2014

Colorado Child Fatality Prevention System (CFPS): Operations Manual

Colorado Department of Public Health and Environment

ACKNOWLEDGMENTS

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Special appreciation to the National Center for Child Death Review and the Michigan, Louisiana, Florida, Kentucky and Wisconsin Child Fatality Review Programs for sharing their review protocols. All existing protocols were reviewed and relevant information was adapted for use in the State of Colorado.

This manual is, and will continue to be, a work in progress. We welcome your feedback and will continue to make improvements based on your recommendations.

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ACRONYMS & DEFINITIONS

ACRONYMS

CAN	Child Abuse and/or Neglect

CDC	Centers for Disease Control and Prevention
CDHS	Colorado Department of Human Services
CDPHE	Colorado Department of Public Health and Environment
CDR	Child Death Review
CFPS	Child Fatality Prevention System
CFR	Child Fatality Review
CFRT	Child Fatality Review Team
CPS	Child Protective Services
CRS	Colorado Revised Statute
DOB	Date of Birth
DOD	Date of Death
EMS	Emergency Medical Services
FTP	File Transfer Protocol
FOIA	Freedom of Information Act
ISVP	Injury, Suicide and Violence Prevention
LPHA	Local Public Health Agencies
NCCDR	National Center for Child Death Review
OPP	Office of Planning and Partnership
ROI	Release of Information
SUID	Sudden Unexpected Infant Death Syndrome
TA	Technical Assistance

DEFINITIONS

Death Certificate FTP Website(s):
Death Certificate FTP Websites are housed by a secure file transfer protocol (FTP) website to protect the confidentiality of each child's case. On a monthly basis, the State Review Team will place case assignments on the FTP website in subfolders labeled by county, year and month for local review teams to retrieve. Each subfolder will have one document per case that will contain select death certificate information.

CDPHE Child Fatality Prevention System support staff:
Child Fatality Prevention System support staff at the CDPHE will serve to help local communities and local public health agencies organize local review teams and conduct effective child fatality reviews. The support team staff is committed to providing guidance, technical assistance and training to foster a statewide, coordinated child fatality review system.

Child Fatality Review (CFR):
CFR is a collaborative process that brings people together at a state or local level, from multiple disciplines, to share and discuss comprehensive information on the circumstances leading to the death of a child and the response to that death. Using a public health approach, local review teams examine the trends and patterns of child deaths to make population-based recommendations to prevent future deaths and to improve the health and safety of children.

Colorado Child Fatality Prevention System (CFPS):
CFPS is the structure for child fatality prevention in the state of Colorado as defined by *Colorado Revised Statute 25-20.5-401-409*. CFPS is used to collectively refer to: State Review Team, CFPS support system (staff at the CDPHE), local review teams and associated infrastructure (e.g. data management system). One key aspect of the CFPS is that it is intended to operate as a non-hierarchical system; that is, no one arm of the system has complete authority over another. When operating ideally, all arms of CFPS system are working together as equal partners.

Colorado Department of Human Services (CDHS) Child Fatality Review Team (CFRT):
CFRT is responsible for reviewing all child deaths, near fatalities and egregious incidents, known to the Department of Human Services (DHS), within the past three years. CFRT focuses on the DHS interaction with the family, makes recommendations to improve DHS systems and is required by the Child Abuse Prevention and Treatment Act (CAPTA) to report on individual cases. In contrast, the Child Fatality Prevention System (CFPS) reviews all child deaths and may identify child maltreatment cases that are unknown to the DHS system. According to *Colorado Revised Statute 25-20.5-407 (1) (i)*, state-level CDHS CFRT and CFPS local child fatality review teams are responsible for developing joint recommendations on an annual basis to the Colorado legislature to prevent child maltreatment.

DEFINITIONS (CONTINUED)

National Center Data Collection Website:
Also known as the National Center for the Review and Prevention of Child Deaths Case Reporting System, the National Center Data Collection Website is an electronic database that local review teams use to record data from all child fatality cases that are assigned by CFPS support staff. The website guides users through each section with ease.

Google Docs Folder:
A Google Documents folder will be used to link training documents and appendices to this operations manual. Folder properties will be set as "public" to allow local team coordinators and team members to have immediate access to templates and training materials.

Local Review Teams:
Local review teams make up a critical component of the CFPS structure for child fatality prevention in the state of Colorado as mandated by *Colorado Revised Statute 25-20.5-401-409*. These teams are responsible for conducting individual reviews of child fatalities in Colorado and making recommendations to prevent child fatalities from occurring in the future. Local public health agencies (LPHAs) are responsible for establishing or arranging for the establishment of local review teams in 2014. These teams will be operational by January 1, 2015. Local review teams may be established as single-county teams or as multi-county (regional) teams.

National Center for the Review and Prevention of Child Deaths:
The National Center for the Review and Prevention of Child Deaths is a resource center for state and local child fatality review programs, funded by the Maternal and Child Health Bureau. The National Center for Child Death Review promotes and supports child fatality review methodology and activities at the community, state, and national levels.

Prevention Services Division Injury, Suicide and Violence Prevention (ISVP) Branch:
The Injury, Suicide and Violence Prevention Branch of the CDPHE is charged with reducing intentional and unintentional injuries in Colorado. The ISVP Branch uses epidemiologic data to guide the development of community and statewide initiatives to prevention injury, suicide and violence.

State Review Team:
The State Review Team is a multidisciplinary committee comprised of volunteer members who are clinical and legal experts in child health and safety. The State Review Team works collaboratively with the CFPS team to review preventable fatalities that occur in children less than 18 years of age in the state of Colorado. Members of the State Review Team are experts in the fields of child abuse prevention, pediatrics, family law, death investigation, motor vehicle safety and sudden infant death syndrome (SIDS)/sudden unexpected infant death (SUID).

INTRODUCTION

This operations manual provides guidelines for the development, implementation and management of the Colorado Child Fatality Prevention System (CFPS). The manual will serve as a reference and source of information for the state and local child fatality review teams.

HISTORY OF COLORADO'S CHILD FATALITY PREVENTION SYSTEM

The Colorado Department of Public Health and Environment (CDPHE) has conducted child fatality reviews at the state level since 1989. The Colorado Child Fatality Prevention System (CFPS) was codified in statute in 2005 *(Article 20.5 of Title 25, Colorado Revised Statutes)* and housed at CDPHE in the Prevention Services Division's Injury, Suicide and Violence Prevention Branch. The 2005 statute created the State Review Team and required the team to review all preventable fatalities of children ages 0-17 that occur in the state of Colorado. This public health review process is different from human service fatality reviews, which focus only on child abuse and neglect cases known to the county human service system. Public health reviews are conducted to identify trends across a variety of child fatality causes and make prevention recommendations for the future.

The 2005 legislation allowed local review teams to form, but did not require them. As of 2014, five of Colorado's 64 counties have actively functioning child fatality review teams: Denver, Morgan, Jefferson, Larimer and Mesa Counties. Pueblo and El Paso Counties had local review teams in the past but have not been active in recent years.

In 2009, the State Review Team began using the National Center for Child Death Review's National Center Data Collection Website. This online database currently contains the complete data on preventable child deaths that were reviewed by the state team from 2004-2012.

This Child Fatality Prevention System statute did not receive an appropriation until Senate Bill-255 passed during the 2013 legislative session. With this bill, all comprehensive reviews of preventable fatalities of children shifted from the State Review Team to the local level. This statute requires local public health agencies to establish or arrange for the establishment of local, multidisciplinary child fatality review teams. CDPHE will provide oversight, funding, and comprehensive technical assistance to the local child fatality review teams.

Colorado Revised Statute 25-20.5-401-409 Child Fatality Prevention Act

OPERATING PRINCIPLE &
OUTCOMES OF A CHILD FATALITY PREVENTION SYSTEM

OPERATING PRINCIPLE

The death of a child should invoke a community response. The circumstances involved in most child fatalities are multidimensional, and responsibility does not rest in any one place.

GOALS

- Improve understanding of how and why children die
- Identify opportunities to influence policies and programs
- Improve child health, safety and protection
- Prevent deaths of children aged 0-17 years in Colorado

OUTCOMES

In order to ultimately prevent child deaths in Colorado, local review teams, the CFPS State Review Team and CFPS support staff will work collaboratively to:

1. Assure that every county in Colorado is represented on a local review team and that each team is fulfilling the local review team duties as defined in *CRS 25-20.5-405*
2. Enhance partnerships and communication among multidisciplinary state and local CFPS stakeholders
3. Complete data entry of child fatality cases in the National Center Data Collection Website that is consistent and accurate
4. Improve understanding of aggregated trends and patterns for child fatality data to promote actionable prevention recommendations
5. Increase the number and quality of evidence-based and actionable prevention strategies developed by local review teams and the State Review Team, in collaboration with the CDHS CFRT
6. Increase and/or leverage funding to support child fatality prevention efforts
7. Increase positive impacts on risk and protective factors for child fatalities resulting from well-designed, implemented and evaluated local-level child fatality prevention projects
8. Increase the number of systems changes to prevent child fatalities
9. Develop and implement state-level policies to prevent child fatalities

CHILD FATALITY PREVENTION SYSTEM SUPPORT STAFF

The Child Fatality Prevention System support staff at the CDPHE will serve to help communities organize local review teams and conduct effective reviews. They are committed to providing guidance, technical assistance (TA) and training to foster a statewide, coordinated system.

