

CHILD DEATH REVIEW IN WISCONSIN: RATIONALE, GOALS AND PROGRESS

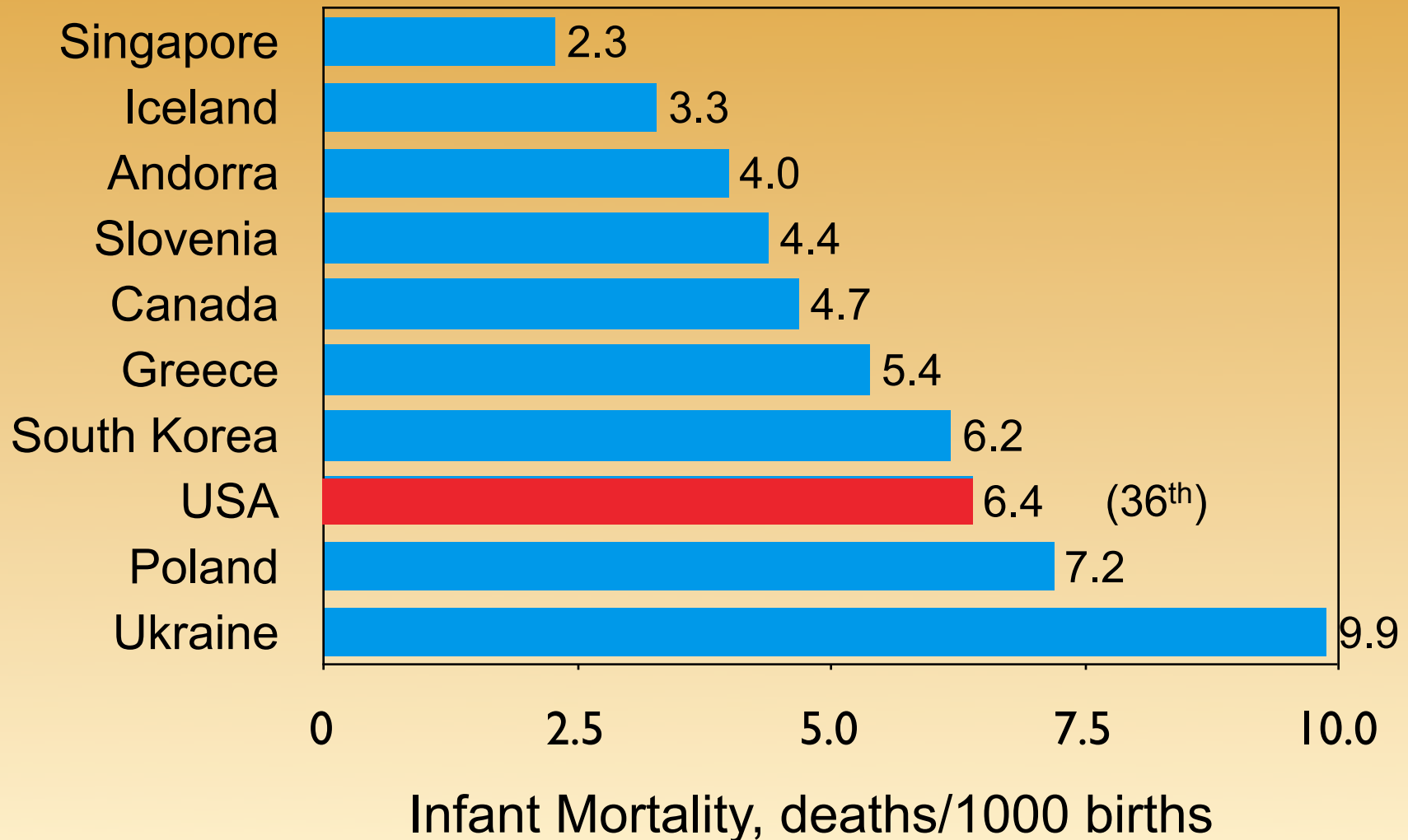


CDRT Training
October 4-5, 2007

THE PROBLEM: CHILD DEATHS IN WISCONSIN

- Each year, > 400 deaths age 1 mo.-17yr.
- Most “unexpected”:
 - Any death in child not terminally ill
 - Examples: unintentional injury, homicide, suicide, asphyxia, aspiration, airway obstruction, infectious illness
- Many (perhaps 50%) preventable
- Many neonatal deaths also (\approx 300)
- Even one preventable death is too many!

