Delaware CDRC

REVIEW & PREVENTION OF CHILD DEATHS

Delaware Child Death Review Commission

Annual Report for Calendar Year 2017

STATE OF DELAWARE
Child Death Review Commission

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♦

The Honorable John Carney, Governor
State of Delaware

♦

Garrett H. C. Colmorgen, M.D., Chair

CDRC Mission Statement:

To safeguard the health and safety of Delaware's children and mothers

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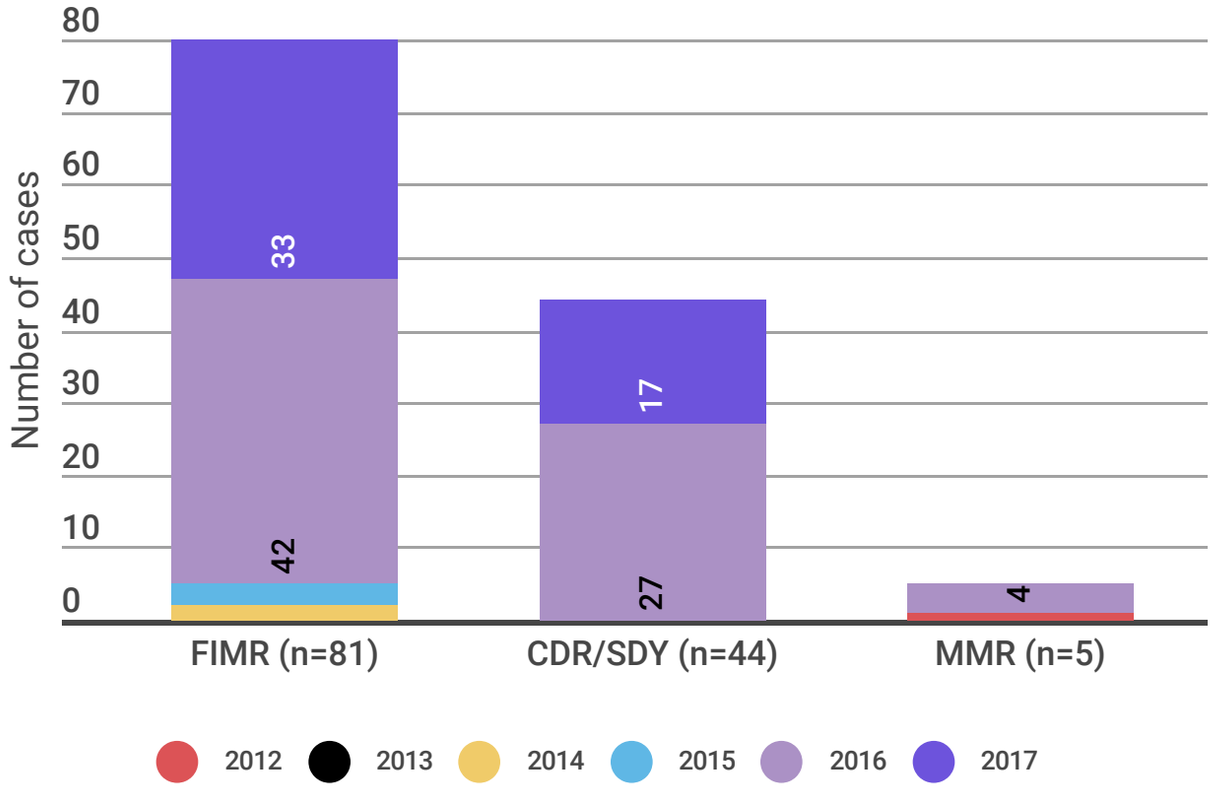
Executive Summary

In 2017, the Child Death Review Commission's (CDRC) three fatality review programs achieved their goal of conducting more contemporaneous reviews. The Child Death Review (CDR) panel and Sudden Death in the Young (SDY) panel reviewed 44 cases, all from 2016 (61%, n=27 cases) and 2017 (39%, n=17 cases) (Figure 1). The Fetal Infant Mortality Review (FIMR) teams reviewed 81 cases of which 52% (n=42 cases) were deaths that occurred in 2016, and 41% (n=33 cases) occurred in 2017. A few older cases were reviewed because they included maternal interviews--which provide valuable insight into the perspective of mothers who have experienced a loss--or involved mothers who had multiple losses over several years. The Maternal Mortality Review (MMR) panel reviewed five cases, one from 2012 and four from 2016.

Figure 1: CDRC cases reviewed in 2017, by year of death



With more concurrent reviews, the CDRC's findings and recommendations have heightened importance, and the in-depth mortality reviews can shed light on current trends that affect the health of women and children in Delaware. Many of these issues stem from psychosocial risk factors and underscore the importance of social determinants of health and the life course perspective in considering what contributes to poor health in this population. The issues summarized below draw upon data from all three mortality review programs and are presented by year of review, not by the year in which the death occurred.

A brief statement of the issue, key findings, and recommendations are presented. The critical issues identified in 2017 mortality reviews include:

1. **Mental health**
2. **Infant unsafe sleeping**
3. **Substance abuse**
4. **Inter-conception care**
5. **Evidence-based home visiting services**

In addition, a summary brief from the findings in MMR cases is highlighted given the rising rates of pregnancy-related mortality in the U.S.

Mental Health

Issue

Individuals with mental health issues often do not get the services they need. Without these services, women and children are at higher risk for poor health outcomes.

Findings

2x higher

Rate of of postpartum depression among FIMR mothers compared to women in the US and DE on average

1 out of 4

FIMR and CDR mothers have a current or past mental health condition

31%

of maternal deaths reviewed to date had a mental health issue that may have contributed to the woman's death

Recommendation

The CDRC recommends that depression screening be conducted universally at the time of birth and also postpartum.

