An Introduction to the System

Colorado Child Fatality Prevention System Operations Manual

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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. The review of each death includes a discussion about community strengths, areas for improvement, and ways to support healthy, thriving children and families and prevent future deaths. 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 Statutes 25-20.5-401-409 Child Fatality Prevention Act (https://drive.google.com/file/d/1UxYZIbj-1jrEG3C_lxCdZKhglB98jdUX/view?usp=sharing)

This operations manual is divided into two sections:

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

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

This operations manual PDF is in line with the Web Content Accessibility Guidelines (WCAG). For more information, see the CDPHE digital accessibility statement (https://cdphe.colorado.gov/accessibility).

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, youth, and families represented within these pages.

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 Children, Youth, and Families Branch of the Prevention Services Division. CFPS is based on a public health approach to the prevention of deaths of infants, children, and youth. 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-informed 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.

Although not codified in Colorado Revised Statutes until 2005, the CFPS has been conducting retrospective reviews of infant, child, 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 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 use 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 reviews deaths of Colorado residents occurring in Colorado, as well as deaths of out-of-state residents who died in Colorado, including those who 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-informed 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, local teams, and other stakeholders to generate system-wide recommendations based on the annual statewide data. The CFPS State Review Team, local teams and community stakeholders 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.

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.

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.[1]In the United States, most residents grew up and continue to live in racially and economically segregated neighborhoods, which can lead to marginalization.[2,3] This marginalization of groups into segregated neighborhoods further impacts access to high-quality education,[4] employment opportunities,[5] healthy foods,[6] and health care.[7] Combined, the economic injustices associated with residential, educational, and occupational segregation have lasting health impacts that include adverse birth outcomes, infant mortality,[8] high rates of homicide and gun violence,[9] and increased motor vehicle deaths.[10]

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 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.

References

1. Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural racism and health inequities in the USA: evidence and interventions. *The Lancet, 389*(10077), 1453-1463.
2. Pager, D., & Shepherd, H. (2008). The Sociology of Discrimination: Racial Discrimination in Employment, Housing, Credit, and Consumer Markets. *Annual Review of Sociology, 34*, 181-209.
3. Williams, D. R., & Collins, C. (2016). Racial residential segregation: a fundamental cause of racial disparities in health. *Public Health Reports, 116*(5), 404-16.
4. Williams, D. R., & Collins, C. (2016). Racial residential segregation: a fundamental cause of racial disparities in health. *Public Health Reports, 116*(5), 404-16.
5. Collins, C. A., & Williams, D. R. (1999). Segregation and mortality: the deadly effects of racism?. In *Sociological Forum*, 14(3), 495-523. Kluwer Academic Publishers-Plenum Publishers.
6. Larson, N. I., Story, M. T., & Nelson, M. C. (2009). Neighborhood environments: disparities in access to healthy foods in the US. *American journal of preventive medicine*, 36(1), 74-81.
7. White, K., Haas, J. S., & Williams, D. R. (2012). Elucidating the role of place in health care disparities: the example of racial/ethnic residential segregation. *Health Services Research, 47*(3pt2), 1278-1299.
8. Acevedo-Garcia, D., Lochner, K. A., Osypuk, T. L., & Subramanian, S. V. (2003). Future directions in residential segregation and health research: a multilevel approach. *American journal of public health*, 93(2), 215-221.
9. Collins, C. A., & Williams, D. R. (1999, September). Segregation and mortality: the deadly effects of racism?. In *Sociological Forum* (Vol. 14, No. 3, pp. 495-523). Kluwer Academic Publishers-Plenum Publishers.
10. King, M. (2017). Under The Hood: Revealing Patterns Of Motor Vehicle Fatalities In The United States. *Publicly Accessible Penn Dissertations. 2396.* Retrieved on June 19, 2019 from: repository.upenn.edu/edissertations/2396.

CFPS State Support Team

The CFPS State Support Team are staff members of CDPHE. They 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 provides oversight and funding to the system.

CFPS Program Manager

The CFPS Program Manager is responsible for providing support, training, technical assistance, and coordination to local and state child fatality review teams. They act as a liaison between local, state, and national partners to establish and maintain best practice in fatality review. They review and develop strategic responses to new or proposed changes in legislation. They are also responsible for synthesizing data and prevention recommendations gathered by state and local teams for inclusion in the CFPS annual legislative report, which is submitted to the state legislature.

Infant and Child Wellbeing Coordinator

The Infant and Child Wellbeing Coordinator is responsible for supporting the Sudden Unexpected Infant Deaths case registry by collaborating with State, Local and Community organizations to support and uplift prevention recommendations and efforts to educate caregivers and family members as they practice safe sleep for their infants. The work focuses on promoting equitable strategies to reduce sleep-related infant deaths. They work to understand cultural nuances of bedsharing and infants' sleep environments. They also collaborate with Children's Hospital Colorado in the Neonatal Intensive Care Unit (NICU) to improve the education that providers give to caregivers when infants with medical conditions are discharged and brought home. Also, they work with Children’s Hospital Colorado to capture stories of the lived

experiences of families whose infants were in the NICU in order to systemically change provider relationships and healthcare practices.

Child Fatality Family Interview Specialist

The Child Fatality Family Interview Specialist is responsible for conducting next-of-kin/family interviews with people who have lost a child to SUID to better understand the families perspectives and the social and environmental life stressors and factors that may have contributed to the death. They also provide bereavement and grief support to families they contact as a member of the Denver Office of the Medical Examiner's Family Advocacy Support Team (FAST) and support the Denver Child Fatality Review Team. The person in this role also works to improve death scene investigation efforts for SUID.

Maternal and Child Mortality Analyst

The Maternal and Child Mortality Analyst performs day-to-day data-related operations of CFPS, including data analysis and dissemination, responding to data requests, creating data products, and updating and maintaining the CFPS dashboard. They also serve as the Data Coordinator for the Colorado Sudden Unexpected Infant Death (SUID) Case Registry. Additionally, they may visit with local teams to share and discuss the community's data and help local teams understand the limitations and strengths of the data collected by CFPS.

CFPS State Review Team

The Colorado CFPS State Review Team is a volunteer, multidisciplinary committee that includes experts in the fields of child abuse prevention, pediatrics, public health nursing, family law, death investigation, motor vehicle safety, and SUID.

State Review Team Role

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. 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. The State Review Team also reviews cases on an ad hoc/as needed basis when local teams cannot review a case. To read reports from previous years, and learn more about the State Review Team please visit the CFPS website (https://cdphe.colorado.gov/prevention-and-wellness/injury-prevention/child-fatality-prevention-system).

State Review Team Membership

The State Review Team has 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 is made up of:

Eighteen Governor-appointed members

- County sheriffs representing both urban and rural areas
- County coroners

- Peace officers specializing in crimes against children
- District 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 (CDHS) (Division of Child Welfare, Division of Youth Services [youth corrections])
- Behavioral Health Administration
- Director of a local department of human or social services
- Colorado Department of Public Health and Environment (including representation from a local public health agency)
- Department of Education
- Department of Public Safety

Twelve team-selected members (nonvoting)

- 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 a 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
- 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 (https://drive.google.com/file/d/1UxYZIbj-1jrEG3C_lxCdZKhglB98jdUX/view?usp=sharing) or contact the CFPS State Support Team.

How to Get Involved

If you know someone who is interested in filling one of the Governor-appointed positions, please direct them to fill out an online application from the Governor's Office of Boards and Commissions (https://www.colorado.gov/governor/boards-commissions-application). 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 someone is interested in serving in another position or serving as a subject matter expert to the team, they should contact the CFPS Program Manager.

