

Child Death Review Annual Report 1999

Presented to Governor Thomas R. Carper and the
Members of the Delaware General Assembly by the
Child Death Review Commission
December 16, 2000

MEMORANDUM

TO: The Honorable Thomas R. Carper
Members of the General Assembly

FROM: Richard T. Callery, M.D., F.C.A.P.
Chairperson, Child Death Review Commission

DATE: December 16, 2000

SUBJECT: 1999 Child Death Review Report

I am pleased to present to you the fourth Annual Report of the Delaware Child Death Review Commission. The Report provides a brief summary of the work of the Review Panels and Commission during 1999. Based on the findings of the Review Panels, the Commission has made several new recommendations this year.

Some of the recommendations made by the Commission in previous years have been acted on and may now be saving lives. In a small state like Delaware it may be years before the true impact of our actions can be seen, but we feel confident that in the future, our State will see a significant decrease in the number of child deaths.

The Child Death Review in Delaware is an example of truly multi-disciplinary cooperation. Coordinating the process, and making possible this report, are staff from the Office of the Chief Medical Examiner, the Division of Public Health, the Department of Justice, and the Department of Children, Youth and Their Families. The Commission members and I commend the efforts of the members of the Review Panels and staff for their efforts.

RTC/bac
Enclosure

Chapter

1

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 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 reside in New Castle County and the other reviews deaths of children in Kent and Sussex Counties. Information contained in this report has been drawn from cases reviewed by both Panels between January 1, 1999 and December 31, 1999.

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.

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. 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.

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:
 - Cause of death undetermined after Medical Examiner's investigation
 - Head trauma
 - Malnutrition/neglect, including Failure to Thrive
 - Drowning
 - Suffocation/asphyxia
 - Drug ingestion
 - Poisoning
 - Fractures/dislocations
 - Blunt force trauma
 - Homicide/child abuse/neglect
 - Burns
 - Any history of or recent physical abuse, sexual abuse, or neglect
 - Gunshot wound/stab wound/puncture/lacerations
 - Suicide
 - Sudden Infant Death Syndrome (SIDS)
 - Other unexplained or unexpected child deaths as appropriate
3. Deaths involving criminal investigations were delayed for at least six months contingent upon authorization of the Attorney General's Office.
4. Special requests to review a case that did not meet the review criteria were considered from agencies and professionals affiliated with the Child Death Review Panels 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 (see Appendix) 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
 - Division of Alcoholism, Drug Abuse and Mental Health
 - Division of Public Health
 - Office of the Medical Examiner
2. Department of Services for Children, Youth and Their Families
 - Division of Family Services
 - Division of Child Mental Health
 - Division of Youth Rehabilitative Services
3. Attorney General's Office (Criminal Division)
4. Law Enforcement
 - Delaware State Police
 - New Castle County Police Department
 - Wilmington Police Department
 - Milford Police Department
 - Dover Police Department
5. Department of Education
6. Medical Specialists: Neonatologist, Obstetrician-Gynecologist, Pediatrician, and 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. Co-chairs, elected by the Review Panel, facilitated the Reviews.
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. The Division of Public Health submitted Child Death Data Sheets describing agency activity at the end of each review for the purpose of data collation.
7. The Child Death Review Findings Form was completed at the end of each review by a co-chair. 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 the Delaware Department of Health and Social Services, Delaware Health Statistics Center and the *Delaware Vital Statistics Annual Report* (for the years 1992–98.) 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.

Most of the deaths in the data analysis, which follows, occurred in 1998. The Panels reviewed these deaths in 1999. Of 165 cases presented to the Panels, 99 were assigned to the New Castle County Panel and 66 to the Kent and Sussex Counties Panel.

Breakdown of Child Deaths by Age Group

Child deaths in Delaware reflect a consistent pattern. The overwhelming majority of deaths occur within the first year of birth. In 1998 the less-than-one age group comprised nearly two-thirds of the child deaths.

