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

A Review of State and Local Fatality Review Team Reports: Recommendations and Achievements

Fall 2012

U.S. Department of Health and Human Services
Administration on Children Youth and Families
Children's Bureau

TABLE OF CONTENTS

SECTION 1. INTRODUCTION

Fatality review processes provide a critical opportunity to gain a better understanding of the causes and circumstances surrounding unexpected infant and child deaths. This knowledge may be used to implement system changes in policies, practices, and procedures to prevent future child deaths. In 2011, the Children's Bureau, Administration on Children Youth and Families in the Administration for Children and Families in the U.S. Department of Health and Human Services funded a study to examine the recommendations of child death review (CDR) teams and related fatality review entities—citizen review panel that review child fatalities (CRP), fetal and infant mortality reviews (FIMR), and domestic violence fatality reviews (DVFR). The purpose of the study was to identify best practices for improving collaboration among fatality review teams and implementing cross-cutting injury and fatality prevention strategies.

This examination of fatality review team reports was conducted as one of four major study components. The purpose was to identify the prevalence and types of recommendations issued by State and local fatality teams and the reported accomplishments of the teams. A key component of fatality reviews is identifying the potential risk factors involved in each death and addressing these factors in recommendations. In general, the recommendations are directed to agencies, organizations or other entities external to the review team itself. The development and dissemination of well-written recommendations for agencies or others who can implement them is a critical step for many fatality reviews. Quality recommendations may help translate the knowledge gained by the review teams into effective prevention interventions that have the potential to make a difference.[i] For fatality review teams, the implementation of prevention strategies and activities and the documentation of such achievements are important tools for improving safety of children.[ii]

Fatality review teams often develop annual or multiyear reports, which include compilations of findings. 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 have been implemented.

Recommendations are one of the key outputs of fatality reviews. Outcomes or achievements are the specific changes in knowledge, policy, and practice. Impact is the fundamental change that is intended from these processes.

This report includes the following sections:

- **Section 2. Recommendations Discussed in Selected Fatality Review Team Reports—** This section provides an analysis of the types of recommendations made by the different fatality review teams by selected causes or manner of death. It also provides a summary of the types of agencies and organizations to whom the recommendations were directed.

- **Section 3. Achievements—**This section provides a summary of the types of outcomes identified in the reports and provides examples of selected outcomes.

- **Section 4. Summary and Conclusions—**This section provides a summary of the findings.

A bibliography is provided at the end of the report. Appendix A provides a summary of the methods used for the study. Appendix B summarizes the reports reviewed. Appendix C provides the template used to review the reports. Appendix D provides supporting data tables for Section 2 of the report.

SECTION 2. RECOMMENDATIONS DISCUSSED IN SELECTED FATALITY REVIEW TEAM REPORTS

This section presents the analysis of the prevalence and types of recommendations from three types of fatality review team reports—child death review (CDR), fetal and infant mortality review (FIMR), and domestic violence fatality review (DVFR). A total of 67 reports were reviewed and analyzed for the types of recommendations made for each individual cause of death. Recommendations were classified using the categories:

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

For this study the patterns of the types of recommendations by cause of death were identified. For each type of fatality review team report, only selected causes of death are discussed in this report based on the identification of notable patterns of types of recommendations. For CDR, the causes of death include child abuse and neglect (CAN), Sudden Infant Death Syndrome (SIDS), motor vehicle and other means of transportation, and drowning. For FIMR, SIDS is the only cause of death that had a notable pattern of recommendations. For DVFR, homicide is the only cause of death discussed in the reports. Examples of the primary types of recommendations made by the fatality review teams also are provided.

In addition, the agencies and organizations identified for the implementation of the recommendations by the fatalities teams are discussed, if notable patterns emerged. Many fatality review teams did not, however, indicate the agencies or organizations that should be responsible for taking action. Agencies and organizations were classified using the 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 treatment providers
- other

2.1 CDR TEAM REPORTS

Based on the selection criteria discussed in the methods appendix (appendix A), 30 CDR team reports were reviewed. Five citizen review panel reports that reviewed child fatalities (CRP) also were reviewed and their recommendations are included in this discussion. CRP teams only had recommendations related to deaths caused by child abuse and neglect (CAN). (We simplify the discussion by calling both groups CDR teams in this section.)

