Examining Child Fatality Review Teams and Cross-System Fatality Reviews to Promote the Safety of Children and Youth at Risk

Developing Best Practices for Fatality Reviews
Part Two: Summary of Findings

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SECTION 1. INTRODUCTION

During the past 3 decades, increasingly more time and resources have been devoted to the development and implementation of fatality review teams. Fatality review teams are widespread in the United States, and more teams are being established as a mechanism to understand the risk factors associated with fatalities and to identify strategies to prevent future fatalities. In 2011, there were child death review (CDR) teams in all States but one. Seventeen States used their CDR team as their State's citizen review panel for review of fatalities (CRP). There were more than 200 fetal and infant mortality review (FIMR) teams in 40 States and 144 domestic violence fatality review (DVFR) teams at the State and local level in 43 States. (See appendix A for a description of the different types of fatality reviews.)

Fatality review processes provide a critical opportunity to gain a better understanding of the causes and circumstances surrounding fatalities. This knowledge may be used to implement system changes in policies, practices, and procedures. The goal of these reviews is to find ways to reduce the risk of future fatalities.

There are many commonalities and variations among the fatality reviews teams. There is not one model that will work in every jurisdiction. Yet, existing and future fatality review teams may learn from the practices and strategies that have been successful within existing teams and through collaboration with other types of fatality reviews, agencies, and stakeholders.

This report summarizes many of the key findings from the study of fatality review teams conducted for the Children's Bureau described below. It also provides background information for teams that choose to use the Developing Best Practices for Fatality Reviews, Part One: A Tool for Planning and Assessment. It provides supporting information for the questions in the planning and assessment tool. The report is organized largely under headings similar to the planning and assessment tool so that supporting information for the questions can easily be identified.

1.1 ABOUT THIS PROJECT

In 2011, the Children's Bureau, Administration on Children Youth and Families, Administration for Children and Families in the U.S. Department of Health and Human Services awarded a contract to Walter R. McDonald & Associates, Inc. (WRMA), and its partner the National Resource Center for the Review and Prevention of Child Deaths (NRCRPCD), to examine the recommendations of CDR teams and related fatality review entities—CRP, FIMR, DVFR, and internal child welfare agency teams. The purpose of the study was to identify promising strategies for fatality reviews and for furthering collaboration for preventing deaths of children. There was a focus on children involved with or are at-risk of involvement with child protective services (CPS).

The study was comprised of four major components.

- **Literature review**—The literature review focused on documents about best practices (from the past 10 years) for the conduct of fatality reviews; recommendations resulting from these reviews; and changes in policy, practice, or legislation resulting from these reviews.

- **Review of Recommendations and Outcomes**—A review of recommendations and outcomes from CDR, FIMR, and DVFR team reports was conducted. A total of 67 reports were reviewed to identify the prevalence and types of recommendations issued by State and local fatality teams and their reported accomplishments. In addition, an analysis of recommendations from CDR teams in 36 States captured in the National Child Death Review Case Reporting System (NCDR-CRS) from 2008–2011 related to death of children from ages 0–5 years was conducted. The purpose of the analysis was to identify differences in recommendations in which child abuse and neglect (CAN) either caused or contributed to the death of the child and those in which CAN was not a factor.

- **Site Visits**—The project team conducted site visits in 4 jurisdictions with promising strategies for maximizing the impact of their review teams. The goal of the site visits was to learn more about the impact of the recommendations made in the last 3 years that led to changes in practice, policy, or legislation, and key elements for collaboration. In addition, two States were interviewed by phone.

- **National Meeting**—A national meeting was held on August 22–23, 2012. More than 80 representatives from 46 States attended. Participants included representatives from child death review teams, citizen review panels, fetal and infant mortality review teams, and child welfare agencies, and a few different Federal agencies. The meeting's goal was to share the project findings and to provide a forum for cross-fertilization of ideas among the attending stakeholders, review teams, resource centers, and Federal agencies.

1.2 REPORT STUCTURE

This report provides a summary of the current status of emerging practices being used by four types of fatality review teams—Child Death Review (CDR), Citizen Review Panels (CRP), Fetal and Infant Mortality Review (FIMR), and Domestic Violence Fatality Review (DVFR). It includes a discussion of the practices that were identified as effective in each of the following areas:

Section 2. Governance and Structure
Section 3. Team Membership and Training
Section 4. Case Selection and Data
Section 5. Prevalence and Types of Recommendations
Section 6. Developing Recommendations
Section 7. Presenting and Disseminating Recommendations
Section 8. Cooperation, Coordination, and Collaboration

SECTION 2. GOVERNANCE AND STRUCTURE

A number of published studies describe the governance and structure of the different fatality reviews. All types of reviews developed independently and originated in organizations with widely differing perspectives. This section summarizes the current status of legislation governing the review processes, the purposes of reviews, and the structure of fatality reviews.

2.1 LEGISLATION GOVERNING THE REVIEW PROCESS

The literature review and the site visits underscore the importance of having State statute(s) governing fatality reviews. Legislation can address confidentiality, liability, and immunity. Comprehensive legislation can provide teams with the necessary access to confidential information, prevent reviewed information from being subject to subpoena or discovery, and provide immunity for all members of the team from civil or criminal liability for an activity related to the review of death. Legislation also may strengthen and enhance program efforts, enhance credibility for the process at the local level, and improve interagency information sharing.

Many child death review (CDR) teams were established before the enactment of State legislation mandating or permitting CDRs. By 2001, 67 percent of States had enabling legislation for CDRs (Douglas & Cunningham, 2008). Currently, most States have legislation that enable or mandate CDR implementation (Shanley, Risch, & Bonner, 2010). State authorizing legislation varies greatly making universal guidelines difficult to implement (Association of State and Territorial Health Officials, 2004). Fetal and infant mortality review (FIMR) is not typically established in State statute. Many FIMR teams operate under their existing state public health statues.

The literature review and the site visits stressed the notion that State legislation governing fatality reviews strengthens and enhances program efforts and processes at the local level. One article highlighted key elements that should be considered in any legislation that supports comprehensive State and local CDR programs. These include:

- program purpose
- program funding sources
- lead agency responsibilities
- advisory committee purposes, duties, members, chairperson designee, and chairperson term of service
- review team purposes, duties, members, chairperson designee, chairperson term of service, training support, technical assistance support, and access to fatality records and data
- confidentiality protection for team meetings and case review records
- reports of individual case reviews
- reports to the legislature

The creation of a fatality review team depends upon the existence of an environment that is conducive to the development of an appropriate infrastructure and resources that would support its full implementation. Authorizing legislation is important for the establishment of fatality

review teams at the State and local levels. Legislation can serve to facilitate, strengthen, and sustain the work of review teams.

