ROCK COUNTY BOARD OF HEALTH
WEDNESDAY, SEPTEMBER 7, 2011 – 6:00 P.M.
HEALTH DEPARTMENT – 3328 N. U.S. HIGHWAY 51
JANESVILLE, WI 53545
(ACROSS FROM SPORTSMAN'S PARK)

AGENDA

1. Call to Order

2. Adopt Agenda

3. Approval of Minutes – August 3, 2011

4. Citizen Participation

5. Unfinished Business

6. New Business

   A. Administrative Division
      (1) Approval of Bills/Transfer of Funds
      (2) Health Department Report
      (3) Infant Death Legislation
      (4) Fee for Flu Vaccine

   B. Public Health Nursing
      (1) International Travel Clinic Update

   C. Environmental Health
      (1) Holding Tank Variance – John Bowditch
      (2) Beach & Surface Water Sampling Results

7. Communications and Announcements

8. Adjournment

If you are unable to attend the Board of Health meeting, **please** contact the Public Health Department (757-5442) or Ms. Kraft at (608) 884-4761. Thank you.

ROCK COUNTY HEALTH DEPARTMENT
LIST OF BILLS FOR 9/7/11 BOARD OF HEALTH MEETING

Account Number	Vendor Name	Item(s) Description	$ Amount
62119	Beloit Memorial Hospital	prenatal classes for client	25.00
	Mercy Hospital OB Dept	prenatal classes for client	35.00
	Mercy Health System	TB client medical charges	89.87
	Barkley Court Reporting	8/3/11 hearing transcript	222.00
62176	State Lab of Hygiene	nitrite water test	27.00
62503	Belem Gonzalez	interpreter services 8/23/11	30.00
	Rene Bue	interpreter services 7/22 – 8/18/11	225.15
	SWITS Ltd	interpreter services 8/4/11	270.00
	Belem Gonzalez	interpreter services 8/3-8/23/11	490.00
	Belem Gonzalez	interpreter services 7/6 – 7/28/11	525.00
	Belem Gonzalez	interpreter services 7/26-8/10/11	465.00
63100	Taylor Technologies	pool testing reagents	89.45
63300	Petty Cash	toll paid while picking up rabies specimen	1.00
64000	McKesson Medical	sharps disposal containers	129.07
	Pinnacle Pharmacy	tuberculin	209.44
	Dickson Company	2 vaccine temperature recorders	547.00
	Petty Cash	disposable camera for paternity testing	7.99
64010	Batteries Plus	6 volt battery for black light	11.50
	Culligan	8/11 deionizer rent	35.00
	IDEXX Laboratories	colisure for laboratory	1,084.53
64203	FSU Center for Prev. & Early Intervention	Before Baby Arrives educational materials	1,244.70
64308	Petty Cash	gift card for volunteer	25.00
64904	Menards	Healthy Homes safety items	209.12