The types of recommendations made by CDR teams, by cause of death, and examples of recommendations are presented below. For two causes of death—CAN and Sudden Infant Death Syndrome (SIDS), there were patterns among the teams with respect to the types of agencies and organizations identified for implementing the recommendations. Appendix D provides supporting data tables for this section.

Child Abuse and Neglect (CAN)

Recommendations for preventing CAN deaths were generated by CDR teams for all seven categories of recommendations. The primary type of recommendation was for strengthened organizational capacity. This category included recommendations for developing new protocols, assessing and improving training systems, and implementing workforce improvement strategies. Two examples of the types of recommendations issued by the CDR teams for strengthened organizational capacity are provided below.

Florida, 2011

The Department of Children and Families Substance Abuse and Family Safety program offices should develop a standardized protocol for screening, assessment, linkage, and retention of substance abusing parents in substance abuse treatment. Essential elements should include required attendance at recovery/support groups, use of family intervention or substance abuse specialists, drug testing, and use of peer recovery specialists

Maine, 2009

The process to review medical records should become standard procedure in cases. The Pediatric Rapid Evaluation Program (PREP) in Central Maine covers 6 counties and provides a thorough medical and mental health evaluation of children entering our child welfare system. In this program, medical and behavioral health records are obtained and reviewed by an expert evaluator. This program should be available for all children in our State's child welfare system.

Recommendations for improved policies and legislation were the second most prominent type of recommendation followed by increased public awareness and education and improved service delivery. Examples are provided below to illustrate these types of recommendations.

New Jersey, 2011

DYFS should have access to the system used by law enforcement to conduct criminal background checks and this should be formalized for specific types of referrals. In addition, it was recommended that everything that can be done to immediately obtain comprehensive criminal information for the purpose of an investigation should be done.

Wyoming, 2008

Prevent Child Abuse Wyoming, the Department of Family Services, and the Department of Health are encouraged to collaborate to develop and implement an aggressive statewide education campaign on preventing Shaken Baby Syndrome and Don't Shake the Baby, targeting males. Areas include DAD 101, TANF agencies, schools, hospitals, public health agencies, etc. It would be desirable to have this completed by the end of August 2008 for implementation in the fall of 2008.

California, 2009

It is recommended that universal neonatal home visitation by a public health nurse be made available to first time parents. At a minimum, home visitation should be provided to teen parents, high risk families in which children have special needs, families in which there are three or more children under the ages of 5 years, and when either parent has a history of substance abuse or domestic violence. Families should have the opportunity to access voluntary services from programs such as the Nurse-Family Partnership, Prenatal Care Guidance, Comprehensive Perinatal Services Program, Black Infant Health Program, and Best Start LA.

Less than one third of the CDR teams included recommendations for improved collaboration. The example from the Wyoming CDR is representative of the types of recommendations made regarding efforts to collaborate.

Wyoming, 2008

Prevent Child Abuse Wyoming, Department of Health, Department of Family Services, and the Department of Education are encouraged to collaborate to review current training availability and requirements for recognizing abuse and neglect, especially sexual abuse. This review should involve physicians, mental health, teachers, school counselors, childcare providers, community human service providers, nurses, law enforcement, and emergency medical technicians. The review will identify best practices, gaps, requirements, opportunities, and communication.

Child welfare agencies and private providers were the organizations most frequently targeted to implement the recommended prevention strategies for deaths resulting from CAN. The second largest number of entities targeted to implement recommendations were categorized as other. In

the other category, communities and parents were most often identified for making changes to prevent future deaths. The medical community also was frequently targeted to implement changes in practice and policy.

