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