Account Number	Name	Yearly Appropriation	Prcnt Spent	YTD Expenditure	Encumb Amount	Unencumb Balance	Inv/Enc Amount	Total
3130000000-62119	OTHER SERVICES	15,000.00	75.0%	7,713.14	3,548.13	3,738.73		
	P1101229-PO# 08/25/11 -VN#021628				MERCY HOSPITAL		35.00	
	P1101535-PO# 08/25/11 -VN#027256				BELOIT MEMORIAL HOSPITAL		25.00	
	P1102989-PO# 08/25/11 -VN#034683				BARKLEY COURT REPORTING		222.00	
	P1103006-PO# 08/25/11 -VN#014550				MERCY HEALTH SYSTEM		89.87	
				CLOSING BALANCE		3,366.86		371.87
3130000000-62176	LABORATORY	100.00	0.0%	0.00	0.00	100.00		
	P1100363-PO# 08/25/11 -VN#034605				WISCONSIN STATE LABORATORY OF		27.00	
				CLOSING BALANCE		73.00		27.00
3130000000-62503	INTERPRETER FEES	19,000.00	0.0%	10,660.70	-10,660.67	18,999.97		
	P1100364-PO# 08/25/11 -VN#039062				BUE,RENE		225.15	
	P1100367-PO# 08/25/11 -VN#017809				GONZALEZ, BELEM		1,510.00	
	P1102402-PO# 08/25/11 -VN#043260				SWITS LTD		270.00	
				CLOSING BALANCE		16,994.82		2,005.15
3130000000-63100	OFC SUPP & EXP	8,400.00	64.1%	5,633.50	-245.21	3,011.71		
	P1102737-PO# 08/25/11 -VN#046997				TAYLOR TECHNOLOGIES INC		89.45	
				CLOSING BALANCE		2,922.26		89.45
3130000000-63300	TRAVEL	40,000.00	59.0%	23,634.42	0.00	16,365.58		
	P1100361-PO# 08/25/11 -VN#015715				ROCK COUNTY PUBLIC HEALTH DEPT		1.00	
				CLOSING BALANCE		16,364.58		1.00
3130000000-64000	MEDICAL SUPPLIES	91,000.00	57.2%	29,232.45	22,878.84	38,888.71		
	P1100360-PO# 08/25/11 -VN#038065				PINNACLE PHARMACY		209.44	
	P1100361-PO# 08/25/11 -VN#015715				ROCK COUNTY PUBLIC HEALTH DEPT		7.99	
	P1100370-PO# 08/25/11 -VN#042626				MC KESSON MEDICAL SURGICAL COR		129.07	
	P1102780-PO# 08/25/11 -VN#012284				DICKSON CO,THE		547.00	
				CLOSING BALANCE		37,995.21		893.50
3130000000-64010	LAB SUPPLIES	6,500.00	40.4%	4,056.75	-1,428.45	3,871.70		
	P1100359-PO# 08/25/11 -VN#010140				CULLIGAN WATER CONDITIONING IN		35.00	
	P1102761-PO# 08/25/11 -VN#028804				IDEXX LABORATORIES INC		1,084.53	
	P1102939-PO# 08/25/11 -VN#018372				BATTERIES PLUS INC		11.50	
				CLOSING BALANCE		2,740.67		1,131.03
3130000000-64203	EDUC MAT & SUPPL	4,000.00	40.3%	1,613.23	0.00	2,386.77		
	P1102735-PO# 08/25/11 -VN#050921				FSU CENTER FOR PREVENTION AND		1,244.70	
				CLOSING BALANCE		1,142.07		1,244.70
3130000000-64308	REC SUPPL & EXP	200.00	0.0%	0.00	0.00	200.00		

Account Number	Name	Yearly Appropriation	Prcnt Spent	YTD Expenditure	Encumb Amount	Unencumb Balance	Inv/Enc Amount	Total
	P1100361-PO# 08/25/11 -VN#015715			ROCK COUNTY PUBLIC HEALTH DEPT			25.00	
				CLOSING BALANCE		175.00		25.00
3130000000-64904	SUNDRY EXPENSE	7,000.00	42.8%	2,999.30	0.00	4,000.70		
	P1100369-PO# 08/25/11 -VN#014534			MENARDS			209.12	
				CLOSING BALANCE		3,791.58		209.12
		HEALTH DEPT.		PROG-TOTAL-PO			5,997.82	

I HAVE EXAMINED THE PRECEDING BILLS AND ENCUMBRANCES IN THE TOTAL AMOUNT OF $5,997.82
INCURRED BY HEALTH DEPARTMENT. CLAIMS COVERING THE ITEMS ARE PROPER
AND HAVE BEEN PREVIOUSLY FUNDED. THESE ITEMS ARE TO BE TREATED AS FOLLOWS

A. BILLS AND ENCUMBRANCES OVER $10,000 REFERRED TO THE COUNTY BOARD.
B. BILLS UNDER $10,000 TO BE PAID.
C. ENCUMBRANCES UNDER $10,000 TO BE PAID UPON ACCEPTANCE BY THE DEPARTMENT HEAD.

