




**KEEPING
KIDS ALIVE**
IN WISCONSIN

★ Children's Health
Alliance of Wisconsin



“A measure of society’s worth is how well it cares for its most vulnerable members. Our children are both our most vulnerable individuals and our future.”

William H. Perloff, M.D.

Past chair, Wisconsin CDRC

Children's Health Alliance of Wisconsin



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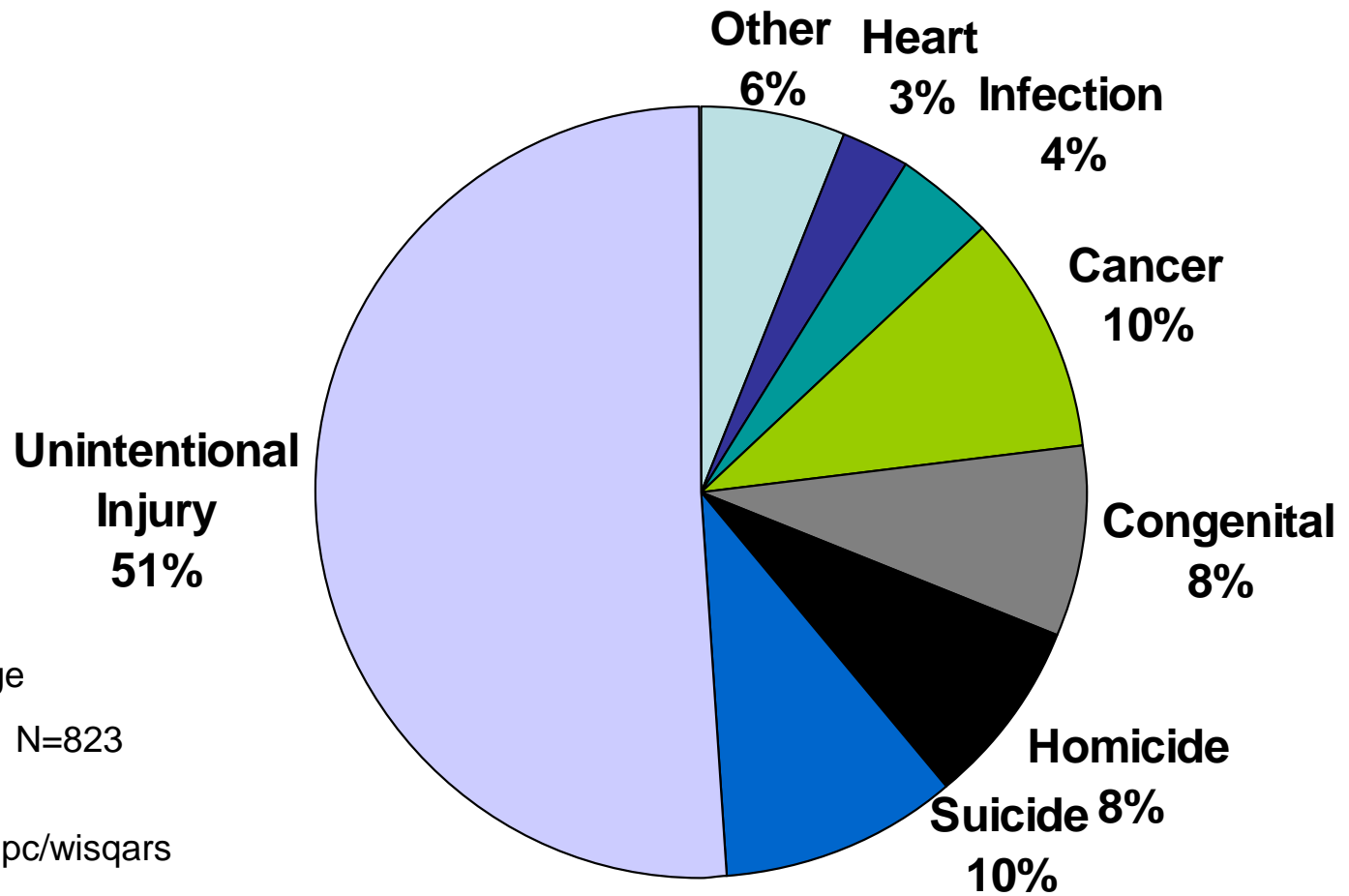
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The problem in WI