2.2 PURPOSE OF REVIEWS

All of the fatality review teams have an overarching purpose of reviewing individual cases of fatalities to identify strategies for improving system responses and prevent future deaths. CDR teams were initially developed in the 1980s and 1990s in response to the lack of identification of child fatalities due to abuse and neglect. In the past decade, the process has evolved so that most States focus on all child deaths with the purpose of identifying risk factors that can be mitigated to keep all children safer and healthier. Therefore, a key part of their work may involve the determination of the cause and manner of death. CDR teams also may work to improve investigations of the child deaths. Some have State-level and county teams; some have State teams only. Some State-level teams review cases, while others provide training and technical assistance to local review teams.

FIMR teams are unique in their focus on improving systems of care for pregnant women. Some domestic violence fatality review (DVFR) teams have a directed focus on improving systems' responses to domestic violence victims at risk of serious harm (e.g., focusing on whether protective orders were appropriate or effective for the victims).

2.3 STRUCTURE

The differences in purpose naturally mean that different types of agencies assume leadership for the establishment and management of each type of fatality review process. CDR originated in child welfare agencies. As CDR teams began using a prevention model, many States shifted their CDR programs to the public health agency. Today, about one-half of all state CDR programs are housed in public health agencies; a third are in child welfare agencies; some are in state attorney general offices; and a few are in independent agencies. Most CDRs have State- level oversight and support.

FIMR is typically based in public health agencies; more specifically in the maternal and child health program. In fact, FIMRs were first established with funding from the Department of Health and Human Services, Maternal and Child Health Bureau (MCHB) and many FIMRs use Federal Maternal and Child Health (MCH) block grant funds to support their reviews. FIMRs are neither controlled nor managed by State-level agencies. Rather, they typically are developed and managed locally.

DVFR is managed by both state and local level agencies, depending on the State. Many teams originated out of social services agencies, offices on violence against women, or local district attorney's offices. Many DVFR teams are housed in a range of community-based organizations, health agencies, and criminal justice offices including domestic violence coordinating councils, coroners' or medical examiners' offices, prosecuting attorneys' offices, and batterers' intervention programs (Watt, 2010).

SECTION 3. TEAM MEMBERSHIP AND TRAINING

The literature has rich information on identifying the types of representatives who should serve on fatality review teams. This section provides a summary of the findings regarding team membership. This section also discusses the importance of training for fatality review team members based on the literature and the site visits conducted for this study.

3.1 MEMBERSHIP

The review of the literature and the site visits brought to light a number of aspects of team membership that contribute to team effectiveness. Members should include people who have authority to return to their agencies to implement recommendations, are available to attend meetings regularly, and are willing to build relationships. Most CDR teams have legislation requiring core members, either at the State or local level. These are most typically the medical examiner/coroner, forensic pathologist, law enforcement, prosecuting attorney, public health, and child protective services. Pediatricians also were identified in the literature as critically important to child death review. During the national meeting that was held as part of this study, it was suggested that tribal members need to be a part of the process. One State CDR team ensures the authority of its members by carefully selecting them and then not permitting agency members to send substitutes to the meetings. The site visits reinforced the theme that it is the building of relationships within a team that permit trust to grow so that a culture of blame or turf conflicts is avoided, and it is relationships that build commitment of the team to itself, each other, and its mission. Covington, Rich, and Gardner (2007) state that the most successful CDR teams include:

- representatives from the community or State agencies with responsibilities for the investigation or prevention of unexpected deaths
- representatives from community or State agencies responsible for protecting the health and well-being of children and families
- representatives of the populations most at-risk and affected by fatalities.
- members willing to advocate for and assist with the implementation of prevention strategies

The site visits reinforced the importance of building trust and relationships within a team. There are other important aspects of relationships that strengthen fatality reviews: the relationship between the State team and local teams, between teams and the communities they serve, and the relationship of local CDR and CRP teams with local child protective services.

One of the positive outcomes of fatality reviews teams seems to be the effect that involvement of its members have on the agencies and organizations they represent. The exposure to case reviews in terms of exchange of information and experience among professionals, were viewed as very positive resulting in changes at the individual and the agency level. Members of fatality review teams may use the information gained from their participation on the team in the development of their own program planning before formal recommendations are made. Opportunities to network and collaborate on prevention or service initiatives were described as positive outcomes of the review meetings.

3.2 TRAINING

Both the literature review and the site visits point to the importance of training and education of fatality review members, especially members that may have limited familiarity with the child welfare system. Training has been identified as a key factor that contributes to the success of teams. Training informs members about new research on different types of deaths and can help members develop critical skills for conducting reviews.

However, because teams vary from State-to-State and across review types, there is only a modest level of standardized or mandated training for fatality review teams. Some States have annual meetings and training for CDR and citizen review panel members. A few States hold them for DVFR and FIMR team members.

One author found that a higher percentage of reported recommendations were implemented among FIMR programs in which the director or staff received training related to perinatal health issues and developing and implementing strategies for systems change. In addition, training in coalition building and group process is identified in the literature as a key factor for successful FIMR teams.

The literature regarding the training of DVFR teams states that team members could greatly benefit from having access to current research to expand their understanding of the diverse contexts and processes contributing to domestic violence and from having training regarding best practices for members in domestic violence risk assessment and management.

SECTION 4. CASE SELECTION AND DATA

The scope of the fatality review determines the parameters that teams follow when collecting, reviewing, and analyzing the information included during the review process. The accuracy, specificity, timeliness, and breadth of the data collected influence the quality and effectiveness of the recommendations that are generated by a death review team. This section provides a summary of the scope of the different types of cases reviewed by fatality reviews teams and the data that may be requested and reviewed as part of the process.

4.1 CASE SELECTION

The types of child deaths that are reviewed by CDR teams vary (Smith et al., 2011; Douglas & Cunningham, 2008). Currently, every State except one reviews deaths of children up to age 18, and most review deaths from accidents, homicides, and suicides (Covington, 2010). Some States focus solely on fatalities resulting from child abuse and neglect, while others are more inclusive in their approach and investigate all child fatalities (Durfee, Parra, & Alexander, 2009). State legislation usually dictates whether teams may review all deaths of children under a specified age or only selected fatalities (Hochstadt, 2006).

CRP review deaths of only those children who were involved with State child protective services or child welfare systems. Potential maltreatment deaths are identified for children ages birth–18 by cross-matching death certificate information collected by State vital statistics, county-based child death review team reports, and State department of human services death abstracts. Published news reports and obituaries also are consulted during the review process.

