

National MCH Center for Child Death Review Meeting
Rural, Urban and Cluster Reviews

Moderator:

Chris Hanna

Discussion Leaders:

Marc Clement, New Hampshire CDR and Neil Hochstadt, Illinois CDR

Illinois CDR

Case study: Fourteen infants died in Chicago all of which had no protective service records. These deaths occurred right around the mayoral election which led to some action. In large cities, oftentimes to accomplish anything you have to bring the issue to the public. The Chicago PD, protective services, ministries and celebrities convened a group to look at these infant deaths. However, no CDR team member was invited. Neil called protective service indicating that CDR was not invited. He then convened a task force to review these cases, in order to look for commonalities and suggest prevention measures. Twenty team members attended this meeting and worked closely with the medical examiner and Chicago protective services on these cases. The team was unable to get data on mental health. They met once a week with tremendous devotion. The 14 cases reviewed did have some common elements. These included geography (location), domestic violence history, criminal history, prior DCFS (protective services), prior wardship, prior encounter with health care or public systems, and family residential instability. The CDR team issued a report with recommendations.

New Hampshire CDR

The New Hampshire team consists of mandated professionals including social workers, police, prosecutors, ME representative, pediatricians etc. The chief ME is the key person. The main goal of the program is prevention. Cases that are still under litigation are not reviewed until prosecution has ended. They review cases retrospectively. Three to four cases are reviewed at each monthly meeting. New Hampshire interacts with neighboring states (New Hampshire, Vermont, and Maine) regarding issues of child/infant deaths. The team also has an educational component during their review meetings. A guest speaker sometimes attends the meeting to share information regarding specific issues. This benefits reviews and recommendations.

NH reviews cluster of suicides because they have small numbers. From their case reviews, recommendations were made to hold a state suicide conference. Other case reviews include motor vehicle crashes. The team recommended graduated licensing should be implemented in the state. In cases that occur in rural areas, team should review a cluster of cases, analyze trends, and strategize ways to prevent child deaths.