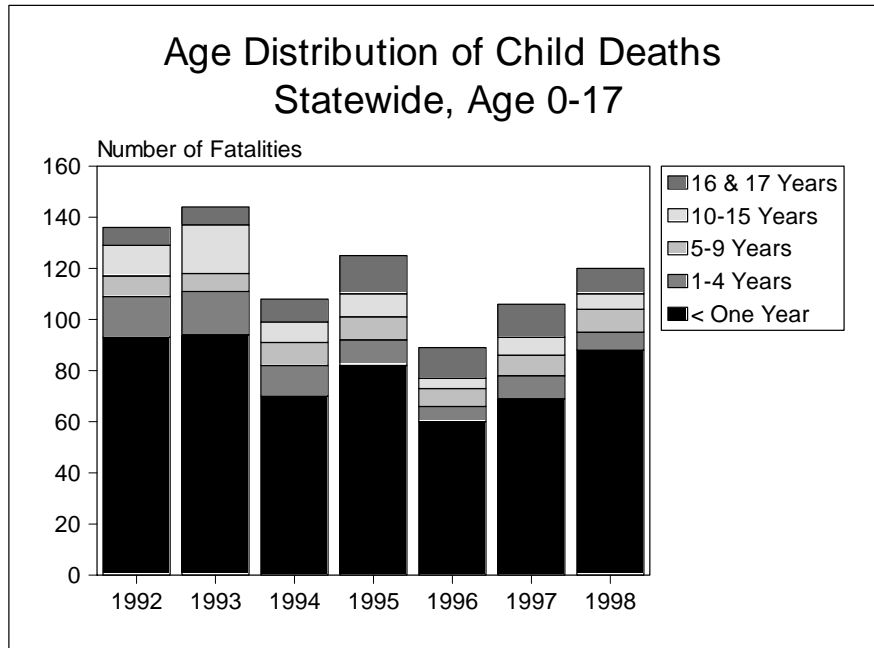


Figure 1. Breakdown of Statewide Child Deaths by Age Group

Neonatal deaths are those deaths occurring between birth and 28 days. In 1998 there were 69 neonatal deaths making up over 47% of all child deaths. The table below shows a breakdown of child deaths in 1998 by age group.

Statewide Child Deaths in 1998		
Age Group	Number	Percent ¹
< 28 Days of Age	69	47
28 – 364 Days of Age	28	19
1 – 4 Years of Age	12	8
5 – 9 Years of Age	10	7
10 – 14 Years of Age	9	6
15 – 17 Years of Age	19	13

Figure 2. Table of Statewide Child Deaths in 1998 by Age Group

¹ Percent is of 147 deaths.

Age Grouping of Cases Reviewed by the Panels

The table below shows the age breakdown of the deaths that were reviewed. There were 64 Neonatal deaths (39% of the total.)

Child Deaths Reviewed by the Panels		
Age Group	Number	Percent ¹
< 28 Days of Age	64	39
28–364 Days of Age	35	21
1–4 Years of Age	20	12
5–9 Years of Age	12	7
10–14 Years of Age	12	7
15–17 Years of Age	22	13
Total	165	100

