Testimony before the Senate Committee
September 20, 2023
Senate Bill 177

Good morning, Mr. Chairman and members of the Committee,

My name is Matt Crespin. I am the executive director of Children's Health Alliance of Wisconsin, affiliated with Children's Wisconsin, who also supports this proposed legislation and has registered in support. I am here today because of my passion for this topic, and my organization's history of being intimately involved in developing the child fatality review system that exists in Wisconsin today.

I want to recognize the detailed work of the Legislative Council Study Committee on Uniform Death Reporting Standards, chaired by Senator Ballweg. On behalf of the Alliance, I want to express our support for the recommendations before you today outlined in Senate Bill 177.

As stated by Dr. William Perloff, the first chair of the Wisconsin Child Death Review State Advisory Council, and revered pediatrician, *"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."* When a child dies, we owe that child a collective and deliberate conversation to better understand what happened, why, and how we can prevent it from happening to another child.

Nearly 20 years ago the Department of Health Services (DHS) approached the Alliance and asked us to evaluate child fatality review programs in other states and create a plan for developing a comprehensive review program in Wisconsin that focused on prevention. Wisconsin was one of a handful of states without any review system. What we built had to make sense for our unique structure of 72 counties, with a mix of medical examiners and coroners, and strong local public health, social service and law enforcement systems.

The Alliance, in collaboration with DHS developed team protocols and training materials used by teams – better known as *Keeping Kids Alive in Wisconsin*. The Wisconsin model is based on recommendations developed by the National Center for Fatality Review and Prevention.

When we began there were only a few loosely organized review teams in our state. Today, there are 40 counties with formal organized fatality review teams. Unfortunately, however, this is down from 55 teams pre-COVID.

Child Fatality Review teams exist to better understand how and why children die. They are multidisciplinary teams that meet, generally monthly or quarterly at the county level to discuss the risk factors and circumstances surrounding unexpected child deaths. Information is shared confidentially, and used to look at trends, gaps and needs. Prevention strategies are recommended by the team and are often implemented by a multitude of community partners with the intent to prevent other child deaths. The teams create collaboration across local agencies, and they allow for a greater understanding of each agency's functions and role.

Vital Statistics can tell us the cause “what the child died from” and manner “How the child died.” But we need to better understand the why if we are going to prevent future deaths. For example, if there was a motor vehicle crash and the death certificate states cause of death as “blunt force trauma” and manner as “accident,” we need to know more about the risk factors and circumstances present. Was the driver impaired? Were there icy roads or poor signage? Were the passengers properly restrained? As review team members come together, this is the information that is brought to light and leads to collaboration across agencies.

I would like to share several real examples of prevention efforts that have resulted from team reviews and data collection.

After reviewing multiple drownings, several counties implemented:

- Placing life jacket loaner stations near bodies of water that were open utilized by the public.
- Offering free swim lessons to children at community pools.
- Identifying unsupervised water access points and placing warning signs of dangers to the public.
- Incorporating water safety messaging in school communications and social media.
- Conducting listening sessions to solicit ideas from parents and children about how to raise awareness and share unique, creative ways to provide water safety education.

Through team reviews of car crashes a community recognized an increase in impaired drivers. This prompted partners to create a cost-effective and hands on learning experience. Yellow tape simulating road lines were applied to the school hallway and students attempted to walk and stay within the lines with eyewear that mimicked that of an impaired driver. Students were recorded and able to observe the outcome. Many were surprised to learn they performed more poorly than they thought.

Other activities included raising awareness about adhering to age-appropriate car seats, seat belts, and safe transportation for children and youth with special healthcare needs. And, educating new drivers about how inclement weather and other hazardous road conditions can contribute to motor vehicle crashes.

It was the work of review teams that led to a statewide infant safe sleep initiative. Data show more than 50 Wisconsin infants die each year with unsafe sleep risk factors present.

- Community and health professionals work together to raise awareness and educate families on the best and safest sleep practices, and are providing resources like Pack N Plays and visual educational materials.
- The Alliance created training materials for counties and agencies to use as partners are working together to promote a uniform and consistent safe sleep message following the American Academy of Pediatrics Safe Sleep recommendations.

Review teams have also improved the understanding and communication between agencies. For example:

- Sheriffs' departments and other local law enforcement have modified death investigation protocols to capture important information on risk factors and circumstances.
- Law enforcement and hospital emergency department staff serving on a review team created a new and improved protocol for contacting parents after their child's death.
- As teams recognize the importance of providing support to families and professionals after a child death, many teams created grief support guides that explain what an autopsy report is; how to prepare for the funeral, and where to go for support for mental health needs that are sometimes brought on after a sudden loss.
- Other resources have been developed to educate professionals, funeral homes, medical examiners and coroners, first responders and others about how to support families grieving a child loss.

As part of the Alliance's Maternal Child Health Title V Contract with DHS, the Alliance continues to provide technical support to the local teams. This includes training and help in creating a team, ongoing guidance on the review of cases, data entry support, and prevention strategy support.

You may be wondering; if we've made great progress under the current system, why would we need state legislation? While we have made great progress, there also have been great challenges. We have 72 Corporation Counsels at the county level that interpret language differently. We have staff change and turnover at the local level and staff come with different levels of knowledge. Most importantly, over the years, we have had many local partners ask for clarity to be provided within one single state statute, rather than trying to cobble together the existing statutes which lends itself to differing interpretations and confusion.

The proposed legislation before you reflects current practices. Everything contained in the proposal is taking place among teams – but inconsistently. Passage of legislation will provide clarity and uniformity across Wisconsin. It will recognize established review teams and clearly define the team purpose and structure, while promoting prevention.

I am happy to provide additional information or answer any questions you may have. Your support of Senate Bill 177 would be greatly appreciated.

Thank you

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