Mental Health

One out of every 10 US women experiences symptoms of depression at some point in her life. (1) Postpartum depression is as common as 1 out of every 9 women in the US as stipulated in the Delaware PRAMS (Pregnancy Risk Assessment Monitoring System) survey. Depression, anxiety, and other diagnoses constitute some of the mental health issues documented in the CDRC cases. Mental health issues are found in one-quarter or more of the cases. Among 2017 MMR cases, two out of five had a mental health issue contributing to the woman's death. In the CDR/SDY reviews, team members have noted concern about the lack of access to mental health services across the state. In addition, the MMR panel has articulated concern about a lack of care coordination with providers not being aware of all prescriptions given to women in different settings.

CDR and SDY	2017	2016
Number of suicide deaths reviewed *	11	
Among suicide deaths, cases with inconsistent or intermittent mental health treatment *	64%	
Child's mother had a past or current mental health condition	25%	17%
Child's father had a past or current mental health condition ^	15%	3%

*2016 and 2017 combined

^This factor is unknown in many cases

CDR/SDY Finding: Community--Access to Care

There is a lack of mental health services in Delaware. (2016)

FIMR*	2017	2016
Mothers with a history of a mental health issue	24%	29%
Mothers who experienced depression during pregnancy	12%	10%
Mothers who experienced postpartum depression	25%	27%
Depression screening done (strength)	69%	56%

*There was a switch in the database used to record FIMR findings: in 2014 and 2015 the BASINET database was used, and from 2016 onward the National FIMR database has been in use. For this reason, the types of factors captured differ between the program years.

Mental Health

MMR	2011-2017
Mental health issue that may have been a contributing factor in the woman's death	31%

MMR Finding: Medical System--Coordination of Care
There was no follow up with a behavioral health provider or a social worker after a woman was prescribed medicines in the Emergency Department. (2016)

1. Centers for Disease Control and Prevention (CDC). Reproductive health: depression among women. Updated Dec 31, 2017. Accessed at: https://www.cdc.gov/reproductivehealth/depression/index.htm on April 19, 2018.

Infant Unsafe Sleeping

Issue

Despite state-wide educational efforts, infant unsafe sleeping deaths have remained constant over the last few years and account for a substantial portion of infant deaths.

Findings

Among the twelve 2017 unsafe sleeping death cases reviewed:

100%

of infants were not in a crib or bassinet

90%

of infants had unsafe bedding or toys

83%

of infants were bed sharing with other people

Recommendation

The CDRC endorses providing support and education to families caring for substance-exposed infants through evidence-based home visiting programs and the Division of Family Services (DFS). The intervention must occur shortly after discharge from the birthing hospital as 60% of the infant unsafe sleeping cases reviewed in 2017 were 0-2 months of age at the time of death, and families with a caregiver impaired by drugs are at higher risk for this outcome.

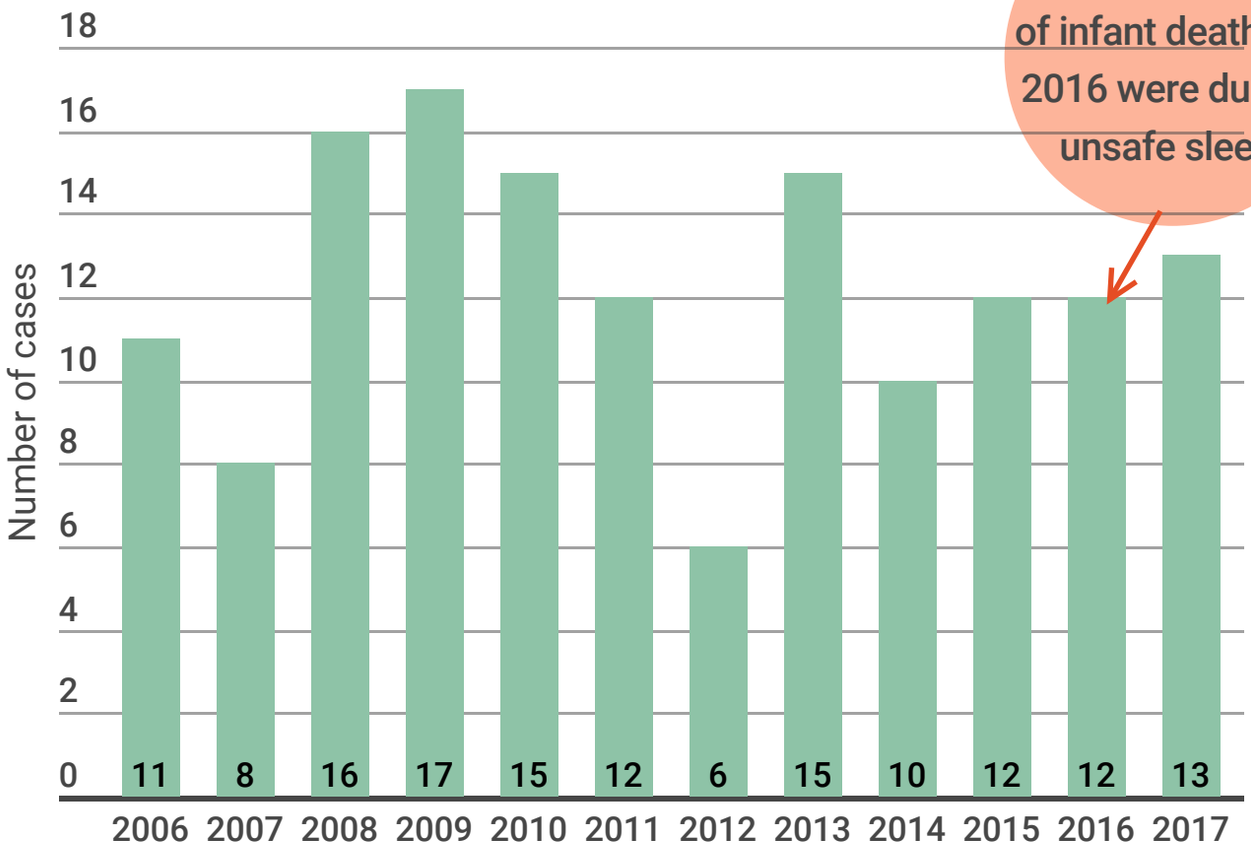
Infant Unsafe Sleeping

In 2016, out of 87 infant deaths statewide, 12 were due to sleep-related causes.(2 and Figure 2) That means that 14% of all infant deaths were due to infant unsafe sleep causes in 2016, the most recent year for which we have infant mortality statistics.

