

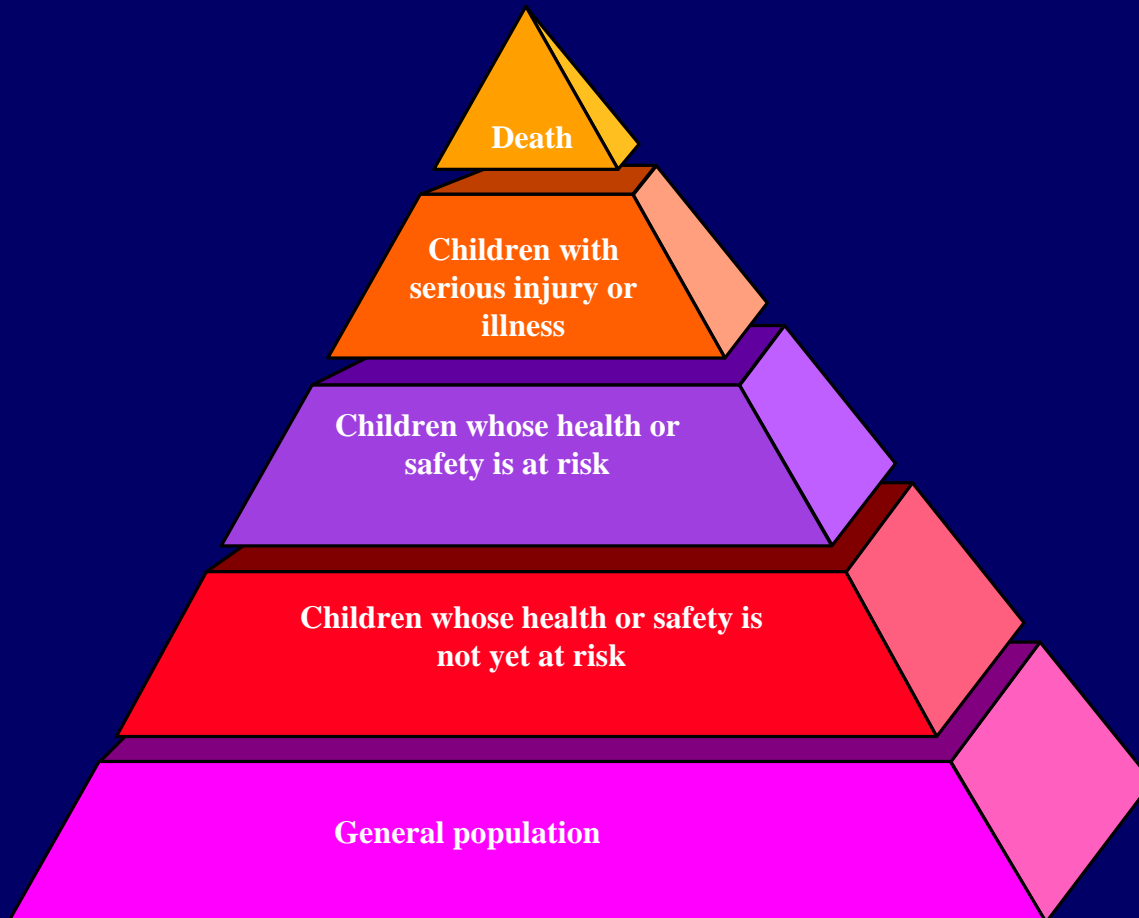
Using Your Review to Take Action to Prevent Other Deaths

It's more fun to play
cops and robbers...
but...

The hard work of
Prevention Planning
■
Gives Teams
Staying Power

Commit to asking and finding the right answers to the right questions to prevent other deaths.

The Death you are Reviewing is a Sentinel Event



Team Discussion on SUID Risk Factors

- Place where child was sleeping or playing.
- Position of child when found.
- Type of bedding, blankets and other objects near child.
- Faulty design of cribs, beds or other hazards.
- Number of and ages of persons sleeping with child.
- Obesity, fatigue, or drug/alcohol use by persons supervising or sleeping with child.
- Exposure to tobacco.
- Possibility of overheating?
- Quality of supervision at time of death.
- Family's ability to provide safe sleep or play environment for child.
- Prior child deaths or repeated reports of apnea episodes by caregiver.

Team Discussion and Action on Prevention

- **Provider Training and Education**
- **Parent Training and Education**
- **Community Education**
- **Provision of Safe Cribs**
- **Child Care Provider Training and Education**
- **Prenatal Drug and Alcohol Treatment Services**
- **Prenatal Smoking Cessation**

The Excuses

- It's not my job.
- I don't have time.
- We don't have resources.
- It's hard to do.
- We don't know what to do.
- We'll send in our report to the state.
- Nothing works anyways.
- It was a bad accident and will probably never happen again.
- You can't prevent stupidity.

WHY ME?

- Team members that do not think of themselves in a preventive role have a lot to contribute.
- You are often the very folks who have standing in the community.
- Prevention is not just for the public health and school nurses.
- It's good P.R.

Who Took the Lead?

Entity	2002	2003
Health Department	98	122
Law Enforcement ■	72	68
Social Services	33	44
Schools	36	28
Mental Health	29	32
Local Community	17	15
Group	82	119

KEY POINTS

- It is not necessary to reinvent the wheel.
- There are often no quick and easy long-term solutions but...
- Quick action can inspire others.
- One person can make a difference.