The goal of a FIMR is to conduct in-depth reviews of all local fetal and infant deaths (children younger than 1 year old). If the overall number of deaths is too great, the team may review a selected sample of deaths (NFIMR, 2001).

The literature reveals that there is a difference in the types of cases reviewed by DVFR teams. While some teams review every death, other teams collect aggregate data on all deaths and conduct in-depth investigations of fewer cases (Wilson & Websdale, 2006). For instance, some teams only review deaths perpetrated by a current or former intimate partner. Other teams review any death that occurs in the context of domestic violence, which may include suicides of perpetrators, homicides of children, new intimate partners, intervening parties, or responding law enforcement officers (Watt, 2010). In some jurisdictions, reviews are conducted for deaths and near deaths in which the death may not have been identified as being caused by domestic violence. Examples include deaths of prostitutes, suicides, suspicious deaths, accidents, and disappearances; and deaths of women with Human Immunodeficiency Virus (HIV), homeless women, and drug-addicted women (Fatality Review Bulletin, 2010; Wilson & Websdale, 2006).

4.2 CASE INFORMATION AND DATA

Comprehensive information on the death and the circumstances surrounding it are critical to all fatality reviews. Each gathers the information from relevant sources in the form of records, presence of relevant officials at review meetings, and, in the case of FIMR, maternal interviews.

What sets FIMR apart is that most do not share the identity of the child, health providers, or their family with the team. Only a case abstractor has this information. Most CDR, CRP, and DVFR teams have a more open process in place in which identifiers are shared among team members. State statutes govern access to case information. Some DVFR and CDR teams meet soon after a death, and make the review part of an active investigation into the death. These more immediate types of reviews share full case information in an effort to assist with the investigation. The type of information reviewed is different among teams due to the variety of information sources. The literature suggests that improving collaboration and developing systems that would allow information sharing would improve the processes.

There are some challenges identified in the literature to gathering the necessary information and records for fatality reviews. First, information collection is time consuming. Sufficient time needs to be allocated for this to be done well in advance of a fatality review meeting. Reviews need to be conducted once all information is collected, which could be several months after a death has occurred (Sidebotham, Fox, & Horwath, 2011). Access to, and collection of, the relevant information also can be challenging in cases when the death occurs in one State and the victim was a resident of a bordering State. Elster and Alcalde (2003) suggest that interstate compacts may be the mechanism to facilitate information sharing. Lastly, confidentiality, privacy and issues of immunity must be addressed. Review teams must be aware of any State laws pertaining to the protection of records, disclosure of identities of patients, and having an understanding of any impact the Federal Health Insurance Portability and Accountability Act of 1996 may have on their ability to get health information related to the case (Elster & Alcalde, 2003).

There was general consensus in the literature and among the site visit participants that sharing mortality and morbidity data at review meetings helps to present a full picture of the problems related to specific types of deaths. Compiling data about specific types of fatalities and using that data to formulate recommendations is critical to preventing future deaths. States that have access to expertise in the use of data seem to do better assessing and utilizing this data. For example, Michigan and Virginia have access to State epidemiology staff that help with data quality, access to vital statistics, and assistance in creating reports at the State Level.

The majority of State child death review programs provide data to a Web-based CDR reporting system supported by the National Center on Review and Prevention of Child Deaths. FIMR teams have access to two national reporting systems. There is no national DVFR reporting system, but many States have created their own systems. In addition, State child welfare agencies submit State case level data on child fatalities due to child maltreatment to National Child Abuse and Neglect Data System (NCANDS).

SECTION 5. PREVALENCE AND TYPES OF RECOMMENDATIONS

Following the review of a death or the analysis of many individual fatalities, a culminating task of a review team is often to develop recommendations for improving legislation, agency systems, and prevention strategies. This section provides an overview of the prevalence and types of recommendations made by fatality review teams as reported in a review of their annual reports and in the Child Death Review Case Reporting System (CDR-CRS). It also provides a discussion of the agencies and organizations that are targeted for implementing the recommendations

5.1 PREVALENCE AND TYPES OF RECOMMENDATIONS

The study included an analysis of the prevalence of recommendations from 67 reports issued within the past five years (2007-2011) from CDR, CRP, FIMR, and DVFR teams.[i] Recommendations from these reports were sorted using the following categories:

- improved collaboration (e.g., partnership development, strategic alliances, joint activities/campaigns)
- increased funding
- strengthened organizational capacity (e.g., workforce training, improvements to agency procedures, improved organizational management and planning)
- improved policies/legislation
- increased public awareness/education (e.g., training for parents, changes in community standards)
- improved service delivery
- other

Data on the number of recommendations made by the fatality review teams were not collected. Rather, patterns of the types of recommendations were identified.

Most Prevalent Types of Recommendations

Many teams made global statements indicating that parents should make specific changes in behavior or that communities should provide particular supports or services. The most common types of recommendations made by all the fatality review teams were for:

- increased public awareness and education
- improved policies and legislation
- strengthened organizational capacity

Both child death review (CDR) and fetal and infant mortality review (FIMR) teams made recommendations for increased public awareness and education for preventing Sudden Infant Death Syndrome (SIDS). In fact, SIDS was the only cause of death for which there were a significant number of recommendations made by FIMR.[ii] Recommendations related to other causes of death were not recurrent in the State-level FIMR reports reviewed. Domestic violence fatality review (DVFR) teams made many recommendations advising the creation of campaigns to raise awareness of domestic violence and prevention strategies among the public and providers of services for domestic violence.

Recommendations of CDR teams for improved policies and practice were made primarily for preventing fatalities caused by SIDS, child maltreatment, drowning, or motor vehicles and other

forms of transportation. A majority of DVFR teams also made recommendations for improved policies and legislation to reduce domestic violence fatalities.

Recommendations for improved organizational capacity related to child abuse and neglect fatalities included recommendations for developing new protocols, assessing and improving training systems, and implementing workforce improvement strategies. Recommendations made by FIMR teams were focused on increasing education for medical and health care providers about safe sleeping habits, and promoting the dissemination of SIDS preventive messages by these providers. Most of the recommendations for strengthened organizational capacity in the prevention of domestic violence fatalities were related to training staff or enhancing internal procedures and processes.

