

# Chapter



---

## General Background

### **Introduction**

The Child Death Review Commission was established by legislation passed on July 19, 1995. The Child Death Review Commission was created after the pilot project showed the effectiveness of having a review process. The Child Death Review Pilot Project (Pilot Project) began in New Castle County, Delaware in January 1995. The Pilot Project was developed by the Abuse Intervention Committee. Information contained herein has been drawn from the New Castle County Review Panel conducted October 1995 through December 1996 and the Kent and Sussex Counties Review Panel conducted from October 1996 until December 1996. There are two Review Panels operating in Delaware at this time. One serves New Castle County and the second reviews cases for Kent and Sussex County.

The report presents information gathered from the quantitative evaluation. Statistical information for the quantitative evaluation was collected from data sheets and findings completed by each Review Panel member on each case reviewed. In addition, data was collected from findings on each case reviewed.

## **Delaware Child Death Review Panel Process**

### **Background**

The Abuse Intervention Committee (AIC) was convened in May 1988 at the invitation of Delaware Attorney General, Charles M. Oberly, III, to address various issues related to child abuse and neglect. The AIC is 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 composed of multiple statewide disciplines for the purpose of developing a proposal for standard child death review procedures in Delaware. *The Child Death Review Panels Proposal* (Proposal) was published in November 1993 and provides a comprehensive model or "blueprint" for conducting statewide child death reviews in Delaware. A timeline of the Child Death Review implementation progress appears in Appendix B.

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 adapted 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 adapt 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 Review Panel was convened in February 1995.

The goal of the Pilot Project was to review child deaths meeting established criteria (page 4 of this document), 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. By special request, the Review Panel also reviewed the deaths of five children who were not residents of New Castle County.

Legislation was drafted to establish a statewide Child Death Review Commission. House Bill 317 was introduced in June, 1995 and was enacted by Governor Thomas R. Carper on July 19, 1995 (Appendix C). The legislation establishes 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 continued to be conducted in New Castle County from February of 1995 until the present. Another Review Panel was appointed to cover Kent and Sussex Counties in October 1996. This Review Panel was trained and then began reviewing cases in October 1996.

### **Purpose Of Child Death Reviews**

The primary purpose of reviewing child deaths is the prevention of future child deaths. A child death is considered to be preventable if one or more interventions (medical, social, 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 (Colorado Department of Social Services and Department of Health, 1991, 15).

### **Sponsorship**

The Child Death Review Commission and regional Review Panels were established through House Bill No. 317 with the Department of Health and Social Services and the Department of Services for Children, Youth and their Families having primary administrative responsibility.

### **Type Of Review**

The reviews were retrospective investigations. A retrospective investigation is a case and system review that focuses on identifying trends, patterns, and obstacles in service delivery, and assessing the adequacy of agency interventions. The reviews did not focus on the performance of individual agency personnel.

## Criteria Of Cases Reviewed

1. All infants, under one year of age, who resided in the State of Delaware and whose deaths occurred within the state.
2. State of Delaware residents under the age of 18 whose deaths occurred within the state and one or more of the following factors were believed to have been present:
  - a. Cause of death undetermined after Medical Examiner's investigation
  - b. Head trauma
  - c. Malnutrition/neglect, including Failure to Thrive
  - d. Drowning
  - e. Suffocation/asphyxia
  - f. Drug ingestion
  - g. Poisoning
  - h. Fractures/dislocations
  - i. Blunt force trauma
  - j. Homicide/child abuse/neglect
  - k. Burns
  - l. Any history of or recent physical abuse, sexual abuse, or neglect
  - m. Gunshot wound/stab wound/puncture/lacerations
  - n. Suicide
  - o. Sudden Infant Death Syndrome (SIDS)
  - p. Other unexplained or unexpected child deaths as appropriate
3. Aggregate data on all other deaths of infants and children under the age of 18 occurring in Delaware and not qualifying for review by the Review Panel was maintained by the Division of Public Health.

4. Deaths involving criminal investigations were delayed for at least six months contingent upon authorization of the Attorney General's Office.
5. Special requests to review a case that did not meet the review criteria were considered from agencies and professionals affiliated with the AIC or the Pilot Project and were approved or denied by the co-chairs.

### **Roles Of Review Panel Members**

The American Bar Association Center on Children and the Law developed minimum role definitions for each of the core Review Panel members. The role definitions were approved by the agency represented on the Pilot Project. Review Panel members (Appendix D & E) were responsible for bringing and discussing their own agency records regarding the deceased child and/or family scheduled for review, providing insight into the case based on their area of expertise, rendering a decision on the preventability of the child's death, formulating recommendations for system changes, and facilitating enhanced service delivery within their own agency.

The following agencies and professions participated in the Review Panel:

1. Department of Health and Social Services
  - a. Division of Alcoholism, Drug Abuse and Mental Health
  - b. Division of Public Health
  - c. Office of the Medical Examiner
2. Department of Services for Children, Youth and Their Families
  - a. Division of Family Services
  - b. Division of Child Mental Health
  - c. Division of Youth Rehabilitative Services
3. Attorney General's Office (Criminal Division)
4. Law Enforcement
  - a. Delaware State Police
  - b. New Castle County Police Department

- c. Wilmington Police Department
  - d. Milford Police Department
  - e. Dover Police Department
5. Department of Public Instruction
  6. Medical Specialists: Neonatologist, Obstetrician-Gynecologist, Pediatrician, Perinatologist
  7. Child Advocates

### **Review Panel Procedures**

1. The Review Panel met monthly for approximately two hours and reviewed an average of four cases each session.
2. Prior to the reviews, the Division of Public Health sent Review Panel members the meeting agenda which included names of deceased children to be reviewed.
3. The Reviews were facilitated by co-chairs elected by the Review Panel.
4. Professionals directly involved in a case were invited by the co-chairs to participate in the review of that case when it was believed that relevant information could be obtained.
5. Review Panel members orally summarized their agencies' interaction with the deceased child and/or family when applicable. Review Panel members were expected to excuse themselves from the Review Panel if a relationship existed with the deceased child or family being reviewed which could compromise objectivity.
6. Child Death Data Sheets describing agency activity were submitted at the end of each review for the purpose of data collation by the Division of Public Health.
7. The Child Death Review Findings Form was completed at the end of each review by a co-chair and an affirmative vote of sixty percent of those present was needed to adopt any findings and recommendations. The form was forwarded to the Division of Public Health.

8. At each case review, Review Panel members and invited professionals signed the Confidentiality Statement for the Delaware Child Death Review Process.
9. Cases that were not reviewed due to a lack of information, were deferred.

# Chapter **2**

---

## Data Presentation

Data provided in this chapter were derived from several sources. In order to obtain an overview of child deaths in Delaware occurring in recent years child death statistics were compiled from the Delaware Department of Health and Social Services, Delaware Health Statistics Center and the *Delaware Vital Statistics Annual Report* (for the years 1992, 1993, and 1994.) Information and data relating to specific child death cases reviewed by the Review Panels were obtained from Child Death Data Sheets, Findings Forms and Death Certificates.

Because the Kent and Sussex Counties Review Panel met only a few times during the period covered by this report, the data from this Review Panel and that of the New Castle County Review Panel have been combined. Data involving cases that were reviewed by either Review Panel come from cases reviewed between October 1995 and December 1996. They involve deaths occurring between October 1994 and January 1996. Review case statistics were derived from deaths that occurred in multiple calendar years, they should not be compared with statewide child death statistics from specific calendar years.