14%

of infant deaths in 2016 were due to unsafe sleep

Figure 2: Delaware unsafe sleeping deaths by year of death



The CDRC has been reviewing infant unsafe sleep deaths and tracking factors associated with these cases. The main contributors to sleep-related deaths in Delaware are: infants not sleeping in a crib or bassinet (100% of deaths), infants sleeping with other people (83% of deaths), and infants sleeping with unsafe bedding or toys (90%). The following table (page 10) presents some of these key factors associated with unsafe sleep cases reviewed in 2016 and 2017.

2 Delaware Division of Public Health, Office of Vital Statistics. Delaware Vital Statistics Annual Report 2016: Infant Mortality. Accessed at http://dhss.delaware.gov/dph/hp/2016.html on April 24, 2018

Infant Unsafe Sleeping

Factor	% 2017 cases reviewed (n=12)	% 2016 cases reviewed (n=23)
Bed sharing with other people	83%	65%
Infant was not in a crib or bassinet	100%	82%
Infant had unsafe bedding or toys	90%	83%
Infant not sleeping on back (Nat'l average is 25%)	60%	50%
Adult was drug impaired at time of death	25%	26%
Substance-exposed infant	10%	32%
Caregiver fell asleep while bottle feeding	0%	14%
Caregiver fell asleep while breast feeding	0%	9%
Family received safe sleep education	50%	45%

These findings illustrate why the ABC's of safe sleep are important:

Babies should sleep Alone, on their Back, and in a Crib

Cribs for Kids®
Helping every baby sleep safer

Action Steps

- The CDRC will partner closely with the Division of Forensic Sciences-Medical Examiner's office to acquire consent for families who want to participate in the sudden death registry.
- The CDRC will enhance collaboration with DFS. This will include hosting an online webinar to educate staff on infant safe sleeping as well as training Substance Exposed DFS liaisons to be Cribs for Kids distributors.
- The CDRC will undertake further de-identified analysis of the infant unsafe sleeping deaths in coordination with the Division of Public Health and a designated epidemiologist.

Some of the 2017 CDRC prevention activities included the following:

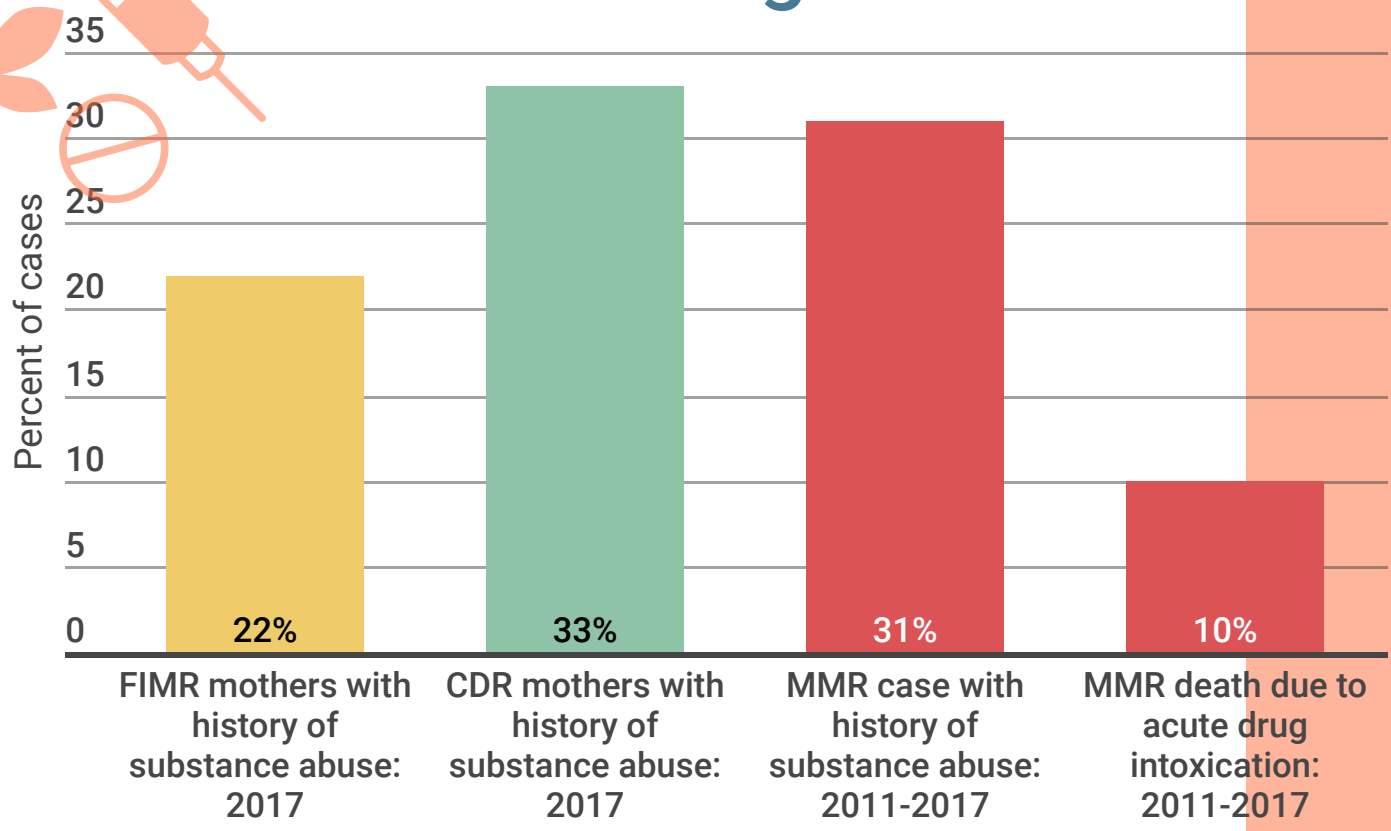
- Continued teaching at the Delaware Adolescent Program, Inc. (DAPI), Brandywine Counseling, New Expectations (a group home for adjudicated pregnant mothers with substance abuse issues), Delaware coalition of Fathers Boot Camp, daycare facilities and other venues.
- Continued oversight of the Delaware Cribs for Kids Program including adding several medical providers and the Wilmington Police Department to the program.
- Distribution of the "Sleep Baby, Safe and Snug" book to every new parent at all Delaware birthing hospitals.