Sudden Infant Death Syndrome (SIDS)
CDR team recommendations for preventing SIDS primarily called for increased public awareness and education. The second largest category of SIDS-related recommendations was strengthened organizational capacity. Recommendations for improved policies and legislation, improved collaboration, improved service delivery, and increased funding were much less common. The following examples illustrate recommendations to increase public awareness and strengthening organizational capacity.

Iowa, 2008
Based on recent review of infant deaths, the Iowa Child Death Review Team (ICDRT) recommends that appropriate safe sleep educational resources based on the American Academy of Pediatrics Safe Sleep Recommendations, be distributed and discussed by healthcare professionals with all new parents before discharge from an Iowa hospital in an effort to proactively campaign to reduce SIDS deaths and other infant accidental sleep-related deaths. In regard to childcare providers providing care for infants less than one year of age, the ICDRT recommends that mandatory safe sleep training is completed by childcare providers within the first three months of employment.

Michigan, 2009
Each county medical examiner should work with their prosecuting attorney and law enforcement agencies to assure that 2004 PA 179 is implemented, by using the State of Michigan Sudden & Unexplained Child Death Scene Investigation Form for every sudden and unexpected death of a child under age two.

A majority of the CDR teams did not identify the agencies and organizations to implement the recommendations in any of the six specific categories. Rather, most identified parents as the target for implementing their recommendations. Of the specific categories of agencies and organizations identified for conducting prevention efforts, the medical community was identified most often, followed by public health providers.

Motor Vehicle and Other Means of Transportation
The primary type of recommendation for preventing deaths caused by motor vehicles and other forms of transportation was improved policies and legislation. The second largest category of recommendations was increased public awareness. In a majority of the reports, the agencies or organizations that should be responsible for implementing the recommendations for preventing

motor vehicle deaths were not identified. Examples that demonstrate the types of recommendations for improved policies and legislation and improved public awareness are shown below.

> Kansas, 2011
> It is the Board's belief that the Legislature should enact laws that encompass the following: No child under the age of 5 may be left in a motor vehicle unless they are accompanied by another person 13-years-of-age or older; No child under the age of 5 shall be left unsupervised or unattended in a vehicle, unless the vehicle is being loaded or unloaded and an adult is in the immediate vicinity; A fine of $25 should be imposed for the first conviction, and subsequent convictions that occur within three years of the first violation should result in a minimum fine of $250, not to exceed $500.
>
> Kentucky, 2010
> Institute statewide the 'Not Even for a Minute' Campaign (leaving kids in cars).

Drowning

Increased public awareness and education was the primary type of recommendation for preventing deaths due to drowning. The second largest category of recommendations was for improved policies and legislation. In a majority of the reports, the agencies or organizations that should be responsible for implementing the recommendations for preventing drowning deaths were not identified. Examples of increased public awareness and improved policies and legislation for drowning are shown below.

> Mississippi, 2010
> Persuade communities to make swimming lessons and water safety classes more readily available to children and parents, especially for children under age 5.
>
> Florida, 2011
> Initiate Legislative action to amend s. 515.27, F.S., mandating that whenever a building permit is issued for remodeling of an existing pool, spa or hot tub, it shall meet and maintain at least one of the requirements relating to pool safety features.

2.2 FIMR TEAM REPORTS

Focusing primarily on State FIMR reports, the project reviewed 9 FIMR team reports. (The majority of FIMR reports are made at the local level, but a comprehensive review of all such reports was beyond the scope of this project.) SIDS was the only cause of death for which there was a significant number of recommendations. Recommendations related to other causes of death were not recurrent in the findings. Examples of the nonrecurrent recommendations related to smoking cessation, nutrition, infectious disease, etc. In addition, there were a number of recommendations made by FIMR teams concerning unspecified causes of death that were not analyzed.

The U.S. Preventive Services Task Force (USPSTF) assigns a range of grades to its recommendations for clinical preventive services based on the degree to which they are evidence-based and likely to have an impact on health outcomes.[iii] The American Academy of

Pediatrics supports the use of this system in determining what prevention efforts should be implemented to reduce SIDS-related deaths.