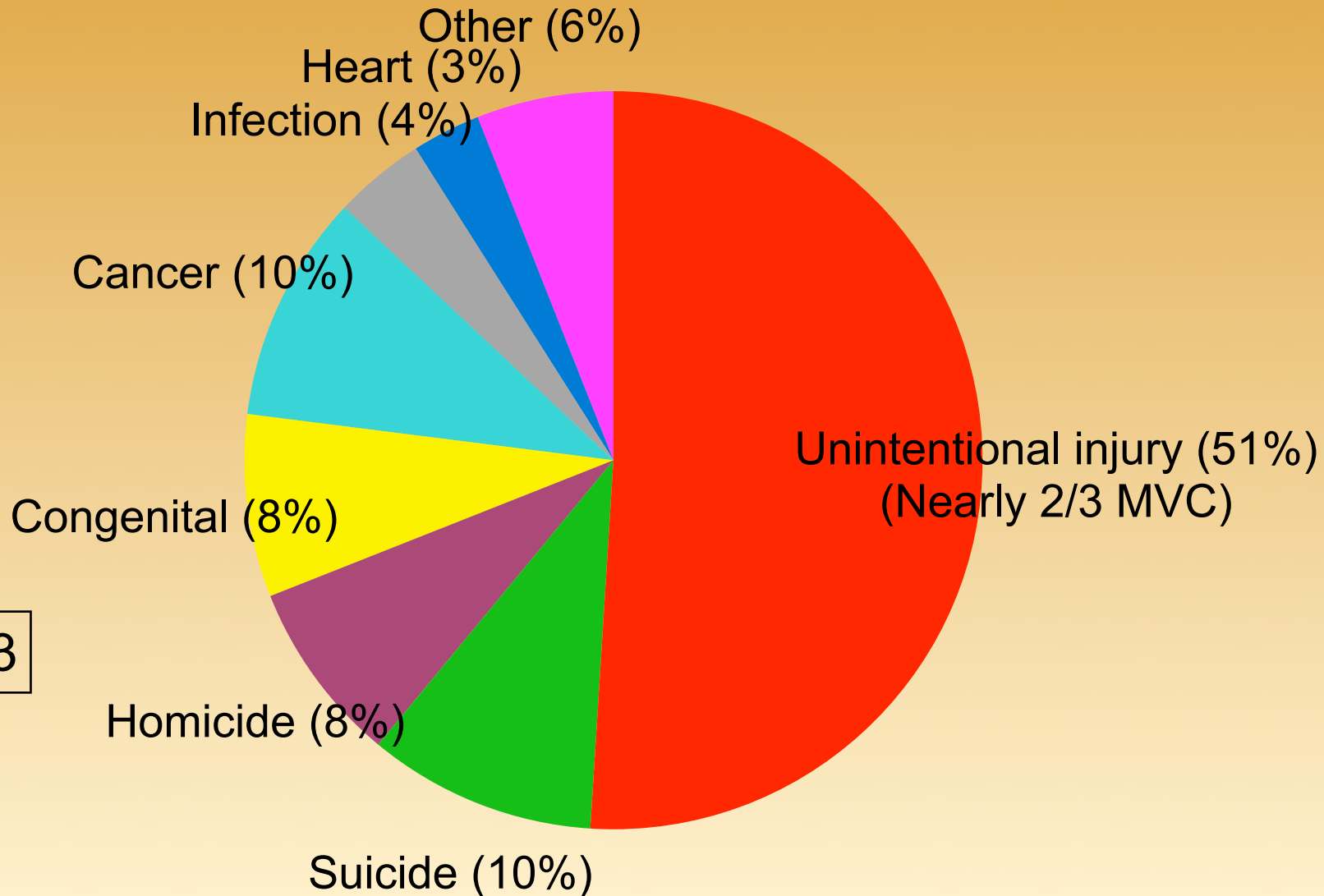
INFANT MORTALITY: USA vs. THE WORLD



CAUSES OF DEATH

WISCONSIN CHILDREN AGE 1-17, 2002-04

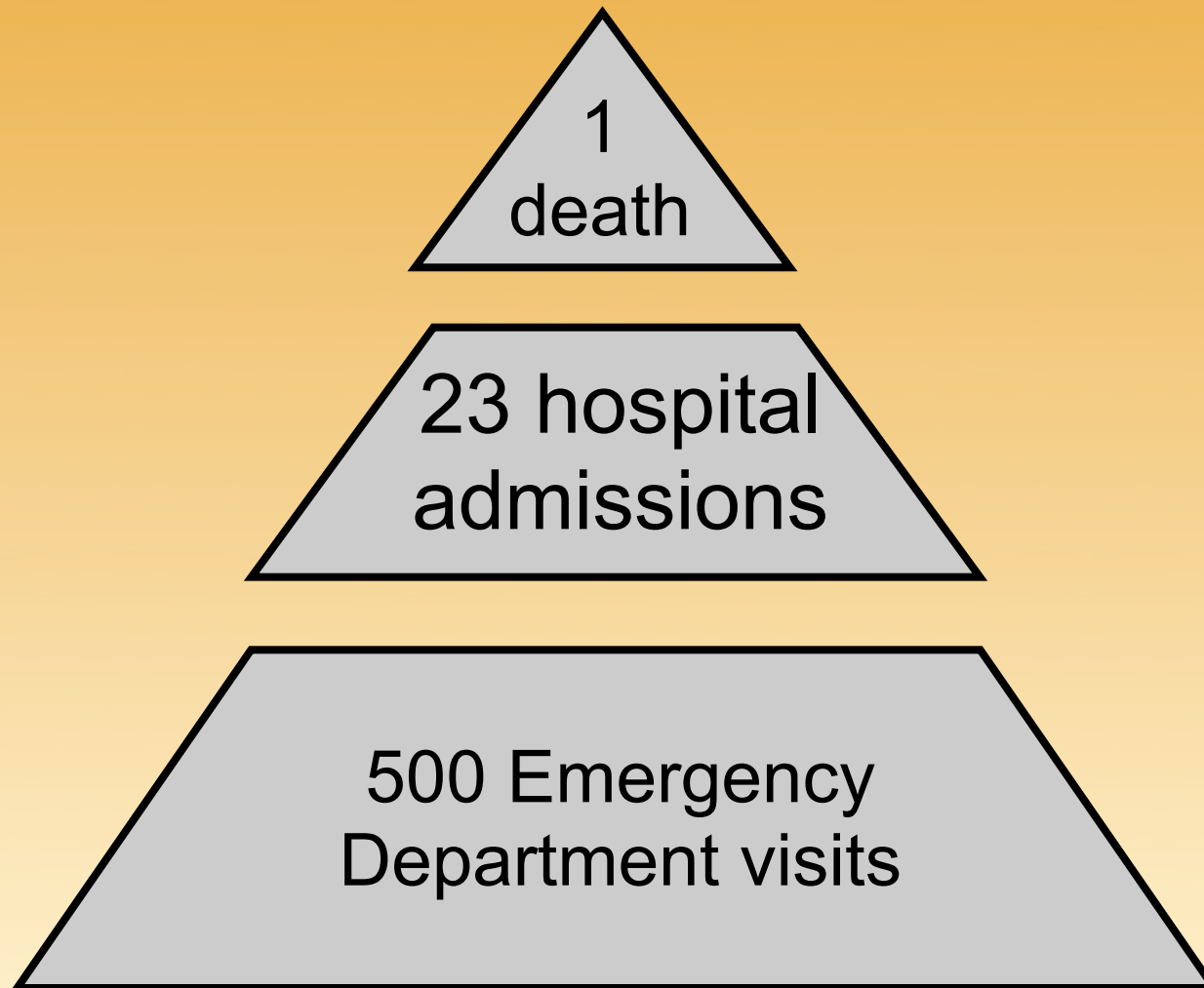
(data from <http://www.cdc.gov/ncipc/wisqars>)



N = 823

WI PEDIATRIC INJURY MORBIDITY 2002-04

(Data from Wisconsin Interactive Services for Health
www.dhfs.wisconsin.gov/wish/)



THE GOAL: PREVENT CHILD DEATHS

- We cannot turn back the clock
- We can learn from each child death to help prevent future deaths
 - What circumstances contributed to the death?
 - How could this death have been prevented?

