Colorado Child Fatality Prevention System

AN INTRODUCTION TO THE SYSTEM

COLORADO
Department of Public Health & Environment

Introduction

The death of an infant, child or youth should invoke a community response. The circumstances involved in most deaths are multidimensional, and responsibility rarely resides in one place. The ultimate purpose of child death review is to keep infants, children and youth alive. By understanding how and why children die, our communities can take action to prevent other similar deaths. Local child fatality prevention review teams should make sure that every child death that could have been prevented makes a difference in the lives of other infants, children and youth. The review of each death concludes with a discussion of how to prevent another death in the community. Focusing on prevention is how your team will find meaning and purpose.

In Colorado, the system to review individual infant, child and youth deaths, review trends and aggregated data, and develop and implement prevention recommendations is called the Child Fatality Prevention System (CFPS). The current structure of the system is established by the Child Fatality Prevention Act (Colorado Revised Statutes 25-20.5-401-409). The Act declares: “The general assembly hereby finds and declares that protection of the health and welfare of the children of this state is an important goal of the citizens of this state, and the injury and death of infants and children are serious public health concerns that require legislative action. The general assembly further finds that the prevention of child abuse, neglect, and fatalities is a community responsibility; that professionals from disparate disciplines have responsibilities to children and have expertise that can promote the safety and well-being of children; and that multidisciplinary reviews of child abuse, neglect, and fatalities can lead to a greater understanding of the causes of, and methods of preventing, child abuse, neglect, and fatalities.”

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

This operations manual is divided into two sections:

- The What: what is the Colorado Child Fatality Prevention System (CFPS)?
- The How: how does the CFPS work?

It serves as a resource and source of information for the state and local child fatality prevention review teams. For quick reference, definitions and acronyms are listed in the resource section.

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

For more information on the Child Fatality Prevention System (CFPS), visit the CFPS website: www.cochildfatalityprevention.com.

Acknowledgements

Thank you to all members and content experts of the Child Fatality Prevention System who volunteer their time and efforts to review cases, enter data, develop and implement prevention recommendations and keep infants, children and youth alive in Colorado. Your work is recognized and appreciated.

It is with deepest sympathy and respect that we dedicate this to the memory of those infants, children and youth and families represented within these pages.

Guidance for the Colorado Child Fatality Prevention System created by the Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, CO 80246
www.cochildfatalityprevention.com
Operations Manual Last Updated: 08/23/19

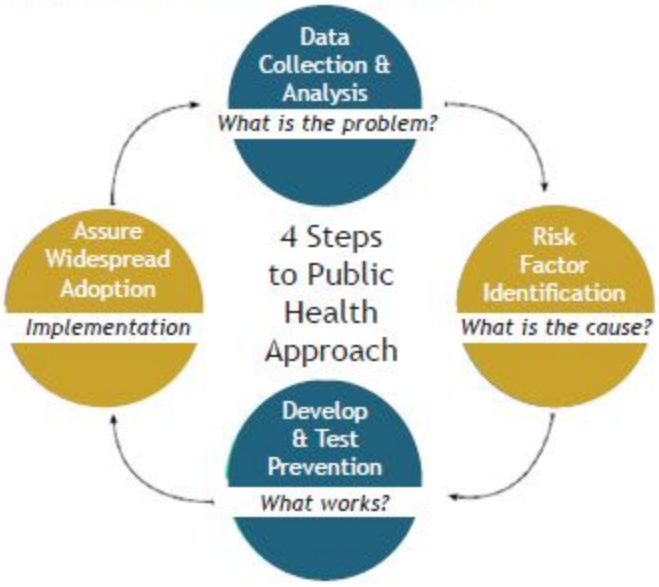
Contents

PART ONE: THE WHAT

Overview of Colorado's Child Fatality Prevention System

The Child Fatality Prevention Act (Article 20.5 of Title 25, Colorado Revised Statutes) establishes the Colorado Child Fatality Prevention System (CFPS), a statewide, multidisciplinary, multi-agency effort to prevent child deaths. CFPS is housed at the Colorado Department of Public Health and Environment (CDPHE) in the Violence and Injury Prevention - Mental Health Promotion Branch of the Prevention Services Division. CFPS is based on a public health approach to the prevention of deaths of infants, children and youth (Figure 1). Areas for improvement are identified through individual case-specific reviews of deaths. These reviews highlight specific risk and protective factors that can be mitigated or enhanced through best practices and evidence-based interventions to prevent infant, child and youth deaths. State and local partners implement and evaluate these interventions to prevent future fatalities from occurring in Colorado.

Figure 1: A public health approach to child fatality prevention



Although not codified in Colorado Revised Statutes until 2005, the CFPS has been conducting retrospective reviews of infant, children and youth deaths in Colorado since 1989. The 2005 statute created the State Review Team, mandating members from the fields of child abuse prevention, pediatrics, public health nursing, family law,

death investigation, motor vehicle safety and sudden unexpected infant death (SUID). It required the team to review injury and violence-related fatalities of children ages 0-17 that occur in the state of Colorado. The 2005 legislation allowed local child fatality prevention review teams to form, but did not require them.

With the passage of Senate Bill 225 in 2013, CFPS statute mandated that comprehensive reviews of infant, child and youth deaths shift 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 prevention review teams and stipulates that teams have representatives of multidisciplinary agencies in the county or counties that provide services to children and their families.

Currently, county or district public health agencies coordinate 43 multidisciplinary, local child fatality prevention review teams (local teams) representing every county in Colorado. Local teams review deaths assigned to them by the CFPS State Support Team at CDPHE, who uses death certificates provided by CDPHE's Vital Statistics Program to assign cases based on coroner jurisdiction. Teams are responsible for conducting individual, case-specific reviews of deaths of infants, children and youth meeting the Child Fatality Prevention Act statutory criteria. Reviewable deaths result from one or more of the following causes: undetermined causes, unintentional injury, violence, motor vehicle/transport-related, child maltreatment, SUID and suicide. The CFPS review process includes review of deaths of Colorado residents occurring in Colorado, as well as deaths of out-of-state residents who died in Colorado or were transported to a Colorado hospital and died. CFPS does not review deaths of Colorado residents that occur outside of Colorado.

The CFPS State Review Team reviews aggregated data and recommendations submitted by all local teams to identify recommendations to prevent infant, child and youth deaths in Colorado, including policy recommendations. The variety of disciplines involved and the depth of expertise provided by the CFPS State Review Team and local teams results in a comprehensive review process, allowing for a broad analysis of both contributory and preventive factors of deaths and the development and implementation of evidence-based prevention strategies.

On an annual basis, the CFPS State Support Team aggregates local team prevention recommendations and facilitates a process for members of the CFPS State Review Team and local teams to generate system-wide recommendations based on the annual statewide data. The CFPS State Review Team, local teams and content experts vote on final prevention strategies for inclusion in the annual legislative report, which is mandated per the statute and shared with the Colorado General Assembly and Governor's Office. For more information and to access annual legislative reports and data briefs, visit the CFPS website: www.cochildfatalityprevention.com/p/reports.html.