Risk Factors

- Medical
- Social
- Economic
- Behavioral
- Environmental
- Systemic (Agency Policies)
- Product Safety

SIDS/Suffocation

- Place where child was sleeping or playing.
- Position of child when found.
- Type of bedding, blankets and other objects near child.
- Faulty design of cribs, beds or other hazards.
- Number of and ages of persons sleeping with child.
- Obesity, fatigue, or drug or alcohol use by persons supervising or sleeping with child.
- Quality of supervision at time of death.
- Child's ability to gain access to objects causing choking or confinement.
- If hanging, child's developmental age consistent with activity causing strangulation.
- Family's ability to provide safe sleep or play environment for child.
- Prior child deaths or repeated reports of apnea episodes by caregiver.

Thinking through for Prevention

- What is extent of prior deaths and injuries?
- What are the demographics of the of the kids at risk?
- Are other children in immediate harm's way?
-
- What does the community think about the problem?
- What has or is being done?
- What works?
- Who are key stakeholders
- What resources are available to address the problem?

Intervention Options

- Influence policy and legislation
- Mobilize neighborhood or the community.
- Change organizational practices/policies
- Build coalitions and networks
- Educate providers and train people who can make a difference
- Promote community education
- Strengthen individual skills

Types of Initiatives

Type of Action	Proposed	Implemented
Advocacy	64	29
Legislation	79	35
Community Safety Project	193	86
Product Safety	39	23
Education in Schools	241	134
Education in Media	366	230
Public Forums	50	28
New Services	42	20
Changes in Agency Practices	140	51
Other Programs	219	104
Total	1433	740

Is our intervention feasible?

How do we know?

Answer the next three questions...



Is it affordable?

Is it sustainable?

and...

Is it politically acceptable?

What about unintended
consequences?

What about [■] “incomplete”
messages?

Intervention-Decision Matrix

Intervention	Option 1	Option 2	Option 3
Effectiveness			
Feasibility	■		
Affordability			
Sustainability			
Political Acceptability			
Unintended Consequences			
Final Priority			

*Adapted from Carolyn Fowler, Johns Hopkins University Injury Research Center

- Recognize that achieving prevention will require strategic partnership development beyond the “obvious” partner circles
- Partner for:
 - Information collection & review
 - Interpretation and planning
 - Resource identification & mobilization
 - Intervention implementation
 - Evaluation
 - Social & political leverage
 - Your own protection
 - Everyone’s capacity development

Key Attributes of a Prevention Model for Child Death Review

- Multidisciplinary, culturally competent team membership.
- Community-based reviews, with strong state support.
- Review all deaths to age 18.
- Uncover all of the layers to understand all of the circumstances involved in the death.
- Identify modifiable risk factors.
- Link review findings to morbidity data.
- Enlist partners to take action to report on and modify the risk factors at the local, state and national levels.

How Do Teams Use Their CDR Data?

- Local teams present annual findings to community groups to push for local interventions
- Teams use data as a quality assurance tool for their reviews
- State teams review local findings to identify trends, major risk factors and to develop recommendations
- State teams use findings to develop action plans based on their recommendations
- Local teams and states use their reports to keep or increase CDR funding

Impact of CDR

- 33 states report that their reviews had direct impact on state legislation and policy changes. ■
- 32 states report that their reviews led to child death prevention programs.

Are the programs leading to Change

- 33 states report that their reviews had direct impact on state legislation and policy changes. ■
- 32 states report that their reviews led to child death prevention programs.

Drowning-Mackinac County

The Case Review

- Vacationers often pull off U.S. 2 and swim in the shallow and warm waters of N. Lake Michigan.
- There were three separate drownings over two years, including a twelve year old boy, Travis Brown.
- He was swimming on a windy day and was carried out into deep water.
- His family had no way to call for help and rescue efforts were slow in coming.

The team sought more information

- A team member, a local police officer, gathered drowning data over ten years with help from the U.S. Forest Service and the local County Extension Office.
- This same police office called a meeting of anyone with anything to do this rescue efforts in county (EMS, LE, DNR...)
- They formed a sub-committee: the water safety review board.
- They asked for and got the U.M. Great Lakes Water Research Consortium to study the lakeshore with science buoys to prove and pin point the existence of rip currents.

- They do education in the schools, on fast food trays, at rest stops, parks and the Bridge.
- The Water Safety Board meets monthly all year long.
- Last Spring the first ever Great Lakes Rip current conference was held.
- The model is being replicated throughout the Great Lakes region.

They now have 9 stations along a 12 mile stretch: phones, equipment, boat patrols.

Lessons for All of Us

- One death can lead to change.
- The team did not wait for the state team to act.
- They used their unfettered access to data.
- They sought more information and looked at morbidity.
- They were stretched thin, so they brought in new partners.
- They created a new coalition.
- The parents and grandparents had a role to play.
- They are now empowered and serving as a resource throughout the great lakes region.

Review Teams are Impacting
the Debate/Discussion at local,
state and national levels on:



