

**National MCH Center for Child Death Review Meeting**  
**State CDR Advisory Boards: Different Approaches and Effective Outcomes**

Presenters:

Lon Walker, Iowa CDR  
Virginia Powell, Virginia CDR  
Wanda Pena, Texas CDR

Lon Walker, Chair of the Iowa State CDR Team

Iowa CDR teams review all deaths under age 17. In 2001, Iowa had 37 SIDS deaths. Of these 25 involved second hand smoke, 15 had an inappropriate sleeping environment and 23 were in an inappropriate sleeping position. Most information comes from the scene investigation. Iowa does have an investigative protocol.

*Iowa CDRT Accomplishments*

- Met with legislators regarding CDRT issues.
- Provided speakers for numerous professional conferences.
- Worked with local review teams.
- Worked with state medical examiner on death scene protocol.
- Worked with DCI on a homicide case.
- Revised CDRT data collection methods.

*Key Recommendations to the Legislature/Governor*

- Funding.
- Increased fine for improper use of child restraints.
- Increased child autopsies/screening.
- Test child caregivers for drugs/alcohol.
- Increased penalty for child endangerment death.
- Increased help to new parents.
- Put alarms on home swimming pools.
- Improve reporting to state medical examiners.

*Recommendations to State Agencies*

- DHS visit surviving siblings after a child death.
- Allow interstate sharing of child death data.
- Train foster care parents in CPR.
- LE follow up on life threatening injuries.
- Educate new parents on parenting & risk factors.
- Require smoke alarms.
- LE academy teach the death scene protocol.
- Increased removal of siblings from unsafe homes.

*Challenges*

- Teen Suicides: How do you see the big picture and what records should you review?
- Develop a suicide protocol.
- Turning recommendations into reality.
- State jurisdictional issues.

## Virginia Powell, PhD

### State Child Fatality Review Team: Virginia's Approach

The state team reviews are done independently of the local teams. Virginia has state, local and regional review teams. The state review team has legislative authority to review sudden and unexpected deaths. They conduct a retrospective record review which means that the case has been fully prosecuted. The local teams are more dynamic because they can review real time cases. The state team has more of a medically focused membership. The Governor appoints these members. Health and injury representatives are not on the state team. The state team meets six times per year and spends most of their time reviewing cases. This team has access to all records according to state statute. The meetings must be advertised as public but are closed when cases are discussed. Before the meeting takes place, the state team is divided into groups that read the case files. At the meeting, they present the information to the entire team and the team determines the preventability of the case. Everyone on the team must agree on preventability. One person can block recommendations. They must reach consensus. When the state team develops recommendations, the CDR coordinator calls the agency that the recommendation will affect. They discuss the recommendation to determine if it fits. This can lead to a better, more target recommendation. Once the recommendations are issued, there is no follow up. The state team needs to remember that they are an advisory board not an action team. The state team publishes an annual report, which is done jointly with vital statistics.

## Wanda Pena, Texas Child Death Review Program

The State CDR Team began as a pilot project with grant funding in 1992. The Governor does not appoint members. Representatives are recruited and there is not a lot of oversight. In 1995, legislation passed that created both state and local teams but with no specific requirements. The state team is required and local teams are permitted. The state team does not conduct any reviews but they do make recommendations to the legislature. There are 254 counties in Texas and 144 teams. The Texas Department of Protective and Regulatory Services is required to provide technical assistance. Both state and local teams can choose ad hoc members and can lobby/advocate. The state team meetings are open and the locals are not. The local teams send their data to the Department of Health. The local teams make recommendations to local agencies/groups and write an annual report. The state team publishes a bi-annual report. The local teams have more influence in advocacy.

### *Challenges*

Funding is an issue. In the beginning of the process, local teams received \$6,000 for the program but this does not happen anymore. Also, there is no coordinator position.

The activities of the state team are dependent on state agency funding. The state team was established to start the CDR program, not to sustain it. The state team needs a subcommittee to serve as an advocacy group. They also need to involve the public and injury prevention people.