KEEPING KIDS ALIVE IN WISCONSIN
Children's Health Alliance of Wisconsin

A Window into Prevention - 2010

An initial report on preventing child death and injury in Wisconsin

Highlights specific to Wisconsin's children 2007-2008

More than 25% of all Wisconsin child deaths were preventable.

Death certificates capture the following information

- **Motor vehicle and other transport crashes** – continue to be the leading cause of injury-related child deaths with the teenage population most affected.
- **Asphyxia and Sudden Infant Death Syndrome (SIDS)** – 62% of asphyxia deaths occur before age 1 and 86% of SIDS deaths occur before 5 months old.
- **Homicide** – 70% of child homicide victims were male. Child homicides peak before age 4 and again during the teen years (age 15-17).
- **Drowning** – is the second leading cause of injury-related death for Wisconsin children ages 1-9.
- **Poisoning** – 75% of poisoning deaths occur between 10 and 17 years of age.

Local child death review (CDR) teams seek to understand and collect data about risk factors and circumstances surrounding the death of a child. Additional information is gained when local CDR teams review cases.*

- **Motor vehicle crashes** – lack of passenger restraint use remains a risk factor for motor vehicle deaths. Other risk factors include: speeding, reckless driving and driver impairment from drug or alcohol use.
- **Asphyxia and Sudden Infant Death Syndrome (SIDS)** – infant bed-sharing with an adult or other children was a common risk factor for infant sleep-related suffocation and SIDS deaths. The non-back to sleep position was also identified as a risk factor.
- **Homicide** – the child's home was the most common place for a homicide to occur.
- **Drowning** – common risk factors for drowning included improper supervision and lack of barriers to water.
- **Poisoning** – opioids, including Methadone are common substances leading to poisoning deaths.

***The above information is based on the cases entered into the National Center for Child Death Review Case Reporting System. During this two year period, a total of 514 cases were reviewed, accounting for over 30% of all child deaths (n=1556).**

Sample prevention recommendations **(see report for all recommendations)**

- **Motor vehicle crashes**
  Strengthen Wisconsin's graduated driver's licensing law to reflect current evidence based best-practice components. (Refer to page 20 in the report)
- **Asphyxia and SIDS**
  Promote the American Academy of Pediatrics recommendations on safe sleep environment for infants. (Refer to page 29 in the report)
- **Homicide**
  Implement home visiting nurse programs that have proven to be effective at reducing homicides in children younger than age 4. (Refer to page 41 in the report)
- **Drowning**
  Implement legislation requiring barriers around residential pools that can reduce child

drowning deaths; and public education regarding the importance of attentive adult supervision of children around water. (Refer to page 46 in the report)

* **Poisoning**
  Promote public education on keeping prescription drugs and toxins out of the reach of small children and promotion of polices that reduce the availability of prescription drugs in a community. (Refer to page 51 in the report)

Keeping Kids Alive in Wisconsin

Keeping Kids Alive in Wisconsin is the statewide child death review (CDR) system comprised of local CDR teams based in individual or multiple counties.

The purpose of a CDR team is to prevent future deaths. CDR teams are multidisciplinary and work to gather the risk factors and circumstances associated with a child's death beyond what is recorded on a death certificate. Current data reporting through death certificates only track the number of child deaths and causes. CDR teams utilize the National Center for Child Death Review Case Reporting System to capture the who, what, when, where, why and how a child's death occurred. For example, in the case of a motor vehicle crash, the child's location within the car, restraint use, driving conditions and other factors are all captured. CDR teams use these important factors to identify trends and drive prevention efforts in the community.

The partners working to implement a comprehensive statewide CDR program include: Children's Health Alliance of Wisconsin, the Injury Research Center at the Medical College of Wisconsin, the Wisconsin Department of Health Services and Department of Justice.

Learn more at www.chawisconsin.org or contact Karen Ordinans, Executive Director - Child Death Review program, Children's Health Alliance of Wisconsin at (414) 337-4561.