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

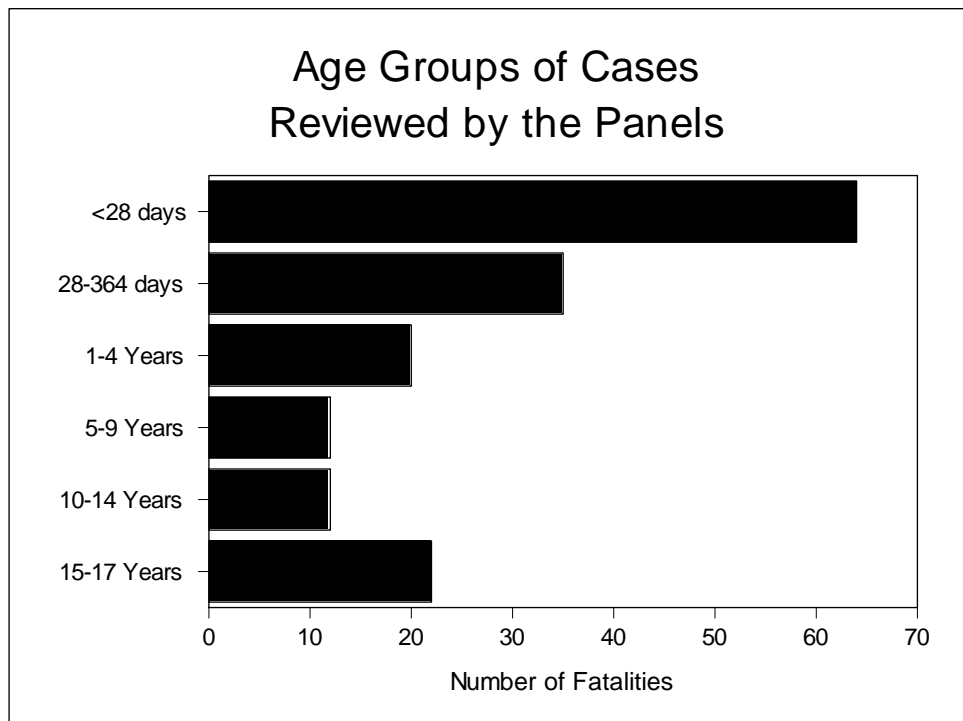


Figure 4. Graph of Cases Reviewed by Age Group

¹ Percent is of 165 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.

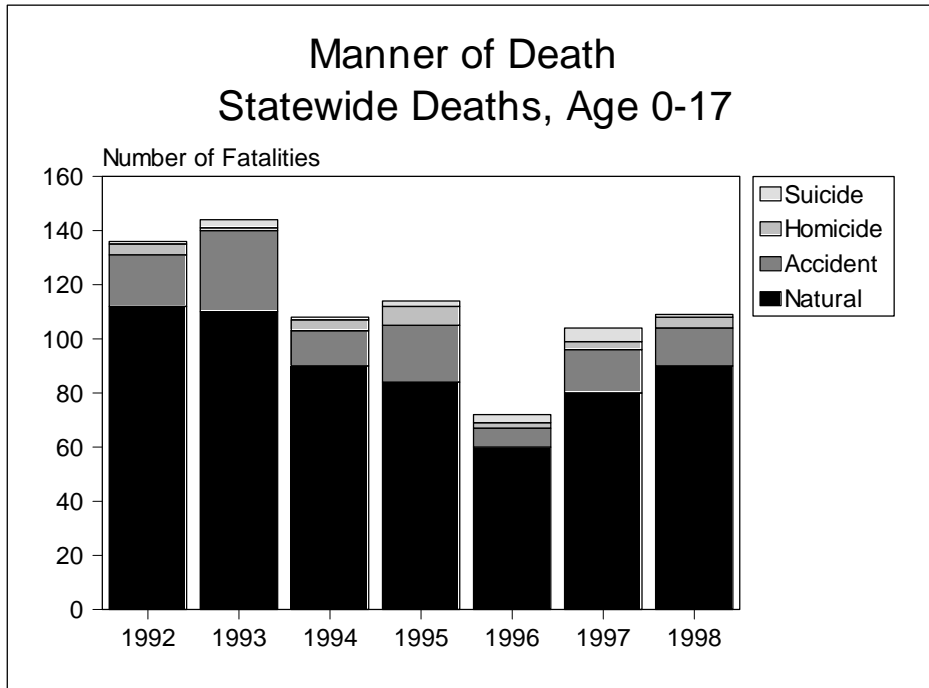


Figure 5. Breakdown of Statewide Child Deaths by Manner of Death

The table below shows age groups and the manner of death (as stated on the death certificate) for child deaths in 1998. Not included are two postneonatal deaths that were listed as Undetermined. All neonatal deaths (68) were Natural. They comprised 47% of the total that were classified (145).

