Child Fatality Review

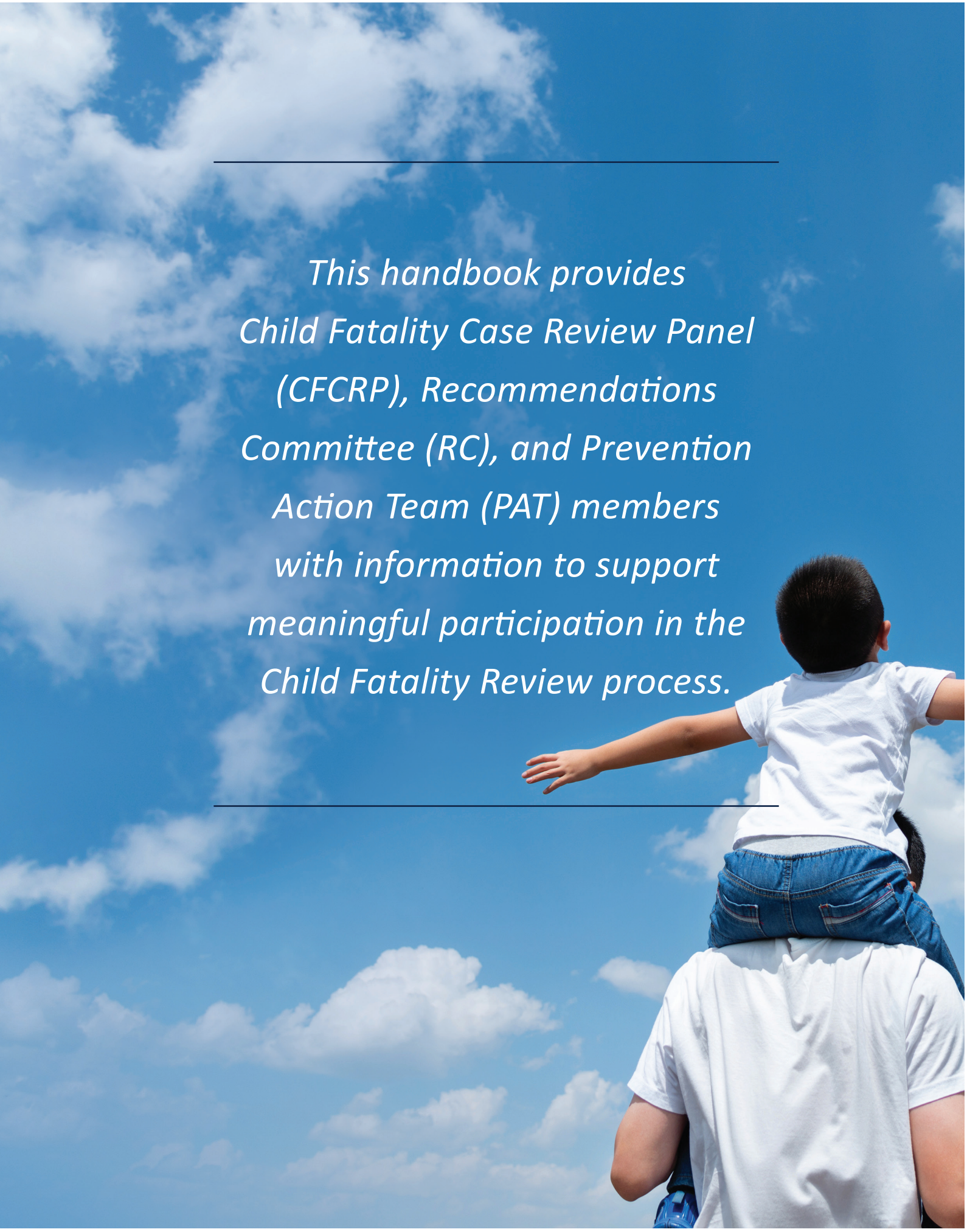
H A N D B O O K

Information for CFCRP, RC and PAT Members

SPOKANE REGIONAL HEALTH DISTRICT

Healthy Living Program
1101 W. College Ave.
Spokane, WA 99201
509.324.1538 | srhd.org

Created: April 2024



This handbook provides Child Fatality Case Review Panel (CFCRP), Recommendations Committee (RC), and Prevention Action Team (PAT) members with information to support meaningful participation in the Child Fatality Review process.