CFPS Local Review Teams

The Colorado CFPS Local Review Teams are established by each county or district public health agency and may represent a single county or a region of several counties. The local teams are multidisciplinary committees that include representatives from agencies that provide services to children and families and other individuals who represent the community.

Local Review Team Role

Per statute, the local teams review specific cases of child fatalities in the team's county or region that occur from birth through seventeen years of age and involve unintentional injury, violence, motor vehicle incidents, child abuse or neglect, sudden unexpected infant death, suicide, or undetermined causes. Local teams identify risk and protective factors and prevention recommendations. These findings can inform local and regional prevention initiatives and policy and practice changes. The findings are also entered into a national data-collection system, the National Fatality Review-Case Reporting System (NFR-CRS), and shared with the state to develop a community approach to the systemic issues related to child fatalities.

Local Review Team Coordinator

The purpose of this position is to coordinate the local child fatality review team, work with community leaders to maintain and enhance the local team, identify equitable prevention strategies and systems improvements, and implement local team prevention recommendations. The local team coordinator serves as a liaison between the local team and the CFPS State Support Team and is usually 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 death certificates 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 Fatality Review-Case Reporting System (NFR-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
- Promote evidence-informed injury and violence prevention strategies that advance health equity

- 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 the CFPS State Support Team
- Manage funding provided by CDPHE

Local Team Member Roles

Local team coordinators need to be familiar with which representatives the statute requires and recommends, their roles, and the value they bring to the local team and review process. Roles of team members include:

- Submitting records to their local team coordinator prior to the review meeting
- Serving as a liaison to respective professional and community counterparts
- Providing definitions of professional terminology
- Explaining the procedures, policies, legal responsibilities, and limitations of their agency or profession
- Discussing systemic, agency-level, and individual factors that contribute to or hinder the health of children and families in their community
- Considering how systemic bias and forms of oppression impact different populations in their community
- Developing and advocating for the implementation of prevention recommendations

Categories of Team Members per Statute

In addition to understanding their role on the review team, members should understand how agencies in the community respond to the death of an infant, child, or youth. When fatality review team members understand each other's roles and agency practices, the team is better able to identify and take action on meaningful prevention initiatives. More specifics of the roles of each agency and member are listed below, as well as whether their participation is mandated by statute or optional.

Child Advocacy Centers (CACs) (optional)

- CACs are nonprofit organizations whose mission is to respond to and prevent child abuse and neglect. As of 2024, there were 19 CACs in Colorado, providing services to 60 of 64 counties.
- CACs provide services to children and families who have experienced abuse and neglect, including conducting forensic interviews of child victims, providing counseling services, and engaging in prevention initiatives.
- CAC staff have first-hand knowledge of the problems of child abuse and neglect in their community, the resources available to help children and families, and where improvements are needed.
- CAC staff may have worked with the infant, child, or youth who died and/or their family. They can provide information on services that were provided before or after the death.

Community At Large (optional)

- We strongly encourage the inclusion of community members on local teams. Community members may have personal experience of the factors that lead to child deaths and have particular insight into a community's strengths and challenges.
- Community members may identify life stressors, risk and protective factors, and prevention recommendations that other team members may be unaware of.
- Community members can bring expertise in the form of lived experience and community knowledge.
- Community members who have had the experience of being on the receiving end of the governmental agencies represented on the team can offer unique perspectives into ways those agencies are or aren't meeting the needs of the community.
- Community members are a broad category and may include: staff and volunteers of local nonprofit organizations, community organizers and advocates, family leaders, and youth activists.
- Look for multiple ways to involve community members in the review process; as regular review team members, on an ad hoc basis depending on the specific death or cause of death, or as members of subcommittees.

Community Mental Health Professionals (optional)

- Provide information and insight regarding psychological issues related to events that caused a death.

- Provide information on effective prevention and treatment of mental health conditions and what the current status of mental health care is in the community
- Mental health professionals cannot share individual treatment records without written consent. However, they can suggest when counseling or other mental health service referrals may be appropriate and can also identify whether there were systemic issues that may have harmed or supported an individual child or family.
- Share knowledge of specific populations and their needs and the resources available for mental health in the community including service gaps in a community (culturally and linguistically relevant care, wrap around services, etc.)
- Provide valuable insight into their own agency policies and practices.

Coroner's Offices (mandated)

- Coroners are central to the function of both local teams and death investigations. In Colorado, coroners determine the cause and manner of death.
- Present information about cause and manner of death, including findings from the scene investigation, autopsy and medical history, and interpreting clinical findings.
- 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 where the fatal injury occurred, depending on the circumstances of a particular death.

County Attorney's Offices and District Attorney's Offices (mandated)

- Prosecutors educate local teams on criminal law and provide information about criminal and civil actions taken against those involved in the death.
- Explain 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.
- Provide information when the child or youth was involved in the criminal legal system.

County Department of Human Services (mandated)

- 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, sibling(s), or caregiver, 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, drug misuse, and previous deaths and/or abuse.
- When needed, human services representatives can provide services to surviving family members.

Court Appointed Special Advocates (CASA) (optional)

- Court appointed special advocates are volunteers who are appointed by judges to advocate for the best interests of children who are going through court cases involving child abuse and/or neglect.
- CASA volunteers can bring a unique perspective on the functioning of courts, child welfare agencies, and foster care providers, as well as how these systems interact with families and children involved with abuse and neglect court cases.
- CASA volunteers can provide perspective on factors that lead to abuse and neglect and what resources are needed to ensure supportive, safe families.

Emergency Medical Services (optional)

- Frequently first at the scene and obtain critical information regarding the scene and circumstances, including witness accounts.
- 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 (optional)

- 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.
- Can provide information when a child was hospitalized or transported to an emergency room prior to their death.
- 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 (mandatory)

- Law enforcement professionals provide information on the fatal incident as well as criminal investigations of 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.

Pediatricians (optional)

- Provide local teams with medical explanations and information about child development.
- May have access to 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.

Private Out-of-Home Placement Providers (optional)

- Out-of-home placement providers are also known as foster care providers. Infants, children, and youth are placed in foster care when a child welfare agency determines that their family is not providing them with a safe living environment.
- Foster care providers can provide first-hand knowledge of the strengths and challenges of the foster care system.
- They have experience with children who have been victims of abuse and neglect, the factors that lead to children being removed from their homes, and ways families have successfully regained custody of their children.
- They know what resources exist or are missing to provide for the needs of children who have experienced abuse or neglect.

Public Health (mandatory)

- Provide the prevention perspective and 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 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 and protective factors and share what local public health services are currently offered to children, pregnant women, and families.

School Districts (mandatory)

- School representatives can provide vital information on the child or youth who died, as well as more general information about school climate, the student body, school-based prevention efforts, and challenges.
- Educators, district school nurses, and district counselors can provide local teams with perspectives on child health, growth and development.
- Their presence at child fatality reviews can enhance the delivery of support services and interventions. Representatives from school districts are also able to provide leadership in implementing prevention recommendations.
- School representatives may be hesitant to share information due to concerns of violating the Family Educational Rights and Privacy Act (FERPA). In Colorado, we have guidance regarding information-sharing and FERPA that was crafted by Cynthia Coffman when she was the Colorado Attorney General in 2018. In her formal legal opinion (https://drive.google.com/file/d/1QSNNish9wAawk_7reMINB57STNkaFUjJ/view?usp=sharing) and an accompanying FERPA-related video (https://www.youtube.com/watch?v=cEnphX0KeDM), AG Coffman clarified the following:

- Information learned through observation and personal interaction as well as records maintained by school security staff are not subject to FERPA;
- Educational records that are protected by FERPA can be shared with 1) educational staff who have a legitimate educational interest in maintaining campus safety, and 2) other agencies to address health and safety emergencies;
- Educators can and should err on the side of promoting safety.