Colleen Kapsimalis, Program Manager
Provides overall leadership for the CFPS and coordinates the State Review Team. The Program Manager works closely with the CDHS CFRT to coordinate joint prevention recommendations. The Program Manager also oversees funding for local public health agencies to support local review teams.

Leah Emerick Anderson, Technical Assistance and Child Fatality Prevention Coordinator
Provides training, technical assistance and prevention coordination for local review teams. The Technical Assistance and Prevention Coordinator provides ongoing technical assistance on the facilitation of child fatality reviews; selection of evidence-based injury, suicide and violence prevention strategies; and the development of actionable community-based prevention recommendations.

Beth Secor, Statistical Analyst
Serves as the statistical analyst for the CFPS and manages all data collection and analysis components of the CFPS, including: assigning cases to local review teams through the Death Certificate FTP Websites; writing annual data reports for local child fatality review teams, as well as summarizing and interpreting aggregated data trends and patterns of child fatalities occurring in Colorado. The Statistical Analyst will provide ongoing technical assistance on using the Death Certificate FTP Websites and the National Center Data Collection Website.

Julie Reichenberger, Records Abstractor
Requests, analyzes, and abstracts child fatality case records for the State Review Team. This is a term-limited position to support the review of child deaths while local review teams are being established. As local review teams begin to form, the Records Abstractor will provide technical assistance on abstracting case records.

Shelli Marks, Sudden Unexpected Infant Death Data Coordinator
Requests, analyzes, and abstracts child fatality case records for the Sudden Unexpected Infant Death (SUID) Case Registry, which is a special project funded through the Centers for Disease Control and Prevention. This project aims to improve the investigation and reporting of sleep-related infant deaths. The SUID Data Coordinator will continue to oversee the review of SUID deaths until formation of local review teams. Starting in 2015, local review teams will begin reviewing SUID deaths and the SUID Data Coordinator will provide technical assistance on abstracting case records.

Lindsey Myers, Injury and Violence Prevention Unit Manager
Manages the Unit where the Child Fatality Prevention System is housed and supervises the CFPS Manager. The Unit Manager provides consultation to the CFPS and serves on the CFPS State Review Team.

 CFPS staff contact information document

STATE REVIEW TEAM MEMBERSHIP AND DUTIES

The Colorado Child Fatality Prevention System State Review Team is a volunteer, multidisciplinary committee comprised of clinical and legal experts in child health and safety. They work

collaboratively with CFPS staff to review deaths of children less than 18 years of age. Members of the State Review Team are experts in the fields of child abuse prevention, pediatrics, public health nursing, family law, death investigation, motor vehicle safety and sudden infant death syndrome (SIDS)/sudden unexpected infant death (SUID).

MEMBERSHIP *(C.R.S. 25-20.5-406)*

The State Review Team is comprised of forty-six members representing multiple disciplines and agencies, explicitly described in the legislation. Members are appointed for three-year terms and are eligible for reappointment. The State Review Team includes:

- Eighteen (18) voting members appointed by the Governor,
- Sixteen (16) voting members who represent state agencies (CDPHE, Department of Human Services, Colorado Department of Public Safety and Colorado Department of Education) appointed by the executive directors, and
- Twelve (12) additional non-voting members selected by majority vote of the State Review Team.

Sate Review Team contact information document

STATE REVIEW TEAM DUTIES REQUIRED IN STATUTE (C.R.S. 25-20.5-407)

- Provide protocols and guidelines for local and regional review teams.
- Provide training and technical assistance to all local and regional review teams regarding the process and facilitation of a child fatality review, confidentiality, data collection, evidence-based prevention strategies and the development of prevention recommendations.
- Aggregate data from all of the local review teams to identify state-level trends and patterns of child deaths to make state-level policy and systems prevention recommendations.
- Provide annual data reports to each local review team that summarizes its single county or multi-county data entered into the National Center Data Collection Website.
- Work with the CDHS CFRT to issue joint prevention recommendations for child abuse and neglect fatalities.
- Generate an annual legislative report to the Colorado State Legislature each July. The report will be based on aggregated data from the local team reviews and will include recommendations for preventive actions and policy improvements to promote the safety and well being of children.

ELECTION OF STATE CHAIRPERSONS

The chairpersons of the State Review Team are elected for two-year terms by a majority vote of the members of the Team. The term of first chairperson must be staggered with the term of second chairperson. One of the chairpersons must be a governor-appointed member of the State Review Team.

TERMINATING STATE TEAM MEMBERSHIP

A member of the State Review Team may resign at any time. All appointees who leave their employment and otherwise cease to be active in their designated discipline must notify the CFPS staff with a resignation letter. Depending on type of appointment, the Office of the Governor, the CFPS staff or the State Review Team will appoint a replacement as soon as possible.

ESTABLISHMENT OF LOCAL OR REGIONAL REVIEW TEAMS

FUNDING FOR LOCAL AND REGIONAL REVIEW TEAMS

Colorado Revised Statue 25-20.5-401-409 appropriates funding to support local and regional review teams throughout Colorado.

PLANNING MONEY

During the first year of funding (between January 15, 2014-June 30, 2014), local public health agencies will receive $2,500 per county to use for the development of local review teams. Local public health agencies will:

- Determine local team structure (single-county team or multi-county "regional" team);
- Identify the coordinating agency of the local review team (the local public health agency or a designated external agency);
- Identify a point of contact or local coordinator for the local review team;
- Determine local review team members included in the legislation (public health agency, department of human services, coroner, law enforcement, county attorney, district attorney, and school district); and
- Register the local coordinator and other team members, as needed, in the National Child Death Review Reporting System's National Center Data Collection Website.

The CDPHE will work directly with local public health agencies to reimburse agencies for local review team planning and prevention efforts. Local public health agencies may spend planning dollars on expenses related to establishing local review teams, such as: reimbursing travel costs for potential local review team members, meeting space, food and meeting materials. If agencies are unable to use the full $2,500 on planning activities, it is acceptable to use the remaining balance to support child fatality prevention efforts (e.g. purchasing car seats, contributing to educational campaigns, etc.).

IMPLEMENTATION MONEY

During the next fiscal year (July 1, 2014-June 30, 2015), and for subsequent years, approximately $314,000 will be allocated to local review teams to coordinate team meetings, request records, review individual child fatality cases, facilitate local review team meetings, enter data into the National Center Data Collection Website and to implement child fatality prevention initiatives.

The funding amount for each local review team will be allocated using a funding formula based on the maximum number of child death cases the local review team will be expected to review in a given year. The total funding amount includes a $1,000 base for each county plus $700 per case. Each year, the funding formula will be reviewed to ensure that local review teams are appropriately funded. The CDPHE anticipates that funding will remain consistent from year-to-year. Funding will be additive if counties are part of a multi-county agency or if counties choose to regionalize for a multi-county review team. Additional details about the funding formula are available upon request.

If a local public health agency is coordinating the local child fatality review team, the implementation money may be incorporated into the CDPHE's Office of Planning and Partnerships (OPP) contracts. If a local public health agency will not be coordinating the local review team, the CDPHE will coordinate the funding and contracts through the Prevention Services Division.

It is acceptable to use the funding to coordinate the local review team, request records, review individual child death cases, facilitate local review team meetings and enter data into the National Center Data Collection Website and to implement child fatality prevention initiatives. Local teams may determine how to allocate funding. For example, team members can be reimbursed for time and travel to and from review meetings. Another option is to enhance communication among team members who are unable to attend child fatality review meetings in person. It is also acceptable for local teams to use this funding to support child fatality, injury and violence prevention efforts (e.g. purchasing car seats, contributing to educational campaigns, etc.).

Local child fatality review teams receive designated funding regardless of whether there are child deaths to review in a fiscal year. It is acceptable for local teams to use this funding to support child fatality, injury and violence prevention efforts. It is also acceptable to use the funding for trainings and phone calls conducted by CFPS support staff, which local team coordinators will participate in throughout CFPS implementation.