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Program Overview

Introduction to Child Fatality Review

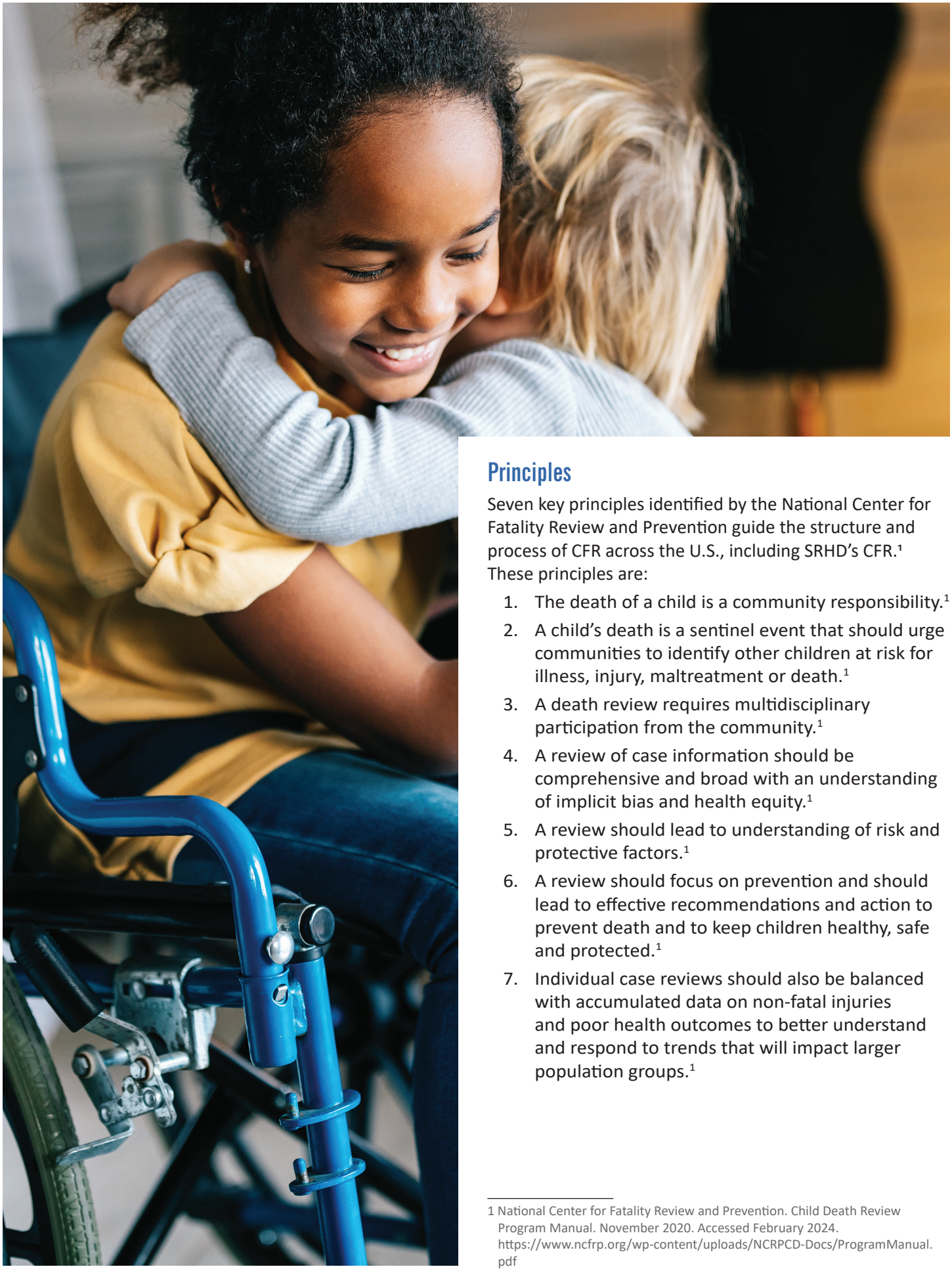
Child deaths have a profound impact on our communities. Each year in the United States, approximately 37,000 children die before their 18th birthday. The death of a single child is a tremendous loss to a family and a community, bringing unjust suffering and the pain of unfulfilled promises.

Understandably, when a community is impacted by a child's death, it wants answers and demands action. Child Fatality Review (CFR) was developed to improve understanding of why children die and motivate action. CFR equips communities to improve safety and prevent future fatalities through multidisciplinary case review. The multidisciplinary case review should lead to a deep understanding of how and why a child died, including underlying risk factors and inequities that otherwise may not have been identified.

Spokane Regional Health District's (SRHD) CFR is a multidisciplinary review of individual child deaths to enhance understanding of why Spokane County's children die and inform effective prevention of future child injury and mortality in Spokane County.

CFR is active in communities across the United States. CFR is authorized in Washington state by RCW 70.05.170 and RCW 70.05.210. Between communities, the process may go by different names, such as Child Death Review (CDR) or Child Mortality Review (CMR), and processes and case definitions may vary slightly. However, all groups with an active review process share a commitment to learn from the tragic instances of local child fatalities and take action to create meaningful change and safer, more equitable communities to support children's safety and well-being and prevent future child deaths.

Content adapted from: National Center for Fatality Review and Prevention. Child Death Review Program Manual. November 2020. Accessed February 2024. https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/ProgramManual.pdf



Principles

Seven key principles identified by the National Center for Fatality Review and Prevention guide the structure and process of CFR across the U.S., including SRHD's CFR.[1] These principles are:

1. The death of a child is a community responsibility.[1]
2. A child's death is a sentinel event that should urge communities to identify other children at risk for illness, injury, maltreatment or death.[1]
3. A death review requires multidisciplinary participation from the community.[1]
4. A review of case information should be comprehensive and broad with an understanding of implicit bias and health equity.[1]
5. A review should lead to understanding of risk and protective factors.[1]
6. A review should focus on prevention and should lead to effective recommendations and action to prevent death and to keep children healthy, safe and protected.[1]
7. Individual case reviews should also be balanced with accumulated data on non-fatal injuries and poor health outcomes to better understand and respond to trends that will impact larger population groups.[1]

1 National Center for Fatality Review and Prevention. Child Death Review Program Manual. November 2020. Accessed February 2024. https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/ProgramManual.pdf

Objectives

Effective fatality review involves multiple layers of action, including identification and investigation of individual deaths, multidisciplinary review of individual deaths, systems improvement, and community prevention. Spanning across these layers, the National Center for Fatality Review and Prevention has identified 10 multifaceted objectives to clarify the focus of CFR across the U.S., including SRHD's CFR.[1] These objectives are:

- Ensure the accurate identification and uniform reporting of the cause and manner of every child death.[1]
- Improve communication and linkages among local and state agencies to enhance coordination of efforts.[1]
- Improve agency responses in the investigation of child deaths.[1]
- Improve agency response to protect siblings and other children in the homes of deceased children.[1]
- Improve criminal investigations.[1]
- Improve delivery of services to children, families, providers and community members.[1]
- Identify barriers and system issues involved in the deaths of children.[1]
- Identify significant risk factors and trends in child deaths.[1]
- Identify and advocate for needed changes in legislation, policy and practices and expanded efforts in child health and safety to prevent child deaths.[1]
- Increase public awareness and advocacy for issues affecting health and safety.[1]

1 National Center for Fatality Review and Prevention. Child Death Review Program Manual. November 2020. Accessed February 2024. https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/ProgramManual.pdf

When building understanding of CFR, it is vital to understand what CFR is not.

CFR should not be punitive in any way toward individuals, families, agencies or communities.

Public health CFR is not intended to identify blame or responsibility for child deaths. Additionally, public health CFR is not a peer review of staff performance or agency actions. Public health CFR is intended to identify the factors and conditions that contribute to child deaths to inform prevention within the community.

During CFCRP meetings, actions or inactions at the individual, family or agency level may be discussed as factors that may have contributed to a child death. During these discussions, it is critically important that CFCRP members consider the system or community conditions driving those factors. Policy and resource distribution that advantages some and disadvantages others often drives the risk associated with physical environments, social environments, economic contexts, and service delivery contexts.

Rather than exclusively identifying individual, family or agency actions or inactions, CFCRP members should broaden their focus and identify root causes, system conditions, and community conditions contributing to a child fatality.

