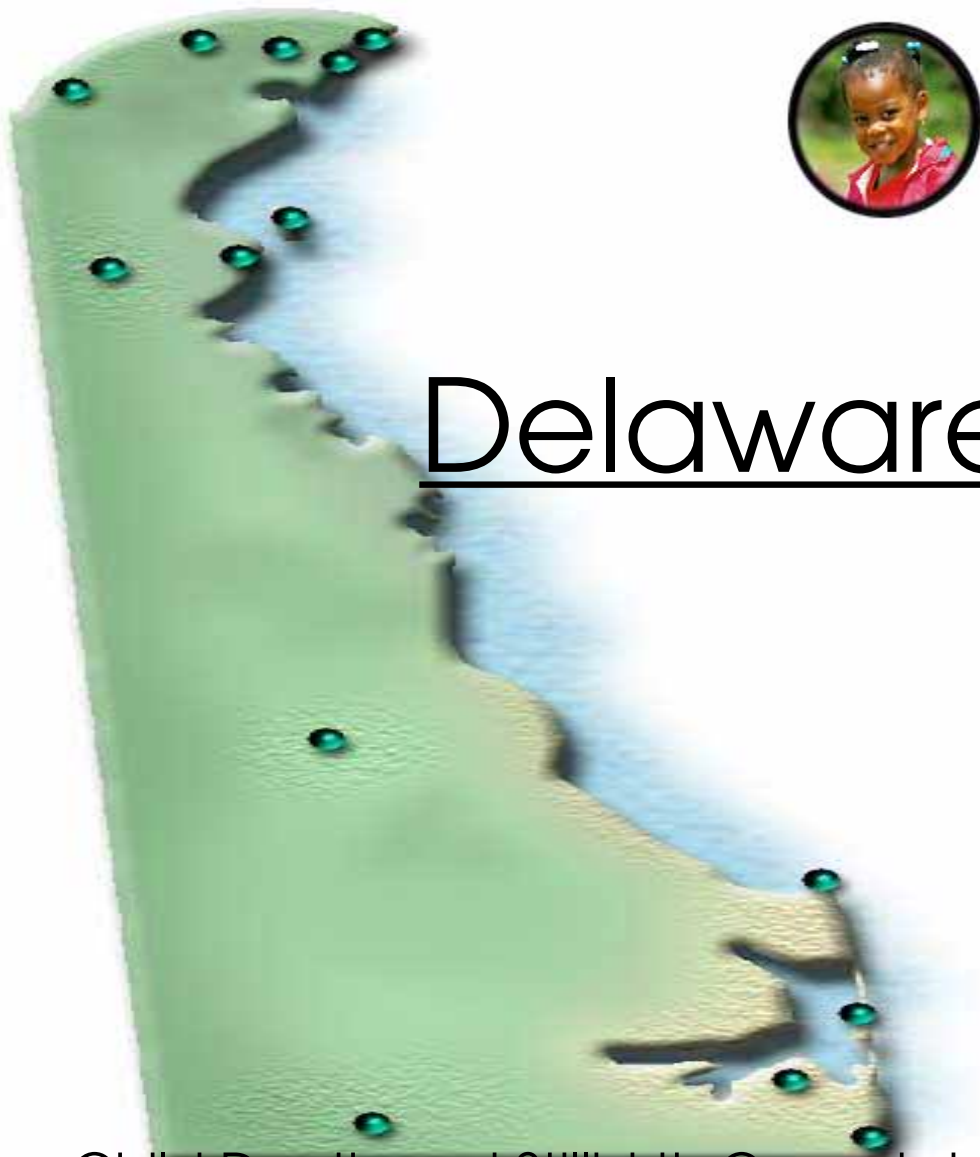


Preventing Child Deaths in the First State



Delaware

Child Death and Stillbirth Commission
2000, 2001
and 2002 Consolidated
Annual Report



MEMORANDUM

TO: The Honorable Ruth Ann Minner, Governor, State of Delaware
State Senate, State House of Representatives

FROM: Garrett H.C. Colmorgen, M.D.
Chairperson, Child Death Review Commission

SUBJECT: 2000, 2001, and 2002 Child Death Review Annual Report

I am pleased to present to you the Fourth Annual Report of the Delaware Child Death Review Commission. The Report provides a summary of the work of the Panels and Commission during the years 2000, 2001, and 2002.

As a result of the statutory changes in 2002, a more intense look has been given to every facet of the Commission and Panels. A subcommittee has met bi-monthly to develop a handbook and training for the most complete review of child deaths. Panels will now develop action steps for each recommendation given to the Commission.

Throughout the last several years, the panels have made significant recommendations, many of which have been acted upon and which may be saving children's lives. However, without action steps in place, many recommendations still need further exploration. The panels are hopeful that the work that has been done will now be taken to the next level to bring about even more positive changes for Delaware's children.

The Child Death Review Commission and Regional Panels are truly an example of multi-disciplinary teamwork in their evaluation of systems and recommendations for protection of Delaware's children. Coordinating the process, and making this report, are staff from the Office of the Child Advocate, the Department of Services for Children, Youth and their Family, the Attorney General's Office, the Department of Health and Social Services, the Department of Education, and Grassroots Citizens for Children. The Commission members and I commend the efforts of the Regional Review Panels and their members for their efforts.

GHCC/amp
Enclosure

"These children are lost to us; they are irreplaceable. Let us learn what we can from their untimely, often tragic deaths and work to benefit future children."

Source: Saskatchewan Child Advocate.

Executive Summary

The Child Death Review Commission was established in 1995. The mission is to safeguard Delaware's children by examining the deaths of children under the age of 18.

Multi-disciplinary Review Panels met monthly in 2000, 2001 and 2002 during the months of September through May. They conducted a retrospective review of the history and circumstances surrounding a child's death. During this period, the deaths of 404 children were reviewed. Out of these 404 deaths, 80 were voted as preventable by the panels. The remaining 324 deaths were voted as not preventable, undecided or as Sudden Infant Death Syndrome/Sudden Unexplained Death Syndrome (with risk factors identified.)

The analyses that follow list the deaths by preventable type, gender, race, and manner of death listed on the death certificate (Natural or Non-natural). The work of the dedicated panels can best be reflected in the Recommendation portion of this Annual Report. Many of these recommendations were implemented and have improved the systems in Delaware in an effort to prevent child deaths. Some examples include: traffic lights installed in dangerous intersections, information included in Office of Child Care Licensing training to help prevent SIDS, and reflector lights installed on Amish buggies.

The new process developed by the Child Death Review Process Subcommittee in 2003 will include action steps and agency accountability for recommendations that are given by the Panels. A new handbook has been developed and will be given to the Commission and Panels at an upcoming training on the recent changes to the process. In the coming year, the Commission will explore funding options for staff needed to support this critical service.

The Commission would like to focus on the following matters that are seen as trends and areas of concern for the State of Delaware:

- African Americans make up 19 percent of Delaware's population, yet represent 40 percent of all deaths in children.
- 41 deaths were a result of motor-vehicle crashes or a pedestrian being hit by a motor vehicle. 31 of the 41 were determined by the panels to be preventable in 2000-2002.
- The risk factors that were most prevalent in SIDS/SUDS cases were smoking in the household, sleeping position of the child, co-sleeping with adults and soft bedding.
- Despite a decrease in overall child deaths (as illustrated under the section Data Presentation of Child Deaths), Delaware's infant mortality rate continues to rise.

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Introduction

The Child Death Review Commission was statutorily established on July 19, 1995. The Child Death Review Commission was created after a pilot project showed the effectiveness of having a review process for child deaths. Currently there are two Review Panels operating in Delaware. One panel reviews deaths of children who resided in New Castle County and the other reviews deaths of children who resided in Kent or Sussex Counties.

Background

The Attorney General's Abuse Intervention Committee ("AIC") was convened in May 1988 to address various issues related to child abuse and neglect as required by the Children's Justice Act grant. The AIC focused on developing coordinated, multi-disciplinary approaches to child abuse and neglect interventions.

In 1990, the AIC applied for and received technical assistance from the American Bar Association and the American Academy of Pediatrics Child Maltreatment Fatalities Project. As an outgrowth of this assistance, the AIC developed a subcommittee comprised of multiple statewide disciplines for developing a proposal for standard child death review procedures in Delaware. *The Child Death Review Panels Proposal* ("Proposal") was published in November 1993 and provided a comprehensive model or "blueprint" for conducting statewide child death reviews in Delaware.

Formal presentations regarding the Proposal were provided to the Criminal Justice Council and the Infant Mortality Task Force and both groups supported the Proposal. The AIC and sponsoring agencies explored funding options, but were unable to secure necessary funding to implement the Proposal on a statewide level. Therefore, it was decided to develop a Pilot Project in New Castle County utilizing existing staff and resources.

The Implementation Subcommittee of the AIC was created to formalize plans for the Pilot Project. This multi-disciplinary workgroup met monthly from July 1994 until March 1996. The Implementation Subcommittee adopted and operationalized the original 1993 Proposal into the *New Castle County, Delaware Child Death Review Pilot Project* (January 1995).

The Pilot Project implementation process involved a series of steps to adopt the Proposal into a county pilot review system. The steps included conducting a mock child death review in September 1994, providing an overview session for prospective Pilot Review Panel member agencies in November 1994, and training Pilot Review Panel members in January 1995. The first Review Panel officially convened in February 1995.

The goal of the Pilot Project was to review child deaths meeting established criteria, maintain and analyze data pertaining to the deaths, present findings regarding preventability, and provide recommendations for policy and system changes. The Pilot Project retrospectively reviewed deaths that occurred on or after June 1, 1994.

In June of 1995, legislation was drafted to establish a statewide Child Death Review Commission. House Bill 317 was passed, and signed by Governor Thomas R. Carper on July 19, 1995. The law established a 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. Child death reviews have been conducted in New Castle County from February of 1995 until the present time. Another Review Panel was convened for Kent and Sussex Counties in October 1996. This Review Panel was trained and began reviewing cases in October 1996.

In 2002, the statute was amended, giving the Commission authority to review stillbirths occurring after 27 weeks of gestation should funding become available. The Commission name was also changed to Child Death and Stillbirth Review Commission to reflect this authority. That same year, Senate Bill 385 passed in the General Assembly requiring that the Commission promptly investigate and review all the facts and circumstances of the death of an abused and/or neglected child. Recommendations from these reviews are immediately sent to the Governor and General Assembly and made available to the public.