- Our reviews happen in response to the health and safety emergency of a child's death with the goal of identifying measures to prevent similar emergencies in the future. The AG's official opinion and the goal of public health child death review may reassure school officials who are hesitant to meaningfully participate in a local team.

Victim advocates (optional)

- Victim advocates work with victims of crime to provide information on the court system, the status of court cases, rights of victims, victim's compensation, and community resources.
- Victims advocates may work with the district attorney's office, or they may work with an organization that provides services to crime victims.
- They can provide expertise on crimes that impact infants, children, and youth including domestic and family violence, sexual assault, human trafficking, and child abuse and neglect.

Ad Hoc Members

Local teams may designate ad hoc members. These members might only attend review meetings when they have been directly involved in a case, only attend cases involving specific causes of death, or attend 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 or law enforcement officers involved in a specific case, or individuals with specific knowledge on a particular cause of death, population, or community factor. 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.

Recruiting and Orienting Local Team Members

People can become members of local review teams in various ways. Members who represent entities mandated in statute are usually designated by their agencies to participate. Non-mandated members are often invited to participate by the local team coordinator or other team members. The following questions can be helpful to ask yourself when recruiting new team members, or when considering the skills, experience, and perspectives of existing team members. These questions aren't a checklist; they are meant to help you get a better understanding of individuals and how they fit in as a review team member. Someone doesn't have to be able to answer "yes" to all of these questions in order to bring value and insight to the review process.

- Is this person invested in preventing child death and in making the community safer and healthier for children and families?

- Is this person a decision maker in their agency? Do they have the authority to implement changes and involve their agencies in cooperative projects?
- Does this person work directly with children and families? If so, in what ways? Do they work with specific populations, such as children and families who are Black, Indigenous, LGBTQ+, immigrant, low-income, etc?
- Does this person have first-hand knowledge of the community, personal experience being on the receiving end of different agencies, or other lived experience that is similar to that of the children and families represented in fatality reviews?
- Is this person committed to improving their understanding of the factors that lead to the deaths of infants, children, and youth? Are they familiar with public health concepts like social determinants of health, health equity, risk and protective factors, or upstream prevention?
- Is this person culturally responsive? Do they consider issues of inclusion, equity, diversity, and accessibility? Do they think about the ways that racism and other forms of systemic oppression impact children and families in their community?
- Does this person have experience working across agencies or with community organizations?
- Does this person have professional or personal experience that makes them uniquely beneficial to the review process?
- Does this person believe they are able to take on the emotional challenge, including the potential vicarious trauma, of reviewing child deaths?

- Does this person have experience in injury and violence prevention or health promotion?
- Is this person open to learning from their colleagues on the review team and considering different points of view?

Local fatality review teams are often a mix of high level agency staff, staff with less decision making authority, and members of the community or community organizations. A benefit of having an agency director on the team can be that person's ability to make organizational decisions and lead inter-agency collaboration. However, a staff member with less official authority might have more experience working day-to-day with families and children and have a better understanding of the unique factors impacting their communities. Community members can bring immense value and experience to a review team. Community members may include: staff and volunteers of local nonprofit organizations, community organizers and advocates, family leaders, and youth activists. Youth, family, and community leaders can be involved as regular review team members, on an ad hoc basis depending on the specific death or cause of death, or as members of subcommittees.

The composition of local teams should be flexible to meet the needs of the community. The members mandated by CFPS statute are a starting point, and additional members, including community leaders, can enhance the team's ability to understand specific deaths, understand systemic factors that impact children and families, and develop meaningful prevention recommendations.

When new members join a review team, it is important that the local team coordinator orients them so that they understand the CFPS, the purpose of local team reviews, their roles as team members, and what to expect during a review. An orientation conversation also gives new members an opportunity to ask questions,

raise concerns, and share their ideas. A local coordinator can do this via email, in a phone conversation, or as part of a review meeting.

Local Team Funding

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 are 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. Local coordinators should document how CFPS funds are spent and that spending is consistent with the statement of work (SOW). If there are any questions, the coordinator should contact the CFPS Program Manager. 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, NFR-CRS data entry, requesting records, etc.)
- Payment for records requests

- Printing costs for paperwork for the meeting (i.e., case summaries, records, data collection tools, etc.)

Facilitation of Case Review Meetings

- Reimbursement for local team coordinator's time spent on the project (i.e., coordination of the meeting, NFR-CRS data entry, note taking, etc.)
- Reimbursement for team members' travel to review meetings
- Reimbursement for time spent on the reviews by team members who do not participate as a function of their job, such as youth and family leaders
- Food costs
- Meeting rental space
- Teleconferencing equipment such as projectors, meeting Owls, or laptops

Injury and Violence Prevention Efforts

- Designing, implementing, and evaluating injury and violence prevention strategies identified by the local team. For example:
    - Purchasing car seats and booster seats, bicycle and ski helmets, and cribs that adhere to safe sleep guidelines
    - Supporting suicide prevention programs in schools
    - Coordinating suicide prevention gatekeeper trainings
    - Purchasing lock boxes for secured storage of firearms and medication
    - Supporting policies that improve caregiver behavioral health, support families in the workplace, or improve access to affordable child care

- Promoting continuing education, training, membership to a professional organization, or conference attendance for local coordinators or other review team members

Part Two: The How

Case Identification, Assignment, and Abstraction

Child Fatality Review Timeline

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 website called MOVEit (https://www.google.com/url?q=https://oitftapp01.state.co.us/&sa=D&source=docs&ust=1716896152201218&usg=AOvVaw0PE54jG7j1t72JVg4t9GFC). Causes of death local teams review include:

    a. Undetermined cases

    b. Unintentional injury (i.e., drowning, falls, fires, poisoning, overdose)

    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 NFR-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 secure website to view the death certificate.

4. Once notified of the death, the local team coordinator begins case abstraction, which is the process of collecting information (requesting records) and entering it into the NFR-CRS prior to the review meeting. Completing as much data entry prior to the meeting increases efficiency, data quality, and confidentiality.

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 completing reviews and data entry follow the year of death. For example, 2022 deaths were reviewed and entered into the NFR-CRS in 2023, with a deadline for completion of 12/31/2023.

    a. One exception to this rule is that SUID deaths must be reviewed, entered, and have a completed quality assurance check within 240 days of the date of death.

7. The CFPS Program Manager on the State Support Team reviews all cases entered into the NFR-CRS for completeness and quality assurance (QA). The Program Manager may need to follow up with local team coordinators if data fields are left blank or for further information regarding data entry choices.

8. The Maternal and Child Mortality Analyst aggregates and analyzes data on an annual basis each spring. The data collected in the NFR-CRS is interpreted to identify trends and patterns of infant, child, and youth deaths. This data, along with aggregated prevention recommendations, is incorporated into topic-

specific data products for the leading causes of death identified by CFPS. These products 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 Maternal and Child Mortality Analyst updates the CFPS Data Dashboard (https://cohealthviz.dphe.state.co.us/t/PSDVIP-MHPPUBLIC/views/CFPSDashboardFinalLocal/Story1?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no) each year following the end of each annual review cycle. The dashboard provides aggregated 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.

