November 27, 2007

Senator Jim Sullivan, Co-Chair
Joint Legislative Audit Committee
P.O. Box 7882
Madison, WI 53707-7882

Representative Suzanne Jeskewitz, Co-Chair
Joint Legislative Audit Committee
P.O. Box 8952
Madison, WI 53708-8952

Dear Senator Sullivan, Representative Jeskewitz and members of the Legislative Audit Committee:

Re: Standards in child death review

At the September 25, 2007 Legislative Audit Hearing, several questions were asked about standards for child death review.

Kids Matter submitted a letter during the Legislative Audit Hearing that mentioned two standards for case review including national child death review standards and the federal child and family service reviews. We received a letter dated September 26, 2007 requesting that we provide additional information about child death review standards to the Legislative Audit Committee.

National child death review standards

There are two nationally funded centers to promote and support the development of child death review standards. The National MCH (Maternal and Child Health) Center for Child Death Review is based in Michigan, and has developed a series of standards and tools to help states develop effective child death review teams. Child death review teams have the broad purpose of identifying risk factors that may contribute to child deaths from a public health perspective and for stimulating action on the part of states and local communities to prevent further child deaths. In part, Michigan was selected for the National Center due to its model child death review practices. This center is funded by Maternal and Child Health funds.

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The National Center on Child Fatality Review is based in California, and also provides technical support and guidance to promote establishment of child death review processes. This center provides technical support related to "cutting edge issues" such as suicide review and prevention, domestic violence fatality review, severe injury review and prevention, and grief and mourning. This center was started with funding from the Office of Juvenile Justice and Delinquency Prevention (OJJDP).

The centers share a commitment to a public health approach to child death review. We are including manuals describing how to set up an effective Child Death Review Team from both centers. The information is included in Appendix A.

Wisconsin lacks legislation supporting child death review
Currently, Wisconsin is one of only three states that do not have legislation supporting a child death review process. The Wisconsin Department of Health and Family Services has contracted with the Children's Health Alliance of Wisconsin to promote child death review standards in collaboration with the Wisconsin Child Fatality Review Team.

This collaborative effort has identified the limits facing Wisconsin children due to this lack of a child death review process:

- Wisconsin does not have a standardized procedure for in-depth review of child deaths, ***including homicides due to abuse and neglect***.
- Reports generated by the state on child deaths are based almost solely on information from death certificates; thus any information on risks leading to those deaths is limited.
- Wisconsin does not have a comprehensive system for collecting information on state and local agency involvement with children and their families prior to or after child deaths.
- Many child deaths are not examined from the perspective of preventability. [1]

The current approach to death review is fragmented and inconsistent. Lack of coordinated death review prevents timely observation of risk factors and prevents coordinated responses.

There are several teams and processes that might review a child fatality, or a child fatality within a child welfare system. For example, there is a Chapter 58 review process for children who die while in institutional care. The Medical Examiner or Coroner reviews suspicious child deaths in many counties. Independent Review Teams may be established by the Department of Health and Family Services when children die while

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[1] Source: "Keeping Kids Alive: Wisconsin Child Death Review Team Guidelines" is attached, p. 2. (Draft copy) (emphasis added)

receiving child protective services. There is an infant death review in the public health commissioner's office in Milwaukee. The Child Abuse Review Team or "CART team" is a multi-disciplinary review of certain fatalities within the Bureau of Milwaukee Child Welfare. There is a Wisconsin Child Fatality Review Team in the Department of Justice that reviews unexpected child deaths identified by local coroners and medical examiners. The Milwaukee Police Department has a new Homicide Commission that has been reviewing adult homicides, and that may begin reviewing child homicides. This list is not comprehensive, and processes vary from county to county. The fact that a child fatality is reviewed in one system does not mean that the information regarding that death will be shared with other systems.

Not only are there multiple possible reviews depending on how a child died and whether or not the child was in institutional care, a child and family may pass through multiple counties while receiving services. There is no consistent pattern regarding whether a death review takes place in the county in which a child welfare case originated, or the county in which the child died. There are no standard child death investigation protocols. The lack of consistent procedures and policies has serious implications for the effectiveness of a review.

Child death reviews focus on prevention. According to Dr. William Perloff, Chair, Wisconsin Death Review Team and proponent of a coordinated child death review process, there are approximately 300 neonatal deaths in Wisconsin annually (deaths occurring in the first 28 days of a child's life). From ages one to 17 years, unintentional injuries are responsible for half of child deaths, with suicide and homicide accounting for another 18 percent. Many of these deaths are preventable. The United States ranks 36th in infant mortality – a close ranking to South Korea. Child death reviews should help us improve these numbers. For example, if Wisconsin had a death review, it might find SIDS deaths at daycare centers and could educate daycare staff in the "back-to-sleep" campaign. A handout from Dr. Perloff entitled "Child Death Review in Wisconsin: Rationale, Goals and Progress" dated May 15, 2007 is attached.