## Breakdown of Child Deaths by Age Group

Over time, child deaths in Delaware reflect a consistent pattern. The overwhelming majority of deaths occur within the first year of birth. In 1996 the less-than-one age group comprised nearly two-thirds of the 105 child deaths Statewide.

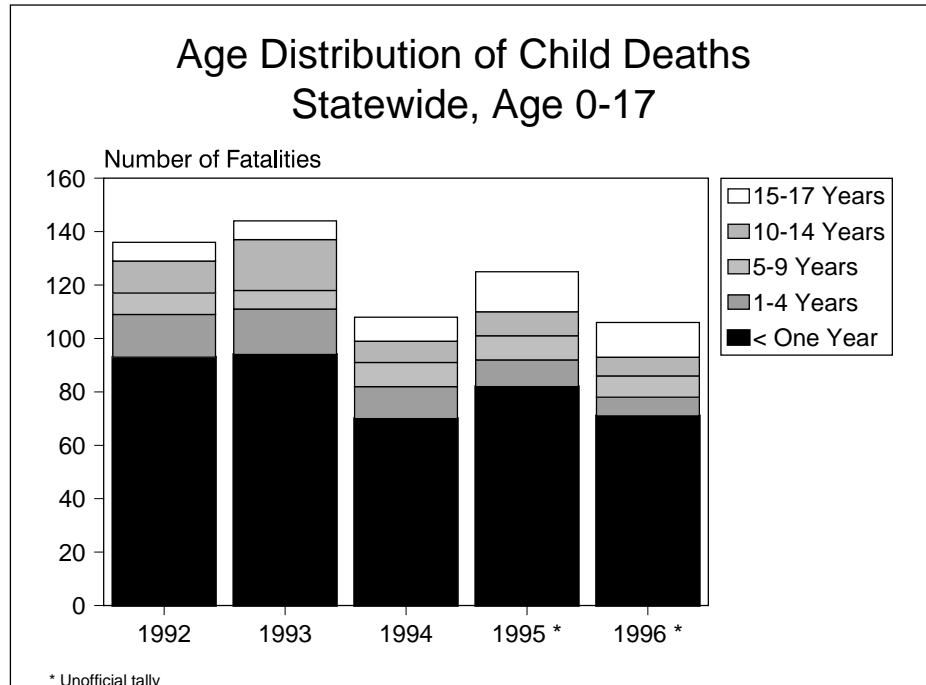


Figure 1. Breakdown of Statewide Child Deaths by Age Group

Neonatal deaths are those deaths occurring between birth and 28 days. In 1996 these deaths made up nearly 45% of all child deaths. The table below shows a breakdown of child deaths in 1996 by age group. Neonatal deaths are included in the Less-Than-One year age group. For closer examination they have also been listed separately in the shaded row.

Statewide Child Deaths in 1996		
Age Group	Number	Percent <sup>1</sup>
Less-Than-One Year Old	68	64.8
Neonatal Only	47	44.8
1 – 4 Years of Age	9	8.6
5 – 9 Years of Age	8	7.6
10 – 14 Years of Age	7	6.7
15 – 17 Years of Age	13	12.4

Figure 2. Table of Statewide Child Deaths in 1996 by Age Group

<sup>1</sup> Percent is of 105 deaths. Due to rounding, percents may not total 100%.

## Age Grouping of Cases Reviewed by the Panels <sup>1</sup>

The Panels reviewed 47 deaths. The table below shows the age breakdown of these deaths. Neonatal deaths are included in the Less-Than-One year age group and are also listed separately in the shaded row.

Child Deaths Reviewed by the Panels		
Age Group	Number	Percent <sup>2</sup>
Less-than-one Year of Age	25	53.2
Neonatal Only	10	21.3
1–4 Years of Age	5	10.6
5–9 Years of Age	4	8.5
10–14 Years of Age	4	8.5
15–17 Years of Age	9	19.1

Figure 3. Table of Cases Reviewed Broken-down by Age Group

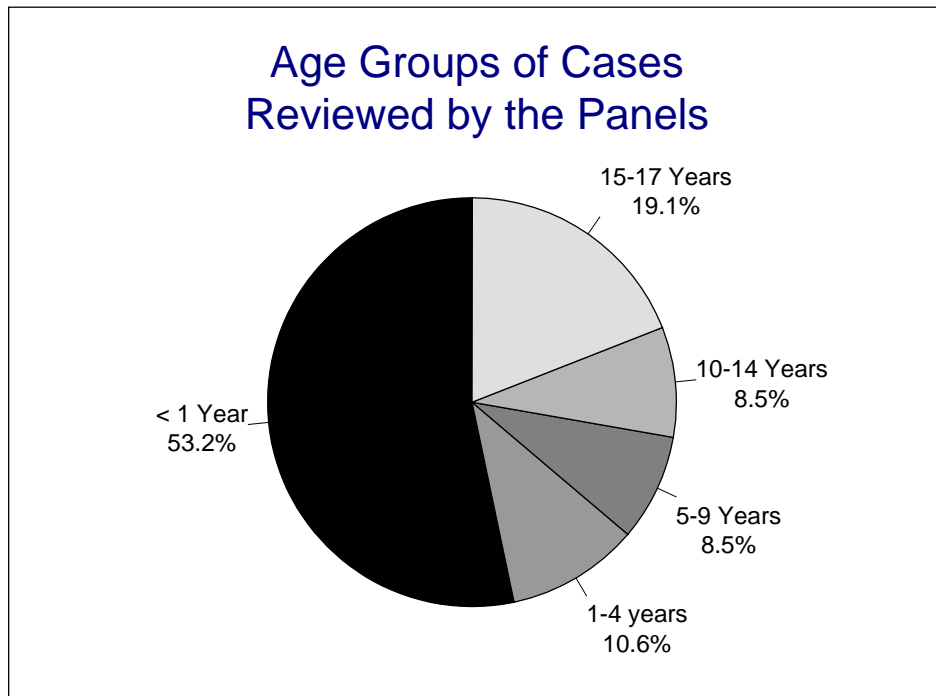


Figure 4. Graph of Cases Reviewed by Age Group <sup>2</sup>

<sup>1</sup> Review case statistics were derived from deaths that occurred in multiple calendar years, they should not be compared with statewide child death statistics from specific calendar years.

<sup>2</sup> Percent is of the 47 cases reviewed. Due to rounding, percents may not total 100%

## Breakdown of Child Deaths by Manner of Death

Over two-thirds of all child deaths are attributed to natural causes. This is not surprising since more than half of all child deaths occur within the first year of life; most of these are related to prematurity.

