheduled to meet jointly with the Child Protection Accountability Commission in September 2005.

Title 31 gives the Commission the authority to review stillbirths occurring after at least 27 weeks of gestation, with consent of both parents. These do not include stillbirths which occur as a result of an elective medical procedure. The Commission has not reviewed stillbirths to date, due to a lack of staff resources and a limited number of qualified physicians participating in the review process. The Commission shall continue to evaluate the viability of conducting such reviews as employees are hired. In addition, the Commission voted in December 2004 to support and implement a Fetal Infant Mortality Review (FIMR) initiative in Delaware, consistent with the Pilot FIMR Project implemented by the Governor's Infant Mortality Task Force. FIMR is a National Model for the review and future prevention of fetal and infant deaths. Effective statewide implementation of this initiative will require an amendment to the current Child Death, Near Death and Stillbirth Commission legislation, and would require additional fiscal and human resources.

B. Policies and Procedures

As the Commission continues to evolve and fully implement Subchapter II of Title 31, policies and procedures will be updated to reflect the new initiatives of the Commission. Examples of procedures to be developed include a process for identifying near deaths and conducting thorough reviews of such deaths by a third Regional Panel in an expedited manner. In addition, a formal process, and policies and procedures will be developed to implement FIMR statewide, if legislation and resources allow.

Once fully staffed, the Commission plans to reevaluate its process of developing action steps intended to turn recommendations into reality. Staff will partner with community stakeholders and State agencies to develop more comprehensive action plans, monitor progress and report such progress to the Governor, General Assembly and Child Protection Accountability Commission.

C. Other Activities and Initiatives

In 2004, The Child Death, Near Death and Stillbirth Commission voted to participate in a national child death review pilot project established by the National Maternal and Child Health (MCH) Center for Child Death Review at the Michigan Public Health Institute. Through a Grant from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services, the MCH Center is developing program models and materials reflecting best practices in Child Death Review Processes across the United States. Commission staff become part of a national consortium of child death review professionals who share information, resources, research, and best practices, and who problem solve collectively in both formal (e.g. National Meetings) and informal (e.g. email, phone conversations) forums.

The National MCH Center for Child Death Review is also developing a national web-based database for the collection of data related to child deaths. Delaware, and other states participating in the pilot project, will collect data related to each child death utilizing a standardized data tool. This will allow the Commission, Regional Panels and staff the ability to analyze current data, as well as identify and make recommendations to eliminate longitudinal trends that may lead to child mortality in the State.

Commission staff are working in collaboration with the Judicial Information Center to create a website for the Child Death, Near Death and Stillbirth Commission.

In 2004, the Commission began working in collaboration with the Division of Public Health (DPH) and Nemours Health and Prevention Services to implement a Fetal Infant Mortality Review (FIMR) pilot under the direction of the Governor's Infant Mortality Task Force. This pilot is currently underway, and includes the review of 50 infant deaths occurring in 2003 using Commission case information and maternal interviews conducted by DPH social workers. The Commission is dedicated to the successful implementation of the pilot and plans to take a leadership role in the statewide implementation of FIMR, should it be adopted.

Appendix A - Current Legislation

TITLE 31 – Welfare
PART I
In General
CHAPTER 3. CHILD WELFARE
Subchapter II. Child Death, Near Death and Stillbirth Commission

§ 320. Declaration of legislative intent.

The General Assembly hereby declares that the health and safety of the children of the State will be safeguarded if deaths of children under the age of 18, near deaths of abused and/or neglected children, and stillbirths occurring after at least 27 weeks of gestation are reviewed, in order to provide recommendations to alleviate those practices or conditions which impact the mortality of children. This subchapter establishes the Child Death, Near Death and Stillbirth Commission. For the purposes of this subchapter, "Commission" means the Child Death, Near Death and Stillbirth Commission. Stillbirths occurring after at least 27 weeks of gestation shall not include stillbirths which occur as a result of an elective medical procedure. (70 Del. Laws, c. 256, § 1; 73 Del. Laws, c. 331, §§ 2, 3; 74 Del. Laws, c. 376, § 3.)

§ 321. Organization and composition.

