Saving Lives Together

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Greetings from the Staff

Greetings fatality review colleagues,

We know many of you are being pulled away from your usual focus on fatality review to assist in the coronavirus/COVID-19 response. Many of your employers may have asked you to set up a home office this week. You may be trying to maintain your program while caring for children, a parent, or your own vulnerable health. A funny thing about public health is that, when done well, it is boring from the outside looking in. We can’t always prove prevention efforts with the same convincing data we can use to highlight the need for it: diseases that weren’t spread; accidents that didn’t happen; lives that weren’t lost. We want you to know the National Center is cheering you on in your work as public health heroes—whether through a special assignment in response to an outbreak, or through your ongoing efforts to investigate, understand, and prevent fatal, infant, or child mortality in your community or state.

Several of you have reached out to us with questions about the possibility of remote fatality review meetings under our new social distancing context. Please take a look at the guide on Planning for Remote Fatality Reviews below in the “Resources for Teams” section should this apply to you.

With you for health and prevention,

Abby Collier
Director,
National Center for Fatality Review and Prevention
The National Center welcomes Krisha Felzke

The National Center is pleased to introduce Krisha Felzke, our new program assistant. Krisha joined our team on February 10, 2020 and has spent the last month immersing herself in the work the National Center does to support fatality review professionals across the country. Center staff are excited for Krisha’s contributions as she supports project coordination and process improvements in the office. Krisha enjoys the inclusive, diverse work environment.

As someone in the early stages of a public health career, she loves that she can clearly see how each of her colleagues cares deeply about the work being done here. “Since joining the National Center team, the thing that has stood out to me the most has been the amount of collaboration it takes across local, state and federal agencies to make things happen,” she said. “I’m now seeing firsthand the amount of work and communication that is being done to educate communities to understand and prevent deaths of as many children as possible. I feel proud to be part of these processes in any way.”

Krisha holds a bachelor’s degree in human biology from Michigan State University, and lives in St. Johns, Michigan with her cat, Mozzie.

Upcoming Events

LAUNCH WEBINAR
National Fatality Review-Case Reporting System Version 5.1
May 6, 2020, 2:00 PM-3:00 PM EST

Please join us as National Center staff highlight the exciting changes and additions in the NFR-CRS Version 5.1, focusing on an enhanced questions related to suicide and a revamp of Section L—where users capture findings and recommendations!
FIMR Regional Technical Assistance and Support Calls

WESTERN Region: April 8, 2020, 4pm-5pm EST-- including CA, UT, WY, MT, NV

NORTHERN Region: April 21, 2020, 9:30am-10:30 am EST--including WV, PA,NJ, DE, MD, ME and DC.

MIDWEST Region: April 21, 2020, 11am-12 noon, EST--including MI, WI, OH, IL, and IN.

SOUTHERN Region: April 23, 2020, 11am-12 noon EST, including KY, TN, MS, AL, and FL..

CENTRAL Region: April 27, 2020, 11am-12 noon EST--including CO, NE, KS, OK, TX, MO, LA.

FIMR State Coordinator’s Conference Call
June 3, 2020, 3pm-4pm EST

National Center convenes Fatality Review Health Equity Learning Collaborative

For the last several years, the National Center has convened a FIMR/CDR Health Disparities Work Group. The charge of the workgroup was to create a toolkit for fatality review teams with resources for onboarding new team members and educating existing team members around issues such as implicit bias, racism, health disparities, and using a health equity lens. The Workgroup released Improving Racial Equity in Fatality Review last August.

The Workgroup will be transitioning to a learning collaborative model, an opportunity for fatality review professionals to network, share, learn from others’ experiences, and advance equity approaches in their state or local fatality review.

The Fatality Review Health Equity Learning Collaborative will meet quarterly, with its next meeting on June 10th, 2020 from 3:00-4:00 PM EST. Reach out to info@ncfpr.org if you are interested in joining the Learning Collaborative. Future meetings will be on September 9th and December 9th.
Black Maternal Health Week coming mid-April

The third annual national Black Maternal Health Week (BMHW) campaign will take place April 11-17, 2020. Founded and led by the Black Mamas Matter Alliance, the event will be a week of awareness, activism, and community building intended to:

- Deepen the national conversation about Black maternal health in the US
- Amplify community-driven policy, research, and care solutions
- Center the voices of Black mamas, women, families, and stakeholders