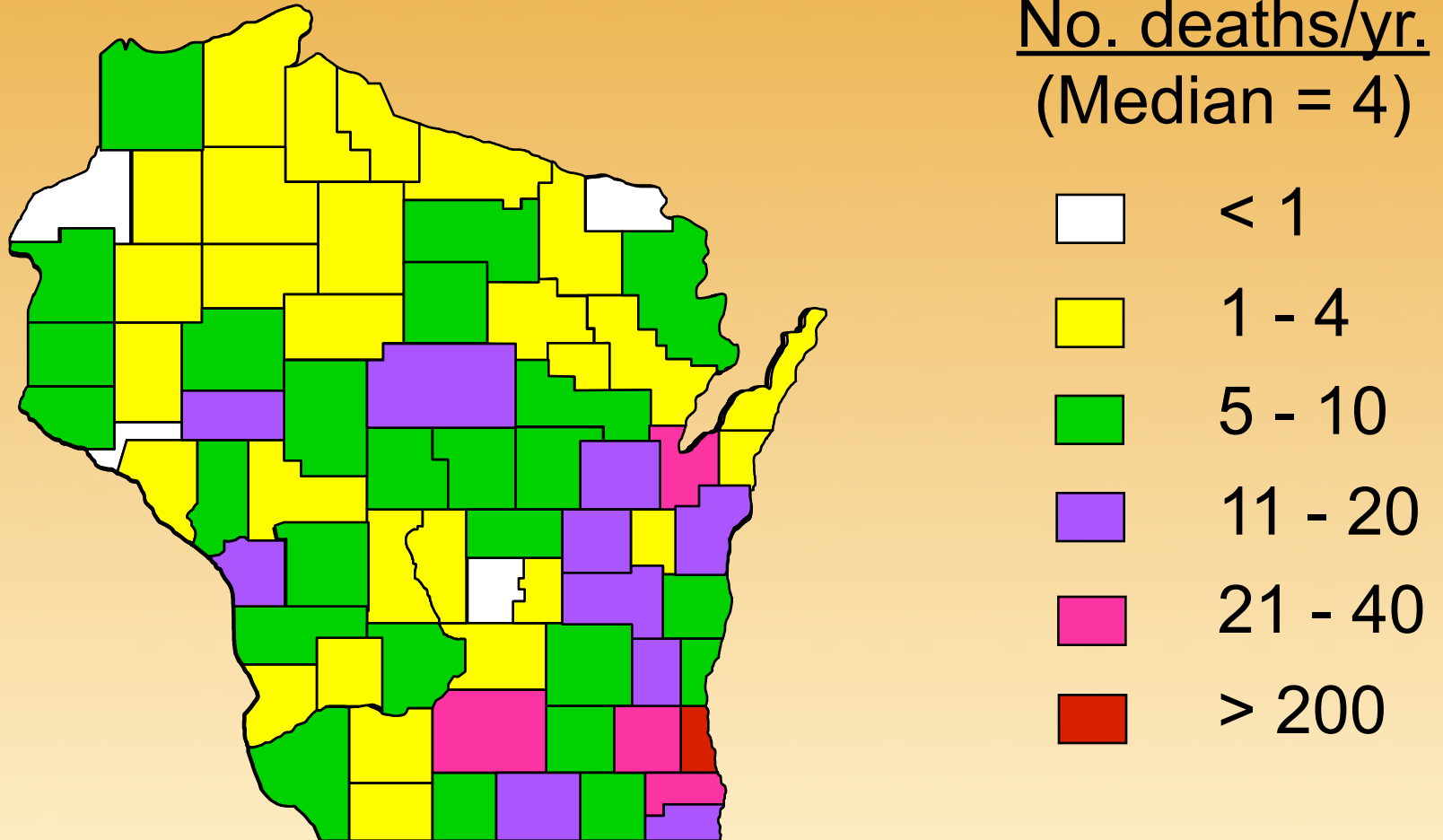


CHALLENGES TO PROGRESS

- Unlike most other states, no legislative mandate → voluntary submission of data
- Wisconsin has an elected coroner system → 72 different death investigation arrangements with varying pediatric expertise
- Only 10 local multidisciplinary CDRT's in Wisconsin with few pediatric deaths in most counties
- ~ 20% of deaths reported to CFRT, with skewed geographic distribution

UNEXPECTED DEATHS IN WISCONSIN CHILDREN AGE 1 mo.-17 yr.

(Data from www.dhfs.wisconsin.gov/wish/)



THE PROCESS FOR OVERCOMING THE CHALLENGES

- Establish a state CFRT
- Promote development of local CDRT's
- Seek legislative support

WISCONSIN STATEWIDE CHILD FATALITY REVIEW TEAM (CFRT)

- May 1998: 12 states without CFRT
- State CFRT formed by Department of Justice under federal Child Justice Act grant
- Goal: Reduce the number of preventable childhood deaths in Wisconsin, not just abuse/neglect
- Multidisciplinary - professional and geographic distribution

WISCONSIN CFRT: ORGANIZATIONS REPRESENTED

- Attorney General
- DHFS/DCFS
- DHFS/DPH
- DPI
- DOT/BOTS
- DNR
- CPSC
- County D.A.
- County Sheriff
- County Coroner/M.E.
- WI Coroner/M.E. Assoc.
- County CPS
- Pediatrician/EMSC
- Child Advocacy Org.
- Staff: DOJ/DHFS

WISCONSIN CFRT APPROACH

- Gather information about unexpected child deaths - standard reporting format from local multidisciplinary team or coroner
- Assess preventability
- Compile statewide data

WISCONSIN CFRT APPROACH (Cont'd)

- Formulate recommendations
 - Public policy
 - Public education
 - Training of organizations
- Foster communication/collaboration among government, professional and advocacy organizations
- Foster development of local CDRTs