BOARD OF HEALTH COMMITTEE APPROVES THE ABOVE. COM-APPROVAL________________DEPT-HEAD

DATE________________CHAIR

SEP 07 2011

INFANT DEATH IN WISCONSIN
Legislative Proposal

Executive Summary

There are an inordinately high number of preventable deaths in children aged 28 days to 12 months in the State of Wisconsin. According to the numbers entered into the Wisconsin Interactive Statistics on Health, 349 infants aged 28 days to 12 months died in Wisconsin during 2007-2008. Compare that figure with the next highest category of 220 deaths to 15-17 year olds, and the discrepancy is glaring.

This problem exists on a national level and is not unique to Wisconsin. Through education, mandating safe behavior at home, and standardizing reporting requirements, the goal of this proposal is to enact progressive and innovative legislation to better address the tragic issue of preventable infant deaths in Wisconsin.

Infants die at home while sleeping due to what are diagnosed as accidental or 'natural' causes at a rate that exceeds numbers seen in any one age bracket. This unfortunate occurrence is the number one cause of death of infants over 28 days and can be largely prevented through education, mandated safe behavior at home and a more standardized reporting system by coroners and medical examiners. These issues are summarized below:

EDUCATION: Currently the State of Wisconsin does not require health care facilities or birthing centers to educate new parents on safe sleep. Safe sleeping techniques for infants should be mandatory for new parents. Illinois and Pennsylvania already have a mandatory educational program in place to help guard against these preventable occurrences.

MANDATING SAFE BEHAVIOR AT HOME: Mandating safe behavior at home is difficult due to the natural resistance from those who wish to be free of government intrusion in their private affairs as parents. However, as this proposal will demonstrate, the manner in which a caregiver places an infant to sleep has direct correlation to the amount of unnecessary risk an infant is exposed to. With an understanding of these competing interests, this proposal focuses on behavior that has been deemed to be highly reckless and uniformly unsafe. For example, a law that prohibits sleeping with an infant while being under the influence of intoxicants will save the lives of children.

STANDARDIZED REPORTING: Currently, the process by which infant deaths are investigated and categorized can dilute the statistics related to the deaths and foster contrary conclusions to these issues. While SIDS (sudden infant death syndrome) is categorized as a natural death, suffocation is listed as accidental. The facts support that SIDS is far less common than

suffocation. However SIDS frequently is listed as the cause of death due to a lack of standardized reporting and investigation.

Introduction

With over thirteen years of service in the detective bureau at the Janesville Police Department it has been my experience that individuals die in a variety of ways. Deaths are typically classified in one of four ways; homicide, suicide, accident or natural. The coroner's office is responsible for completing death certificates using these classifications. The statistics created by the coroner related to manner and causes of death are then used to dictate public policy, identify safety concerns and generate prevention plans.

Background

When I first entered law enforcement in 1992, the idea that a "mysterious killer lurked within infants waiting to take them in the middle of the night" was a standard common fear of many parents. This tragedy of unknown origin is commonly referred to as Sudden Infant Death Syndrome.

When I became a detective in 1998, I expected to encounter this mysterious phenomenon as an investigator. However, what became clear as I continued to investigate a number of infant deaths was that each infant was found lying face down in suffocating materials such as an air mattress, plastic, soft bedding/pillows or they had been sleeping with a parent. The mystery deaths that were classified as SIDS were actually suffocations. It is my contention that nearly 100% of these deaths were preventable.

Analysis

We are a state and a nation of laws and regulations that attempt to prevent unnecessary death and injury. Helmets, seat belts, child restraint seats, texting while driving, and even mandating carbon monoxide detectors are laws substantiated by the statistics provided by coroners' offices regarding the risks we face and how we can address those risks.

According to a study conducted by the Children's Health Alliance of Wisconsin, using figures supplied by the Wisconsin Interactive Statistics on Health, 349 infants between the ages of one month and one year died in Wisconsin between 2007 and 2008. (These figures do not include fetal deaths, stillbirths and deaths associated with known medical complications occurring during the first month of life.)

When compared to the 935 total deaths of all children between twenty-eight days to eighteen years old, infant deaths accounted for 37% of all child deaths in Wisconsin between that same

time period of 2007 and 2008. Therefore, 37% of all child deaths occur to an age group of only eleven months in span.