Statewide Child Deaths in 1998 ¹								
Age Group	Natural		Accident		Suicide		Homicide	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
<28 Days of Age	68	47	0	0	0	0	1	1
28-364 Days of Age	21	15	3	2	0	0	2	1
1-4 Years of Age	7	5	4	3	0	0	1	1
5-9 Years of Age	5	3	5	3	0	0	0	0
10-14 Years of Age	6	4	2	1	1	1	0	0
15-17 Years of Age	5	3	12	8	2	1	0	0
Totals	112	77	26	18	3	2	4	2

Figure 6. Table of Statewide Deaths in 1998 Relating Manner of Death and Age Group

¹ Percent is of 145 deaths. Two postneonatal deaths were listed as undetermined.

Manner of Death of Cases Reviewed by the Panels

The table below shows the manner of death listed on the death certificates of children whose deaths were reviewed by the Panels. One Neonatal death was classified a homicide. All other Neonatal deaths (56) were classified as Natural.

Child Deaths Reviewed by the Panels ¹								
Age Group	Natural		Accident		Suicide		Homicide	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
<28 Days of Age	63	38	0	0	0	0	1	1
28–364 Days of Age	30	18	4	2	0	0	1	1
1–4 Years of Age	11	7	8	5	0	0	1	1
5–9 Years of Age	5	3	5	3	0	0	2	1
10–14 Years of Age	7	4	2	1	3	2	0	0
15–17 Years of Age	6	4	12	7	2	1	2	1
Totals	122	74	31	19	5	3	7	2

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

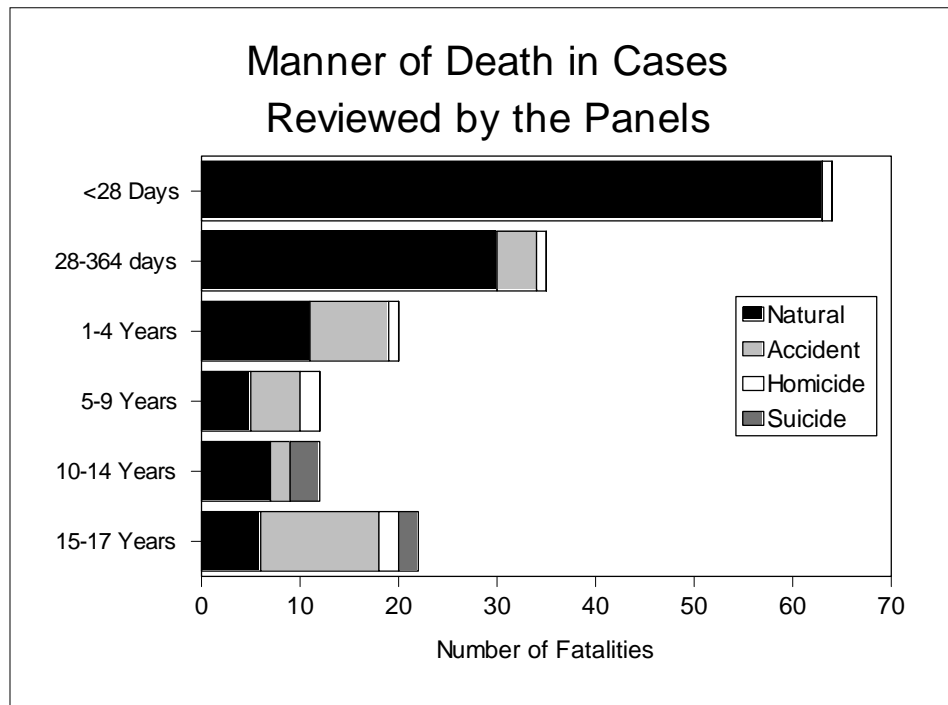


Figure 8. Graph of Reviewed Cases by Manner of Death

¹ Percent is of 165 cases reviewed. Due to rounding, percents may not total 100%.