Sudden and
Unexplained
Infant Deaths

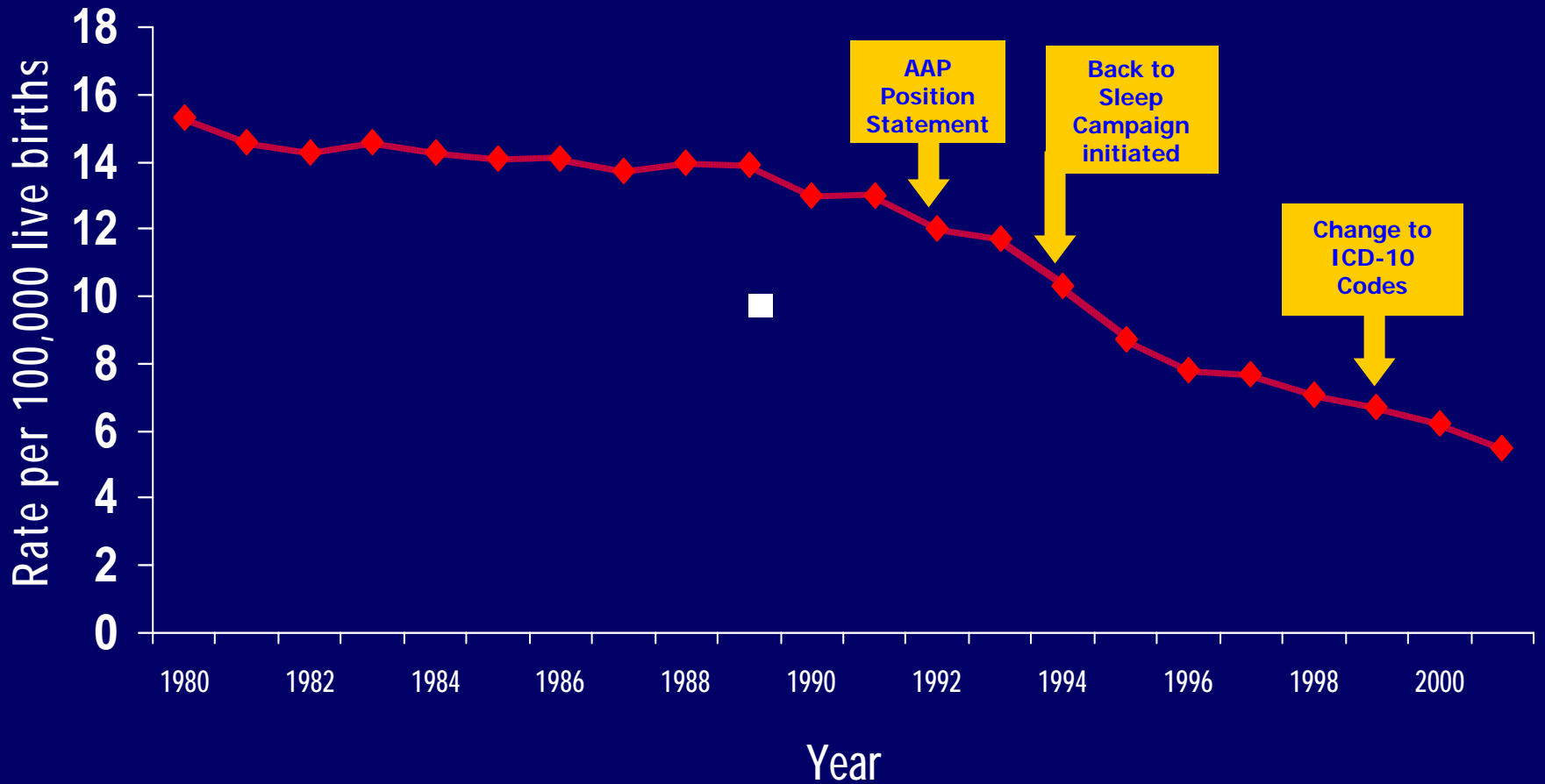
Characteristics of SIDS

- **SIDS occurs suddenly without warning, often during periods of sleep**
- **Cause unknown after thorough investigation, review of medical records and autopsy**
- **Not due to suffocation, aspiration, abuse or neglect**
- **Peak incidence at 2 to 4 months of age**