Purpose of Child Death Reviews

The primary purpose of reviewing child deaths is the prevention of future child deaths. The review is a *retrospective* system review intended to provide meaningful, prompt, system-wide recommendations in an effort to prevent future deaths and to improve services to children. A child death is considered preventable if one or more interventions (medical, community, legal, psychological) might reasonably have averted the child's death. The reasonableness of the intervention is defined by the conditions and circumstances of the death and available resources.

Criteria of Cases Reviewed

1. All State of Delaware residents under the age of 18 whose deaths occurred within the state.
2. Deaths involving criminal investigations (with the exception of abuse/neglect cases) are delayed contingent upon authorization of the Attorney General's Office.
3. Deaths involving abuse and/or neglect shall be reviewed within three months of a report to the Commission notwithstanding unresolved criminal charges.

Commission Structure

The Commission Members are either designated by position as outlined in the statute or are appointed by the Governor. The Commission chair is elected annually. Commission members and panel members receive no compensation for their service. There are no positions dedicated to the Commission. Optimally, three full-time positions to manage the child death review process; CDRC Administrator, Medical Records Abstractor and a Secretary, were recommended in the Child Death Review Panel Proposal. Currently these recommended positions have not been designated or funded despite the significant increase in work since 1993.

In the 1997 Annual Report, the Commission recommended that a full-time Project Director be hired with a limited training budget. At the current time, the Child Death Review Commission is assisted by two employees from the Children's Department. This is not their designated job and they do this work in addition to their primary job responsibilities for the Children's Department. As a result, the Commission and Panels continue to struggle with timely reports and statistics to help make system recommendations as needed. The Commission will continue to advocate for full-time staffing.

DELAWARE CHILD DEATHS

2000 – 2002

CATEGORIES OF DEATH AND RECOMMENDATIONS FOR CHANGE

- 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., Ch. 3, Subch. II.*



Adolescent Suicide/ Firearms

The Delaware Child Death Review panels continue to review cases where suicide was by means of a firearm. Gun safety education is important for all parents. Nationally, in the year 2000, 86 children died from gun-related injuries. *Source: National Safe Kids Campaign.* Reducing accessibility and storing firearms safely are necessary steps to protect our children. Did you know:

- ❑ Few children under age 8 can distinguish between real and toy guns nor do they understand the consequences of using a gun. Surprisingly enough, children as young as age three have the strength to pull the trigger of many types of handguns.
- ❑ One study discovered that when a gun is in the home 75 percent to 80 percent of children in the first and second grade knew where their parents kept the gun. This is a frightening study when you consider that 40 percent of all homes with children have a gun (often unlocked or loaded).

Source: National Safe Kids Campaign.

SUICIDE PREVENTION

- Improve the identification and treatment of children with behavioral health problems.
- Educate health care providers, parents, and school staff to identify children at risk.
- Encourage involvement of teens with positive peer and adult role models.
- Increase youth involvement in structured after school programs, including team sports and other team activities.
- Teach parents and caregivers to recognize children at risk for suicide.
- Publicize suicide prevention resources to the community.
- Restrict youth access to guns, drugs, and alcohol.
- Build the self-esteem of children by teaching them decision-making skills, conflict resolution, and improving their communication skills.

Source: Childhood Injury in Delaware, 2001.

Delaware Death Statistics

In the year 2000, the Delaware panels reviewed two deaths caused by suicide, one from Kent County, and the other from New Castle County. In one of the suicides, the manner of death was by use of a firearm that was unsecured in the home. In the year 2001, the panels reviewed three deaths caused by suicide, two were from New Castle County, and the other was from Kent County. None of the suicide deaths in 2001 can be attributed to the use of a firearm. In the year 2002, the panels reviewed one death by suicide by use of a firearm in New Castle County. Another possible suicide (not determined as suicide by Office of the Medical Examiner) was reviewed where the death was a result of a firearm injury. *These numbers include those cases voted as preventable and not preventable or unknown by the panels.*

Recommendations for Change **Adolescent Suicide/Firearms**

1. Employ individuals to provide Social Services to schools for children at risk (possibly in Wellness Centers). Suicide prevention education should be promoted in schools and wellness centers. Schools should follow-up on students with identified problems. Schools should have staff development on how to recognize behavior changes that may influence other outcomes, including health and psychological. All schools should have Wellness centers. All school districts must have a suicide program/crisis source. Schools should promote coordination in school health programs. Parents, teachers, and friends should know the warning signs of suicide. (2000)
2. Put Crisis Hotline number on computers in schools (2000)
3. Ensure children receive mental health services in the same timely manner they receive medical health services. Resources need to be placed where the children are, i.e. wellness centers. Schools and providers need to be aware that Child Advocacy Office can be used as a resource. (2001)

Action taken or next steps: Amendments have been made to the Violent Crimes Compensation Board to support mental health treatment for children and procedures have been developed at the Children's Advocacy Center to expedite mental health treatment.

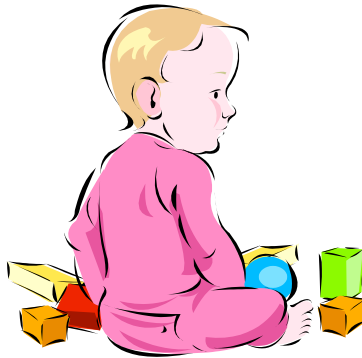
4. Provide long-term counseling support for crisis intervention when needed in the schools. (2001)
5. Provide gun safety information in schools. (2002)

Action taken or next steps: Gun safety education is a part of the Risk Watch

Injury Prevention Program. The number of schools utilizing this curriculum continues to grow each year.

6. DSCYF staff should discuss dangers of firearms and other risk factors in the home that can affect safety of a child. Resources should be allocated for the interstate compact with respect to the juvenile justice system to better monitor children moving between jurisdictions. Re-evaluation of risk assessment system to be developed for the Children's Department to reliably inform case managers of percent of risk when case is transferred within the juvenile probationary system. (2002)

Action taken or next steps: The entire safety model was revised and implemented summer 2001. Resources for ICPC have been sought in the FY05 Budget.



Child Abuse and Neglect

The Child Welfare League of America documented that 1,236 children died in the year 2000 from abuse and neglect. Throughout the country, states are seeing increased homicides because of abuse. From 1995 until 2002, there were 27 child deaths from abuse and neglect in Delaware. The First State takes this concern seriously and legislators changed the law in June 2002 for expedited reviews of child death abuse and neglect cases. State code requires that the Commission shall investigate and review all the facts and circumstances of the death of an abused and/or neglected child. Deaths involving abuse and/or neglect shall be reviewed within three months of a report to the Commission notwithstanding unresolved criminal charges. System-wide recommendations arising from an expedited review of a death due to child abuse or neglect must 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. All recommendations made pursuant to the new law shall comply with applicable state and federal confidentiality provisions. 31 Del. C. § 323. (Please see Appendix B for the first letter sent to the Governor after passage of the new law).

CHILD ABUSE PREVENTION

Risk factors in some families include the following:

- Seem to be having economic, housing or personal problems
- Have difficulty controlling anger or stress
- Are isolated from their family or community
- Abuse alcohol or drugs
- Are dealing with physical or mental health issues
- Appear uninterested in the care, nourishment or safety of their children.

You can help -- by helping parents who might be struggling with any of these challenges, you reduce the likelihood that their children will be abused or neglected.

Behavioral changes and/or warning signs in children may manifest prior to outward physical signs such as:

- Aggression toward adults or other children
- Inability to stay awake or to concentrate for extended periods
- Nervousness around adults
- Sudden, dramatic changes in personality or activities
- Frequent or unexplained bruises or injuries
- Poor hygiene
- Low self-esteem
- Unnatural interest in sex

You can help -- by reaching out to children with these signs and offer a helping hand to them or their parent.

Source: <http://www.preventchildabuse.org>

All Delawareans are mandated to report suspected child abuse or neglect to the Child Abuse Hotline at 1-800-292-9582.

Delaware Statistics

In the year 2000, one death from abuse and neglect was reviewed. In the year 2001, no children were reviewed under this category. This changed in 2002 with the new expedited reviews of abuse and neglect deaths. Two children were reviewed under this new law.

Recommendations for Change

Child Abuse and Neglect

1. 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. (2002 – expedited review)
2. Expand education and training on child abuse, child neglect, and domestic violence to health care providers. (2002 – expedited review)
3. Make referrals to the appropriate medical/nursing licensing organizations regarding a particular case if there is evidence of a breach of the standard of medical or nursing care. (2002 - expedited review)
4. Require child abuse investigators to routinely contact primary care physicians to assess prior care and risk for future abuse of other children. (2002 – expedited review)
5. Ensure compliance with 16 Del. C. § 906 (b) (3) through training and supervision of all appropriate personnel in the child welfare community. (2002 – expedited review)

Action taken or next steps: The Abuse Intervention Training Consortium sponsored training at Dover Downs on April 15 and April 16, 2003. The theme was “Putting the Pieces Together: Working Together for Delaware’s Children and Families”. American Prosecutor’s Research Institute trained on conducting multi-disciplinary investigations of child abuse.

6. 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. (2002 – expedited review)

Action taken or next steps: There is a committee (under the Abuse Intervention Committee) revising the Memorandum of Understanding between the Department of Justice, Law Enforcement, The Division of Family Services, the Medical Community and the Children’s Advocacy Center. (Delaware Code, Title 16, Chapter § 906 requires that a joint investigation between Police and DFS be completed when a criminal offense of child abuse and neglect has occurred).

7. Pursue Development of policy and procedure that would enable appropriate and necessary utilization of DELJIS and premise history by the Division of Family Services’ workers. (2002 – expedited review)

8. Review coordination and communication between Investigative Officials (police, medical examiner, social services) (2001)

Action taken or next steps: Currently there is a committee (under the Abuse Intervention Committee) underway to revise the Memorandum of Understanding between the Department of Justice, Law Enforcement, DSCYF, the Medical Community and the Children's Advocacy Center. (Delaware Code, Title 16, Chapter § 906 requires that a joint investigation between Police and DFS be completed when a criminal offense of child abuse and neglect has occurred

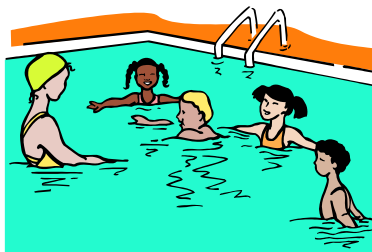
9. Require individuals with history or charge of domestic violence to go through domestic violence offender treatment. (2002)

Action taken or next steps: This is currently being ordered by the court.

