Amy Loudenbeck
REPRESENTING WISCONSIN'S 31ST ASSEMBLY DISTRICT

Assembly Committee on Children and Families
Public Hearing on Assembly Bill 554
December 18, 2013

Thank you Chairman Krug and committee members for the opportunity to provide testimony to the Assembly Committee on Children and Families in support of Assembly Bill 554 related to creating a statewide program to review child deaths.

No greater tragedy exists than the loss of a child. Each year, more than 700 deaths occur to children under age 18 in Wisconsin.

Child death review (CDR) teams are multidisciplinary groups of experts charged with determining all risk factors and circumstances leading to the child's death in an effort to generate recommendations for preventing future deaths.

- CDR is a professional process aimed at understanding the risk factors and circumstances surrounding the death of a child.
- CDR is not an opportunity to second guess agency polices or critique individual performance.
- These multidisciplinary CDR teams collect data and use their findings to recommend prevention strategies.
- At a minimum, local CDR teams review deaths of children younger than age 18 that occur within their county.

The CDR program in Wisconsin was established in 1998 when the Department of Justice created a state CDR team under the federal Child Justice Act. Over the past 20 years, CDR programs have spread across the United States. Altogether, there are more than 1,200 state and local teams nationwide. Although CDR teams currently operate in 51 Wisconsin counties, Wisconsin is one of seven states that do not recognize the CDR process in statute. Wisconsin CDR teams in Wisconsin are challenged by this lack of regulatory certainty. Specifically, legislation is needed to:

- Establish a recognized CDR program for Wisconsin.
- Affirm the current *ad hoc state* CDR Council to provide advisory oversight and guidance.
- Resolve barriers confronting local CDR teams related to data collection, data sharing, and agency cooperation to support prevention efforts and outreach.
- Protect the process and information shared at CDR team meetings

Senator Olsen and I have introduced Assembly Bill 544 and Senate Bill 436 at the request of the many CDR team members and stakeholders. Many of them are here to provide testimony today. I encourage you to carefully consider their testimony, and hope that you will agree that AB 544 and SB 436 will provide the critical legislative support that is needed to allow these CDR teams to continue their important work to help prevent child deaths in Wisconsin.

State Capitol: P.O. Box 8952 ★ Madison, WI 53708 | (608) 266-9967 ★ Toll-Free: (888) 529-0031 ★ Fax: (608) 282-3631
District: (262) 296-1030 | Rep.Loudenbeck@legis.wi.gov

Luther S. Olsen
State Senator
14th District

Testimony in favor of AB 554
Wednesday, Dec. 18, 2013
Assembly Committee on Children and Families

Thank you Chairman Krug and committee members for holding a hearing on Assembly Bill 554. I greatly appreciate the opportunity to discuss this legislation, and the time the committee members are investing in the hearing. It was my pleasure to co-author this bill with Representative Amy Loudenbeck.

As we all know, when a child dies, it is a tragedy that touches the family, their friends and the community as a whole. Those involved often ask themselves if something could have been done to prevent this senseless loss of life. Child Death Review (CDR) teams strive to identify prevention strategies so fewer families experience similar losses. They do this by looking at the circumstances surrounding a child's death to learn if the death could have been prevented. This process allows individuals to gain a better understanding of the risk factors and conditions influencing child deaths, and helps to develop policies that will aid in preventing future deaths. This legislation seeks to recognize the current CDR program in place in our state, and address the barriers that many CDR teams face while conducting their work.

The current CDR program in our state was established in May 1998, and today, Wisconsin has 48 established teams covering 51 counties. These teams bring individuals from multiple disciplines together, at the local and state level, to share and discuss the causes, circumstances, and issues surrounding the deaths of children. However, Wisconsin is one of only 7 states without comprehensive legislation on the topic. Due to this, teams face several barriers including access to the information needed to conduct effective reviews and a lack of certainty in the ability to safeguard the process and the information shared during reviews.

Under this bill, the CDR program in the state is recognized, and a State CDR Council is established to provide guidance and advisory oversight to local teams, review statewide information to identify trends in child deaths, and offer policy recommendations. Further, a process to recognize local CDR teams is established, and they are allowed access to assistance from the State Council. The bill also addresses access to the relevant records needed to conduct reviews. These include vital, health, child welfare, mental health, court records of children and juveniles, and school records. Finally, the bill protects the sensitive information shared at reviews. This is achieved by confirming all CDR information and records shared at reviews are confidential, the information is not subject to subpoena or discovery, and it creates a penalty for those who intentionally violate the confidentiality portion.

As Chair of the Senate Committee on Education and as a Father, I take the wellbeing of all children very seriously. As heartbreaking as each child's death is, it is important to seek whatever lessons can come from these tragedies, in order to prevent future deaths and improve the health and safety of all children.

Once again, thank you for your time today. Here today to offer testimony are CDR team members and stakeholders who can offer their personal experience on the topic.

State Capitol • P.O. Box 7882 • Madison, WI 53707-7882
Office: 608-266-0751 • Fax: 608-267-4350 • Toll-free: 1-800-991-5541 • E-mail: sen.olsen@legis.wisconsin.gov

Testimony on AB 554

Good morning chairman Krug and members of the committee. Thank you for allowing me this opportunity to testify today. My name is Karen Nash. I am one of the injury prevention and death review coordinators at Children's Health Alliance of Wisconsin (Alliance).

- What Mark Hahn shared is an example of what teams are accomplishing across the state.
- We have created an organized and comprehensive death review model.
- This is the framework our teams use to identify and carry out prevention activities.
- My technical support provides guidance to teams through the training, case review, and prevention processes.
- I am able to witness how team members work together to make their community a safe place for families to live, work and play.

