TO: **Assembly Committee on Local Government**
FROM: **Jodi Bloch, Director, State & Local Government Relations, Children's Wisconsin**
DATE: **Wednesday, September 10, 2025**
RE: **Support for AB 192 – Fatality review teams**

Chair Novak and members of the Committee, thank you for the opportunity to share Children's Wisconsin's support for AB 192 today. Children's Wisconsin would also like to acknowledge the Legislative Council Study Committee on Uniform Death Reporting Standards and all those whose experience and expertise informed the Study Committee's work.

Children's Wisconsin is the region's only independent health care system dedicated solely to the health and well-being of kids. As such, we offer a wide array of programs and services inside our hospital and clinic walls and out in our communities aimed at preventing injury and keeping kids and their families healthy, well and thriving. Our highly specialized teams are there for children and their families during some of their hardest moments, including, tragically, the heartbreaking experience of losing a child.

Children's Health Alliance of Wisconsin, part of Children's Wisconsin, has been involved in developing the child death review system that exists in Wisconsin. Children's Health Alliance of Wisconsin, in partnership with the Department of Health Services, developed team protocols and training materials used by child fatality review teams to better understand the risk factors and circumstances surrounding a child's death and to develop policy and program recommendations to prevent future deaths. Currently, Wisconsin has established 45 CDR teams (please see map).

Child fatality review teams exist to better understand how and why children die. They are multidisciplinary teams that meet, generally monthly or quarterly at the county level to discuss the risk factors and circumstances surrounding unexpected child deaths. Information is shared confidentially, and used to look at trends, gaps and needs. Prevention strategies are recommended by the team and are often implemented by a multitude of community partners with the intent to prevent other child deaths. The teams create collaboration across local agencies, and they allow for a greater understanding of each agency's functions and role. Reviews and data collection have resulted in implementation of awareness and actionable prevention efforts to help mitigate risk and address circumstances involved in these tragic incidents. Child fatality review teams also promote collaboration and improved understanding and communication between local public health, schools, law enforcement, first responders, health care and other professionals, medical examiners, coroners and others on best practices on data collection and ensuring families have the resources and support they need when grieving a loss.

AB 192 will help codify current fatality review team practices into state statute to ensure consistency and clarity across all counties in the state. This will formalize the work being done in many counties and communities and ensure more uniformity across Wisconsin. It will recognize established fatality review teams and clearly define the team purpose, structure and best practices known today. This will help counties and fatality review teams in their efforts to support standardized data collection and thereby improve prevention efforts.

Thank you for the opportunity to share Children's Wisconsin's support for this legislation. Children's is happy to answer any questions, including through my contact information listed below.

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