Breakdown of Child Deaths by Race

In Delaware, about 25% of all babies are born to Black mothers. (Racial categories are those used by the Delaware Health Statistics Center.) Black children, however, die in numbers far greater than their proportion of the population. In 1998, Black babies comprised 55% of all neonatal deaths (less than 28 days). Black children continued to die in disproportionate numbers in each age group up to age five. (See figure 10.)

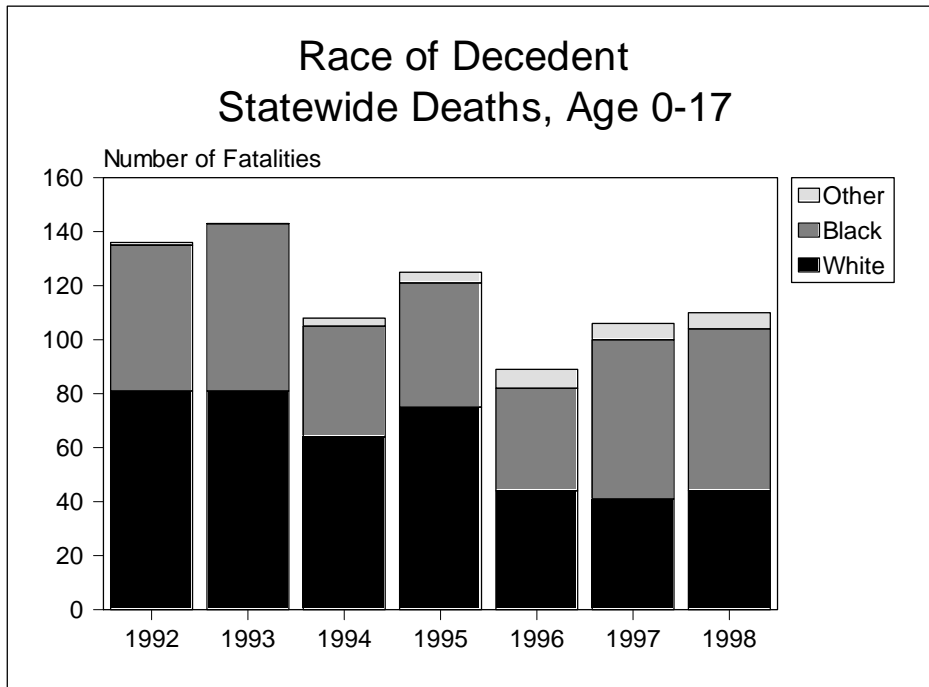


Figure 9. Breakdown of Statewide Child Deaths by Race

Blacks comprised 29% of the postneonatal deaths and 42% of the deaths in the 1-4 year age group. Blacks made up 20% of the 5-9 year olds, 11% of the 10-14 year olds, and 26% of the 15-17 year olds.

Statewide Child Deaths in 1998 ¹						
Age Group	Black		White		Other	
	Number	Percent	Number	Percent	Number	Percent
<28 Days of Age	38	26	31	21	0	0
28-364 Days of Age	8	5	20	14	0	0
1-4 Years of Age	5	3	7	5	0	0
5-9 Years of Age	2	1	8	5	0	0
10-14 Years of Age	1	1	7	5	1	1
15-17 Years of Age	5	3	14	10	0	0
Totals	59	40	87	59	1	1

Figure 10. Table of Statewide Deaths in 1998 Relating Race and Age Group

¹ Percent is of 147 deaths. Due to rounding, percents may not total 100%.

Race of Cases Reviewed by the Panels

The table below shows the race listed on the death certificates of children whose cases were reviewed by the Panels. Neonatal deaths include 38 Black (23%) and 24 White (15%).