Thank you for the opportunity to testify and I'm happy answer any questions.

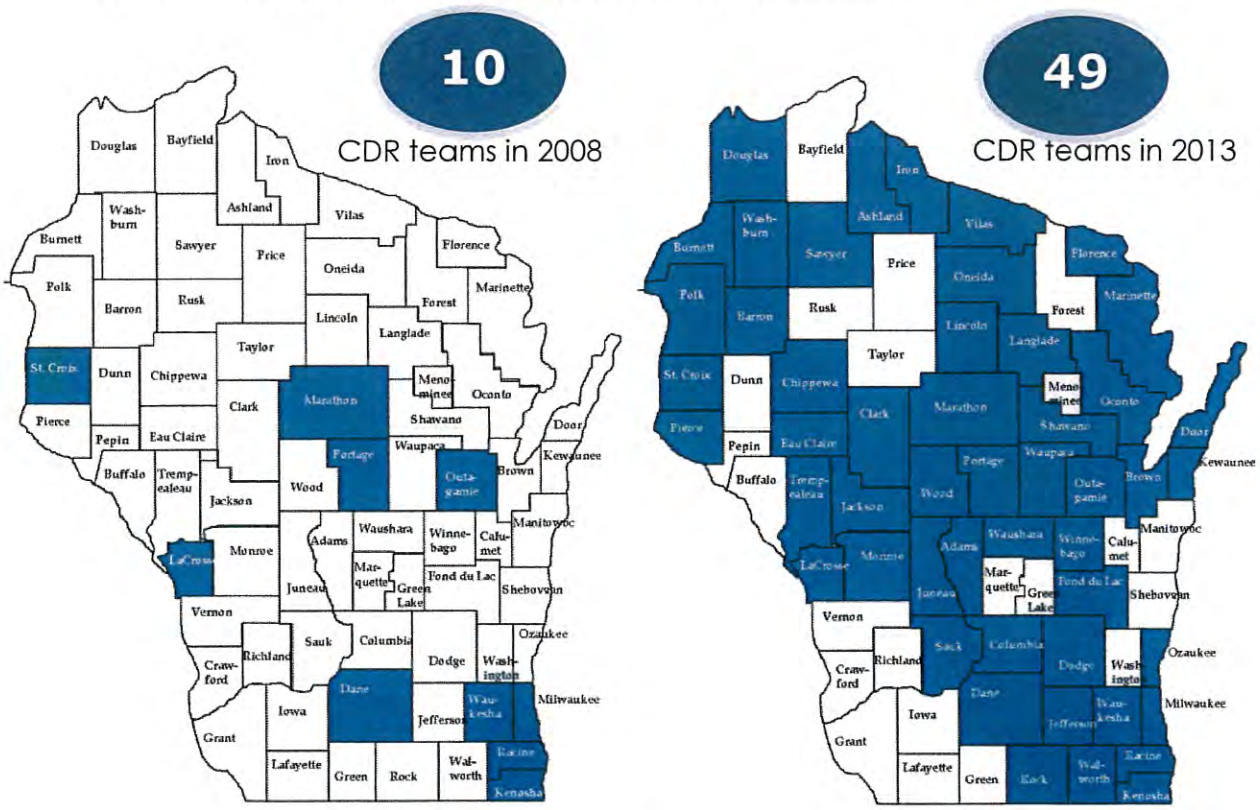
Testimony on AB 554

About the Alliance

- Good morning Chairman Krug and members of the committee. Thank you for allowing me this opportunity to testify today. My name is Abby Collier and I am the Injury Prevention and Death Review Project Manager at Children's Health Alliance of Wisconsin (Alliance).
- Children's Health Alliance of Wisconsin is Wisconsin's voice for children's health. We are a statewide organization and our mission is to ensure Wisconsin children are healthy, safe and able to thrive. The Alliance leads seven key initiatives, including Keeping Kids Alive in Wisconsin.

Keeping Kids Alive

- The Alliance leads the Keeping Kids Alive in Wisconsin program in partnership with the Wisconsin Department of Health Services, Maternal and Child Health, Title V Program.
- Child death review teams are multidisciplinary and seek to prevent future injuries and deaths.
- The Alliance assists local communities with establishing local teams and implementing prevention strategies based on recommendations developed from data gathered during child death reviews.
- Currently Wisconsin has child death review teams in 52 counties, covering more than 90 percent of the population. Child death review teams review child deaths occurring to children younger than age 19 in most Wisconsin counties.



Over

- We could provide you with countless examples of how local teams have made a positive impact on Wisconsin's children and families. However, you will hear those directly from our local partners.
- Wisconsin is looked to as a national leader in CDR. Our staff leads a national coalition of state coordinators and serves on the advisory board for the National Center for the Review and Prevention of Child Deaths.
- Additionally, Wisconsin CDR staff has provided training and technical assistance to a variety of other states. In 2011, a fellow from Ireland spent time with our staff to learn about Wisconsin's CDR process.
- Wisconsin has been awarded a number of state and federal grants to support and enhance our CDR system. These grants have provided resources to develop tools and enhance review processes.
- We share this information with the committee to demonstrate the effectiveness of the Wisconsin CDR system. Thank you Chairman and- committee for the opportunity to testify today and would be happy to answer any questions.