Additional Concerns

The Commission 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.

The Commission is interested in exploring collaboration with the Domestic Violence Coordinating Council 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.



Drowning

In the United States, there has been a 34 percent decline from 1987 to 1998 regarding drowning. However, drowning is still the second leading cause of unintentional injury-related death for children 14 and under. Nearly 1,000 children lose their life to drowning each year in this country. 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. *Source: National Safe Kids Campaign.*

Drowning Prevention/Pool Safety Strategies

- Promote parental awareness of drowning risk for young children.
- Seek advice from pediatricians for information and prevention tips.
- Enforce laws requiring that fences completely encircle pools at all times. Pool gates must be self-latching and kept locked.
- Install fences around canals and drainage ditches in populated areas.
- Permit swimming in public places only in the presence of certified lifeguards.
- Train educators and health care providers to teach drowning prevention.
- Integrate drowning prevention into school curricula.
- Enforce regulations requiring personal flotation devices for children on boats.
- Parents should maintain constant supervision while child is near or in water, no matter what skills your child possesses or how shallow the water.
- Parents should never leave a container with any amount of water unattended.
- Parents should take a CPR (cardiopulmonary resuscitation course).
- Do not rely on flotation devices and inflatable toys to sustain child in water.

Sources: Delaware Childhood Injury 2001; JPMA 2002.

Delaware Statistics

In the year 2000, the panels reviewed the deaths of eight children due to drowning. This number was relatively high as compared to one death reviewed for the year 2001 and one death in 2002.

Recommendations for Change Drowning

1. Continued support for the need for pool alarms. (2000)
2. Public Service Announcement alerting people to the dangers involved with flooding especially in areas where it has never flooded before. (2000)

Action taken or next steps: In 1999, the News Journal wrote an article on the dangers surrounding flooding and safety for children and adults. As recently as September 2003, the Governor's office issued a public service announcement during Hurricane Isabel.
3. Report all cases of drowning to the DFS Child Abuse Report Line by police or first responders. (2000)

Action taken or next steps: This has been addressed in the Memorandum of Understanding shared by law enforcement and DSCYF.



Fire

Fires remain a leading cause of death among children in the United States. Nationally, there were 561 children (ages 14 and under) who died because of a fire. This is despite a 56 percent decrease since 1988. *Source: National Safe Kids Campaign.*

Fire Prevention Strategies

- Install smoke alarms on every floor of your home or in every sleeping area. This dramatically cuts the probability of dying by 50 percent.
- Keep matches, lighters, and other elements of heat out of children's grasp. The major cause of death by fire for children five and under is children playing with matches or lighters. (National Safe Kids Campaign)
- Education and preparation continue to be key for preventing fires. Practice fire escape routes with your family, and talk to children about what to expect during a fire.

Delaware Statistics

The panels reviewed 2 deaths caused by fire during 2000. There was a dramatic increase in 2001 due to fires in homes with multiple family members. 11 deaths were reviewed in 2001. No deaths due to fire were reviewed in 2002.

Recommendations for Change

Fire

1. Continued education on fire safety and smoke detector use, which would include potential hazards such as unattended candles and extension cords. (2000/2001)



SUDDEN INFANT DEATH SYNDROME SUDDEN UNEXPLAINED DEATH SYNDROME

SIDS, Sudden Infant Death Syndrome, 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. SIDS is the leading cause of death in infants between one week and one year. In the United States, approximately 7,000 infants die of SIDS per year (This equates to one infant death per hour, every day). The average age of death is between two to four months and most deaths occur during the winter months. *Source: Facts about Sudden Infant Death Syndrome, <http://sids-network.org>.*

SIDS by definition is not preventable but numerous risk factors have been identified. The Delaware panels do not determine preventability but do track the risk factors and make recommendations based on these findings. Risk factors that are tracked by the Child Death Review Panels include the following:

- Smoking in the household
- Sleeping on Side/Stomach
- Co-Sleeping. In some cases, bed sharing can be unsafe. Between 1999-2001, 180 children died in this country under the age of two while co-sleeping with an adult. *Source: Hidden Hazards for Babies in Big Beds, News to Use, Spring/Summer, 2003, jpma.org-babysafetymonth.*
- Soft bedding
- Fever Infection/cold
- Late or No Prenatal Care
- Pre-maturity
- Animal in the home
- Drug/Alcohol usage by adult caretaker
- Race
- Teen mother

SIDS/SUDS Prevention Strategies

- ❑ The American Academy of Pediatrics recommends babies sleeping on their back as the preferred sleep position.
- ❑ Ensure that the baby's head is uncovered and no loose blankets, pillows, and bedding are near the baby. Do not let your infant overheat during sleep; too many layers of clothing can cause overheating.
- ❑ Decrease risk by not exposing the infant to second-hand smoke.
- ❑ Maintain regular prenatal and pediatric care of your child.
- ❑ Extra care and caution should be utilized while-co-sleeping. Guidelines would include: using a firm mattress, not sleeping on a water mattress or a sofa with the baby, and never using alcohol/drugs/or cigarettes. Parents who use alcohol or drugs may roll over their children and suffocate them. Make sure that the child cannot be trapped between the bed frame and the mattress or side of the couch.
- ❑ No heavy blanket/comforters while co-sleeping. Do not allow siblings to sleep with a baby under 9 months.

Source: Facts about Prevention Strategies, <http://www.aap.org/>

Delaware Statistics

10 children were determined to have died from SIDS or SUDS in 2000, 9 in 2001 and 6 in 2002. In 2000, biggest risk factors were smoking, sleeping position and soft bedding. In 2001, the risk factors were smoking, sleeping with parent, soft bedding and drug/alcohol consumption. In 2002, the most common risk factors were sleeping position and soft bedding.

Recommendations for Change
Sudden Infant Death Syndrome
Sudden Unexplained Death Syndrome

1. Provide ongoing public education regarding sleep position and practices. It was also recommended that groups such as Mommy/Baby classes held at Christiana Care Hospital (that meet after the birth of a baby) address these educational issues. (2000, 2001, 2002)
2. Provide ongoing education to licensed daycare providers, recognizing that this does not address unlicensed day care providers. SIDS education to be included as a mandatory component of basic preparation for licensure as a daycare provider. Stress the importance of official agencies that have a role in investigation on potential SIDS death to follow departmental protocols for SIDS. Would like to see a movement to encourage primary providers to routinely ask caregivers if child is in a daycare and what are the sleeping practices for infants and to educate parents on sleep practices. Educational materials already available and it is recommended that the Children's Department collaborate with the perinatal association for these materials (2001/2002)

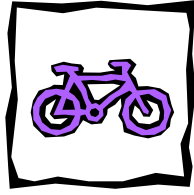
Action taken or next steps: For the year 2003, there are currently 13,000 children in home daycares and 24,000 in daycare centers. Three years ago, the Office of Child Care Licensing also did a mass mailing to all licensed providers on the "Back to Sleep Campaign." The Office of Child Care Licensing is currently working on a core curriculum regarding "Back to Sleep" recommendations that will be part of their Mandatory First Aid/CPR training. All new daycare center regulations have this education as part of their procedures.

3. Track cases of positional asphyxia to see if a certain population is more at risk. (2001).

Action taken or next steps: Will be tracked with the new data tracking system once in place.

4. A fine should be imposed on individuals running an unlicensed daycare. This fine could be consistent with other fines given when operating licenses are required. (2002)

Action taken or next steps: This has been in Delaware Code since 1915 but has never been utilized.



Vehicular Crashes

Motor Vehicle Deaths

Current statistics for the State of Delaware average between 45-50% of all childhood deaths are related to Motor Vehicle Injury. It is the leading cause of death between ages 15 –20. *Source: State teens drive better than average, News Journal, 10/22/03.* Nationally, 1,654 children died in the year 2000 from motor vehicle crashes. *Source: National Safe Kids Campaign, 2003.*

Statistics showing the importance of continued prevention:

- “Over the past ten years 73% of those killed in a crash in Delaware were not wearing a seatbelt.”
- In 2002, 16 teens died in motor vehicle accidents in the State of Delaware. Of those 16 only, five were wearing seatbelts. (The Child Death Review Panel only reviewed 13 of these deaths)
- Every day in this country, six children die because of a motor vehicle accident. *Source: www.co.new-castle.de.us/police.*

The Graduated license has had an immediate impact on the number of motor vehicle accidents. 21 Del. C. §2710. The Graduated license (GDL) requires that adolescent drivers be accompanied for six months with a designated adult and/or parent. During the next six months, the adolescent may drive from 6:00 a.m. until 9:00 p.m. without adult supervision. After 9:00 p.m. supervision by an adult is mandatory. After 12 months of supervised driving, the adolescent may drive unrestricted. Since the recent implementation of the GDL, there has been a 41% decrease in motor vehicle accidents. *Source: Department of Education, 2003.*

MOTOR VEHICLE DEATH PREVENTION STRATEGIES

- ❑ Continued support of community-based child passenger safety programs.
- ❑ Increase the number of personnel trained in child passenger safety.
- ❑ Continued support for the Graduated licensing law in Delaware for adolescent drivers.
- ❑ Continued support for the Primary Child Restraint law, allowing police officers to stop vehicles with children not properly restrained in a car seat or booster seat.

- ❑ Instruct parents and caregivers that airbags are dangerous and possibly lethal for children under 12. All children under 12 should ride in the back seat of a car and be properly restrained.
- ❑ Continued education for parents and caregivers on proper car seat installation and use of booster seats. The National Highway and Traffic Safety Administration support booster seat use for children ages 4-8 and weighing up to 80 lbs. On January 1, 2003, Delaware's Child Restraint Law was upgraded. 21 Del. C. § 4803.

Source: Kids Count 2003.

One prevention initiative is the New Castle County Police Department's S.L.A.M program (Students Learn About Mortality). This is a graphic and powerful demonstration shown to high school students who are at an age to drive. Aggressive driving, driving while under the influence, not using a seatbelt, and inattentive driving are all subjects discussed along with the possible consequences.

The Delaware Child Restraint law includes the following:

- All children must be properly restrained in a federally approved child safety seat appropriate for the child's age, weight and height up through 6 years old or 60 lbs.
- Children ages 7 through 15 years old are required to be properly secured in a seatbelt.
- It is recommended that children who are least 7 years old and 60 lbs continue to ride in a booster seat secured by the vehicle's seatbelt, until they reach the booster seat's upper weight limit.
- Children fewer than 12 years old or 65 inches tall must sit in the back seat if there are active airbags in the front passenger seating position.
- The fine for not following the law is \$28.75.