Special Guidance: Reviewing Homicides and Other Deaths in Litigation

Your team may be assigned a death that is under investigation and/or being litigated in court. Homicides, in particular, are frequently in litigation. During litigation, you may have limited access to records, and community partners such as law enforcement or county attorneys may be hesitant to discuss the details of their investigation.

CDPHE recommends that local teams review deaths in litigation based upon the best available information, which may be limited to the death certificate, hospital records, and human services records. Despite these challenges, teams can still have valuable discussions about risk and protective factors; ways to support children, youth, and their families; and prevention efforts.

Not reviewing deaths in litigation has led to limited data and a lack of prevention recommendations, particularly for homicides. The lack of information and discussion

about homicides is also an urgent equity issue considering that Black and Hispanic children die of homicide at rates far surpassing non-Hispanic white children. CFPS local team reviews are crucial for understanding and addressing systemic factors that perpetuate these disparities.

CDPHE understands and appreciates that local teams may have agreements requesting reviews be paused until litigation is concluded. If this is the case, CDPHE requests that you revisit these agreements. There may have been staff turnover, changes in agency practices, or changes in perspectives since an agreement was made. When talking to your partners, it may be helpful to highlight that the child death review process focuses on prevention, not assigning blame, so the review should not compromise ongoing litigation.

Options for reviewing deaths in litigation include:

- Conducting the review with the understanding that certain documents or information may not be available.
- Not reviewing the death at the request of attorneys/law enforcement. Instead, the local team coordinator collects as much information as they can about the death and enters data into the NFR-CRS. Once the litigation has concluded, the team will conduct the full case review with their team, despite this potentially being some years after the death.

IMPORTANT: If a local team is unable to review a death in litigation, the local coordinator should inform the CFPS Program Manager so it can be properly tracked in the case assignment database. **Your team is expected to review the death once litigation is complete**.

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. Records can be obtained by formal written requests and directly from local team members. 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.

IMPORTANT: Due to staff turnover or extended time between child deaths, agency staff may be unfamiliar with the CFPS and local fatality reviews. Due to the sensitive and confidential nature of the records, people may be suspicious and hesitant to share information that is unexpectedly requested with no additional context. The local coordinator should explain, over the phone or in an email/fax, that the records are being requested as part of a statewide, multidisciplinary system governed by the Child Fatality Prevention Act; that all documents are protected by confidentiality; and that local reviews do not have legal outcomes, rather they are for the purposes of prevention. The coordinator can direct people to the CFPS website and the Child Fatality Prevention Act statute, and, if applicable, refer to the agency's previous involvement on the local review team.

Colorado Revised Statute 25-20.5-408. Access to records:

"...review teams shall have access to all records and information in the possession of the department of human services and the county departments of social services…including records and information related to previous reports and investigations of suspected child abuse or neglect." and,

"...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."

Local coordinators should request records from agencies and team members before the case review meeting. This allows the coordinator to complete much of the data abstraction in the NFR-CRS and write the case summary/narrative prior to the review meeting. The majority of the meeting should be used for discussing specific sections of the NFR-CRS, risk and protective factors, and prevention recommendations. Team members can also bring records from their respective agencies to the case review meeting.

Records request template (https://docs.google.com/document/d/1LQ_0MpD9nJCtIrVO_gN2q0kc76clpryj/edit?usp=drive_link&ouid=102007452408739227599&rtpof=true&sd=true). The italicized, highlighted text should be customized by the local coordinator. The CDPHE seal can be replaced with the requesting local public health agency's logo.

If local team coordinators have any issues requesting and/or obtaining records, please contact the CFPS Program Manager for assistance.

Secure Record Keeping

The case review files contain a variety of highly confidential documents. Local teams should determine how to store these confidential files and records, based on their agency's 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 is locked when not in use. Digital records should be kept on a secure, password-protected computer.
- Case files and records should be kept until data entry for every case is marked as complete, quality assurance is complete and annual data analysis is complete. The 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 2023 deaths will be entered into the CRS and have quality assurance completed by 12/31/2024, data analysis will be done in early 2025, and case review files can be destroyed after 7/1/2025.
- 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 by Type of Death

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

- Please read all documents related to a case, because information is sometimes found in unexpected locations.
- Limited 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 and information for all types of death:

- Death Certificate
- Birth Certificate for infant deaths under 1 year of age
- Law enforcement scene investigation reports
- Autopsy reports/Coroner reports
- Medical Records/Hospital Records (may include: emergency department reports, admit and discharge notes, EMS trip reports, case or social worker reports, pediatric records for well and sick visits, and the death summary)
- Prior Child Protective Services (CPS)/Department of Human Services (DHS) history or Trails reports on child, caregivers, person supervising child at time of death
- School records (if applicable) - PLEASE NOTE: Sharing student information in the context of child death review does NOT violate FERPA. However, school representatives are usually reluctant to share student records in advance of a meeting. Team members representing schools should be encouraged to share student information during the review meeting.
- Media articles related to incident (if applicable)

Accidental Firearm:

- Information regarding the storage of firearm

- Type of firearm and other ballistics information
- Police and crime lab reports
- Juvenile and criminal records of persons involved in shooting

Child Abuse and Neglect:

- Home nursing visit reports from public health or medical healthcare services
- Human services records, if applicable, of parents, caregivers, or person responsible for abuse and/or neglect

Drowning:

- Information on zoning, code inspections and violations, or other safety concerns regarding drowning location

Fires:

- Fire department reports that include source of fire and presence of detectors
- Information on zoning or code inspections and violations

Homicides:

- Information regarding the storage and type of firearm (if applicable)
- Police and crime lab reports
- Juvenile and criminal records of victim and perpetrators

Motor Vehicle:

- Blood alcohol and drug toxicology results from drivers involved in accident
- State Patrol Full Crash Investigation Report (to request fee-free Colorado State Patrol crash investigation reports, follow the guidance below):
    - Go to the CSP records request portal (https://coloradostatepatrol.govqa.us/WEBAPP/_rs/(S(obf4mgskleoahbuy2wpvzv2d))/supporthome.aspx) and select the "Submit a Records Request" tab to request a full crash investigation report.
    - Log in or create an account.
    - Complete the request explaining that you are requesting records as a function of your role working with the Child Fatality Prevention System housed at the CO Department of Public Health and Environment. This will let the CSP know that they do not need to charge you for the records.
    - **NOTE**: Do not request the Basic Crash Report on the "Basic Crash Report" tab or you will be charged an automatic fee. Use the "Submit a Records Request" tab instead.
    - **NOTE**: If the full investigation report is still being completed, you can check back with the CSP in several months to obtain the full, completed report.
    - If you have issues accessing either the basic crash report or the full investigation report contact the technician listed as processing your request to get updates. You can also call the Central Records Unit at 303-239-4180.

Overdose/Poisoning:

- Toxicology results from hospital records and/or autopsy reports
- Source of toxic substance: how it was obtained, where it was located, how it was stored, etc.
- History of substance use, including treatment for substance use disorders
- Information regarding whether or not Poison Control was contacted

Sudden Unexpected Infant Death (SUID):

- Pregnancy and birth-related medical records
- Sudden Unexplained Infant Death Investigation Reporting Form (SUIDIRF) (https://www.cdc.gov/sids/SUIDRF.htm) from coroner or law enforcement agencies
- Doll reenactment reports and photos
- Home nursing visit reports from public health or medical healthcare services

Suicide:

- Suicide Death Investigation Form (https://cdphe.colorado.gov/suicide-prevention/suicide-investigation-form)
- Scene investigation reports to include criminal and mental health histories (including prior suicide attempts) obtained through interviews

Case Review Meeting Guidance

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.