State of Wisconsin
Department of Health Services

Scott Walker, Governor
Kitty Rhoades, Secretary

December 18, 2013
Assembly Committee on Children and Families
2013 AB 554 relating to: creating a statewide program to review child deaths and providing a penalty.
Karen McKeown, Division of Public Health, Department of Health Services

Good morning and thank you Chairman Krug and Committee Members for allowing me to speak on behalf of the Department of Health Services regarding Assembly Bill 554. As one of its main priority initiatives, the Department aims to reduce infant mortality. In order to achieve this goal, we need to understand the cause of death in cases across the state. This data can then be used to help make informed policy decisions at the state level.

Public health collects data in two ways. The first is from large data sets, such as survey responses and vital records statistics. The second is from individual case review, such as child death review. Child death review is a prevention-focused, multi-disciplinary approach to reviewing information about the death of an infant or child in order to identify system gaps and opportunities to prevent future deaths.

Today, there are 49 child death review teams, covering 52 Wisconsin counties accounting for 90 percent of Wisconsin's population. The Department continues to support Child Death Review (CDR) as a community-level, community-driven process. DHS has identified the establishment of local death reviews as a maternal and child health priority. As a result, local health departments are able to use their Title V, Maternal and Child Health funds to support the development and implementation of local death review teams. Additionally, the Department uses Title V funds to contract with Children's Health Alliance. Under this contract, Children's Health Alliance provides ongoing training and technical support to local teams on CDR process, works to support the statewide council, and provides bereavement support for parents of infants who die of Sudden Infant Death Syndrome.

AB 554 requires DHS to:
Provide professional and administrative support to the council.

- We recognize the importance of a council. Currently, we have a council in Wisconsin, but there is no formal support structure for the council.

Collect data that pertains to childhood deaths, including by entering into data-sharing agreements with other state agencies that collect similar data.

- Currently, local teams report challenges collecting data. Some participants are reluctant to share data because of fear of legal consequences and lack of protections. Local teams also need ongoing training and technical assistance to collect and submit data.

Cooperate with other state agencies to develop and implement programs and policies to prevent the death of children in this state.

- Currently, DHS encourages communities to use the results of their local child death work to drive programs and policies to prevent the death of children. DHS also works with the council (which includes representatives of other state agencies) to identify programs and policies needed to improve outcomes statewide.

After considering any recommendations received from the council, provide information to the public about the risk factors for and circumstances surrounding childhood deaths in this state and about specific strategies to prevent childhood deaths.

- This would be a new requirement. This report will be more meaningful as local communities are able to implement CDR and access local information.

Again, thank you for your time today and I will be happy to take any of your questions.

ROCK COUNTY HEALTH DEPARTMENT

North Office

P.O. Box 1088
Janesville, WI 53547-1088
608-757-5440
608-758-8423 (fax)
www.co.rock.wi.us

South Office

61 Eclipse Center
Beloit, WI 53511
608-364-2010
608-364-2011 (fax)

Legislative Testimony
Assembly Committee on Children and Families
December 19, 2013
Janet Zoellner, RN MS Rock County Health Department

Thank you Chairman Krug and committee members for the opportunity to speak in support of Assembly Bill 554. This bill is authored by Representative Amy Loudenbeck, a valuable partner in our county's efforts to reduce the rate of infant death.

My name is Janet Zoellner. I am the public health nursing director for the Rock County Health Department. The health department has been a lead agency on the Rock County Child Death Review Team since its development in 2006.

Over the course of the past 8 years our team has had the difficult task of reviewing over 100 child deaths that have occurred in our county. We review each case with great care, realizing that the events we unfold describe unimaginable sadness for the families involved, and reflect the loss to our community of this child that should have lived, worked and played alongside of us. The information we gain from the review team process does not stay as words on a page. I am here to share just a few of the partnerships that have developed to move our discoveries to prevention strategies.

Each time the team meets it is an occasion to step out of our individual roles in the community as nurse, coroner, law enforcement, firefighter, human services worker, paramedic, school staff, clinician, to join together and ask ourselves if there is some way that we can use what we know together to make a bigger impact that any of us could alone. We ask the question that every child experiencing an untimely death deserves. Could this death be prevented? And if so, how do we work together to move closer to that solution?

Unsafe infant sleep environments are a primary cause of infant death in Rock County. The Rock County Health Department has developed a partnership with Dean Health Systems, St. Mary's Janesville Hospital and Mercy Health Systems to provide information and education on infant safe sleep to the families we serve through our home visiting program. Without the donations we have received from our community partners we could not have provided over 200 pack and play cribs to these needy families. Because of our collaborative work, this year we were one of 40 agencies nationwide that were awarded a grant from Cribs for Kids to fund an additional 80 cribs to families in need.

Even more important is the chance to inform and educate our community about how a baby should be safely put to sleep. One of our team members, a law enforcement officer, educates on safe sleep in local prenatal classes. Another, a fire department, resolved to distribute safe sleep materials on every ambulance run to a household with an infant. Together we have used the knowledge gained in child death review to prevent infant death. Those numbers are beginning to decline.

I would like to tell a story about the impact of just one child death on prevention efforts in Rock County. The health department has long had a desire to eliminate the practice of rinsing and flushing unused and expired medication into our water supply. Our focus was primarily environmental protection for our groundwater. Our efforts began with special events when citizens could bring unused medication to a location in one of our larger population centers. The health department advocated for a more comprehensive strategy, the installation of drop-off boxes in our communities that could be used whenever it was convenient for the consumer. This strategy, however, came at considerable cost due to the need to co-locate these boxes within local police departments. In 2010 we lost a young teen to prescription drug overdose. This tragedy motivated our communities to move past the barriers of cost and provide a place where unused medications could be safely disposed of at any time. It motivated us at the health department to look beyond environmental impact and see that medications stored in all our homes can, and do, cause early death. Since that tragic death, drop-off locations have been established in all corners of our county. Over 17,000 pounds of unused and expired medications have been removed from households around Rock County since 2006.