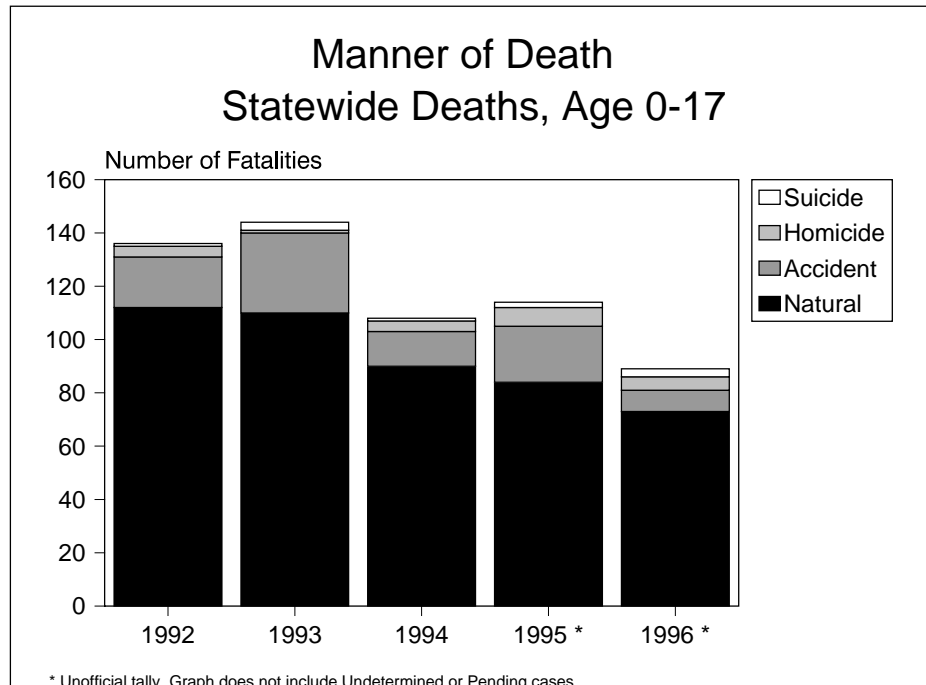


Figure 5. Breakdown of Statewide Child Deaths by Manner of Death

The table below shows age groups and the manner of death (as stated on the death certificate) for child deaths in 1996. Not included are seven deaths listed as pending, three deaths listed as undetermined and five deaths for which manner of death was left blank on the death certificate.

Statewide Child Deaths in 1996 <sup>1</sup>								
Age Group	Natural		Accident		Homicide		Suicide	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Less-than-one Year	58	55.2	1	1.0	0	0.0	0	0.0
Neonatal Only	44	41.9	0	0.0	0	0.0	0	0.0
1–4 Years of Age	7	6.7	1	1.0	1	1.0	0	0.0
5–9 Years of Age	2	1.9	0	0.0	1	1.0	0	0.0
10–14 Years of Age	3	2.9	3	2.9	0	0.0	0	0.0
15–17 Years of Age	4	3.8	3	2.9	3	2.9	3	2.9
Totals	74	70.5	8	7.6	5	4.8	3	2.9

Figure 6. Table of Statewide Deaths in 1996 Relating Manner of Death and Age Group

<sup>1</sup> Percent is of 105 deaths. Due to rounding, percents may not total 100%.

## Manner of Death of Cases Reviewed by the Panels <sup>1</sup>

The table below shows the manner of death listed on the death certificates of children whose cases were reviewed by the Panels. One death certificate had no listing for manner of death and is not included in Figures 7 and 8.

Child Deaths Reviewed by the Panels <sup>2</sup>						
Age Group	Natural		Accident		Homicide	
	Number	Percent	Number	Percent	Number	Percent
Less-than-one Year	22	47.8	2	4.3	1	2.2
Neonatal Only	9	19.6	1	2.2	0	0.0
1–4 Years of Age	3	6.5	2	4.3	0	0.0
5–9 Years of Age	3	6.5	0	0.0	0	0.0
10–14 Years of Age	3	6.5	1	2.2	0	0.0
15–17 Years of Age	1	2.2	7	15.2	1	2.2
Totals	32	69.6	12	26.1	2	4.3

Figure 7. Table of Reviewed Cases Relating Manner of Death and Age Group

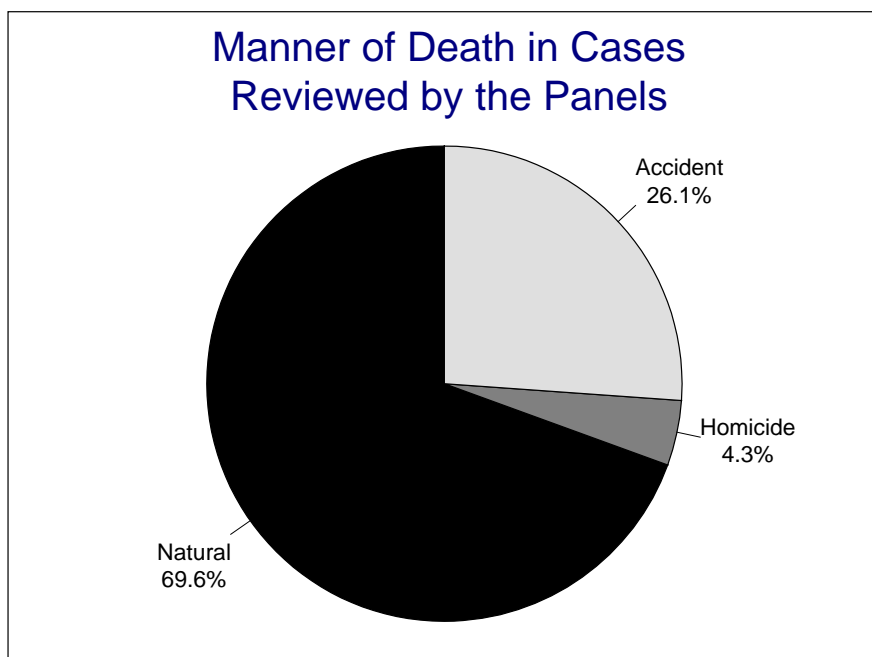


Figure 8. Graph of Reviewed Cases by Manner of Death <sup>2</sup>

<sup>1</sup> Review case statistics were derived from deaths that occurred in multiple calendar years, they should not be compared with statewide child death statistics from specific calendar years.

<sup>2</sup> Percent is of the 47 cases reviewed. Due to rounding, percents may not total 100%.

## Breakdown of Child Deaths by Race

In Delaware, births of Black babies are constant at around 23% of all live births. Black children, however, die in numbers far greater than their proportion of the population. In 1996, Black babies comprised 47% of all neonatal deaths. Black children continued to die in disproportionate numbers in each age group up to age ten. (See figure 10.)

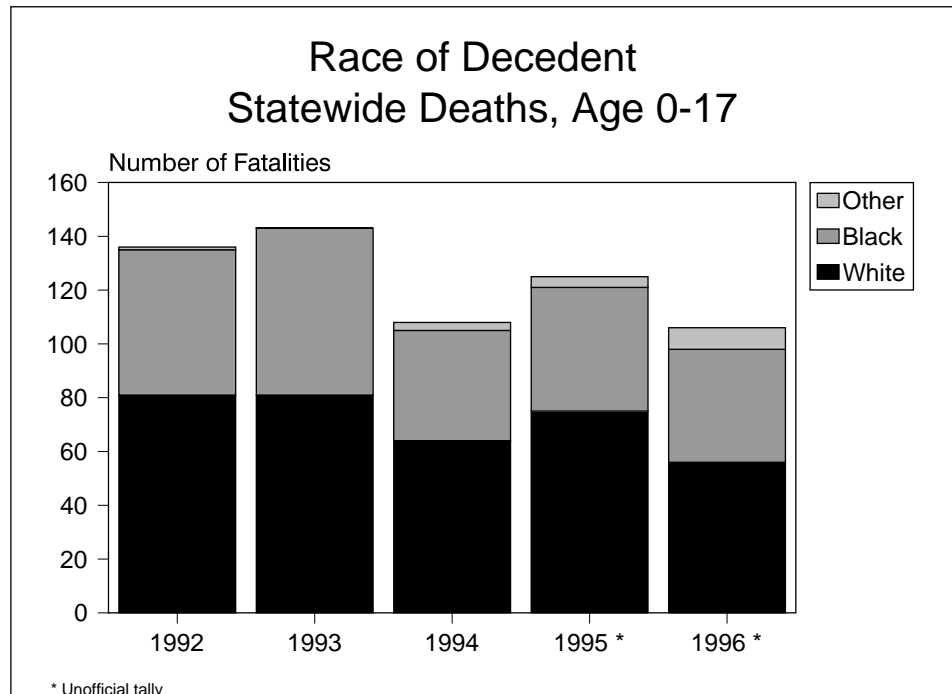


Figure 9. Breakdown of Statewide Child Deaths by Race

The table below shows age groups and race. Asian, Hispanic and Indian children are included in Other. (Racial categories are those used by Delaware Health Statistics Center.) The less-than-one age group includes neonatals.

