NATIONAL CFRP

Center for Fatality Review & Prevention

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Findings Guidance

National Center Guidance Report

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Findings Guidance

The key purpose of fatality review is identifying prevention opportunities. In order to do this, fatality review teams need to write and share prevention recommendations. Based on annual surveys from child death review (CDR) teams, this is a common barrier and one of the most challenging aspects of the fatality review process.

In order to support fatality review teams in writing strong, evidence-based prevention recommendations, the National Center for Fatality Review and Prevention (National Center) has revised the recommended process for authoring prevention recommendations. This new process will focus on identifying findings during the review meeting and then aggregating the findings to inform prevention recommendations.

Findings, the objective facts that relate to risk and protective factors, are key.

By focusing on findings, review teams will be able to efficiently identify common system gaps and successes across many deaths to guide the development of recommendations for prevention.

Although it may seem counterintuitive to collect protective factors and/or system successes, these are critical items to document for two key reasons. **The first reason to document system successes is to identify and promote policies and procedures that are effective and share them.** This is also an effective way of identifying solutions to common barriers. For example, law enforcement agency in community A can obtain in-depth doll reenactments but law enforcement agency in community B is unable to obtain doll reenactments. By collecting these findings, the fatality review team can assist community B to learn about community A. **The second reason is to provide direct feedback to agencies about policy and procedures that are effective.** This can be tremendously helpful for agency staff to hear about the positive impact of their work. Many fatality review teams communicate with agency staff about these systems successes.

In order to support this shift in practice, the National Center has modified the National Fatality Review-Case Reporting System (NFR-CRS). The graphic below describes each step in the new process along with the corresponding place in NFR-CRS to document findings, run standardized reports and document prevention activities.

Step 1: Creating Findings

During the case review process, findings should be documented about each case. At least one positive finding and one system gap should be identified for each case. It can be helpful to develop a standard list of findings in order to compare findings from multiple cases. When developing findings please consider the following:

- ☐ *Characteristics of the child*
- ☐ *Characteristics of the parents and/or caregiver*
- ☐ *Physical environment*
- ☐ *Social environment*
- ☐ *Agency practices*
- ☐ *Collaboration across systems*
- ☐ *Social determinants*
- ☐ *Unique state systems considerations*

Findings should contain three key components.

1. **System being targeted (e.g., legal, education, medical, child welfare, safety, public health)**

2. **Policy/program area (e.g., home visitation, transport, substance-exposed infant, risk assessment)**