Local teams are required to use the National Fatality Review-Case Reporting System (NFR-CRS) to report cases.

The National Center for Fatality Review and Prevention has PDF documents of the most recent version of the NFR-CRS, the data dictionary, and a tips and tricks guide on the NFR-CRS page of the NCFRP website (https://ncfrp.org/data/nfr-crs/).

Case Summaries or Narratives

Coordinators need to write case summaries, or narratives, for each death. These are used for the "narrative" section of the data collection tool and shared with the review team. This is a very important piece of data that allows you to include information that may not be asked in other sections and to paint a fuller picture of the life and death of the child. The state support team relies on a detailed narrative in the QA process to check for errors and understand the answers to certain questions.

The following information should be included in the case summary/narrative:

- Manner of death - i.e. accidental, homicide, suicide, undetermined, or natural
    - Only natural deaths where there is an indication of 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.

- Cause of death - the specific reason the child died (car crash, gunshot, blunt force trauma, etc.)
- Description of incident and timeline of events surrounding the death.
- Demographics, including age, sex, race, ethnicity, place of residence, medical history, etc.
- Social history
- Investigation information
- Autopsy information
- Additionally, in an effort to honor and humanize the child, some coordinators include a photo of the child, tributes to the child from loved ones or the community, details about the child's interests and talents, or other personal information that can be obtained from the child's obituary, media accounts, or team members who knew the child.

Writing the narrative - Guidance Document
(https://drive.google.com/file/d/1bsz6TszhuBCIP2tDwjNeG9mMGDaY1n7S/view?usp=sharing)

Case summary/Narrative Template
(https://drive.google.com/file/d/1ic5w3mcoPK2EU1KQ8PnUtTWSUj6capQM/view?usp=sharing)

Confidentiality

At a case review meeting, all information regarding the life and death of an infant, child, or youth is confidential. Although review meetings are subject to Colorado's Open Meetings Law, the majority of the meeting, including any discussion of individual deaths, takes place during a closed, confidential executive session. Public data is aggregated and de-identified in order to protect the privacy of children and families. ***Child death reviews are for the purposes of prevention, not for criminal-legal purposes. CFPS can only legally release information to governmental agencies on individual cases under very narrow and extraordinary circumstances.***

In order to uphold confidentiality, each member of the State Review Team, each member of a local team, and each invited meeting participant must sign a confidentiality statement indicating their understanding of and adherence to confidentiality requirements. Team members should be reminded about the confidentiality requirements at the beginning of each meeting. Team members should have an updated signed confidentiality form each year.

In order to protect the privacy of children and families, safeguards for protecting confidentiality include:

- 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.
- Only enter de-identified information in the NFR-CRS.
- Report data in aggregate form.

- The public and/or media must leave the review meeting during the executive session.

Sample confidentiality agreement (https://drive.google.com/file/d/1Uhp2gUVWY5C-UwVDR2LmYJ2Mlgqo_usl/view?usp=drive_link)

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, contact the CFPS Program Manager 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 CDPHE to get a legal opinion regarding whether or not release of information meets the criteria of the Child Fatality Prevention Act.

Colorado Open Meetings Law

Child fatality case review meetings are subject to the Colorado Open Meetings Law, which is part of the Colorado Sunshine Law. In order to comply with the law, coordinators need to publicly post a notice of the meeting at least 24 hours in advance. Posting a notice on an agency's public website or bulletin board meets this requirement. In addition, meeting minutes must be taken and be open to public inspection. Minutes should be brief and exclude any confidential information. Finally, the team needs to formally enter an executive session in order to discuss individual case reviews. The executive session is closed to the public and media.

The executive session must be electronically recorded, and the recording must be retained for at least 90 days. After this date, the recording can be deleted. As the recording contains confidential information, store it in a locked file cabinet or secured file folder during the 90 days. 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.

Open Meeting Law Guidance and Executive Session Script (https://drive.google.com/file/d/1yQ2cnc4SMLsA7GvSsN74FKJrTW3WRAC4/view?usp=sharing)

Prior to the Review Meeting

1. Schedule the meeting(s).

    a. Some local teams wait to schedule meetings until after they have been assigned a death to review. However, if you schedule the review meetings at the beginning of the year, this allows for more time to plan and for all of the team members to be notified well in advance. Teams in more populous counties may need to meet every month or every quarter, whereas teams in more rural counties may only meet once or twice a year. Even if you are in a county that thankfully doesn't have any deaths to review, it is still helpful for your team to meet at least once a year in order to keep team members connected to child death prevention efforts at the local and state level. For example, the team can discuss local prevention initiatives, local issues related to child safety, and statewide trends and legislative recommendations.

    b. The length of a meeting depends on how many deaths are being reviewed. The average time to review a death is 45-60 minutes,

depending on the circumstances and available information. In general, we recommend reviewing no more than three deaths during a single review. Reviewing four or more deaths during a single meeting can make the meeting overly long as well as emotionally difficult for team members.

2. Begin requesting records. As soon as you're notified of a death, you can start to request records. Collecting records from different agencies can take time. Requesting records early gives you more time to prepare for the meeting, enter data, and write the case summary/narrative.

3. Enter as much data as you can from the records received into the NFR-CRS. Entering as much data as possible prior to the meeting will help the meeting to be efficient and allow the team to focus on missing information and prevention discussions.

4. Write the case summary/narrative. The summary will be shared with the review team members and a de-identified version will be entered into the NFR-CRS. A detailed case summary/narrative not only provides the team with essential information about the child's life and death, but can also identify gaps in information that can be solicited from team member's during the review.

5. Address any logistical issues or conflicts of interest that may have arisen prior to the review. For example, you may need to change the meeting location or identify a replacement team member to represent a certain agency. Or, a team member might have a conflict of interest regarding a specific death. This is most frequently seen when a team member has a personal connection with the infant, child, or youth who died and they do not feel comfortable participating.

It is up to each team to determine whether a conflict exists based on the unique circumstances of a case. 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, teams are welcome to adapt from this model to accommodate their needs. The complete meeting script document (https://drive.google.com/file/d/1S8Ucv_z_cxExjS97mLzwAmcQ8NQcjBAz/view?usp=sharing) will help guide you through the stages of the review meeting.

1. Opening
    a. Welcome members.
    b. Moment of silence - use the example in the meeting script or create your own.
    c. Equity statement - use the example in the meeting script or create your own.
2. Executive session
    a. New and ad hoc members sign the confidentiality agreement.
    b. Use the meeting script to begin the meeting. If members of the public and/or the media are present, they must leave at this time.
3. Summarize the case

a. Allow team members to read the case summary.

4. Discuss case details

    a. Share - Allow team members who played a direct role in responding to the case or who worked with the child and/or family share their knowledge of the case.

    b. Ask - 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 NFR-CRS along the way.

5. Address any outstanding questions related to the specific cause of death in section H.

6. For sleep-related deaths of children under 5 years of age, address any outstanding questions in section I2. In order to properly categorize SUIDs, it is essential that this section is completed as thoroughly as possible.

7. Complete section I5, “Child Abuse, Neglect, Poor Supervision And Exposure To Hazards.” See the “Data Entry Best Practices” section below for more information. This section should always be completed as a team.