LOCAL REVIEW TEAM MEMBERSHIP

CORE TEAM MEMBERSHIP

Colorado Revised Statue 25-20.5-404 (3)(a)(I) stipulates that local and regional review teams have representatives of public and nonpublic agencies in the county or counties that provide services to children and their families, including:

- County department(s) of public health;
- Local law enforcement agency/agencies);
- District attorney's office;
- School district(s);
- County department(s) of human services;
- Coroner's office or medical examiner's office; and
- County attorney's office.

If a mandated member chooses not to participate, the local child fatality review team should meet to review the child death with the information that is available to them. The local review team coordinator may request records from the absent member's agency and abstract the records prior to the meeting to fill out the National Center Data Collection Website and for discussion during the meeting.

ADDITIONAL TEAM MEMBERSHIP

In addition to the above members, local and regional review teams may have representatives from the following agencies:

- Hospital(s), trauma center(s), or other emergency medical services agencies;
- County board of social services;
- Mental health professional(s);
- Medical professional(s) specializing in pediatrics;
- Court-appointed special advocate (s);
- Child advocacy centers;
- Private out-of-home placement providers;
- Victim advocates associated with law enforcement agencies; and
- Community members at large.

AD HOC MEMBERS

Local Review Teams may designate ad hoc members. Since ad hoc members are not permanent, they do not regularly receive local review team notices. They attend meetings only when they have been directly involved in a case that is scheduled for review or to provide information on team related activities. Ad hoc members provide valuable information without increasing the number of permanent local review team members. They may be child protective service workers involved in a specific case, law enforcement officers that handled a case or a child advocate who worked with a family. All ad hoc members must sign a confidentiality form prior to participating in a child fatality review meeting.

LOCAL REVIEW TEAM STRUCTURE

Colorado Revised Statue 25-20.5-404 (1) requires each county or district public health agency to establish, or arrange for the establishment of a local review team. County or district public health agencies may choose to collaborate to form a regional review team. Local public health agencies may also decide to delegate the coordination of the local review team to another agency or organization within their community. If a public health agency chooses to delegate the coordination of the local or regional review team, the public health agency must submit a formal letter on letterhead to the CFPS staff delegating team responsibilities to the designated agency.

District public health agencies that serve multiple counties may choose to establish a separate review team in each of their counties or they may consider establishing a multi-county review team that reviews child fatality cases from all counties in their jurisdiction.

SINGLE COUNTY TEAM STRUCTURE

County or district public health agencies may choose to convene single-county review teams. Under this model, the single county team would comprise representatives from agencies and organizations within that county.

Components of a single-county review team:

- Local public health agency or a designated agency facilitates the child fatality review process for its jurisdiction
- Local review team members are from agencies within the county
- Local review team members may bring information for review during the meeting or they may send agency records in advance to the local coordinator
- Local review teams meet as often as necessary to review child death cases
- Single-county review team can meet with other single-county review teams within a region to discuss prevention recommendations

These meetings occur after the CFPS Statistical Analyst sends out annual data reports to the local review teams to facilitate a discussion about trends, patterns and prevention strategies.

MULTI- COUNTY (REGIONAL) TEAM STRUCTURE

Multi-county review teams consist of representatives from more than one county. These "regional" teams are an alternative option to single county review teams where the annual number of child deaths may be small, making it difficult for the local review team to maintain continuity and efficiency. Such review teams are recommended for counties where current relationships, natural boundaries and sharing of resources exist.

When building a regional review team, organizers should consider inter-county collaborative agencies or facilities that cross county jurisdictions, for example, health department districts or emergency medical services regions. Every county covered by a local review team should be represented on the local review team. An agency regional director or other professional whose jurisdiction or responsibilities include all of the counties can fulfill this requirement.

To ensure that the concept of community involvement is met, reviews should be attended by at least one representative from each core member agency in the county where the illness/injury/event that caused the child fatality occurred. This allows regional review teams to receive information from professionals directly involved with a death while strengthening local review team relationships with various local agencies. Establishing and maintaining such relationships is critical if team prevention, training and education objectives are to be achieved.

Components of a multi-county team review:

- LPHA jurisdiction covers multiple counties or LPHAs partner to form a multi-county team
- Coordinating LPHA or a designated coordinating agency facilitates the child fatality review process for all counties on the regional review team
- Multi-county team membership options:
    - All county agencies present: large team with team members from all county agencies within a team's jurisdiction. There may be multiple agencies from the same discipline from different counties.
    - Discipline representatives present: this multi-county team has representatives from all of the legislatively required disciplines but the agencies may be from different counties in the local review team's jurisdiction
- Specific local review team members are invited, as necessary, to review cases
- Team members can bring information for review during the meeting or send agency records in advance to the local coordinator
- Multi-county review teams meet as often as necessary to review child death cases
- Multi-county review teams require a Memorandum of Understanding (MOU) among county agencies that are part of the regional team.

 Sample MOU document

ROLE OF LOCAL REVIEW TEAM MEMBERS

The role of local review team members can be flexible to meet the needs of particular communities. The individual abilities of members should be tapped to enhance team effectiveness. The role of team members is to:

- Identification of child fatalities
- Contribute information from his or her records
- Serve as a liaison to respective professional counterparts
- Provide definitions of professional terminology
- Interpret agency procedures and policies
- Explain the legal responsibilities or limitations of his or her profession
- Assist in the creation of prevention recommendations
- Advocate for the implementation of prevention recommendations

Each local review team member must maintain a clear understanding of their own role and the role of other professionals and agencies in the community's response to a child fatality. In addition, local review team members need to be aware of and respect the expertise and resources offered by each profession and agency represented on the team. The integration of these roles is critical to a well-coordinated community child fatality review system.

PUBLIC HEALTH

Local public health agencies provide the prevention perspective and can apply the public health approach to child fatality reviews. Public health agencies facilitate and coordinate preventive health services and community health education programs. Public health local review team members can provide vital records and epidemiological risk profiles of families for early detection and prevention of child fatalities, as well as information on county public health services. Public health doctors and nurses can help identify public health issues that arise in child deaths and

provide medical explanations and public health guidance. If a child was treated in a local public health facility or received home visits, they can provide medical histories and explain previous treatments, which may be especially helpful in the review of infant deaths. Many local public health agencies can provide information on risk factors as well as services to high risk pregnant women and their families.

CORONER'S OFFICES

Coroners are central to the function of both local review teams and child death investigations. In Colorado, coroners determine the cause and manner of death. They lay the groundwork for discussion by presenting basic information about cause and manner of death, including findings from the scene investigation, autopsy and medical history. They can also interpret clinical findings and provide additional details that help local review teams better understand a cause of death ruling. Local review teams will review child fatalities based on county coroner jurisdiction. Coroners have jurisdiction for cases when the incident leading to the death occurred in the coroner's county of jurisdiction. In out-of-state fatality cases, the jurisdiction will be based on where the patient is pronounced dead.

LOCAL LAW ENFORCEMENT AGENCIES

Law enforcement professionals provide information on criminal investigations of child fatalities under local team review. They also check criminal histories of children, family members and/or suspects in intentional child death cases. To ensure sufficient representation, both the sheriff's department and the police department with the largest jurisdictions should have members on the local review team. Law enforcement professionals serve as liaisons between the local review team and other local law enforcement departments. They assist in persuading officers from other agencies to participate in reviews of deaths in their jurisdictions. Law enforcement professionals are usually the local review team members who are best trained in scene investigation and interrogation, essential skills for determining how a child died. Such expertise provides useful information and training to other members.

COUNTY DEPARTMENT OF HUMAN SERVICES

County departments of human services have the legal authority and responsibility to investigate child deaths and to provide protection to siblings who might be at risk. As local review team members, County departments of human services representatives can provide detailed information on families and on their investigations into child deaths. County departments of human services may have prior agency contact information including reports of neglect or abuse on a child or sibling(s), and services previously or currently provided to a family. Human Services professionals may be able to provide information on a family's history and sociological factors that influence family dynamics, such as unemployment, divorce, previous child deaths, history of domestic violence or drug abuse, and previous child abuse. When reviews indicate a need, County departments of human services representatives can provide services to surviving family members. Human Services professional's knowledge on issues related to child abuse and neglect cases is essential to local review team effectiveness.

COUNTY ATTORNEY'S OFFICES AND DISTRICT ATTORNEY'S OFFICES

Prosecutors educate local review teams on criminal law and provide information about criminal and civil actions taken against those involved. They can also explain when a case can or cannot be

pursued and provide information about previous contact or criminal prosecutions of family members or suspects in child deaths.

SCHOOL DISTRICTS

Educators, district school nurses and district counselors can provide local review teams with perspective on child health, growth and development. Although federal laws preclude educators from sharing student case records with local review teams, their presence at child fatality reviews enhances the delivery of support services and interventions. This is especially true in cases of traumatic death, particularly in developing school support services in the event of suicides and homicides. Representatives from school districts are also able to provide leadership in implementing local review team prevention recommendations.