With a nonjudgemental, inquiring approach, the CFCRP should ask and seek to understand: What drives the behavior we observed? What was its root cause? What could be driving these types of incidents to occur?

Identifying root causes, system conditions, and community conditions contributing to a child fatality creates opportunities for policy, system and environmental change to increase health and well-being broadly and prevent a higher number of future child fatalities. Taking action to change these root causes, system conditions, and community conditions will foster a safer, more equitable Spokane County.

Content adapted from: National Center for Fatality Review and Prevention. Child Death Review Program Manual. November 2020. Accessed February 2024. https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/ProgramManual.pdf

Health Equity and Child Fatality Review

Health equity is "the state in which everyone has a fair and just opportunity to attain their highest level of health."[1]

Fatality reviews are uniquely poised to promote health equity by describing and addressing historic and contemporary injustices contributing to child fatalities, including health inequities. Inequity means "lack of fairness or justice that describes differences that result from a lack of access to opportunities and resources."[2] Inequities are avoidable, unfair and unjust.[2] Health inequities exist when "avoidable inequalities lead to an uneven distribution of the resources and opportunities for health and are differences in health that are avoidable, unfair, or stemming from injustice."[3]

Promoting health equity should involve a focus on social determinants of health, the conditions where people live, work, learn, play and worship.[1] Social determinants of health affect many health risks and outcomes, and have strong, clear implications for health equity.[1] Social determinants of health can be grouped into these six key areas:

- Social and community content, including racism and discrimination[1]
- Healthcare access and use[1]
- Neighborhood and physical environment[1]
- Workplace conditions[1]
- Education[1]
- Income and wealth[1]

Longstanding inequities in each of these key areas of social determinants of health interrelate and can influence health outcomes.[1] For instance, "segregation impacts access to high-quality education, employment opportunities, healthy foods and health care. Combined, the economic injustices associated with residential, educational, and occupational segregation have lasting health impacts that include adverse birth outcomes, infant mortality, high rates of homicide and gun violence and increased motor vehicle deaths."[4] When identifying root causes, system conditions, and community conditions contributing to a child fatality, the CFCRP must consider the impact of historic and current inequities. When creating and implementing prevention recommendations, the RC and PATs must consider health inequities and their connection to the social determinants of health.

1 What is health equity? Centers for Disease Control and Prevention. July 1, 2022. Accessed February 6, 2024. https://www.cdc.gov/healthequity/whatis/index.html

2 Governor's Interagency Council on Health Disparities. Equity Language Guide. Washington State Office of Financial Management. December 6, 2018. Accessed February 21, 2024. https://ofm.wa.gov/sites/default/files/public/shr/Diversity/SubCommit/EquityLanguageGuide_Final.pdf

3 Vermont Department of Health. Health Equity Terms. 2018. Accessed February 21, 2024. https://www.healthvermont.gov/sites/default/files/documents/pdf/PLN_HE_Glossary.pdf

4 National Center for Fatality Review and Prevention. Child Death Review Program Manual. November 2020. Accessed February 2024. https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/ProgramManual.pdf

Child Fatality Review Process

Authorized in Washington state by RCW 70.05.170 and RCW 70.05.210, SRHD's CFR process includes three steps: identification, review and prevention.

Identification

Review

Prevention

Identification

The identification process is conducted by SRHD's Keeping Children Safe coordinator, who reviews information from the Spokane County Medical Examiner's Office and the Washington State Department of Health to identify cases.

Cases are unexpected deaths of Spokane County residents that occurred after live birth and before age 18 due to external, non-natural causes. This includes infant, child and adolescent deaths caused by suicide, homicide, sudden unexpected infant death (SUID), unintentional overdose, motor vehicle collisions, falls, fires, drowning, unintentional firearm-related injuries, and other means of injury.

SRHD uses the following criteria to identify cases meeting the CFR case definition:

Age of Decedent:

Deaths of individuals 0-17 years of age will be reviewed.

Decedent's Former Place of Residence:

Deaths of Spokane County residents will be reviewed.

Location of Death:

Deaths occurring inside Spokane County will always be reviewed. Deaths occurring outside Spokane County will be reviewed when possible.

Manner of Death:

Homicide and suicide will always be included.

Accident, other than complication of medical treatment, will always be included.

Sudden unexpected infant death (SUID) cases will always be included; these deaths may be classified with a manner of death that is undetermined, accident or natural.

Other cases with an undetermined or natural manner of death will be included if they are determined by SRHD staff to be unexpected and due to an external, non-natural cause; this determination will be made on a case-by-case basis.

Review

The review process includes confidential discussion of individual cases among CFCRP members during scheduled meetings. For SRHD's CFR, cases are reviewed in a time lag, so deaths that occur within a calendar year are reviewed by the CFCRP within the following calendar year.

Members of the CFCRP are professionals from organizations who influence the health, safety and well-being of children and families in Spokane County, including representatives from local cultural organizations. Organizations invited to participate in the CFCRP are described in the CFCRP composition guidelines.

To prepare for CFCRP meetings, SRHD's Keeping Children Safe coordinator abstracts information from available records to write case summaries describing what is known about the life and death of each decedent. Case summaries are confidential, not available to the public, and only shared during case review meetings.

During CFCRP meetings, CFCRP members seek to understand as much as possible about the life and death of each decedent through confidential discussion of case summaries and additional information contributed by CFCRP members. After thorough discussion of the life and death of a decedent, the CFCRP identifies findings related to risk factors, protective factors, and preventability of death for each case reviewed during the CFCRP meeting.

Importantly, discussions among the CFCRP are not intended to be punitive in any way toward individuals, communities, agencies or families. The focus of these discussions is increasing understanding to accurately identify findings that can be used to improve prevention of child injury and mortality locally.

Prevention

The prevention process involves developing recommendations, formulating and carrying out action plans to implement the recommendations, and sharing information with partners and the general public.

Developing recommendations

Each year, the RC, a subset of the CFCRP, develops three priority prevention recommendations for Spokane County. The RC's recommendations are based on their review of aggregate findings from all cases reviewed by the CFCRP within the year, as well as population-level data on child health, non-fatal injury and mortality, and evidence-based practices for preventing child injury and mortality.