(a) The following shall be members of the Commission: The State Attorney General, the Secretary of the State Department of Health and Social Services, the Secretary of the State Department of Services to Children, Youth and Their Families, the person appointed as the child advocate pursuant to § 9003A of Title 29, the Chair of Child Protection Accountability Commission, the State Secretary of Education, the State Medical Examiner, and the Superintendent of the Delaware State Police, or the designee of any of the preceding persons. Additionally, the following shall be appointed by the Governor as members of the Commission: (i) A representative of the Medical Society of Delaware specializing in each of pediatrics, neonatology, obstetrics and perimatology; (ii) a representative of the Delaware Nurses Association; (iii) a representative of the National Association of Social Workers; (iv) a representative of the Police Chiefs' Council of Delaware who is an active law enforcement officer; (v) a representative of the New Castle County Police Department; and (vi) 2 child advocates from state-wide non-profit organizations. A Chairperson of each regional child death, near death and stillbirths review panel established pursuant to subsection (d) hereof shall also serve as members of the Commission. The term of members appointed by the Governor shall be 3 years and shall terminate upon the Governor's appointment of a new member to the Commission. The members of the Commission and of the regional panels shall serve without compensation. The Commission shall be staffed, and its staff shall include an Executive Director. The General Assembly may annually appropriate such sums as it may deem necessary for the payment of the salary of the Executive Director and the staff, and for the payment of actual expenses incurred by the Commission.

(b) The Commission shall, by affirmative vote of a majority of all members of the Commission, appoint a chairperson from its membership for a term of 1 year. The Commission shall meet at least semi-annually.

(c) Meetings of the Commission and regional panels shall be closed to the public. The Commission shall meet at least annually with the Child Protection Accountability Commission to jointly discuss the public recommendations generated from reviews conducted pursuant to § 323(e) of this title. This meeting shall be open to the public.

(d) The Commission shall by resolution passed by a majority of its members establish at least 1 but no more than 3 regional child death, near death and stillbirth review panels. One of the panels shall be designated to review cases pursuant to § 323(e) of this title; however, for good cause shown to the Commission, any panel may investigate and review any death, near death, or stillbirth entitled to review by the Commission. Members of the Commission shall appoint representatives to each regional panel such that the regional panel reflects the disciplines of the Commission. The Commission shall also appoint to each regional panel (i) a representative from each of the 3 police departments which investigate the majority of

child deaths in the region covered by the panel, and (ii) a citizen of the region interested in child death, near death and stillbirth issues.

(e) Each regional panel shall have the powers, duties and authority of the Commission as delegated by the Commission. Each regional panel shall, by affirmative vote of a majority of all members of that regional panel, appoint co-chairpersons from its membership for a term of 1 year. (70 Del. Laws, c. 256, § 1; 72 Del. Laws, c. 327, § 1; 73 Del. Laws, c. 65, § 43; 73 Del. Laws, c. 331, §§ 4, 5; 74 Del. Laws, c. 376, §§ 4-7, 14.)

§ 322. Voting.

Except as expressly provided herein, an affirmative vote of 60% of all members of the Commission or any regional panel shall be required to adopt any findings or recommendations of the Commission or such regional panel. (70 Del. Laws, c. 256, § 1.)

§ 323. Powers and duties.

(a) The Commission shall have the power to investigate and review the facts and circumstances of all deaths and near deaths of children under the age of 18 and stillbirths which occur in Delaware. The review of deaths involving criminal investigations will be delayed until the later of the conclusion of such investigation, or the adjudication of related criminal charges, if any. The Commission shall make recommendations to the Governor and the General Assembly and Child Protection Accountability Commission, at least annually, regarding those practices or conditions which impact the mortality of children. System-wide recommendations arising from an investigation and review conducted pursuant to subsection (e) of this section shall be made to the Governor and General Assembly and Child Protection Accountability Commission, as well as any members of the public requesting the recommendations, within 20 days of the completion of such investigation and review. All recommendations made pursuant to this subsection shall comply with applicable state and federal confidentiality provisions, including but not limited to those enumerated in § 324 of this title and § 9017(d) of Title 29. Notwithstanding any provision of this subchapter to the contrary, such recommendation shall not specifically identify any individual or any nongovernmental agency, organization or entity.

(b) The Commission shall conduct reviews according to procedures promulgated by the Abuse Intervention Committee of the State Attorney General's Office, which procedures shall be adopted in writing prior to the 1st review. The Commission may amend such procedures upon a three-quarters affirmative vote of all members of the Commission.

(c) In connection with any review, the Commission shall have the power and authority to:

(1) Administer oaths; and

(2) Compel the attendance of witnesses whose testimony is related to the death or near death under review and the production of records related to the death or near death under review by filing a praecipe for a subpoena, through the Attorney General or a Deputy Attorney General, with the Prothonotary of any county of this State, such a subpoena to be effective throughout the State and service of such a subpoena to be made by any sheriff of the State; failure to obey said subpoena will be punishable according to the rules of the Superior court.