Structural Inequity

CDPHE acknowledges that generations-long social, economic and environmental inequities result in adverse health outcomes. They affect communities differently and have a greater influence on health outcomes than either individual choices or one's ability to access health care. Reducing health disparities through policies, practices and organizational systems can help improve opportunities for all Coloradans.[1]

Some families lose infants, children and youth to the types of deaths reviewed by CFPS not as the result of the actions or behaviors of those who died, or their parents or caregivers. Social factors such as where they live, how much money or education they have and how they are treated because of their racial or ethnic backgrounds can also contribute to a child's death.[2] In the United States, most residents grew up and continue to live in racially and economically segregated neighborhoods, which can lead to marginalization.[3,4] This marginalization of groups into segregated neighborhoods further impacts access to high-quality education,[5] employment opportunities,[6] healthy foods[7] and health care.[8] Combined, the economic injustices associated with residential, educational and occupational segregation have lasting health impacts that include adverse birth outcomes, infant mortality,[9] high rates of homicide and gun violence[10] and increased motor vehicle deaths.[11]

When reviewing individual cases and interpreting the data, it is critical not to lose sight of these systemic, avoidable and unjust factors. These factors perpetuate the inequities that we observe in infant, child and youth deaths deaths across populations in Colorado. Research is making progress in understanding how race and ethnicity, economic status, sexual orientation and gender identity correlate with health. It is

critical that data systems like CFPS identify and understand the life-long inequities that persist across groups in order to eradicate them.

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Child Fatality Prevention System Structure

State Support Team

The CFPS State Support Team are committed to aiding local and state teams in conducting effective reviews, by providing guidance, technical assistance and training to foster a statewide coordinated system. Additionally, the State Support Team at CDPHE provides oversight and funding to the system.

Program Manager

Oversees implementation and evaluation of CFPS to ensure the program meets its goals and objectives to review infant, child and youth deaths and develop recommendations to prevent these deaths. Facilitates the 46-member, multidisciplinary CFPS State Review Team and associated subcommittees and works closely with the Colorado Department of Human Services (CDHS) Child Fatality Review Team to develop joint prevention recommendations. Oversees funding for local public health agencies to support local teams and provides guidance to local team coordinators to ensure they have the skills, knowledge, and resources to convene and facilitate local team meetings and implement prevention strategies.

CFPS Coordinator

Provides in-person and remote technical assistance and training to local teams on the following topics: records requesting, data abstraction, data entry, team facilitation, and development of prevention recommendations. Assigns cases to local teams and ensures data quality assurance for all cases, but with specific emphasis on Sudden Unexpected Infant Death (SUID) cases. Manages the monthly CFPS newsletter, which contains information regarding system best practice, trainings and events, funding opportunities and articles related to CFPS.

Epidemiologist and Data Analyst

Oversees and performs day-to-day data-related operations of CFPS, including case assignments and quality assurance, analysis and dissemination, and modification and maintenance of the CFPS dashboard. Facilitates the Investigative and Data Quality Subcommittee, which focuses on areas for improvement in both data quality captured by the system and collaborating with investigative agencies to improve investigative standards and subsequent data quality. Visits with local communities to share and discuss the community's data with the local team and help local teams understand the

limitations and strengths of the data collected by CFPS. The author of “Inside the CFPS Data Lab,” the data component of the CFPS newsletter.

Prevention and Technical Assistance Coordinator

Works with CDPHE and the Colorado Department of Transportation to provide motor vehicle injury and fatality prevention expertise including best practice recommendations, development of educational resources, traffic safety shared risk and protective factors, advocacy support and evaluation planning. Leads the Colorado Occupant Protection Task Force and helps local teams identify strategies for success.

 CFPS State Support Team contact information

CFPS State Review Team

The Colorado CFPS State Review Team is a volunteer, multidisciplinary committee comprised of clinical and legal experts in child health and safety, explicitly described in the legislation. 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 SUID.

The State Review Team is comprised of 46 members, mandated by statute, as well as diverse content experts from a variety of disciplines. Members are appointed for three-year terms that are eligible for reappointment. The State Review Team includes representatives from the following disciplines:

Eighteen governor-appointed members

- County sheriffs representing both urban and rural areas
- County coroners
- Peace officers specializing in crimes against children
- District and county attorneys representing both urban and rural areas
- Medical professionals specializing in traumatic injury or children's health
- Local fire department representatives
- County attorney specializing in the area of dependency and neglect
- County commissioner
- Representative from the Office of Colorado's Child Protection Ombudsman

Sixteen state agency-appointed members

- Colorado Department of Human Services (DHS) (Division of Child Welfare, Office of Behavioral Health, Division of Youth Corrections, Administrative Review Division)
- Colorado Department of Public Health and Environment (including representation from a local public health agency)
- Department of Education
- Department of Public Safety
- Director of a local department of human or social services

Twelve team-selected members

- Injury prevention or safety specialists from hospitals
- Representative specializing in auto safety or driver safety
- Sudden unexpected infant death specialist
- Representative from the state network of child advocacy centers
- Representative from the state domestic violence coalition
- Representative from the court-appointed special advocate program directors
- Representative from the office of the child's representative
- Representative from a private out-of-home placement provider
- A member of the community with experience in childhood death

For more information about the members, please review the Colorado Revised Statute 25-20.5-406 or contact the CFPS State Support Team.

Per statute, the State Review Team reviews the aggregated data and recommendations submitted by all of the local teams to identify recommendations to prevent infant, child and youth deaths in Colorado, including policy recommendations. The recommendations for prevention from the State Review Team and local team discussions, as well as trends and patterns of deaths, are compiled at the end of each data year and discussed by the full State Review Team. On an annual basis, the CFPS prioritizes policy and practice recommendations to prevent infant, child and youth deaths and submits the recommendations to the Governor and the Colorado General Assembly in an annual legislative report. Members participate in workgroups and subcommittees that meet on a monthly or quarterly basis. Visit our website for more information about these groups: www.cochildfatalityprevention.com/p/state-review-team-membership.html. That State Review Team also reviews cases on an ad hoc/as needed basis when local teams cannot or will not review a case. To read reports from previous years, and learn more about the State Review Team please visit our website: www.cochildfatalityprevention.com/p/reports.html.

How to Get Involved

If you are interested in filling one of the Governor-appointed positions, please fill out an online application from the Governor's Office of Boards and Commissions. The application can be accessed here: https://www.tfaforms.com/290254. When applying for a position, please select "Child Fatality Prevention Review Team, Colorado State" under the question that asks, "Which Boards and Commissions are you interested in?"

If you are interested in serving in another position or serving as a subject matter expert to the team, or participating in a work group and/or subcommittee, please contact the CFPS State Support Team: CFPS State Support Team contact information

Local and Regional Team Structure

The Child Fatality Prevention Act requires each county or district public health agency to establish, or arrange for the establishment of, a local child fatality prevention review team, or form a regional child fatality prevention review team. Communities have the option to form single or regional/multi-county teams. Regional teams are an alternative option to single county teams and may be preferred when the annual number of deaths may be small, making it difficult for the local team to maintain continuity and efficiency, or for counties where current relationships, natural boundaries and sharing of resources already exist.

As with the State Review Team, local team members are mandated by statute and include representatives from 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 the county attorney's office. If a mandated member chooses not to participate, the local team should meet to review the death with the information that is available to them. The local team coordinator should request records from the absent member's agency prior to the meeting to fill out the National Center for Fatality Review and Prevention's (NCFRP) Case Reporting System (CRS) and for discussion during the meeting.

Additional Team Membership

In addition to the above members, local 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
- Community members at large

Ad Hoc Members

Local teams may designate ad hoc members. These members 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 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 review meeting. Since ad hoc members are not permanent, they typically do not receive local team notices.