Source: Delaware Office of Highway Safety and 21 Del. C. § 4803.

Delaware Statistics

Motor Vehicle Deaths of children continue at a steady rate in Delaware. In 2000, the panels reviewed 11 children who died from a motor vehicle crash and 3 children who were pedestrians struck by a motor vehicle. In 2001, there was 6 children reviewed who died from a motor vehicle crash and 1 pedestrian. In 2002, the panels reviewed 8 children who died from a motor vehicle crash and 2 pedestrians.

Recommendations for Change Motor Vehicle Crashes

1. Increase motorcycle education and enforcement of current Dirt Bike laws. (2000)
2. Continue support of adolescent seatbelt use and continued education on motor vehicle safety. “Don’t drink and drive.” Schools to revisit the early dismissal policy. (2000)

Action taken or next steps: This is mandated by Delaware Code, Title 14, Chapter 1, § 122 (16) which states K-12 students must be instructed in seat belts usage and the avoidance of drug abuse.

3. Track accidents and adolescents identified with conditions such as ADHD and the use of medication. (2000)

Action taken or next steps: The CDR process subcommittee will be implementing a tracking sheet that will track this specific information and other risk factors for future annual reports.

4. Increase awareness and education about proper car seat use. (2000)

Action taken or next steps: The Child Restraint Law has become a primary offense. A police officer can stop a vehicle when a child is not properly restrained in a car seat.

5. Education on pedestrian’s responsibility when crossing a roadway. (2000)
6. Examine other state driving laws for minors. (2001)

Action Taken or Next steps: The panels reviewed New Jersey, Maryland, and Pennsylvania driving laws.

7. Continued Safety instruction for adolescents to wear seat belts and carry ID on them. Continued reinforcement of the rules of the road. Need for more active MADD programs. (2001)

Action taken or next steps: Delaware MADD has received additional funding to provide services statewide and will establish an 800 line.

8. DEL DOT to look at intersection of westbound Delaware Rt. 7. (2001)

Action taken or next steps: Traffic light was installed.

Other Vehicular 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. In 2000, 168 children in the United States 14 and under died in bicycle accidents.

OTHER VEHICULAR DEATH PREVENTION STRATEGIES

- Integrate Bicycle Helmet safety in school curriculum.
- Continued education to all parents/caregivers on the use of helmets and other safety gear.
- Increase awareness of the Bicycle Helmet Bank Program available through the Office of Highway Safety.
- Support and continued enforcement of the law stated above and fine parents when violated.

Source: Kids Count 2003.

Delaware Statistics

The panels have not distinguished between pedestrian and bicycle accidents in regards to statistics. This is something that will be tracked in the upcoming years.

Recommendations for Change Other Vehicular Crashes

1. Continued support of wearing bike helmets and education regarding Bike Safety. (2000)

Action taken or next steps: There are currently 14 pilot classes being held in Delaware that is part of a national program on risk prevention education. This serves children from pre-school to eighth grade. If the pilot classes are successful, it should be considered as part of the general school curriculum.

2. Continued education on Bike Safety. Look at safety prevention programs for all schools and grades, such as the "Risk Watch" program. (2001)
3. Education in High School needed to address safety equipment when undertaking high-risk behaviors. Also, need for reinforcement of road usage while sharing the road with motor vehicles. (2001)

Miscellaneous Recommendations For the Prevention of Future Child Deaths

Legal Issues

1. Develop “Boot Camp” or alternative for children under 18 years of age that are repeat offenders. (2000)

Action Taken or Next steps: The Children’s Department Division of Youth Rehabilitative Services (YRS) has “Boot Camps” for adjudicated youth sentenced to level IV services. This service was available before the year 2000.

2. Have children who are going back into school from legal trouble assigned a counselor (mentor), such as an Intervention Specialist. (2000)

Action taken or next steps: The Department of Education is working with the Children’s Department to provide “wrap around services”, I.e. Behavioral Support Services, to children who have been involved with Foster Care of any Delaware Mental Health services. This is especially important for those returning to school after a hospitalization. The training and support given to districts will result in increased support services for all children.

3. Find more effective ways to address habitual DUI offenders and evaluate the treatment programs in which they are required to participate to assess effectiveness. (2002)

4. Develop an effective process for transfer of cases from juvenile to Adult Corrections system to prevent gaps in services. (2002)

5. Establish a mechanism to implement Child Mental Health (CMH) services upon discharge from Ferris School; that would also address continuity in care for mental health needs for children discharged from Ferris. (2002)

Action taken or next steps: An internal review between CMH and YRS is in progress to address these issues.

Medical/Hospital Issues

5. Prenatal testing for Maternal substance abusers. (2000) This recommendation was previously made in the 1999 Annual Report.

Action taken or next steps: The Attorney General's Office has agreed to explore legal issues regarding this matter.

6. Physicians to follow guidelines for Beta Strep cultures. (2000)

Action taken or next steps: This information is disseminated to the American Academy of Pediatrics through this Child Death Review Annual Report. This specific case was reviewed by the Internal Department of the Hospital. The Delaware Perinatal Board's Standard of Care Committee has developed and updated the Group B Strep Guidelines on a continuous basis.

7. In hospitals, every effort should be made to insure that all patients that need translation services have it provided at the time of care. (2000)

Action taken or next steps: The Joint Commission on the Accreditation of Hospitals and Healthcare Organizations requires that translation services be available in all hospitals.

8. Panel recommends looking at Hospice for pediatric population and what services are available for this population. (2000)

9. A letter will be drafted and Dr. Callery will be requested to send this letter to the chairs of the obstetric departments of all hospitals in Delaware that have a GYN/OB service. It is requested that hospitals consider coordinating review of newborn and premature deaths between the Obstetrics and Pediatric services while taking into account the pathology of each case. (2000)

Action taken or next steps: This letter was drafted and sent to the hospitals.

10. Internal Review of Maternal Trauma Protocol (2001)

Action Taken or Next steps: This was completed.

11. Need for education of health care providers and social workers about referrals for part C (Child Development Watch). (2001)

Action taken or next steps: Panel members agreed to take this educational suggestion to their individual agencies.

- 12.** Asked the Commission to review “quality of care” when an infant had been turning blue and presents at the emergency room. (2002)
- 13.** Heightened sense of awareness for teen pregnancies. (2002)
- 14.** Panel indicated a need for a referral to the Board of Medicine but felt that some input could be helpful in maintaining the acceptable medical standard of care. Pre-natal care should be made available to all residents of Delaware regardless of citizenship. Medicaid only covers delivery. (2002)

Action taken or next steps: A letter was written by Dr. Callery to the Board of Medicine regarding acceptable medical standard of care.

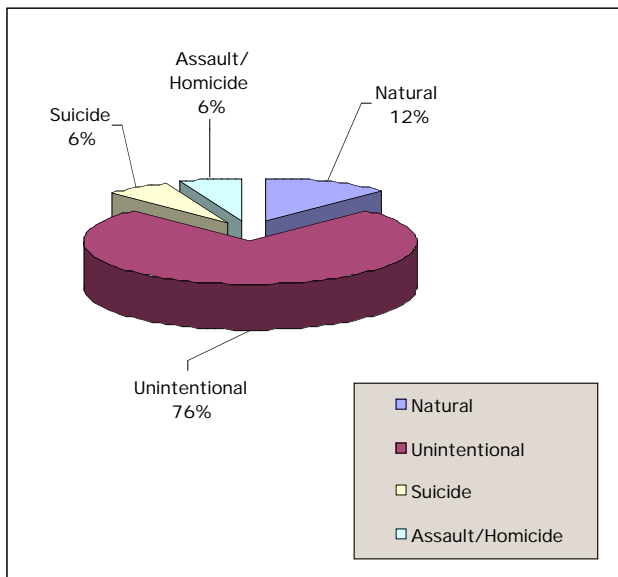
- 15.** Parents should be strongly urged to share medical treatment information with school officials to ensure consistency in care of the student. (2002)
- 16.** Legislation should be passed to increase monitoring of dangerous dogs. Need for owners of dangerous dogs to carry insurance to cover potential injuries. Pet safety education for children in school. (2002)

Data Presentation Of Child Deaths Reviewed In 2000, 2001, and 2002

Information and data relating to specific child death cases reviewed by the Review Panels were obtained from the Child Death Data Sheets, recommendations from the panels and Death Certificates. Child Deaths are reviewed and recorded as Preventable, Not Preventable or Undecided. An affirmative vote of sixty percent of those present is needed to adopt any findings and recommendations.

Preventable Cases Reviewed (Deaths Ruled as Preventable by the Panels)

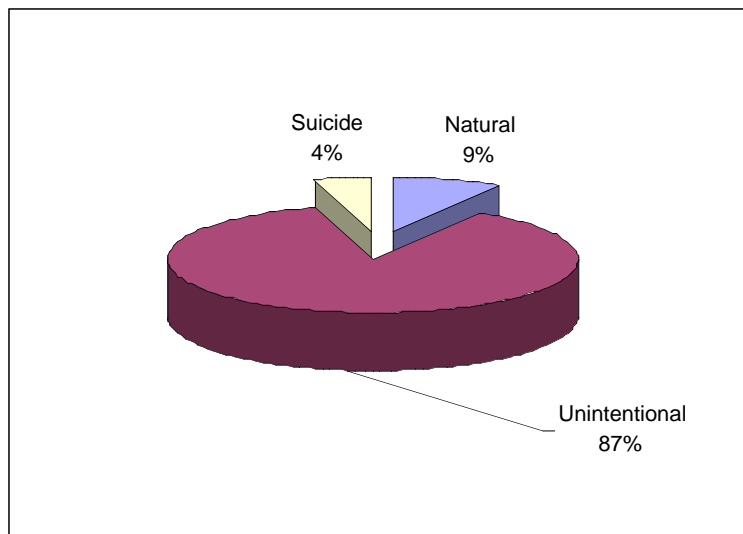
Preventable Deaths Reviewed in Calendar Year 2000		
(Information reflects deaths that occurred in 1997, 1998, 1999 & 2000)		
<u>Manner of Death</u>	<u>Cause of Death</u>	<u>Number of Deaths</u>
Natural	Respiratory Arrest	1
	Renal Failure	1
	Extreme Prematurity	2
Unintentional	Drowning	8
	Pedestrian	3
	Motor Vehicle	11
	Fire	2
	Accidental ingestion of medicine	1
Suicide	Gun	1
	Hanging	1
Assault/Homicide	Stabbing	1
	Cocaine Intoxication of Infant	1
Total Number of Preventable Deaths		33



- During the year 2000, the panels reviewed eight deaths due to drowning.
- Since 1997, the Commission has stressed the importance of pool alarms and for increased public awareness of drowning prevention.
- Motor Vehicle Deaths remained high, with 14 of these deaths deemed preventable in 2000.