Child Deaths Reviewed by the Panels ¹						
Age Group	Black		White		Other	
	Number	Percent	Number	Percent	Number	Percent
<28 Days of Age	38	23	24	15	2	1
28–364 Days of Age	12	7	22	13	1	1
1–4 Years of Age	8	5	10	6	2	1
5–9 Years of Age	2	1	9	5	1	1
10–14 Years of Age	2	1	9	5	1	1
15–17 Years of Age	5	3	17	10	0	0
Totals	67	41	91	55	7	2

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

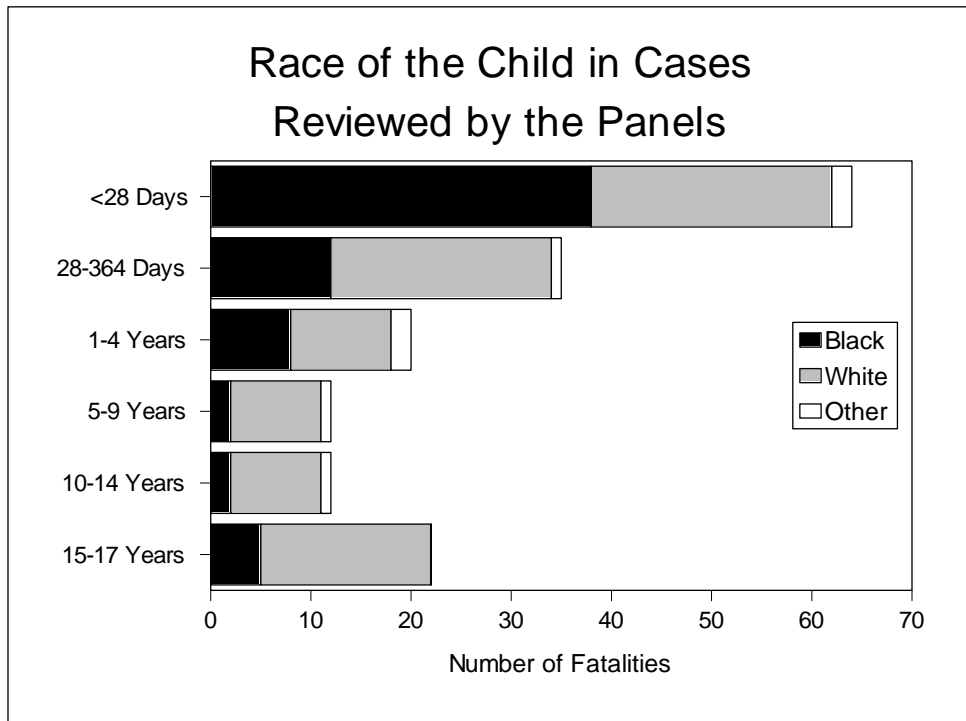


Figure 12. Graph of Reviewed Cases by Race

¹ Percent is of 165 cases reviewed. Due to rounding, percents may not total 100%.

Breakdown of Child Deaths by Sex

In 1998 the number of male child deaths exceeded the number of female child deaths in every age group after one year of life. Overall male deaths outnumbered female deaths nearly three to two.

