Luther S. Olsen
State Senator
14th District

Testimony in favor of SB 436
Wednesday, Feb. 12, 2014
Senate Committee on Transportation, Public Safety, and Veterans and Military Affairs

Thank you Chairman Petrowski and committee members for holding a hearing on Senate Bill 436. 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.

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Amy Loudenbeck
REPRESENTING WISCONSIN'S 31ST ASSEMBLY DISTRICT

Senate Committee on Transportation, Public Safety, and Veteran and Military Affairs
Public Hearing on Senate Bill 436
February 12, 2014

Thank you Chairman Petrowski and committee members for the opportunity to provide testimony to the Senate Committee on Transportation, Public Safety, and Veteran and Military Affairs in support of Senate Bill 436 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 554 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 554 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.

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Wood County
WISCONSIN

HEALTH
DEPARTMENT

Susan E. Kunferman
DIRECTOR

2/10/2014

Dear Chairman Petrowski and Members of the Transportation, Public Safety, and Veterans and Military Affairs Committee,

I'd like to express my strong support for SB 436-AB554. 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.

SB 436-AB554 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 teen driving safety. Since our team began, we have reviewed a handful of teen driving deaths that very much could have been prevented. A county-wide assessment proved that more efforts were needed in this area. Equipped with the CDR data, we have been able to engage committed partners to the cause. We are collaborating with law enforcement, driver education instructors, schools, safety/youth coalitions, and most importantly, teens to work on spreading a consistent message county-wide on the dangers of distracted driving. We have been able to initiate several steps towards prevention efforts, which include:

- Commitment from teens and professionals from at least three school districts, and we are working on partnering with a few more that are interested in joining the campaign
- Wrote two grants, one has been awarded, and one is in the review process
- Created a toolkit for a distracted driving week in April to offer to schools as a starting point in their efforts
- Coordinating with AT&T to bring their distracted driving presentation to high schools in Wood County
- Obtained driving simulators through partners and are working on getting them in the schools
- A student is working with Senator Julie Lassa on declaring a day in April, "Distracted Driving Awareness Day"
- Four teens from a neighboring county have volunteered to come into the schools and present peer to peer to help spread the message
- Held golf cart distracted driving courses at Marshfield High School and the Marshfield fair

In closing, SB 436-AB554 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.

Sincerely,

Tyler Zastava

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

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"Where the North Begins"

Testimony for SB 436

Chairman Petrowski 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 at the scene of an infant death. We were made aware of a form called SUIDI (sudden unexpected infant death). This form is a comprehensive form that guides officers and investigators on questions to ask, 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. The in depth information gained from asking the questions on the form is extremely beneficial in conducting a thorough investigation of an infant death. This same information also helps later in a death review in identifying risk factors that may have attributed to the infant's 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 to improve 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

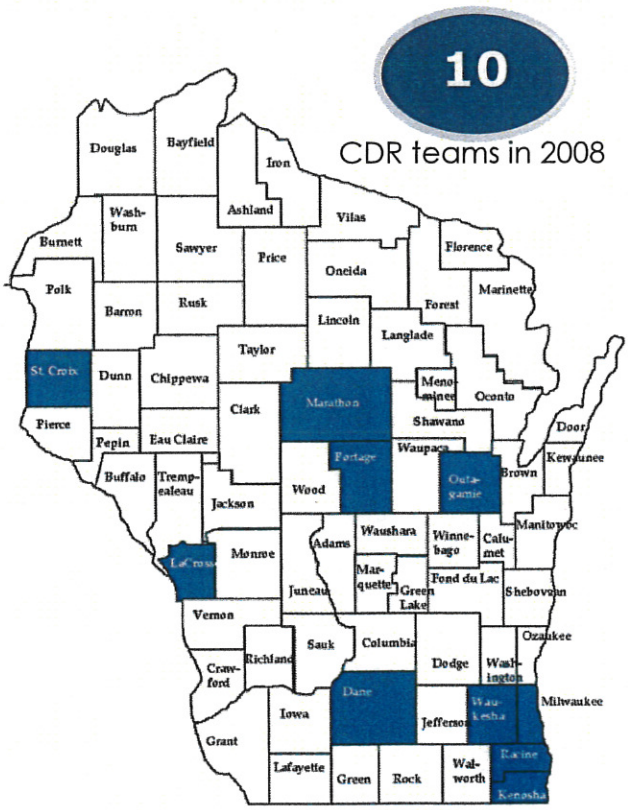
Testimony on SB 436

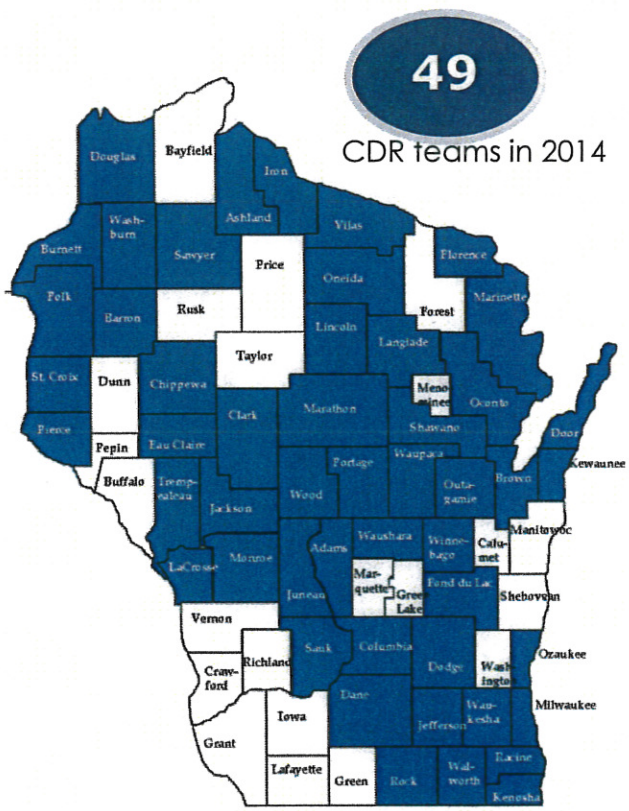
About the Alliance

- Good morning Chairman Petrowski 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.





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- 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.

Children's Health Alliance of Wisconsin

Celebrating 20 years as Wisconsin's voice for children's health.

The following organizations and associations have signed on to support AB-554/SB-436, which is legislation recognizing the Wisconsin child death review system.

- American Family Children's Hospital
- Children's Health Alliance of Wisconsin
- Children's Hospital of Wisconsin
- Columbia St. Mary's Hospital
- Medical College of Wisconsin
- Medical Society of Wisconsin
- Ministry Healthcare
- Minstiry St. Joseph's Children's Hospital
- ThedaCare
- University of Wisconsin Hospitals and Health System
- Wisconsin Association of Local Health Departments and Boards
- Wisconsin Chapter of the American Academy of Pediatrics
- Wisconsin Coroner and Medical Examiner Association
- Wisconsin Counties Association
- Wisconsin Department of Health Services
- Wisconsin Department of Justice
- Wisconsin Public Health Association

For additional information please contact Abby Collier at 414-292-4016 ajcollier@chw.org or Karen Ordinans at 414-292-4004 or kordinans@chw.org.

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