Sudden Infant Death Syndrome (SIDS)
Four different categories of recommendations for preventing SIDS-related deaths were discussed in the FIMR team reports. The majority of recommendations issued by FIMR teams were related to strengthened organizational capacity. Many of these recommendations focus on educating medical and health care providers about safe sleeping habits, and promoting SIDS preventive messages by these providers. Few recommendations for improved collaboration and improved service delivery were discussed in this group of reports.

> Virginia, 2011
> Promote the Back to Sleep campaign and other preventative messages regarding SIDS and safe-sleep practices (target daycare providers); Increase public and professional awareness and education on risk factors associated with SIDS; Identify SIDS risk-reduction factors to all infant caregivers.

FIMR teams also generated recommendations concerning increased public awareness and education. These recommendations mostly centered on educating parents and caregivers via public awareness campaigns and through more direct interventions by health care providers. The following examples illustrate this type of recommendation found in the reports.

> Florida, 2010
> All parents and caregivers should be informed about SIDS reduction strategies and safe sleep practices and standards. Health care providers should provide safe sleep education and infant sleep messaging that is consistent, clearly understood and uniformly practiced.
>
> Alabama, 2009
> Provide education and information regarding safe sleep, raise public awareness of the importance of safe sleep including developing public service announcements, use zip code data to place billboards in communities promoting safe sleep education in areas most affected, give education materials to parents during prenatal care and before birth, and distribute Safe Sleep posters to daycare centers in Mobile County.

In terms of the involvement of specific agencies, the reports indicated that the medical community and public health providers should play key roles in the implementation of these 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.

2.3 DVFR TEAM REPORTS

Twenty-three DVFR team reports were reviewed. Homicide was the only cause of death for which patterns of recommendations were identified. Some of the reports also identified the agencies and organizations that should be responsible for implementing the recommendations.

Homicide

The analysis showed that the most common types of recommendations were related to strengthened organizational capacity and increased public awareness and education. A majority of the DVFR teams included these types of recommendations in their reports. Most of the recommendations in the category of strengthened organizational capacity in the prevention of homicide-related deaths were related to training staff or enhancing internal procedures and processes of agencies relevant to domestic violence victims and their families. The examples below illustrate the types of recommendations made in this area.

Washington, 2010

The Administrative Office of the Courts should develop and provide specialized training to judges and commissioners who hear family law cases on how to appropriately address safety risks to victims of domestic violence and their children when drafting orders containing visitation and visitation exchange provisions.

California, 2007

The Domestic Violence Council continues to encourage local school districts to develop a curriculum that addresses the issues of domestic violence, dating violence and stalking. It should also help children feel safe in reporting domestic violence by educating teachers and counselors and setting aside a confidential place for children to make the report. Schools should also track very carefully the attendance rate of children.

Iowa, 2009

Iowa Department of Education

1. Include dating violence and healthy relationships in the curricula for health education; 2. Ensure that schools implementing positive behavioral supports also provide domestic violence training to staff so they are aware of resources and supports for children who live in families with domestic violence; 3. Teachers, school nurses, and guidance counselors should be better equipped to respond to disclosures of domestic abuse besides just filing a child abuse report. They should offer referrals to local service programs and have a basic understanding of safety planning.

There were many recommendations that advised the creation of campaigns to raise awareness of domestic violence and prevention strategies among the public and among providers of domestic violence services. The recommendations below exemplify these suggested practices.

Minnesota, 2011

Develop a public outreach campaign targeting leaders in Minnesota regarding domestic violence to clearly define what domestic violence is, to encourage interaction with agencies that offer helping services and to build understanding of and confidence in the US legal system's ability to assist victims of domestic violence.