Children under twelve months of age die at a rate that is substantially higher than all other age brackets. In fact, the number of 349 is nearly equal to the next TWO highest categories put together; 1-4 and 15-17 year olds, which are 150 and 220 respectively. This statistic is staggering considering most of these deaths occur while the child is asleep and are predominantly preventable through education and awareness.

"Safe Sleep" as opposed to "Unsafe Sleep Environments" is defined by the American Academy of Pediatrics, US Consumer Product Safety Commission, Center for Disease Control, and the American SIDS Institute. The recommendations are virtually universal and any agency concerned with the welfare of children uses these standards:

SAFE SLEEP –

Infant alone, lying directly on a firm crib mattress with a tight fitting crib sheet tucked in securely around the corners of the mattress and the infant on his/her back.

UNSAFE SLEEP –

-Infant lying face down

-Soft objects in or near the infant sleep space including; pillows, soft toys, loose bedding, quilts, and sheepskin

-suffocating materials in or near the infant sleep space including; plastic, vinyl and rubber

-co-sleeping with adults or siblings

-chairs, couches, waterbeds, air mattresses

History of SIDS

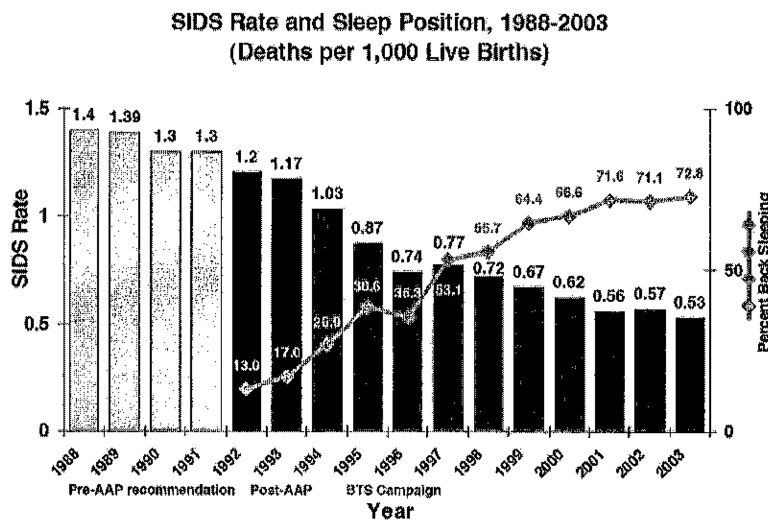
As far back as biblical times, the term 'overlaying' referred to the death of an infant while sleeping with an adult. Priests of the Catholic Church in Europe during the 13th century began recommending mothers stop sleeping with their infants and cribs became more commonplace. Chapter 4 of Aletha Solter's book, *The Aware Baby (revised edition)*

In 1969, at the National Institute of Health 2nd International Conference, Dr Marie Valdez-Dapnea referred to the tragedy of the unexpected death of a sleeping infant as Sudden Infant

Death Syndrome or "SIDS." Children who fall victim to SIDS commonly show no outward sign of fatal injury and their autopsies show no physical cause for the death.

Over time, death investigators began to establish a more inclusive and thorough scene inquiry and search. Team members included a coroner, medical examiner and the law enforcement agency assigned to the death. Sharing information regarding the environment the child was in and his/her position with the pathologist performing the autopsy, agencies have been more effective in establishing the true cause of an infant's death.

By 1992, the America Academy of Pediatrics released an educational initiative known as 'Back to Sleep'. This initiative was in response to the increasing evidence that infants laid on their stomachs were far more likely to succumb to "SIDS" than those children laid on their backs. As a result, the incidence of "SIDS" deaths dropped by 50% in the ensuing years. The following graph shows the decline of "SIDS" deaths compared to the increase of infant back sleeping before and after the 'Back to Sleep' initiative in 1992.



Graph taken from Wikipedia via the National Institute of Child Health and Human Development

However, the rate of decline in Sudden Infant Deaths could be statistically attributed to the number of deaths now being diagnosed as suffocation. As agencies began to take the more comprehensive investigative approach as described above, the inclination to diagnose a death as suffocation as opposed to "SIDS" became more prevalent. As such, the actual decline in infant mortality as a result of the 'Back to Sleep' program could be slightly skewed.