By focusing on identifying findings for individual cases during CFCRP meetings, then using aggregate findings from all cases reviewed by the CFCRP within the year to develop prevention recommendations, priority prevention recommendations can address system gaps or other risk factors common across deaths.

Formulating and carrying out action plans

SRHD's Keeping Children Safe coordinator then uses these recommendations to develop a PAT for each recommendation. PATs collaboratively formulate and carry out action plans aimed at preventing injury, violence and mortality. No case-specific or confidential information is shared with PATs. PATs are intended to include an expanded group of community members, partners and stakeholders. Therefore, participation in PATs is not restricted to CFCRP members.

Sharing information with partners and the general public

SRHD shares information with partners and the general public by publishing a fact sheet every year with the RC's three priority prevention recommendations and publishing a report every four years including data on child mortality and injury trends in Spokane County, aggregated findings from cases reviewed, RC prevention recommendations, and the PATs' progress in advancing the prevention recommendations. These reports contain no identifiable individual case information or other confidential information, such as non-zero counts less than 10, as well as rates and proportions derived from non-zero counts less than 10.

Child Fatality Review Acronyms

Describing Spokane Regional Health District's CFR process involves multiple acronyms. A succinct description of these acronyms and guidelines for their use are provided here.

Child Fatality Review (CFR)

The Child Fatality Review (CFR) is an established public health process with the purpose of enhancing understanding of why Spokane County's children die and informing effective prevention of future child injury and mortality. The CFR process includes three steps: identification, review and prevention.

Child Fatality Review is considered a formal name, and the first letter of each word should always be capitalized.

Child Fatality Case Review Panel (CFCRP)

The Child Fatality Case Review Panel (CFCRP) is a multidisciplinary group of professionals who review cases through confidential discussions resulting in identification of case findings related to risk factors, protective factors, and preventability of death.

Individuals participating in the CFCRP are referred to as CFCRP members.

Child Fatality Review Case Review Panel is considered a formal name, and the first letter of each word should always be capitalized.

Recommendations Committee (RC)

The Recommendations Committee (RC) is a multidisciplinary group of professionals who review annual aggregate case findings, population level data, and information about evidence-based prevention practices through confidential discussions that result in the identification of three priority prevention recommendations annually. The RC is a subset of the CFCRP, comprised of CFCRP members who self-select to participate.

Individuals participating in the RC are referred to as RC members.

Recommendations Committee is considered a formal name, and the first letter of each word should always be capitalized.

Prevention Action Team (PAT)

The Prevention Action Team (PAT) is a multidisciplinary group of professionals who formulate and carry out an action plan aimed at implementing a priority prevention recommendation identified by the RC without reviewing confidential or case-specific information.

A singular Prevention Action Team is referred to as a PAT. A lowercase s should be added to the end of the acronym when referring to multiple Prevention Action Teams (PATs).

Individuals participating in a PAT are referred to as PAT members.

Prevention Action Team is considered a formal name, and the first letter of each word should always be capitalized.

Confidentiality for Child Fatality Review

CFR is a protected and confidential public health process.

Child Fatality Case Review Panel and Recommendations Committee

The information shared during meetings of the CFCRP and RC is protected from disclosure by law. CFCRP members and RC members are required to sign a confidentiality agreement at the beginning of each CFCRP meeting and RC meeting. The information protection requirements and procedures from the confidentiality agreement are described here. Additionally, after each CFCRP meeting and RC meeting, CFCRP members and RC members may request and receive a signed copy of their confidentiality agreement for their records.

Information Protection Requirements and Procedures

As specified in RCW 70.05.170 and RCW 70.05.210, records, statements, analyses of individual case information, and other materials containing individual case information that are collected, prepared, and maintained for CFR constitute confidential information and may only be used for the review process.

Confidential information shared during CFCRP meetings and RC meetings shall not be photographed or otherwise duplicated. Printed files prepared by SRHD containing confidential information will be collected by SRHD at the conclusion of in-person meetings.

Individual case information includes, but is not limited to, names and other identifying information for the deceased child and family members, names of organizations or facilities involved with the deceased child or family, information about the child or their family from autopsies, medical records, law enforcement, Child Protective Services (CPS), or other records, statements or documents collected from witnesses, statements from interviews, and summaries of such information prepared for the purpose of CFR.

As specified by RCW 70.05.170 and RCW 70.05.210:

- This information is not subject to public disclosure.
- This information is not subject to discovery, subpoena, or introduction into evidence in any administrative, civil, or criminal proceeding related to the death of a child reviewed.
- This does not prohibit the discovery or subpoena of records, statements, or other documents maintained in the ordinary course of business from agencies who have supplied records to a local health jurisdiction for the purpose of Child Fatality Review.
- All individuals who participate in Child Fatality Review, including local health jurisdiction employees and CFCRP members, may not be questioned, or examined in any administrative, civil, or criminal proceedings regarding the existence or contents of confidential information collected, prepared, and maintained for Child Fatality Review.

SRHD is authorized by RCW 70.05.170 and RCW 70.05.210 to publish statistical compilations and reports with aggregate data related to SRHD's CFR. In these documents, no individual case information shall be shared. No other person or entity participating in the CFR may use the data received while a member of the CFCRP or RC.

Outside of CFCRP and RC meetings, participants may make statements about the general purpose or nature of the CFR process. However, no individual case information, information about the findings or conclusions of any individual case review, or information about trends not published by SRHD shall be shared. **Failure to observe this procedure may violate various federal and state confidentiality laws.**

All media inquiries or requests for information related to CFR shall be directed to SRHD's Public Information Officer, who can be reached via email at srhd-pio@srhd.org.

As specified in RCW 70.05.170, the only permitted disclosure of individual case information collected, prepared, and maintained for SRHD's CFR is in the case of reporting suspected child abuse and neglect, under chapter 26.44 RCW, or responding to civil or criminal action arising out of a report made pursuant to chapter 26.44 RCW. SRHD's Keeping Children Safe coordinator is defined by SRHD as a mandated reporter and shall adhere to mandated reporting policies, including RCW 26.44.

Prevention Action Teams

PATs do not require confidential or case-specific information to formulate and carry out action plans aimed at preventing injury, violence and mortality based on the recommendations identified by the RC. Therefore, no confidential or case-specific information is shared with PATs, and PAT members do not need to sign confidentiality agreements to participate in PATs.