New Jersey, 2011

The Domestic Violence Fatality Review Board recommends that the DVFRB coordinate with the Division on Women, other government entities and the New Jersey Coalition for Battered Women towards the creation of a statewide public education campaign promoting awareness of domestic violence in a manner that is culturally sensitive and linguistically appropriate to the diverse communities within New Jersey. The campaign should include the following areas of concern: 1. How to help victims of domestic violence and how to identify local resources. 2. Outreach specific to different cultures, ethnicities, and socio-economic group. 3. Deliver the message that relationship separation is a dangerous time. 4. Suicide prevention and awareness within a domestic violence relationship. 5. The recognition of signs/factors associated with increased risk of lethality and danger. 6. Promotion of the domestic violence hotlines, in diverse languages, as a place to call in addition to the police.

There were several DVFR team reports that contained other types of recommendations. These included recommendations for improved service delivery, improved collaboration and improved policies and legislation. In addition, there were many types of recommendations found in the reports for improved service delivery and adopting policies or legislation to support the prevention of homicide-related deaths. Compared to other types of recommendations, DVFR team recommendations for increased funding were low. The following exemplify some of the most detailed recommendations found in the reports reviewed.

Minnesota, 2011

Child Protection Services

- Provide ongoing and more frequent assessment of mental health needs for children receiving child protection services due to abuse/neglect incidents and ensure follow-through on recommended treatment services for the children.
- Immediately address, through assessment and counseling, the impact of grief and abandonment on the children who have experienced family violence.
- Develop a consistent response to truancy, including a more comprehensive look at attendance from year to year and training first responders on how to identify and report educational neglect.

Iowa, 2009

Iowa Department of Human Services

1. The department should work to ensure that child abuse protection staff has been trained in domestic violence they are able to identify the presence of domestic abuse and make appropriate interventions and referrals.
2. When clients with a history of domestic violence are identified, assess homicidal/suicidal potential by both parties to enhance service needs assessment and referral for safety planning.
3. Conduct child abuse investigations on families following domestic violence homicides. Always offer services in cases where a child has lost a parent to domestic violence or has witnessed serious abuse.

School districts should develop and adopt policies and training designed to aid children who live in homes where domestic violence is occurring, while at the same time support and strengthen the relationship between the child and the non-abusing parent.

There were very few recommendations for improved collaboration. Some of the best examples highlight the efforts that need to be made by agencies to enhance different aspects related to the coordination of procedures and the delivery of services. The following provide examples of the recommendations for the coordination of procedures and the delivery of services.

Maryland, 2008

Department of Social Services Child Protective Services should be notified by law enforcement of all fatalities whose families include minor children. The child protective worker should provide linkages to community resources and referrals to resources outside of Frederick, if the child has relocated.

Kansas, 2011

The Kansas Coalition Against Sexual and Domestic Violence should work with the Kansas Association of School Boards to develop educational campaigns about domestic violence which should be implemented across the state beginning with pre-school children

With regard to entities to which the recommendations were directed, DVFR teams most frequently targeted 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 directed their recommendations to other types of agencies and organizations, including the medical community, substance abuse agencies, churches, local businesses, community-based organizations, and civic groups.

SECTION 3. ACHIEVEMENTS

This section discusses selected achievements identified in the available State child death review, fetal infant mortality review, and domestic violence fatality review team reports. A majority of fatality review teams report on their intermediate outcomes or achievements that show how they have influenced practice and policy aimed at reducing fatalities. The specific activities that have been implemented are intended to improve knowledge, practice, and policy with the goal of preventing future deaths. Overall, the fatality team reports were primarily focused on the successes in:

- improving collaboration
- increasing public awareness
- addressing the needs of high-risk populations
- enhancing organizational capacity and improving service delivery

This section discusses these areas of accomplishments by types of fatality review team. However, all three types of fatality review teams did not, have accomplishments in all areas that were included in their reports. In fact, many reports did not discuss the accomplishments of the teams. A majority of the reports did not directly link their accomplishments to specific recommendations. The accomplishments were, however, advanced by the work of the fatality review teams. Examples are also provided to illustrate how different types of activities translate what has been learned by the fatality reviews into action.