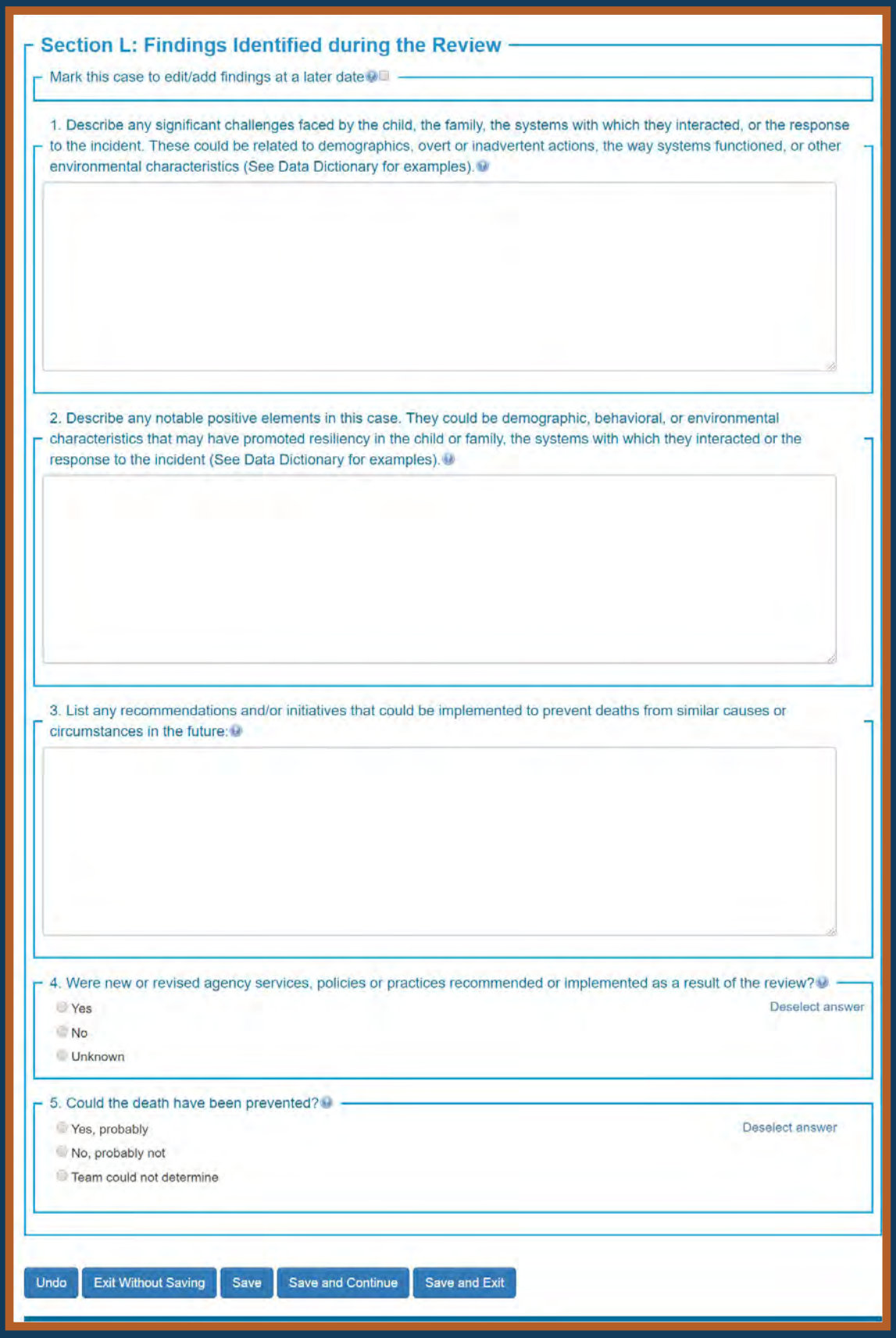
3. **Case-specific rationale (e.g., multiple complaints, child history not considered, lack of access to appropriate medical care)**

Sample findings include:

- ☐ *Death of infant in which where there which more than six reports of neglect that were not accepted for child welfare investigation.*
- ☐ *Caregiver was not provided with infant safe sleep education at birth.*
- ☐ *Caregiver with domestic violence conviction(s) was left alone with child(ren).*
- ☐ *Law enforcement conducted an in-depth doll reenactment at the scene.*
- ☐ *Family had access to Medicaid funded transportation to community services and medical care.*

See Appendix for an example of Delaware's findings as well as the National Center's training module on findings.

Findings should be documented in Section L of NFR-CRS.