Meetings and Members

Annual Meeting Schedule

There are three opportunities for community partners and stakeholders to be involved in CFR, through the CFCRP, the RC, and PATs. Meetings of the CFCRP, RC, and PATs occur on the following annual schedule.

Prevention Action Teams (PATs)

January

Each PAT has an initial action planning meeting in January, then may participate in additional meetings throughout the year as scheduled by the PAT.

At least one month prior to each PAT initial action planning meeting, SRHD selects the specific date and time of the meeting and notifies all PAT members.

Child Fatality Case Review Panel (CFCRP)

CFCRP meetings occur five times per year, with cases clustered by similar cause or manner of death, as follows:

February

Previous year's transportation-related accident cases and other accident cases.*

April

Previous year's unintentional overdose cases and other accident cases.*

June

Previous year's suicide cases.*

August

Previous year's SUID cases.*

October

Previous year's homicide cases and firearm-related accident cases.*

**This reflects how cases will generally be clustered for CFCRP meetings; this may change from year to year based on the annual caseload.*

Each year, prior to the end of January, SRHD selects the specific date and time of each of the annual CFCRP meetings and notifies all relevant CFCRP members.

Recommendations Committee (RC)

December

An RC meeting occurs once per year in December.

Each year, prior to the end of January, SRHD selects the date and time of the annual RC meeting and notifies all CFCRP members who have self-selected to participate in the RC.

Child Fatality Case Review Panel Composition Guidelines

The CFCRP includes members from core organizations, who attend all CFCRP meetings, and members from ad hoc organizations, who attend CFCRP meetings for a specified purpose related to the case(s) being reviewed, such as expertise related to decedents' cause or manner of death, age or developmental context, cultural context, or other lived experience.

The CFCRP composition guidelines describe which organizations are invited to send representatives to participate in CFR as core and ad hoc CFCRP members.

All CFCRP members, core and ad hoc, who have participated in at least one CFCRP meeting within a year are invited to self-select to participate in the annual RC.

Core CFCRP Members

Core members attend all CFCRP meetings.

Core Organizations Represented

- Spokane Regional Health District
  - Keeping Children Safe Coordinator
  - Resilient Families Coordinator
  - Healthy Living Administrative Assistant
- MultiCare
- Excelsior Wellness
- Kaiser Permanente
- City of Spokane Police Department
- Spokane County Medical Examiner's Office
- Spokane County Sheriff's Office
- Spokane Fire Department Emergency Medical Services (EMS)
- Washington State Department of Children, Youth, and Families Child Protective Services (CPS)
- Providence
- Spokane County Prosecutor's Office
- CHAS
- Akin Counseling Program

Ad Hoc Child Fatality Case Review Panel Members

Ad Hoc members attend CFCRP meetings when invited, as subject matter experts.

Panelist Description	Subject/Professional Area	Organization Represented
Educational and life-stage focused professionals to attend based on decedents' ages	For 5–17-year-olds	NorthEast Washington ESD 101 Student Support Services
	For 0–5-year-olds	Catholic Charities CAPA/PREPARES Community Colleges of Spokane Head Start/ ECEAP
Topical experts to attend based on type of death	Sudden unexpected infant death (SUID)	Safe Start
	Suicide (including intentional overdose)	FailSafe for Life Frontier Behavioral Health
	Overdose (intentional and unintentional)	Washington State University Washington Poison Center
	Unintentional traffic and transportation related deaths	Spokane County Target Zero Task Force
	Unintentional fire related deaths	Spokane Fire Department
	Unintentional drowning deaths	Spokane Regional Health District Environmental Public Health Program
	Death in a childcare facility	Washington State Department of Children, Youth, and Families Childcare Licensing Program
Topical experts to attend based on the context of decedents' lived experiences	Involved with the criminal justice system	Spokane County Juvenile Court Services
	Suspected or confirmed gang involvement	NorthEast Washington ESD 101 Safe Communities Partnership
	Experienced homelessness or housing insecurity	Volunteers of America
	Experienced child abuse, domestic violence, sexual assault, and other victimization	Partners with Families and Children: Children's Advocacy Center Lutheran Community Services Northwest Victim Advocacy and Education Program
Cultural context experts to attend based on decedents' identity-based lived experiences	Asian	Asians for Collective Liberation Spokane
	Black	The Shades of Motherhood Network, Carl Maxey Center, Dr. Martin Luther King Jr. Family Outreach Center, or NAACP Spokane
	Disabled	Spokane Regional Health District Healthy Families Program
	Hispanic/Latino	Nuestras Raíces
	Indigenous/American Indian/Alaska Native	The NATIVE Project, American Indian Community Center, or Hałmxiłp Indigenous Birth Justice
	Immigrant or Refugee	Refugee and Immigrant Connections Spokane
	Military Family	Fairchild Airforce Base
	LGBTQIA+	Odyssey Youth Movement or Spectrum Center

What to Expect: Child Fatality Case Review Panel Meeting

CFCRP meetings include a series of activities recommended by the National Center for Fatality Review and Prevention.[1] The activities include:

- Welcome members.[1]
- Complete introductions.[1]
- Share updates on local, state or national CFR issues and programs.
- Remind the panel of the purpose pf the CFCRP and group agreements.[1]
- Sign confidentiality agreements.[1]
- Complete individual case reviews:
    - Share, question and clarify case information.[1]
    - Discuss the investigation.[1]
    - Discuss services.[1]
    - Identify findings.[1]
    - Discuss system improvements and other prevention opportunities.[1]
- Identification of action or follow up steps.[1]
- Closing remarks and grounding activity.[1]

This series of activities results in the identification of findings for each case reviewed during the CFCRP meeting.

SRHD staff use the Institute of Cultural Affairs Technology of Participation (ToP) focused conversation method to facilitate meaningful, inclusive conversation during CFCRP meetings. This facilitation method is recommended by the National Center for Fatality Review and Prevention.[2] CFCRP members do not need prior knowledge or experience with this method to participate.

1 National Center for Fatality Review and Prevention. Child Death Review Program Manual. November 2020. Accessed February 2024. https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/ProgramManual.pdf

2 National Center for Fatality Review and Prevention. Effective facilitation for fatality review. Accessed February 2024. https://ncfrp.org/wp-content/uploads/NCRPCD-Docs/Fatality_Review_Facilitation_Guide.pdf

The CFCRP always meets in person, and all individuals in attendance are required to sign a confidentiality agreement at the beginning of each CFCRP meeting.

