





What we will share

- History of Child Death Review (CDR) and cause for concern
- Death review process and team membership
- Value and use of data collection
- Actions the Study Council & Legislature can take







Purpose of death review

"Nothing compares to the death of a child, in the sadness, the sense of loss, the unfulfilled promise. It reverses the natural order, and challenges our belief in a universal good."

- William H. Perloff, MD



What is Child Death Review?

- County or regional multidisciplinary team
- Professional process
- Opportunity to improve the health and safety of children

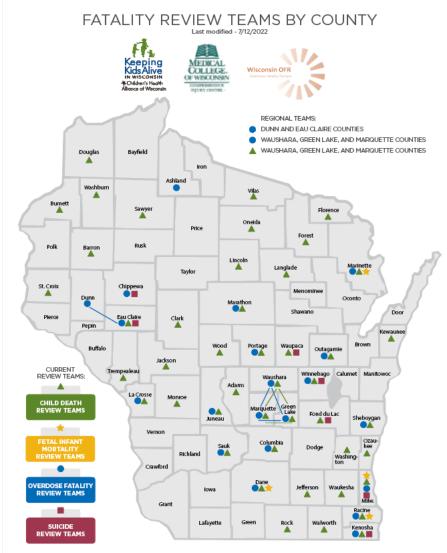




How a review is conducted

- County or multi-county team
- Focus on unexpected deaths
- Multidisciplinary team members
- Closed and confidential meetings





Fatality review efforts are supported through Wisconsin Department of Health Services, Wisconsin Department of Justice, and Wisconsin Partnership Program at the Medical College of Wisconsin.



Child Death Review Council

- Review statewide data
- Advise the state legislature and agencies on policy and practices
- Educate public and recommend prevention actions
- Foster development of local Child Death Review teams
- Provide training resources
- Review SUID deaths for counties that do not have Child Death Review teams



Data collection

- Who enters data
- What data are collected
- Challenges



Use of data

- Conduct annual reviews of aggregate data
- Discuss trends and/or community needs
- Identify partners needed to develop, execute and lead the activity
- Evaluate outcomes
- Disseminate findings









Challenges

- Capacity of team members and data collection
- Uniformity in reviews and access to records
- Local county resources



Proposed legislative action





"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?"

- William H. Perloff, MD

Questions and thank you

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