3.1 ACHIEVEMENTS NOTED IN CDR TEAM REPORTS

The CDR reports provided many examples of activities and accomplishments. These activities and accomplishments were viewed as being intermediary steps to preventing child abuse and neglect fatalities.

Improving Collaboration

CDR teams recognize that working with other groups and agencies and that collaboration among agencies themselves is critical to advancing the goals of fatality review teams. Many agencies were identified as ongoing partners. These partners included departments of health, behavioral health, child welfare, highway safety, medical examiner offices, local law enforcement, the office of the mayor and other local government officials, childcare providers, family support centers, schools, local libraries, universities, and hospitals. When CDR teams work with other groups or agencies, the result is often the establishment of new groups or task forces that focus on addressing a specific issue. These groups formalize the collaborative activities that may have been evolving. Below are a few examples of partnerships that were reported.

> Florida, 2011
> The Florida's Children and Youth Cabinet established a Child Death Data Review Workgroup as an ad hoc committee. Members from the State Committee have been included to assist in improving communication and collaboration across agencies regarding the investigation of child deaths and to recommend ways to improve the response to the investigation of deaths.

Pennsylvania, 2011

Local Teams have developed or joined community-based Suicide Prevention Task Forces. Local Teams continue to develop subcommittees that review deaths resulting from the completion of suicide as part of their CDR Team. Select coroners are developing a death scene investigation tool for suspected/confirmed suicides. Local County Teams in Lackawanna, Luzerne, and Schuylkill participate in DPW Garrett Lee Smith Suicide Prevention Grant Task Force activities.

Ohio, 2011

The Ohio Collaborative to Prevent Infant Mortality was formed in 2010 as a permanent organization dedicated to implementation of the task force's recommendations. Membership consists of government agencies including Ohio Department of Health (ODH), advocacy groups, medical and public health providers, and a wide variety of other organizations and individuals committed to eliminating infant mortality and disparities. The collaborative operates through five workgroups: Coordinated Healthcare, Disparities/Racism, Data/Metrics/ Quality Improvement, Education/Outreach, and Public Policy, and is guided by an executive/steering committee. For more information on the collaborative, visit the Web site at http://www.odh.ohio.gov/odhPrograms/cfhs/OCTPIM/infantmortality.aspx

Increasing Public Awareness

Many of the CDR teams discussed accomplishments in increased public awareness. The development of brochures or handouts, often bilingual, distributed at a large number of locations was a common strategy used for disseminating information to the community or targeted populations. Information was also distributed through a variety of venues including newspaper articles, billboards, and movies. In Maryland, a statewide website and county specific websites have been created.

Maryland, 2010

The Department of Health developed a website (www.aahealthybabies.org) with a 'taking care of baby' online module to promote safe sleep and avoidance of shaken baby syndrome. Since July 2010, there have been over 5,400 hits to the Healthy Babies web pages. In September/October2010, a Safe Sleep Media Campaign ran for two months in the Maryland Gazette and Pennysaver.

The Baltimore for Healthy Babies website has been created. The website address is www.healthybabiesbaltimore.com. The website addresses issues that affect pregnancy outcomes such as safe sleep, prenatal care, etc. A database is under development that maps out all providers in the City who could potentially benefit from safe sleep training. BCHD is working on developing targets based on the total number of providers at each agency.

Some reports described integrating multiple messages about different safety issues in public awareness campaigns. For example, Arizona is addressing both safe sleeping information and motor vehicle safety together.

> Arizona, 2010
> Two of Arizona's Safe Kids Coalitions (Coconino County and Maricopa County) have included safe sleep information as part of their child passenger safety education materials distributed to families at all car seat safety check-up events.

Addressing the Needs of High Risk Populations

Many CDR teams focus on issues related to infants and very young children recognizing that these children are particularly vulnerable to many forms of preventable deaths. Activities related to safe sleeping, SIDS, and abusive head trauma prevention often were mentioned as areas of achievement in which progress was made in response to team recommendations. Some review teams themselves implemented prevention activities, while others recognized implementation of their recommendations by external entities. The majority of such activities were designed to raise awareness of strategies that can be used to reduce known risk factors. Some examples are provided below.