Funding to Local Teams

The Child Fatality Prevention Act appropriates general fund dollars to support local child fatality prevention review teams throughout Colorado. Funding is allocated to local teams using a formula based on the population size of children ages 0-17 years in the county of the local team and the total number of reviewable infant, child and youth deaths in the local team jurisdiction for the most recent 5-year time period. The percentage of the childhood population and the percentage of reviewable deaths were calculated for each county. The funding amount determined for each county is based on which percentage is higher (percent of the childhood population or percent of reviewable deaths). Each year the formula is reviewed to ensure that local teams are appropriately funded. The State Support Team anticipates that funding will remain largely consistent from year-to-year. Funding will be additive if counties are part of a regional/multi-county review team. Additional details about the funding formula are available upon request.

Local teams determine how to allocate funding. The following are examples of appropriate uses of this funding:

Preparation for Case Review Meetings

- Reimbursement for local team coordinator's time spent on the project (i.e., pre-abstracting records, CRS data entry, etc.)
- Payment for records requests
- Printing costs for paperwork (i.e., case summaries, records, data collection tools, etc.) for the meeting
- Encryption options for sharing confidential information

Facilitation of Case Review Meetings

- Reimbursement for local team coordinator's time spent on the project (i.e., coordination of the meeting, NCFRP CRS data entry, etc.)
- Reimbursement for team members' travel to review meetings
- Reimbursement for team members' time spent on the project

- Food costs
- Meeting rental space
- Teleconferencing options

Injury and Violence Prevention Efforts

- Designing, implementing, and evaluating infant, child and youth death, injury, and violence prevention strategies identified by the local team. For example:
    - Purchasing child passenger safety seats (car seats and booster seats), bicycle and ski helmets and pack 'n' plays and cribs for infant safe sleep environments
    - Supporting suicide prevention programs in schools
    - Coordinating suicide prevention gatekeeper trainings
    - Purchasing lock boxes for secured storage of firearms
    - Supporting policies to improve caregiver behavioral health, paid leave for families and access to affordable child care
    - Utilize the Menu of Strategies, from our Communities That Care partners, to develop prevention action plans
- Promoting continuing education for professionals involved in investigating child deaths (i.e., training on the Sudden Unexpected Infant Death Investigation Reporting Form)
- Supporting injury and violence prevention training for local team coordinators and team members
- Becoming a member of the Safe States Alliance and/or attending the annual Safe States Alliance meeting

Role of Team Members

Child Fatality Local Team Coordinator

The purpose of this position is to coordinate the local child fatality prevention review team, work with community leaders to maintain and enhance the local team, develop partnerships with child health and safety organizations, implement local team recommendations in order to prevent infant, child and youth deaths and serve as a liaison between the local team and the CFPS State Support Team. Often, the local team coordinator is a representative from local public health.

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

- Invite/recruit members to participate on the local team
- Determine meeting dates and send meeting notices to local team members
- Access the Death Certificate FTP Website to identify child deaths assigned for review
- Write case summaries and distribute to local team members prior to each meeting
- Prior to the review meeting, request records required for each case
- Coordinate sharing of records from individual agencies represented on the local team
- Abstract records
- Enter data/cases into the National Center for Fatality Review and Prevention CRS
- Ensure that all new local team members and ad hoc members sign a confidentiality agreement prior to their first meeting
- Coordinate and facilitate review meetings
- Ensure that the team operates according to protocols as defined by the team and/or Colorado statute
- Promote and implement prevention initiatives and activities
- Orient new members to the local team prior to their first meeting
- Maintain contact with the CFPS State Support Team
- Request training and technical assistance from CFPS State Support Team
- Manage funding provided by CDPHE

Map of local teams

Team Members

Local team coordinators need to be familiar with which representatives the *Colorado Revised Statute 25-20.5-404 (3)(a)(I)* requires and recommends, their roles and the value they bring to the local team and review process. When recruiting local team members, request the highest level of agency staff join the team, as they 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. If possible, designate an individual who is knowledgeable and experienced with infant, child and youth deaths to represent the

agency. The role of local team members can be flexible to meet the needs of particular communities. The individual abilities of members should be tapped to enhance team efficiency and effectiveness. Roles of team members include:

- Submit their records to their Local Team Coordinator **prior** to the review meeting
- 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 their profession
- Assist in the creation of prevention recommendations
- Advocate for the implementation of prevention recommendations

Each 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 an infant, child or youth death. In addition, 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 prevention review system. More specifics of the roles of each agency and member are listed below.

Community Mental Health Professionals

- Provide information and insight regarding psychological issues related to events that caused a 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.
- Provide valuable insight into their own agency policies and practices.

Coroner’s Offices

- Coroners are central to the function of both local teams and death investigations of the infant, child or youth. In Colorado, coroners determine the cause and manner of death.
- Present 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 teams better understand the cause of death ruling.

- Local teams review deaths 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. For out-of-state death cases, the jurisdiction may be based on where the infant, child or youth is pronounced dead or the county the fatal injury occurred, depending on the circumstances of a particular death.

County Attorney's Offices and District Attorney's Offices

- Prosecutors educate local teams on criminal law and provide information about criminal and civil actions taken against those involved.
- Explains when a case can or cannot be pursued and provide information about previous contact or criminal prosecutions of family members or suspects in the death.

County Department of Human Services

- Human services professionals' knowledge on issues related to child abuse and neglect cases is essential to local team effectiveness.
- County departments of human services have the legal authority and responsibility to investigate infant, child and youth deaths and provide protection to siblings who might be at risk.
- Provide detailed information on families and on their investigations into the death.
- Might 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.
- Provide information on a family's history and sociological factors that influence family dynamics, such as unemployment, divorce, history of domestic violence or drug abuse, and previous deaths and/or abuse.
- When needed, human services representatives can provide services to surviving family.

Emergency Medical Services

- Frequently first at the scene and obtains critical information regarding the scene and circumstances, including the behavior of witnesses.
- The EMS Run Report is useful in determining body position at death and identification of other evidence that may have been moved before an investigator's arrival at the scene.

- Has well-established relationships with local hospitals and may be able to provide a perspective from these agencies.

Hospitals

- Local hospital representatives may be emergency department staff, quality assurance officers, social workers or key administrators.
- Can facilitate the sharing of medical records with a local team.
- When an infant, child or youth is transported to an emergency room, hospital representatives can provide a local team with pertinent information.
- Can 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 teams to reach out to hospitals because they often have injury prevention specialists on staff who can help determine and implement prevention strategies or connect recommendations to resources.

Local Law Enforcement Agencies

- Law enforcement professionals provide information on criminal investigations of infant, child and youth deaths under local team review.
- Check criminal histories of youth, family members and/or suspects in intentional death cases.
- Both the sheriff's department and the police department with the largest jurisdictions should have members on the local team, to ensure sufficient representation.
- Serve as liaisons between the local team and other local law enforcement departments and assist in ensuring officers from other agencies participate in reviews of deaths in their jurisdictions.
- Law enforcement professionals are usually the 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.

Pediatricians

- Provide local 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, their expert opinion regarding medical evidence can be useful.

- It is preferable to have a pediatrician who is experienced in treating victims of child abuse and neglect.
- If a pediatrician is unavailable, local teams may select a physician who specializes in pediatrics and child development.

Probate or Family Court

- Juvenile judges or probation officers can provide local 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.
- Provide information related to child abuse and neglect.
- Learn from reviews and improve child protection and juvenile court proceedings.

Public Health

- Provide the prevention perspective and can apply the public health approach to child fatality reviews
- Facilitate and coordinate preventive health services and community health education programs
- Provide vital records and epidemiological risk profiles of families for early detection and prevention of infant, children and youth deaths, as well as information on county public health services
- Public health doctors and nurses can help identify public health issues that arise in deaths and provide medical explanations and public health guidance. If an infant, child or youth 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.
- Provide information on risk factors as well as services to high risk pregnant women and their families.