Rock County is one of four communities that have one of the highest rates of infant death among African American families in the nation. Our common desire to see every child grow up strong and healthy has forged a new resolve to end health disparities in our communities of color. We have partnered with the Beloit Lifecourse Initiative for Healthy Families to develop strategies to reduce this gap. The child death review team has provided data and statistics to add to that understanding and help target our efforts locally to be sure that what we are doing meets specific needs that are responsive to our community. We will move forward in 2014 to review deaths occurring due to stillbirth and prematurity. Child death review has set the stage to learn even more about prevention in our communities.

Our school districts, juvenile justice systems, human services providers, alcohol and tobacco awareness coalitions, and others, have benefited from the work of the child death review team in supporting strategies for prevention. In our schools the information we have provided regarding traffic fatalities steers our schools to provide information and education about how to stay safe behind the wheel.

Our rural communities have learned ways to increase farm safety and keep young family members safe when working around large equipment and livestock.

No matter our specific disciplines, there is no division surrounding our collective desire to end the death of infants and children. Every death is not preventable, but every child that dies deserves a comprehensive review to ensure we are doing all that we can to make our communities a safe and healthy place in which to grow.

This legislation strengthens and supports the work that we are doing around death review at the local level. I am asking this legislative body to be another partner in the dedicated work of our child death review team. Please support the passage of Assembly Bill 554. I thank you for your time.

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CITY OF PORTAGE

OFFICE OF
CHIEF OF POLICE

117 West Pleasant Street
Portage, Wisconsin 53901
Telephone: (608)742-2174 Fax: (608)742-1175

"Where the North Begins"

Testimony for AB 554

Chairman Krug and members of the committee. Thank you for allowing me this opportunity to testify today. My name is Mark Hahn, I am a Detective Lieutenant with the City of Portage Police Department and Chairperson for the Columbia County Child Death review Team.

Our team in Columbia County was established in 2009. Our team consists of members from Columbia County Sheriff's Department, District Attorney's Office, Medical Examiner's office, Health and Human Services, Public Health officer, mental health from both the public and private sector, school representative, and a physician from a community hospital. We chose to review deaths of persons age 21 and younger. This was done to gain a larger data base that would encompass high school graduates and younger adults age 18 to 21.

My role as Chairperson and as a Law Enforcement representative is to set up and facilitate the meetings, which we hold quarterly. If the case being reviewed is from my department, I bring all the case information to share. If it is from another jurisdiction, we invite them to the meeting or we get reports from them to share at the meeting. All members bring information that they have concerning the people involved in the case being reviewed. After the review of each case, we jointly make recommendations on any changes to agency practice or policies and recommendations to prevent another similar death.

The Columbia County CDR team has made a positive impact on our community. Our prevention work has centered on "safe sleep" and suicide prevention. One of the greatest success stories of our CDR team is that we were able to use the data collected during our review meetings to identify recent trends that suicide was a significant burden in our county. Through the partnerships of the team, we were able to secure sustainable funding from our county board to support suicide awareness activities. A group "Prevent Suicide Columbia County" was formed with other key partners and through these efforts, our hope is that this will result in lower emergency department visits, hospitalizations and deaths.

Since 2008, 8 children younger than age 1 have died due to an unintentional injury. After reviewing an infant death that occurred in an unsafe sleep environment, I realized that our department could do a better job of obtaining more information. This information would not only help in the initial investigation but also in a review to identify risk factors that may have attributed to the infant's death. We were made aware of a form called SUIDI (sudden unexpected infant death). This form is a comprehensive form that asks questions not only about the scene but also past history of the child. Upon reviewing the form we felt that it would be a valuable tool for officers and investigators to use when investigating an infant death. This form was incorporated in our death investigation scene checklist and is used for any infant death. The Columbia County Sheriff's department also implemented the form and we attended the area Chiefs' meeting to encourage them to use it as well. This was well received by the different police agencies in our county.

These are a couple of examples on how our CDR team has been able to make positive recommendations to change policies on investigating children deaths and help create preventative measures in our community to help reduce and prevent children deaths .

Directly relating to my work in Law Enforcement, participating in CDR has resulted in a better understanding of and identifying risk factors with children deaths in our community. We have improved our ability to thoroughly investigate these difficult types of deaths. We have been able to identify recent trends of behavior that may increase the risk of death of children. As an officer, children deaths are the most difficult to investigate and are emotionally draining on everyone including an officer. As difficult as these are, it is very rewarding when you are able to actively take a role in preventing these tragic deaths.

Detective Lieutenant Mark A. Hahn

Timothy E. Corden, MD

I am Tim Corden, I am a critical care pediatrician at Children's Hospital of Wisconsin, faculty at the Injury Research Center at the Medical College of Wisconsin and chair of the Wisconsin state child death review council. I also represent the over 800 members of the Wisconsin chapter of the American Academy of Pediatrics.

I have had an interesting career, almost 25 years as a childhood critical care physician. It has been a privilege to care of children and their families under what many may consider the most stressful of times, the critical illness of a child. The goal in every encounter is to return a child to their family as whole as possible, giving them a chance to get on with their life's work - fulfilling their potential and hopefully enjoying the journey. Fortunately, most of the time care goals are met, unfortunately sometimes not. We also learn a great deal along the way. What brings a child and family to needing care in the first place; can we use what we learn to prevent other children and families from future illness; what "determines" childhood and future adult health; and as a society can we use this understanding of health determinants to optimize our environment and give all kids the best chance for a strong healthy life.