Child death review may also be helpful in reducing child fatalities due to abuse or neglect. The remainder of this letter will be focused on how coordinated child death review can help improve child welfare practice and prevent child deaths due to abuse and neglect.

Child Death Review May Help Reduce Child Deaths in Institutional Care

Seven year old Angelika Arndt, a child under the jurisdiction of the Bureau of Milwaukee Child Welfare, died on May 26, 2006 due to an improper control hold at Northwest Counseling and Guidance Clinic in Rice Lake, WI. A 200+ pound man who had not been trained in proper restraint sat on 56 pound Angie face-down for an hour, compressing her chest and causing her to suffocate. Angie's death received a "Chapter 58" review as she died in institutional care. Although she was under the jurisdiction of BMCW at the time, the local child death review teams did not review her death.

Northwest Counseling and Guidance Clinic was later closed due to its improper use of restraint and inability to implement corrective actions. The clinic had several complaints filed against it at the time of Angie's death.

Since Angie's death in 2006, at least two other BMCW children have died in institutional care. In November of 2006, Sherrona Stedman committed suicide at St. Rose in Milwaukee. The staff at St. Rose were not trained in suicide prevention although state licensing regulations *require* that staff have such training. St. Rose has been required to implement a corrective action plan. In March of 2007, Elizabeth Collins died as a resident of Willowglen Academy. Elizabeth had a seizure disorder and refused to take life-sustaining medication. Willowglen did not require that Elizabeth take the medication or refer her to a doctor. Elizabeth died due to her untreated seizure disorder.

In less than 12 months, three BMCW youths died in institutional care. None of the institutions were in compliance with State regulations and policies that would have prevented the deaths of these children. However, there has been no comprehensive inquiry or review of agency certifications to make sure that other agencies are in compliance. Due to the poor state of fatality review, it is unlikely that any of the death reviewing committees or agencies have even noticed the high rate of death among BMCW children in institutional care.

St. Rose and Willowglen are well-known local care providers. If they are having difficulties maintaining consistent policies regarding the administration of life-saving medications and training staff in suicide prevention as required by state licensing authorities, then it is quite likely that other agencies are facing similar challenges.

Further, we do not currently have data regarding deaths of children from other counties in institutional care, though we have requested this data. This problem may be limited to BMCW youth, or may include other foster youth from other counties.

A child death review would notice patterns of preventable deaths in institutional care, and be able to alert appropriate authorities about changes in licensing and certification, or practice improvements that may be necessary to prevent child death.

Instead, these children's deaths have gone largely unnoticed because there is not a single coordinated process to take notice of their deaths.

Child Death Review May Help Prevent Infant and Toddler Deaths

Since May of 2007, at least eight infants and toddlers have died while in BMCW custody or while the reports of their abuse were being investigated by BMCW. (A ninth infant died of congenital birth defects and is not included as his/her death was not preventable.) Autopsy reports are still being completed for most of these children. It is possible that this is an unusual coincidence, and that there have been eight natural deaths of infants and toddlers known to BMCW in less than eight months. However, it is also possible that some of these deaths may be preventable – perhaps by ensuring safe sleep conditions or appropriate medical care. As things stand today, however, there are no consistent death review procedures or processes that would even take notice of this unlikely cluster of

infant and toddler deaths to ask for a review or investigation. A comprehensive child death review would take notice of this cluster of infant and toddler deaths, and could review these deaths within the context of overall infant and toddler deaths in Wisconsin. It may be that this cluster of infant and toddler deaths reflects a larger problem relating to inadequate sleeping conditions or medical care for infants and toddlers. As it stands, we are left to simply count up the deaths without adequate information about lessons to be learned or applied to preventing other deaths.

Child Death Review May Help Prevent Starvation Deaths and Deaths of Children Whose Parents Are Receiving Mental Health Services

In Milwaukee County, at least three infants and toddlers have starved to death in recent years. In 2004, Jatavius McKillon starved to death after numerous reports of abuse and neglect to BMCW. In 2006, Layunnia Cole starved to death while her family received ongoing case management from BMCW. In August, 2007, two year-old Fred Vaughn-O'Neal starved to death in the care of his mother who had known mental health problems, had prior BMCW referrals, and was supposed to be receiving twice weekly home visits from the Social Development Commission. In September of 2007, an eighteen-month old baby nearly died of hypothermia and starvation. The child was in the 30th percentile for body weight at six months, and in the 1st percentile for body weight when it took paramedics 21 minutes of CPR to revive him. On October 26th, 5 month old Will Robert Johnson died during a four-hour unsupervised visit to his mentally ill mother. His mother reportedly, "sent him to god."