PEDIATRICIANS

Pediatricians provide local review teams with medical explanations and information about child development. They can access medical records from hospitals and from other doctors. If a pediatrician testifies regularly in child abuse trials, his or her expert opinion regarding medical evidence can be useful. It is preferable to have a pediatrician as a local review team member who is experienced in treating victims of child abuse and neglect. If a pediatrician is unavailable, local review teams may select a physician who specializes in pediatrics and child development.

EMERGENCY MEDICAL SERVICES

Emergency Medical Services (EMS) is frequently first at the scene and obtain critical information regarding the scene and circumstances, including the behavior of witnesses. The EMS Run Report is also useful in determining body position at death and identification of other evidence that may have been moved before an investigator's arrival at a scene. EMS also has well-established relationships with local hospitals and may be able to provide a perspective from these agencies.

HOSPITALS

Local hospital representatives on local review teams may be emergency department staff, quality assurance officers, social workers or key administrators. Their participation can facilitate the sharing of medical records with a local review team. When a child is transported to an emergency room, hospital representatives can provide a local review team with pertinent information. They can also use recommendations from reviews to help improve hospital practices. Though hospitals, trauma centers and EMS are part of the optional member list, it is strongly encouraged for local review teams to reach out to hospitals because they often have injury prevention specialists on staff and can help determine and implement prevention strategies or connect recommendations to resources.

COMMUNITY MENTAL HEALTH PROFESSIONALS

The mental health representative on a local review team provides information and insight regarding psychological issues related to events that caused a child death. Although federal guidelines preclude community mental health from sharing case-specific information unless consent is obtained, they can suggest when counseling or other mental health service referrals may be appropriate. Their participation at the review can provide valuable insight into their own agency policies and practices.

PROBATE OR FAMILY COURT

Juvenile judges or probation officers can provide local review teams with information on crimes and delinquencies involving older children. A large number of teenagers die as a result of suicide and homicide. Records from juvenile probation workers can assist in reviews of such deaths. The court can provide information related to child abuse and neglect. The courts can also learn from reviews and improve child protection and juvenile court proceedings.

Contact list for county coroner's offices, law enforcement agencies and hospitals
If you have updates to these lists, please contact the CFPS staff to make the change.

LOCAL REVIEW TEAM COORDINATOR

Local review teams are created through individual efforts and voluntary cooperation among agencies and professionals involved with child fatalities. Though it is not required for local review teams to have a coordinator, it is recommended to designate one person who is willing to commit the time and effort required to form a local review team and to establish a multiagency, multidisciplinary team in your jurisdiction. It is required, however, for local review teams to identify a point of contact to act as a liaison between the local review team and the CFPS support staff.

Typically, the local review team coordinator will be a representative from the LPHA. If the LPHA chooses not to act as the coordinating agency, they will be responsible for designating a local review team coordinator from another agency. Individuals interested in organizing local review teams may come from any profession. Local review teams have been initiated by public health professionals, medical examiners, prosecutors, law enforcement personnel, social service and child advocates.

Within existing resources, the LPHA may choose to employ a local review team coordinator to facilitate the local review team. If your LPHA decides to do so, a sample job description for the local coordinator is available.

Sample job description

COMMON DUTIES

The following list describes the most common duties of the local review team coordinator:

- Recruit members to participate on the local review team.
- Determine meeting dates and send meeting notices to local review team members.
- Access the Death Certificate FTP Website to identify child deaths assigned for review.
- Compile the summary sheet of cases to be reviewed and distribute to local review team members prior to each meeting.
- Request records required for each case or coordinate the sharing of records from individual agencies represented on the local review team.
- Ensure that all cases are entered into the National Center Data Collection Website.
- Ensure that all new members and ad hoc members sign a confidentiality agreement prior to their first meeting.
- Coordinate and facilitate local review team meetings.
- Ensure that the team operates according to protocols as defined by the team or law.
- Promote team success by following through with recommendations and prevention initiatives and activities.
- Ensure that new members receive a manual and an orientation to the local review team prior to their first meeting.
- Facilitate contacts with the media.
- Maintain contact with the CFPS support staff.

LOCAL REVIEW TEAM MEMBER RECRUITMENT

The local review team coordinator should contact the directors of local member agencies to discuss establishing a local review team. Before meeting with various agencies, local review team coordinators need to become familiar with agency roles and the value they bring to the local review team. In recruiting local review team members, request the highest level of agency staff join the team. They will have the authority to implement changes and to commit their agencies to cooperative projects. When an agency director is not available, a staff member authorized to make agency decisions should be recruited. Designate an individual who is knowledgeable and experienced with child deaths to represent the agency.

TECHNICAL ASSISTANCE AND TRAINING

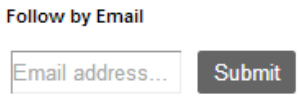
Observing an existing local review team will answer many questions regarding how local review teams operate and may also provide direction for recruiting potential members. In addition to studying the informational materials and guidance documents supplied by CFPS support staff and attending scheduled trainings, we encourage you to attend a State Review Team meeting to become familiar with the child fatality review process. A formal training for local review team coordinators will be held on June 5-6, 2014.

The CFPS support staff serve to help local communities organize a local child fatality review team and conduct effective reviews. The staff is committed to providing guidance, technical assistance and training to foster a statewide, coordinated child fatality prevention system. Throughout implementation of the system, there will be ongoing training and technical assistance on the facilitation of child fatality reviews; selection of evidence-based injury, suicide, and violence prevention strategies; development of actionable community-based prevention recommendations; records abstraction and data collection into the National Center Data Collection Website. By participating in the training and technical assistance opportunities provided by CFPS support staff, local child fatality review team members will be able effectively review child deaths.

CHILD FATALITY PREVENTION COLLABORATION WEBSITE

To stay abreast of all upcoming training opportunities, local team members should follow the CFPS's collaboration website to be informed by e-mail. To sign up, please visit the website and enter your email address in the "follow by e-mail" section; click the submit button to confirm.

www.cochildfatalityprevention.com



A calendar of training opportunities and CFPS events is also available on the collaboration website.