Statewide Child Deaths in 1996 <sup>1</sup>						
Age Group	Black		White		Other	
	Number	Percent	Number	Percent	Number	Percent
Less-than-one Year	29	27.6	35	33.3	4	3.8
Neonatal Only	22	21.0	22	21.0	3	2.9
1–4 Years of Age	3	2.9	4	3.8	2	1.9
5–9 Years of Age	5	4.8	2	1.9	1	1.0
10–14 Years of Age	1	1.0	5	4.8	1	1.0
15–17 Years of Age	3	2.9	10	9.5	0	0.0
Totals	41	39.0	56	53.3	8	7.6

Figure 10. Table of Statewide Deaths in 1996 Relating Race and Age Group

<sup>1</sup> Percent is of 105 deaths. Due to rounding, percents may not total 100%.

## Race of Cases Reviewed by the Panels <sup>1</sup>

The table below shows the race listed on the death certificates of children whose cases were reviewed by the Panels. Neonatal deaths are included in the less-than-one age group and are also listed separately in the shaded row.

Child Deaths Reviewed by the Panels <sup>2</sup>						
Age Group	Black		White		Other	
	Number	Percent	Number	Percent	Number	Percent
Less-than-one Year	6	12.7	18	38.3	1	2.1
Neonatal Only	1	2.1	8	17.0	1	2.1
1–4 Years of Age	3	6.4	2	4.3	0	0.0
5–9 Years of Age	1	2.1	3	6.4	0	0.0
10–14 Years of Age	2	4.3	2	4.3	0	0.0
15–17 Years of Age	4	8.5	4	8.5	1	2.1
Totals	16	34.0	29	61.7	2	4.3

Figure 11. Table of Reviewed Cases Relating Race and Age Group

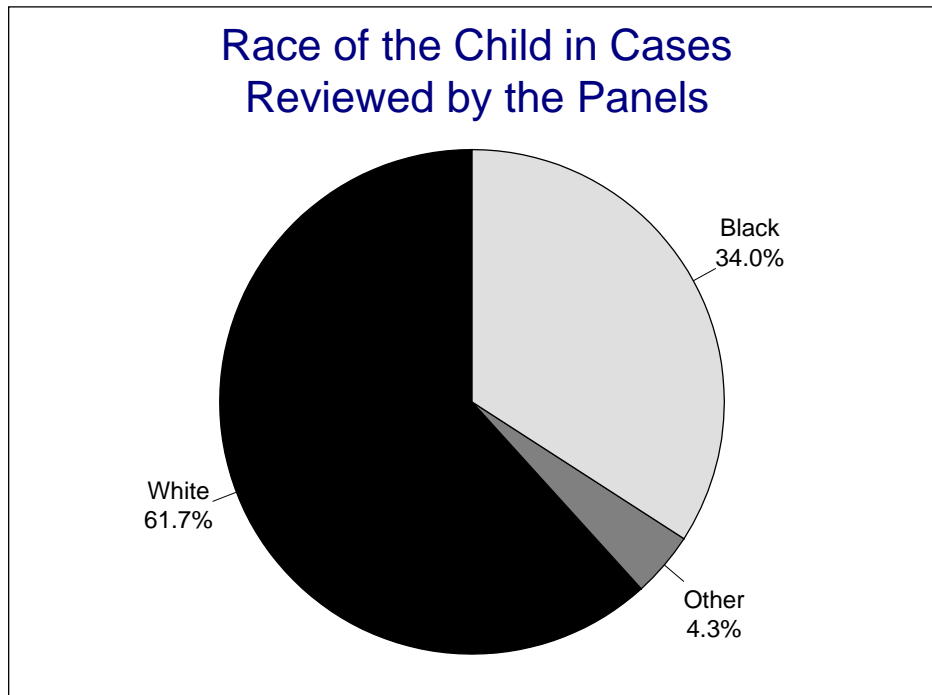


Figure 12. Graph of Reviewed Cases by Race <sup>2</sup>

<sup>1</sup> Review case statistics were derived from deaths that occurred in multiple calendar years, they should not be compared with statewide child death statistics from specific calendar years.

<sup>2</sup> Percent is of the 47 cases reviewed. Due to rounding, percents may not total 100%.

## Breakdown of Child Deaths by Sex

As usual, in 1996 the number of male child deaths exceeded the number of female child deaths in every age group. Male deaths out-numbered female deaths approximately three to two.

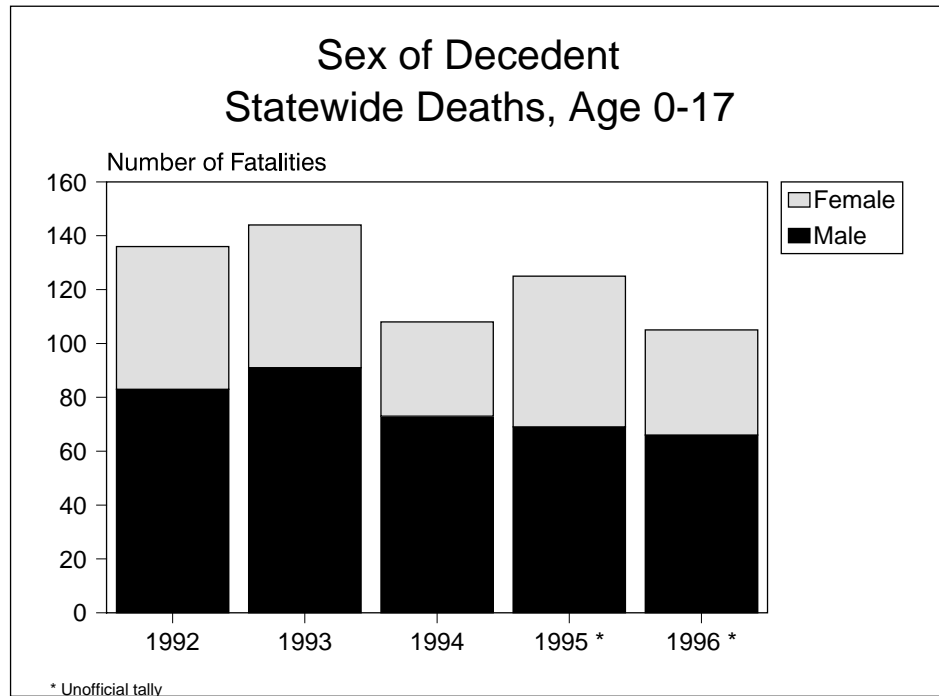


Figure 13. Breakdown of Statewide Child Deaths by Sex

The table below shows age groups and sex (as stated on the death certificate) for child deaths in 1996. Sex was undetermined for one child (not included.) Neonatal deaths are included in the less-than-one age group.

Statewide Child Deaths in 1996 <sup>1</sup>				
Age Group	Male		Female	
	Number	Percent	Number	Percent
Less-than-one Year	44	42.0	23	22.0
Neonatal Only	29	27.6	17	16.2
1-4 Years of Age	3	2.9	6	5.7
5-9 Years of Age	5	4.8	3	2.9
10-14 Years of Age	4	3.8	3	2.9
15-17 Years of Age	9	8.6	4	3.8
Totals	65	62.0	39	37.1

Figure 14. Table of Statewide Deaths in 1996 Relating Sex and Age Group

<sup>1</sup> Percent is of 105 deaths. Due to rounding, percents may not total 100%.