Recommendations for Improved Collaboration and Increased Funding

The analysis of the reports indicated that collaboration among many agencies and providers was necessary to effectively implement most recommendations. There were very few recommendations for increased funding despite that fact that it is well documented that lack of time and resources are often barriers to collaboration. There was no mention of how the different fatality review teams may collaborate to enhance injury prevention despite the fact that both CDR and FIMR teams made many recommendations for preventing SIDS-related deaths. It also is notable that DVFR teams did not address child deaths given that some have estimated that as many as 70 percent of homes where child abuse or neglect has occurred involved domestic violence, and 40 percent of cases resulted in critical injury or death of a child.[iii]

5.2 TARGETS OF RECOMMENDATIONS

In the review of fatality team reports, it was noted that many teams did not indicate the agencies or organizations that should be responsible for implementing the recommendations. When agencies or organizations were identified, they were classified using the following categories:

- child welfare agencies and providers
- education
- domestic violence support and advocacy providers
- law enforcement and criminal justice
- medical examiner or coroner's office
- medical community
- mental health
- public health agencies and providers
- substance abuse providers
- other

CDR teams most often identified child welfare agencies, private providers, and the medical community for involvement in the implementation of recommended prevention strategies for deaths resulting from CAN. The medical community and public health providers were most frequently identified for conducting SIDS prevention efforts. In a majority of the reports, the agencies or organizations that should be responsible for implementing the recommendations for preventing drowning or motor vehicle deaths were not identified.

Most FIMR reports indicated that the medical community and the public health providers should play key roles in the implementation of the recommendations. This is compatible with the fact

that FIMR teams were developed as a public health strategy to address risk factors contributing to infant mortality.

With regard to the involvement of agencies, DVFR teams most frequently included the participation of law enforcement and criminal justice agencies, followed by domestic violence support providers. The involvement of child welfare agencies, private providers, and public health agencies was addressed to a lesser extent. A number of teams recommended the involvement of other types of agencies and organizations, including the medical community, substance abuse agencies, churches, local businesses, community-based organizations, and civic groups.

During the site visits, representatives from the fatality review teams strongly agreed that identifying the entity responsible for implementing the recommendations is an important component of the recommendation itself. The importance of working with these agencies and organizations early in the process of developing recommendations also was emphasized. In addition, it is critical that team members have an understanding of the practice and policy framework in which these agencies provide services and supports to families and children.

SECTION 6. DEVELOPING RECOMMENDATIONS

This section summarizes the study findings regarding the development of recommendations by fatality review teams. Suggestions are provided for developing strong recommendations based on the literature review and information from fatality review team representatives during the site visits.

6.1 ASSESSMENT OF RECOMMENDATIONS

In general, child fatality review teams all follow similar protocols in their review processes. While variations may stem from differences in structure, focus populations, and historical or situational factors, the process tends to encompass three aspects: (1) understanding the circumstances related to the deaths being reviewed, (2) identifying risk factors related to both specific deaths and multiple deaths that have similar circumstances, and (3) offering recommendations to relevant stakeholders and decision makers regarding how to reduce fatalities that share similar circumstances.

Many recently released reports do not include recommendations. In other reports, the recommendations are not entirely clear. Some fatality review teams categorize recommendations by the cause of the fatality (e.g., CAN, SIDS, drowning). Fewer teams categorize the information by the agencies or organizations targeted to implement the recommendation.

A few assessments of recommendations have been conducted. These assessments consistently identify the need for recommendations to be specific, include best or promising practices and or cost benefit analyses to improve their impact and effectiveness. (Wirtz, Foster, Lenart, 2011; S.P. Alexander, 2007).

In a study of FIMR team recommendations, it was noted that FIMR teams make very few recommendations for improving policy and focus only on program and practice (Misra et al., 2004). A study of DVFR team recommendations found that there is disagreement as to whether recommendations should be case specific as a means of honoring the victim or aggregated to ensure that they represent common or systemic problems (Watt, 2010; Wilson & Websdale, 2006).

6.2 KEY COMPONENTS IDENTIFIED IN THE LITERATURE

To formulate effective recommendations, teams must have an understanding of the multifaceted approaches to injury prevention. “The most successful interventions have been those that have addressed a combination of education, environmental improvements, engineering modifications, enactment and enforcement of legislation and regulations, economic incentives, community empowerment, and detailed program evaluation” (Liller, 2001). The Spectrum of Prevention framework developed by Larry Cohen of the Prevention Institute also has been identified as one tool for teams to use as guidance during the development of recommendations (Wirtz, Foster, & Lenart, 2011). This framework describes a range of levels at which prevention activities take place:

- strengthening individual knowledge and skills
- promoting community education
- educating providers

- changing organizational practices
- fostering coalitions and networks
- mobilizing neighborhoods and communities
- influencing policy and legislation

It also is important that teams are aware of best practices and have the skills to formulate effective recommendations. One study found that the provision of injury-prevention training and technical assistance, collaborative process improvement coaching, access to decisionmaking support resources and templates, and access to Web-based prevention resources could improve the quality of recommendations developed by review teams (Johnston, Bennet, Pilkey, Wirtz, & Quan, 2011).

Most of the literature on the promising practices for developing recommendations is included in the literature regarding CDR teams. However, these promising practices can be applied to other types of fatality reviews. Guidelines for writing effective recommendations indicate that they should include the following (Wirtz, Foster, & Lenart, 2011; S.P. Alexander, 2007):

- an assessment of the problem that clearly defines the problem and includes local, State, and national data and known risk and protective factors
- information on best and promising practices for addressing the problems as well as the current efforts, resources, and capacity for addressing the problem.
- the primary outcome from the prevention strategy that is sought
- an explicit link between the number of deaths and the recommendation(s) made coupled with the cost to society or the community if the recommendation is not implemented.
- identification of the agency, persons, or organizations responsible for implementing the recommendations
- a detailed plan of action that includes a timeframe for completion.
- an identification of the person who has been assigned to follow up and track progress on the implementation of the recommendation

6.3 SUGGESTIONS FROM FATALITY REVIEW TEAM REPRESENTATIVES

This section describes the most common themes that emerged in the interviews conducted during the site visits and from the national working meeting concerning the development of recommendations. The following is a summary of common themes and suggestions for developing more "effective" recommendations taken from site visits and the national meeting.

- **Link Data and Findings to Recommendations—**It was agreed that an effective recommendation begins with correctly analyzing the problem. Analysis of the problem should be based on the data. Recommendations of effective teams are influenced by the trends and patterns they see in their assessment of their data. In addition to data from the reviews, data from other sources that supports the recommendations should be included (e.g., national data). Teams should also include support for the preventions strategies being suggested that demonstrate their effectiveness.

- **Build Consensus—**All of the representatives thought that there was a need for more time for developing the recommendations. The process for developing strong recommendations should be one of building consensus by which recommendations are

re-examined and refined. Recommendation should be reviewed and prioritized to ensure that they are useful, realistic, and feasible.