Preventable Cases Reviewed (Deaths Ruled as Preventable by the Panels)

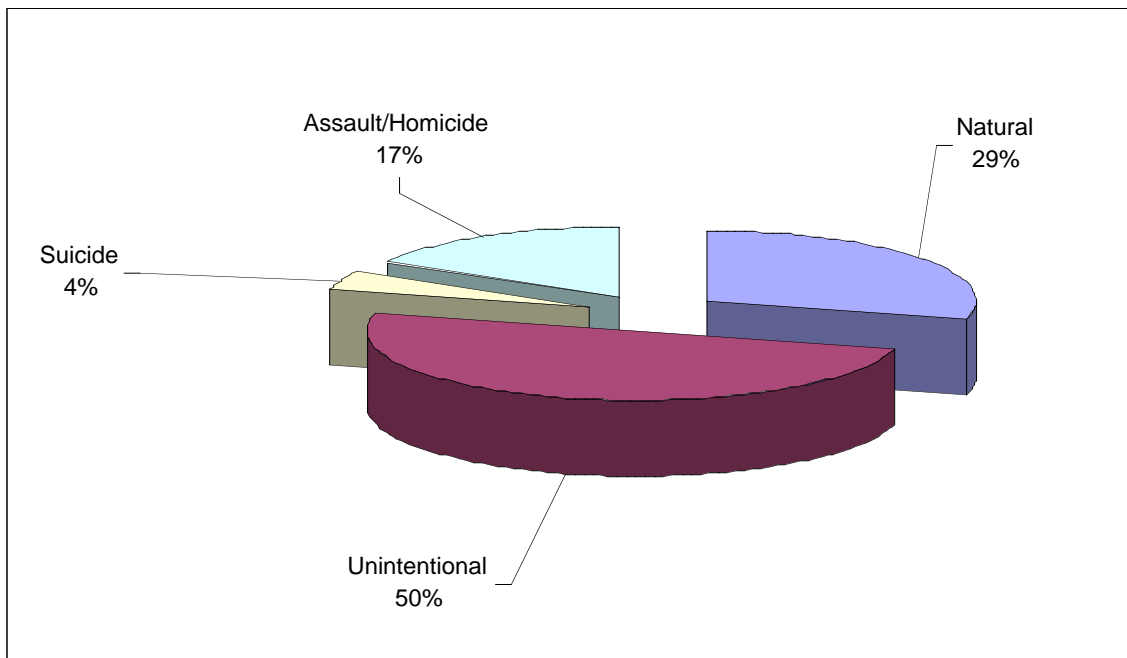
Preventable Deaths Reviewed in Calendar Year 2001		
<i>(Information reflects deaths that occurred in 1998, 1999, 2000 & 2001)</i>		
<u>Manner of Death</u>	<u>Cause of Death</u>	<u>Number of Deaths</u>
Natural	Asphyxia (smothering/wedging)	1
	Infection	1
Unintentional	Fire	11
	Sleep Positioning	2 (SUID)
	Motor Vehicle	6
	Fall	0
	Pedestrian struck by Motor Vehicle	1
	Vehicle	1
Suicide	Blunt Force	
	Trauma/Drowning	1
Assault/Homicide		0
Total Number of Preventable Deaths		23



- The most prominent type of unintentional death reviewed in 2001 were the deaths of eleven children in different fires.
- Motor Vehicle Deaths were the 2nd most likely cause of preventable deaths in 2001.
- The Commission continues to advocate for fire education, safety, and prevention.
- Two cases of SUIDS were voted as preventable before the policy changed that a vote of preventable/not-preventable would no longer be taken.
- Risk factors included drugs, co-sleeping, smoking, and soft bedding.

Preventable Cases Reviewed (Deaths Ruled as Preventable by the Panels)

Preventable Deaths Reviewed in Calendar Year 2002		
(Information reflects deaths that occurred in 1997, 1998, 2000, 2001 & 2002)		
<u>Manner of Death</u>	<u>Cause of Death</u>	<u>Number of Deaths</u>
Natural	Severely Premature	4
	Infection	2
	Birth Complications	1
Unintentional	Pedestrian Hit by a Motor Vehicle	2
	Motor Vehicle	8
	Gun Accident	2
Suicide	Gun	1
Assault/Homicide	Firearm	1
	Child Abuse/Neglect	2
	Trauma to mother's abdomen	1
Total Number of Preventable Deaths		24



The panels reviewed 10 preventable deaths that were a result of motor vehicle accidents and pedestrian injury. This number continues to remain high as in the year 2000 and 2001. Pedestrian Injury remains the second leading cause of injury-related death among children ages 5 to 14 nationally. (National Safe Kids Campaign) A total of motor vehicle child deaths for the year 2002 is 16 (six were voted as non-preventable).

The first two expedited reviews for abuse and neglect deaths were reviewed this year. Two deaths that were unintentional were because of the use of a firearm. A total of four deaths were related to firearms.

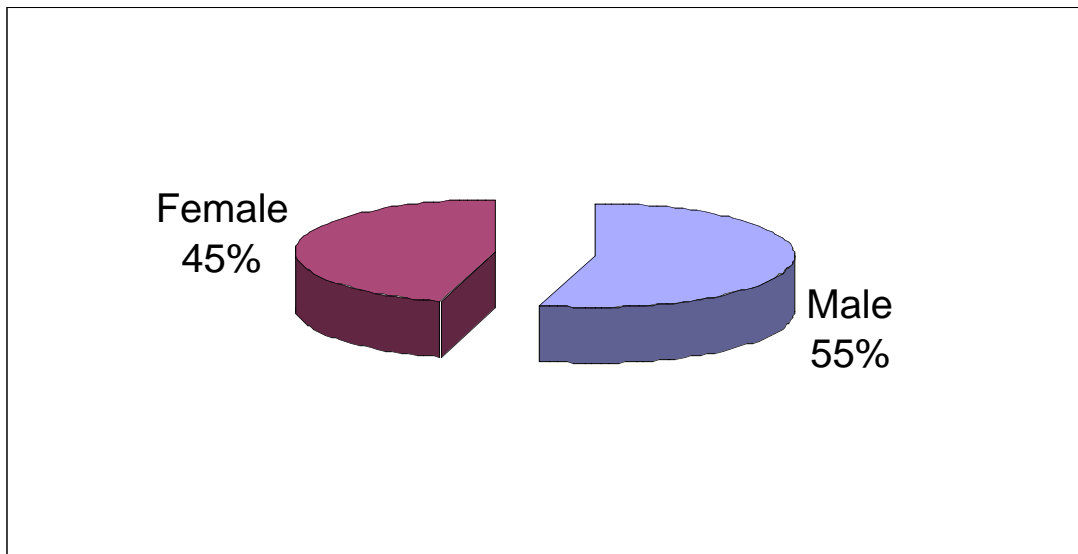
Gender Specific Analyses Natural Deaths (As listed by manner of death) - 2000

Male (60)

Female (50)

Natural		
Cause	#	%
Prematurity	30	50
Congenital Defects	12	20
Cancer	3	5
Infection	2	3.4
Birth Complications	0	0
Asthma	0	0
Diabetes	0	0
Other	2	3.4
SIDS	6	10
Sepsis	5	8.2

Natural		
Cause	#	%
Prematurity	26	52
Congenital Defects	14	28
Cancer	0	0
Infection	1	2
Birth Complications	0	0
Asthma	0	0
Diabetes	0	0
Other	2	4
SIDS	4	8
Sepsis	3	6



82 children, or more than 50% of all natural deaths reviewed in 2000 were the result of pre-maturity or congenital birth defects.

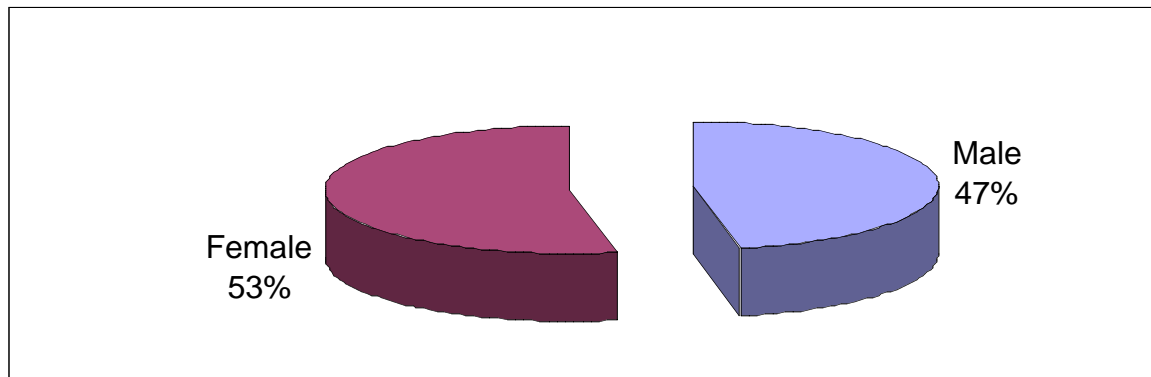
Gender Specific Analyses Non- Natural Deaths (as listed by manner of death) – 2000

Male (16)

Unintentional		
Cause	#	%
Motor Vehicle	9	23.6
Pedestrian	1	2.6
Machinery	0	0
Fire/Flame	0	0
Drowning	4	10.5
Other	0	0
Self Inflicted		
Cause	#	%
Suicide	1	2.6
Cause	#	%
Firearm	1	2.6

Female (18)

Unintentional		
Cause	#	%
Motor Vehicle	8	44.4
Pedestrian	1	5.5
Machinery	0	0
Fire/Flame	2	11.1
Drowning	4	22.2
Other	0	0
Self Inflicted		
Cause	#	%
Suicide	3	16.6



In 2000, the panels reviewed 19 children that died as a result of motor vehicle crashes or as a pedestrian being hit by a motor vehicle. Out of the 34 non-natural deaths, eight children died from drowning.