## Sex of Cases Reviewed by the Panels <sup>1</sup>

The table below shows the sex listed on the death certificates of children whose cases were reviewed by the Panels. Neonatal deaths are included in the less-than-one age group and are also listed separately in the shaded row.

Child Deaths Reviewed by the Panels <sup>2</sup>				
Age Group	Male		Female	
	Number	Percent	Number	Percent
Less-than-one Year	14	29.8	11	23.4
Neonatal Only	2	4.3	8	17.0
1–4 Years of Age	3	6.4	2	4.3
5–9 Years of Age	2	4.3	2	4.3
10–14 Years of Age	1	2.1	3	6.4
15–17 Years of Age	6	12.8	3	6.4
Totals	26	55.3	21	44.7

Figure 15. Table of Sex of Cases Reviewed Relating Sex and Age Group

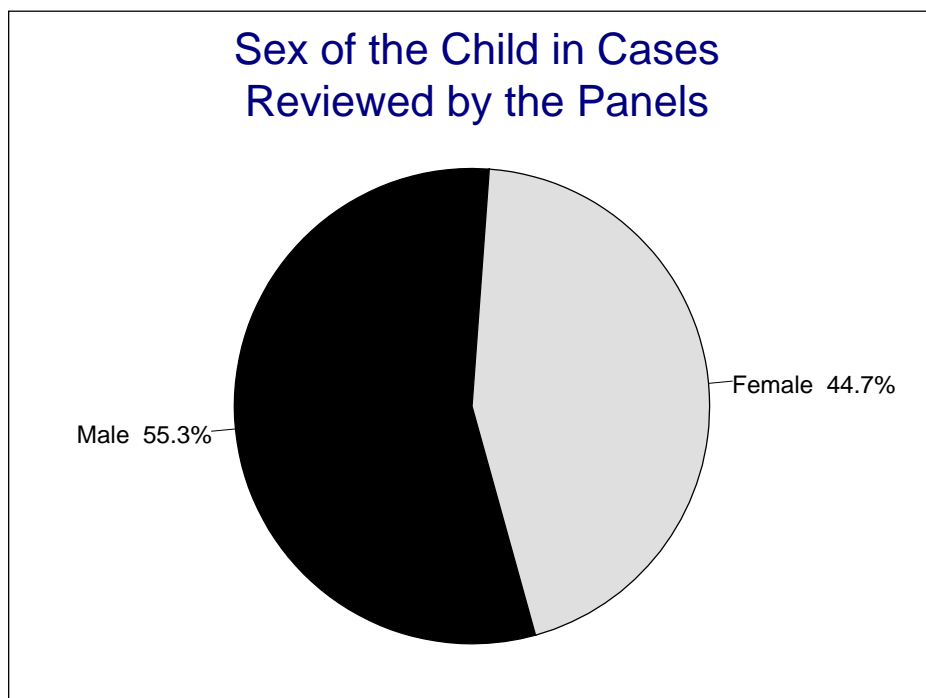


Figure 16. Graph of Reviewed Cases by Sex <sup>2</sup>

<sup>1</sup> Review case statistics were derived from deaths that occurred in multiple calendar years, they should not be compared with statewide child death statistics from specific calendar years.

<sup>2</sup> Percent is of the 47 cases reviewed. Due to rounding, percents may not total 100%.

## Preventability of Cases Reviewed <sup>1</sup>

Of the 47 cases reviewed, 18 were considered preventable. In five cases preventability was undetermined. In one case the Review Panel could not achieve a majority vote.

Below is a table showing a breakdown of deaths considered by the Review Panels to be preventable. For purposes of categorization, the cause of death listed in the table may not be exactly as it appears on the death certificate.

Preventable Deaths <sup>2</sup>		
Manner of Death	Cause of Death	Number
Accident	Adverse Drug Reaction	2
	Motor Vehicle Related	5
	Drowning	3
	Other	4
Homicide	Gunshot	1
	Shaken Baby	1
Natural	Extreme Prematurity	1
	Pneumonia	1

Figure 17. Table of Preventable Child Deaths Reviewed by Panels.

## SIDS

In 1996 there were five SIDS-related deaths. This was a decline from eight SIDS deaths in 1995.

Of the seven SIDS deaths reviewed by the Panels, four were considered to be not preventable. In the remaining cases preventability was undetermined.

Although the risk factors that may play a role in SIDS deaths have been identified, the etiology of SIDS is still unknown. Because of this, the Panels no longer determine preventability of such cases. In the future, preventability in SIDS cases will be considered undetermined and risk factors involved in each case will be identified.

---

<sup>1</sup> Review case statistics were derived from deaths that occurred in multiple calendar years, they should not be compared with statewide child death statistics from specific calendar years.

<sup>2</sup> Manner of death is determined by the death certificate. This does not reflect any criminal charges brought as a result of the death investigation.

## Chapter

---

# 3

## Recommendations

During the year the Review Panels have recorded various suggestions that might lead to a reduction in child deaths. Following a final review and selection, the most significant of these suggestions have been compiled and grouped together. Presented here as recommendations, they concern Sudden Infant Death Syndrome, Car Safety, Water Safety and the Operations of the Review Panels and Program.

## **Recommendations Concerning SIDS**

The Commission recommends that a SIDS prevention and education effort be implemented targeting three groups:

- Parents and Child Care Givers
- Child Birth Educators and Medical Professionals
- Law Enforcement Professionals

In November, 1996, in response to the concerns of the Child Death Review Panels, the Abuse Intervention Committee established a SIDS Workgroup, which includes members from public health, law enforcement, the medical community, day care licensing and the local SIDS Affiliate, to undertake public education efforts in conjunction with the American Academy of Pediatrics "Back to Sleep" campaign. Using the Centers for Disease Control guidelines, the Workgroup also is developing a death scene investigation protocol for law enforcement agencies to use when responding to sudden, unexplained child deaths.

The Commission supports the education efforts already underway and encourages the medical community to help establish peer education efforts for nurses, physicians, midwives and child birth educators about SIDS risk reduction strategies.

The Commission recommends that the law enforcement protocol be adopted by all law enforcement agencies statewide through the Delaware Police Chiefs' Council.

The Commission Chairperson will communicate with the Consumer Products Safety Commission to encourage the makers of baby products, particularly cribs, to enclose information about SIDS risk reduction strategies in the packaging of these baby products.

## **Recommendation Concerning Child Safety Seats**

Currently, Delaware law allows a judge to dismiss a motor vehicle fine against a driver for not having a child properly restrained in a car safety seat if the driver can produce evidence that a car safety seat has been purchased or obtained when the driver appears in court.

The Commission requests that the Department of Justice draft legislation to amend the statute so that the violation can no longer be dismissed simply because a car safety seat is produced at the time of the hearing.

Further, the Commission recommends that a letter be drafted to the Chief Magistrate of the Justice of the Peace Court and the Chief Judge of the Wilmington Municipal Court. The letter will inform them of the Commission's request for a legislative amendment to this section of the

motor vehicle code. Since a legislative change cannot be affected until January, 1998, the letter will also request the issuance of a policy directive to judges of those courts, informing them of the Commission's proposal and requesting that they no longer exercise their discretion to dismiss the violation.