- **Vet Recommendations—**Engaging leadership, stakeholders, and the targets of the recommendations is critical to the development of recommendations. The purpose of vetting recommendations is to obtain buy-in and to determine if the recommendations are consistent with the mission and statutory framework in which the agency targeted for implementation conducts its work. Through this process, strategies to assist the agency in moving the recommendations forward can also be identified.

- **Obtain Expert Input—**As needed, teams should seek input from experts to assist them in better understanding and identifying evidence-informed and evidence-based practices for reducing risk factors and promote protective factors.

- **Develop Realistic Recommendations—**Some fatality review team members believe that it is very important to formulate realistic and feasible recommendations. They indicated that too often recommendations are made at the macro level and are not specific enough to be deemed actionable by the decisionmakers. Other representatives indicated that it is critical to conduct geographical analysis of where fatalities are occurring. This allows the development of more meaningful recommendations, based on an understanding of the resources of the community, the culture of the community, and gaps in services and supports in the community. It was also suggested that it is important to involve members of the community in the process.

- **Provide a Rationale—**Each recommendation should include a discussion of why it is important and where it fits within or enhances other programs, policies, initiatives.

SECTION 7. PRESENTING AND DISSEMINATING RECOMMENDATIONS

The main goal of fatality review teams is to prevent and reduce the number of fatalities. Through their work and influence, review teams fulfill an advocacy role that seeks to change and enhance existing systems, policies, legislation and practices, and create more effective strategies. Recommendations are a critical output of the work that review teams do and are the catalyst for change. In the case of the child death review (CDR) teams, the literature recognizes that ensuring that recommendations result in the implementation of recommendations is a major challenge (S.P. Alexander, 2007).

The literature reveals that teams should include a specially trained prevention advocate for ensuring a systematic discussion of prevention efforts and members must spend time working to change public opinion and build public will for change. This may require an understanding of social marketing and communication, building strategic partnerships, and data sharing among local and State teams. It also requires turning recommendations into messages that "stick" and selecting a messenger that has credibility or visibility with the target audience (S.P Alexander, 2007).

A higher level of advocacy includes influencing legislators and elected officials by conveying messages that include a few key facts and a brief proposal for addressing the identified issues related to child fatalities. Working proactively with the media and having a strategy for getting stories published or aired about how and why children die in the community, and how these tragedies may be prevented, also are vital practices for review teams. Being prepared to respond to the media when contacted about high-profile deaths provides an opportunity for teams to advocate for changes that are needed to prevent future child fatalities.

The following sections provide an overview of the current thinking about the key components for ensuring action occurs as a result of recommendations made by fatality review teams.

7.1 EFFECTIVELY DISSEMINATING RECOMMENDATIONS

The dissemination of the findings and recommendations developed by fatality review teams is vitally important to the prevention and reduction of future child deaths. Many site visit participants acknowledged that implementing recommendations is a difficult task that begins with the dissemination of the recommendations and raising awareness of the issues. Recommendations are typically included in review team reports that are distributed to local agencies, legislators, policy makers, and other review team members. Fatality review teams often develop and disseminate annual or multiyear reports. These reports are typically sent to the legislature, governor, and State agencies, and may be made available to the public via the Internet. The reports often provide mortality data and discuss data trends, major risk factors, recommendations aimed at reducing the number of future deaths, and information on initiatives that were implemented.

The dissemination of reports and how these are received and acted upon by the target audience are an important component of the process. In Oklahoma, the CDR team develops an annual

report and submits it to the Oklahoma Commission on Children and Youth (OCCY). The OCCY determines whether or not it will implement the recommendations made by the CDR. The Sacramento County CDR sends the annual report to the County Board of Supervisors, as required by statute. The Virginia State CDR team distributes its reports to injury prevention groups, FIMR, domestic violence advocates, policy chiefs, sheriff departments, medical examiners, social services directors, child protective services supervisors, members of the General Assembly, Commonwealth attorneys, and child advocate organizations. The Michigan CDR report is sent to a similar set of stakeholders as the Virginia CDR report.

It is good practice to work proactively with the media and have a strategy for getting stories published or aired about how and why children die in the community and how these tragedies can be prevented. For instance, the Sacramento County CDR team issue press releases and put on press events to get media coverage. They receive assistance in these efforts from a public relations firm, free of charge, as a member of the firm is on the board of directors of the Child Abuse Prevention Center (CAPC) where the CDR is housed. The public relations firm also helps the team develop recommendations into effective messages and get stories aired or published on why children die in their community and how these deaths can be prevented. The team also attributed its success to the fact that CAPC is a nonprofit agency and, therefore, has more latitude in speaking out than CDR teams housed in government agencies.

7.2 IMPLEMENTATION

The literature recognizes that ensuring that recommendations result in the implementation of preventions strategies, systems change, and change in legislation and policy is a challenge for fatality review teams (S.P. Alexander, 2007). This section provides a brief overview of the strategies discussed in the literature and those identified during the site visits. Most of the strategies for getting recommendations implemented discussed at the national meeting mirrored these suggestions. The strategies below are discussed by the type of fatality review team. These strategies, however, can be used by any type of fatality review team.

In the case of CDR teams, it is suggested that each team member should use the knowledge gained from the review process to educate their own agencies and the community that injuries to children “are predictable, understandable and preventable” (R. Alexander, 2007a). During the site visits, a few fatality review team members provided examples of how they have used data and the information learned through the review process to implement changes in practice or policy in their respective agencies. They indicated that that it is critical that the members of the team be respected by the entities they represent (e.g., law enforcement, CPS, public health) and that members of the team include people with the authority to effect changes in their own agencies. The literature on CDR also indicates that part of the strategy for getting recommendations implemented should include engaging a person or agency that will take responsibility for implementing the team’s recommendations. It also is important that someone on the fatality review team is accountable for follow-up regarding the progress on the actions taken (S.P Alexander, 2007).

To date, research is limited on the current strategies and promising practices used by fatality review teams for ensuring the implementation of their recommendations. However, some of the suggestions found in the literature include:

- having the CRP process as complementary to FIMR and CDR team
- conducting a series of activities to strengthen trust and build good will between them
- educating citizen participants on the policies, procedures, goals, and daily challenges of the child welfare agency (Collins-Carmago, Jones, & Krusich, 2009)
- implementing prevention strategies identified by FIMR and CDR in systems outside of the child welfare agency may be critical to the efforts of child welfare in improving their system
- facilitating collaboration between CDR and CRP teams (Palusci, 2010) since the outcomes that child welfare systems can achieve are often interrelated to the supports, services, and policies of other social services agencies (e.g., mental health, domestic violence)

Crafting and entering into a memorandum of understanding (MOU) between the CRP and the child welfare agency was one strategy identified at the national meeting that can assist in getting recommendations implemented. A MOU provides clear roles and responsibilities of the CRP and the child welfare agency and timelines for addressing the recommendations issued. It has also served as a foundation for developing a positive working relationship.