8. For suicide deaths, address any outstanding questions in section I6.

9. Complete section I7, “Life Stressors.” This section should be completed as a team and is an opportunity to discuss the societal, institutional, and individual factors that may have impacted the child and family. This section can help your team have discussions around the systemic issues that fuel health

disparities and also leads naturally into section L on risk and protective factors and prevention.

10. Complete section I8, "Deaths During the COVID-19 Pandemic." This section allows the team to indicate whether the pandemic was directly or indirectly a factor in the death. Although the lock-downs, school and business closures, and other measures taken during the early months of the pandemic have passed, COVID-19 continues to make people sick, to kill people, and to leave lasting health impacts, including what is commonly referred to as long COVID. We are still learning about the long-term and ongoing impacts of COVID-19 and having a discussion about it as a team is one way to improve our understanding.

11. Complete section J, "Person Responsible." If your team decided that child abuse, neglect, poor or absent supervision, or exposure to hazards caused or contributed to the death (section I5), then you will complete this section. You will also complete this section if the death was caused by an assault or other action of a person other than the child or the caregiver.

12. Complete section L, "Findings During the Review." This section is one of the most important parts of the review. It is where your team will discuss risk and protective factors and prevention.

    a. Describe any significant challenges faced by the child, the family, the systems with which they interacted, or the response to the incident. Did the child or family experience racism or discrimination, did they live in poverty, did the systems they interacted with harm them, was there a lack of coordination between agencies, did an agency inadequately respond to the death, etc?

b. Describe any notable positive elements in this case. What were the strengths of the child and family, were there systems that were providing them help, were there supportive community factors, etc?

c. List any recommendations and/or initiatives that could be implemented to prevent deaths from similar causes or circumstances in the future. These could be local community prevention efforts, initiatives at the agency or state level, or changes to federal laws. Your team can think as local and as broad as they like. The prevention discussion may lead to action at the local level, or may inform statewide prevention recommendations.

d. Were new or revised agency services, policies, or practices recommended or implemented as a result of the review?

e. Could this death have been prevented? While the CFPS primarily reviews preventable deaths, each death is unique and sometimes the team does not have enough information to determine if the death could have been prevented. Also, teams can have different beliefs in the preventability of different types of deaths. This is a team decision and there isn't a right or wrong answer.

13. Complete section M, "The Review Meeting Process."

a. Record who attended the meeting and with what documents. Discuss what might have reduced effectiveness.

b. Agree whether or not the review is complete. 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.

14. Close the meeting with a reflection, gratitude exercise, discussion of biases that were present during the review, or other activity to bring acknowledgement and closure to the difficult task the team has just completed.

15. Conclude executive session using the script referenced above.

16. Collect and shred all hard copies of case summaries from team members and remind them to delete any digital case summaries from their computers.

17. Complete data entry in the NFR-CRS.

    a. Include any additional information discussed 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.

    c. Review all sections in the NFR-CRS for completeness. The best practice is to have zero blank fields. Use the “unknown” option, if available.

    d. Check “data entry completed for this case” in section P. This alerts the State Support Team that they can conduct their quality assurance check of the case.

Local Team Best Practices

Maintain Your Team

Proactively resolve conflict

Team members may disagree with how an agency interacted with a family or responded to a specific death, or they may disagree more broadly with an agency policy or practice. Team members may also disagree on different questions asked during the review, such as whether child abuse, neglect, exposure to hazards, or lack of supervision was a factor in the death; whether poverty, racism, or other life stressors were present for the child; and what types of prevention initiatives could be effective.

Reviews are opportunities to better understand agency decisions and to constructively think about what can be done within agencies, systems, and communities to prevent death and improve health. Disagreement among team members can be productive and appropriate. Often, disagreements on certain sections of the NFR-CRS can be resolved through further team discussion and coming to a decision through a consensus process or a vote. The local coordinator can also include dissenting viewpoints from the team review in the narrative section of the NFR-CRS. Conflicts can also arise between specific agencies or team members and may be representative of different philosophies, worldviews, or experiences. If conflicts can't be resolved at the local team level and are impacting the ability of the team to conduct professional, thorough reviews, contact the CFPS State Support Team for help.

Respect team agreements

For a local team to operate effectively, it is essential that agreements be recognized and followed by all team members. Team agreements document expectations, roles, and responsibilities of a team. They are usually created collaboratively and agreed upon by all team members. The group agreements page from New York University (https://wp.nyu.edu/coaching/tools/group-agreements/) is a helpful starting point for developing your own team agreements.

Be prepared for and participate in meetings

Case review meetings require regular attendance and participation by all members. Members will become familiar 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 should submit any relevant information that has been requested by the local coordinator.

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.

Learn From and Teach Each Other

Understand what local resources are available to families following a death and how referrals for services are made

In order to identify challenges and positive elements, and to develop robust prevention recommendations, it is important that team members understand how different agencies are supposed to respond to the death of a child, what resources are offered to families, and how referrals for services are made. This information can be shared by members representing each agency during a team meeting and should be documented so that it can be shared with new team members and referenced in future reviews.

Section K in the NFR-CRS focuses on referrals for service that were made to the family or community as a result of the death and whether the referrals were made prior to or as a result of the review. Teams can also indicate if a specific type of service was needed, but unavailable. This section connects directly with section L, "findings identified during the review."

If a local team identifies that the family of the decedent is in need of services, referrals should be made. The Department of Human Services is often the appropriate agency to handle referrals, but depending on the situation and the service, other agencies may make the referral. Local teams should discuss how referrals will be made and who will be responsible for handling them.

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. Teams can also discuss the data and recommendations in the annual CFPS legislative report, or look more closely at CFPS data for their county or region. 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.

Support Each Other

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 can also support other teams in case reviews 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, link to professional resources, and provide coordination with other local teams.

Provide other members with support

Each profession brings its perspective, professional knowledge, and expertise to the team. The team coordinator and all team members are responsible for creating a collaborative and productive team environment that is respectful towards diverse perspectives and ideas. A review team can be an opportunity to support each other professionally through more collaborative involvement on relevant initiatives. Team members can also support each other on a more personal level by empathizing and reflecting together on the difficult work of child death review.

Practice self care and professional debriefing

It is important to acknowledge the emotional toll that may result from the child death review process. Local coordinators and team members may feel a heavy burden from reviewing the details of each tragedy. For some members, the case review process

will bring up memories of personal interactions with the deceased child or the 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 a short gratitude exercise at the end. It can also be helpful to talk about your experiences of vicarious trauma or emotional strain with other team members, other local coordinators, the State Support Team, or a mental health professional.

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.

Stay Focused on the Big Picture

Maintain an equity lens during meetings

When we use a public health approach to child death review we encourage team members to look beyond the individual decisions of a child, caregiver, or agency employee and focus on the larger context in which those decisions are made. The review is not a space to shame or blame a child or family.

"Social determinants of health" is a public health term that refers to the social, economic, and environmental factors that impact a person's life, including their health status. Social determinants such as where a child or family lives, how much money or education they have, and how they are treated because of their race, ethnicity, gender, or sexual orientation are contributing factors in child deaths.

Social determinants influence health outcomes more than individual choices or someone's ability to access health care and they perpetuate the disparities and inequities that we observe in child deaths. For example, in Colorado we see disparities in deaths by rural vs urban geography, race and ethnicity, and sexual orientation and gender identity. When a team can identify inequities that contribute to these differences in death rates, such as social isolation and lack of resources, racism and discrimination, or stigma directed at LGBTQ+ people, they can develop prevention recommendations that address the root causes of many childhood deaths. It is important to remember that we can change the systems and policies that create these inequities, and that this systemic change will improve the lives of all children in Colorado.