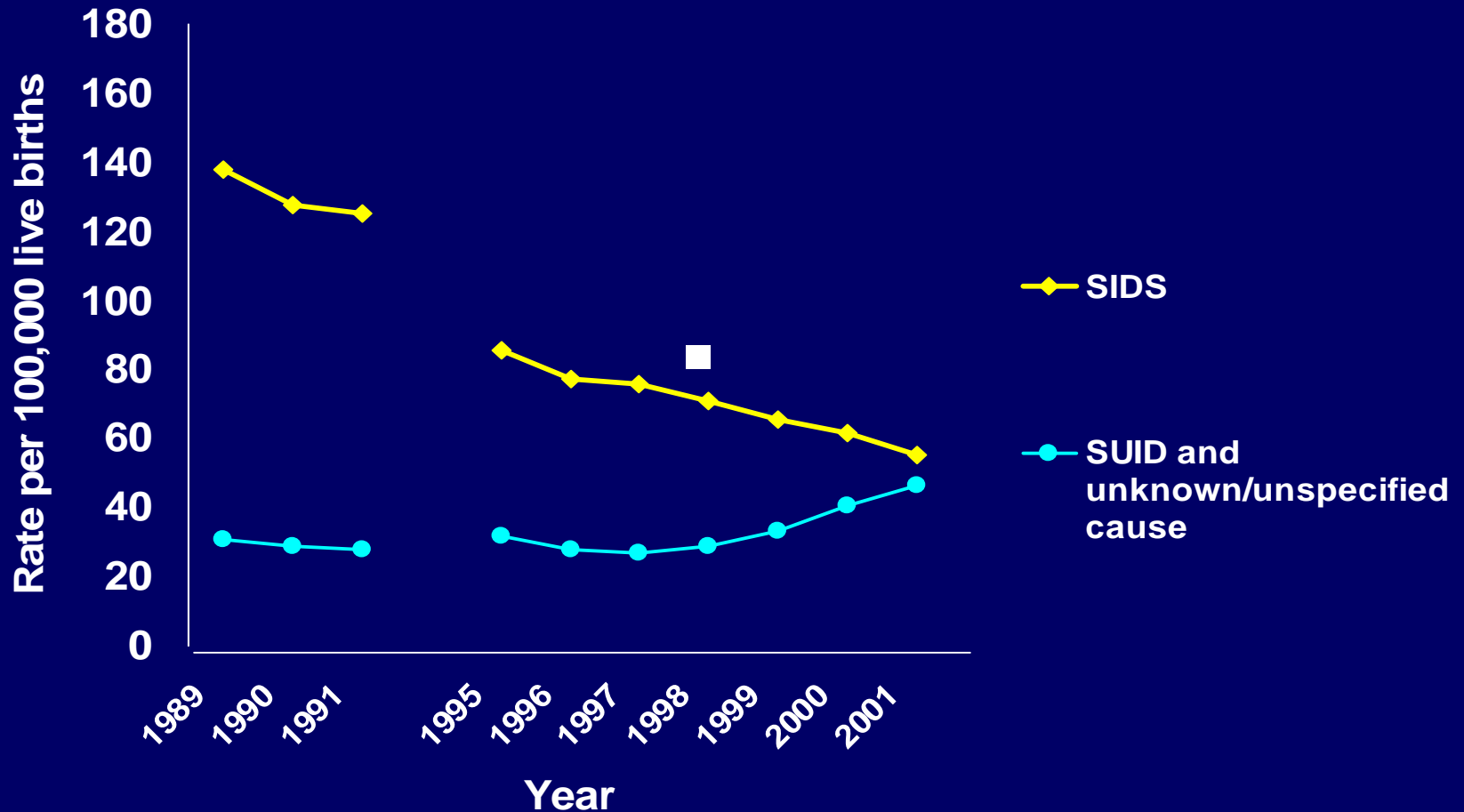
Characteristics of Suffocation

- In a sleeping environment
- Overlay by persons, or
- Wedging between bed and object, or
- Covered by heavy bedding or object; or
- Face pressed into soft bedding or other object.
- Similar autopsy findings as SIDS

Mortality Rates Due to SIDS, U.S., 1980-2001

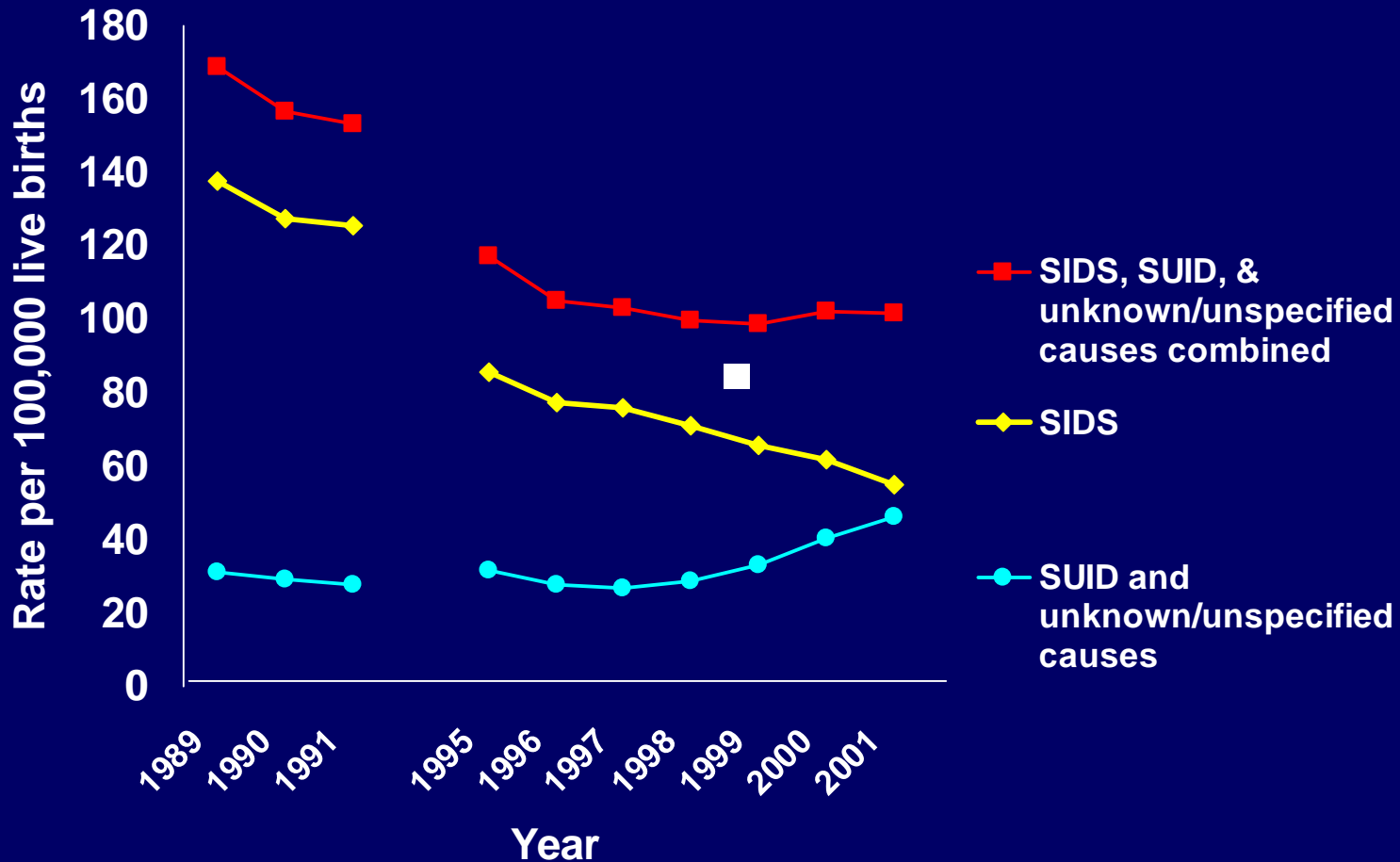


Infant Mortality Rates Due to SIDS, SUID*, and Unknown/Unspecified Causes, U.S., 1989–1991 and 1995–2001



* SUID include accidental suffocation and strangulation in bed; other accidental suffocation and strangulation; and neglect, abandonment and other maltreatment syndromes.