### **Recommendation Concerning Seat Belt Use by Children**

The Commission recommends a clarification to the current motor vehicle law that requires children age 4 through 16 to wear seat belts. Despite current law enforcement practice, it is the legal interpretation of the Department of Justice that, although a seat belt violation for an adult is a secondary offense, the legislature clearly intended a different standard for children age 4 to 16.

The Commission requested that the Department of Justice communicate with all Delaware police chiefs to clarify the statute and the enforcement policy.

### **Recommendation Concerning Water Safety**

The Commission supports the Review Panels' recommendation that a public awareness/parent education campaign be implemented regarding the possibility of children drowning in ornamental ponds, natural bodies of water, drainage ditches and storm run-off ponds as well as swimming pools. The Chairperson of the Commission will communicate with school superintendents, pediatricians and day care providers asking them to share water safety information with parents. The New Castle County Police Department will provide the water safety tips to be included in the correspondence.

The Commission further recommends that pool alarms be required in swimming pools at schools, camps, community centers and other agencies where children are the primary users as well as apartment complexes. The Commission requests that the Department of Justice research this issue and recommend implementation alternatives.

## **Recommendations Concerning Review Panel/Program Operations**

### **Death Certificates Should Be Legible and Completed by Physicians**

The Commission recommends that Sections 30 through 40 Part II inclusive of Delaware's Certificate of Death be legible and completed by the attending certifying Physician. This would insure that the data used by the Child Death Review Panels is readable and uniform statewide.

### **Limitation of Cases Included in the Annual Report**

The Commission recommends that the Child Death Review Annual Report should confine discussion of cases that were reviewed to those that occurred in a single calendar year. Currently cases that were reviewed may extend over multiple calendar years. This makes it impossible to relate reviewed case data to statewide data.

### **Child Death Review Project Director**

The Commission recommends that a full time Project Director (See Appendix F.) with a limited training budget be hired. It is further recommended that this position be established and located within the Division of Public Health.

Child Death Review Panels have moved from a New Castle County pilot project in 1995, to now being legislatively mandated and operational on a statewide basis. Panels meet twice monthly in addition to a recently formed Perinatal Subcommittee, which meets prior to the New Castle County Review Panel and limits its review to neonatal deaths. Thirty (30) statewide rotating Panel members have alternates, which bring the total to over 50 persons.

Currently operations of this project are being coordinated through several agencies, with the administrative support of the program residing in the Division of Public Health. In order to maintain continuity throughout the state, Review Panel administration and training of Review Panel members should be assigned to one agency. To be effective, there is a constant need to standardize training of Review Panel members (as well as alternates).

The Division of Public Health would continue to provide one full-time support person and, with the addition of a full-time Director, would be the agency responsible for total program administration, including training of Review Panel members and production of the annual report.

Appendix

A

Child Death Review  
Commission Members

## Delaware Child Death Review Commission

Richard Callery, MD, FCAP  
Chair of the Child Death Review Commission  
Chief Medical Examiner  
Office of the Medical Examiner

Secretary Thomas P. Eichler  
Department of Services for  
Children, Youth and their  
Families

Secretary Carmen Nazario  
Department of Health and  
Human Services

Attorney General M. Jane Brady  
Department of Justice

Garrett H. Colmorgan, MD  
Perineonatologist

James J. Cosgrove, MD  
OB/GYN

Allan J. Daul  
Executive Director of Catholic  
Charities

Sandra Dyer, LCSW  
Delaware Guidance

Colonel Alan Ellingsworth  
Superintendent of the Delaware  
State Police

Michael Ferguson  
Department of Public Instruction

John Forest, MD  
Pediatrician

Fran Franklin  
Chair of the Kent/ Sussex  
Review Panel

Jonnie M. Green-Stubbolo  
National Association of Social  
Workers

Colonel Thomas P. Gordon,  
New Castle County Police  
Department (retired)

Kathleen L. Peeke, RN  
duPont Hospital for Children

Chief Samuel Pratcher  
Wilmington City Police

Adrienne Sekula-Perlman, MD  
Chair of New Castle County  
Review Panel

Michael L. Spear, MD  
Neonatologist

Appendix

---

**B**

## Child Death Review Progress Timeline

## Child Death Review Progress Timeline

- May, 1991* The Delaware Attorney General's Abuse Intervention Committee (AIC) sponsored a Working Session conducted by staff of the American Bar Association and the American Academy of Pediatrics Child Maltreatment Fatalities Project with key professionals in Delaware on issues regarding child death reviews.
- June, 1991* The Child Death Review Panel Subcommittee of the AIC was formed to develop a plan for the multi-disciplinary review of child deaths in Delaware.
- November, 1993* The Child Death Review Panel Subcommittee published the *Delaware Child Death Review Panels Proposals*, a comprehensive model for reviewing child deaths statewide. The Department of Health and Social Services and Department of Services for Children, Youth and Their Families would have primary responsibility for implementation. Three staff positions were recommended to fully implement the Proposal, however, the funding was not secured.
- July, 1994* The Child Death Review Implementation Subcommittee was formed to develop a Pilot Project based on the 1993 Proposal. 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.
- December, 1994* Legislation was drafted to create a statewide Child Death Review Commission.
- January, 1995* The Subcommittee published the *New Castle County Child Death Review Pilot Project* report which outlined procedures for implementation of the Pilot Project.
- January 19, 1995* Training for Pilot Project Review Panel members was conducted.
- February 27, 1995* Pilot Project Review Panel members conducted their first child death review and have been retrospectively reviewing child deaths on a monthly basis.

- June 15, 1995* Legislation to create a statewide Child Death Review Commission was introduced into the House (H.B. 317), passed by the Senate on June 30, 1995 and enacted by the Governor on July 19, 1995.
- January, 1996* Governor Thomas R. Carper announced the appointments of members to the newly established Child Death Review Commission.
- March, 1996* The Child Death Review Implementation Subcommittee published the *New Castle County Child Death Review Project Final Report*.
- March 11, 1996* Governor Thomas R. Carper convened the first meeting of the Child Death Review Commission.
- March 1996* The Pilot Project Review Panel continued to review child deaths during the transition to establish Regional Child Death Review Panels by the Commission.
- October 1996* The Kent/Sussex Review Panel was convened and received training on the Child Death Review process.
- June 1997* The Child Death Review Commission published the *Child Death Review Annual Report*.

## Appendix

---

---



## Legislation

This appendix contains three pieces of legislation. The first is the legislation that created the Child Death Review Commission. The last two pertain to automotive restraint usage.



HOUSE OF REPRESENTATIVES

138TH GENERAL ASSEMBLY

HOUSE BILL NO. 317  
AS AMENDED BY  
HOUSE AMENDMENTS NOS. 1 & 3 AND  
HOUSE AMENDMENT NO. 1 TO HOUSE AMENDMENT NO. 3

AN ACT TO AMEND CHAPTER 3, TITLE 31 OF THE DELAWARE  
CODE RELATING TO CHILD WELFARE.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE  
OF DELAWARE:

Section 1. Amend Chapter 3 of Title 31 of the Delaware  
Code by redesignating Subchapters II through VI thereof as  
Subchapters III through VII, respectively, and by adding thereto a  
new Subchapter II, to read as follows:

“Subchapter II. Child Death Review Commission.

§ 320. Declaration of Legislative Intent.

The General Assembly hereby declares that the health and safety of the children of the State of Delaware will be safeguarded if deaths of children under the age of eighteen 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 Review Commission (for purposes of this subchapter, the "Commission").

§ 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 State Superintendent of Public Instruction, 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) two child advocates from state-wide non-profit organizations. The Chairperson of each regional child death 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 three 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.