FIMR teams have a different structure that affects their approach to the implementation of recommendations. The FIMR process is different from the other fatality reviews in that it has a community action team (CAT), which is tasked with prioritizing and implementing the recommendations from the case review team (CRT). CATs also address a wide range of community actions, view improving services and resources as a long-term process, assess the status of proposed actions to ensure their implementation and obtain community feedback about the changes that have occurred (NFIMR, 2001). Information gathered through the site visit shows that having a separate CAT responsible for getting recommendations implemented was a successful strategy. Some members of the CRT may serve on the CAT, but generally the team is comprised of people with skill in developing and implementing strategies for system change, coalition building, and with the power to make change (e.g., legislators, directors of social services, commissioners of health, advocates).

Findings from the literature suggest that having a separate CAT with the responsibility of implementing recommendations “appears” to enhance the effectiveness of FIMRs (Misra et al., 2004). FIMR teams with CATs implemented a higher mean percentage of reported recommendations than FIMR teams with a combined CRT and CAT or a CRT only. The two-tiered FIMR teams also implemented more activities in all five of the essential maternal and child health services examined:

- data assessment and analysis
- community partnerships and mobilization
- quality assurance and improvement
- policy development
- informing and educating the public

FIMR representatives interviewed during the site visits confirmed that implementing recommendations is challenging. Implementation was challenging due to the lack of available

funding to develop new programs and services, conduct public education and awareness campaigns, and advocate for changes in legislation and policy.

The literature does not identify strategies used, or the best practices for, implementing recommendations by DVFR teams. Watt (2008) briefly mentions implementation of recommendations and states that DVFR team members are, "…often responsible for implementing and evaluating changes to services delivery in their respective agencies…" based on the recommendations they develop.

SECTION 8. COOPERATION, COORDINATION AND COLLABORATION

The study revealed that fatality review teams vary in where they are on the continuum of collaboration. It also pointed out that there are opportunities along the continuum for fatality review teams to work together and improve the efficiency of their process and efficacy of their reviews. This section provides an overview of what is meant by cooperation, coordination, and collaboration, findings on how fatality review teams are currently working together, and strategies for improving cooperation, coordination, and collaboration among review teams.

8.1 DEFINITIONS

Cooperation is characterized by informal relationships that exist without any commonly defined mission, structure, or planning effort. Information is shared as needed, and authority is retained by each entity involved (Collins & Marshall, 2006).

The essential elements of coordination include compatible missions and goals, leadership support for the relationships, some joint planning and identification of roles and responsibilities, and some shared resources. Coordination, however, does not reach the level at which the individual entities have become interdependent (Collins & Marshall, 2006).

The literature often defines collaboration as a multistep process which includes cooperation, coordination, and collaboration. Collaboration is defined as a long-term, well-defined relationship. It brings together two or more separate entities into a new structure to achieve common goals. It involves genuine sharing of authority, accountability, and resources (Collins & Marshall, 2006).

8.2 HOW FATALITY REVIEW TEAMS ARE WORKING TOGETHER

Many States and communities are finding opportunities to blend review processes, coordinate activities, or communicate with each other. Coordinating across reviews is important because many of the deaths share similar risk factors that can and should be addressed by multiple systems. Some fatalities even include circumstances that cut across more than one type of review. For example, a murder suicide of a mother by her partner in which children witnessed the event or also were killed may involve CDR, CRP, and DVFR teams. It is important to consider collaboration because it can lead to a more efficient use of resources and the effectiveness and impact of reviews. Through working together, fatality review teams can identify systems issues that are the same or similar across types of death. Lastly and most importantly, collaboration can identify the same or similar recommendations that different fatality review teams have for improvements and prevention and identify strategies for working together for implementation.

During the site visits and the national meeting, there were discussions of efforts to promote cooperation, coordination, and collaboration. There are many varied ways in which fatality review teams work together. They range from sharing reports to holding biannual joint meetings between DVFR teams and CDR teams.

Fatality review teams are working together to jointly train their members. Trainings have taken place to expand their knowledge on the scope of the team's reviews and findings. In more than one site visit, it was reported that there has been cross-training between the CDR and DVFR teams. Through this activity, team members from both teams were trained about domestic violence and the issues and implications surrounding this topic and the work of the DVFR team.

Information sharing is also an area where fatality review teams are working together. State teams communicate data trends that it obtains from the local teams. As a result, the recommendations included in the reports consider what panels are doing at the local level. Local teams also have created memoranda of understanding to exchange information and records, which benefit their respective case review processes by making them more efficient. Annual reports on the team's findings and activities are also shared with other fatality review teams.

Membership overlap and the involvement of staff with diverse backgrounds in multiple review teams can enhance the collaboration process among teams. Information obtained from the site visit indicates that the membership of the teams is typically multidisciplinary and involved representatives from many different agencies. Membership overlap occurs often and permits collaboration among agencies involved in the review teams. The working relationship among overlapping members is deemed beneficial and contributes to a productive collaboration between teams.

Meetings among review teams or team coordinators occurred regularly in the sites included in the study. Some teams have been holding an annual joint meeting. Other teams are considering implementing joint reviews among some of the fatality review teams in the State. In addition, coordinators from both teams attend in each other's review meetings and actively participate in them.

8.3 BARRIERS AND SOLUTIONS

During the site visits and the national meeting, fatality review team members identified a number of barriers to collaborative work. These included different terminology, different backgrounds, inconsistent definitions (e.g., abuse and neglect, safety plan), different purposes and goals, the perception that another team is too "prosecution" oriented, lack of resources to facilitate joint work, and differences in the review processes (e.g., frequency of meetings, types of cases reviewed, number of cases reviewed). The barriers have not kept teams from trying to collaborate with one another. Strategies for collaboration include:

- **Shared administrative home**—Michigan has one agency managing CDR, FIMR, and CRP; and Virginia coordinates both CDR and DVFRT in the Office of the Chief Medical Examiner.

- **Joint membership**—One form of collaboration addressed in some of the literature was shared membership across teams, which has been done successfully in several States (e.g., Michigan, South Carolina, Oklahoma, and Virginia). Both the literature and the site visits highlighted efforts in States to hold joint meetings when there are overlapping risk factors, such as FIMR and CDR, and DVFR and CDR.