(d) Notwithstanding any provision of this subchapter to the contrary, no investigation or review shall be made of a stillborn if either parent objects.

(e) Notwithstanding the above, the Commission shall investigate and review the facts and circumstances of the death or near death of an abused and/or neglected child within 3 months of a report to the Commission by the Attorney General, the Department of Services for Children, Youth and Their Families, or other state agency that the child was the victim of abuse or neglect. The Attorney General, the

Department of Services for Children, Youth and Their Families, and any other state or local agency with responsibility for investigating child deaths shall report to the Commission any death or near death of a child who is determined to have been abused and/or neglected within 14 days of that determination. For good cause shown to the Commission, completion of an investigation and review under this subsection may be extended from 3 to 6 months.

(f) Notwithstanding any provision of this subchapter to the contrary, no person identified by the Attorney General's office as a potential witness in any criminal prosecution arising from the death or near death of an abused or neglected child shall be questioned, deposed or interviewed by or for the Commission in connection with its investigation and review of such death or near death until the completion of such prosecution. (70 Del. Laws, c. 256, § 1; 73 Del. Laws, c. 331, §§ 6, 7; 73 Del. Laws, c. 386, §§ 1, 2, 6; 74 Del. Laws, c. 376, §§ 8-11.)

§ 324. Confidentiality of records and immunity from suit.

(a) The records of the Commission and of all regional panels, including original documents and documents produced in the review process with regard to the facts and circumstances of each death or near death, shall be confidential and shall not be released to any person except as expressly provided in Chapter 3, Subchapter II of this title. Such records shall be used by the Commission, and any regional panel only in the exercise of the proper function of the Commission or regional panel and shall not be public records and shall not be available for Court subpoena or subject to discovery. Subject to constitutional requirements, statements, records or information shall not be subject to any statute or rule that would require those statements to be disclosed in the course of a criminal trial or associated discovery. Aggregate statistical data compiled by the Commission or regional panels, however, may be released at the discretion of the Commission or regional panels.

(b) Members of the Commission and of the regional panels, and their agents or employees, shall not be subject to, and shall be immune from, claims, suits, liability, damages or any other recourse, civil or criminal, arising from any act, proceeding, decision or determination undertaken or performed or recommendation made, provided such persons acted in good faith and without malice in carrying out their responsibilities, authority, duties, powers and privileges of the offices conferred by this law upon them or by any other provisions of the Delaware law, federal law or regulations, or duly adopted rules and regulations of the Commission or its regional panels. Complainants shall bear the burden of proving malice or a lack of good faith to defeat the immunity provided herein.

(c) No person in attendance at a meeting of any such Commission or regional panel shall be required to testify as to what transpired thereat. No organization, institution or person furnishing information, data, reports or records to the Commission or any regional panel with respect to any subject examined or treated by such organizations, institution, or person, by reason of furnishing such information, shall be liable in damages to any person or subject to any other recourse, civil or criminal. (70 Del. Laws, c. 256, § 1; 73 Del. Laws, c. 386, §§ 3, 4; 74 Del. Laws, c. 376, § 12.)

Appendix B – Commissioners, Proxies and Regional Panel Members

Child Death, Near Death and Stillbirth Commissioners – February 2005

Commissioner	Legislative Role
Attorney General M. Jane Brady	State Attorney General
Dr. Richard T. Callery	Office of the Medical Examiner
Col. L. Aaron Chaffinch	Delaware State Police
Dr. Garrett H.C. Colmorgen, Chair	Perinatologist
Dr. James J. Cosgrove	OB/GYN
Tania M/ Culley, Esq.	State Child Advocate
Secretary Cari DeSantis	Dept. of Services for Children, Youth and Their Families
Marjorie Lynn Hershberger	Chair, New Castle County Panel
Dr. Kathy A. Janvier	Delaware Nurses Association
Col. David McAllister	New Castle County Police Department
Secretary Vincent P. Meconi	Dept. of Health and Social Services
Janice Mink	Child Advocate (Non-Profit)
Dr. Lani-Nelson Zlupko	National Association of Social Workers
Dr. David Paul	Neonatologist
Jennifer Barber-Ranji, Esq.	Chair, Child Protection Accountability Commission
Marie E. Renzi	Child Advocate (Non-Profit)
Dr. Kevin Sheahan	Pediatrician
Dr. Phillip Shlossman	Chair, Kent/Sussex Regional Panel
Chief Michael J. Szczerba	Police Chiefs Council of Delaware
Secretary Valerie Woodruff	Department of Education
Proxy	
Cpt. Harry Downes	Delaware State Police - Proxy
Trish Hearn	Dept. of Services for Children, Youth and Their Families - Proxy
Sgt. Phillip Hill	New Castle County Police Department - Proxy
Cpt. James Jubb	Police Chiefs Council of Delaware - Proxy
Mariann Kenville-Moore	State Attorney General - Proxy
Ms. Anne Pedrick	State Child Advocate - Proxy