Use the CFPS Equity Toolkit

The Child Fatality Prevention System: Equity Toolkit (https://drive.google.com/file/d/1Y_sT7WusMXfqrxKE6ZjlSqhYKaDEfYPL/view?usp=sharing) is a resource that can help local coordinators promote equity in the review process. The toolkit is meant as a starting point and has information including preparing for meetings; using additional data to understand health inequities; including youth and community representatives on your team; relationship building to foster trust; creating group norms and values; facilitating case review meetings; and considering burnout and vicarious trauma.

Remember that local team membership is a long-term commitment

A local team is not an ad hoc committee. It is a panel of professionals dedicated to establishing a better understanding of the causes of child deaths in their community. Discovering the patterns and inequities that contribute to these deaths is an ongoing

process. The collective knowledge acquired by team members over time provides structure for achieving effective results.

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

The ultimate purpose of public health child death review is prevention. The Child Fatality Prevention Act that directs the work of the CFPS is based on the belief that the abuse, neglect, or death of a child is a community responsibility. By analyzing the factors of individual child deaths and developing prevention recommendations, we can change systems and policies in order to support the safe and healthy development of children and prevent deaths. Local team reviews are a way to ensure that the findings and recommendations of the review are relevant and useful for families at the local level. 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.

Data Entry Best Practices

Below are some important tips for entering data into the NFR-CRS. For help with specific questions, look at the NFR-CRS data dictionary (https://ncfrp.org/data/nfr-crs/).

General Data Entry

Do not include identifiers

This is extremely important! The NFR-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 or death dates, or addresses in any text boxes or the narrative section. Review the document "Writing the Narrative" (https://drive.google.com/file/d/1bsz6TszhuBCIP2tDwjNeG9mMGDaY1n7S/view?usp=sharing).

Make sure to include death certificate numbers

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

Complete all data fields

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 NFR-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.

Data Entry for Child Maltreatment Deaths

Identify 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 (section I5); and if a person(s) actions contributed to or caused the death (section J). The NFR-CRS Data Dictionary includes extensive guidance for completing these sections. Additionally, you can access guidance while entering data into the NFR-CRS by hovering over the information icon, represented by a question mark, in each section.

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 - Any injury inflicted on a child by a parent, caregiver, or supervisor. Includes physical abuse (such as abusive head trauma, chronic battered child syndrome, beating/kicking, scalding/burning and Munchausen Syndrome by Proxy), sexual abuse (a single or series of sexual assaults or sexual exploitation), and emotional abuse (verbal assault, belittling, threats, and blaming).

- Child neglect - Failure on the part of a parent or caregiver to provide for the shelter, safety, supervision, and nutritional needs of the child that results in

harm. Child neglect includes physical, medical, supervisory, and emotional neglect.

- Poor Supervision - A parent or caregiver's failure to supervise, provide alternative appropriate supervision, or engage in other behavior that causes or contributes to the child's 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 - A behavior by a parent or caregiver that exposes a child 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. Hazards can include items in the sleep environment, firearms, poisons or drugs, drowning hazards, and motor vehicle hazards.

The decision to document an act of child abuse, neglect, poor supervision or exposure to hazards does not have legal ramifications.

A child maltreatment determination is a subjective opinion on the part of the local teams and does not trigger any prosecution. Per statute, members of the review team are not subject to examination in any civil or criminal proceeding concerning information presented or opinions formed during a review meeting. Additionally, documents and records from the review team are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding. If, however, a team receives information that is exculpatory to a person charged with a criminal offense, that information is subject to release.

On rare occasions, a review team may discover information that raises concerns that a child or children may currently be in danger of abuse or neglect, thereby obligating team members to make a mandatory report to human services. For example, a review

team may learn, during the course of their review, that abuse was a factor in a child's death, but that human services was never informed and the team members are concerned for other children who currently live in the home. If your team encounters a situation that they think might meet criteria for mandatory reporting, please make the report to CO4Kids (https://co4kids.org/) by calling 844-CO-4-Kids and contact the CFPS State Support Team for guidance.

CFPS child maltreatment data differs from CDHS data

Because CFPS uses different criteria than CDHS in determining child maltreatment, the number of deaths classified as child maltreatment by CFPS are different than the number of child abuse or neglect deaths reported by CDHS. Typically, CFPS identifies child maltreatment as a factor in more deaths than CDHS. One reason is because the CDHS Child Fatality Review Team (CFRT) uses different criteria to identify reviewable deaths. For instance, the CFRT only reviews deaths of children who had involvement with county departments of human or social services within three years prior to their death. A CFPS team may identify child abuse or neglect as a factor in the death of a child who never had involvement in human or social services. Additionally, CFPS determinations are based on the collective decision of the review team, not on strict legal or agency criteria. Child maltreatment data reported by CFPS includes deaths classified as due to child abuse and neglect. Deaths determined to be due to poor or absent supervision and exposure to hazards are not counted as child maltreatment for purposes of CFPS reporting.

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 child's

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. The purpose of 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.

Data Entry for Sudden Unexpected Infant Deaths (SUIDs)

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 carefully reviews all SUID cases for quality assurance (QA) after they are reviewed by local teams. In order to properly categorize SUIDs, it is important that the NFR-CRS is correctly and comprehensively filled out. There are three main points to consider when completing data entry for a SUID:

1. Be sure that no critical fields listed in the SUID priority variables document (https://drive.google.com/file/d/1_M__328f357EQ-N5ECPNh4XU5zUoXSb2/view?usp=drive_link) 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.

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 Program Manager might contact the local coordinator for clarification of an answer. This might mean the local coordinator will need to review the documentation again or reach out to partners for additional or clarifying information.

Request the SUID Investigation Reporting Form (SUIDIRF) and encourage death scene investigators to use it

The SUIDIRF is a voluntary tool for collecting information during an infant death scene investigation. The most recent version of the SUIDIRF (https://www.cdc.gov/sids/SUIDRF.htm) was released in 2020 and was developed by the CDC in partnership with experts in death investigation.

The SUIDIRF is Important for Several Reasons:

- It standardizes data collection to help improve classification of sleep-related infant deaths.
- It assists in determining accurate cause of death by strengthening information about the circumstances of the death available before an autopsy.
- It guides investigators through the steps involved in an investigation.
- It allows investigators to document their findings easily and consistently.

- It produces information that researchers can use to recognize new risk factors for SUID and sudden infant death syndrome (SIDS).

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 and is also available online as a fillable PDF. Local team coordinators should request the SUIDIRF from these agencies when conducting case reviews of SUID. If the SUIDIRF is not being used, local coordinators can ask the coroner's office or law enforcement agency if they are familiar with the SUIDIRF and if they would be willing to use it.

Promote the Colorado Sudden Unexpected Infant Death Investigation Training

This free, online training was developed by CFPS and Colorado experts on death scene investigation. The training is self-paced and takes 2.5 hours to complete. It is designed to provide the tools and best practices with which death scene investigators, coroners, medical examiners, and law enforcement officers can investigate and learn from each SUID death to improve the health and safety of families and children. Local coordinators can ensure that the relevant partners on the review team are aware of this training opportunity.

The course curriculum (https://drive.google.com/file/d/1rMQQq2u3Jsi1MKLQy-EWRSc98yrzjDyF/view?usp=sharing) includes an outline, objectives, and information about continuing education credits. The course access instructions (https://drive.google.com/file/d/1rq5IvpUSrtyGkejc0JVysl5ZhDAZlmVX/view) include information on how to register for and navigate through the training.