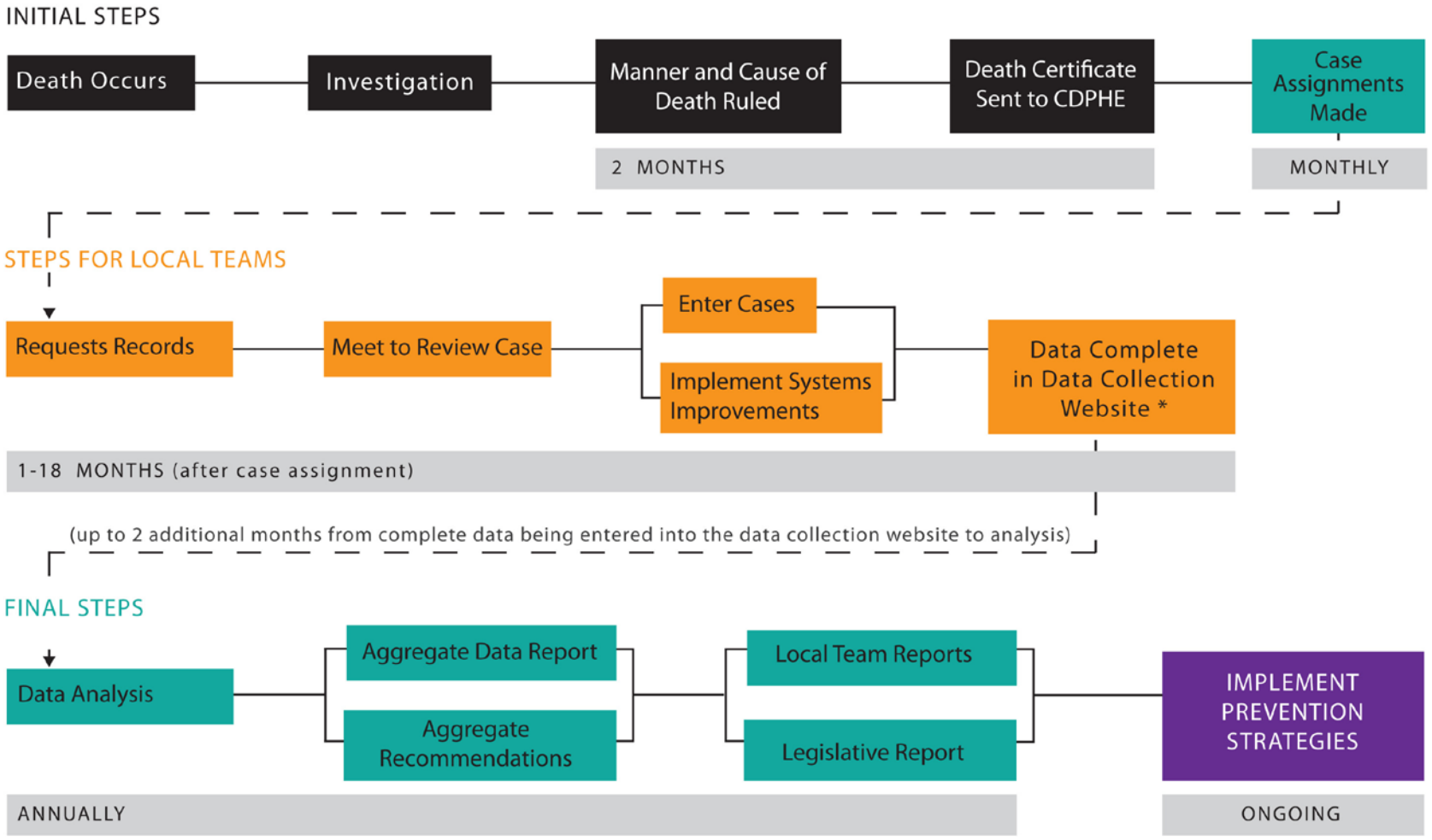
CFPS Training and Events Calendar

REQUEST IMMEDIATE ASSISTANCE

You may also request immediate assistance from the CFPS support team at the collaboration website, by clicking the "contact CFPS staff" button in the right page margin. After clicking through, you will be directed to a short form where you can submit your request. CFPS support staff will be notified immediately and will respond to your request as soon as possible during normal business hours.

Request assistance here

REVIEW TIMELINE



KEY:

= Steps for local teams | = Steps for state team | = Collaborative steps

* cases for a given data year must be completely entered into the data collection website by March 31st, two years following the year of death.

CASE IDENTIFICATION AND ASSIGNMENT

1. Within 30 days of a death being reported to CDPHE's Office of the State Registrar of Vital Statistics, the CFPS staff will upload death certificates by county coroner jurisdiction to a secure File Transfer Protocol (FTP) website referred to as the Death Certificate FTP Website. Local review teams will identify cases for review through the Death Certificate FTP Website. The CFPS staff will create a modified death certificate that will include the information needed to answer some of the questions on the National Center Data Collection Website, as well as the identifying information (name, birth date, death date, and etc.) that local review teams will need to determine which agencies may have records related to the case.
2. Local review teams will have at least a year from the time that a case is identified in a local review team's Death Certificate FTP Website to review the case and enter the review information into the National Center Data Collection Website. Local child fatality review teams should meet as often as necessary to review and collect data on assigned child fatality cases. Frequency of review meetings will vary for each team depending on how many child death cases they are required to review.
3. The CFPS Statistical Analyst will aggregate and analyze data on an annual basis each April. Local review teams will need to have all of their case reviews in the National Center Data Collection Website by March 31st of each year. The data year will always be two years behind the calendar year. For example, by March 31, 2016, local and regional review teams will need to have their 2014 cases entered into the National Center Data Collection Website. On an annual basis, the CFPS Statistical Analyst will reconcile the number of cases assigned with the number of cases actually reviewed to ensure that each preventable child death is reviewed and that data is entered in the National Center Data Collection Website.
4. Cases need to be reviewed and completed by March 31st of each year, which is the end of the data year. At this time, the CFPS Statistical Analyst will analyze and interpret data collected in the National Center Data Collection Website to identify trends and patterns of child fatalities in Colorado. This data, along with aggregated prevention recommendations, will be incorporated into local data reports, which will be disseminated to local child fatality review teams on an annual basis, and the legislative report due to the Colorado General Assembly on July 1st of each year.

RECORDS NEEDED FOR REVIEW

Local review teams are not a mechanism for criticizing or second-guessing any agency decisions; they are a forum for sharing information essential to the improvement of a community's response to a child fatality. Background and current information from local review team members' records and other sources is necessary to assess circumstances of death.

NECESSARY DOCUMENTS FOR CASE ABSTRACTION BY TYPE OF DEATH

The usual documentation sources for finding information are listed in the table below. Some tips to keep in mind:

- Please read all documents pertinent to a case because information is sometimes found in unexpected locations.
- All or no records may be available for review.
- Some documents may not be applicable depending on the circumstances.
- Please contact your local agency representative or contact person for more information.

Type of Death	Documents
Accidental Firearm	Scene investigation reports Police and crime lab reports Child protective services (CPS) histories on family, child and perpetrators Medical Records/Emergency department reports Ballistics information on firearms Juvenile and criminal records of teen and perpetrators Autopsy reports/Coroner reports EMS trip reports Media articles related to incident
Child Abuse and Neglect	Autopsy reports/Coroner reports Scene investigation reports Hospital Medical Records. Shall or may include: EMS trip reports, Emergency Record reports, and Case or Social Worker reports. Prior and most recent CPS or TRAILS reports. Child's hospital medical records. Specify date or dates of admission. For example date of death. Home nursing visit reports from public health or medical healthcare services Media articles related to incident
Drowning	Autopsy reports/Coroner reports Scene investigation reports EMS trip reports Prior CPS history on child, caregivers and persons supervising child at time of death Ages of other children in home Information on zoning and code inspections and violations regarding pools or ponds Media articles related to incident
Fires	Autopsy reports/Coroner reports Scene investigation reports Fire department reports that include source of fire and presence of detectors EMS trip reports Medical Records/Emergency Department reports Information on zoning or code inspections and violations Prior CPS history on child, caregivers and persons supervising child at time of death Home nursing visits from public health or other medical healthcare services Any information on prior deaths of children in family Media articles related to incident
Homicide-Firearm	Scene investigation reports, including storage of firearm Police and crime lab reports CPS histories on family, child and perpetrators Juvenile and criminal records of teen and perpetrators Media articles related to incident Autopsy reports /Coroner reports School records (if applicable)
Motor Vehicle	Autopsy reports /Coroner reports Scene investigation reports and photos

Type of Death	Documents
	State Patrol Full Accident Reconstruction Reports EMS trip reports CDOT Motor Vehicle Accident Reports with road and weather conditions at time of crash Medical Records/Emergency Department reports Blood alcohol and drug toxicology results from surviving drivers of accident Media articles related to incident School records (if applicable)
Other Accidents	Birth records Pediatric records for well and sick visits Death certificates Medical Records/Emergency Department records Ages of other children in home Law enforcement reports CPS reports on caregivers and child Autopsy report/Coroner reports U.S. Consumer Product Safety Commission findings as applicable Media articles related to incident School records (if applicable)
Sudden Unexpected Infant Death (SUID)	Birth and Death certificate information Autopsy reports /Coroner reports Law enforcement scene investigation reports SUIDR-Form from coroner or law enforcement agencies Doll re-enactment reports and photos Infant Birth or Delivery Medical Records Medical Records at time of death. May include previous well baby visits. Hospital Medical Records from death admission. Shall or may include ER Department reports, EMS trip sheet, Social and Case worker notes. Prior CPS history or TRAILS reports on child, caregivers and person supervising child at time of death.) Home nursing visit reports from public health or medical healthcare services State metabolic screening results at birth Any information on prior deaths of children in family
Suicide	Autopsy reports/Coroner reports Scene investigation reports to include criminal and mental health histories (including prior suicide attempts) obtained through interviews Suicide notes Hospital Medical Records. Shall or may include EMS trip report and Emergency Department report. Prior CPS history or TRAILS report on child, caregivers and person supervising child at time of death Law enforcement agency investigative report School records (if applicable)

CONTACT LISTS

In order to access records necessary for review, CFPS has contact lists for the following agencies in Colorado:

- Coroner's Offices
- Law Enforcement Agencies (police departments, sheriff's departments, state patrol)
- Hospitals
- Local Public Health Agencies (specifically for Home Visitation records and Metabolic Screenings)
- Protective Services
- US Consumer Product of Safety Commission

Contact list for county coroner's offices, law enforcement agencies and hospitals **
If you have updates to these lists, please contact the CFPS staff to make the change.

***Note to reviewers: We will be updating this document to include LPHAs, Protective Services, Consumer Product Safety and District Attorney. This updated version will be added to the final document.*

REQUESTING RECORDS

1. Request records from necessary agencies and enter the data into the National Center Data Collection Website with as much information as possible prior to the review meeting.
2. Enter the death certificate data in the National Center Data Collection Website. Ask local review team members to bring records from their respective agencies to enter the remaining information into the National Center Data Collection Website during the review meeting. Local review team members will leave the meeting with their own records.
3. Send out sections of the National Center Data Collection Website to local review team members and ask local review team members to complete their respective sections before the meeting. Compile the sections prior to the review meeting.