2003 Commissioners and Proxies (no longer serving):

Mr. Allan J. Daul, Catholic Charities
Dr. John A.J. Forest, Pediatrician
Ms. Helene Diskau, Delaware Nurses Association
Col. John Cunningham, New Castle County Police Department
Lt. Mark Daniels, Delaware State Police
Sgt. Renee Taschner, New Castle County Police Department
Dr. William Lybarger, Dept. of Education
Ms. Mary Kate McLaughlin, Dept. of Health and Social Services

Key Support Staff (2003 – 2005):

Ms. Karen Golden
Mr. Stuart Mast
James Maxwell, Esq.

New Castle County Regional Panel Members – February 2005

Member/Proxy	Legislative Role
Alice Coleman	National Association of Social Workers
Dr. Garrett H.C. Colmorgen	Perinatologist
Sgt. Matthew Cox	Delaware State Police
Dr. Kate Cronan	Pediatrician
Dr. Carlos Duran	Neonatologist
Melissa Espinal	Citizen Interested in Child Death
Karen Golden	Dept. of Services for Children, Youth and Their Families
Marjorie Hershberger, Chair	Delaware Nurses Association
Sgt. Phillip Hill	New Castle County Police Department
Mr. John Humphrey	Child Advocate (Non-Profit)
Mariann Kenville-Moore	Office of the State Attorney General
Dr. Richard Leader	Obstetrician
Dr. Ross Megargel	Office of Emergency Medical Services
Janice Mink	Child Protection Accountability Commission
Anita Muir	Division of Public Heath (DHSS)
Joyce Dobratz	Child Advocate (Non-Profit)
Anne Pedrick	Office of the Child Advocate
Pat Pheris	Division of Substance Abuse and Mental Health (DHSS)
Dr. Jennie Vershvovsky	Office of the Medical Examiner
Linda Wolfe	Department of Education
Sgt. Raymond Wyatt	Wilmington Police Department

Kent/Sussex Counties - Regional Panel Members – February 2005

Member/Proxy	Legislative Role
Dr. Steven Berlin	OB/GYN
Lt. Lester Boney	Dover Police Department
Det. Kenneth Brown	Milford Police Department
Barbara DeBastiana	Division of Public Heath (DHSS)
Helene Diskau	Delaware Nurses Association
Lt. John Evans	Delaware State Police
Angela Fowler	Office of the Child Advocate
Dr. Fran Franklin	Child Advocate (Non-Profit)
Karen Golden	Dept. of Services for Children, Youth and Their Families
Cherelyn Homlish	Child Advocate (Non-Profit)
Dr. Patrick Jarvie	Pediatrician
Dr. Ross Megargel	Office of Emergency Medical Services
Pat Pheris	Division of Substance Abuse and Mental Health (DHSS)
Ralph Richardson, III	Citizen Interested in Child Death
Dr. Phillip Shlossman	Perinatologist
Dr. Judith Tobin	Office of the Medical Examiner
Maxine Travis	National Association of Social Workers
Melanie Withers	Office of the State Attorney General
Linda Wolfe	Department of Education

2003 Regional Panel Members (no longer serving):

Ms. Cathie Frost, Division of Public Health
Sgt. William Brown, Wilmington Police Department
Ms. Christine Stapleford, Dept. Health and Social Services
Ms. Linda Hawthorne, Citizen Interested in Child Death
Adrienne Sekula-Perlman, Office of the Medical Examiner
Sgt. Gerard Donovan, New Castle County Police Department
Ms. Mary Crowley, Child Advocate
Sgt. Michael Kelly, New Castle County Police Department
Ms. Cheryl Homlish, Child Advocate
Ms. Jackie Howard, Citizen Interested in Child Death
Ms. Rosemary Joseph-Kappel, Dept. of Health and Social Services
Mr. James Atkins, Department of Justice
Michele Ostafy, CHILD, Inc.

.