The CDR system uses this concept of learning about local childhood health determinants and risk factors for children in their community, and uses the knowledge to make prevention recommendations and develop evidence-based prevention programing that protects the health of children in their community. It has been exciting to be a part of the WI CDR leadership team over the past 10 years - as you have heard, or will hear the growth of CDR in Wisconsin has been substantial; Wisconsin is now a recognized national leader in CDR development and prevention programing. Most importantly you will hear from local teams - volunteer multidisciplinary groups that are making a difference in their communities, and doing so with few resources. The legislation before you today is policy that will enable and strengthen the CDR process in Wisconsin, and allow Wisconsin to join the 43 other states that have similar policy. The CDR system in our state is a model for the nation, developed with strong partnerships between local and state level public health departments, along with community agencies and academic involvement, but the system is also fragile without enabling legislation. Passing CDR legislation will establish a long lasting solid foundation for the benefits of CDR to continue to grow and keep our volunteer teams running efficiently, improve data quality, recognize local efforts, and most importantly help give Wisconsin children the opportunities afford by having good health.

TESTIMONY FOR AB 554

Good morning Chairman Krug and members of the committee. I consider it an honor to be able to testify here today. My name is Teresa Paulus. I am from Neenah, Wisconsin; a city in Winnebago County about two hours north of Madison.

The Loss of My Child

I am the mother of Brian Jacob Paulus. He was a silly happy three year old who loved soccer, Skittles candy, McDonald's play land, and to run around with little on, but his boots. He was his dads little buddy, his sisters best - friend and my little snuggler. He affectionately called me "doodyhead" and his last words to me were "goodnight farthead". An officer showed up at my door in the middle of the night to tell me Brian fell into a pond at grandpa's cottage. He was scooped up by his Uncle David out of the water and given CPR. He was rushed to the local hospital and then flown to Children's Hospital in Madison. I got to the hospital just in time. There, as I held him close, Brain died in my arms. He died of an unintentional, but preventable injury: brain injury from drowning.

The loss from the death of one child is far reaching. After Brian died, myself and other family members have experienced extreme emotional pain and other mental health challenges I have experienced physical ailments from the stress as well as strained relationships and financial burdens. Brian's sister, Alyssa, born after he died, struggles with the sadness and anger of never having the chance to know her brother. Luckily, my husband and I are still together as the marriage of most parents who have lost a child ends with divorce. The loss of my son extended to my co-workers, who struggled with how to help me and carried the burden of my work when I just didn't have the strength to do it. Community members wanted to help, but were at a loss and could only say: "If there is anything I can do, let me know".

The Purpose of the Child Death Review Team

When my son died, I knew I was going to do something special to make his life and death meaningful. Fortunately, I am a public health nurse and have skills that I could use to help make this happen. In 2009, I initiated the Winnebago County Child Death Review Team along with my co-worker Belinda DeGoey under the guidance of Abbie Collier from Children's Health Alliance of Wisconsin. We review deaths of children aged 0-19.This age group makes up 25% of our population. We focus on injury related deaths.

My role on the Child Death Review Team is coordinator of the team. I identify cases to review, ensure key members are at the meeting and facilitate the meeting. I am involved in data entry as well as lead subcommittees that make recommendations to the community.

At the beginning of each Child Death Review Team meeting, we read out loud our mission statement: Through a comprehensive and multidisciplinary review of child deaths, we will better understand how and why children die and use these findings to take action to prevent other deaths and improve the health and safety of our children.

Our team takes very seriously the confidentially of the information shared. We review the deaths in closed session and sign a confidentiality agreement at each meeting. Sharing of information is vital in order to identify the risk factors and to make appropriate recommendations. Missing information can affect the ability to do these things and thus ultimately prevent keeping children safe and alive.

Our community is supportive of the child death review team as we have representation on our team from a multitude of disciplines: The Coroner, District Attorney, Local Health Care Organizations, Law Enforcement, Emergency Medical Systems, Human Services including Child Protective Services and Behavioral Health, Public Health Departments, Local School Districts, and other community groups such as the Victim Crisis Response Team, Community for Hope(suicide prevention), Parent Connection/Family Services, Children's Hospital Child Advocacy, and Goodwill Industries.

Successes of the Winnebago County Child Death Review Team

Winnebago County Child Death Review Team (CDRT) has been successful in making a number of recommendations to the community as a result of our reviews. Listed are the three main ones:

-In 2010, the CDRT was able to identify that Motor Vehicle Crashes were the number one cause of death in our children. Our team recommended to the community to initiate a Center for Disease Control and Prevention evidence based campaign entitled "Parents Are the Key". This provides parents proven steps and tools to keep teens safe while driving with emphasis on a parent-teen driving contract. Winnebago County Health Department took on the campaign. Over 1500 parents of 10th graders received the contracts. The Winnebago County Health Department has now partnered with Theda Care to do a program that brings teens and parents together from 35 different schools to educate on the consequences of risky behavior and promote safe driving habits. Also, the Health Department has helped initiate a countywide Safe Teen Driving Coalition.