To access a community toolkit, find out about local events, or download a film guide for FusionTV’s, The Naked Truth Documentary Series: Death by Delivery, visit: https://blackmamasmatter.org/bmhw/

Recognizing the contributions of nurses and midwives

The World Health Organization has designated 2020, the 200th anniversary of Florence Nightingale’s birth, the International Year of the Nurse and the Midwife. This is a great opportunity for fatality review teams and their member agencies to recognize the significant contributions of nurses and midwives who support case review activities. Do you have a clinical or public health nurse or midwife contributing to your team? This is a great opportunity to tell them thank you! For more information on the International Year of the Nurse, click here: https://2020yearofthenurse.org/#/June

Field Notes:
Updates from state & local teams
The Dane County, Wisconsin FiMR team conducted a program evaluation in 2017 using the Ripple Effects Mapping technique, a process used to assess the impact of community programs or projects. The evaluation identified the need for a structured way to continue taking FiMR data and catalyze action for infant mortality prevention through improved services, resources, and systems for women, infants, and families. Last year, Dane County FiMR responded to this need by creating FiMR Action Networks, or FANs. The FANs are designed to address a very specific issue identified through the FiMR process in the time between quarterly FiMR meetings. FANs activate community experts and experts from the Case Review Team (CRT) to engage for action in the three-month timeframe. The FAN members then report back to the CRT at the next case review meeting.

To select FiMR themes for FANs to address, the CRT analyzes findings from the case review meeting, quantifying topics that came up in each case review through content analysis (see graph below). This allows the teams to stay accountable to the data and to what the CRT members thought was most important. Common themes identified through these analyses include clinical care access and quality, infant safe sleep, bereavement services, care coordination, and mental health. The teams also consider health equity and the feasibility of achieving impact in a three-month time frame, as well as what actions other organizations and groups may be taking around the same topic areas.

The recent FAN working groups have coordinated a Healthy Women, Healthy Babies Letter of Support in support of the Governor’s budget to extend maternal Medicaid services through one year postpartum and provide support for doula care; conducted a mapping of local bereavement systems; and completed safe sleep dialogues through collaboration with Nurse Family Partnership to facilitate discussion around nuanced safe sleep messaging with physicians.
FANs are a creative solution to achieve meaningful action and change to improve infant outcomes. The National Center welcomes the opportunity to assist your community in finding solutions to meet its unique needs. Contact us at info@ncfp.org.

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**New York State launches state advisory team for Child Fatality Review**

**New York State Office of Child and Family Services** convened its inaugural Child Fatality Review Team on March 5, 2020. The OCFS will support and advance the work of 19 active local child fatality review teams across New York State.

Margaret Bissell (pictured), Director of the OCFS’s Bureau of Protective Services, will serve as the state team coordinator.

She and her staff invited diverse interdisciplinary partners representing agencies and non-profits that support families across the state, including: New York’s Office of Temporary and Disability Assistance, Department of Homeland Security, Office of Addiction Services and Supports, Office of Mental Health, the Department of Health, Office for Justice Initiatives, State Police, and Office of Victim’s Services.

The statewide CFRT will meet quarterly, working to promote communication within and between state and local agencies, and identifying initiatives to promote across the state to prevent child deaths. “New York state invests heavily in preventative services for families,” Lisa Gharley Ogundimu, OCFS Deputy Commissioner for Child Welfare and Community Services, said. “This team will, for the first time, bring child fatality investigators from across the state together to identify systemic issues and make recommendations on policies, practices, and programs that promote child health, safety, and wellbeing.”
Kudos Corner

Call for Nominations: Theresa M. Covington Award for Excellence in Fatality Review

The National Center for Fatality Review and Prevention is seeking nominations for the Theresa M. Covington Award for Excellence in Fatality Review. This award acknowledges and celebrates the significant contribution Ms. Covington has made to the field of child fatality review.

Child Death Review became a known and respected public health and injury prevention program due, in large part, to her national leadership and the interdisciplinary partnerships she helped to build. Teri spent more than two decades working in fatality review. She built and managed the Michigan CDR and Fetal and Infant Mortality Review (FIMR) programs, later becoming the founding director of the National Center from its inception in 2002 through 2017. She continues to be a tireless advocate for the health and wellbeing of America’s infants and children.

This award will be given in Teri’s honor to fatality review professionals who exhibit fatality review leadership, excellence in collaborating with partners, and advocacy for the health and wellbeing of children.

