Our mission...

...to safeguard the health and safety of all Delaware children.
31 Del. C. c. 3.
Key Objectives:

- "The General Assembly hereby declares that the health and safety of the children and pregnant women of the State will be safeguarded if deaths of children under the age of 18, and stillbirths occurring after at least 20 weeks of gestation and maternal deaths are reviewed, in order to provide recommendations to alleviate those practices or conditions which impact the mortality of children and pregnant women."

- Provide the Governor, the General Assembly, and the community with recommendations to alleviate those practices or conditions that impact the mortality of children and pregnant women.

- Assist in facilitating appropriate action in response to recommendations.
Delaware’s child death review process was statutorily established on July 19, 1995, after a pilot project showed the effectiveness of such a review process for preventing future child deaths. The legislation established the Child Death Review Commission, which has been charged to create up to three regional Review Panels, establish confidentiality for the reviews, and provide the Commission with the ability to secure pertinent records. In addition, legislation provides protection to members of the Commission and regional Review Panels from civil or criminal liability.
In FY05, the Commission worked in collaboration with the Division of Public Health (DPH) to implement a Fetal Infant Mortality Review (FIMR) pilot project under the leadership of the Governor’s Infant Mortality Task Force. In FY06, FIMR’s budgetary positions were placed with the Commission. During FY08, the Commission’s statute was amended to include Maternal Death Review and allow for public disclosure of deaths and near deaths due to abuse and neglect, after prosecution, to fulfill the federal CAPTA (Federal Child Abuse Prevention and Treatment Act) statute mandate. On September 20, 2015, the Governor signed legislation transferring the Child Abuse/Neglect Panel (which reviews all deaths/near deaths due to abuse/neglect) to the Child Protection Accountability Commission. CDRC will attend these meetings and will be responsible for entering these deaths into the national data tool. In addition, cases for the SDY panel or CDR panel will be jointly reviewed with the CAN panel if there are significant child welfare issues noted. As a part of this legislation, the name of the Commission was changed to the Child Death Review Commission.
The objectives of the Commission are:
- to review in a confidential manner, the deaths of children under the age of 18, stillbirths occurring after 20 weeks gestation, and Maternal deaths occurring within 364 days of giving birth.
- to provide the Governor, and General Assembly and with recommendations to alleviate those practices or conditions that impact the mortality of children.
- to assist in facilitating appropriate action in response to those recommendations.
By tracking issues that occur in each child death review, the team can put forth recommendations that will help to improve Delaware’s systems that protect and serve children.

Recommendations also help to form action teams that reach out to the communities and promote services available to them, or help to create new services that may improve community health.

Another important function of the team is to understand and track risk factors that cause infant/child death, and develop ways to educate the public on these risk factors.
Child Death review panels operate in all 50 states, the District of Columbia, Australia, Canada, New Zealand and the United Kingdom. All sharing the common goal of protecting our children.
Child Death Review Panels

- Community problem
- Multi-dimensional

“May their deaths bring a small measure of meaning to other children at risk.”
(Terri Covington, Director, National Center for Child Death Review)

Child Death Review Panels are needed because the death of a child is a community problem and the death of a child is too multi-dimensional for responsibility to belong in any one place.
The Commissioners that form the Child Death Review Commission are appointed by the Governor. As you will notice, the Commission is made up of a wide range of multiple disciplines, that create a vast background and a wealth of knowledge for the team.
CDRC consists of…cont’d

- Chief Judge of the Family Court
- Superintendent, Delaware State Police
- Secretary, Department of Health and Social Services (DHSS)
- New Castle County Police
- National Association of Social Workers
- Child Advocate from statewide nonprofit organization (two)
- Director, Division of Public Health (DPH)
- Neonatologist
CDRC consists of…cont’d

- Perinatologist
- Pediatrician
- Obstetrician
- Chair, Sudden Death in the Young Panel
- Chair, Child Death Review Panel
- Chair, New Castle County FIMR Panel
- Chair, Kent / Sussex Counties FIMR Panel
- Chair, Maternal Mortality Review Panel
The Commission has established two child death review panels. The Sudden Death in the Young (SDY) Panel, the secondary medical SDY panel, and the child death review (CDR) panel (state-wide review of all deaths not reviewed at SDY panel). The panels meet bi-monthly or quarterly as caseload dictates. The Commission meets quarterly to review and approve the work of the Panels.