-In 2012, the CDRT realized that suicide was fast becoming the main cause of death in our children. Our team formed a suicide prevention recommendation committee. With other community members, we identified appropriate recommendations based on our data and information from our reviews and shared them with the community. A group housed in the Winnebago County Health Department called Re:TH!NK took on the challenge of youth suicide prevention. As a result, one of our school districts will initiate and fund mental health screening for all 9th graders. Another community group has begun to promote and distribute gun locks.

-The CDRT also assesses follow-up services for grieving parents. In 2013, Our CDRT discovered that there was not an up to date resource list of grief services for parents and that resources were actually scarce and made recommendations related to this to the community. The Winnebago County Health Department is now working on a resource guide of grief resources for the community. Another agency is looking into expanding its services to include grief support specific to parents.

The Benefit of My Role as a Public Health Nurse

Directly related to my work in public health, participating in the CDRT has allowed me to provide important information relevant to a specific death review. I also know how to access statistics that are important to see trends in the health of our youth such as causes of hospitalizations as well as youth risky behavior surveys. As a public health nurse, I have positive relationships with community organizations and its members. I am able to assist to identify the right agency/person to take on a recommendation. I also am able to take an active part in carrying out recommendations. I co-ordinate the Parents Are the Key campaign.

The Value of the Child Death Review Team to a Mother

As a mom who knows the loss of a child, I value the worth of the Child Death Review Team. It is the answer to "If there is anything I can do, let me know". It ultimately prevents other families and communities from going through the devastation I just relayed to you. It keeps our children safe and alive. It allows our children to become healthy productive members of our community.

All of the life support and expert medical care could not save my son. Ultimately, my son's death was preventable. But it is too late to save him. But it is not too late to save other children; to keep them alive. In the words of Dr. Perloff, my child's doctor and former chair of the state CDRT, "A measure of a society's worth is how well it cares for its most vulnerable members. How then can we not treat the loss of even one child as an event to be prevented if at all possible? To do this we must study each child death to learn the lessons contained in the events leading to the death, and find ways to translate these lessons into actions that will prevent future deaths." This is the primary purpose of the Child Death Review Team.

Wood County
WISCONSIN

HEALTH
DEPARTMENT

Susan E. Kunferman
DIRECTOR

12/13/2013

Dear WI Assembly Children and Family Committee,

I'd like to express my strong support for Assembly Bill 554. As a co-chair of the Wood County Child Death Review (CDR) Team, I can personally vouch for how critical our CDR team is to Wood County. Our team has been in existence since 2010. In that time, we've made vast improvements in regards to policy, community education and partner collaboration on various safety topics. I can honestly say, I don't think such progress would have been made without the child death review team.

Assembly Bill 554 is so important to me because I know how instrumental our team has been in Wood County in the implementation of injury prevention programming. Many counties are hitting major road blocks in creating their team, and this legislation would make the process possible for those who are confronting barriers. I feel that every county in Wisconsin should have a child death review team, and this legislation will allow for that to occur.

A major benefit of having the team is that a multidisciplinary group of professionals working in a position to make a difference in preventing these senseless deaths are made aware of them. Without the formal reviews, information in regards to child deaths in the county is informal and inconsistent.

One initiative, based on recommendations by our team that I'd like to discuss further, is our work on safe infant sleep. In 2010, our team reviewed three sleep related infant deaths. For our county, these three very similar deaths were a real hit, and a spike in our typical trend. Our child death review team played a pivotal role in initiating the prevention measures that came from those reviews. We were able to lead several prevention efforts related to safe infant sleep, some of which include:

- Hospital birth center safe infant sleep policies
- Improvements in law enforcement investigation of these deaths through death scene investigation training, doll reenactment training and the use of the nationally recommended SUID investigation form
- Statewide Safe Infant Sleep Summit, presented by internationally renowned Dr. Rachel Moon, targeted to healthcare providers, public health staff, home visitors programs, social workers and child care providers
- Education in the high schools for teen parents and students interested in an early childhood career path
- Safe sleep education to WIC staff
- Distribution of easy to read books with the latest safe infant sleep research to all social workers and licensed child care providers county-wide
- Promotion with partners of the Cribs for Kids program that is available to low income families
- Increased safe sleep education in hospital prenatal classes

In closing, Assembly Bill 554 will give a voice to the children in Wisconsin that have died from preventable deaths. Their story will be able to be told to child death review teams who can make a difference in implementing change to prevent future similar deaths.

420 Dewey Street PO Box 8080 Wisconsin Rapids WI 54495-8080 • Telephone (715)421-8911 • Facsimile (715)421-8962
City Hall Plaza • 630 S. Central Ave, Suite 303 • Marshfield, Wisconsin 54449-4196 •Telephone (715)387-8646

Sincerely,

Tyler Zastava, MPH CHES
Wood County Health Department
Wood County Child Death Review Team Co-Chair

400 Market Street • PO Box 8095 • Wisconsin Rapids, Wisconsin 54495-8095 • Telephone (715)421-8700 • Facsimile (715)421-8775
City Hall Plaza • 630 S. Central Ave, Suite 220 • Marshfield, Wisconsin 54449-4196 •Telephone (715)384-5345 • Facsimile (715)384-4602

RACINE COUNTY HUMAN SERVICES DEPARTMENT

December 13, 2013

Re: Consideration of a State-Wide Child Death Review Team

To Whom It May Concern:

In 2009, with a grant and technical assistance from the Children's Health Alliance of Wisconsin, Racine County established the Racine County Child Death Review Team (RCCDRT). The primary focus of our team has been to gain a better understanding of why Racine County children die and how to most effectively reduce preventable childhood deaths. Through the use of "Keeping Kids Alive" team guidelines, our multidisciplinary team reviews all intentional and unintentional child deaths, so that our community can be better equipped to prevent such deaths in the future.