School Districts

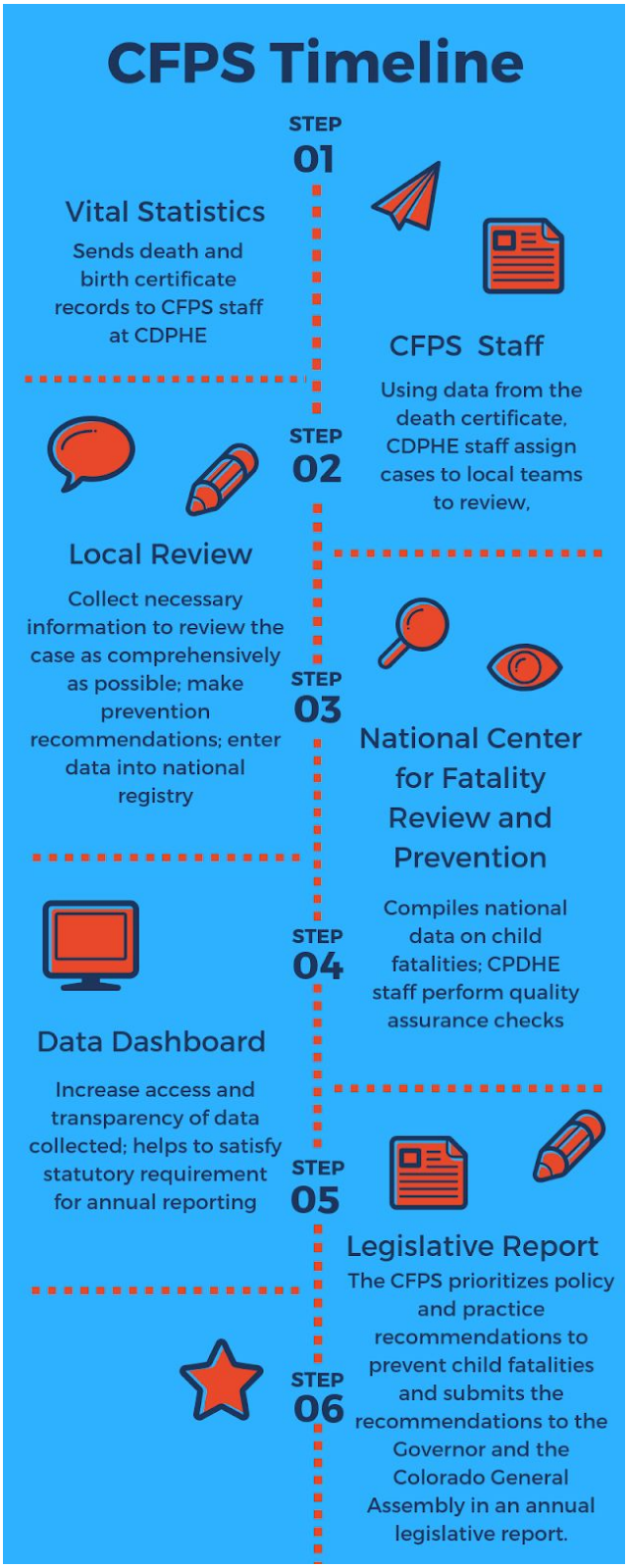
- Educators, district school nurses and district counselors can provide local teams with perspective on child health, growth and development.
- Federal laws preclude educators from sharing student educational case records with local teams, however anything that is not part of a student's education record, such as records from the School Resource Officers (school law enforcement record), social media posts, overheard conversations, CAN be

shared during your case review. This kind of information is often what is most relevant to our reviews anyway.

- Their presence at child fatality reviews can enhance 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 prevention recommendations.

PART TWO: THE HOW

Child Fatality Review Timeline



Case Identification, Assignment and Abstraction

Steps for Case Identification and Assignment to Local Teams

1. Within 30 days of a death being reported to CDPHE's Vital Statistics Program, the CFPS State Support Team uploads death certificates by county coroner jurisdiction to a secure File Transfer Protocol (FTP) website. Causes of death local teams review include:
    a. Undetermined cases
    b. Unintentional injury (i.e., drowning, falls, fires, poisoning)
    c. Violence (i.e., homicide, any firearm death)
    d. Motor vehicle crashes or transport-related deaths
    e. Child maltreatment (abuse or neglect)
    f. Sudden unexpected infant deaths (e.g. sleep-related infant deaths)
    g. Suicide
2. Death certificates are modified to only include the information needed to answer questions in the NCFRP CRS, as well as identifying information (name, birth date, death date, etc.) that local teams need to determine which agencies may have records related to the case.
3. A weekly email is sent to alert local teams of case assignment and to access the FTP site to view the death certificate.
4. At this time, the local team coordinator begins case abstraction, which is the process of collecting information (requesting records) and entering the relevant information into the NCFRP CRS, prior to the review meeting.
    a. Completing as much data entry prior to the meeting increases efficiency, data quality and confidentiality.
    b. If the case is under litigation, enter as much of the case information as possible and wait until after the trial to complete the case review. Enter "case under litigation" in the narrative field of the NCFRP CRS so the State Support Team knows the review is on hold.
5. Review meetings are scheduled depending on the number of cases a team is required to review, meeting as often as necessary to meet the deadlines listed below.

6. CFPS deadlines for review and data entry completion follow the year of death. For instance, 2017 fatalities were reviewed and entered into the NCFRP CRS by 12/31/2018.
    a. One exception to this rule is that SUID deaths must be reviewed and entered within 270 days of the date of death.
7. The CFPS Coordinator on the State Support Team reviews all cases entered into the NCFRP CRS for completeness throughout the year for quality assurance. Follow up with local team coordinators is sometimes necessary if data fields are left blank or for further information regarding data entry choices, for example. Expect follow up via email and/or phone.
8. The CFPS Epidemiologist aggregates and analyzes data on an annual basis each spring. The data collected in the NCFRP CRS is interpreted to identify trends and patterns of infant, children and youth deaths. This data, along with aggregated prevention recommendations, is incorporated into topic-specific data briefs for the leading causes of death identified by CFPS. These reports are shared with local teams and other prevention partners and serve as the foundation for the annual legislative report submitted to the Colorado General Assembly and the Governor's Office on July 1st of each year.
9. The CFPS Data Dashboard is another valuable resource local and state team members have access to. This resource provides data on leading causes and circumstances of death for all jurisdictions across Colorado and summarizes some of the most frequently requested circumstance data available from CFPS. The CFPS Data Dashboard is also one way to report aggregated data compiled and prepared following the end of each annual review cycle and will be updated yearly. The dashboard contains data on the overall number of reviews conducted by jurisdiction, SUID, youth suicide, motor vehicle/transport-related deaths, child maltreatment (abuse and neglect), firearms, unintentional drowning and unintentional poisoning deaths occurring among infants, children and youth in Colorado.

Requesting Records

After receiving a case assignment, local team coordinators should request specific records to better understand the circumstances of the death. Both current and historical information can be helpful in assessing each case. Records will be obtained from team members, but others might require a formal written request from other

agencies. These records are highly confidential and must be shared and stored in secure manners. Per statute, state and local teams have access to all relevant records from the coroner's office, the Colorado Department of Human Services, county departments of human services and other state and local government agencies. Colorado Revised Statute 25-20.5-408 Access to records:

> "the local or regional review teams shall have access to all other records and information that are relevant to a review of a child fatality and that are in the possession of a state or local governmental agency. These records include, but are not limited to, birth certificates, records of coroner or medical examiner investigations, and records of the department of corrections."