Herein lays a major issue that needs to be addressed. Suffocation MUST BE ruled out as a cause of death BEFORE Sudden Infant Death Syndrome is identified as the cause. The continuing disparity between those deaths called SIDS and those called suffocation will shroud the facts and cost children's lives.

The National Center for Disease Control recognizes this and has begun an initiative to standardize the diagnosis and reporting practices on infant deaths. The State of Wisconsin should adopt and mandate the implementation of the CDC's Sudden Unexpected Infant Death investigation protocol.

> Since 1998, it appears that medical examiners and coroners are moving away from classifying deaths as SIDS and calling more deaths accidental suffocation or unknown cause, suggesting that diagnostic and reporting practices have changed. Inconsistent practices in investigation and cause-of-death determination hamper the ability to monitor national trends, ascertain risk factors, and design and evaluate programs to prevent these deaths. - *Centers for Disease Control and Prevention, CDC's unexpected infant death initiative*

To the average person, the outward signs and internal findings of an autopsy are identical in both "SIDS" and suffocation. To be put even simpler, very often there are no findings to suggest any cause of death at all. The sad fact remains that infants are very susceptible to suffocation and will do so while sleeping without much struggle or indication of a crisis.

Janesville Wisconsin Case Study

Critical information needed for a proper diagnosis in these cases is likely to be found in the death scene investigation. This investigation sometimes includes a doll reenactment showing the infants positioning within its sleep environment at the point when he/she was found.

To provide further explanation, statistics from the City of Janesville, Wisconsin will be used to demonstrate this approach. Between 2005 and 2010, there were 12 infant deaths that occurred outside a hospital setting in the City of Janesville (these figures exclude fetal deaths and those deaths that occurred in a hospital setting). All 12 of these infant deaths occurred while the child was sleeping.

During this same time period, 41 people under the age of 25 died in auto accidents within Rock County, Wisconsin. None were younger than 12 months old. Statistically speaking, sleeping is far more hazardous than riding in a car for an infant. In fact, to take a random sampling of any one single age group, infants in Janesville died at a much higher rate. For example, four 19-year olds died in car accidents in all of Rock County while 12 children aged one to twelve months old died while sleeping in the City of Janesville.

Of these 12 children, seven (7) were discovered facedown and three (3) were co-sleeping (bed sharing) with parents. One (1) child was not identified as to position at time of discovery and one (1) was face up strapped into a bouncy seat. The child in the bouncy seat is the only infant who was not at risk for suffocation based upon sleep position. However, this child also was suffering from an unidentified respiratory illness.

Of the seven (7) found face down, two (2) were categorized as natural deaths due to SIDS and four (4) were called suffocation/asphyxiation. The last was ruled natural due to pneumonia. However, this still does not take into account the potential that a suffocating environment complicated the pneumonia or vice versa.

I was either a participant in, or reviewed each of these cases individually. The two (2) SIDS cases involved infants found with their face into the mattress or bedding. According to SIDS standards these cases should be ruled accidental suffocations/asphyxiations, since that is a likely cause and SIDS should not be diagnosed unless this can be ruled out. SIDS must be a diagnosis of exclusion, eliminating all other possible causes.

The three main points to be taken from the sample Janesville cases are:

1. Out of 12 infant deaths in Janesville all occurred during sleep and only one (1) was confirmed to be in a **safe** sleep position.
2. Even within our county, two (2) deaths that were suffocations by scene evaluation/investigation were labeled SIDS. By definition, the SIDS diagnosis must rule out all other causes.
3. Co-sleeping with an infant is hazardous.

Recommendations

Standardized Reporting

Mandating that all death investigations of infants rule out the possibility of suffocation before a finding of SIDS can be declared will provide clarity to the statistics and more accurately identify the underlying causes. Current medical standards and recommendations already in place have to be fortified with legislative directives to ensure that a more uniform and standardized reporting practice identifies these tragedies accurately.

Education

For years new parents have been educated by health care providers about "safe sleep" and the AAP recommendations for putting babies to sleep on their backs. It's likely that most birth centers and hospitals probably deliver this message in some format to new parents. However, given the magnitude of this problem, mandating those facilities to provide safe infant sleep training to parents in a very direct and descriptive manner will reduce these deaths even further.