Data Analysis

On an annual basis the Maternal and Child Mortality Analyst analyzes and interprets data collected in the NFR-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 (https://cohealthviz.dphe.state.co.us/t/PSDVIP-MHPPUBLIC/views/CFPSDashboardFinalLocal/Story1?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no) 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 and overdose deaths occurring among infants, children, and youth in Colorado.

Resources

Acronyms and Definitions

CDPHE Child Fatality Prevention System (CFPS) State Support Team

The CFPS State Support Team at the Colorado Department of Public Health and Environment (CDPHE) are the staff members who manage the program. They help communities and public health agencies organize local teams to 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 (i.e. NFR-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 the 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)

The CFRT is responsible for reviewing fatal, near fatal, and egregious incidents of child maltreatment when the family, child, and/or alleged perpetrator had prior involvement with the child protection system in the prior 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 CFPS State Review Team are responsible for developing joint child maltreatment prevention recommendations on an annual basis to the Colorado legislature.

MOVEit Software

Death certificates and birth certificates are housed online using a software called MOVEit. MOVEit is a secure managed file transfer application. It encrypts and provides IT security controls for sensitive data. Local coordinators will be granted access to retrieve the death certificates, and if applicable, the birth certificates, for their county or region. On a weekly basis, the CFPS support staff places death and birth certificates on the MOVEit website and notifies local coordinators. Instructions on how to download files and change a user's password can be found in the MOVEit user guide (https://drive.google.com/file/d/1HcvdTYX3VsLVyjA-5N3JjrfDKmAZd_qQ/view?usp=drive_link).

Lived Experience

Lived experience is knowledge based on a person's perspective, personal identities, culture, and history, beyond their educational or professional experience. In child death review, the lived experience of people who have been personally impacted by barriers that the CFPS works to understand and address is crucial in order to develop

prevention initiatives that shift policies and practices in favor of supporting families and children. CFPS local review teams should include community representatives on their team and value and uplift all team member's lived experience as it relates to circumstances that contribute to child fatality and disparities that exist. The experiences of Black, Indigenous, Latinx, and other people of color; LGBTQ+ people; and people who are immigrants should be represented in child fatality reviews. Additionally, teams should include people with experience being on the receiving end of different government agencies, such as child welfare and law enforcement; or who have faced similar challenges as families impacted by child fatality, such as poverty, geographic isolation, substance misuse, or homelessness. Every local team probably won't have team members with personal experiences that resonate with each death reviewed. However, teams that have members with a diversity of identities and experiences, and who value people's lived experiences as much or more than their professional experience, will be better able to understand the systemic issues impacting the lives and choices of families and children in their community.

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, and began reviewing cases on January 1, 2015.

National Center for Fatality Review and Prevention (NCFRP or "The National Center")

The NCFRP serves as a resource and data center for state and local child death review (CDR) and fetal and infant mortality review (FIMR) programs. The NCFRP is housed at the Michigan Public Health Institute (MPHI) and is 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. The NCFRP manages the National Fatality Review-Case Reporting System (NFR-CRS).

National Fatality Review-Case Reporting System (NFR-CRS)

The NFR-CRS is a web-based, standardized case report tool, or database, used by local teams to record the data from all child death cases assigned to them by the CFPS State Support Team. The NFR-CRS is used to enter case data, summarize findings, review team recommendations, access and download data, and create standardized reports. The NFR-CRS is managed by the NCFRP.

Out-of-State Death or Out-of-State Case

An “out-of-state” death or case refers to a child who resided outside of Colorado, but who died in Colorado. The CFPS reviews all deaths of infants, children, and youth under the age of 18 who die in Colorado from violence, injury, or undetermined causes, regardless of their residence location. Out-of-state deaths are usually assigned to the local team where the fatal injury occurred, where the death occurred, or where the death was certified. Examples of out-of-state cases include a child who was injured in a car accident in Wyoming and was brought to Children’s Hospital in Aurora via flight-for-life to receive medical care and died at the hospital. Or, a child from Texas who was vacationing with his family in Colorado and drowned.

Depending on the circumstances, available Colorado records can include the death certificate, autopsy, hospital records, or police reports. Local coordinators can contact relevant agencies in the child's home state to request additional records, such as child welfare records, police reports, and crash scene investigations. If appropriate, local coordinators can also invite agency staff from the child's home state to attend the review. The access to records provision of the Child Fatality Prevention Act does not apply to out-of-state agencies, so they are not obligated to release records. However, staff at out-of-state agencies are often helpful and willing to share information when they understand the purpose of the CFPS.

Sometimes, a team might determine that a child's death should also be reviewed by a team in the child's state of residence. This may be the case if the injury occurred out-of-state and the team thinks that a separate review in the state of residence would benefit that state's prevention efforts. A CFPS local review team is permitted, by statute, to share information with a child fatality review team from another state for the purposes of preventing future deaths. However, the policies and laws governing child fatality review differ by state. Please contact the CFPS State Support Team if you are considering referring a death for review by another state and want more information on that state's process for reviewing child deaths and who to contact.

Public Health Approach

A public health approach seeks to define the problem(s), identify risk and protective factors, develop and test prevention initiatives, and assume widespread adoption of effective initiatives. The CFPS defines the problem of child fatality through individual case-specific reviews. These reviews identify specific risk and protective factors and potential prevention measures that can prevent infant, child, and youth deaths. Data

from individual case reviews are aggregated to identify trends and patterns. Risk and protective factors and prevention recommendations from reviews are used to inform local, regional, and statewide prevention initiatives. Prevention recommendations that are referred to the state legislature are tracked to assess whether they were adopted and what impact they make.

State Review Team

The State Review Team is a multidisciplinary committee of volunteer members who have expertise 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 unexpected infant death (SUID). The State Review Team is responsible for creating the annual CFPS legislative report, including prevention recommendations. The State Review Team also reviews cases on an ad hoc/as needed basis when local teams cannot 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.

Systemic Oppression

Systemic oppression is the mistreatment of individuals or groups of individuals based on identities, such as race, class, gender, sexual orientation, age, ability, etc. It disadvantages specific groups of people, resulting in a myriad of interconnected health outcomes. It is upheld and implemented by harmful institutional policies and practices, and across structures such as education, health, child welfare, criminal

legal, and economic systems. It is systematic, historical, and interconnected. It's important to remember that systemic oppression is a human creation and, by recognizing and taking intentional action to address it, people can create more equitable institutions and social structures.

Prevention Guidance

As a result of what local teams learn from the reviews of individual infant, child, and youth death cases across Colorado, they 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 promoting safer behaviors through life jacket, bicycle helmet, or smoke and CO2 detector distribution, to changing an agency practice or policy, to expanding programs such as home visitation or suicide prevention.

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.

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. The CFPS State Support Team and local teams work collaboratively to analyze data trends and patterns, interpret the data, select evidence-informed prevention strategies, and implement community-based prevention strategies. To learn about funding opportunities, or to discuss ideas for local prevention initiatives, please contact the CFPS State Support Team.

Leadership is key to sound child fatality prevention, and local teams play a vital role in leading prevention efforts and 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. The CFPS State Support Team, State Review Team, local teams, and community stakeholders prioritize prevention recommendations made by local teams every year. 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.

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-informed injury, suicide, and violence prevention strategies; development of actionable community-based prevention recommendations; technical assistance around records abstraction and data collection into the NFR-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. The team provides local teams with periodic 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.