Best practice is to obtain the records in advance of the meeting. This allows for the majority of the meeting to be used for discussing specific sections of the NCFRP CRS and prevention recommendations. Coordinators should request that local team members provide electronic or hard copy records pertaining to the death to aid in abstraction of pertinent information before the case review meeting. These records will be used to create a case summary of the circumstances that is used at the case review meeting. Team members can also bring records from their respective agencies to the case review meeting. Local team members will leave the meeting with their own records.

If local team coordinators have any issues requesting and/or obtaining records, please contact the State Support Team for assistance.

 Sample Records Request Letters

Secure Record Keeping

The case review files contain a variety of highly confidential documents, exist in various formats and may reside in a number of locations. Local teams should determine how to maintain and retain these confidential files and records, based on their agencies policies. Local teams should consider the following when securing records and files:

- Case review files and records should be kept in a designated area that must be locked when not in use.
- Case files and records should be retained until data entry for every case is marked as complete, quality assurance is complete and annual data analysis conducted by the CFPS Epidemiologist is complete. Best practice is to keep all

files for **18 months** following the close of the year of death. After this time, any case review files and records should be destroyed. As an example, all 2018 deaths will be entered into the CRS and finalized by 12/31/2019, which means all files should be retained until 7/1/2020.

- If using fax to request records from external agencies, the fax machine should be in a secured area and not available for public access and use.
- Encryption programs are necessary if documents are shared via email.

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 related to a case, because information is sometimes found in unexpected locations.
- All, partial or no records may be available for case reviews.
- Some documents may not be applicable depending on the type of death or case circumstances.
- If more records or information are needed, contact local team representatives from various agencies who may have information about the death.

	Essential Documents for All Cases
All Deaths	Death Certificate Law enforcement scene investigation reports, with scene photos Autopsy reports/Coroner reports Medical Records/Hospital Records (may include: emergency department reports, EMS trip reports, case or social worker reports, pediatric records for well and sick visits) Prior Child Protective Services (CPS)/Department of Human Service (DHS) history or Trails reports on child, caregivers, person supervising child at time of death School records (if applicable) Media articles related to incident (if applicable)
	Additional Documents Per Type of Death
Accidental Firearm	Police and crime lab reports Ballistics information on firearms Juvenile and criminal records of teen and perpetrators
Child Abuse and Neglect	Home nursing visit reports from public health or medical healthcare services

Drowning	Ages of other children in home Information on zoning or code inspections and violations regarding pools or ponds
Fires	Fire department reports that include source of fire and presence of detectors Information on zoning or code inspections and violations Home nursing visits from public health or other medical healthcare services Any information on prior deaths of children in family
Homicide-Firearm	Information regarding the storage of firearm Police and crime lab reports Juvenile and criminal records of teen and perpetrators
Motor Vehicle	State Patrol Full Accident Reconstruction Reports Colorado Department of Transportation (CDOT) Motor Vehicle Accident reports with road and weather conditions at the time of crash Blood alcohol and drug toxicology results from surviving drivers of accident
Other Accidents	Birth and Death Certificate Birth Records Ages of other children in home U.S. Consumer Product Safety Commission findings as applicable
Sudden Unexpected Infant Death (SUID)	Birth and Death Certificate Infant birth and delivery medical records Law enforcement scene investigation reports Sudden Unexplained Infant Death Investigation Reporting Form (SUIDIRF) from coroner or law enforcement agencies Doll reenactment reports and photos 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	Suicide Death Investigation Form Scene investigation reports to include criminal and mental health histories (including prior suicide attempts) obtained through interviews Suicide notes

Case Review Meeting Guidance

Local teams are required to use the National Center for Fatality Review and Prevention (NCFRP) Case Reporting System (CRS) to report cases.

National Center for Fatality Review and Prevention Case Reporting System

National Center for Fatality Review and Prevention Case Reporting System user's manual

Case Summaries

To help facilitate local team meetings, coordinators should write case summaries for each infant, child or youth death. These can 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, undetermined or natural
  - *Not all natural cases will be reviewed by local teams. Natural cases where there may be an indication of potential preventability will be reviewed. For example, where there is an unusual or untreated medical condition for 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, but funding amounts are determined only by cases that are assigned to the local team by the State Support Team.*
- Cause of death – 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 applicable)
- School history (if applicable)
- Social history
- Investigation information
- Autopsy information

Case summary templates

Confidentiality

Pursuant to the Child Fatality Prevention Act at Colorado Revised Statutes § 25-20.5-408 (2) (c) (I), members of the State Review Team, members of the local teams, a person who attends a review, and a person who presents information to a local team may release information to governmental agencies as necessary to fulfill the requirements of the Act.

Each member of the State Review Team, each member of a local team, and each invited participant at a meeting signs a confidentiality statement indicating an understanding of and adherence to confidentiality requirements. State statute protects vital records data as confidential (Colorado Revised Statutes § 25-2-117). As such, data from CFPS should only be released in aggregate. Generally, the State Review Team and local teams are not allowed to release information unless it is de-identified. Additionally, aggregated data is only reported where there are three or more deaths in a particular category. CFPS can only legally release information to governmental agencies on individual cases under very narrow and **extraordinary circumstances.**

At a local team case review meeting, all data and information regarding the death of an identified infant, child or youth is confidential. Local 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 team member is still active on the local team, and 2) the hard documentation case file still exists. A local team member need only sign one confidentiality form while participating in reviews.

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

- Pursuant to Colorado Revised Statute 25-20.5-408(2)(b), 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 NCFRP CRS.
- Report data in aggregate form.
- The public and/or media must leave the review meeting during the executive session.

 Sample confidentiality agreement

Steps for Local Teams when contemplating release of information

If a local team thinks it may be necessary to release information on an individual case to a governmental agency, the CFPS State Support Team is available to offer support. Contact Kate Jankovsky, Child Fatality Prevention System Manager, kate.jankovsky@state.co.us or 303-692-2947, to discuss the circumstances of the case. In some circumstances, the CFPS State Support Team may consult with the Director of the Office of Legal and Regulatory Compliance at the CDPHE to get a legal opinion regarding whether or not release of information meets the goals of the Child Fatality Prevention Act.

Colorado Open Meetings Act

Child fatality case review meetings are subject to the Colorado Open Meetings Act, which requires coordinators to post a notice of the meeting at least 24 hours in advance. While the public and media are welcome to attend, they are asked to leave during the case review so the local team can conduct a confidential case review, which is called the executive session of the meeting.

The executive session must be electronically recorded, and the recording must be retained for at least 90 days after the date of the executive session. After this date, the recording can be deleted. As the recording contains confidential information, store in a locked file cabinet or secured file folder during the 90 days. It is acceptable to use CFPS funding from the CDPHE to purchase electronic recording equipment for the purpose of recording executive sessions. Local teams record the executive session to demonstrate that it was appropriate for the team to go into executive session if a member of the public disagrees with this decision. If this occurs, a judge listens to the recording to ensure that confidential matters are being discussed. For this reason, it is important for members of the local team to limit their discussion during the executive session to the announced topics. Any written meeting minutes taken during the executive session can also be destroyed after 90 days.

 Open Meeting Law Guidance and Executive Session Script

Conducting an Effective Review Meeting

The purpose of the local team is to improve investigations, services and agency practices and to identify ways to prevent the deaths of other infants, children and youth. The local team is not an investigative body.