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Risk Factors Seem Similar

- Young maternal age
- High parity
- Late or no prenatal care
- Low birth weight and preterm birth
- Prenatal maternal smoking and substance abuse
- Postnatal exposure cigarette smoke

- **Prone and side sleep positions**
- **Overheating**
- **Soft sleep surfaces**
- **Loose bedding**
- **Sharing a sleep surface**

Without a Comprehensive Scene Investigation, the Risk Factors Cannot be Known



- Difficult to make sense of the data and monitor trends.
- Provide appropriate services to families.
- Develop and implement effective prevention efforts.
- Respond to advocates of certain positions.

CDR Teams Across the Country are
Working to Improve Local Death
Scene Investigations

SUIDI Reporting Form

SUIDI

Sudden Unexplained Infant Death Investigation

INVESTIGATION DATA

Infant's Information: Last _____ First _____ M _____ Case # _____
 Sex: Male Female Date of Birth: Month / Day / Year Age: _____ Months SS# _____
 Race: White Black/African Am. Asian/Pacific Islander Am. Indian/Alaskan Native Hispanic/Latino Other
Infant's Primary Residence Address:
 Address _____ City _____ County _____ State _____ Zip _____
Incident Address:
 Address _____ City _____ County _____ State _____ Zip _____
Contact Information:
 Relationship (circle appropriate response):
 Biological Mother/Father Grandmother/Father Adoptive or Foster Parents Physician Health Records Other: _____
 Last _____ First _____ M _____ DOB _____ SS # _____
 Address _____ City _____ State _____ Zip _____
 Place of Work _____ City _____ State _____ Zip _____
 Phone (H) _____ Phone (W) _____

WITNESS INTERVIEW

1 Are you the usual caregiver? Yes No
 Name _____ Relationship (ex. aunt) _____
2 Please tell me what happened to the infant. _____

3 Did you notice anything unusual or different about the infant in the last 24hrs? No Yes → Describe: _____
4 Has the infant experienced any recent falls or injury? No Yes → Describe: _____
5 When was the infant last **PLACED**? _____
 Month / Day / Year Military Time Location (room)
6 When was the infant **FOUND**? _____
 Month / Day / Year Military Time Location (room)
7 When was the infant **LAST KNOWN ALIVE**? .. _____
 Month / Day / Year Military Time Location (room)
8 Explain how you knew the infant was still alive. _____
9 Where was the infant - (P)laced, (L)ast know alive, (F)ound (circle appropriate)?

P L F Bassinette	P L F Bedside co-sleeper	P L F Car seat	P L F Chair
P L F Cradle	P L F Crib	P L F Floor	P L F In a person's arms
P L F Mattress/box spring	P L F Mattress on floor	P L F Playpen	P L F Portable crib
P L F Sofa/couch	P L F Stroller/carriage	P L F Swing	P L F Waterbed
P L F Other _____			

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SUIDI

Sudden Unexplained Infant Death Investigation

SUPPLEMENTS

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1



SIMULATED RECONSTRUCTION



SIMULATED RECONSTRUCTION



2



SIMULATED RECONSTRUCTION



SIMULATED RECONSTRUCTION

3



SIMULATED RECONSTRUCTION



SIMULATED RECONSTRUCTION



4



SIMULATED RECONSTRUCTION



SIMULATED RECONSTRUCTION

- Learn about current practices for investigations: who, when and how.
- Introduce the new SUID materials.
- Promote coordination with coroner/medical examiner, law enforcement and social services.
- Assist in data collection efforts.
- Offer training resources in working with families.
- Provide leadership in prevention efforts.

Actions

- Several front page stories initiated by team.
- M.E. did grand rounds with staff.
- Health Dept. presented findings to nursing staff. ■
- Loan a Crib Program started in hospital, expanded throughout the state.
- Teaching revised at hospital.

Combinations of Risk

In all 94 asphyxia cases a combination risk factors existed in all 94 cases.

- Young mother ■
- Bed sharing
- Substance Abuse →
- Position
- Poverty

56%
Couch, Recliner,
Waterbed, Adult Bed

91%
Open Medicaid, food stamps, and or
assistance

Social Service Contacts prior to death

- 230 cases had social service contact within 6 months of the child dying.
- On average twice a week a CPS worker is called upon to investigate an infant death as a result of poor sleeping conditions.

- Local offices distribute print and video information on safe sleep
- Prevention workers do anticipatory guidance and service referrals.
- Crib distribution programs put into place.
- State launched a safe sleep campaign



Sample Letter to State and Local Medical Examiners/Coroners

[insert date]

Dear [insert name],

Each year in the United States, 4,500 families experience the sudden, unexpected death of a precious baby. The data that is collected as part of scene investigations and the accuracy and consistency with which these deaths are classified is critical, not only in helping grieving families begin to cope with their loss but for public health professionals as they attempt to monitor national trends and develop prevention strategies.

[insert personal story/opinion here]

I can only imagine the difficult task you have in helping to identify the causes of these deaths and in sharing this information with grieving families. Thank you so much for all you do in providing this compassionate community service.

As you may be aware, the Centers for Disease Control and Prevention (CDC) began working with medical examiners, coroners, death scene investigators, emergency medical personnel, law enforcement, and SIDS parents to standardize and improve protocols for the national reporting of sudden, unexpected infant deaths (SUID). As a result, the CDC recently released the ***Sudden Unexplained Infant Death Investigation (SUIDI) Reporting Form***. This valuable new tool is designed for state and local use in conducting infant death scene investigations.