It is extremely rare for a child to die of starvation. It is extremely rare for a child to be killed by a parent with mental health issues. Yet, Milwaukee County is experiencing both problems.

Without suitable multi-systemic child death review, it will be difficult to prevent future deaths. For example, Fred Vaughn-O'Neal's death was not reviewed by any of the homicide or child death teams even though he died of dehydration while receiving twice weekly home visits. No connections were made between two very young children dying in the care of mothers receiving mental health services, even though the children died within three months of each other (One death in August, 2007, the other in October, 2007). Due to the fact that Fred's death was not reviewed, it is not possible to tell if there is an issue of lack of communication between local mental health and child welfare providers. According to multiple news reports, Fred's mother was smoking the yellow pages and refusing all mental health treatment, but the mother's case managers did not make referrals to child welfare authorities. In Will Robert Johnson's case, his mother was given unsupervised visits even though she had lost custody of Will and did not have a completed psychiatric evaluation, despite her lengthy mental health history.

Wisconsin's lack of an adequate child death review process means that such problems cannot be identified or addressed. Other states have developed model programs to support parents with mental illness, to evaluate when an illness is interfering with parenting (treated mental illness most often does not present safety risks), and to develop standard risk assessments and safety plans for infants with mentally ill parents.

While Layunnia Cole's death received a comprehensive review, her death was treated as an isolated case of starvation and recommendations were made for systemic improvements based on that single case review. While many solid recommendations were made, the starvation death did not occur in isolation, and the fact that further deaths are taking place due to starvation indicate a need for further improvement.

Child Death Review May Help Prevent Abuse and Neglect Deaths of Children Receiving Supervision from Multiple Jurisdictions

One challenge in child protection is that families often choose to avoid court supervision or social services from one county simply by moving to another county, or from state to state. It is not uncommon for a family to have engaged services in three or more counties within a year. However, it is often difficult for three or more counties to coordinate services.

Three year old Alysha Adlam died on May 13, 2006 in Milwaukee County due to child abuse. At the time of her death, Alysha Adlam was under courtesy supervision of BMCW in Milwaukee. Her family was also receiving supervision and/or services from Dodge County and Fond du Lac County. The family's child welfare case originated in Fond du Lac County.

Although Alysha died in Milwaukee of injuries sustained in Milwaukee, the record review and on-site interviews for the Department of Health and Family Services Independent Review took place in Fond du Lac County, with a follow-up interview conducted in Milwaukee. No review was conducted by the multidisciplinary CART team in Milwaukee. The extensive Milwaukee Police Department record on the family was not included in the Independent Review that took place in Fond du Lac County. Alysha's death was not included in a homicide review. There were many concerns raised locally about multiple calls to the Milwaukee Police Department and inconsistent screening of child welfare referrals among the various counties and agencies. A comprehensive review would include local police departments with the health care and service providers who had multiple interactions with the family and were involved in documenting the injuries of Alysha and her siblings' injuries over a period of years. This did not happen.

Even without the additional information available from Milwaukee County, the Department of Health and Family Services Independent Report states, "The dynamics of the case indicate that a transfer of jurisdiction may have been the appropriate strategy to use when the family moved to Milwaukee. However, there are no statutes or policies that require Wisconsin CPS agencies to transfer jurisdiction to another county."[2] The report recommends the DCFS develop best practice guidelines for local agencies regarding change of venue.

Recommendations relating to improved safety practices for children and families moving from county to county are made regularly. The Department of Health and Family Service's Independent Review of the death of two year old Cristian Cisneros in 2003 makes similar recommendations relating to transfer of jurisdiction and best practice

[2] Report p. 14.

guidelines when multiple counties are involved with a single family, as have other death reviews. However, as there is no death review process to take note of the frequency with which children are impacted by disconnects in services among counties, or to advocate for transfers of jurisdiction, the same patterns are repeated from year to year and from fatality to fatality.

Child Death Review Reports Are a Training Tools for Prevention

Most states with child death reviews develop written reports that are training tools for improving child health and child welfare practices.

For example, one state identified a high number of child deaths due to unmanaged asthma, particularly among foster children. The child protection system developed an asthma management protocol that dramatically reduced asthma-related deaths in children.