Substance Abuse

Issue

Substance abuse is having widespread repercussions on the health of women, children and infants. Lack of screening, referral and access to treatment options for addiction puts individuals at increased risk for poor health outcomes.

Findings



Recommendations

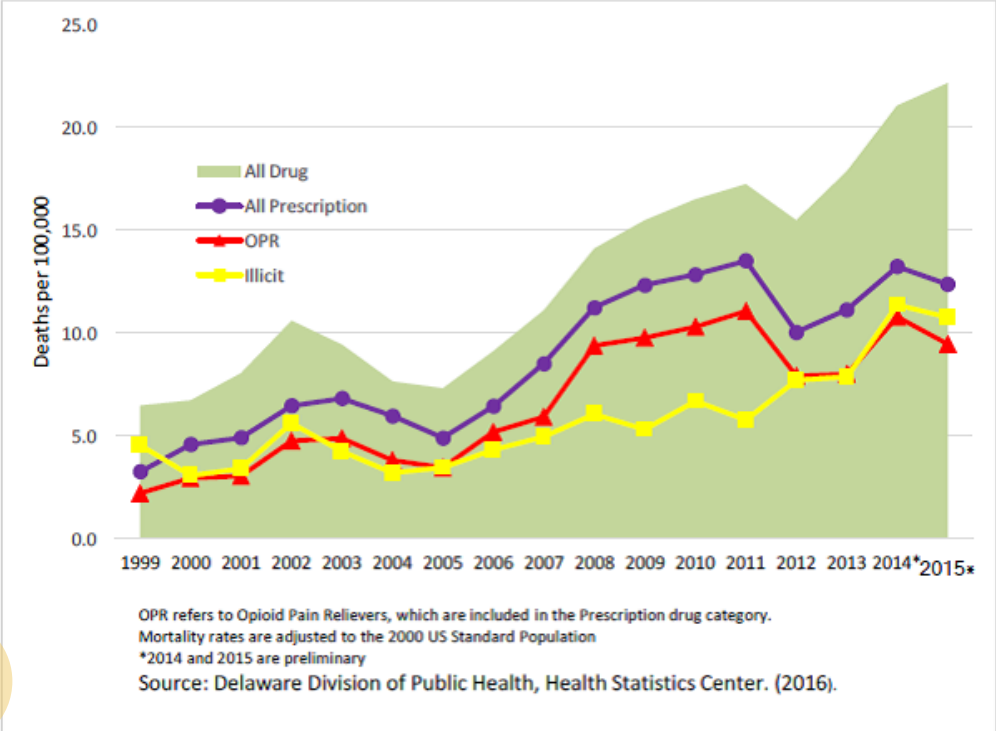
- Increase counseling and referral for substance abuse
- Improve access to treatment options
- Pass legislation HB140 (Aiden's Law) to implement plans of safe care for every substance-exposed infant
- Reduce the stigmatization of selectively applying screening by screening all pregnant and postpartum women for substance abuse

Refer every patient, every time.

Substance Abuse

The upward trend in drug overdose deaths in Delaware has been evident over several years and primarily driven by the uptick in prescription drug deaths. (Figure 3)(3) In 2016, the rate of drug overdose deaths in Delaware increased significantly by 40% to 30.8/100,000 people, well above the overall US rate of 19.8 deaths/100,000 people.(4)(5) There is also reason for concern that rates of drug overdose deaths is rising faster among women in the US. Between 1999 and 2015, the rate of deaths from prescription opioid and heroin overdoses increased twice as fast among women compared to men. Notably, the rate of deaths due to synthetic opioids increased over 8-fold among US women between 1999 and 2015.(6)

Figure 3: Annual age-adjusted drug overdose death rate in Delaware per 100,000 people and by type of drug, 1999-2015 (3)



Maternal substance abuse has been prevalent among MMR cases for several years, found in about one-third of cases reviewed between 2011 and 2017 overall. Also, one-quarter of infant unsafe sleep deaths involved an adult caregiver under the influence of drugs. Clearly parent and caregiver drug use is a concern for the health of women and infants in Delaware and stands to worsen perinatal outcomes.

Substance Abuse

CDR and SDY-cases reviewed	2017	2016
Suicide death: history of substance abuse*	27% (n=11 cases)	
Weapon-related death: victim with history of substance abuse	Not applicable	31%
Child's mother with history of substance abuse	33%	30%
Child's father with history of substance abuse	25%	18%
Substance-exposed infant	6%	19%
Adult caregiver was drug impaired at time of infant unsafe sleep death	25%	26%

*2016 and 2017 combined

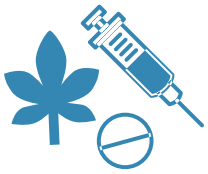
25%

of adult caregivers were drug impaired at the time of an infant unsafe sleep death

FIMR	2017	2016
Mother with history of drug use	15%	11%
Mother with illicit drug use	11%	10%
Mother with substance abuse (past or current)	22%	23%
Father with substance abuse (past or current)	10%	Not recorded
Substance-exposed infant	2%	0%

Substance Abuse

MMR	2011-2017 (n=29)
Mother with history of substance abuse	31%
Death due to acute drug intoxication	10%



31%

of maternal deaths reviewed between 2011-2017 had a history of substance abuse

MMR: Systems of care--Referral

There is no standard of care for making a referral to social workers when a patient is seen in the Emergency Department with a complication of drug use or discloses a recent drug use history. (2017)

3. Silverman PR, Mack J, et al. The Delaware opioid epidemic. DE J Publ Health 2017; 3(4): 26-33.
4. CDC. Opioid overdose: drug overdose death data. Accessed at: https://www.cdc.gov/drugoverdose/data/statedeaths.html on April 19, 2018.
5. CDC National Center for Health Statistics. Drug overdose mortality by state. Accessed at: https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm on April 19, 2018.
6. US Dept of Health and Human Services. Office of Women's Health. Final report: opioid use, misuse, and overdose in women. July 19, 2017. Washington DC. Accessed at: https://www.womenshealth.gov/files/documents/final-report-opioid-508.pdf on April 19, 2018.