(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 one 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 one but no more than three regional child death review panels. Each member of the Commission shall appoint one representative to each regional panel. The Commission chairperson shall also

appoint to each regional panel (i) a representative from each of the three police departments which investigate the majority of child deaths in the State, provided, however, that if any such police department is otherwise represented, then another representative need not be so appointed for that police department, and (ii) a citizen of this State interested in child death 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 a chairperson from its membership for a term of one year.

#### § 322. Voting.

Except as expressly provided herein, an affirmative vote of sixty percent 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.

#### § 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 eighteen which occur in Delaware. 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. Such recommendations shall be available to the public upon request.

(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 first review. The Commission may amend such procedures, with the consent of the Abuse Intervention Committee, upon a three-quarters affirmative vote of all members of the Commission.

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

(1) administer oaths; and

(2) compel the attendance of witnesses and the production of documents by the filing of a praecipe for a subpoena 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.

§ 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 herein. 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. 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.”

### SYNOPSIS

This Act creates the Child Death Review Commission, which is empowered to investigate the death in this State of any person under the age of 18. The Commission is required to report recommendations to the Governor and the General Assembly at least annually on issues affecting child mortality.

DELAWARE CODE ANNOTATED  
TITLE 21. MOTOR VEHICLES  
PART III. OPERATION AND EQUIPMENT  
CHAPTER 48. OCCUPANT PROTECTION SYSTEM  
SAFETY ACT

s 4802 Driver requirements; front seat passenger; exceptions; sales requirements; working condition of system.

(a) (1) The driver of a motor vehicle operated on a street or highway in this State shall wear a properly adjusted and fastened seat belt which meets the applicable federal motor vehicle safety standards.

(2) The driver of a motor vehicle shall secure or cause to be secured in a properly adjusted and fastened seat belt system, as defined by the applicable federal motor vehicle safety standards, any passenger in the front seat.

(b) The term “motor vehicle,” as used in this chapter, is defined in s 101 (20) of this title, with the exception of motorcycles.

(c) The provisions of this section shall not apply to;

(1) Any person in a motor vehicle who possesses a written verification from a licensed physician or a licensed physical therapist that such person is unable to wear an occupant protection system for physical or medical reasons;

(2) A motor vehicle which is not required to be equipped with an occupant protection system under federal law; or

(3) A motor vehicle operated by a letter carrier of the United States Postal Service while performing the duties of a letter carrier.

(d) A motor vehicle shall not be stopped by a police officer for failing to comply with this section.

(e) No person shall install, distribute, have for sale, offer for sale or sell any occupant protection system for use in a motor vehicle unless it meets current minimum standards and specifications under federal law.

(f) Every owner of a motor vehicle shall maintain all occupant protection systems and assemblies and mechanisms required by this section in proper working condition and in a manner that will enable occupants to use them.

(g) (1) Failure to comply with this section shall be considered as an aggravating circumstance for sentencing purposes for persons convicted of violations of other provisions of this title.

(2) a. Any person who is found to have violated this section in connection with the prosecution of a violation of any other provision of this title shall in addition to any fine, and at the same time as any fine is assessed to the defendant, be levied for credit to the Victim's Rights Fund an

additional penalty assessment of 40% not to exceed \$20 of every fine, penalty or forfeiture imposed or collected by the court for the offense under this title. Where there are multiple offenses under this title involved, the penalty assessment pursuant to this section shall be based upon a total fine for all offenses but not to exceed a total additional penalty assessment of \$20. When a fine, penalty or forfeiture is suspended in whole or in part the additional penalty assessment shall not be suspended.

b. The assessment imposed herein shall be in addition to the penalty assessment imposed by 11 De. C. s 9012(a).

(h) No motor vehicle points shall be assessed against any person for failing to comply with subsection (a) of this section and there shall be no entry made on the person's driving record for failing to comply with subsection (a) of this section.

(i) Failure to wear an occupant protection system shall not be considered as evidence of either comparative or contributory negligence in any civil suit or insurance claim and adjudication arising out of any motor vehicle accident, nor shall failure to wear an occupant protection system be admissible as evidence in the trial of any civil action or

insurance claim adjudication.

(68 Del. Laws, c. 34, s 1; 69 Del. Laws, c. 169, s 1.)

#### NOTES, REFERENCES, AND ANNOTATIONS

Reviser's note. -- Section 3 of 69 Del. Laws, c. 169, provides: "The Victims' Rights Fund shall be appropriated and expended in conformity with the annual appropriation act of the State. Nothing in this subchapter shall preclude the appropriation of general funds to the Victims' Rights Fund."

Effect of amendments. -- 69 Del. Laws, c. 169, effective July 19, 1993, substituted "Victims' Rights Fund" for "Victim Compensation Fund" in (g) (2) a.

DELAWARE CODE ANNOTATED  
TITLE 21. MOTOR VEHICLES  
PART III. OPERATION AND EQUIPMENT  
CHAPTER 48. OCCUPANT PROTECTION SYSTEM  
SAFETY ACT

s 4803 Child restraint in motor vehicles.

(a) Every person shall be responsible, when transporting a child under the age of 4 years in a motor vehicle operated on the roadways, streets or highways of this State, for providing for the protection of the child by properly using a child passenger restraint system meeting the federal motor vehicle safety standards. The duty imposed by this subsection shall not apply to any operator or passenger of a motor bus, limousine or taxicab as defined in s 1801 of Title 2.

(b) Every child who has attained the age of 4 and has not yet attained the age of 16 shall wear a fastened seat belt or child passenger restraint system at all times while in a motor vehicle operated on the roadways, streets or highways of this state.

(c) The court may, upon presentation of evidence that a violator of subsection (a) of this section has purchased or obtained a child passenger restraint system subsequent to the violation, dismiss all charges pursuant to this section.

(d) A violation of this section shall be an offense

punishable by a fine of no more than \$28.75 for each violation. The failure to provide a child restraint system or seat belt for more than 1 child in the same vehicle at the same time, as required by this section , shall not be treated as a separate offense.

(e) A violation of this section shall not be considered as evidence of either comparative or contributory negligence in any civil suit or of criminal negligence or recklessness in any criminal action arising out of any motor vehicle accident in which a child under 16 is injured, nor shall failure to wear a child passenger restraint system or seat belt in violation of this section be admissible as evidence in the trial of any civil action.

(63 Del. Laws, c. 251, s 1; 66 Del. Laws, c. 409, ss 1, 2; 68 Del. Laws, c. 9, s 38; 68 Del. Laws, c. 34, s 2; 69 Del. Laws, c. 418, ss 1-8.)

#### NOTES, REFERENCES, AND ANNOTATIONS

Effect of amendments. -- 69 Del. Laws, c. 418, effective July 14, 1994, inserted present (b) and redesignated the remaining subsections accordingly; deleted “and weighing less than 40 pounds” preceding “in a motor vehicle” in the first sentence of (a); inserted “of subsection (a)” in present (c); inserted “or seat belt” in the second

sentence of present (d); and in present (e), substituted “A violation of this section” for “Failure to wear a child passenger restraint system” at the beginning, inserted “or of criminal negligence or recklessness in any criminal action,” substituted “16” for “4,” and inserted “or seat belt in violation of this section.”