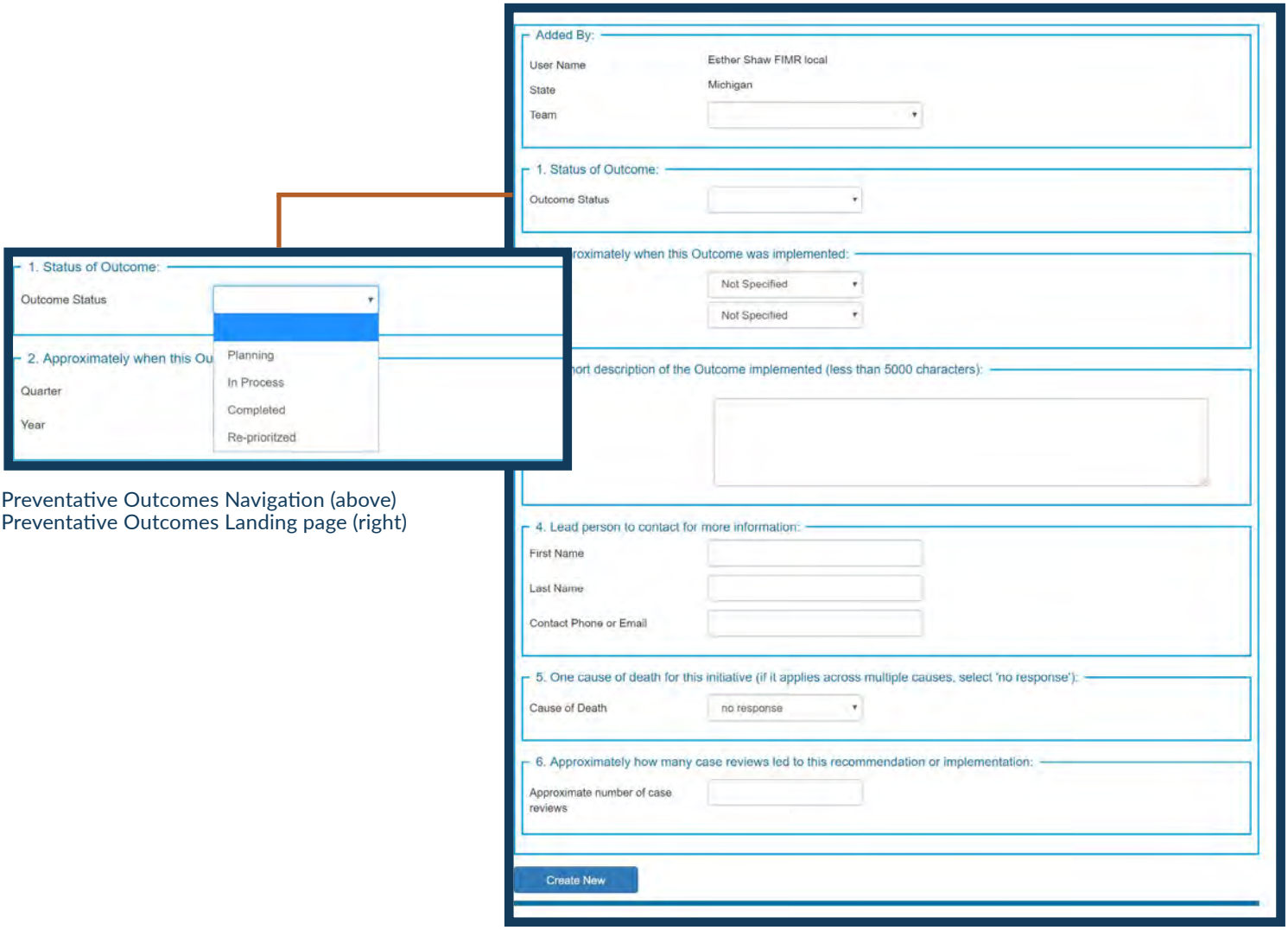
Step 2: Running Standardized Reports to Identify Trends and Findings

At least once every 12 months, state and/or local fatality review teams should review all their data and findings. This can be done by running a variety of standardized reports. The National Center recommends starting with report #3 (Manner and Cause of Death by Age Group) to gain an understanding of cause and manner of death by age group. From that report, you can identify additional standardized reports that need to be run.

Once you've run all your standardized reports, you can obtain a list of findings by running standardized report #30 (Findings from the Review). The data elements included in this standardized report are:

- ☐ *Age of child (Question A4)*
- ☐ *Cause of death (Question G6)*
- ☐ *Manner of death (Question G5)*
- ☐ *Key risk factors (Question L1)*
- ☐ *Key protective factors (Question L2)*
- ☐ *Recommendations to prevent future deaths (Question L3)*
- ☐ *Implemented agency change (Question L4; gatekeeper only)*
- ☐ *Could this death have been prevented (Question L5)*

After creating the list, group the findings into the systems identified in the first step of creating findings. This will help highlight common findings across multiple cases. The National Center training module (URL: https://mediasite.mihealth.org/Mediasite/Catalog/catalogs/cnpi) on Findings demonstrates this process.