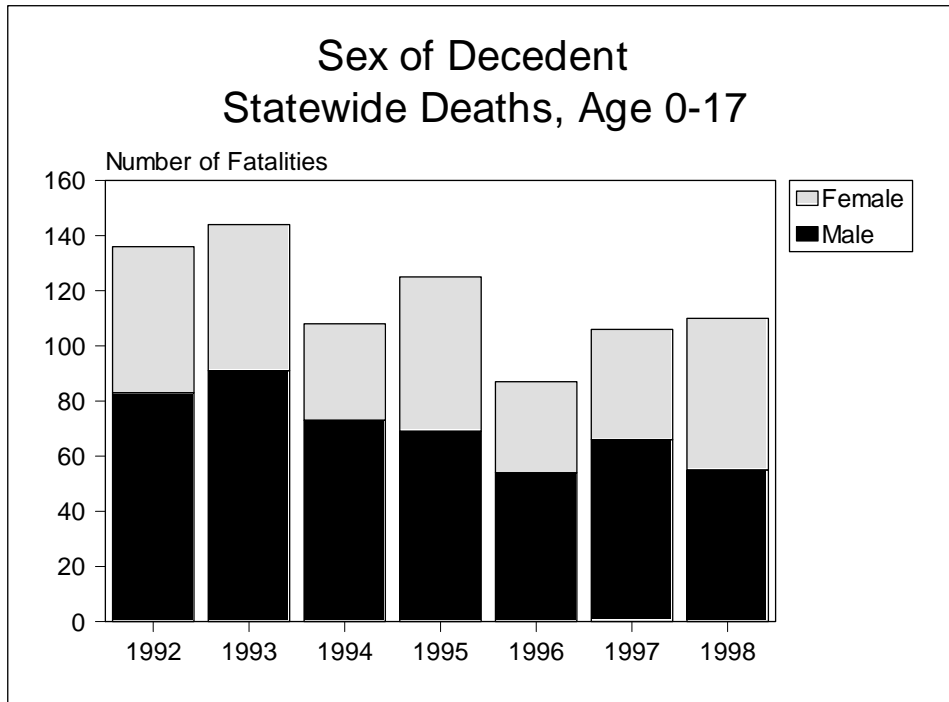


Figure 13. Breakdown of Statewide Child Deaths by Sex

The table below shows age groups and sex (as stated on the death certificate) for child deaths in 1998. Of the neonatal deaths, 33 (48%) were male and 36 (52%) were female.

Statewide Child Deaths in 1998 ¹				
Age Group	Male		Female	
	Number	Percent	Number	Percent
<28 Days of Age	33	22	36	25
28–364 Days of Age	13	9	15	10
1–4 Years of Age	8	5	4	3
5–9 Years of Age	8	5	2	1
10–14 Years of Age	5	3	4	3
15–17 Years of Age	15	10	4	3
Totals	82	56	65	44

Figure 14. Table of Statewide Deaths in 1998 Relating Sex and Age Group

¹ Percent is of 147 deaths. Due to rounding, percents may not total 100%.

Sex of Cases Reviewed by the Panels ¹

The table below shows the sex listed on the death certificates of children whose cases were reviewed by the Panels. Thirty-five (21%) Neonatal deaths were male and 29 (18%) were female.

Child Deaths Reviewed by the Panels ¹				
Age Group	Male		Female	
	Number	Percent	Number	Percent
<28 Days of Age	35	21	29	18
28–364 Days of Age	19	11	16	10
1–4 Years of Age	12	7	8	5
5–9 Years of Age	9	5	3	2
10–14 Years of Age	6	4	6	4
15–17 Years of Age	17	10	5	3
Totals	98	59	67	41