Each CFCRP meeting is no more than four hours long, with no more than eight cases reviewed. The agenda is adjusted for each CFCRP meeting based on the cases being reviewed. The meeting agenda template below describes a four-hour long CFCRP meeting with eight cases reviewed.

Time Frame	Activities	Led By
10 minutes	Welcome members, complete introductions, share updates on CFR issues and programs, remind of purpose and group agreements, sign confidentiality agreements.	SRHD staff
25 minutes	Case review 1	SRHD staff
25 minutes	Case review 2	SRHD staff
5 minutes	Break	N/A
25 minutes	Case review 3	SRHD staff
25 minutes	Case review 4	SRHD staff
5 minutes	Break	N/A
25 minutes	Case review 5	SRHD staff
25 minutes	Case review 6	SRHD staff
5 minutes	Break	N/A
25 minutes	Case review 7	SRHD staff
25 minutes	Case review 8	SRHD staff
10 minutes	Discussion of prevention opportunities	SRHD staff
5 minutes	• Summary of action items or follow-up steps • Collection of case summaries and any notes taken by CFCRP members during the meeting • Closing remarks and grounding activity	SRHD staff

What to Expect: Recommendations Committee Meeting

RC meetings include presentation of data and evidence-based practices followed by a series of activities resulting in the identification of three priority prevention recommendations for Spokane County.

SRHD staff use the Institute of Cultural Affairs Technology of Participation (ToP) Consensus Workshop facilitation method during RC meetings. This facilitation method is recommended by the National Center for Fatality Review and Prevention.[1] RC members do not need prior knowledge or experience with this method to participate.

1 National Center for Fatality Review and Prevention. Effective facilitation for fatality review. Accessed February 2024. https://ncfrp.org/wp-content/uploads/NCRPCD-Docs/Fatality_Review_Facilitation_Guide.pdf

The RC always meets in person, and all individuals in attendance are required to sign a confidentiality agreement at the beginning of each RC meeting.

Each RC meeting is no more than three hours long. The agenda for each RC meeting may be adjusted based on the information being presented and discussed. The meeting agenda template below describes a three-hour long RC meeting.

Time Frame	Activities	Led By
15 minutes	Welcome members, complete introductions, share updates on CFR issues and programs, remind of purpose and group agreements, sign confidentiality agreements.	SRHD staff
25 minutes	Presentation of data trends • Child mortality, national, statewide and local • Non-fatal child injury, local • Child health indicators, local • Aggregate case information and findings from the year o Types of deaths o Risk factors o Protective factors o Prevention	SRHD staff
30 minutes	Presentation of selected evidence-based practices in child mortality and injury prevention	SRHD staff or external subject matter expert
10 minutes	Break	N/A
75 minutes (1 hour, 15 minutes)	ToP Consensus Building Workshop • Context • Brainstorm • Cluster • Name • Resolve	SRHD staff
15 minutes	Discussion of individuals to include in PATs for each recommendation.	SRHD staff
10 minutes	Summary of action items or follow-up steps. Closing remarks and grounding activity.	SRHD staff

What to Expect: Prevention Action Team Meeting

PATs may have multiple types of meetings. All PATs complete an initial action planning meeting to develop an action plan for implementing a priority prevention recommendation identified by the RC. All SRHD PAT initial action plan meetings have the same structure, including a common set of activities.

SRHD staff use the Institute of Cultural Affairs Technology of Participation (ToP) Action Planning Workshop method to define and promote the successful launch of the PAT's project. This facilitation method is recommended by the National Center for Fatality Review and Prevention[1] PAT members do not need prior knowledge or experience with this method to participate.

After a PAT initial action plan meeting, the PAT may participate in additional meetings throughout the year. PAT meetings after the initial action plan meeting do not necessarily have a shared structure or include the same activities. During the initial action plan meeting, the PAT will determine how and when to complete additional PAT meetings.

1 National Center for Fatality Review and Prevention. Effective facilitation for fatality review. Accessed February 2024. https://ncfrp.org/wp-content/uploads/NCRPCD-Docs/Fatality_Review_Facilitation_Guide.pdf

PATs may meet in person or virtually.

Individuals in attendance are not required to sign a confidentiality agreement because no confidential or case-specific information is shared during PAT meetings.

Each PAT initial action plan meeting is no more than 4.5 hours long. The agenda is adjusted for each PAT initial action plan meeting based on the information being presented and discussed. The meeting agenda template below describes a 4.5-hours long PAT initial action plan meeting.

Time Frame	Activities	Led By
15 minutes	Welcome members, complete introductions, share updates on CFR issues and programs, remind of purpose and group agreements.	SRHD staff
85 minutes (1 hour, 25 minutes)	ToP Action Planning Workshop Part 1 • Context • Victory • Current Reality • Commitment	SRHD staff
15 minutes	Break	N/A
140 minutes (2 hours, 20 minutes)	ToP Action Planning Workshop Part 2 • Key Actions • Calendar • Coordination • Resolve	SRHD staff
15 minutes	• Summary of action items or follow-up steps • Closing remarks and grounding activity	SRHD staff

Online Training

Directions and Training Outline

In addition to the content in this booklet, SRHD compiled a training video series to prepare you for participation in CFR.

CFCRP members are required to watch all videos in the series and complete the CFR online training completion attestation form prior to participating in any CFCRP meetings.

PAT members are highly encouraged, but not required, to watch all videos in the series and complete the CFR online training completion attestation form.

Watch the CFR online training video series at srhd.org/cfr-training.

Complete the CFR online training completion attestation form at srhd.org/cfr-training-attestation.

All videos must be watched before individuals fill out the CFR online training completion attestation form.

The CFR online training video series is approximately two hours long. The entire series does not have to be watched within a single period of time.

Orientation for Child Fatality Review Participation

Keeping Children Safe Program and CFR

- Time: 19 minutes
- Source: Spokane Regional Health District

Confidentiality and Compliance in SRHD CFR

- Time: 15 minutes
- Source: Spokane Regional Health District

Understanding and Addressing Vicarious Trauma in Fatality Review

- Time: 19 minutes
- Source: Spokane Regional Health District

Health Equity in Fatality Review

- Time: 34 minutes
- Source: National Center for Fatality Review and Prevention, Michigan Public Health Institute

Introduction to Public Health

That's Public Health

- Time: Four minutes
- Source: American Public Health Association

Why are Everyday Injuries a Public Health Issue?