Inter-conception Care

Issue

Women with prior history of complications during pregnancy or poor pregnancy outcomes are at greater risk for problems in their future pregnancies. For these women, it is particularly important to have continuity of medical care in the inter-conception period between their pregnancies, which includes making informed decisions about the spacing interval between pregnancies.

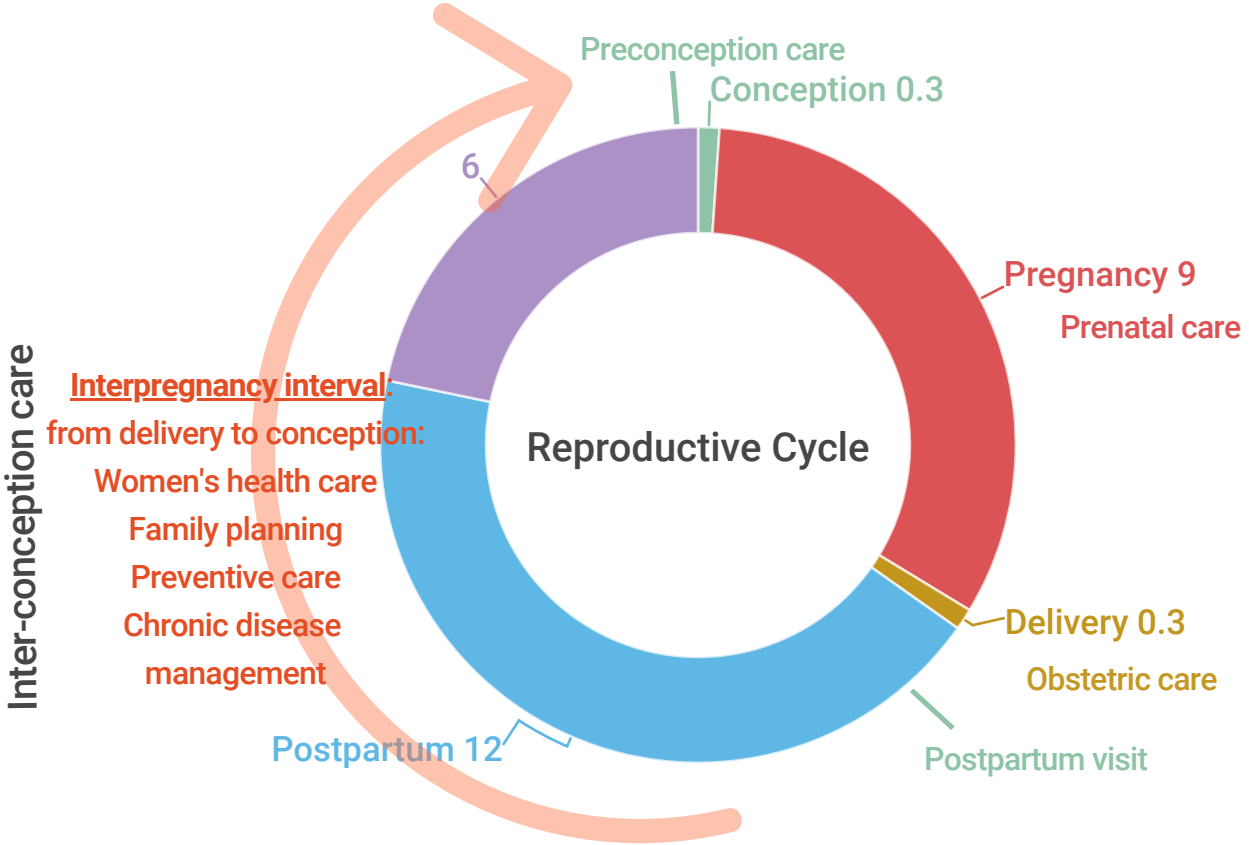


Figure 4: Reproductive cycle with months of duration, based on an 18-month interpregnancy interval & opportunities for health care

Recommendation

The CDRC supports the Delaware Healthy Mother and Infant Consortium's birth spacing campaign to reframe the postpartum visit as an inter-conception care visit and the optimal birth spacing of 18 months.

Findings

Inter-conception Care

There is room for improvement in getting women—particularly those at highest risk and with a recent fetal or infant loss—to follow up for postpartum and family planning care. There was lack of documented counseling on birth spacing intervals in most FIMR cases, and only a small fraction had documentation of counseling to wait at least 18 months. An interpregnancy interval of at least 18 months is recommended by the American College of Obstetricians and Gynecologists because evidence shows that short interpregnancy intervals increase the risk for poor subsequent pregnancy outcomes such as preterm birth and small for gestational age infants.(7)(8)(9)

FIMR	2017	2016	2014-2015
Mother went to her postpartum visit	61%	71%	63%
Mother with a prior history of a fetal loss	3%	6%	35%^
Mother with a prior history of an infant loss	4%	11%	
Mother with a prior low birthweight delivery*	12%	7%	15%#
Mother with a prior preterm delivery*	24%	19%	
Preconception care visit documented	11%		Not recorded
Mother who received care for her chronic health condition prior to her pregnancy	21%	18%	Not recorded
Mother who received pregnancy planning or birth spacing education prior to the pregnancy	18%	17%	Not recorded
Mother who was counseled to wait at least 18 months prior to getting pregnant again	6%	4%	5%
Family planning counseling offered postpartum	64%	58%	63%
Mother with <18 month interpregnancy interval	19%	19%	15%
No prenatal care	11%	6%	7%
Late entry into prenatal care in 2nd or 3rd trimester	13%	13%	17%