FIMR is divided into two regional teams that review cases from that particular region. Upon inception, FIMR also had a Wilmington CRT that strictly covered the City of Wilmington which further identified risk factors and needs of the inner city communities. Due to respect of participants time and the number of cases being received, the Wilmington CRT was combined with NCC in September 2011.

At this time, the MMR team consists of only one team that meets semiannually.

The Panels, CRTs and MMR are comprised of volunteer members of the same organizations listed in the Commission members slide, with the exception that FIMR’s CRT members are more medically focused while the Panels and MMR have more of a variety of agencies for a broader approach to the review.
As a Commissioner what should I be doing?

- **Attendance:** Attend at least 60% of all Commission quarterly meetings. In addition, attend the annual public meeting held jointly with the Child Protection Accountability Commission to discuss advancement of recommendations resulting from reviews.

- **Conduct:** Commissioners will acknowledge the diverse backgrounds and expertise of the commission members, respect the dialogue required to fulfill the Commission’s mission, and communicate with each other in a productive and respectful manner.

- **Voting:** Vote on recommendations to be reported out and ensure your agency or affiliation uses the recommendations and actions plans to make improvements.
As a Commissioner what should I be doing?

- Relationship to Review Panel Representatives: Commissioners should communicate as needed with their representatives on Review Panels to ensure full participation contributing to a quality review of a child death as well as completion of any relevant action plans. For Commissioners without organizational ties to their Panel representatives, the Commission staff shall provide contact information so that the Commissioners can establish collaborative relationships with their representative(s).
There are certain criteria to follow when bringing a case for review.
-The child must be a Delaware resident < 18 years of age, and whose death occurred within the state.
-Deaths involving criminal investigations are delayed contingent upon authorization of the Attorney General’s (AG) office.
-Special cases that are reported but do not meet the criteria can be reviewed upon approval of the Panel Chairs.
All cases reported to the Commission, that meet the criteria listed on the previous slide, are brought to the Panels for review.

Cases received for out-of-state residents that die in Delaware are triaged for any glaring issues that may have occurred to prevent the death. If such a case arises, the case can be referred to the residential state for their review.

Other cases that may be received in the office that do not meet criteria and/or are not referred to another state can be held for tracking and/or referencing purposes. For example, such cases can be a death from a rare disease (maybe a child passed from this condition and later we find that an adult passed from the same condition) or in recent history, Delaware experienced a rash of suicides, many were within our review criteria; however, some were young adults at the age of 18 or 19, these cases (obituaries and news articles) were saved for referencing and possibly future educational reasons.
FIMR cases are reviewed by a random process – from January to June only those cases with an even-numbered date of death are reviewed and from July to December only those cases with an odd-numbered date of death are reviewed.

The remaining cases are “triaged” for any glaring issues. If an issue arises, the case will be considered for review or forwarded to the CDR, if it appears to be an unsafe sleep related incident.

Maternal interviews are offered to all FIMR cases regardless of dates of death via letters and phone call follow-up by the Senior Medical Social Worker. If the mom in a “triage” case accepts an interview, the case is then transferred over to be reviewed.
The goal of the MMR program is to conduct in-depth, multidisciplinary reviews of pregnancy-related deaths and some pregnancy-associated deaths.

A pregnancy-related death is defined as the death of a woman while pregnant or within one year of the end of her pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by her pregnancy or its management, but not from accidental or incidental causes.

A pregnancy-associated death, also called a maternal death, is defined as the death of a woman while pregnant or within one year of the end of her pregnancy, irrespective of cause.

As with the maternal interviews offered for FIMR cases, a family interview is offered for maternal death cases. This interview can provide valuable information on the case, which may not be available from medical records.
As we talk about reviewing and triaging cases, cases that meet criteria and those that do not, you may ask yourself “Where do these cases come from?”