- Time: Five minutes
- Source: American Public Health Association

The Cliff of Good Health

- Time: Five minutes
- Source: Dr. Camara Jones, Urban Institute

Introduction to Developmental Science

How Early Childhood Experiences Affect Lifelong Health and Learning

- Time: Five minutes
- Source: Center on the Developing Child at Harvard University

Brains: Journey to Resilience

- Time: Eight minutes
- Source: Alberta Family Wellness Initiative

HOPE Science

- Time: 14 minutes
- Source: Spokane Regional Health District

Practice Resources

Risk and Protective Factors

The CFCRP identifies findings related to risk factors, protective factors, and preventability of death for each case reviewed during CFCRP meetings. The National Center for Fatality Review and Prevention compiled lists of risk factors and protective factors that can be referred to when identifying findings for individual cases.

Protective factors are circumstances that may have reduced a risk factor's impact or lowered the likelihood of negative outcomes, such as injury or death.

Protective Factors			
Social/Economic			
Strong social support networks	Safe, stable, affordable housing	High-quality preschool	Economic and financial help
Focus on the strengths and needs of marginalized communities	Healthy and affordable food	Fresh air, parks, and safe places to play	Work opportunities with family-friendly polices
Affordable, nurturing, and safe childcare	Steady employment	Basic needs are met	
Medical			
Mastery of communication and language skills	Medical and mental health services	Positive physical development	Family or social support for medical care
Comprehensive health insurance	Early and comprehensive screening	Trusted providers	
Relationships			
Emotional self-regulation	Protection from harm and fear	Language-based discipline	Caring adults (outside of immediate family)
Secure attachment(s)	Opportunities to resolve conflict	Mentors	Extended family support
Positive peer relationships	Positive norms	Clear expectations for behavior	Emotional support from family
Engagement and connection in two or more of the following contexts: peers, school, athletics, employment, religion or culture			
Transitions (Age 5 and Older)			
Navigates changes in routine or schedule	Behavioral and emotional autonomy	Opportunities for exploration in work and school	Future planning
Technology (Age 5 and Older)			
Age-appropriate access to technology	Age-appropriate monitoring	Technology used to access needed health care	Technology used to reduce isolation
Trauma (Age 5 and Older)			
Physical safety	Psychological safety	Health care to address previous trauma	

Content adapted from: National Center for Fatality Review and Prevention. Life Stressors and Protective Factors Handout Draft. Distributed in person during a meeting in May 2023.

Risk factors are significant challenges faced by the child, the family, the systems with which they interacted, or the response to the incident; these may also be referred to as life stressors.

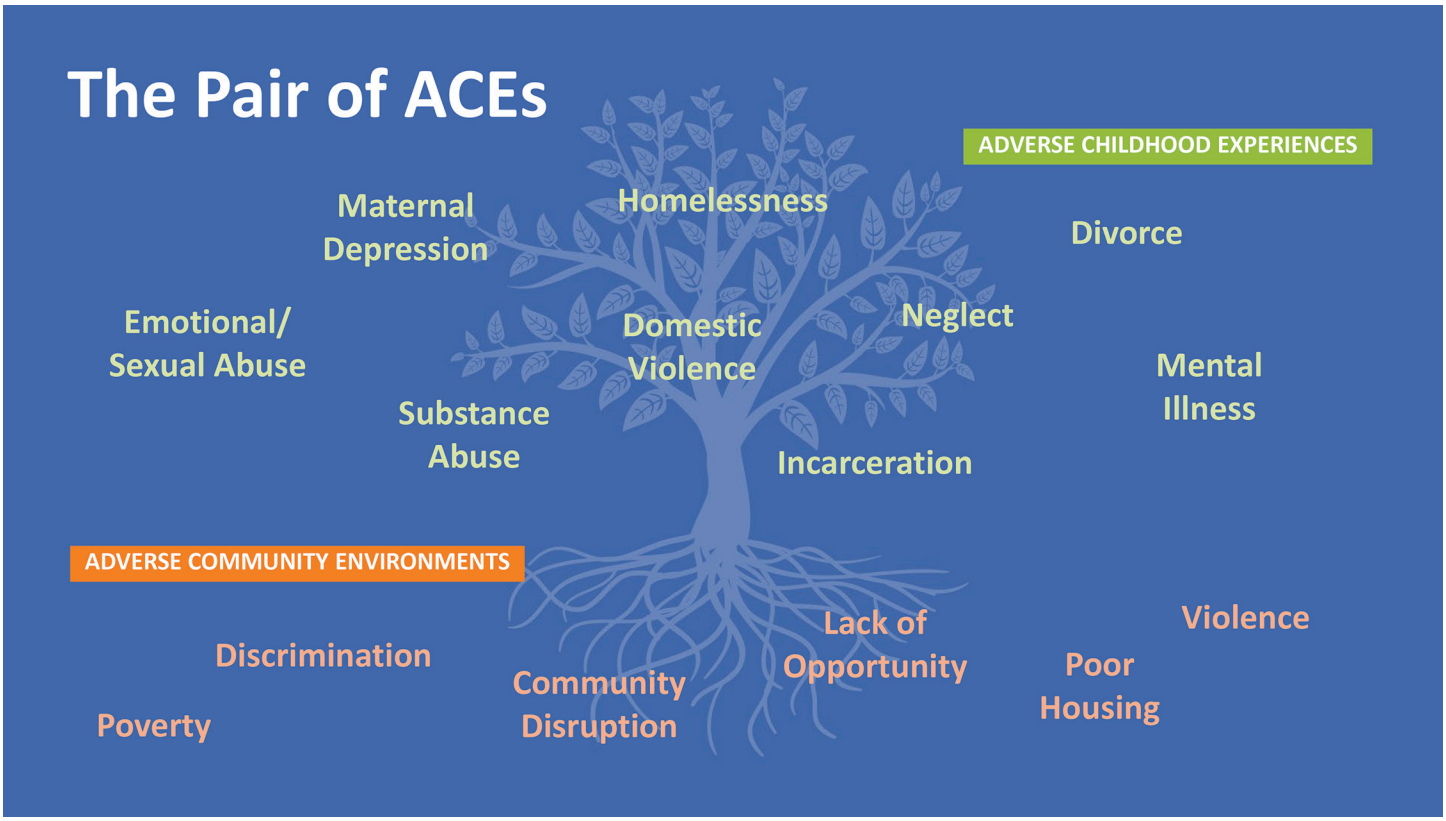
Risk Factors			
Social/Economic			
Structural racism	Job problems	Housing instability	Cultural differences
Discrimination	Money problems	Witnessed violence	Language barriers
Poverty	Food insecurity	Tobacco exposure	Lack of childcare
Neighborhood discord	No phone	Lack of transportation	Pregnancy scare
Pregnancy			
Medical			
Lack of money for care	Caregiver unskilled in providing care	Multiple providers; not coordinated	Felt dismissed by provider
Provider bias	Limitations of health insurance	Lack of provider-family compatibility	Caregiver distrust of healthcare system
Lack of family or social support care	Services not available		
Relationships			
Isolation	Family discord	Peer violence as a victim	Bullying as a victim
Social discord	Argument with parent(s) or caregiver(s)	Peer violence as a perpetrator	Bullying as a perpetrator
Argument with friends	Parents' divorce or separation	Stress due to gender identify	Cyberbullying as a victim
Argument with significant other	Parent's incarceration	Stress due to sexual orientation	Cyberbullying as a perpetrator
Breakup			
School (Age 5 and Older)			
School failure	New school	Pressure to succeed	Extracurricular activities
Other school problems			
Transitions (Age 5 and Older)			
Release from hospital	Release from juvenile justice facility	Release from immigration detention center	Transition to or from child welfare system
End of school year or school break	Transition from any level of mental health care to another (e.g., inpatient to outpatient, inpatient to residential)		
Technology (Age 5 and Older)			
Electronic gaming	Texting	Restriction of technology	Social media
Trauma (Age 5 and Older)			
Rape or sexual assault	Family violence	Domestic or intimate partner violence	Previous abuse