*Mothers with an infant death had a significantly higher prevalence of this history compared to those with a fetal death

^History of fetal or infant loss

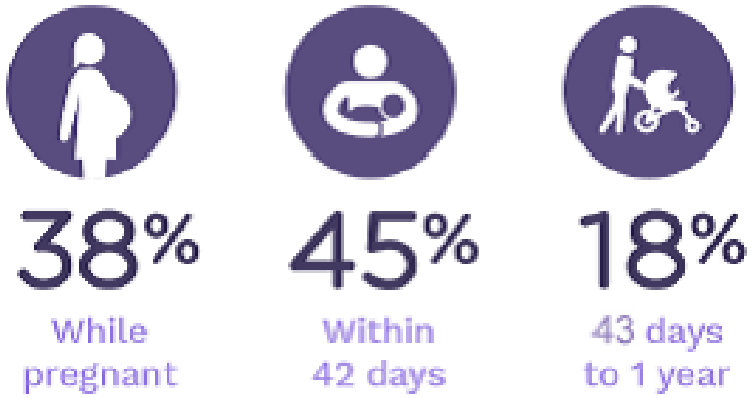
#Low birthweight or preterm history

Inter-conception Care

MMR	2011-2017 (n=29)
Maternal death occurred <42 days postpartum	52%
Maternal death occurred 43 days-365 days postpartum	10%

Postpartum is also a time when the mother's physical and mental health needs to be monitored. Over the course of seven years of maternal mortality review in Delaware, 62% of maternal deaths have occurred in the first year postpartum, mostly within the first 42 days. Nationally, findings from nine MMR programs compiled by the Centers for Disease Control and Prevention (CDC) also found that the early postpartum period was the most common time for pregnancy-related deaths: 45% of 237 pregnancy-related deaths occurred in the first 42 days after pregnancy (Figure 5).

Figure 5: Distribution of pregnancy-related deaths by timing of death in relation to pregnancy



Source: Building U.S. Capacity to Review and Prevent Maternal Deaths. Report from nine maternal mortality review committees. 2018. Accessed from: http://reviewtoaction.org/sites/default/files/national-portal-material/Report%20from%20Nine%20MMRCs%20final%20edit.pdf on April 16, 2018.

7. ACOG. Committee Opinion: optimizing postpartum care. Number 666. June 2016. Accessed at: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Postpartum-Care on April 19, 2018.

8. Grisaru-Granovsky S, Gordon E, et al. Effect of interpregnancy interval on adverse perinatal outcomes—a national study. Contraception 2009; 80(6): 512-518.

9. Conde-Agudelo A, Rosas-Bermudez A, Kafury-Goeta AC. Birth spacing and risk of adverse perinatal outcomes: a meta-analysis. JAMA 2006; 295(15): 1809-1823.

Inter-conception Care

Figure 6: Materials developed for the Delaware birth spacing campaign for patients and providers

Evidence-Based Home Visiting Services

Issue

Women and families with significant psychosocial and medical risk factors for poor perinatal outcomes are not accessing evidence-based home visiting (EBHV) programs, representing a lost opportunity to impact those families who have the most to gain.

Findings

Percent of CDRC cases referred to EBHV services:

11%

FIMR cases 2017

25%

CDR/SDY infant cases 2017

9%

MMR cases 2016-2017

Recommendation

The Commission strongly supports improvement in the process for vulnerable populations to access and accept evidence-based home visiting services. (2016 and 2017)

Evidence-Based Home Visiting Services

Delaware's EBHV continuum includes Healthy Families America (HFA), Parents as Teachers (PAT), Early Head Start, and Nurse Family Partnership (NFP) and all follow families from the perinatal period to early childhood. Review of evidence compiled by the Administration for Children & Families shows that all EBHV have favorable impacts on outcomes related to child development and school readiness, child health, reductions in child maltreatment and positive parenting practices. In addition, NFP has demonstrated impact on indicators pertaining to family economic self-sufficiency and maternal health.(10)(11). NFP focuses on first time Mothers and PAT provides services up to the child's fifth birthday.

Delaware has the third highest per capita health care expenditures in the nation, yet health indicators in the state are not strong. To improve the health of our population, more spending on medical care is unlikely to move the needle on key outcomes. Delaware is working to implement a statewide health care spending benchmark focusing on quality of outcomes achieved.(12) Other ways of improving health—by focusing on the social determinants of health and community-based support for at-risk families—is necessary. EBHV is one part of a multifaceted approach to improve health outcomes for women and young children, which in turn has the potential to reduce health care spending on maternal and neonatal complications.

Families experiencing a fetal or infant death represent a subpopulation that has high prevalence of psychosocial stressors as well as medical risk factors. Despite this fact, years of CDRC data reveal that very low percentages of women and families are referred and enroll in EBHV programs whose eligibility criteria are designed to serve such families. In 2017, only 11% of FIMR mothers were referred to an EBHV, and this proportion did not differ among mothers seen at private practices for prenatal care and those seen at public clinics. This data suggests that the site of prenatal care did not affect the rate of referral.

FIMR	2017	2016
Multiple stresses	45%	51%
Social chaos	19%	20%
Concerns about money	9%	25%
EBHV referral made	11%	8%
EBHV referral not made	86%	92%
Family enrolled in EBHV program	1%	3%

Evidence-based Home Visiting Services

Among CDR/SDY infant cases, 25% had a referral made to an EBHV program, but no families enrolled.

CDR/SDY infant cases	2017 (n=16)	2016 (n=31)
EBHV referral made	25%	19%
EBHV referral not made	44%	19%
Family enrolled in EBHV program	0%	10%

CDR/SDY Case Finding: Home visiting--Assessment and referral
No referral was made to an EBHV program despite pertinent maternal risk factors.