Prior to the Review Meeting

1. After the CFPS Program Coordinator notifies you of a death, begin requesting records.
2. Prior to the meeting, enter as much data as you can from the records received into the NCFRP CRS.
3. Schedule the meeting.
4. The length of meetings is influenced by how many cases need review. The average time to review a case that is abstracted prior to the meeting is 30-60 minutes, depending on the circumstances.
5. The frequency of meetings will vary by team, based on the number of deaths.
6. Address any logistical issues prior to conducting the review.
7. Determine if there are any conflicts. A conflict is defined as any "vested interest" in a specific case, and may arise for any team member. It is the responsibility of the individual team member to excuse him/herself from the case discussion. If there is collective team conflict, contact the State Support Team to discuss how the State Review Team can support you.

Steps for Facilitating the Review Meeting

The steps below are intended to serve as guidance for facilitating child fatality review meetings. Because each local team has a unique structure, it is understood that this guidance may not be the best model for all teams. As such, teams are welcome to adapt from this model to accommodate their needs.

1. Executive session
    a. New and ad hoc members sign the confidentiality agreement.
    b. If members of the public and/or the media are present, it is at this time they are asked to leave.
    c. Use the executive session script to begin the meeting.
2. Moment of silence

a. If your team chooses to do this, there script in the self care folder, and you are welcome to modify this for your team.

3. Equity Statement
    a. Read an equity statement at the beginning of every review meeting.
4. Summarize the case
    a. Allow team members to read through the case summary or read the case summary aloud to the team.
5. Discuss case details
    a. Share
        i. Allow team members who played a direct role in responding to the case share their knowledge of the case.
            1. A helpful strategy is asking team members to share chronologically (meaning who arrived first on scene) instead of one-by-one around the table to hear the story from beginning to end.
        ii. Each discipline present will have unique knowledge of each case. For more information, please revisit the Team Members section in part one of this manual.
    b. Ask
        i. Allow team members to ask questions about the events surrounding the death. Use the case records and team member recollections of the event to address these questions.
    c. Document new details into the NCFRP CRS along the way.
        i. It is helpful to have someone complete data entry while the Coordinator facilitates the conversation.
6. Child Abuse, Neglect, Poor Supervision And Exposure To Hazards
    a. Discuss whether Child Abuse, Neglect, Poor Supervision And Exposure To Hazards caused or contributed to the death and document in the “Child Abuse, Neglect, Poor Supervision And Exposure To Hazards” section of the NCFRP CRS.
    b. Discuss whether or not a person(s) did something, or failed to do something, that caused or contributed to the death and document in the “Person Responsible” section of the NCFRP CRS.

c. The decision to document an act of child abuse, neglect, poor supervision or exposure to hazards does not have legal ramifications.
d. See below for best practices for Identifying Acts of Child Abuse, Neglect, Poor Supervision or Exposure to Hazards and use the guidance document Coding sections I5 and J.

7. Prevention Recommendations
    a. What risk factors were involved in this case?
    b. What protective factors were present and/or missing in this case?
    c. Could this death have been prevented?
    d. What do we recommend should be done to prevent another death in the future? *Keep in mind that prevention is the heart of child death review.*
        i. Changes to agency practices or policies based on what we know about the circumstances, cause and manner of this death?
        ii. Who should take the lead in implementing our recommendations for prevention?
    e. Document risk and protective factors and prevention recommendations in the "Prevention" section of the NCFRP CRS.
8. Review Meeting Process
    a. Document who attended the meeting and with what documents in the "Review" section of the NCFRP CRS. Discuss what might have reduced effectiveness.
    b. Is our review of this case complete or do we need to discuss it at our next meeting? A case may need more than one meeting to complete. For example, there might be time restraints, a team member with relevant information may be absent or a case might be in litigation.
9. Gratitude Exercise
    a. Before the close of the session, complete the gratitude exercise from the self care folder, or something similar, if your team chooses to do so.
10. Conclude executive session
11. Shred
    a. Collect and shred all case summaries and notes taken during the meeting and all other confidential materials.
12. Complete data entry in the NCFRP CRS
    a. Include notes taken during the meeting, if not already added.

b. Cut and paste the case summary into the narrative section, adding any relevant notes from the review meeting. **Be sure to remove all identifiers.** Review the document "Writing the Narrative".
c. Review all sections in the NCFRP CRS for completeness, best practice is to have zero blank fields. Use "unknown" option, if available.
d. Check "data entry complete" to alert the State Support Team of completion.

Referrals

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

Agency Conflict Resolution

Local teams are not peer reviews. They are designed to examine system issues, not the performance of individuals. Local child fatality prevention review is a professional process designed to improve system responses to the deaths of infants, children and youth.

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 infant, child and youth 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.

When conflict among team members interrupts a review, the 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 case review meetings should be conducted in a respectful and professional manner. The CFPS State Support Team can support you if team conflict arises.

Local Teams Best Practices

Respect team agreements

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

Be prepared for and participate in meetings

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

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 team's ability to gather information and hinders the cooperative networking of the members. A team can only achieve its objectives by meeting routinely. Teams are encouraged to meet, even when they do not have a case to review, to discuss prevention efforts, team membership, etc.

Maintain an equity lens during meetings

Some families lose infants, children and youth to the types of deaths reviewed by CFPS not as the result of the actions or behaviors of those who died, or their parents or caregivers. Social factors such as where they live, how much money or education they have and how they are treated because of their racial or ethnic backgrounds are also contributing factors in child deaths. Generations-long social, economic and environmental inequities result in adverse health outcomes. They affect communities differently and have a greater influence on health outcomes than either individual choices or one's ability to access health care. These factors perpetuate the inequities that we observe in child deaths across populations in Colorado. It is incredibly important that when we are reviewing cases to not lose sight of the root causes for why these inequities exist.

Provide an educational element at local team meetings

Members can inform each other of team-related trainings, changes in laws regarding their professions and new death or injury prevention programs for infants, children and youth. Ongoing education should be an integral part of every team's operation. Periodic presentations and informative handouts enhance a team's ability to accomplish its objectives.

Use the Colorado network of local teams

When a team needs information on a case or identifies trends, be sure to contact other local teams for suggestions on how they handled a problem or to obtain input on innovative team efforts. Coordinators from other teams can also support other teams in case review and the development and implementation of prevention initiatives.

Use the CFPS State Support Team and the State Review Team

The CFPS State Support Team and the State Review Team are available to provide technical assistance, support case reviews, linkages to professional resources and coordination with other local teams.

Provide other members with support

Each profession brings its perspective, professional knowledge and expertise to the team. Each member must acknowledge and respect the professional role of each participating agency. The team coordinator and all team members are responsible for creating a collaborative and productive team environment that is respectful towards all perspectives and ideas.

Do not lose sight of the team's purpose and objectives

A periodic review of a team's stated purpose, including goals and objectives, will provide direction to the team and remind members why the local team was originally formed. The CFPS State Support Team and the State Review Team are also available to present to the team to share the larger purpose and accomplishments of the whole system.

Local team membership is a long-term commitment

A local team is not an ad hoc committee that collects data on infant, child and youth deaths for a designated period. It is a panel of professionals dedicated to establishing a better understanding of the causes of these deaths in their community. Discovering

the patterns that cause or contribute to preventing these deaths is an ongoing process. Patterns change over time within a community. The aggregate knowledge acquired by team members provides structure for achieving effective results.