Appendix

---



New Castle County  
Child Death Review Panel

**New Castle County Child Death Review Panel**

Adrienne Sekula-Perlman , MD  
**Co-Chair**  
Office of Medical Examiner

Lew Bennett  
Div. of Youth Rehabilitation  
Services

Garrett Colmorgan, MD  
Perinatologist

Jonnie Green-Stubbolo  
National Association of Social  
Workers

Linda Hawthorne  
SIDS Affiliate

Dr. Cliff Hutton  
**Alternate:** Edith Vincent  
Dept. of Public Instruction

Shirlee Kittleman  
Div. of Public Health

Neil McLaughlin  
**Alternate:** Kristine Stapleford  
Div. of Alcohol, Drug Abuse &  
Mental Health

Vinay Nadkarni, MD  
Pediatrician

Carol Ann Schumann  
Delawareans United to Prevent  
Child Abuse

Lt. Drew Outten  
**Co-Chair**  
New Castle County Police Dept.

Alice Smith Coleman  
National Association of Social  
Workers

James J. Cosgrove, DO  
OB/GYN

Lt. Mark Daniels  
Delaware State Police,  
Troop 2

Carolyn Hartsky  
Wilmington Police Dept.

Marjorie Hershberger  
**Alternate:** Kathie Peeke  
Delaware Nurses Association

Rosemary Killian  
**Alternate:** Lori Sitler  
Dept. of Justice

Theresa Marshall  
Div. of Family Services

Hilna Moskowitz  
Div. of Child Mental Health

Stephen A. Pearlman, MD  
Attending Neonatologist

Susan White  
CHILD, Inc.

Appendix

---



Kent and Sussex Counties  
Child Death Review Panel

## Kent and Sussex Counties Child Death Review Panel

Fran Franklin  
**Co-Chair**  
Family & Children's Service of DE  
Child Advocate

James Adkins, Esquire  
Deputy Attorney General

Steven Berlin, MD  
OB/GYN  
Bayside Health Association

Regina G. Chace, Ph.D.  
Child Mental Health

Helene Diskau  
Delaware Nurse's Association  
**Alternate:** Meri Jo Montague  
Child Development Watch

Cherelyn Homlish  
Child Advocate- People's Place

Rebecca Kopriva  
Dept. of Public Instruction

Francis J. Montone, MD  
duPont Nemours Child Clinic

Ms. Maxine Travis  
**Alternate:** Jonnie Green-  
Stubbolo  
National Association of Social Workers

Judith Tobin, MD  
**Co-Chair**  
Office of the Medical Examiner

Carla Benson-Green  
**Alternate:** Ione Truesdale or  
Alice Tholstrup  
Division of Family Service

Detective Kenneth Brown  
**Alternate:** Chris Plack  
Milford Police Dept.

Barbara DeBastiani  
**Alternate:** Lorraine Rouse  
Div. of Public Health

Lieutenant Robert Hirt  
**Alternate:** Jeff Horuath  
Dover Police Dept.

Ms. Jackie Howard  
Citizen Interested in Child Death

Melissa McGinty  
**Alternate:** Sondra Payne  
Kent/Sussex Community Mental  
Health Ctr.

Sergeant Gregory D. Nolt  
Delaware State Police

Philip A. Shlossman, MD  
Perinatal Association

Appendix

---



Job Specifications

Class Code: 73233  
Health Group  
Medical Administration, Research and Training Series

CLASS TITLE: Public Health Treatment Program Administrator

SUMMARY STATEMENT:

An incumbent in this class is responsible for administering a statewide specialized health program.

NATURE AND SCOPE:

An incumbent in this class functions at the management level and reports to an administrative superior. An incumbent is responsible for the on-going implementation of a specific statewide health program(s) by directing the technical and programmatic operation and by developing, implementing and evaluating program goals and objectives. Additional responsibilities include educating and informing other agency staff, community organizations, health care providers and the general public about current health issues and compliance to rules and regulations. An incumbent supervises a staff of professional, para-professional and clerical employees associated with the program.

PRINCIPAL ACCOUNTABILITIES:

1. Develops, manages and directs operations of statewide health program(s); supervises staff, identifies needs, forecasts resources and personnel requirements, conducts fiscal monitoring, recommends hiring and firing, develops management operational systems and information system.
2. Plans, develops and implements new proposals, policies, projects and activities to address unmet health needs in program areas.
3. Coordinates public and private health services to reduce duplication of services, strengthen existing services and address the needs of the community. Evaluates existing programs.
4. Designs and directs surveys to determine problems and unmet health needs. Studies survey findings, analyzes information and makes recommendations.
5. Develops program strategies and protocols including standards of care with other health care providers.
6. Assists in developing proposals for contractual services, operating agreements, public and private grants. Reviews projects bids and proposals. Recommends funding. May draft operating budget.
7. Trains, directs, supervises program staff on administrative and technical procedures.

8. May develop and provide in-service training activities for health professionals, community organizations, state and federal agencies, industry and others.

PRINCIPAL ACCOUNTABILITIES:

9. Performs related work as required.

KNOWLEDGE, SKILLS AND ABILITIES:

Knowledge of public health principles, practices, issues and current developments;  
Knowledge of particular needs and care in specific program area(s);  
Knowledge of survey methodology, program evaluation, data collection and data analysis;  
Knowledge of program development and management techniques;  
Knowledge of state agencies and of federal, state and private health resources;  
Knowledge of techniques of proposal writing and of sources of funding;  
Skill in interpretation of health risking assessments, program reports, investigations and enforcement activities;  
Skill in designing and implementing research studies, involving data collection and analysis;  
Skill in oral and written communication in public speaking and in report preparation;  
Ability to plan, analyze and evaluate information and activities and implement courses of action;  
Ability to read blueprints and specifications;  
Ability to prioritize, plan, direct and review the work of professional and clerical staff;  
Ability to implement effective health programs within the constraints of state, federal and other regulations;  
Ability to develop and implement program evaluation criteria, organizational management systems and operating budgets;  
Ability to establish and maintain effective working relationships with superiors, associates, subordinates, the general public, public and private health care providers, state officials and other groups.

MINIMUM QUALIFICATIONS:

1. Experience working with the practices and principles of public health.
2. Experience in program administration.
3. Experience conducting complex research studies and projections.
4. Experience in management relations and supervisory techniques.
5. Knowledge of grant and proposal writing.
6. Ability to communicate effectively both orally and in writing.

Appendix

---



References

## References

Abuse Intervention Committee. (1993). *Delaware Child Death Review Panels Proposal*. Wilmington, DE: Delaware Department of Justice.

Abuse Intervention Committee. (1995). *New Castle County Child Death Review Pilot Project*. Wilmington, DE: Delaware Department of Justice.

Colorado Department of Social Services and Department of Health. (1991). *Colorado Child Fatality Review Committee Annual Report and Conference Proceedings*. Denver, CO: Department of Social Services and Department of Health.

Delaware Department of Health and Social Services, Division of Management Services. (1995)(1993). *Delaware Vital Statistics Annual Report*. (DHSS Doc. No. 35-01-20-94-12-04) Dover, DE: Delaware Health Statistics Center.

Franklin County Children Services. (1993). *Franklin County Deceased Child Review System 1993 Annual Report*. Grove City, OH: Franklin County Children Services.

Maternal and Child Health Bureau, U.S. Department of Health and Human Services. (1993). *Recommendations of the Child Fatality Review Advisory Workgroup*. Rockville, MD: U.S. Department of Health and Human Services.

State Technical Assistance Team. (1994). *National Symposium on Child Fatalities: The Missouri Experience*. St. Louis, MO: Missouri Department of Social Services and Department of Family Services.

U.S. Department of Health and Human Services, Administration for Children and Families. (1995). *A Nation's Shame: Fatal Child Abuse and Neglect in the United States*. Washington, DC: U.S. Advisory Board on Child Abuse and Neglect.