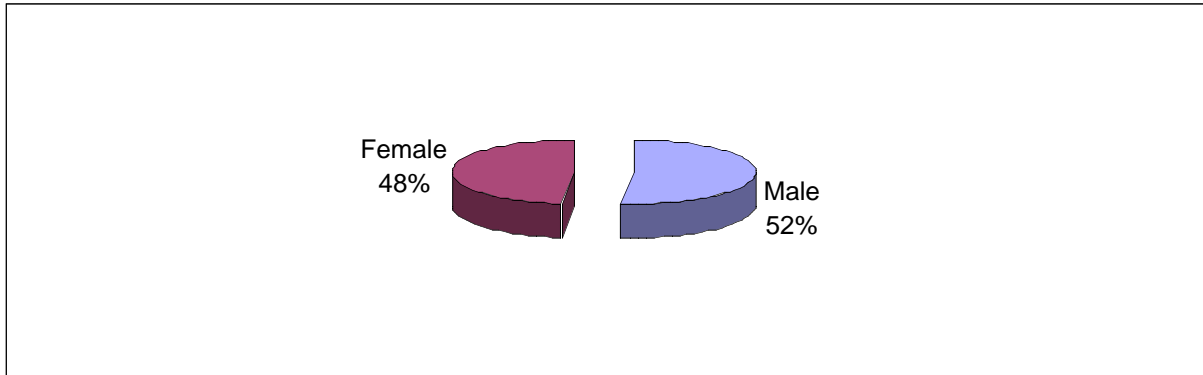
Gender Specific Analyses Natural Deaths (as listed by manner of death)- 2001

Male (46)

Natural		
Cause	#	%
Prematurity	15	33
Congenital Defects	9	20
Cancer	0	0
Infection	6	13
Birth Complications	0	0
Asthma	1	2
Diabetes	0	0
Other	8	17
SIDS	2	4
Sepsis	5	11
Respiratory Failure	0	0

Female (42)

Natural		
Cause	#	%
Prematurity	16	38
Congenital Defects	3	7
Cancer	5	12
Infection	2	5
Birth Complications	2	5
Asthma	0	0
Diabetes	0	0
Other	6	14
SIDS	7	17
Sepsis	1	2
Respiratory Failure	0	0



In 2001, panels reviewed 43 deaths from pre-maturity and congenital defects. 9 children died from SIDS in 2001. (See table on page 40 for risk factors involved). The panel in Kent/Sussex was concerned that a number of infants with what turned out to be lethal congenital anomalies had the anomaly missed on a mid-late second trimester ultrasound.

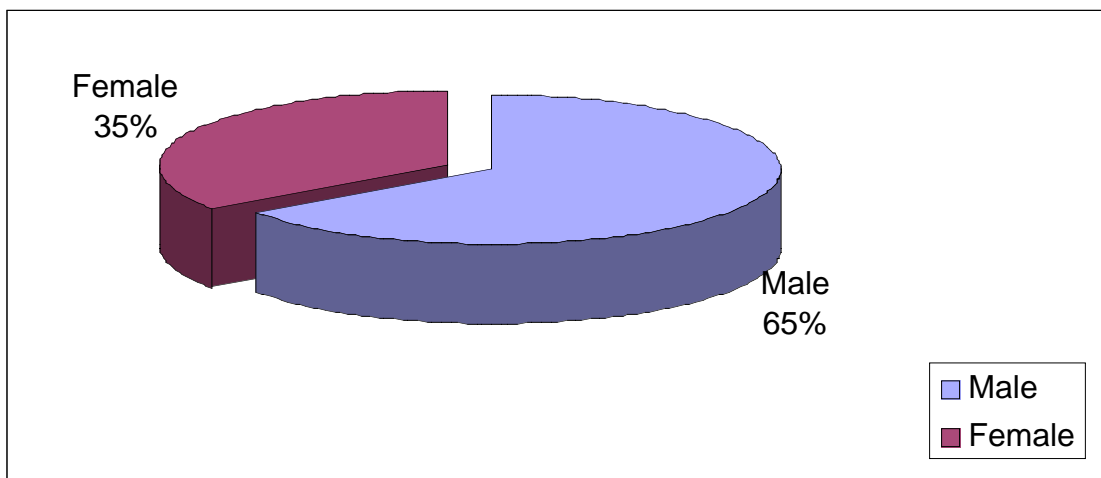
Gender Specific Analyses Non Natural Deaths (as listed by manner of death) – 2001

Male (17)

Unintentional		
Cause	#	%
Motor Vehicle	4	25%
Complications of Near Drowning	1	5%
Asphyxia	1	5%
Fire/Flame	8	50%
Drowning (possible suicide)	1	5%
Other	0	0%
Self Inflicted		
Cause	#	%
Suicide	2	10%
Assault		
Cause	#	%
Firearm	1	5%

Female (9)

Unintentional		
Cause	#	%
Motor Vehicle	6	66%
Pedestrian	0	
Asphyxia	0	
Fire/Flame	3	34%
Drowning	0	
Other	0	
Self Inflicted		
Cause	#	%
Suicide	0	



There were three suicides reviewed in the year 2001, but none as a result of a firearm. Motor vehicle deaths reviewed declined by 9 children. However, fire/flame deaths rose significantly from the previous year with 11 deaths reviewed.

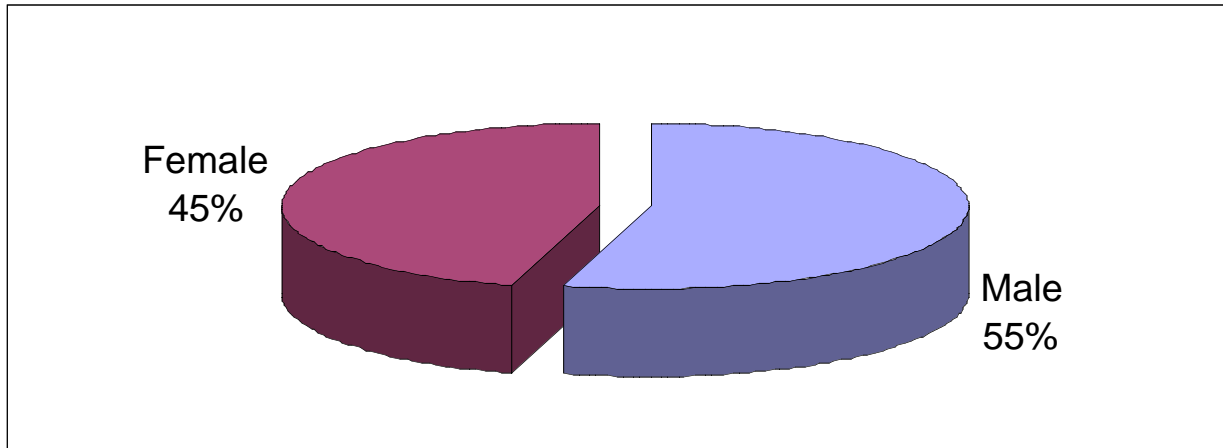
Gender Specific Analyses Natural Deaths (as listed by manner of death) – 2002

Male (61)

Female (51)

Natural		
Cause	#	%
Prematurity	37	61
Congenital Defects	8	13
Cancer	2	3
Infection	0	0
Birth Complications	0	0
Asthma	1	2
Diabetes	0	0
Other	8	13
SIDS	3	5
Sepsis	2	3
Respiratory Failure	0	0

Natural		
Cause	#	%
Prematurity	27	53
Congenital Defects	7	13
Cancer	3	6
Infection	1	2
Birth Complications	1	2
Asthma	0	0
Diabetes	0	0
Other	6	12
SIDS	3	6
Sepsis	3	6
Respiratory Failure	0	0



Panels reviewed the deaths of 45 males (an increase of 21 from 2001) and 34 females (an increase of 15 from 2001) who died of pre-maturity and congenital defects. The deaths of six children due to SIDS, were reviewed in 2002. (See table on page 41 for risk factors involved).

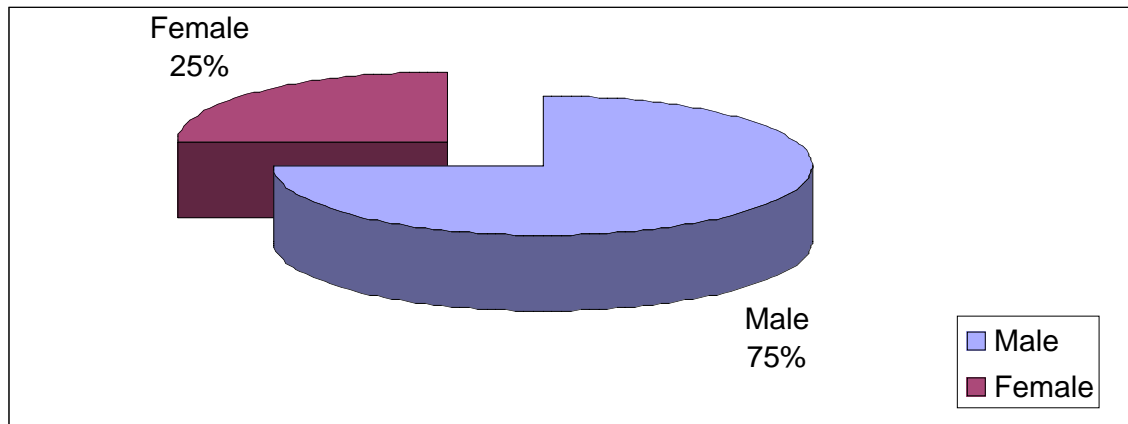
Gender Specific Analyses Non Natural Deaths (as listed by manner of death) – 2002

Male (18)

Unintentional	
Cause	#
Motor Vehicle	7
Complications of Near Drowning	0
Asphyxia	0
Fire/Flame	0
Drowning	1
Other	6
Self Inflicted	
Cause	#
Suicide	2
Assault	
Cause	#
Firearm	2

Female (6)

Unintentional	
Cause	#
Motor Vehicle	5
Pedestrian	0
Asphyxia	0
Fire/Flame	0
Drowning	0
Other	0
Self Inflicted	
Cause	#
Suicide	0
Assault	
Cause	#
Suffocation	1



During the 2002 review period, 12 deaths were reviewed and attributed to motor vehicle crashes.