> Nevada, 2007-2008
> Starting in SFY 2007, the Executive Committee funded the printing of bilingual brochures intended to educate parents of newborn infants and young children about safe sleeping environments. These were distributed to 30 hospitals statewide for inclusion in new birth packets and/or distribution through labor and delivery units. From SFY 2008 through the present, the Executive Committee continues brochure distribution by fulfilling refill requests for participating hospitals. Also during SFY 2009, distribution was expanded to child welfare agencies and foster parents, as well as Family Resource Centers, Family-to-Family programs, and Women, Infants, and Children (WIC) Offices statewide. The safe sleeping brochure is also available through partner websites including www.canpreventnv.org.
>
> Maryland, 2010
> Hyperthermia Initiative, 'Just One Minute is Just Too Long,' to remind parents/caretakers of the dangers of leaving children in cars for 'only one minute' in hot weather and to highlight different methods to use to remember a child in a vehicle. Posters were distributed to CFR team membership agencies, Howard County Government offices, LCB childcare providers, local MCO providers, senior centers, and the county library system for public display to promote community awareness. Funding secured from the LCB.

New York, 2010

Implemented the Take Good Care of Your Baby public service campaign in collaboration with the Department of Health and Mental Hygiene (DOHMH) to educate all New York City parents about how to prevent injuries and deaths among babies and young children. Information on shaken baby syndrome, the importance of carefully choosing a caregiver, and getting help for drug and alcohol abuse have appeared citywide in subways, buses, and billboards, and featured in radio ads.

Some teams also identified the implementation or expansion of programs that distribute cribs, sleeping sacks, and car seats as accomplishments. The implementation of a number of tools that encourage standardization in practice for high-risk populations was also discussed. Some of the reports specifically discussed the efforts to develop community supports to adopt the Centers for Disease Control's (CDC) Sudden Unexpected Infant Death Investigation form. Other teams identified the use of suicide prevention checklists and water safety checklists. Many of the accomplishments discussed were about providing early access to education, services, and supports to vulnerable population including teen mothers and parents with substance abuse issues. Below are two examples of the activities that have been conducted.

New Hampshire, 2009

Educate teenagers regarding keeping children in childcare situations safe, and how to recognize and report child abuse. Information about child abuse is routinely shared with schools. The Department of Education offers guidance to teachers via a protocol available on the Department of Education's website: http://www.ed.state.nh.us/education/doe/ChildAbuseandReportingProtocol.htm. School nurses work with pregnant and parenting teens on a case-by-case basis and offer extensive support as needed that would include anticipatory guidance about childcare arrangements.

Michigan, 2007-2008

High numbers of cases reviewed were unplanned pregnancies. Personnel encouraged prenatal care providers to discuss family planning through the creation of Prenatal Care Core Concepts and provided referral information for providers in the web based and hard copy 'Pregnancy Resource Guide' (www.healthykent.org and hard copy). In addition, FIMR personnel presented a poster presentation at the City Match annual conference in September 2008. The title of the poster is Neighborhood Outreach to Engage African American Women in Family Planning Services.

Enhancing Organizational Capacity and Improving Service Delivery

Many of the achievements related to enhancing organizational capacity and improved service delivery were activities for improving data collection and use of data, increased funding, and advocating for and obtaining changes in policies or legislation. A number of CDR teams discussed creating new data sets and sharing data to inform program development and efforts for

increased organizational capacity. The achievements in the use of data, however, go beyond the use of data by the review teams and include the use of data by multiple agencies and organizations in their efforts to better identify risk factors and improve practice.

New York, 2010
ACS uses data to inform goals of reducing incidents of repeat abuse of children, strengthening investigative procedures, increasing quality supervision, and improving recruitment and retention of caseworkers.