Mandating Safe Behavior At Home An adult sleeping with a baby in an adult bed is very dangerous. An intoxicated adult doing so is even more hazardous due to the sedating effects of many intoxicants. This is dangerous to the point of being reckless and should be legislated, just as an adult who might drive while intoxicated with a child in the vehicle.

I have included the Pennsylvania law pertaining to mandatory education to parents at discharge from a health care facility after birth and also the New Jersey legislation on child death investigation protocol, both serving as examples of what Wisconsin would benefit from.

Conclusion

Through parental education, mandating safe behavior at home, and standardized reporting, instances of an infant dying in their sleep could be extensively mitigated. By providing educational programs and information to new parents on safe sleep environments, creating additional awareness and consequences for intoxicated co-sleeping, and creating a standardized reporting procedure for infant deaths, law enforcement, health care providers, and parents will have the necessary tools to help combat this silent tragedy.

I ask for your consideration for this very important legislation. Children are often left in defenseless situations. With very minimal effort, precautions can be taken to lessen the occurrences of preventable infant deaths with this legislation. Thank you for your consideration.

Available sources and references on the internet:

http://www.aap.org/

http://www.cpsc.gov/

http://www.sids.org/nprevent.htm

http://www.cdc.gov/SIDS/index.htm

ROCK COUNTY HEALTH DEPARTMENT

North Office

P.O. Box 1143
Janesville, WI 53547-1143
608-757-5440
608-758-8423 (fax)
www.co.rock.wi.us

South Office

61 Eclipse Center
Beloit, WI 53511
608-364-2010
608-364-2011 (fax)

"Healthful Hints"
Monthly Health News Column

Early Education Prevents Animal Bites

Ask anyone who owns a pet and I'm sure they'll tell you their dog or cat is like another member of their family. However, like any other animal, even pets can be dangerous when irritated or provoked. Because they typically don't know how to treat pets, children are at the highest risk for bites and scratches. In 2010, there were 382 reports of animal bites to the Rock County Health Department. The majority of these victims were children 10 years old and younger.

Animal bites don't only happen from contact with wild animals, like stray dogs. Among children and adults, having a dog in the household is associated with a higher incidence of dog bites. Adults with two or more dogs in the household are five times more likely to be bitten than those living without dogs at home.

To help prevent children from being bitten, teach the following basic safety tips and review them regularly:

- Do not approach an unfamiliar dog or cat.
- Do not run from a dog or scream.
- Remain motionless (e.g. "be like a tree") when approached by an unfamiliar dog.
- If knocked over by a dog, roll into a ball and sit still (e.g. "be still like a log").
- Do not play with a dog or cat unless supervised by an adult.
- Immediately report stray dogs or dogs displaying unusual behavior to an adult.
- Avoid direct eye contact with a dog.
- Do not disturb a dog that is sleeping, eating or caring for puppies.
- Do not pet a dog or cat without allowing it to see and sniff you first.
- If bitten, immediately report the bite to an adult.

If you are thinking about getting a dog or cat for your home, do some research. Be sure to consult with a veterinarian to learn what breeds are the best fit for your household. Also, be sensitive to your child's feelings about a pet. For example, if they are frightened by dogs, wait before bringing a dog into your household. Spend time with a dog or cat before buying or adopting it. Lastly, spay or neuter your dog or cat as it often reduces aggressive tendencies.

ROCK COUNTY HEALTH DEPARTMENT

North Office

P.O. Box 1143
Janesville, WI 53547-1143
608-757-5440
608-758-8423 (fax)
www.co.rock.wi.us

South Office

61 Eclipse Center
Beloit, WI 53511
608-364-2010
608-364-2011 (fax)

Teaching your children how to approach and treat dogs and cats is one of the most important steps you can take to prevent an animal bite.

Laura Fadrowski is the Health Educator for the Rock County Health Department. If you would like to ask Laura a health-related question to be answered in a future column, e-mail her at fadrowsk@co.rock.wi.us. The Rock County Health Department reserves the right not to answer any questions deemed unsuitable.