REQUEST LETTERS

Request letters for the records should contain the following: letterhead, purpose of request, a reference to section 25-20 5-408 of the Colorado Revised Statutes allowing the release of information without prior authorization, name of decedent, DOD, DOB and the name and address of the person requesting the records. Additionally, the requestor should include a bolded and/or highlighted list of the specific documents being requested and indicate if electronic format is acceptable.

- Request letters by fax: sending request letters by fax is the quickest and most efficient way to request information.
- Request letters by email: sending requests by email is only recommended if you have a contact person's email address, and if your email system is equipped with encryption software.

The requestor should use a tracking system (electronic or paper) to monitor the status of record requests and should allow 30 days for records to be received. After 30 days, the requestor should

follow up with a telephone phone call to the agencies that have not fulfilled a request. In some cases, re-request of the records may be necessary. Requests should be kept on file until you have received the desired documentation.

 Sample request letters and supplemental questions

TIPS FOR REQUESTING HOSPITAL RECORDS

- Request letters should be placed on official letterhead
- Request letters should include: purpose of request, the Colorado Statute allowing the release of information without prior authorization, name of decedent, DOD, DOB and the name and address of the person requesting the records.
- Requests for medical records should be addressed to the Health Information Management or Medical Records Department with an attention line titled "Release of Information (ROI)".
- When requesting records by fax, be sure to establish a secured fax area where you can receive faxed documents while maintaining the confidentiality of the records.
- When requesting records by email, encrypted software must be used.
- Local team Coordinators should develop a working relationship with the Health Information Management or Medical Records Department contact person.
- If the hospital is unable to locate a medical record, determine if the decedent could have been admitted under a different name. Check with Health Information Management or Medical Records Department for the spelling, a variation of the name, a different name, or if a hyphenated name was used. Birth records may also be filed under the mother's maiden name. A pseudo-name is sometimes used to protect the individual from media attention or the perpetrator.
- If doing an on-site record review, the local team Coordinator should make an appointment with Health Information Management or Medical Records Department at least one week in advance and should bring appropriate identification available to the hospital site.
- NOTE: Many health facilities require the name of the requesting agency/facility when birth and/or death records are requested (HealthOne is one such hospital system).

TIPS FOR REQUESTING LAW ENFORCEMENT RECORDS

- Send requests "Attention: Records Department".
- Some agencies prefer requests be emailed to a particular law enforcement agent. Please see the Law Enforcement Directory, for specific instructions for each agency.

 Law enforcement directory

TIPS FOR REQUESTING MILITARY RECORDS

- If the incident occurred on a military base and military police responded to the scene, the investigation and autopsy will be conducted by the military.
- Military investigation record offices require additional permissions as a result of the Freedom of Information Act (FOIA).

CASE ABSTRACTION

TYPES OF CASES BY MANNER

- Accidental
- Homicide
- Suicide
- Undetermined
- Sudden Unexpected Infant Death (SUID)
- Natural
- Natural (SIDS)

**not necessarily all "Natural" cases, definitely SIDS cases and some cases, for example, where there is an unusual medical condition for the age of the child or a premature infant death due to some preventable risk factor during pregnancy. If a team wishes to review all natural cases, they may do so.*

NATIONAL CENTER DATA COLLECTION WEBSITE (NATIONAL CENTER FOR CHILD DEATH REVIEW CASE REPORTING SYSTEM) USER'S MANUAL

Local review teams will be required to use the national National Center Data Collection Website, also known as the National Child Death Review Case Reporting System to report cases.

National Center Data Collection Website

Every local review team coordinator will receive a username and password to access and enter data into the National Center Data Collection Website. If additional team members will be entering data into the system, CFPS support staff can provide them with a username and password as well.

National Center Data Collection Website user's manual

ABSTRACTING TIPS

Whenever possible enter information directly into the National Center Data Collection Website instead of writing it on paper and transferring it at a later time. This will increase efficiency, data quality and confidentiality. Enter as much information as possible into the data collection tool before and during the review. All records that are received before the review meeting in hard copy are entered into the National Center Data Collection Website before the review and are distributed to the local review team members. If you find that the case is under litigation, complete as much of the abstraction as possible without interfering with the trial or investigation, and wait until after the trial to complete abstraction.

CASE SUMMARIES

To help facilitate local review team meetings, coordinators may choose to develop case summaries for each child fatality. Information in the case summaries may be used for the "narrative" section of the data collection tool. The following information should be included in the case summary:

- Manner of death – This is determined as accidental, homicide, suicide or undetermined.
- Cause of death – This is the specific reason the child died (e.g. car crash, gunshot, blunt force head injury, etc.)
- Synopsis of incident/timeline of events surrounding the death
- Demographics, including county, age, medical history of child and caretaker, if relevant
- School history (if applicable)
- Social history
- Investigation information
- Autopsy information

 Case summary templates

DATA ENTRY TIPS

- Missing Variables: it is important to get as much information on a case entered into the National Center Data Collection Website, but if one of the questions is unanswerable because the local review team does not have the record or necessary documentation, leave the question blank.
- Omission/Commission: Follow the National Center for Child Death Review's instructions on how to fill this out. If you disagree on whether it is an act of omission or commission, mark it as probable.
- Do not include identifiers: this is extremely important. The National Center Data Collection Website is secured by the National Center for Child Death Review, but to further protect the data, please do not enter any personal identifying information including names, birthdates, and addresses.
- Make sure to include death certificate numbers: Very important! Since personal identifying information will not be entered into the National Center Data Collection Website, the only way to keep track of cases is to enter the death certificate number. The CFPS statistical analyst also needs this number for data analysis so entering the death certificate number is necessary to include the case in analysis and reports.

SPECIAL CONSIDERATIONS FOR CHILD ABUSE AND NEGLECT (CAN)

*** This section will be added.*

SPECIAL CONSIDERATIONS FOR SUDDEN UNEXPECTED INFANT DEATH (SUID)

These are the usual documents for finding information. Information may be discovered from any document. Please read all documentation during data abstraction. All variables should be completed to the best of the team's ability. Below is a table of priority variables for SUID cases and sources used to obtain the information.

Priority variable(s)	Likely data source(s)
Case Number: date local review team notified of death	This is the date the case was first identified by the local review team. This must be obtained from the CFPS program coordinator.
Section A: 3-7 demographics	Death certificate, birth certificate, medical record admission face sheet
Section A: 19 health insurance	Birth certificate full form, child's medical records admission face sheet
Section A: 14, 15 height & weight	Autopsy records, hospital medical records
Section A: 20 disability/chronic illness	Child's medical records, CPS reports, law enforcement investigation report, autopsy report, birth and/or death medical record
Section A: 24-29 maltreatment	Child protection agency records, law enforcement records,
Section A: 30 - 31 acutely ill	Child's medical records, , hospital records, Autopsy/pathology records, SUIDI form or jurisdictional equivalent, law enforcement records
Section A: 34-46 birth information & prenatal care	Birth certificate, child's birth and delivery medical records, , SUIDI form or jurisdictional equivalent, law enforcement narrative
Section A: 47 abnormal metabolic	Birth Records, autopsy/pathology records, newborn screening results, Birth certificate
Section A: 48-53 last 72 hours	SUIDI form or jurisdictional equivalent, child's medical records, law enforcement records, coroner investigation reports
Section D: 4, 12 incident information	SUIDI form or jurisdictional equivalent, law enforcement records, EMS run sheet, coroner investigation reports
Section E: autopsy information	Autopsy and coroner records, death medical record, SUIDR-form, law enforcement investigative report.
Section H: 1-3 other circumstances of incident	Autopsy and coroner records, death medical record, SUIDR-form, law enforcement investigative report.

SUID supplemental questionnaire

SUIDI reporting form and instructions

SECURE RECORD KEEPING

The CFR case file is no longer just a paper file. It now exists in various formats: paper, film, electronic, or a combination of all three. And, it may reside in any number of locations. Documentation may include birth or death certificates, child protection service reports, autopsy and/or coroner reports, medical records, local and state health records, law enforcement reports, photos, and other reports deemed highly confidential. Once the desired documents are collected, the local review team will determine how to maintain and retain the confidential files. Locked files are recommended for files not in use.

RETENTION

- Length of time determined by team and/or local agency

FILE SYSTEM

- Recommended option such as: by year, sequence number

DESIGNATED FILE AREAS

- Locked locations
- Easy access and retrieval

CONFIDENTIALITY

In order to protect the privacy of individuals and their families, safeguards for the confidential exchange of information must be in place, including:

- All members (including ad hoc members and visitors) attending meetings or discussions sign a confidentiality agreement.
- No identifying information leaves the meeting.
- Maintain only non-identifying information in the child death review web-based data collection system.
- Report data in aggregate form.