Eligibility criteria:

- Fatality review professional working in CDR
- Experience and innovation in leading fatality review
- Experience and innovation in collaborating with partners
- Experience and innovation in advocacy for the health and wellbeing of children

Please visit https://www.surveymonkey.com/r/Covington2020 to complete a nomination form. The National Center will accept nominations through June 1, 2020.

New Study on Sleep-Related Infant Deaths

The paper examines 5030 infant cases between 2009 and 2013 where both death certificates and child fatality review (CFR) cause of death data were available and linked. Of these, the most common causes of death based on death certificates were other perinatal condition (1477), congenital anomaly (1000), and prematurity (951), the most common causes identified through CFR were prematurity (2356), congenital anomaly (725), and other medical condition (444). Some of these differences were due to different criteria for determining prematurity as the cause of death.

The researchers identified that, overall, differences between the death certificate and CFR causes of death were more common among medical causes of death than deaths due to injuries. They concluded that these differences are not due to inaccuracies or reporting errors, but because the two processes have different purposes. Death certificates have a nationally-standardized process to allow for comparisons at national, state, and jurisdictional levels, while CFR focuses on data collection and determination for prevention. The authors suggest considering the purpose of the reporting method when determining which system should be used to better understand and describe infant mortality burden.

Congratulations to the authors!

Wedding bells ring at the National Center

Please join us in congratulating Erik Buczkowski on his recent marriage! He is picture on the right. Erik and Matt Gessler tied the knot in a beachside ceremony on February 20, 2020 in Miami, Florida. Erik joined the National Center in the summer of 2016 as a data analyst. He transitioned to a project coordinator position with the Sudden Unexpected Infant Death (SUID) and Sudden Death in the Young (SDY) Case Registry Data Coordinating Center last year, supporting the work of SUID/SDY Case Registry grantees. He continues to offer technical support to all of the National Center’s webinars, social media platforms, and support data quality reporting.

Congratulations, Erik and Matt! We wish you every happiness.

Data Matters
Version 5.1 coming soon!

The National Center has been working to prepare version 5.1 of the National Fatality Review Case Reporting System (NFR-CRS), launching April 27, 2020. The major changes in this release include an emphasis on fine tuning prevention recommendations (Section L) and suicide data collection (Section J.6). A few other changes also managed to sneak their way into this release.

For more information about version 5.1, please attend an informational webinar on May 6, 2020. Click here to register: https://bit.ly/2GjwKAm

The webinar will be recorded in case you cannot attend the live event. If you would like a sneak peak at version 5.1, we would be happy to send you a highlighted PDF of the paper form that summarizes the changes. State fatality review coordinators should email info@ccfrn.org to request paper versions of version 5.1.

Major changes in version 5.1 include:

Section A2 (Child information, over one year of age):

- Expanded questions about child’s mental health and substance use/abuse treatment.
- Added gender identity and sexual orientation questions back into the report tool.

Section J.6 (Suicide)

- Added new questions about child’s use of social media.
- Added new questions about Youth Warning Signs, questions based on scientific research, that looks at child’s behavior 30 days prior to death.

Section L (Life Stressors)

- Added a new section on Life Stressors that captures many risk factors that existed in the child’s environment and may have contributed to the death. Examples include factors such as racism and stress due to sexual orientation.

Section L.1 (Findings)

- Re-focused this section on findings (objective facts about the case) with an eye towards system successes and gaps and ways to work with existing programs to address issues identified (recommendations).

If you have any questions about this upcoming release, please feel free to contact us at info@ccfrn.org.

Data Quality Corner: FIMR Data Quality Initiative underway

The National Center launched the FIMR Data Quality Initiative with its first meeting of participants on January 30, 2020. Led by Dr. Patricia Schnitzer, the goal of the FIMR Data Quality Initiative is to improve the quality and consistency of the data entered into the Case Reporting System, and to improve usefulness of the data at local, state, and national levels for identifying prevention strategies and monitoring the effectiveness of prevention measures that have been implemented by FIMR teams.
Resources for Teams

National Center releases guidance on virtual fatality reviews

In light of the state and national responses to the coronavirus/COVID-19 pandemic, teams have contacted the National Center inquiring how fatality reviews can be conducted remotely. This week, the National Center released Planning for Remote Fatality Reviews, a resource for teams holding fatality review meetings in light of new social distancing considerations. While in-person reviews are preferred, these unprecedented times will require adjustments and creativity to ensure a responsive public health approach to new problems and ongoing program management.