THE KEY ELEMENT: THE LOCAL CHILD DEATH REVIEW TEAM (CDRT)

- A child death is a *community* tragedy
- We owe it to the child and grieving survivors to try to understand:
 - What happened
 - How to prevent it from happening again
- CDRT is the mechanism for doing this:
 - Community based
 - Multidisciplinary
 - Confidential
 - Does not supplant responsible agencies

COUNTY CDRT'S IN WISCONSIN: A SMALL, BUT GROWING NUMBER

- Currently 10 teams operating or in development:
 - Dane
 - Kenosha
 - Manitowoc
 - Marathon
 - Milwaukee
 - Outagamie
 - Portage
 - Racine
 - Rock
 - Waukesha
- Several additional counties are considering

LOCAL CDRT'S: THE BIG QUESTIONS

- How to set up a team?
- How does the team function?
- What happens during a death review?
- What is the outcome of a review?
- What happens then?

CDRT: MEMBERSHIP

CORE

- County Coroner/M.E.
- Law Enforcement
- Child Protective Svcs.
- District Attorney
- Health Department
- Pediatrician

ADDITIONAL

- Emergency Medical Svcs
- Hospital representative
- Community Mental Health
- Juvenile Court
- Public Schools
- Child Care Licensing

CDRT: ADDITIONAL MEMBERS TO CONSIDER

- Neonatologist
- Clergy
- Child Advocacy Organization
- Tribal Council
- Domestic Violence Agency
- SIDS Support Agency
- Community Foundation Officers
- Ad hoc members: involved in a specific case

CDRT: WHAT DEATHS TO REVIEW

- Consider *all* deaths for children 0 - 17 yrs
- Review all “unexpected” deaths
- Review all infant (< 1 yr) deaths
- Review all coroner’s cases

CDRT: WHEN TO REVIEW

Generally: Periodic meetings to discuss cases for which all data are available - typically 2 - 5 weeks after the death

Possible: “Immediate” response when requested by responsible agency