Child death reports are used in trainings for front-line staff from police officers to child protection staff to mental health staff and hospital emergency room and social work staff. Death reports are often able to show how first responders can assess crisis situations to avoid errors by learning from the mistakes of others. These reviews are written in plain language, without disclosure of confidential information.

For example, an Illinois child death report tells briefly of a toddler taken to a hospital emergency room with burns over 70% of his body. His family told the police who were called to the hospital that the toddler fell into an "industrial-sized pot" of boiling water that the family placed on the floor to heat their home. The police found the family's story to be consistent with the injuries. The child welfare investigator accepted the story and the existence of the "industrial-sized pot." The case was screened out. Two weeks later an infant brother died of bronchial pneumonia that could have been treated. After two deaths in one family within two weeks, both child deaths were investigated. Once an investigator visited the home and saw the "industrial sized pot," it became clear that the burning of the child was intentional. The pot had a 12 inch diameter, and it would not be possible for a two year old to submerge 70% of his body in a pot of boiling water that size.

This is an example of how important real stories are as teaching tools. Having read this paragraph, most investigators will remember to ask to "see the pot" if confronted with similar circumstances. Forty page reports typically provided in Department death reviews that include a mention on page thirty-five that "the investigator should have sought independent confirmation" are not as useful as teaching tools. Confidential information does not have to be disclosed.

For example, the December 16, 2004 minutes of verbal recommendations to the Bureau of Milwaukee Child Welfare Partnership Council by the CART team state that: " BMCW should ensure that: i. Investigators do not rely solely on the self-reports by the persons being investigated. Statements made by those under investigation must be verified by outside sources." How many people ever see BMCW Partnership Council minutes, and how many would know that "verify through an outside source" means "look at the pot"?

Without a comprehensive child death review, the general public and most BMCW staff remain unaware of how to apply generally worded recommendations, or that the recommendations that were issued in 2004, were also issued in 2005, 2006 and now 2007. Without written child death assessments and reports to use in training, we keep making the same mistakes.

Legislation is necessary to create an adequate child death review process.

It has taken extensive advocacy by this agency and several committed legislators to have basic information on child fatalities and near fatalities reported publicly as required by federal law.[3] The scope of various death reviews are so limited and/or fragmented, that none of the existing review committees noticed that BMCW's refusal to provide fatality data was not in compliance with federal law, much less best practices. We do not believe that BMCW will be able to implement an adequate death review on its own based on past performance and difficulties in reporting basic data.

Leadership from the legislature will benefit all Wisconsin counties. Some counties such as Waukesha County have already taken the lead and have implemented child death review committees from a public health perspective.

At a minimum, provisions should be made legislatively so that child death review is accomplished in a timely manner, and that death reviews are not limited to paper record reviews. Recently, child death reviews by the CART team in Milwaukee County are taking place as much as a year after the child's death. At that point, information is not current, records may be altered, and there is less opportunity for prevention. Further, if a review is limited to a paper review, errors in the record are simply passed on. For example, a pediatric nurse from Children's Hospital attended a meeting and stated that she personally made more child abuse and neglect referrals to the child abuse hotline regarding the safety concerns relating to Layunnia Cole than were reported in the record as the sum total of calls received regarding Layunnia. She also notified legislators of this apparent error in the record. However, there is currently no process for reviewing or correcting errors in the record of any child death. This may impact the validity of the review.

Perhaps most importantly, the child death review process should look at all child deaths, not only the deaths of children related to abuse and neglect. The recent series of deaths of infants and toddlers known to BMCW may or may not be reviewed once an autopsy determines cause of death. A better review would put those deaths into the context of infant and toddler deaths in the overall community so that we can hope to improve overall infant health and well-being.

Finally, child death review reports must be made in writing for the purpose of helping the community move forward and prevent future deaths. States report very positive experiences improving child safety based on effective child death review. Currently, death reviews relating to BMCW children are provided orally once per year to the

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[3] See attached letter to the Partnership Council from Kids Matter, letter to Legislative Counsel from Reps. Grigsby and Jeskewitz and Sen. Darling and Legislative Counsel Response, and Letter from DHFS Legal Council Diane Welsh .

Partnership Council. With an ongoing case manager turnover rate of 40 -50%, it is next to impossible to improve practices with oral reports given to limited audiences. Recommendations of a child death review team and responses of affected agencies must be in writing, and should be incorporated into staff training.

The purpose of a child death review team is to identify risk factors and prevent child deaths. It is an understatement to say that over the last year and a half, the lack of a coordinated child death review has resulted in missed opportunities to keep children safe.

With a comprehensive child death review process, we can do better.

Sincerely,

Susan Conwell
Executive Director

Attachments