- **Joint meetings**—The documented connection between domestic violence and child maltreatment and fatalities led Oklahoma to hold joint reviews twice each year. In Michigan, the CRP team does not meet jointly with the state CDR team, but meets right after the CDR meeting and has almost entirely overlapping membership. Teams that do not hold joint meetings can collaborate in other ways that promote efficiency and common initiatives. For instance, in Virginia the FIMR and CDR local teams implemented a pilot initiative in which CDR reviewed infant deaths and FIMR reviewed fetal deaths and CDR and FIMR are working jointly on the deaths of infants in the sleep environment.

- **Shared case identification**—The local Michigan CDR and FIMR teams work to identify and triage infant deaths so that the most appropriate review process reviews the case.

- **Sharing of case data**—Some States have official data sharing agreements between different fatality review teams. In Oklahoma and Michigan, CDR and FIMR have a data sharing agreement.

- **Joint reports**—Michigan issues one State annual report for the findings of CDR and FIMR teams.

- **Joint training**—Joint training is another avenue for teams from different fatality review types to learn about each other's purpose, mission and culture, and for members to discuss common fatality issues. Oklahoma DVFR and CDR worked together during a two-day retreat to better understand each other's perspectives regarding victims. Michigan CDR and FIMR participate in each other's trainings.

Collaboration among review teams is an area with much potential for growth. The literature supports the notion that the coordination of CDR teams with CRP, FIMR, and DVFR teams would assist in the translation of recommendations into action. The literature suggest all types of fatality review teams have the same overall purpose of decreasing preventable deaths and considers family violence as a "causal link" between the various types of reviews (Elster & Alcalde, 2010). This link should serve as a foundation for the integration of the teams.

During the national meeting held August 23, 2012 through August 24, 2012, participants worked together to identify challenges to collaboration and ideas for promoting collaboration among teams. Following are highlights of the strategies for enhancing collaboration:

- Joint training, transparency, and relationship building will provide teams with a better understanding of each other's processes and philosophies; reduce defensiveness, turf issues, and cultural and jurisdictional barriers.
- Demonstrating the efficiency of working together on similar issues and combining resources to attack similar problems can facilitate collaboration among fatality review teams.
- Working together in development of the recommendations on overlapping issues can facilitate joint ownership of the recommendations. It also can lead to joint strategies for implementing them.

- Memoranda of understanding (MOUs) may provide a solid foundation for developing strategic partnerships among fatality review teams. MOUs can contain joint goals, processes, and respective roles and responsibilities
- Legislation, interagency agreements, or agency policies should be developed to allow for the sharing of information between review teams.

Two additional documents are available that provide more in-depth information from the study.

- **Fatality Review Teams: A Literature Review**—The literature review provides a summary of the articles, reports, book chapters, and other documents published within the last 10 years that provided information about practices for conducting fatality reviews and outcomes resulting from the fatality review processes.

- **A Review of State and Local Fatality Review Team Reports: Recommendations and Achievements**—This report provides a summary of the prevalence and types of recommendations issued by State and local fatality review teams and the reported accomplishments. It is based on a review of reports that included information from reviews within the last 5 years (2007-2011). A total of 67 reports were reviewed—30 CDR team reports, 5 citizen review panel reports, 9 State-level FIMR reports, and 23 DVFR team reports.

APPENDIX A. FATALITY REVIEW TEAM DESCRIPTIONS

Following is a brief summary of the five fatality review processes. It discusses the history, purpose, structure, and scope of each process.

Child Death Review (CDR)
The first CDR teams were developed in response to rising concerns that the number of child deaths due to maltreatment was increasing and that many cases of inflicted injury or child homicide were being overlooked or misclassified (Johnston & Covington, 2011). Most State CDR teams were established in the 1990s. The early goal was to better investigate, identify, and prosecute perpetrators of fatal child maltreatment (M. Durfee, Parra, & R. Alexander, 2009; Covington, Rich, & Gardner, 2007). In the 1990s, both the Maternal and Child Health Bureau and the Advisory Board on Child Abuse and Neglect called for the expansion of CDR programs. In response, many CDR teams expanded to include a broader focus on examining the causes and circumstances of all child fatalities with the goal of preventing future deaths (Johnston & Covington, 2010; M. Durfee, Parra, & R. Alexander, 2009; Covington, Rich, & Gardner, 2007).

The overall purpose of CDR teams is to review deaths to better understand how children die and use the review process to suggest actions which would prevent further deaths (Covington, 2010). Another purpose for the reviews is to improve the classification of child deaths due to maltreatment. The premise is that by bringing professionals from various agencies and disciplines together to share information, child fatalities due to maltreatment would be better identified (Webster & Schnitzer, 2007). Some CDR teams also have the stated purpose of proposing effective interventions on behalf of surviving children and assisting in the prosecution of child maltreatment fatalities (Webster & Schnitzer, 2007).

In the 1990s, most CDR teams were administratively housed and supported by the department of social services or the State attorneys general's offices. More recently, many are administratively housed within public health departments. According to Covington (2010), of 42 CDR teams, 27 are coordinated and supported by State health departments, 11 by social services agencies, and 3 are housed in attorneys generals offices. Others are in a variety of organizations including State child advocates'offices, State universities, and courts.

In 2010, all but one State had a CDR process in place. Thirty-eight States have a network of local CDR teams at the county level, city level, and/or at the regional level. Thirty-five States have state-level advisory boards that either review individual cases or review the local findings and make recommendations for improvement to State policy and practice (Covington, 2010).

Citizen Review Panel (CRP)
In 1996, Congress passed amendments to the Child Abuse Prevention and Treatment Act (CAPTA) (P.L. 104–235). As a condition of receiving CAPTA funds, States are required to establish at least three citizen review panels to develop recommendations for improving the State's child welfare system. These panels were mandated to assess agency compliance with the review of child fatalities, foster care and adoption services, and child abuse prevention services. States were given the flexibility to use existing review panels, such as CDR teams, to serve as their citizen review panel for the review of child fatalities (Collins-Camargo, Jones, & Krusich,

2009). For purposes of this study, citizen review panel fatality reviews (CRP) are reviews conducted by teams that were established separately and are distinct from CDR teams.

CRP teams are different from CDRs in that they review only those fatalities of children who were known to the State child welfare agency or to child protective services (CPS). In addition, the purpose of the review is to identify child welfare practices and policies that may have been a factor in the fatality. CRPs may review procedures for screening and intake of reports of abuse and neglect, investigation of reports, and the types of services provided. They also may assess issues related to training, caseworker caseloads, and supervision (Palusci, 2010).