Preventative Outcomes Navigation (above)
Preventative Outcomes Landing page (right)

Step 3: Crafting and Documenting Prevention Recommendations

The final step in the process is to author prevention recommendations and document prevention activities. Start by crafting prevention recommendations. In order to do this successfully, the National Center recommends a diverse group of engaged stakeholders come together to review the data and findings from step 2. It is vital the group of stakeholders is representative of the community and the problems the team is trying to impact.

There are a variety of frameworks that can be used to write recommendations. SMART(IE) goals identify the key components of a recommendation. On the following page is a brief summary of each step.

S **Specific:** Answers to "who, what, where, when, which, and why" are described.

M **Measurable:** A tangible plan for measuring impact is determined. It is important to ensure that the measures in the plan are accessible.

A **Achievable:** Decide how important this activity is to your end goal and if it is possible.

R **Realistic:** Can this work be done with the resources available? It is also important to assess political and social will in deciding if an activity is realistic.

T **Time Sensitive:** Identify a timeline and a due date. It is important to identify a final due date but also dates to measure progress.

I **Inclusive:** Engage the most impacted population in all aspects of the work. It is vital to ensure there is a meaningful way to include everyone.

E **Equitable:** Identify how to ensure principles of social justice and health equity are used to address systematic inequity and oppression.

A worksheet with SMARTIE goals is available on the National Center website (URL: https://ncfrp.org/).

There are two relevant training modules titled Partnering for Prevention and Writing Recommendations available on the MPHI Media Library website (URL: https://mediasite.mihealth.org/Mediasite/Catalog/catalogs/cnpi).

Conclusion

Improving the health and safety of communities is the goal of all fatality review work. By shifting the team's focus to identifying findings during case review and using those findings to write prevention recommendations, fatality review teams should be able to clearly identify systems gaps and help write recommendations to address these gaps.

System Areas (Step 1)	Findings (Step 2)	Rationale (Step 3)
Education	Regulations/Policies/Contracts	CASE SPECIFIC
Legal	Court Hearings/ Process DFS Contact with DOJ Regulations/Policies/Contracts	
Multi-Disciplinary Team Response	Communication Crime Scene Documentation Doll Re-enactment General - Civil Investigation General - Criminal Investigation General - Criminal Investigation / Civil Investigation Intake with DOJ Interviews - Adult Interviews - Child Medical Exam Prosecution/ Pleas/ Sentence Reporting	
Medical	Documentation Home Visiting Programs Medical Exam/ Standard of Care - Autopsy Medical Exam/Standard of Care - Birth Medical Exam/Standard of Care - CARE Team Medical Exam/ Standard of Care - ED Medical Exam/ Standard of Care - Forensics Medical Exam/Standard of Care - PCP Medical Exam/Standard of Care - PCP/ED Medical Exam/ Standard of Care - Radiology Medical Exam/Standard of Care - Specialist Medical Exam/ Standard of Care - Urgent Care Regulations/Policies/Contracts Reporting Substance-Exposed Infant Transport	
Risk Assessment / Caseloads	Caseloads Collaterals Communication Documentation Reporting Risk Assessment - Abridged Risk Assessment - Alternative Response Risk Assessment - Closed Despite Risk Level Risk Assessment - Screen Out Risk Assessment - Tools Risk Assessment - Unsubstantiated	
Safety / Use of History / Supervisory Oversight	Safety - Completed Incorrectly/ Late Safety - Inappropriate Parent/ Relative Component Safety - No Safety Assessment of Non-Victims Safety - Oversight of Agreement Safety - Violations of Safety Agreements Supervisory Oversight Transport Use of History	
Unresolved Risk	Child Risk Factors Contacts with Family Home Visiting Programs Legal Guardian Parental Risk Factors Substance-Exposed Infant	

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