To ensure proper and consistent use of the SUIDI Reporting Form, CDC has also developed a comprehensive training curriculum and materials for infant death scene investigations. These materials will be used to train investigators and death certifiers in how to consistently collect data at the death scene and accurately report their findings on the death certificate.

I am writing today to ask that you review these materials (if you haven't already!) and consider adopting any portion of the materials that are not already included in your death scene investigation protocols. Proper and consistent use of these protocols will go along way toward ensuring that each and every family that experiences the tragic death of a baby in your jurisdiction receives a thorough, comprehensive and compassionate death scene investigation. I can assure you that the families experiencing these deaths, as well as the researchers trying to identify prevention strategies, would be ever grateful!

As I understand that quite often the staffing and funding resources needed to implement these thorough investigations are not available, I will also be advocating for increased funding at the state and local levels to support this important initiative.

Thank in advance for considering my request . . . in the belief that every baby should live.

Sincerely,

[insert your name and contact information]

State Actions

- 1 million trigger locks purchased and distributed by state police.
- Truck bed legislation.
- Safe Sleep funding and campaign.
- Major policy and practice changes at CPS.
- New birth match project.
- State suicide plan
- Abandoned new born program.....

Going National

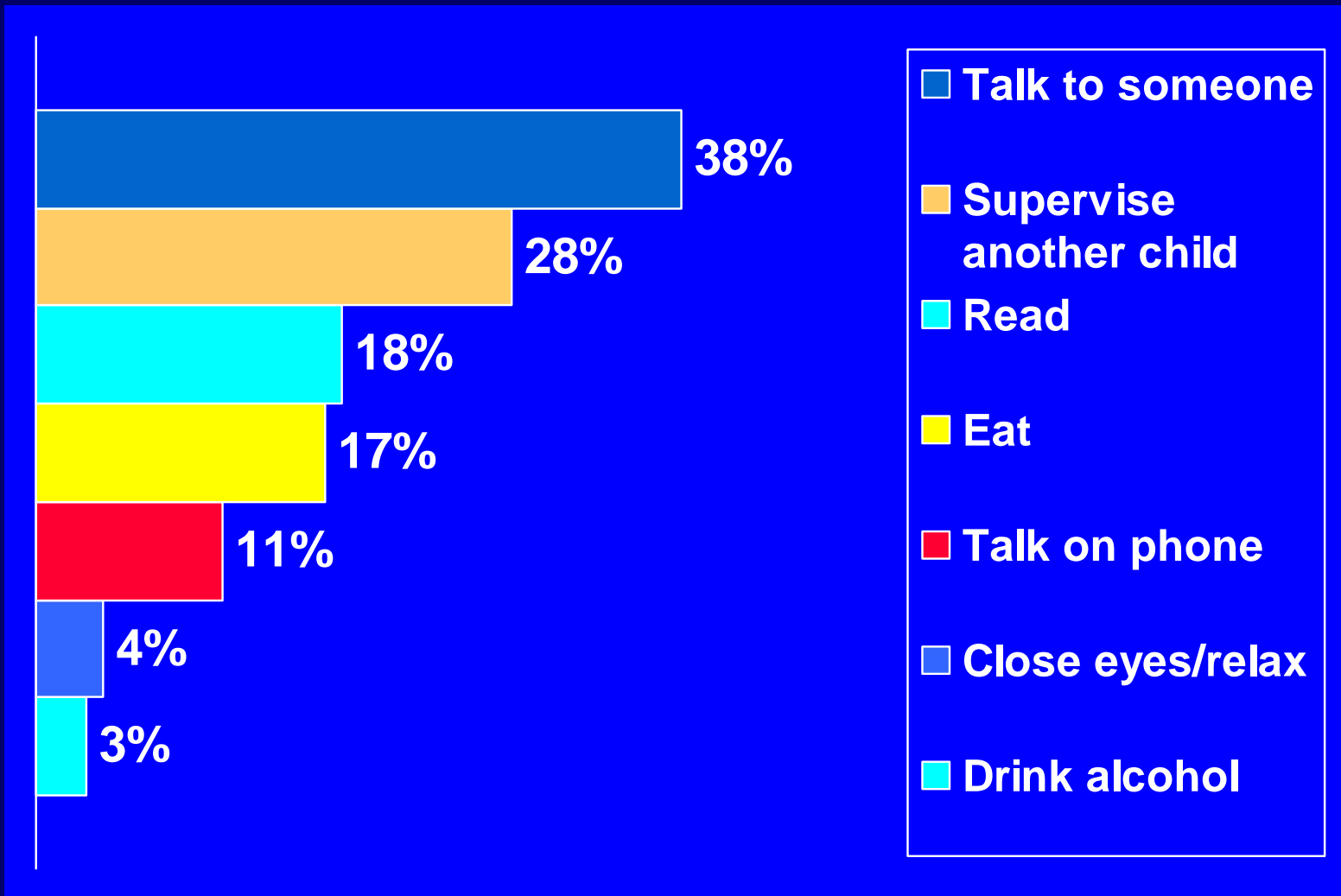
- Clear Danger Report
- Arizona Suicide by Firearms
- 2010 Objectives
- National Organization