The National Center is grateful to be a resource to you as you navigate new challenges. Do not hesitate to reach out to us at info@ncfrp.org with questions or concerns.

March is Sudden Unexplained Death in Childhood Awareness Month

Conor Bowen was 17 months old in October 2016, when—on a normal morning full of Elmo, Cheerios, bananas, and playing with his sister—he was found unresponsive after his nap.

Conor became one of the approximately 400 children under 18 who die annually of Sudden Unexplained Death in Childhood (SUDC), the sudden and unexpected death of a child 12 months and older that remains unexplained after a thorough death investigation is conducted. His mother, Dr. Erin Bowen—a pediatrician—felt betrayed by her medical education for not preparing her for this possibility.
Dr. Bowen now serves as the Vice President of the SUDC Foundation, working to spread awareness about SUDC and provide resources to families who experience one of these deaths. The Foundation and Dr. Bowen have developed a number of resources that can support your work as you investigate and respond to SUDCs, including:

- **Kisses for Conor**, an article highlighting how pediatricians can support families who experience SUDC: [https://bit.ly/3dJ9UmC](https://bit.ly/3dJ9UmC)
- **Unexplained Pediatric Deaths: Investigation, Certification & Family Needs**: consensus guidelines on SUDC, developed by the National Association of Medical Examiners and the American Academy of Pediatrics: [https://sudpedsb.com](https://sudpedsb.com)
- **AAP News Article March 2020**: "Pediatricians can play important role after a child’s unexplained death": highlighting recommendations from consensus guidelines for pediatricians: [https://bit.ly/2iRbbr1](https://bit.ly/2iRbbr1)
- **SUDC Registry & Research Collaborative (SUDCRC)**: a multi-site collaborative between NYU, Columbia University and Mayo Clinic investigating sudden unexpected deaths of children 11 months-18 years old. Performs comprehensive multidisciplinary case review, neuropathology, neuroimaging and genetic analysis, including whole exome sequencing of both parents and deceased child at no cost to families. Find out more: [https://bit.ly/2Qk2qud](https://bit.ly/2Qk2qud)
- Refer a family to the SUDCRC: Laura.crandall@nyulangone.org
- Refer a family to the SUDC Foundation: laura@sudc.org. Referrals can be made before the investigation is complete. The SUDC Foundation can provide services for sudden and unexpected deaths, even if the cause of death becomes known during the investigation and autopsy.
- Contact Dr. Bowen at erinbowenmd@gmail.com

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**New and Departing Coordinators**

![Welcome on Board](image_url)
WELCOME

- Janice Smiley, interim state FIMR Coordinator, Alabama
- Christopher Borges, state FIMR Coordinator, California
- Miranda Creech, state CDR Coordinator, South Carolina
- Deedree Zerfas, Program Director for FIMR & the Healthy Start Coalition, Flagler & Volusia Counties, FL
- Sharon Cooley, state FIMR Coordinator, New Jersey
- Jodi Bailey, Mississippi Delta Region FIMR
- Aubrey Baker, West Central Indiana FIMR project coordinator
- Dana Miramontes, Louisville, KY FIMR
- Whitnee Smith and Adriana Leio, Ingham County, MI FIMR
- Karamoko Andrews and Janet Clewe, Dallas, TX FIMR

FAREWELL:

- Amy Stratton, state FIMR Coordinator, Alabama
- Eboni Whitehurst, state CDR Coordinator, South Carolina
- Denise Peele, FIMR Coordinator, Mobile, AL
- Karla Shaw and Diamonel Young, FIMR Coordinators, Dallas, TX

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Staff Out & About

Meeting with our state and local partners is the best part of our job. This map highlights the places National Center staff provided on-site technical assistance in the first quarter of 2020. Selected topics included:
• Best Practices in Child Abuse and Neglect Fatality Reviews, a presentation to the North Carolina Child Fatality Prevention System Stakeholder Workgroup
• Working with Bereaved Families, a presentation to the Michigan FIMR Network
• Congressional testimony, Committee on Children and Seniors, Kansas House of Representatives

The National Center is funded to be your one stop shop for all things related to your FIMR and CDR programs. Questions? Concerns? An exciting idea? We would love to hear from you! We are happy to work with your program to address your technical assistance or training needs.

Please reach out at info@ncfrr.org if:
• You are interested in exploring training or technical support opportunities
• You would like to join the FIMR or CDR listserv
• You would like to subscribe to the National Center's quarterly newsletter

Email the National Center

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