The administrative staff of the Commission do an excellent job at playing “detective” and finding cases. First and foremost, the Office of Vital Statistics prints death certificates for all infant/children between 0 and 17 years of age. These copies are picked up by the staff on the first work day of each month. Another outlet is the media. All local newspapers and small-town papers are researched online to find articles and obituaries of anyone that meets our age criteria. Word of mouth and social media are also wonderful outlets to learn about the happenings in our small state! However, these deaths obtained from media, social media and word-of-mouth must be backed up by proper documentation before being processed for review. And finally, cases are referred to the Commission by professional agencies such as DFS, Division of Forensic Sciences hospitals, local law enforcement, etc.
When cases are received, they are entered into their respective databases, files are created and subpoenas are issued to the appropriate agencies or medical facilities. By statute, CDRC has been granted subpoena power.

For the Panels, a coversheet containing basic information of the case is disseminated to each member so that each applicable agency can submit information they may have on the case. Once medical records are received, medical abstractions are performed by the appropriate personnel. All information obtained is disseminated to the Panel members prior to the scheduled review meeting, this allows the members to become familiar with the case ahead of time and bring any other pertinent information to the table.

For the CRTs, the Program Coordinator reviews the medical records and provides a de-identified review to the members prior to the next scheduled meeting.

During the review, information is shared and discussed amongst all members, risk factors are identified, recommendations for system improvements are developed, and the appropriate sources to handle the action are identified.
When the reviews are complete, the outcomes and recommendations are forwarded to the Commission for approval. The Commission meets quarterly to review the work of the Panels and CRTs.

Once approved, a letter annotating the recommendations is submitted to the Governor’s office. The action is then implemented by the appropriate agencies. The data is reported publicly via the CDRC Annual Report.
The recommendations submitted by the Panels must be thorough and must serve a distinct purpose. Some examples of these are to raise awareness of issues within the state and local communities; to educate the public on certain safety hazards, risk factors and prevention methods; to influence public policy; and to involve the communities in prevention initiatives, such as a Neighborhood Fire Prevention Program or a Neighborhood Watch Program.
Confidentiality

- Discussion is confidential
- Sharing of information within the Panels, CRTs, and Commission are protected and permitted
- Information used shall not be made public and shall not be available for subpoena or subject to discovery
- Statistical data is reported out annually

All information contained in the Panels, CRTs, Commission meetings, etc. are kept confidential. Confidentiality statements are signed by each member prior to commencement of the meetings.

As mentioned previously, only statistical data is made public by means of the CDRC Annual Report.
In 2010, CDRC, with the help of a generous anonymous donor, partnered with the National Cribs for Kids Organization to begin a Delaware Chapter. The program provides cribs to families that could not otherwise afford them. The caveat to the program is that a 45 minute safe sleep education is provided and a Department of Public Health nurse goes into the home to provide the training and provide the crib (Graco Pack n Play). A follow-up phone call is provided about 6 to 8 weeks after the initial training. An in-house database is kept to ensure each family only receives one crib. To qualify for the program, the mother must be due within six weeks or the infant must be younger than twelve months of age.

All Babies Cry (ABC) is an evidence-based program designed to promote healthy parental behaviors and prevent child abuse in the first year of life. Funded by the Eunice Kennedy Shriver National Institute of Child Health and Human Development it incorporates the protective factors of the Strengthening Families initiative, and empowers new mother and fathers with practical demonstrations of infant soothing and clear strategies for managing normal stress in parenting. The ABC video is an 11 minute video that comes with a 28-page, 4 color booklet with checklists, activities, hotline numbers and other resources. All materials are in English and Spanish with closed captioning. Strengthening Families is a new public health model developed by Center for the Study of Social Policy designed to prevent child abuse and neglect. This model has been adopted nationally by child welfare organizations, states (over 60%) and federal partners.

We are currently working with Nemours, the Delaware American Academy of Pediatricians, and the March of Dimes to provide infant safe sleeping education at the first infant well visit. This is expected to begin in the Spring of 2016.

The CDRC staff attend any and all local health fairs advertised to educate the public on the rising issue of Sudden Infant Death Syndrome (SIDS) and unsafe infant sleep practices.
2016 Goals

- Website
- Annual Report (Approved at April Commission meeting/Released May)
- By-Laws
- All Policies Updated
- Databases Back Filled and Complete
- Facebook page created for Cribs for Kids
- Providing more education to High Risk families.
- Pilot and Adjust to new FIMR database.
“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.”
(Saskatchewan child advocate)

Every child deserves a tomorrow!
Please contact the Child Death Review Commission at (302)255-1760 or visit our website if you should have any questions or concerns.