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

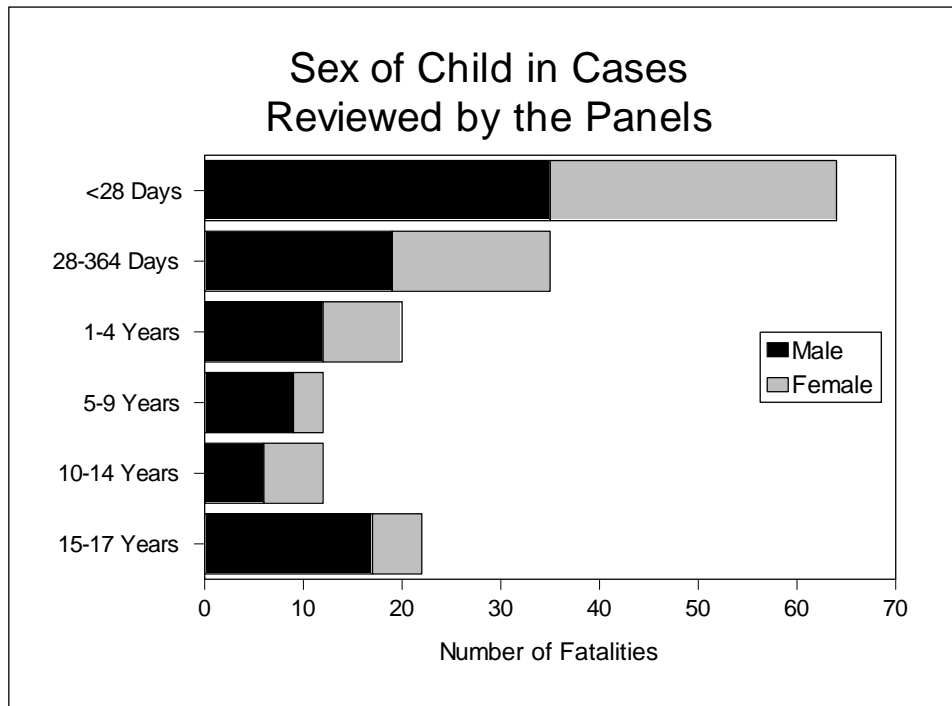


Figure 16. Graph of Reviewed Cases by Sex

¹ Percent is of the 165 cases reviewed.

Preventability of Cases Reviewed

Of the 165 cases reviewed, 24 were considered preventable. In six cases preventability was undetermined.

Below is a table showing a breakdown of deaths considered by the Review Panels to have been 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 Deaths¹		
Manner of Death	Cause of Death	Number
Accident	Motor Vehicle Related	10
	Drownings	5
	Asphyxia	3
	Gunshot	1
Homicide	Ethanol Intoxication	1
	Shaken Baby	1
Suicide	Hanging	1
Natural	Airway Obstruction	1
	Respiratory Failure	1
Total Number of Preventable Deaths		24

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

¹ Manner of death is taken from the death certificate and does not reflect any criminal charges brought as a result of the death investigation.

Sudden Infant Death Syndrome (SIDS)

In 1999 13 SIDS-related deaths were reviewed. This was an increase from five SIDS deaths reviewed in 1998.

Although the etiology of SIDS is still unknown, certain risk factors that may play a role in SIDS deaths have been identified. Because of this, the Panels no longer determine preventability of such cases. Instead, SIDS cases are now listed as “SIDS with risk factors.” The risk factors identified were:

- Smoking in household
- Smoking during pregnancy
- Soft bedding
- Baby sleeping on stomach.

In all but one SIDS death reviewed in 1999, smoking in the house and/or sleeping in the prone position was a factor.

Risk Factors and SIDS Deaths Reviewed in 1999													
Factor	Case												
	1	2	3	4	5	6	7	8	9	10	11	12	13
Smoking in household	X	X	X	X	X	X			X	X	X	X	
Sleeping on stomach	X				X	X		X			X		X
Sleeping with Parent		X	X				X						
Soft Bedding													

Figure 18. Table of SIDS Deaths and Risk Factors in 1999.

Chapter **3**

Recommendations

During the year the Review Panels have recorded various suggestions that might lead to a reduction in child deaths. Following a review of these suggestions, the Commission has formulated the following recommendations.

Recommendations

Education/ Safety

- Continue to support SIDS awareness campaigns. These should educate the public about all SIDS risk factors.
- Require baby monitor reports be given to the medical provider. If the monitor is not used, the provider should be required to notify the Division of Family Services.

Education and Services for Substance Abusers

- The Commission supports the testing of all pregnant women. Once identified, the Commission recommends that treatment options be made known to the mothers.
- The Commission feels that a top priority should be to support expanded treatment for pregnant woman and women with newborns.

Teen Suicide Prevention

- The Commission recommends that the Department of Education conduct a statewide survey to determine the adequacy of psycho/social resources available.

Accidents

- The Commission supports placing warning labels on all large plastic bags to which children have access. The Division of Public Health should include a warning in the packet of information that all new mothers are given. This warning should also include vinyl and plastic mattress covers.

Chapter

4

Commission and Panel Members

The following individuals were members of the Child Death Review Commission and/or Panels during the time covered by this report.