Race/Ethnicity Specific Analyses Over-all Deaths

Deaths in 2000-151 reviewed

	New Castle County	Kent County	Sussex County	Total
African American	46	3	7	56
Caucasian	46	21	13	80
Other	9	3	3	15
Total	101	27	23	151

Deaths in 2001-116 reviewed

	New Castle County	Kent County	Sussex County	Total
African American	23	9	12	44
Caucasian	37	13	13	63
Other	6	2	1	9
Total	66	24	26	116

Deaths in 2002-137 reviewed

	New Castle County	Kent County	Sussex County	Total
African American	33	11	11	55
Caucasian	39	14	16	69
Other	9	2	2	13
Total	81	27	29	137

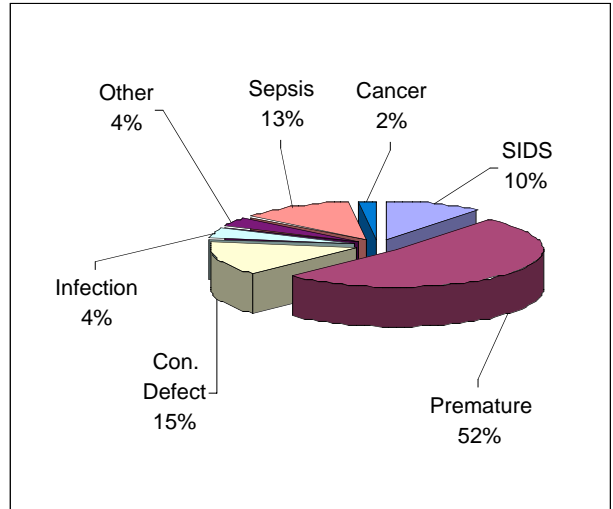
The totals above reflect all deaths presented at the panels during the specified years. Natural deaths and non-natural deaths are not to be confused with the terms of preventable versus non-preventable. Natural versus non-natural are terms that are used on the Death Certificate. So out of the above 404 deaths, only 80 were voted upon by the panels as preventable. This may differ from the natural versus non-natural totals in previous pages.

It is again noted that African Americans make up 19 percent of Delaware's population. However, they represent 40 percent of all deaths in children. This is clearly disproportionate when compared to the Caucasian population. In the coming years, the Child Death and Stillbirth Commission will closely monitor and continue to evaluate this disparity.

Race/Ethnicity Specific Analyses Natural Deaths (as listed by manner of death)

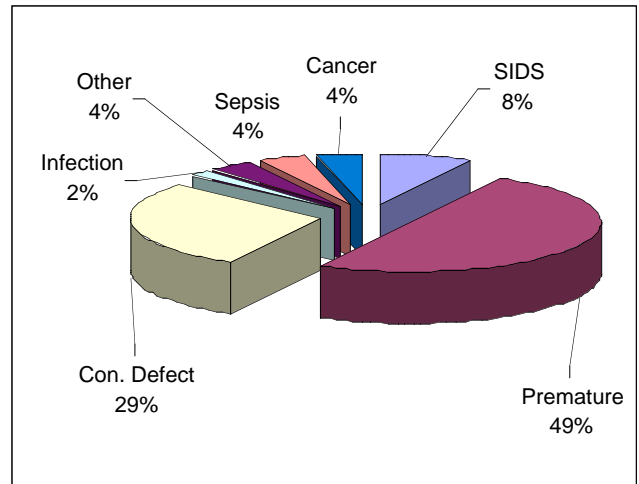
2000 Deaths

African American	
Cause	#
SIDS	5
Pre-maturity	25
Congenital Defects	7
Infection	2
Birth Complications	0
Asthma	0
Diabetes	0
Other	2
Sepsis	6
Cancer	1
Total	48



2000 Deaths

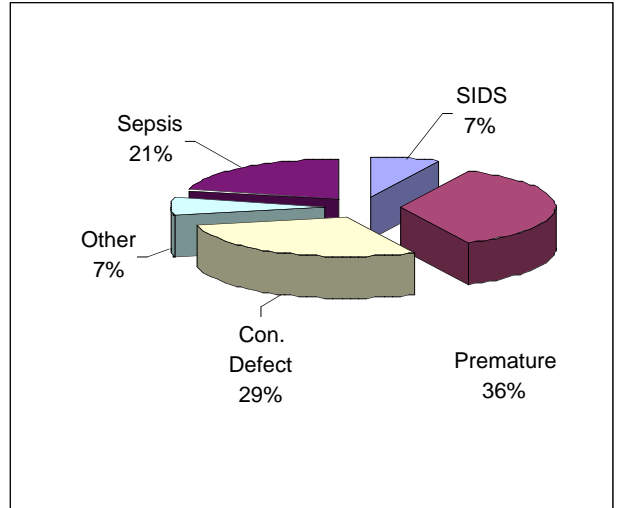
Caucasian	
Cause	#
SIDS	4
Prematurity	26
Congenital Defects	15
Infection	1
Birth Complications	0
Asthma	0
Diabetes	0
Other	2
Sepsis	2
Cancer	2
Total	52



Race/Ethnicity Specific Analyses Natural Deaths (cont.)

2000 Deaths

Other	
Cause	#
SIDS	1
Prematurity	5
Congenital Defects	4
Infection	0
Birth Complications	0
Asthma	0
Diabetes	0
Other	1
Sepsis	3
Cancer	0
Total	14

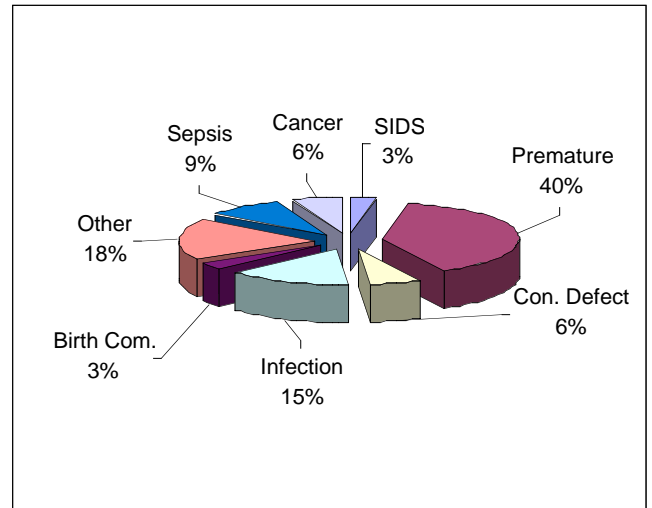


Race/Ethnicity Specific Analyses Natural Deaths (cont.)

2001 Deaths

African American

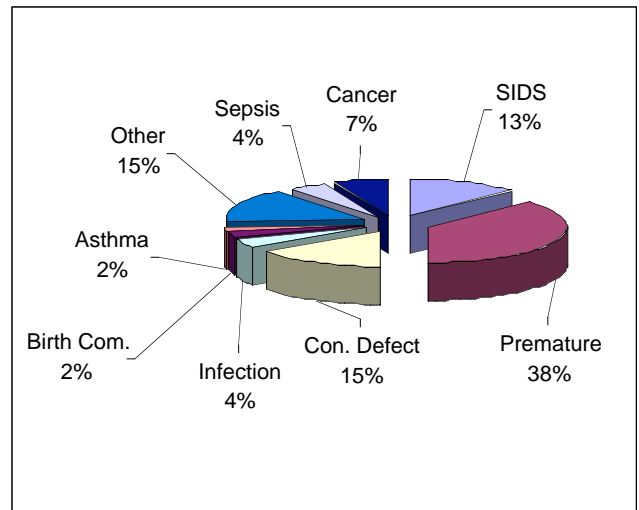
Cause	#
SIDS	1
Prematurity	13
Congenital Defects	2
Infection	5
Birth Complications	1
Asthma	0
Diabetes	0
Other	6
Sepsis	3
Cancer	2
Total	33



2001 Deaths

Caucasian

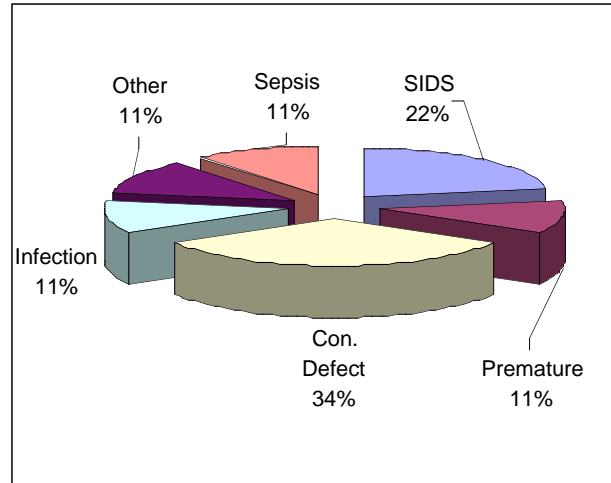
Cause	#
SIDS	6
Prematurity	17
Congenital Defects	7
Infection	2
Birth Complications	1
Asthma	1
Diabetes	0
Other	7
Sepsis	2
Cancer	3
Total	45



Race/Ethnicity Specific Analyses Natural Deaths (cont.)

2001 Deaths

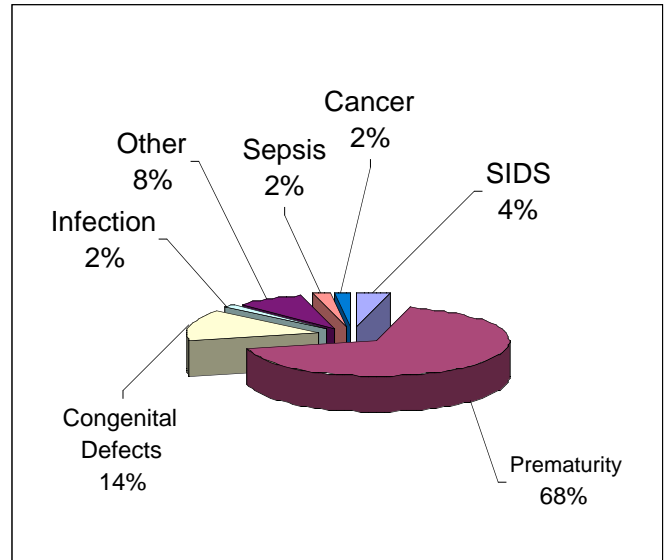
Other	
Cause	#
SIDS	2
Prematurity	1
Congenital Defects	3
Infection	1
Birth Complications	0
Asthma	0
Diabetes	0
Other	1
Sepsis	1
Cancer	0
Total	9



Race/Ethnicity Specific Analyses Natural Deaths (cont.)

