

## OVERVIEW OF CHILD DEATH REVIEW IN WISCONSIN

### THE PROBLEM

Each year more than 400 Wisconsin children between 1 month and 17 years of age die. Most of these deaths are “unexpected”, that is, occurring in a child not known to be terminally ill. Some examples are unintentional injury, suicide, homicide, asphyxia, infectious illness. Perhaps *half* of these are preventable.

There are also approximately 300 neonatal deaths (occurring in the first 28 days of life). Many of these are preventable too, as evidenced by the fact that the U.S. is 42<sup>nd</sup> in the world in infant mortality. Our infant mortality rate is almost twice that of Iceland, and slightly greater than for South Korea!

From one to 17 years, unintentional injuries cause one-half the deaths, with suicide and homicide accounting for another 18 percent. So more than two-thirds of the deaths are injury related, a majority of which are likely preventable.

### THE GOAL: PREVENT CHILD DEATHS

We cannot turn back the clock on these deaths, but we can learn from each child death to help prevent future deaths. Key questions to address include: what circumstances contributed to the death? How could this death have been prevented? When examined in the aggregate with other deaths are there trends that suggest the need to focus preventive measures? An example would be a number of SIDS deaths at daycare centers where infants are placed on their tummies at nap time, rather than their backs, suggesting the need for an education program for daycare workers about the importance of the “back-to-sleep” campaign.

### CHALLENGES TO PROGRESS

Unlike most other states, Wisconsin has no legislation enabling or mandating multidisciplinary child death review and compiling of statewide data. We also have no standard child death investigation protocols for our 72 counties.

There are currently only 13 local multidisciplinary child death review teams. Most counties have only a few child deaths (the median is four per year); that precludes identifying trends that may be obvious at the state level. Because submission of data beyond the limited information on the death certificate is presently voluntary, only about 20 percent of the deaths are reported to the state Child Death Review Team (CDRT).

### 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 and how to prevent it from happening again. The CDRT is the mechanism for doing this because it is community-based, multidisciplinary and confidential. Why is it so important for the CDRT to be multidisciplinary? Because there are many factors that may affect a child’s risk of death, and they are not all likely to be identified by one individual or agency.

An example is the case of seven year-old child on a bicycle struck by a car. While the circumstances may clearly indicate that the child rode into traffic and the driver of the car could not have seen the child in time to stop, important questions remain. Risk factors for this event include whether the bicycle being ridden was appropriate for the child’s development, the extent to which the child was supervised, and whether the child was wearing a helmet.

Other appropriate questions relate to the emergency care of the child: Did the EMT’s at the scene have the necessary pediatric equipment and training? Was the child transferred to an appropriate trauma center? Were the injuries so severe that the most expert hospital care could not have altered the outcome? It would be important to know if County Social Services had previous contact with the family. To address these issues requires a variety of expertise and input.

The multidisciplinary team does not supplant the responsible agencies, but provides an opportunity to interact and delve more deeply into the potential for prevention.

### **WHAT CASES TO REVIEW, AND WHEN?**

It is useful to consider all deaths of children 0 to 17 years of age for possible review. In general, reviews are conducted for all “unexpected” deaths, all infant deaths, and any coroner’s cases not otherwise selected.

### **QUESTIONS TO CONSIDER:**

In the discussion surrounding each case, the team members need to address, at least, the following questions:

1. Is the investigation complete? If not, what additional information is missing?
2. Are needed services being provided to the child’s family, and others affected by the death?
3. What risk factors were involved in the death, and are other children at risk?
4. Are there interventions that might prevent future deaths?
5. What specific prevention activities could produce these changes?
6. Who will take the lead?
7. Who do we need to involve?
8. Is the review complete?

### **WHAT IS THE OUTCOME OF THE REVIEW?**

Answers to the above questions provide a road map for action resulting from the review. There may be recommendations to service agencies, law enforcement, etc. These may include suggestions concerning public information campaigns.

The final step is to forward a report to the State Child Fatality Review Team (CFRT) and the National Center for Child Death Review (NCCDR), preferably using the NCCDR case reporting form. The report should include a brief summary of the case, the “Casepoint” data, when available, and the results of the CDRT review, including potential preventability of the death, and recommended preventive measures. The State CFRT has the mission of compiling data from around the state, identifying trends that may not be obvious from the data of a single county, and mobilizing statewide prevention activity. Such activity may include legislation, State Agency policy or practice changes, and public information initiatives.

The expectation is that the combined efforts of the local CDRT’s and the State CFRT will lead to fewer preventable child deaths and the devastating consequences for families. The child death review process allows us to make the best of an otherwise unmitigated disaster and, hopefully, spare others a lifetime of loss and regrets.