At a local review team meeting, all data and information regarding the death of an identified child is confidential. Local review team members should be reminded at each meeting of confidentiality and agree not to disclose any confidential information acquired at the review, except within the mandates of their agencies' responsibilities. Signed confidentiality forms for individual team members are retained for as long as the hard documentation case file exists. A signed confidentiality form for an individual team member or participant is considered effective as long as: 1) the local review team member is still active on the local review team, and 2) the hard documentation case file still exists. Therefore, a local review team member need only sign one confidentiality form while participating in reviews.

Sample confidentiality agreement

COLORADO OPEN MEETINGS ACT

Child fatality review meetings are subject to the Colorado Open Meetings Act, but they must be closed to the public and held as an executive session during the review of individual child deaths. The public and/or media are asked to leave so the local review team can conduct confidential business.

Executive session script

CONDUCTING AN EFFECTIVE REVIEW MEETING

SIX STEPS TO EFFECTIVE REVIEWS

1. Share, question and clarify all case information.
2. Discuss the investigation.
3. Discuss the delivery of services.
4. Identify risk factors.
5. Recommend systems improvements.
6. Identify and be a catalyst for action to implement prevention recommendations.

SCHEDULING A MEETING

Meetings are scheduled during a designated time period to discuss deaths assigned to the local review team. Reviews of such deaths always occur after completion of the investigation and information gathering. Frequency of meetings will vary by team, but will be based on the number of deaths in a county. The average time to review a case that is abstracted prior to the meeting is 20-30 minutes, depending on the circumstances. Review findings are used primarily for identifying potential prevention measures, but also may influence systems and procedures for future death investigations. Before the meeting, the local review team coordinator will compile a summary for each to be reviewed and will send to all team members. This information is gleaned from the death certificate, and will be used as the agenda for the meeting.

BEGINNING THE MEETING

At the meeting, new members and ad hoc members sign the confidentiality agreement prior to the start of the meeting. Each member agrees to keep meeting discussions and information confidential. Confidentiality is essential for each agency to fully participate in the meetings. A confidentiality agreement signed by team members and required for other meeting attendees should be kept at each meeting by the local review team coordinator. Local review team members are reminded by the coordinator that:

- The local review team is not an investigative body.
- Review meetings are open to the public per Colorado Open Meetings Act.
- All participants agree to keep the discussion confidential and discussion of specific cases is protected by *CRS 25-20.5-408 (2)(b).*
- The local review team keeps no written record of the meeting, although members can make notes in their private records. The local review team coordinator can also maintain a record of meeting discussions relating to local review team operation, however, information dealing with specific cases should be verbal.
- Individuals come and leave with only their own records on specific cases.

- The purpose of the local review team is to improve investigations, services and agency practices and to identify ways to prevent other child deaths.
- The coordinator addresses any logistical issues prior to conducting reviews.

CONFLICT OF INTEREST

A conflict of interest may arise for a local review team member. A conflict is defined as any "vested interest" in a specific case. It is the responsibility of the individual team member to excuse him/herself from the case discussion.

SHARING INFORMATION

Reviews are conducted by discussing each child death individually. It is helpful to use the National Center Data Collection Website as a discussion guide. This will help meetings run smoothly and make report completion easier. Participants provide information from their agency's records and, when appropriate, distribute it to other members. If information is distributed, it must be collected again before the end of the meeting. Information can be shared in the following order:

1. The coroner presents information on the investigation, autopsy and final determination of cause and manner of death.
2. The EMS provider presents the run report and any other data.
3. The hospital representative or physician shares information from the emergency room and/or other health care setting.
4. The law enforcement officer presents information on the scene and other investigations.
5. Human services reports on any information it has on the family, child or circumstances.
6. Public health reports on any information it has on the family, child or circumstances.
7. Other team members report on any information they have and can share with the local review team.
8. The prosecutor reports on the status of the investigation and any legal action.

CLARIFICATION

Local review team members next ask for clarification or raise questions about the information shared. Prior to moving on with a review, all members should feel confident that they understand all information as presented or ask for further clarification.

DISCUSSION

The following questions are a guide for facilitating the local review team discussion. These questions align with questions in the National Center Data Collection Website. When all the questions have been answered to the local review team's satisfaction, the review should move to the next case.

1. Are there services we should provide to family members and other persons in the community as a result of this death?
2. Are other children at risk of imminent harm? If so, what action should be taken to protect them?
3. Should we recommend any changes to agency practices or policies based on what we know about the circumstances, cause and manner of this child death?
4. What risk factors were involved in this child death?
5. Could this death have been prevented?
6. What do we recommend should be done to prevent another death in the future?
7. Who should take the lead in implementing our recommendations for prevention?
8. Is our review of this case complete or do we need to discuss it at our next meeting?

HOLDOVER REVIEWS

Cases may need to be discussed at more than one meeting. Local review team members may wish to obtain additional information from their agencies. A local review team member with significant information may be absent. Or, a case may continue to progress and need to be updated.

REFERRALS

If a local review team identifies the need for services, referrals should be made. Referrals are usually handled by the local review team member professionally associated with the program or agency that provides the appropriate service. However, any member can assist in making a referral. Local review teams should discuss how referrals will be made and who will be responsible for handling them.

AGENCY CONFLICT RESOLUTION

Participating agencies may have individuals with concerns or disagreements regarding specific cases. Reviews are not opportunities for others to criticize or second-guess agency decisions in child death cases. Issues with procedures or policies of particular agencies are sometimes identified; however, team members are responsible for any further action taken by their agencies on such issues.

Local review teams are not peer reviews. They are designed to examine system issues, not the performance of individuals. Local child fatality review is a professional process aimed at improving system response to child deaths.

Many agencies involved in local review teams do not have an internal fatality review process. Child Protective Services conducts multi-agency reviews for child fatalities, in which the child or family had prior contact with the agency. Some hospitals conduct internal reviews for in-hospital child deaths.

When conflict among local review team members interrupts a review, the local review team coordinator should intervene so the review can progress. The coordinator can contact the team members outside the meeting to discuss and help resolve conflicts. Sometimes disagreement is both productive and appropriate, but disruption of the review is not acceptable; reviews are to be conducted in a professional manner.

MAINTAINING EFFECTIVE LOCAL REVIEW TEAMS

A local review team follows three stages of development to achieve its goal of reducing the number of preventable child deaths in the community:

1. Organization.
2. Operation.
3. Initiation of prevention efforts and strategies developed from team findings.

Once a local review team has been established and its operating procedures are thoroughly understood, maintenance of the local review team is essential. Some recommendations for maintaining a functional local review team follow:

RESPECT LOCAL REVIEW TEAM AGREEMENTS

For a local review team to operate effectively, it is essential that agreements be recognized and followed by all review team members.

PARTICIPATE AND BE PREPARED FOR MEETINGS

Reviews require regular attendance and participation by all members. Members should become acquainted with the questions that will be addressed at every review and come prepared to present their agency's information and perspectives. Prior to each meeting, team members should gather relevant information on each case on the agenda.

KEEP REGULAR MEETING SCHEDULES

Regularly scheduled meetings allow team members to make long-term plans and allow for better attendance. Canceling scheduled meetings diminishes a local review team's ability to gather information and hinders the cooperative networking of the members. A team can only achieve its objectives by meeting routinely.

PROVIDE AN EDUCATIONAL ELEMENT AT LOCAL REVIEW TEAM MEETINGS

Keep members informed of team-related training, changes in laws regarding their professions and new child death or injury prevention programs. Ongoing education should be an integral part of every local review team's operation. Periodic presentations and informative handouts enhance a team's ability to accomplish its objectives.

USE THE COLORADO NETWORK OF LOCAL REVIEW TEAMS

When a local review team needs information on a case or identifies trends, be sure to contact other local review teams for suggestions on how they handled a problem or to obtain input on innovative team efforts.

USE THE CFPS STAFF AND THE STATE REVIEW TEAM

The CFPS staff and the State Review Team are available to provide technical assistance, linkages to professional resources and coordination with other local review teams.

PROVIDE OTHER MEMBERS WITH SUPPORT

Each profession brings to the local review team its perspective, professional knowledge and expertise. It is support, not criticism, which will encourage change and foster improvements. Realize that disagreement between members is sometimes unavoidable, but if handled appropriately, can help the team to function effectively. It is the responsibility of the local review team coordinator to reinforce productive exchanges and discourage dialogue disruptive to the

review process. Each member must acknowledge and respect the professional role of each participating agency. Improvements will come through cooperative effort, not through coercion.

