



PENNINGTON COUNTY CHILD DEATH REVIEW COMMITTEE (PCCDRC)

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HISTORICAL INFORMATION

- ◆ 1980 Indian Health Services manual required review of all infant deaths
- ◆ 1985 Aberdeen Area Indian Health Services infant death reviews started
- ◆ 1994 Governor's Justice Task Force on Children's Issues established
- ◆ 1997 ACOG FIMR promotes review of infant and maternal deaths
- ◆ 1997 Statewide review of deaths recommended



HISTORICAL INFORMATION

- ◆ March 1998 Committee established
- ◆ 1998 spent working on purpose, bylaws, memorandums of agreements, committee composition
- ◆ Data collection tool
 - Cumulative data to be reported by cause and other parameters



PURPOSE

- ◆ Promote the safety and well being of our children
- ◆ To reduce preventable child deaths through conducting a systematic, multidisciplinary multi agency and multi modality review of child deaths



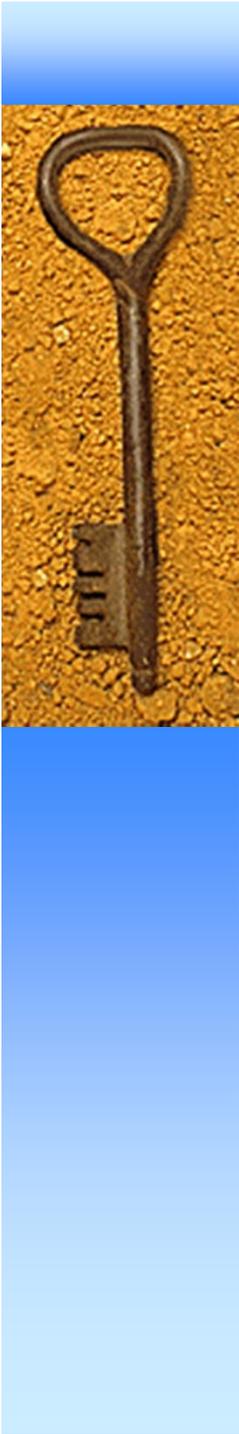
COMMITTEE FINALIZATION

- ◆ South Dakota Dept. of Social Services Child Protection Team – SD Codified Law 26-8A-17
- ◆ Memorandums of Agreement
 - Aberdeen Area Indian Health Services
 - South Dakota Dept. of Health
- ◆ Screening of all members for substantiated reports of abuse and neglect



COMMITTEE COMPOSITION

- ◆ Pediatricians
- ◆ Coroner
- ◆ States Attorney
- ◆ Pathologist
- ◆ Ad Hoc as needed
- ◆ Representatives from:
 - Fire Department
 - Law Enforcement
 - Department of Social Services
 - ICWA



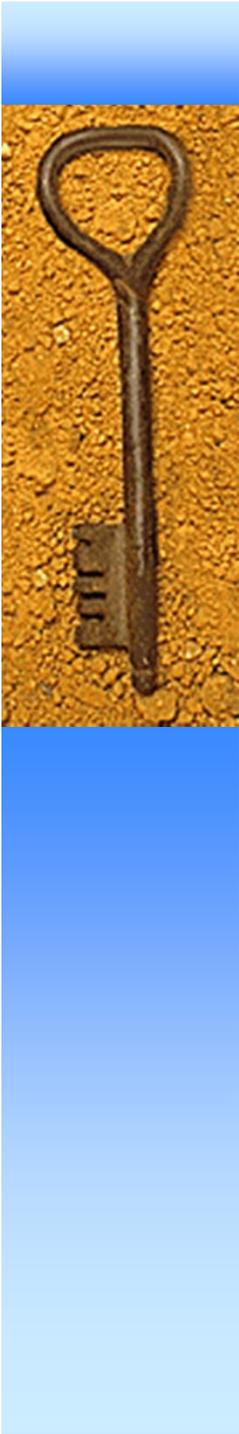
CRITERIA FOR REVIEW

- ◆ Deaths of children from birth to 18 years of age (Does not include stillbirths)
- ◆ Death occurs in Pennington County
- ◆ Death of Pennington County resident which occurs elsewhere



UNIQUE PROPERTIES OF PENNINGTON COUNTY

- ◆ Rapid City Regional Hospital is the referral center for western South Dakota as well as parts of Nebraska and Wyoming
 - Perinatologists have been added in clinic settings but not present in community 24/7
- ◆ Transportation issues to receive prenatal care
- ◆ Level 3 NICU
 - Large percentage of Native American deliveries (33% of admissions to NICU)
 - No pediatric surgeon
- ◆ Child care providers not all licensed (family members)



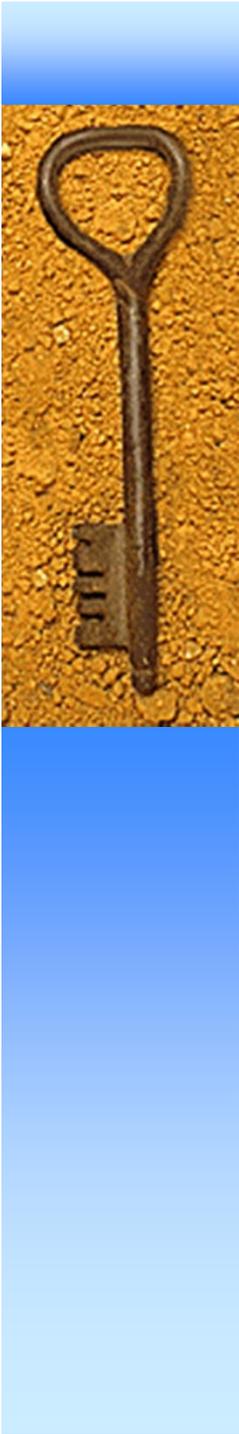
REVIEWS

- ◆ Annual meetings
 - Review approx. 40 deaths
 - Approx. 50% infant deaths
 - Approx. 50% occur prior to hospital discharge



PROBLEMS ENCOUNTERED

- ◆ Data collection tool issues
 - “To what degree was death preventable”
 - Computerized
- ◆ New prevention strategies – most of the issues have been and are being addressed
- ◆ Obtaining hospital/clinic records
- ◆ Funding
- ◆ Personnel (secretarial, data entry, etc.)



ACCOMPLISHMENTS

- ◆ Article and TV “noon day” presentation about “Safe Sleep” practices
- ◆ Adults involved in deaths placed on central registry for perpetrators
- ◆ Public service announcement and article about water safety



VISIONARY STRATEGIES

- ◆ Improved education postnatally for parents about infant care
 - Safe Sleep
 - Care of the irritable infant
- ◆ Increased resources for parents