Our team consists of members of the Racine County Human Services (as well as the Child Protective Services), the three Health Departments located in Racine, the District Attorney's Office, Law Enforcement, local Fire Department Officials, staff from the Racine County Child Advocacy Center, the Racine County Medical Examiner, a local pediatrician, and a community based child safety expert. These diverse agencies have all determined that preventing child deaths in this community is a priority and all are committed to this effort.

As stated earlier, the RCCDRT reviews intentional child deaths. This has allowed our child welfare team to identify trends in who is harming our children. Of note, RCCDRT recently reviewed cases where boyfriends of moms with toddlers of potty training age have killed said toddlers. Using this information we were able to approach the Racine County Home Visiting Network to encourage teaching, modeling and increased discussions regarding this issue with the families they serve. We hope that this will have a positive impact on families and the lives of children.

The RCCDRT also reviews unintentional deaths. The team has identified co-sleeping as linked to some infant deaths in our community. The RCCDRT was able to partner with existing organizations, such as our Fetal Infant Mortality Review team and the Greater Racine Collaborative for Healthy Births, to increase awareness and utilization of the Cribs for Kids program. This program not only provides Pack 'n Plays for families but provides training and information to parents on the dangers of co-sleeping and of putting baby on its back to sleep. Through the efforts of the team, this training has become routine and systematic for all of our community partners and home visiting programs. Additionally, through the efforts of team members, funding was secured to allow Cribs for Kids to continue to function.

One of RCCDRT's largest prevention efforts to date followed several years of childhood drowning deaths at our public beach. The team was able to work with the City of Racine to increase precautions in both the identified swimming areas as well as those areas that are off limits. The City of Racine was able to put together a comprehensive plan that included:

1717 Taylor Avenue Racine, WI 53403-2497 Tel: 262/638-6353 Fax: 262/638-6369
209 North Main Street Burlington, WI 53105-1576 Tel: 262/767-2900 Fax: 262/767-2949

increased signage and postings, additional buoys and flags for increased visibility, increased responsibility for Lifeguard rotations, purchase and use of a jet ski to provide faster response times, addition of a second Head Lifeguard position, and the creation of an "Open Water Safety Course" that would educate the public on the dangers of open water.

A small increase in the number of youth suicide has prompted CDRT members to work collaboratively with a local group to increase access to mental health services for youth, early identification of mental health issues amongst children and the need for prompt treatment. This has also expanded to working with other agencies on issues involving the use of heroin as well as prescription drug abuse. Racine County now has six Drug Drop Boxes that the community can use to safely dispose of old prescription medications. Additionally we have three "Medication Take Back" days throughout the year to assist in this effort.

Following the death of four children and youth in house fires, the fire department team members alerted us to the fact the homes had no working smoke detectors. The RCCDRT has identified this as an issue and plans to work toward securing funding to provide free smoke detectors to families in need.

What all these efforts show is that Racine County, like other counties, values the lives of our children. A statewide Child Death Review Team effort allows each of us to determine what risks and safety issues exist in our communities and provides us an opportunity to make a positive impact. It also gives us the opportunity to identify issues that cross county lines so that we can address issues collaboratively across the state. Given the diversity of team members, it is obvious that child safety and preventing child deaths is a priority in Racine County. This priority should be State-wide. Protecting our most precious and our vulnerable members should be at the fore front of your discussion today.

Feel free to contact me with any questions or concerns.

Sincerely,

Kerry Milkie

Kerry Milkie, Manager
Youth and Family Division
Racine County Human Services Department
1717 Taylor Avenue
Racine WI 53403
262-638-6511
kerry.milkie@goracine.org

District Attorney
Brad D. Schimel

Deputy District Attorneys
Stephen J. Centinario, Jr.
Debra L. Blasius
Timothy F. Westphal

Office Services Coordinator
Dani M. Danielski

Victim/Witness Program
Jennifer S. Dunn, Coord.

Secretary Supervisor
Julie A. Delain

Waukesha COUNTY

OFFICE OF DISTRICT ATTORNEY

Assistant District Attorneys
Barbara A. Michaels
Kevin M. Osborne
Pablo Galaviz, Jr.
Susan L. Opper
Ted S. Szczupakiewicz
Lesli S. Boese
Michele W. Hulgaard
Mary C. Brejcha
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Timothy Suha
Jayne Davis Dewire
Andrea M. Will
Lindsey H. Hirt
Brian J. Juech

December 17, 2013

RE: Support for 2013 AB 554

Dear Chairman Krug and Committee Members:
I am writing in support 2013 AB 554, which would create a statewide program to review child deaths and provide a penalty for disclosure of confidential information.

Waukesha County has had a vigorous Child Death Review Team for over 13 years. The CDRT is co-chaired by the District Attorney and Medical Examiner and meets quarterly to critically review all child deaths reported to the Medical Examiner in our county. The meetings are attended by representatives from: the Waukesha County departments of Public Health, Human Services and Child Protection; Children's Hospital of Wisconsin; our child advocacy center; several non-profit organizations whose missions revolve around child safety; Children's Health Alliance; hospital trauma coordinators; pediatricians; a pediatric pathologist; the Consumer Product Safety Commission; and multiple county law enforcement agencies.

Our CDRT has several important goals. We work to improve investigations into child deaths through information sharing and critical peer review of investigations to identify challenges and develop best practices for future responses to child deaths.