DO NOT LOSE SIGHT OF THE LOCAL REVIEW TEAM'S PURPOSE AND OBJECTIVES

A periodic review of a local review team's stated purpose; goals and objectives will provide direction to the team and remind members why the local review team was originally formed.

LOCAL REVIEW TEAM MEMBERSHIP IS A LONG-TERM COMMITMENT

A local review team is not an ad hoc committee that collects data on child deaths for a designated period. It is a panel of professionals dedicated to establishing a better understanding of the causes of child deaths in their community. Discovering the patterns that cause or contribute to preventable child deaths is an ongoing process. Patterns change over time within a community. The aggregate knowledge acquired by local review team members provides structure for achieving effective results.

A LOCAL REVIEW TEAM IS BOTH A MESSAGE TO THE COMMUNITY AND MESSAGE FROM THE COMMUNITY

By participating on a local review team, local professionals who take responsibility for the protection, health, and safety of their community's children communicate their pledge to better understand child deaths. Their participation represents their commitment to eliminating obstacles to integrated community responses to child deaths and to creating opportunities to prevent deaths to other children.

TAKING ACTION TO PREVENT CHILD DEATHS

The ultimate purpose of child death review is to keep kids alive. By understanding how and why children die, our communities can take action to prevent other similar deaths. Local review teams should make sure that every child death that could have been prevented makes a difference in the lives of other children. The review of each child death concludes with a discussion of how to prevent another death in the community. Local teams can focus their discussion on short- and long-term interventions relating to policy, programs, and practice. Teams are not expected to design and implement recommendations; reviews are intended to catalyze community action. Teams should identify the best way to translate prevention recommendations into action. Individual agencies or team members can assume responsibility and work with existing prevention coalitions or establish new ones.

The key to good prevention is leadership at the local level. Local review team members can provide this leadership by serving as catalysts for community action. Prevention efforts can range from simply changing one agency practice or policy, to more complex interventions like intensive home visitation programs for high-risk parents.

To assist local review teams with the development of these efforts, local, state, and national programs are available. Such programs address specific prevention needs for the health, safety and well-being of children and families. Available in both the public and private sectors, these programs can be sponsored by religious, community, professional, and/or government organizations. Some are short-term projects with temporary funding; others are established programs with documented results and proven track records.

Again, local review teams are not expected to design and implement prevention recommendations; reviews are intended to catalyze community action. Individual agencies or local review team members can assume responsibility to work with existing or new prevention coalitions to enact change. Some communities have child safety coalitions, prevention coalitions or active citizen advocacy groups. Connect your local review team findings with these community groups to ensure results. In addition, assist these groups in accessing state and national resources in the prevention areas targeted by your community.

A short list of prevention categories include:

- Safe Infant Sleep
- Teen Pregnancy Prevention
- Suicide Prevention and Counseling
- Firearm Safety
- Crime Victim's Assistance
- Gang Prevention and Intervention
- Substance Abuse Counseling and Education
- Drowning Prevention
- Child Car Seat Safety
- Teen Driving Safety
- Bicycle Safety
- Fire Safety
- Prenatal Care
- Parenting Skills
- Infant and Child Day Care Programs
- Child Abuse and Neglect Prevention Programs
- Poison Control
- Consumer Product Safety

Focusing on prevention is how your team will find meaning and purpose over the long haul. The CFPS support staff developed tools using the public health framework for prevention to help you identify preventive action that can be taken at all levels of the social ecology. These tools will lead you through the process of formulating effective recommendations, identifying key individuals, and following up on recommendations for preventive action. Prevention tools may be found on the Colorado Child Fatality Prevention website under the "Prevention Efforts" tab.

The reviews can lead to many initiatives, some involving short-term, easy-to-fix problems and others requiring long-term, extensive planning efforts. However, due to the small number of deaths in many rural counties, important trends may not be apparent to the local teams, and only become evident when statewide data are compiled by CFPS support staff. The CFPS State Review Team will develop recommendations for legislation, administrative agency policy and practice, and public education based on the collective experiences and recommendations from local review teams.

As part of the funding available to develop and implement local child fatality review teams, there is funding available to implement prevention strategies based on the recommendations from local child fatality review team discussions. CFPS support staff and local child fatality review teams will work collaboratively to analyze data trends and patterns, interpret the data, select evidence-based prevention strategies, and implement community-based prevention strategies.

DATA ANALYSIS

Local review teams will have access to their own data through the National Center Data Collection Website, also known as the National Center for Child Death Review Case Reporting System. Through this system, review teams will also be able to generate standardized reports by going to the menu on the left and clicking "Standardized Reports". You will want to select only your local team. For data on years before and including 2013, you do not want to select "All of

Colorado" because there are duplicates. The State Review Team and a few local child fatality review teams were reviewing some of the same cases. There are many interesting reports that you can generate based on other criteria. However, local review teams will also be able to generate standardized reports. For more complex analyses, contact the CFPS Statistical Analyst for assistance. In addition to individual requests, the CFPS Statistical Analyst will provide each local review team a data report of their cases on an annual basis.

On an annual basis the CFPS statistical analyst will analyze and interpret data collected in the National Center Data Collection Website to develop trends and patterns of child deaths in Colorado. This data, along with aggregated prevention recommendations, will be incorporated into local data reports, which will be disseminated to local child fatality review teams on an annual basis. The data and aggregated prevention recommendations will also be incorporated into the annual legislative report.

MEDIA REQUESTS

It is important that local review teams establish effective working relationships with the media. Media involvement is fundamental to a local review team's ability to promote awareness and educate the public regarding child deaths. It is recommended that the local coordinators serve as the team's media contact. Confidential case information is not to be disclosed to the media. Because the objectives and review process are frequently misunderstood by the media, the local review team coordinator and members need to reinforce that this is not a "fault-finding panel." When interacting with the media, it is important to highlight that the purpose of child fatality reviews is to develop child fatality prevention recommendations.

For media requests regarding data/statistics, the local coordinator should contact the CFPS statistical analyst, Beth Secor, beth.secor@state.co.us.

By viewing the media as a useful tool for promoting child death prevention strategies, local review team members can more comfortably interact with media representatives. This allows local review teams to function more effectively and better serve the community.

EVALUATION

EVALUATION PLANNING PROCESS

As part of the implementation of *CRS 25-20.5-401-409*, CDPHE created a five-year evaluation plan to measure the impact of the new Colorado Child Fatality Prevention System. Representatives from the CFPS support staff, the State Review Team, existing local review teams and local public health agencies that will be establishing local review teams for the first time served as stakeholders for the evaluation planning process and made up the evaluation team. The

Epidemiology, Planning, and Evaluation (EPE) unit within CDPHE was contracted by CFPS to plan an evaluation. EPE has developed a guide for planning evaluations that incorporates three workshops to engage stakeholders in a sequential planning process.

The workshop planning process is designed to facilitate evaluation planning by engaging the evaluation team in group discussions about the use and priorities of the evaluation in a sequential fashion. The evaluation plan was written based on the content of the workshops and was a working document reviewed by the evaluation team in between workshops. The specifics covered during the workshops included brainstorming a list of evaluation stakeholders, determining and prioritizing evaluation questions, and identifying data sources and indicators to answer process and outcome evaluation questions.

EVALUATION BACKGROUND

Conducting child fatality reviews at a local level is considered 'best-practice,' but due to a lack of evaluation efforts there is little evidence supporting this claim. Colorado is in a unique position to evaluate a Child Fatality Prevention System that conducts reviews at a local level as well as evaluating the process needed to implement such a system. As such, there are two goals of this evaluation:

1. A process evaluation of how the CFPS is implemented in order to provide:
    - Data for continuous quality improvement during implementation and maintenance of the system, and
    - Evidence-based, best-practice recommendations for implementing and running a state-wide, locally implemented Child Fatality Prevention System.
2. Evaluation of the outcomes of the CFPS with a particular focus on how successful CFPS is at producing actionable prevention recommendations and the actions taken as a result of these recommendations.

EVALUATION DESIGN

A multi-faceted evaluation is required in order to capture the different processes that are occurring during the implementation of the legislation as well as the outcomes of the legislation change. A two-pronged evaluation design is proposed:

1. A process evaluation of how the CFPS is implemented and run in order to provide (a) data for continuous quality improvement and (b) evidence-based recommendations for implementing and running a state-wide, locally implementation Child Fatality Prevention System.
2. An outcome evaluation with these two overarching evaluation questions:
    - What actionable prevention recommendations result from the CFPS process?
    - What actions are taken as a result of these recommendations?

The structure of the CFPS means that there are three domains in which evaluation will occur:

- Local review teams
- State child fatality review team
- State support system

The CFPS evaluation plan