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

Causes of death



**Unintentional
Injury
51%**

Other Heart

6%

3%

Infection

4%

**Cancer
10%**

**Congenital
8%**

Homicide

**Suicide 8%
10%**

Wisconsin Children Age
1-17, 2002-2004 N=823

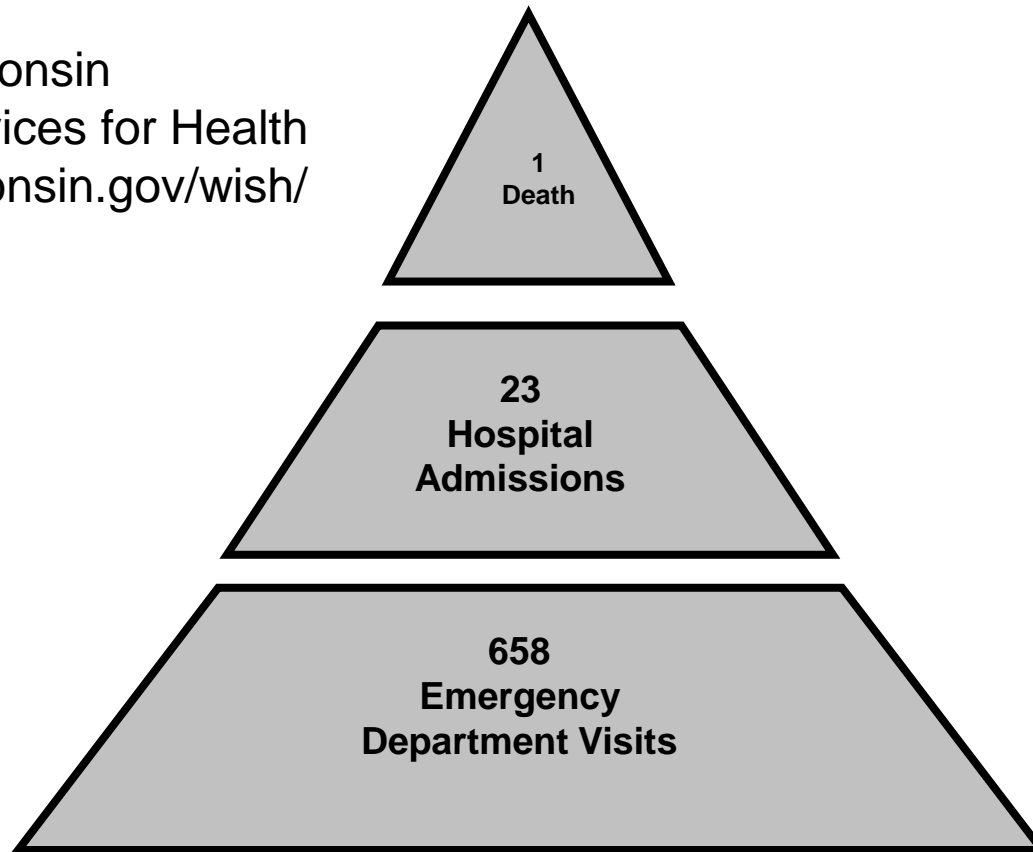
Data from
<http://www.cdc.gov/ncipc/wisqars>

Causes of death, cont

Rank	<1 years	1- 4 years	5 - 9 years	10 - 14 years	15 - 17 years
1	Suffocation (38)	Homicide (18)	MVC (39)	MVC (35)	MVC (168)
2	Homicide (19)	Drowning (18)	Drowning (9)	Suicide (20)	Suicide (62)
3	MVC (6)	MVC (14)	Homicide (<5)	Nontraffic Trans (14)	Homicide (())
4	Falls (<5)	Suffocation (14)	Fire (<5)	Drowning (11)	Drowning (13)
5	Drowning (<5)	Fire (7)	Nontraffic Trans (<5)	Homicide (8)	Nontraffic Trans (11)

WI Pediatric Injury Morbidity 2008

Date from Wisconsin
Interactive Services for Health
www.dhfs.wisconsin.gov/wish/



Child death review is...