A local team is both a message to the community and message from the community

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

Self care and professional debriefing

The review of infant, child and youth deaths is an important step in understanding how and why children die, and this process is critical to developing and implementing prevention strategies that will help prevent similar deaths from occurring in the future. It is important, however, to acknowledge the emotional toll that may result from this process, for example feeling a heavy burden from reviewing the details of each tragedy. For some members, the case review process will bring up memories of personal interaction with the deceased child and/or the deceased child’s family or memories of a personal experience. There may be a cumulative effect of reviewing multiple tragedies over time. It is important to allow time during each meeting to debrief and discuss team members’ emotional responses. Some teams have found it helpful to have a moment of silence prior to the start of the meeting, and additionally, a short gratitude exercise at the end. You can find an example script for both practices in the self care folder (link below). If your team chooses to include these in your review, and these formats do not feel exactly right, please cater them to you team and do what feels best.

As a safeguard against this secondary trauma, individual team members may opt out of reviewing a particular case if they feel that the review process will be too difficult emotionally for them due to personal history with the family or other extenuating circumstances. Additionally, if a local team is assigned a case and the team, as a whole, feels that the case will be too difficult or too contentious to review, please contact the State Support Team. Please visit the Self Care folder for resources.

Maintaining a list of resources for your team to access if they need assistance coping with primary and secondary trauma is recommended for each team.

Data Entry Best Practices

Below are some important tips for entering data into the NCFRP CRS. For help with specific questions, look at the NCFRP data dictionary.

Do not include identifiers

This is extremely important! The NCFRP CRS is secured by the National Center for Fatality Review and Prevention, but to further protect the data, do not enter any personal identifying information including names (of people, hospitals, schools, etc.), birth dates, and addresses (county and state are fine) in any text boxes or the narrative section. Review the document "Writing the Narrative".

Make sure to include death certificate numbers

Also very important! Since no personal identifying information is entered into the NCFRP CRS, the only way to keep track of cases is to enter the death certificate number. The CFPS Coordinator also needs this number for data analysis and reports.

No Missing Variables

Choose "unknown" or "N/A" instead of leaving the field blank. It is important to get as much information on a case entered into the NCFRP CRS as possible. If one of the questions is unanswerable because the team does not have the record or necessary documentation, always choose "unknown" or "N/A" if given the option, leave the question blank if not or document "none" in the text box.

Identifying Acts of Child Abuse, Neglect, Poor Supervision or Exposure to Hazards

Team members are asked to collectively decide, using available information, if they believe that any acts of child abuse, neglect, poor supervision or exposure to hazards caused or contributed to the death. Use the information icon ( ) to review definitions to assist in making this determination. Although Colorado's Children's Code (19-1-103 (1)) and legal definitions of child abuse and child neglect serve as guidance, the final decision *is based on available information and professional judgments made by the multidisciplinary CFPS local child fatality prevention review teams.*

- **Child abuse -** includes physical abuse (any non-accidental act that results in physical injury or imminent risk of harm such as abusive head trauma, chronic battered child syndrome, beating/kicking, scalding/burning and Munchausen Syndrome by Proxy), emotional abuse (verbal assault, belittling, threats and

blaming) or sexual abuse (a single or series of sexual assaults or sexual exploitation).

- **Child neglect -** failure on the part of a parent or caregiver to provide for the shelter, safety, supervision and nutritional needs of the infant, child or youth that results in harm. Child neglect includes physical, medical, supervisory, and emotional neglect.
- **Poor Supervision -** caregiver's failure to supervise, provide alternative appropriate supervision, or engage in other behavior that causes or contributes to the infant, child or youth death. Typically used when the team does not feel that the lapse in supervision meets criteria to be classified as child neglect.
- **Exposure to Hazards -** behavior by a parent or caregiver that expose an infant, child or youth to hazard(s) that pose a threat of harm to the child. Typically used when the team does not feel that the circumstances meet the criteria to be classified as child neglect.

The decision to document an act of Child Abuse, Neglect, Poor Supervision or Exposure to Hazards does not have legal ramifications.

The determination is subjective opinion on the part of the local teams and does not trigger any prosecution or action on the part of departments of human services. As such, deaths classified as child maltreatment by CFPS will not be reflective of official counts of abuse or neglect deaths reported by CDHS. Additionally, some of these deaths do not meet the criteria for review by the CDHS Child Fatality Review Team (CFRT). This is because they were deaths of children with no previous involvement with county departments of human or social services prior to the death and deaths of children for whom child maltreatment was not the direct cause of death.

Documentation of Child Abuse, Neglect, Poor Supervision or Exposure to Hazards is essential to child fatality reviews

The CFPS identifies and aggregates the circumstances involved in child maltreatment deaths to develop prevention recommendations, regardless of whether the infant, child or youth death was substantiated as child maltreatment by human services. CFPS applies the public health approach to achieve a better understanding of child maltreatment deaths and improve its ability to prevent these deaths.[1] The purpose of

[1] Covington, T. (2013). The public health approach to understanding and preventing child maltreatment: A brief review of the literature and a call to action. *Child Welfare, 92*(2), 21-39.

the CFPS is to interpret trends, common risk factors and multiple variables among all potential child maltreatment deaths to develop strategies that will prevent the occurrence before it happens. This will impact a broad population of children in Colorado rather than specific efforts only for children at-risk of being maltreated or mitigating the effects of serious maltreatment that has already occurred. To view a training webinar, please visit our website: www.cochildfatalityprevention.com/p/case-assignments-and-data-entry.html

Identifying Sudden Unexpected Infant Deaths (SUID)

The Center for Disease Control (CDC), along with many public and private partners developed the SUID Case Registry, which builds on the work of CFPS and the NCFRP by collecting and analyzing comprehensive data on SUID to better understand the circumstances and factors associated with these deaths, including unsafe sleep environments. Colorado has been participating in the SUID Case Registry since the pilot launched in 2009.

Because the State of Colorado is a grantee in the SUID Case Registry, the State Support Team will be carefully reviewing all SUID cases after they are reviewed by local teams for quality assurance (QA). The following are the guidelines for the State to use when 'cleaning' a SUID case. As such, it is best practice for local teams to use the SUID Clean Case Definition form (link below) while entering SUID case data to ensure that all 'critical' fields are completed during the data entry process.

Cleaning a case for the SUID Case Registry means that you must go back and check that critical information is filled out. This is an important QA activity. For certain sections and fields, you must double check the answers in the NCFRP CRS. There are three main points to consider when cleaning a SUID case:

1. Be sure that no critical fields are left blank. A blank field means "we never looked for the information." Instead, teams should use "unknown" as a response when they have searched for an answer but were unable to find one. *You may also leave a field blank if a critical document was missing and you were unable to adequately look for the information.*
   a. *Click here to access the SUID Clean Case Definition for the list of critical fields.*
2. If the team did not have anything to add to a text field, "none" must be entered in that field.
3. During the QA process, the CFPS Coordinator might reach out for clarification of an answer. This often means the local team coordinator will need to review the documentation again or reach out to the relevant partners for additional or clarifying circumstance information.

SUID Investigation Reporting Form (SUIDIRF)

To standardize investigations of, and reports on, the causes of SUID, the CDC collaborated with organizations who investigate infant deaths to revise the 1996 SUIDIRF and develop training curriculum and materials for investigators of infant deaths.

The SUIDIRF is Important for Several Reasons:

- It contains 25 questions that medical examiners must ask before an autopsy is done.
- It guides investigators through the steps involved in an investigation.
- It allows investigators to document their findings easily and consistently.
- It improves classification of SIDS and other SUIDs by standardizing data collection.
- It produces information that researchers can use to recognize new health threats and risk factors for infant death so that future deaths can be prevented.