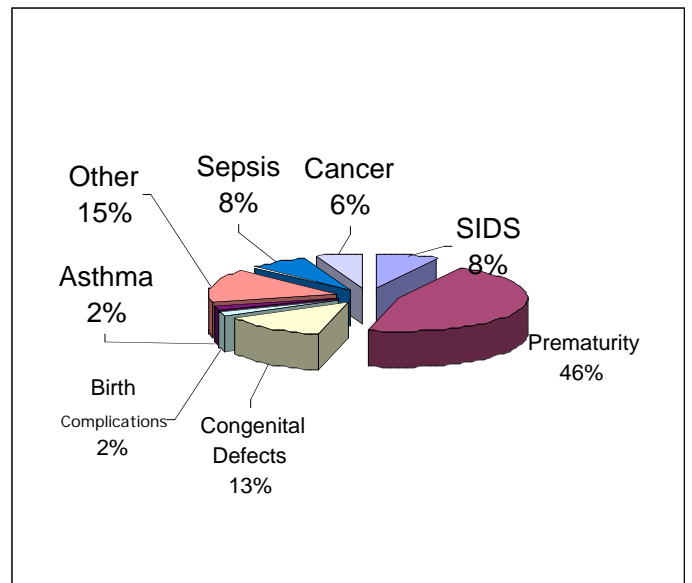
2002 Deaths

African American	
Cause	#
SIDS	2
Prematurity	33
Congenital Defects	7
Infection	1
Birth Complications	0
Asthma	0
Diabetes	0
Other	4
Sepsis	1
Cancer	1
Total	49



2002 Deaths

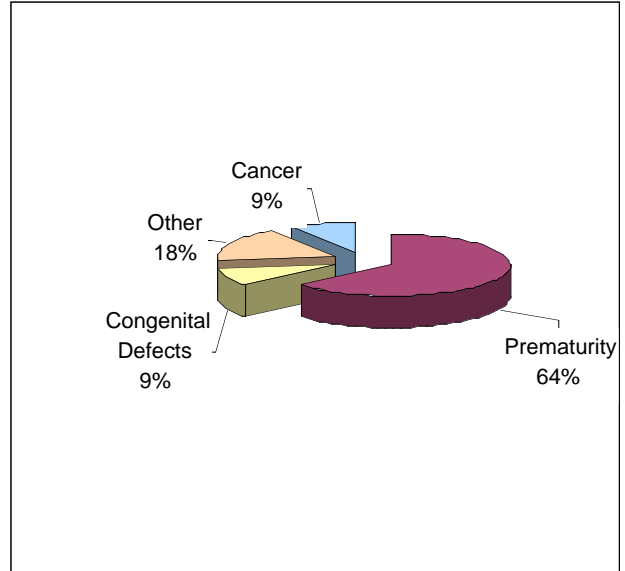
Caucasian	
Cause	#
SIDS	4
Prematurity	24
Congenital Defects	7
Infection	0
Birth Complications	1
Asthma	1
Diabetes	0
Other	8
Sepsis	4
Cancer	3
Total	52



Race/Ethnicity Specific Analyses Natural Deaths (cont.)

2002 Deaths

Other	
Cause	#
SIDS	0
Prematurity	7
Congenital Defects	1
Infection	0
Birth Complications	0
Asthma	0
Diabetes	0
Other	2
Sepsis	0
Cancer	1
Total	11



**Sudden Infant Death Syndrome (SIDS)/Sudden Unexplained
Death Syndrome (SUDS)
2000**

	NCC	NCC	NCC	NCC	NCC	NCC	NCC	NCC	KC	SC	Total
No Risk									X		1
Smoking		X		X			X			X	4
Sleeping on Side/Stomach	X		X		X	X					4
Sleeping w/ Parent				X	X			X			3
Soft Bedding	X		X	X				X			4
Fever/ Infection/cold	X						X				2
Late or No Prenatal Care							X				1
Pre-maturity							X			X	2
Animal				X							1
Drug/Alcohol											0
Teen Mom											0
Race	AA	O	AA	C	AA	AA	AA	C	C	C	

In 2000, ten children were reviewed who were classified as having died from SIDS/SUDS. Eight of the ten were from New Castle County. The risk factors that were most prominent in these cases include: smoking in household, sleeping on side/stomach, and soft bedding.

2001

	NCC	NCC	NCC	NCC	NCC	KC	SC	SC	SC	Total
No Risk				X						1
Smoking	X		X		X	X	X	X		6
Sleeping on Side/Stomach	X							X		2
Sleeping w/ Parent	X	X				X		X	X	5
Soft Bedding						X	X	X		3
Fever/ Infection/cold							X			1
Late or No Prenatal Care										0
Pre-maturity										0
Animal										0
Drug/Alcohol		X	X		X					0
Teen Mom										0
Race	C	C	C	O	C	C	AA	BI	C	

In 2001, nine children were reviewed who were classified by the Office of Medical Examiner as having died from SIDS/SUDS. In six of these cases, there was smoking in the household. Another prominent risk factor was co-sleeping, this occurred in five of the nine cases. (See section on SIDS under recommendations, page 41)

2002

	NCC	NCC	NCC	KC	KC	SC	Total
No Risk							0
Smoking	X		X				2
Sleeping on Side/Stomach	X	X	X				3
Sleeping w/ Parent	X						1
Soft Bedding	X	X					2
Fever/ Infection/cold				X	X		2
Late or No Prenatal Care							0
Pre-maturity							0
Animal							0
Drug/Alcohol						X	1
Teen Mom			X				0
Race	C	C	C	AA	AA	C	

In 2002, six children's deaths were reviewed that were classified as SIDS/SUDS. Of these six, three children were sleeping in the prone position.

(C=Caucasian AA=African American O=Other BI=Biracial)

Data Presentation Of Child Deaths 1996 - 2000

Data provided in this chapter was derived from the Delaware Department of Health and Social Services, Delaware Health Statistics Center and the Delaware Vital Statistics Annual Report (2000)

Appendix A

TITLE 31

Welfare

PART I

In General

CHAPTER 3. CHILD WELFARE

Subchapter II. Child Death and Stillbirth Review 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 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 and Stillbirth Commission. For the purposes of this subchapter, "Commission" means the Child 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.)

§ 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 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 perinatology; (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 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. Subject to the availability of the appropriate and necessary funding, the Commission shall have the authority to appoint staff members to whom certain duties and authority may be delegated as deemed appropriate 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.

(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 and stillbirth review panels. 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 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.)

§ 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 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, 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, 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 under review and the production of records related to the 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 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 deceased 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 of a child who is determined to have been abused and/or neglected within 14 days of that determination.

(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 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 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.)

§ 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, 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.)

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Appendix B

Appendix C

Commission Members (2000 -2002)

Steven Berlin, MD, (Inactive)
Bayside Health Association
Kent/Sussex Panel Chair

M. Jane Brady, JD
Attorney General
Department of Justice

Richard T. Callery, MD, FCAP
Office of the Medical Examiner
Commission Chair (End date 1/31/03)

Colonel L. Aaron Chaffinch
Delaware State Police

Garrett H.C. Colmorgen, MD
Christiana Care Health System

James. J. Cosgrove, DO
Chair of the Dept. OB/GYN at St. Francis Hospital

Tania M. Culley, Esquire
Child Advocate
The Office of the Child Advocate

Colonel John Cunningham, (Inactive)
New Castle County Police Department

Lt. Mark Daniels, (Inactive)
Delaware State Police

Allan J. Daul, MSW
Catholic Charities

David Paul, MD

Cari DeSantis
Cabinet Secretary
Department of Services for Children, Youth, and their Families

Helene Diskau, M.S., R.N., A.P.N
Current Kent/Sussex Panel Chair
Delaware Nurses Association

John A.J. Forest, MD, (Inactive)

Marjorie Lynn Hershberger, MSN, APN
New Castle County Panel Chair,
Delaware Nurses Association

Kathy A. Janvier, MS, PhD
Delaware Nurses Association

Colonel David McAllister
New Castle County Police

Vincent P. Meconi
Cabinet Secretary
Department of Health and Social Services

Janice Mink
Grassroots Citizens for Children

Lani L. Nelson-Zlupko, MSW, PhD
University of Pennsylvania School of Social Work

Kevin Sheahan, MD

Michael L. Spear, MD, (Inactive)

Chief Michael J. Szczerba
Wilmington Police Department

Valerie Woodruff, MED
Cabinet Secretary
Department of Education

Commission Attendees

Captain Harry Downes
Delaware State Police

Trish Hearn
Department of Services for Children, Youth, and their Families

Captain James Jubb
Wilmington Police Department
Mariann Kenville-Moore, MSW
Department of Justice

William M. Lybarger, MSW, PhD
Department of Education

Mary Kate McLaughlin
Department of Health and Social Services

Anne Pedrick, MS
Office of the Child Advocate

New Castle Review Panel (2000 until 2002)

Joe Avallone, (Inactive)
Department of Services for Children, Youth, and their Families

Sgt. William Browne
Wilmington Police Department

Terri Charles, (Inactive)
Child Inc.

Alice Smith Coleman
Delaware Psychiatric Center

Garrett H.C. Cologne, M.D., Commission Chair and Panel Member
Christiana Hospital Maternal Fetal Medicine

Kate Cronan, M.D.
A.I. duPont Hospital for Children

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Child Inc.

Lt. Mark Daniels, (Inactive)
Delaware State Police

Sgt. Gerard Donovan, (Inactive)
New Castle County Police

Captain Harry Downes
Delaware State Police

Carlos Duran, M.D.
Christiana Hospital
Lt. John Evans, (Inactive)
Delaware State Police

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Division of Public Health

Karen Golden
Department of Services for Children, Youth, and their Families

Kathy Goldsmith, (Inactive)
Child Inc.

Linda Hawthorne
SIDS Affiliate

Marjorie Hershberger, M.S.N., A.P.N.,
Current Chair
A.I. duPont Hospital for Children

John Humphrey
Children's Advocacy Center

Sgt. Michael Kelly
New Castle County Police

Mariann Kenville-Moore, M.S.W.
Department of Justice

Richard Leader, M.D.
St. Francis Hospital

Stuart Mast
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Anne Pedrick, M.S.
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Pat Pheris
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New Castle County Police

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Office of the Medical Examiner

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Bayside Health

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Dover Police Department

Lt. Benton Counselman, (Inactive)
Dover Police Department

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Children and Families First

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