As a result of the CDRT, we have better sharing of information between different agencies and better communication and interaction in investigations. Due to the stronger relationships we have developed through our CDRT, we are able to sincerely ask what could have been done better without the usual barriers to open collaboration.

A major accomplishment has been the development of a comprehensive Child Death Investigation Tool. This valuable resource was the result of a collaborative effort to critically examine county-wide child deaths over many years. We were able to identify lessons learned and determine the best practices for what are perhaps some of the most difficult investigations to conduct. This has led to dramatic improvements in the quality of investigations in our county and makes us better able to determine the truth.

515 West Moreland Boulevard, Room CG-72
Waukesha, Wisconsin 53188-2486
Phone: (262) 548-7076

Other goals of the team are to identify preventable deaths and develop strategies to reduce preventable deaths. The work of our team has resulted in 3 child wellness fairs, more vigorous enforcement of construction fencing codes, enactment of a new municipal ordinance relating to pool locks, and development of a county suicide prevention team.

I hope this Committee will approve AB 554 so that those on the front lines of child safety and protection can work collaboratively to develop the best ways to keep our children safe. The terms of AB 554 will support the work being done by existing CDRTs and will encourage the development of other teams at the state and regional levels that will be able to collaborate to make all of Wisconsin a safer and healthier place for children.

Very truly yours,

Brad Schimel
District Attorney

515 West Moreland Boulevard, Room CG-72
Waukesha, Wisconsin 53188-2486
Phone: (262) 548-7076

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Written Testimony of Raymond Georgen, M.D.

Trauma Center Medical Director
Theda Clark Medical Center
A ThedaCare Hospital
Neenah, Wisconsin

Submitted to the Wisconsin State Assembly Committee on Children and Families
The Honorable Scott Krug, Chair
Public Hearing of December 18, 2013, 9 a.m.

My name is Dr. Ray Georgen. I am a trauma surgeon and the Trauma Medical Director at Theda Clark Medical Center in Neenah. The Trauma Center at Theda Clark Medical Center is the longest continuously verified Level II trauma center in Northeast Wisconsin. On behalf of myself and our president and CEO, Dean Gruner, who is a long-time advocate of traumatic injury prevention, I wish to endorse Assembly Bill 554, which would establish a child death review program within the Department of Health Services.

My three decades of experience in trauma help me know that when critical, complex decisions need to be made quickly, even immediately, there's no time to ponder, discuss, or second-guess. With a collaborative and cooperative attitude a trauma team comes together to save lives. There is really only one way to solve problems effectively: **teamwork**.

It is the teamwork of the Child Death Review Teams (CDRT) that offers an opportunity to improve the health and safety of the children of Wisconsin. Utilizing a professional process aimed at seeking to understand risk factors surrounding the death of a child, the CDRT:

- Accesses preventability,
- Compiles county/regional data,
- Formulates recommendations,
- Fosters communication/collaboration among government, professional and advocacy organizations.

A CRD team is often comprised of:

- County medical examiner or coroner
- Child Protective Services
- Local public health
- Emergency medical services
- Community mental health
- School districts
- Local law enforcement
- District attorney's office
- Pediatrician
- Community hospital
- Family court

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At Theda Clark, we believe prevention is a vaccine against injury. Our dedicated Injury Prevention Coordinator is a member of the Outagamie and Winnebago CDR teams, and works closely with many local, regional and state-wide organizations to offer evidence-based injury prevention. We are tightly connected not only in our communities, but throughout the state.

We especially hope you will gain a strong sense of our passion and collaboration around the issue of injury prevention, and the positive outcomes of that work both within our organizations but also within our communities. At Theda Clark and within our larger healthcare system, ThedaCare, we have worked tirelessly to deliver effective injury prevention education. Since 1998, we have reached more than 30,000 teens with our P.A.R.T.Y. (Prevent Alcohol and Risk related Trauma in Youth) at an annual program held at the Performing Arts Center (PAC) in Appleton. It is a reality education program for high school sophomore students. The half-day program aims to empower tenth-grade students from area schools to make safe choices by shedding light on the dangers of risk-taking behaviors, their often life-changing outcomes, and the importance of personal responsibility.

The P.A.R.T.Y. at the PAC program is a collaborative effort between the Theda Clark Medical Center Foundation, the Trauma Center at Theda Clark Medical Center, local schools, fire and police departments, healthcare workers, physician groups, and survivors who volunteer to share their stories. These groups join together to provide a powerful message with the goal of saving lives and preventing injury to the youth in our communities.

Collaboration or teamwork is the key to so many successful prevention programs. Our CDRT prevention work is tempered by the barriers that still exist in access to information and relevant records needed to conduct reviews. This includes vital, health, mental health, child welfare, law enforcement (exceptions for pending investigations), and school records. The legislation would not only resolve the barriers to access information, but would protect the process and confidential information shared at the CDR team meetings.

At ThedaCare, we are always looking for ways to improve our care delivery so patients are healthier. This legislation provides a similar opportunity for the state and especially for local CDR teams as we together work to eliminate child deaths. The specific provisions of the bill address the key areas that need attention, and provide clear, helpful steps for allowing local CDR teams to do their work more effectively. Importantly, these steps do not compromise patient confidentiality.

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Wisconsin is one of seven states without comprehensive CDR legislation, and the current bill will affirm the already existing CDR system – which is a strong foundation for this work. It does not need to be remade, only enhanced to further improve our efforts in preventing child deaths in Wisconsin.

Thank you for your willingness to address ways to prevent child deaths in our state by **allowing prevention efforts to flourish. And thank you for your attention to ThedaCare's** support of AB 554.

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