The form is typically filled out by investigators at the coroner's office or law enforcement agency. The form can be completed in paper form or is also available online as a fillable PDF. Local team coordinators can request the SUIDIRF from these agencies when conducting case reviews of SUID. To learn more, access a blank copy of the form and view the User Guide, visit the CDC's website: www.cdc.gov/sids/SUIDRF.htm.

Other helpful SUID resources:

 What is a Sudden Unexpected Infant Death?

 SUID Categorization Flow Chart

 SUID Categorization Guide

 SUID Clean Case Definition

Data Analysis

On an annual basis the CFPS Epidemiologist analyzes and interprets data collected in the NCFRP CRS to observe trends and patterns of infant, child and youth deaths in Colorado. This data, along with aggregated prevention recommendations, are shared in the annual legislative report and online and can be incorporated into local data reports upon request.

The CFPS Data Dashboard is another valuable resource local and state team members have access to. This resource provides data on leading causes and circumstances of death for all jurisdictions across Colorado and summarizes some of the most frequently requested circumstance data available from CFPS. The CFPS Data Dashboard is also one way to report aggregated data compiled and prepared following the end of each annual review cycle and will be updated yearly. The dashboard contains data on the overall number of reviews conducted by jurisdiction, SUID, youth suicide, motor vehicle/transport-related deaths, child maltreatment (abuse and neglect), firearms, unintentional drowning and unintentional poisoning deaths occurring among infants, children and youth in Colorado.

 CFPS Data Dashboard

Evaluation

As part of the implementation of *Colorado Revised Statute 25-20.5-401-409*, CDPHE created a five-year evaluation plan to measure the impact of the new Colorado CFPS. Local-level case reviews of infant, child and youth deaths is considered a national 'best-practice,' but due to a lack of evaluation there is little evidence supporting this claim. Colorado is in a unique position to evaluate CFPS that conducts reviews at a local level as well as evaluating the process needed to implement such a system. CFPS is currently being evaluated on the process used to improve both data quality and the prevention recommendations generated by the system. As part of this process, all three parts of the system are evaluated: local teams, State Review Team, and the State Support Team and prevention initiatives implemented by the system are tracked and evaluated. The five-year evaluation process will conclude in 2019. For more information on how the system is evaluated, visit the CFPS website: www.cochildfatalityprevention.com/p/evaluation.html.

Resources

Acronyms and Definitions

CDPHE Child Fatality Prevention System (CFPS) State Support Team

CFPS State Support Team at the Colorado Department of Public Health and Environment (CDPHE) will serve to help local communities and local public health agencies organize local teams and conduct effective child fatality reviews. The support team is committed to providing guidance, technical assistance and training to foster a statewide, coordinated child fatality review system.

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, State Support Team, local teams and associated infrastructure (NCFRP CRS). 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 Public Health and Environment (CDPHE)

The principal department of the Colorado state government responsible for public health and environmental regulation.

Colorado Department of Human Services (CDHS) Child Fatality Review Team (CFRT)

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

Death Certificate File Transfer Protocol (FTP) Website

The death certificate FTP website is housed by a secure FTP website to protect the confidentiality of each case. On a weekly basis, the CFPS support staff will place case assignments on the FTP website in subfolders labeled by county, year and month for local teams to retrieve. Each subfolder will have the necessary documents for each case that will contain selected birth and death certificate information, and may potentially contain reports from the CDHS CFRT, if applicable.

Local Child Fatality Prevention Review Teams (local teams)

Local 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 infant, child and youth deaths in Colorado and making recommendations to prevent these deaths from occurring in the future. Local public health agencies coordinate the majority of the teams across the state. These teams serve either a single county or a region, as determined by the communities, and began reviewing cases on January 1, 2015.

National Center for Fatality Review and Prevention (NCFRP)

NCFRP serves as a resource and data center for state and local child fatality prevention review programs, funded by the Health Resources and Services Administration of the Maternal and Child Health Bureau. It promotes and supports child fatality review methodology and activities at the community, state and national levels.

National Center for Fatality Review and Prevention Case Reporting System (NCFRP CRS)

The NCFRP CRS is the data collection website that is an electronic database used by local teams to record the data from all child death cases assigned to them by CFPS State Support Team.

Public Health Approach

Problem areas are identified through individual case-specific reviews. These reviews highlight specific risk and protective factors that can be mitigated or enhanced through best practices and evidence-based interventions to prevent infant, child and

youth deaths. Lastly, these interventions are implemented and evaluated to understand the potential impact on preventing these deaths in Colorado.

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. As mandated by the Child Fatality Prevention Act, 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). That State Review Team also reviews cases on an ad hoc/as needed basis when local teams cannot or will not review a case.

Sudden Unexpected Infant Death (SUID)

The sudden and unexpected death of an infant less than 1 year old in which the cause was not obvious before investigation. These deaths often happen during sleep or in the infant's sleep area.

Violence and Injury Prevention - Mental Health Promotion (VIP-MHP) Branch

The VIP-MHP Branch of CDPHE's Prevention Services Division is charged with reducing intentional and unintentional injuries in Colorado. The VIP-MHP Branch uses epidemiologic data to guide the development of community and statewide initiatives to prevent injury, suicide and violence. The Colorado CFPS is housed in the VIP-MHP Branch.

Prevention Guidance

As a result of what local teams learn from the reviews of individual infant, child and youth death cases across Colorado, local teams are primed to take action to prevent similar future tragedies from occurring. The reviews can lead to many initiatives, some involving short-term, easy-to-fix problems and others requiring long-term, extensive planning efforts. Prevention efforts can range from simply changing one agency practice or policy, to more complex interventions like intensive home visitation programs for families.

Individual agencies or local 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 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.

The CFPS State Support Team develops 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."

Funding may be available to implement prevention strategies based on the recommendations from local team discussions, including funding allocated by CDPHE to support local teams. CFPS State Support Team and local teams work collaboratively to analyze data trends and patterns, interpret the data, select evidence-based prevention strategies and implement community-based prevention strategies. For more information on current funding opportunities, please visit the CFPS website: www.cochildfatalityprevention.com. Funding opportunities are also included in our monthly CFPS newsletter.

Leadership is key to sound child fatality prevention across our state, and local teams play a vital role in leading prevention efforts, serving as catalysts for community and statewide action. In addition to the opportunity to design, implement and evaluate

prevention initiatives at the community or county level, local teams are vital in the process to develop system and statewide CFPS prevention recommendations as part of the annual legislative reports submitted to the Colorado General Assembly every July 1st. The CFPS State Support Team, State Review Team and local teams prioritize prevention recommendations made by local teams and entered into the NCFRP CRS every year. As such, local team reviews directly contribute to communicating with legislators and decision makers in Colorado the lessons learned from the review of individual child death cases and how to prevent these deaths from occurring in the future.

 Prevention guidance

Technical Assistance and Training

The CFPS State Support Team at CDPHE serves to help local teams conduct effective reviews, develop and implement prevention initiatives and foster a statewide, coordinated child fatality prevention system. The team is committed to providing training, guidance and technical assistance. Services provided include training and technical assistance on the facilitation of child death reviews; selection of evidence-based injury, suicide, and violence prevention strategies; development of actionable community-based prevention recommendations; TA around records abstraction and data collection into the NCFRP CRS; and presentations on both statewide and local level data from the system. The team can also assist with customized trainings that local teams identify will benefit their process. A monthly newsletter provides local teams with information regarding system best practice, trainings and events, funding opportunities and articles related to our work. Please contact any member of the State Support Team with training or technical assistance requests. CFPS State Support Team contact information

The CFPS website has networking information and other resources for the State Review Team and local teams, including helpful documents for case review and data entry. Team members can also choose to receive blog post via email. 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