CDR Data Uses at a National Level

■
National Safe Kids Week 2004

Splash Into Safety

Self-Reported Activities of Parents while Supervising their Child Swimming



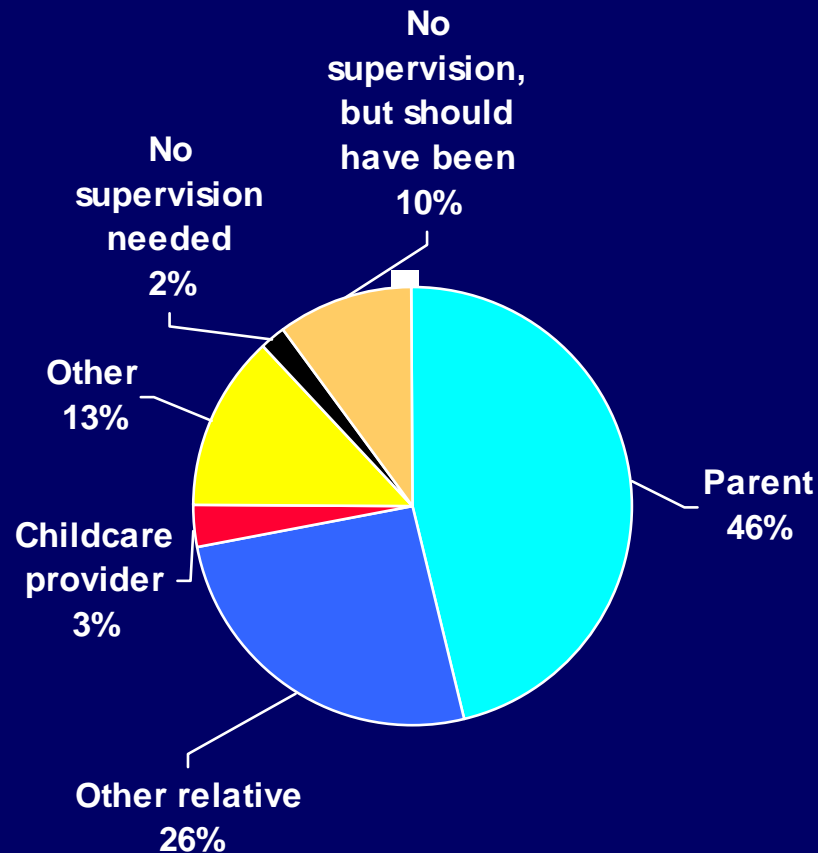
Supervision Results: Parent Survey

- One in five parents believes that when lifeguards are present, the lifeguard is the main person responsible for supervising children in the water.
- Most parents (55%) felt there were some instances where it is okay for a child to swim without adult supervision.
 - If the child swims with a buddy (31%)
 - If the child is an excellent swimmer (29%)
 - If the child has had several years of swimming lessons (23%)

Supervision Results: Tween Survey

- Four in 10 tweens said that they would feel safe swimming without a lifeguard or an adult watching them, and 31% reported they have gone swimming without any adult present.
- Older tweens (ages 10-12) were more likely to have swum without supervision (37%) than younger tweens (19%).
- 39% of children ages 10-12 and 21% of children ages 8-9 reported that they have supervised a younger child while they were swimming.

Reviewed Unintentional Drownings by Primary Supervisor at Time of Drowning



Supervision Results: Child Death Review

- 68% of children were in or near water right before the drowning incident.
- 32% were last known to be in another location in or around the home, most often playing outdoors (31%).
- Of drowning deaths occurring away from home, only 6% of children drowned in the known presence of a lifeguard.
- Rescue was known to have been attempted in 60% of the reviewed drowning deaths, most commonly by a parent or other relative (66%).

Summary of Results: Parent/Tween Survey

- Parents and children report child participation in many types of water recreation.
 - 97% of children ages 8 -12 report that they have been swimming in the last year.
 - 61% of parents report that their children ages 14 and under have ridden on boats, and 32% report that their child participates in water sports.

SAFE POWER WINDOW CAMPAIGN

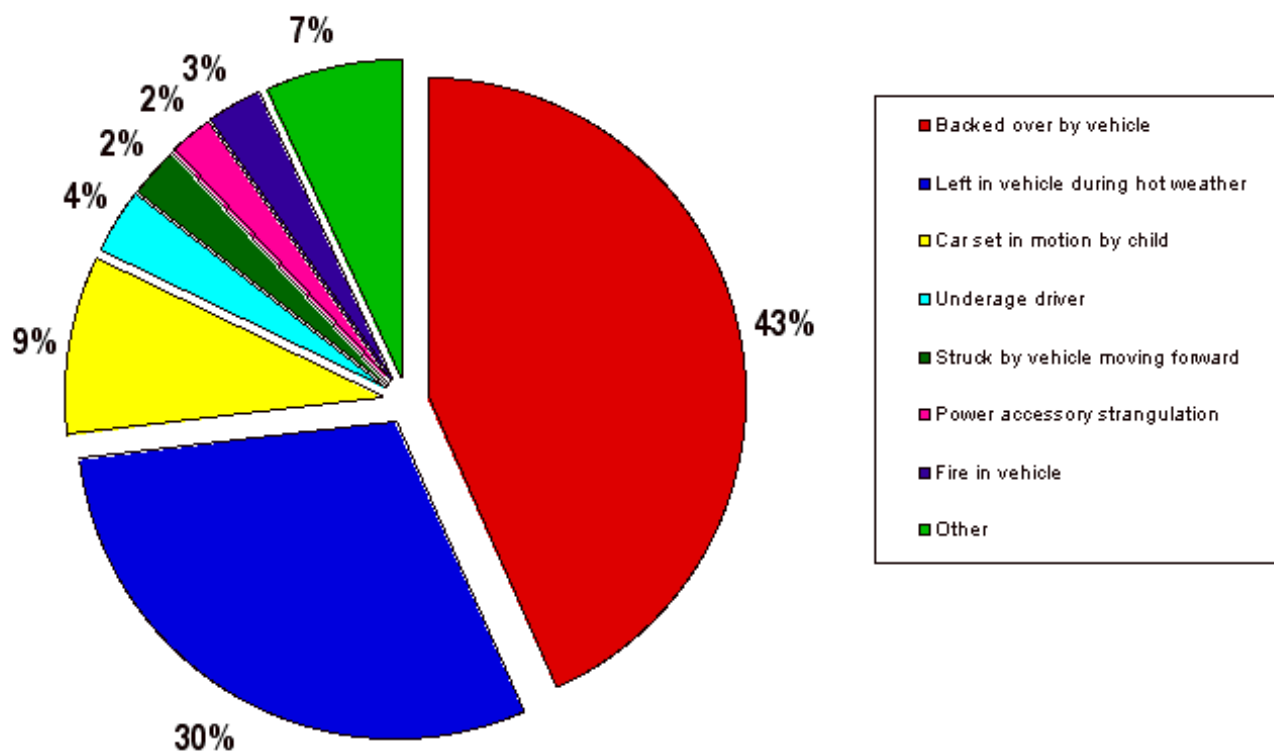
*2005 Omnibus Transportation Act
SEC. 7258. POWER WINDOW SWITCHES.*