MMR	2016-2017 (n=11)
EBHV referral made	9%
Mother enrolled in EBHV program	0%

10. Administration for Children & Families, US Dept of Health & Human Services. Home Visiting Evidence of Effectiveness: Healthy Families America: in brief. Updated in April 2017. Accessed at: https://homvee.acf.hhs.gov/Model/1/Healthy-Families-America--HFA--In-Brief/10 on April 19, 2018.

11. Administration for Children & Families, US Dept of Health & Human Services. Home Visiting Evidence of Effectiveness: Nurse Family Partnership in brief. Updated in May 2016. Accessed at: https://homvee.acf.hhs.gov/Model/1/Nurse-Family-Partnership--NFP--In-Brief/14 on April 19, 2018.

12. Department of Health & Social Services. Delaware's road to value (draft). Accessed at: http://www.dhss.delaware.gov/dhss/roadmapmerged.pdf on April 19, 2018.

Maternal Mortality Review

Issue

Maternal deaths have been rising in the United States. Delaware's MMR reveals the toll that violence and substance abuse, along with medical complications, take on the well-being of pregnant and postpartum women. MMR is an important public health surveillance program that provides a snapshot of women's health in general and contributes to the national effort to conduct quality reviews and take action to reduce maternal deaths.

Findings

MMR panels see a snapshot of deaths occurring among women of childbearing age. These cases are identified by vital statistics data from the death certificate. In Delaware, all deaths occurring among pregnant women or up to one year postpartum are reviewed by the MMR regardless of cause. This broad inclusion criterion allows the Delaware MMR key insights into the health of women overall. Among 2017 cases, what is striking is the preponderance of psychosocial risk that accounted for 4 out of 5 of the maternal deaths.

Maternal Mortality Review

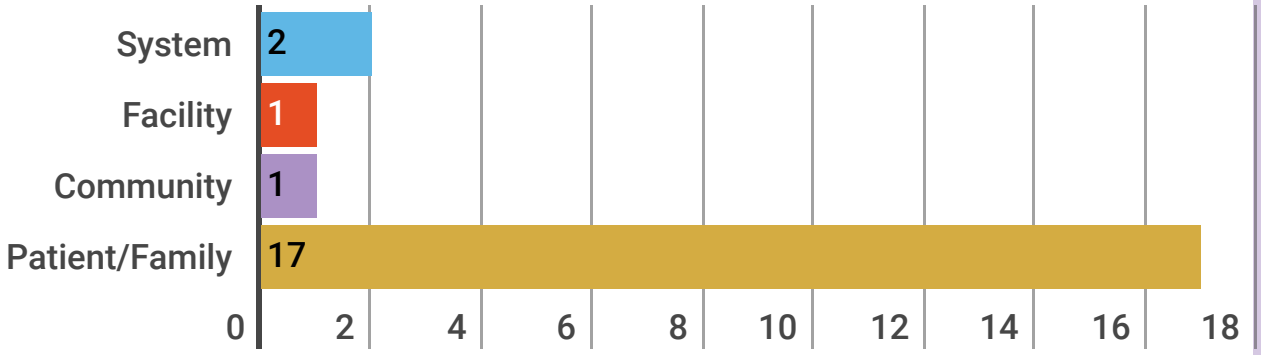
In 2017, Delaware's MMR panel met once and reviewed 5 cases of maternal deaths. Three mothers were White, and two mothers were Black. The panel deemed one of the five cases to be pregnancy-related, meaning the woman's death was causally linked to pregnancy or its complications. This pregnancy-related death was due to a medical complication in the immediate postpartum period. The other four cases reviewed were designated as pregnancy-associated but not -related, meaning the cause of death was not related to the woman's pregnancy. Two of these deaths were homicides, and two were due to acute drug intoxication.

Of the five maternal deaths, three occurred while the woman was still pregnant. One death occurred in the early postpartum period (before 42 days postpartum), and one death occurred in the late postpartum period (between 43 days and one year postpartum).

The MMR panel reviewed each case to identify pertinent contributing factors at various levels that may have impacted the outcome of the case. On average, 4 to 5 factors were identified for each case reviewed. Contributing factors (Figure 7) identified include:

- Lack of referral for intimate partner violence (IPV) (Systems of care level)
- Lack of referral for substance abuse (Systems of care level)
- Desensitization to violence (Community level)
- Lack of IPV screening (Facility level)
- Delay in seeking care (Patient/family level)
- Difficulty adhering to medical advice (Patient/family level)
- Substance abuse (Patient/family level)
- Mental health (Patient/family level)
- IPV (Patient/family level)

Figure 7: Contributing factors identified in 2017 MMR cases (n=5)



Maternal Mortality Review

In 2017, CDRC staff worked closely with the Office of Vital Statistics-Division of Public Health, to implement a process for linking Mothers' information from live birth and fetal death certificates with death certificates of women of reproductive age. Many MMR programs and the CDC have found that this type of linkage improves the chances of identifying potential maternal death cases compared to the use of the pregnancy check box question on death certificates alone, which until now has been the way the Delaware MMR has primarily been identifying cases.