- A county or regional multidisciplinary team seeking to understand the risk factors surrounding the death of a child.
- A professional process aimed at improving system responses to child deaths.
- An opportunity to improve the health, safety and children.

Child death review is NOT...

- A peer review.
- Designed to examine individual performance.
- An opportunity to second guess agency policy or practice.

Child Death Review Council

- May 1998: 12 states without CDRC.
- State CDRC 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.

Child Death Review Council

- Assess preventability.
- Compile statewide data.
- Formulate recommendations:
 - Public policy
 - Public education
 - Training of organizations
- Foster communication/collaboration among government, professional and advocacy organizations.
- Foster development of local CDR teams.

CDR team members

- County medical examiner or coroner.
- Local law enforcement.
- CPS.
- District attorney's office.
- Local public health.
- Pediatrician.
- Emergency medical services.
- Community hospital.
- Community mental health.
- Family court.
- School districts.
- SIDS center.

Expectations of team members

- Contribute information from agency records.
- Serve as a liaison to respective professional counterparts.
- Provide definitions of professional terminology.
- Interpret agency procedures and policies.
- Explain the legal responsibilities or limitations of his or her profession.

Team coordinator role

- Schedule and set agenda for meetings.
- Compile Child Death Summary Sheet and distribute to members one week prior.
- Chair team meetings and maintain professional decorum.
- Ensure data reports are submitted to National Case Reporting System within one month.
- Ensure team operates according to guidelines.
- Ensure signing of confidentiality agreement.

Review meeting

- Share, question and clarify all case information.
- Discuss the investigation.
- Discuss the delivery of services.
- Identify risk factors.
- Recommend systems improvements.
- Identify and be a catalyst for community action.

Order for conducting a review

- Coroner/M.E. reviews death investigation:
 - Autopsy findings.
 - Cause and manner of death.
- EMS presents run report.
- Hospital representative presents ED/inpatient info.
- CPS reports any previous contacts.
- Public health reports any previous contacts.
- Prosecutor reports on investigation, and prior info.
- Others may have input as well.

Discussion questions

The following questions should be asked:

1. Is the investigation complete, or is the team missing critical information?
2. Does the family need services? Others?
3. Has CPS determined that other children are at risk of harm?
4. Should we recommend any changes to agency practices or policies?

Discussion questions, cont.

5. What risk factors were involved in this child death?
6. Could this death have been prevented?
7. How do we prevent another similar death in the future?
8. Who should take the lead in implementing our recommendations for prevention?
9. Is our review of this case complete or do we need to discuss it at our next meeting?

Prevention

- CDR teams are intended to catalyze community action.
- CDR teams should connect with community groups already working on prevention (e.g., safe kids, injury free coalitions, hospitals, etc.)

Why collect data

- Provides the ability to track trends at county, regional, state, and national level.
- Allows prevention to be targeted to specific groups or risk factors.
- Captures the risk factors and circumstances contributing to the death of a child.

How do we collect data

- National Case Reporting System:
 - Paper form can be used during the meeting to collect information.
 - Information can then be entered into the system.
 - Takes about 10 minutes.

Case reporting system


- Internet based, confidential database used to collect national data.
- Allows teams to enter their case information.
- Training and resources available to all users.

WI CDR data: sleep-related deaths, 2007-2008

- 133 deaths reviewed
- Circumstances
 - 16 were on top of object
 - 3 under person
 - 2 under object
 - 4 between person
 - 10 wedged
 - 6 pressed
- 108 (81%) under one year of age

WI CDR data: sleep-related deaths, 2007-2008

- Other factors:
 - 99 Not in a crib/bassinette
 - 51 Not sleeping on their back
 - 22 Unsafe bedding or toys
 - 68 Sleeping with other people
 - 5 Adult was alcohol impaired
 - 4 Adult was drug impaired
 - 2 Caregiver fell asleep while bottle feeding
 - 2 Caregiver fell asleep while breastfeeding



**“Even as we grieve our loss,
we must seek whatever good
can come from such a
catastrophic event. We must
find how the death could
have been prevented, so that
other children might be
spared the same fate.”**

**William H. Perloff, M.D.
Past chair, Wisconsin CDRC**