The Secretary of Transportation shall upgrade Federal Motor Vehicle Safety Standard 118 to require that power windows in motor vehicles not in excess of 10,000 pounds have switches that raise the window only when the switch is pulled up or out. The Secretary shall issue a final rule implementing this section by April 1, 2007.



US Fatalities by Type 1999-2003

Nontraffic noncrash fatalities involving children < 15 years of age



Data source: Kids And Cars
www.kidsandcars.org



Child Deaths Spike from Vehicle Backovers and Power Windows; Congress Should Require Simple Auto Fixes in Pending Bill

Survivors and Advocates Step-up Campaign to
Approve Safety Measures;

New National Poll and State-By-State Fatality
Numbers Released ■

(Washington, DC) - July 20, 2004 – Child safety advocates KIDS AND CARS today released new statistics that show a sharp increase in the number of children killed and injured in backover and power window incidents and CONSUMERS UNION released a poll showing 8 in 10 Americans want more car-safety regulations to protect children. The figures, poll and new public awareness materials are part of a stepped-up public information campaign launched as legislators consider the Safe and Flexible Transportation Efficiency Act of 2004 (SAFETEA), which includes measures to help prevent these tragic incidents.

Challenges

- Trust
- Confidentiality
- Number of Deaths
- staff changes
- Taking Ownership
and
- Translating Information
into Action

The Top 10 Mistakes A CDRT Can Make

1. **Keep the lessons learned to itself**
2. Become immersed in the process of data collection
3. Be adversarial
4. Require consensus on every issue
5. Assume you (any or all members) know everything
6. Compromise objectivity through narrow focus
7. Assume the team's ability to function is proportionate to the financial resources
8. Have agency heads "in charge" at the table
9. Focus exclusively on child abuse and neglect
10. Be prosecutorial or punitive in focus

... an unfulfilled promise

- Recommendations often incomplete:
 - Generic
 - Vague
 - May not be based on best practices
- Without leadership, no mechanism for follow-through or implementation
- Successful prevention programs developed through the CDR process are not well documented.

Making Good Recommendations

- Problem Assessment
- Written recommendation
- Action on Recommendation

Problem Assessment

- What risk factors are you trying to mitigate?
- Are you using other data on injuries?
- Do you know what might work-have you consulted experts, the literature, your knowledge?
- Do you know what is happening already?
- Do you have an idea of available resources?
- What is the political will?
- Are there any potential opportunities to exploit?

Writing the Recommendation

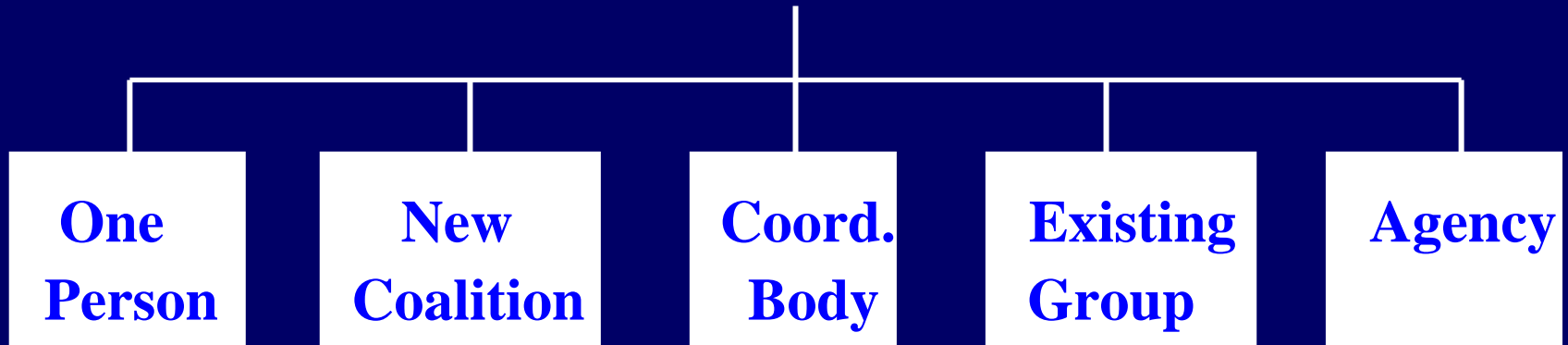
- Specificity: the plan will have sufficient detail to allow somebody to track/follow up with:
 - - Your problem statement
 - Any appropriate actions people should be taking
 - Places, persons, institutions where change should occur.
 - Your timeframe for action

Written Recommendation

- Accountability
is critical
 -
- Use the Spectrum of
Prevention for focus

Refer Recommendations

Child Death Review Team



**Don't leave a case without assigning
responsibility for follow through**