Recommendation

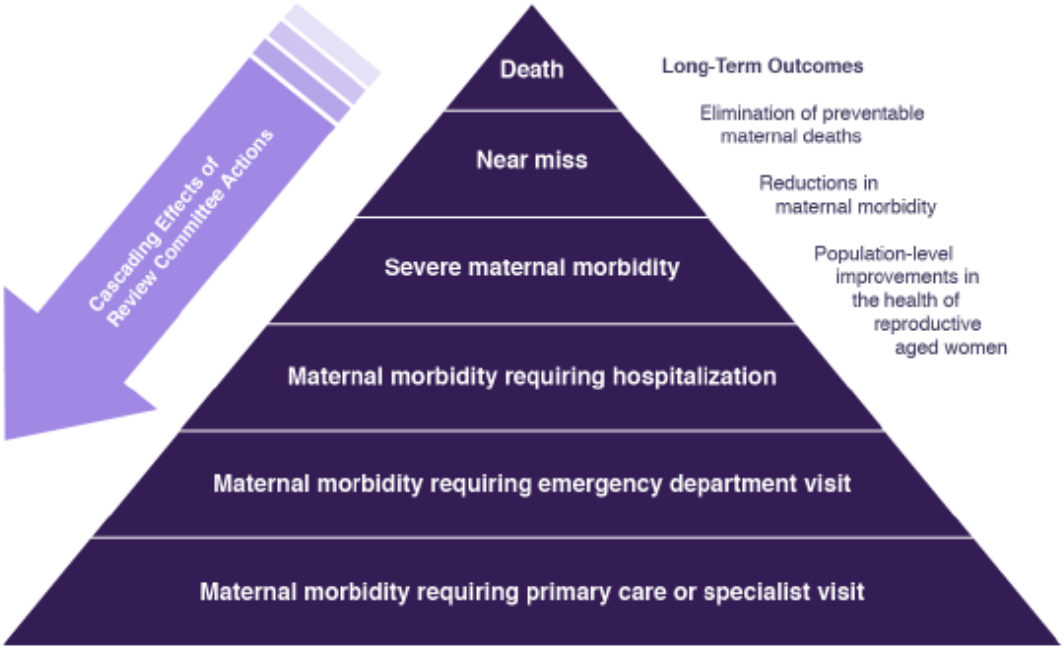
Improve case identification of possible maternal deaths by linking live birth and fetal death certificate information with death certificates of women of reproductive age.

Maternal deaths are the tip of the iceberg in the spectrum of outcomes for pregnant women, representing the most dire and rarest outcome (Figure 8). For every maternal death that occurs, it is estimated that 100 women suffer a severe maternal morbidity.(13) Yet what we can learn from in-depth reviews of pregnancy-associated deaths can shed broader light on issues affecting a larger group of women. Some of these women may suffer a complication or morbidity, one that may result in a hospitalization or ER visit for example, but does not progress to the severity of being fatal. Data from Delaware on severe maternal morbidity shows an increasing trend in these rates, which climbed by 37% between 2010 and 2014.(14)

The CDC is spearheading efforts to standardize data collected by MMR programs across the US and identify key issues and recommendations to inform impactful action. Delaware is working with partners nationally in these efforts and was one of 9 states that contributed data to the 2018 CDC report available at: https://www.cdcfoundation.org/sites/default/files/files/ReportFromNineMMRCs.pdf.

Maternal Mortality Review

Figure 8: Prevention impact of MMR



Source: Building U.S. capacity to review and prevent maternal deaths. 2018. Report from nine maternal mortality review committees. Available at: https://www.cdcfoundation.org/sites/default/files/files/ReportFromNineMMRCs.pdf.

13. Callaghan WM, Creanaga AA, Kuklina EV. Severe maternal morbidity among delivery and postpartum hospitalizations in the United States. OB Gyn, 2012; 120(5): 1029-1036.
14. Hussaini, SK. Severe Maternal Morbidity: Delaware, 2010-2014. Data Brief. Delaware Health and Social Services, Division of Public Health. Published August 2017.

Conclusion

Continued, coordinated efforts will be needed to further impact the over-arching issues presented here and that adversely impact the health of women and children in Delaware. While progress has been made on some key indicators such as the state's infant mortality rate, other numbers have plateaued—such as the count of unsafe sleeping deaths—or have been increasing—such as the national pregnancy-related mortality ratio. Also, the racial disparity in these key indicators persists or increase, so progress made is not equally shared and in fact intensifies health inequities in some cases. The CDRC supports efforts by key partners in the field of women and children's health to look at root causes, social and community factors whenever possible, and build upon demonstrated successes to bring better outcomes across the state, irrespective of geography, race, or socioeconomic factors.

Appendix

Commissioners

Margaret-Rose Agostino, DNP, MSW, RN-BC (MMR Chair)
Aleks Casper (NCC FIMR Chair)
Patricia Ciranni, RN (K/S FIMR Chair)
Dr. Garrett Colmorgen (Chair, Perinatology)
Mary Ann Crosley (Child Advocate, statewide nonprofit organization)
Tania Culley, Esq. (OCA)
Nancy Forsyth (DE Nurses Association)
Dr. Gerard Gallucci (DHSS)
Mawuna Gardesey (DPH)
Chief Laura Giles (Police Chief's Council)
Susan Haberstroh (DOE)
Marjorie Hershberger, MSN, APN (NCC/SDY Panel Chair)
Judge Joelle Hitch (Family Court)
Dr. Amanda Kay (Pediatrician)
Leslie Newman (Child Advocate, statewide nonprofit organization)
Cpl Adrienne Owen (DSP)
Rebecca D. Walker, PhD, JD, MSN (Division of Forensic Sciences)
Dr. David Paul (MS/Neonatology)
Allison Reardon, Esquire (DOJ)
Shirley Roberts and Trenee Parker (DSCYF)
Dr. Philip Shlossman (K/S Panel Chair, MS/Obstetrics)
Jennifer Donahue (CPAC)
Lt. Teresa Williams and Lt. Mike Bradshaw (NCCPD)

CDR Panel Members

Dr. Kevin Bristowe
Det. Kenneth Brown and Lt. Richard Jefferson (Milford PD)
Helene Diskau / Maureen Ewadinger(Child Development Watch)
Capt. Melissa Hukill and Det. Roger Cresto (DSP)
Carrie Hyla and Addie Asay (Family Court)
Dennis Kelleher (DOJ)
Lt Chad Bernat and Lt. Todd Case (Dover PD)
Deborah Miller (LCSW)
Angela Birney (OCA)
Dr. Phillip Shlossman (Chair / Christiana Care)
Linda Smith and Cindy Brown (DOE)
Renee Stewart (DSCYF)
Aimee String (DVCC)
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