Content adapted from: National Center for Fatality Review and Prevention. Life Stressors and Protective Factors Handout Draft. Distributed in person during a meeting in May 2023.

Pair of ACEs Tree and Community Resilience Tree

The Pair of ACEs Tree and the Community Resilience Tree developed by Dr. Wendy Ellis and the Center for Community Resilience can also be referred to when identifying findings for individual cases and when developing prevention recommendations. These models may be especially helpful when identifying root causes or drivers of individual factors contributing to child fatalities.

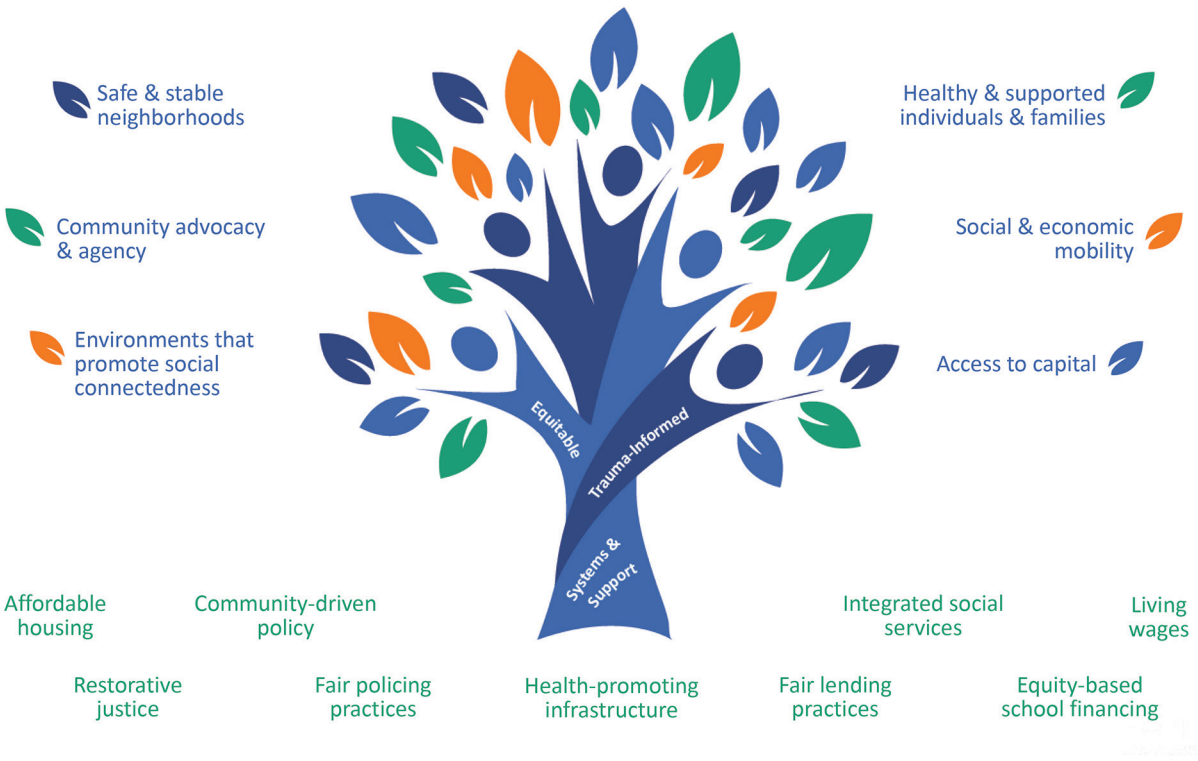
"The Pair of ACEs Tree illustrates the relationship between Adverse Childhood Experiences, experienced at the individual level within a family, and Adverse Community Environments."[1]



1 Center for Community Resilience: Milken Institute School of Public Health. The George Washington University. Accessed February 7, 2024. https://ccr.publichealth.gwu.edu/

"The Community Resilience Tree illustrates positive outcomes produced in comunities with equitable access to integrated supports that prevent adversity and promote social an economic wellbeing."[1]

Community Resilience Looks Like...



The Community Resilience Tree is a strengths-based companion to the Pair of ACEs tree, and it illustrates what nurtures equitable, thriving, resilient communities.[1]

1 Center for Community Resilience: Milken Institute School of Public Health. The George Washington University. Accessed February 7, 2024. https://ccr.publichealth.gwu.edu/

Healthy Living Program
1101 W. College Ave., Spokane, WA 99201 | 509.324.1538 | srhd.org