The literature does not contain information about how many CRP teams are active at this time. According to a survey conducted by the National Center for the Review and Prevention of Child Deaths, 17 States indicated that the CDR team has assumed the responsibilities for review of child fatalities of children involved with child welfare (National Center for Child Death Review, 2011). Most of the literature focuses on citizen review panels more generally.

Fetal and Infant Mortality Review (FIMR)

FIMR is a public health strategy developed in the 1980s in response to the growing concern over infant mortality trends. For much of the 20th century, there were significant reductions in maternal and infant mortality rates and improved quality of care for at-risk mothers and infants. However, in the 1980s, the rates began to rise in some cities and the overall rate of decline slowed. There also were numerous media stories about an infant mortality crisis and a call for a better understanding of and data on infant mortality (Koontz, Buckley, & Ruderman, 2004).

FIMR is a community-based process with the purpose of improving services and resources for women, infants, and families with the long-term goal of reducing infant mortality (Hutchins, Grason, & Handler, 2004). Typically, FIMRs are organized into two teams with two specific functions—Case Review Teams (CRT) and Community Action Teams (CAT). Key members of the community serve on the CRTs that review de-identified cases of fetal and infant deaths and consider the social, economic, cultural, safety, and education issues in each community, which can affect fetal and infant fatalities (Hutchins et al., 2004). CATs facilitate the implementation of recommendations made by the CRTs.

Local health departments and community-based organizations typically administer FIMRs. Coalitions and collaboratives also serve as the organizational home for FIMRs (Hutchins, Grason, & Handler, 2004). During the past two decades, the use of FIMR has grown from six pilot communities in 1984 to more than 200 FIMR programs in 40 States today (Davidson, 2011).

Domestic Violence Fatality Review (DVFR)

Traditionally, the goal in review of cases of domestic violence fatalities was to identify the perpetrators and hold them accountable through the criminal justice system (Websdale, Town, & Johnson, 1999). During the last 15 years, DVFR teams were established to understand and prevent future deaths related to domestic violence. The DVFR process consists of reviewing a number of deaths over a defined period of time and looking for common issues, trends, and

missed opportunities for intervention. Websdale (2003) compares DVFR to the inspection of the "black box" following an airplane crash to find ways to prevent future crashes.

The principal purpose of DVFR is to reduce these deaths through the identification of issues in service delivery systems—including the criminal justice system—that, if addressed, may prevent future injuries and deaths from domestic violence. The focus of the reviews is to discover factors that will improve identification, intervention, and prevention efforts; preserve the safety of battered women and their children; and hold perpetrators of domestic violence accountable (Websdale, 2003; Wilson, & Websdale, 2006). Other goals identified in the literature are identifying homicides resulting from intimate partner violence, increasing knowledge, and fostering collaboration (Watt, 2010).

DVFR teams are housed in a range of community-based organizations, health agencies, and criminal justice offices including domestic violence coordinating councils, coroners' or medical examiners' offices, prosecuting attorneys' offices, and batterers' intervention programs (Watt, 2010). As of 2011, there were DVFR initiatives in 43 States and a total of 144 DVFR teams at the local and State levels (Wieglus, 2010).

Additional Types of Reviews

In addition to the four types of reviews discussed in this report, there are other mortality and morbidity reviews being conducted. States and localities also conduct maternal mortality reviews and elder abuse reviews. There are also review teams that focus on deaths in the workplace, deaths of persons with asthma, persons with disabilities, suicides, and homicides. In addition, the Air Force, the Navy, and the Marine Corps conduct annual headquarter level reviews. The Army conducts both installation level and annual headquarter level reviews. Tribes have not traditionally conducted fatality reviews and have limited involvement with the reviews conducted by States and localities. However, every region has an injury prevention specialist who works with tribal agencies. Currently, the Navajo Tribe is in the process of developing a tribal review team.

APPENDIX B. SELECTED RESOURCES

FEDERAL AGENCY WEBSITES

- **U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau**
  http://www.acf.hhs.gov/programs/cb/

- **U.S. Department of Justice, Office of Violence Against Women**
  http://www.ovw.usdoj.gov/

- **U.S. Department of Health and Human Services, Indian Health Service, Injury Prevention Program**
  http://www.ihs.gov/MedicalPrograms/InjuryPrevention/index.cfm

- **U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health**
  http://mchb.hrsa.gov/index.html

- **Centers for Disease Control and Prevention**
  http://www.cdc.gov/injury/

RESOURCE CENTERS

- **Child Welfare Information Gateway**
  http://www.childwelfare.gov/responding/review_teams.cfm

- **National Resource Center for Child Protective Services**
  http://www.acf.hhs.gov/programs/cb/tta/nrccps.htm

- **National Child Welfare Resource Center on Legal and Judicial Issues**
  http://www.americanbar.org/groups/child_law/what_we_do/projects/rclji.html

- **The National Center for the Review and Prevention of Child Fatalities**
  http://childdeathreview.org/

- **National Center on Child Fatality Review**
  http://ican-ncfr.org/

- **National Citizens Review Panel Virtual Community**
  http://www.uky.edu/SocialWork/crp/

- **National Center on Substance Abuse and Child Welfare**
  http://www.ncsacw.samsha.gov

- **National Child Welfare Resource Center for Organizational Improvement**
  http://muskie.usm.maine.edu/helpkids/index.htm

- **National Child Welfare Workforce Institute**
  http://www.ncwwi.org/

- **National Domestic Violence Fatality Review Initiative**
  http://www.ndvfri.org/

- **National Fetal and Infant Mortality Review Program**
  http://www.nfimr.org/

- **National Domestic Violence Fatality Review Initiative**
  http://www.ndvfri.org/

- **National SUIDS/SIDS Resource Center**
  http://www.sidscenter.org/

- **Children's Safety Network**
  http://www.childrenssafetynetwork.org/

- **Prevention Institute**
  http://ww.preventioninstitute.org/spectrum_injury.html

APPENDIX C. REFERENCES

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ENDNOTES

[i] For purposes of this analysis, 30 CDR, 5CITIZEN REVIEW PANELS THAT REVIEW CHILD FATALITIES, 9 State FIMR, and 23 DVFR team reports were reviewed.

[ii] Only State level FIMR reports were reviewed.

[iii] Colorado Department of Human Services (2008). *Child Maltreatment Fatality Report*. Retrieved July 21, 2011, from http://www.thedenverchannel.com/download/2008/0416/15893148.pdf.