Florida, 2011
The MEC Annual Reports and Standards of Excellence Advisory Committee proposed changes to the Annual Workload Report that is prepared by each of Florida's ME districts. The proposed changes will expand the classification of SIDS from simply SIDS to include infant suffocation deaths resulting from unsafe sleeping environments and bed sharing. These changes were adopted at the November 17, 2011, meeting of the MEC and supported by the State Committee and will facilitate the collection of data.

A few CDR team reports noted improved funding to implement programs, increase public awareness activities, and provide outreach and education. The examples below also illustrate how grants and funding facilitate collaboration among organizations and agencies and also help to improve service delivery.

Maryland, 2010
Baltimore County State's Attorney's Office has secured funds for the development of Infant Sleep Safety Resources for new parents at target birth hospitals in Baltimore County. Baltimore County Department of Health provided outreach, education and in-service training to the major providers of substance abuse treatment and mental health services regarding infant sleep safety. This training will be used by the Service Providers to educate their pregnant and parenting clients. Written infant sleep safety materials were also provided to support the training.

Maryland, 2010
With funding from the Suicide Prevention Program (SPP) Grant that Worcester County Health Department was awarded in FY 2011, improvements to identification of youth at risk, support, coordination of services, outreach, and educational activities have been initiated. A full report is available upon request.

Several reports acknowledged the efforts to change policies at the State or agency level in accord with CDR recommendations. Representative examples are provided below.

Ohio, 2011

Among Ohioans of all ages, prescription drug abuse has become an epidemic. According to the ODH Office of Vital Statistics, since 2007, unintentional drug poisoning has been the leading cause of injury death for adults in Ohio, surpassing motor vehicle crashes and suicides. In an effort to curb prescription drug abuse and diversion in Ohio, House Bill 93 was passed unanimously in the Ohio legislature and signed into law by Governor John Kasich in May 2011. This bill provides the state medical, pharmacy boards, and law enforcement agencies with additional tools to shut down pill mills, and investigate and prosecute those providers that are illegally and unethically prescribing and dispensing medication. The bill is not intended to restrict access or impose a barrier for patients who suffer from chronic or intractable pain and need pain medication. The Ohio Department of Alcohol and Drug Addiction Services, the Ohio Attorney General's Office and ODH are actively engaged in addressing this problem through funding community coalitions, promoting public awareness campaigns, implementing drug disposal events, funding prevention programs in schools, colleges and work sites, and revising and expanding criminal justice and treatment programs to respond appropriately to increasing needs related to prescription drug abuse. Although the law focuses on the problem among Ohio adults, the outcomes will benefit the health and safety of children who must depend on adults. Additional information and resources about this topic and details on program activities are available on the ODH Violence and Injury Prevention Program Drug Poisoning Web site at: http://www.healthyohioprogram.org/vipp/pdaag/pdaag.aspx.

Pennsylvania, 2011

In 2010, Governor Rendell signed into law Act 73 (HB47), which mandates that all birthing hospitals and midwives provide information on safe sleep practice to reduce the risk of sudden infant deaths. Pennsylvania implemented a statewide SIDS program aimed at decreasing the incidence of SIDS and increasing awareness of safe sleep practices. Local communities have implemented community 'Cribs for Kid' programs that follow the recommendation for safe sleep practices. Twenty-three community groups received funds from the PA Department of Health to implement safe sleep initiatives.

3.2 ACHIEVEMENTS NOTED IN FIMR REVIEW TEAM REPORTS

The FIMR process is a community-based, two-tiered process that includes a case review team (CRT) and a community action team (CAT). The CRT makes findings and recommendations which are presented to the CAT. The CAT is responsible for getting the interventions implemented in a manner designed to address the problems identified by the CRT. Following is a description of the types of activities that were promoted and implemented by FIMR teams.

Increasing Collaboration

Enhanced collaboration was identified as an important accomplishment of FIMR teams. Some reports discussed working with other agencies to ensure that agency staff in hospitals, clinics, and doctors' offices, disseminate the message of "back to sleep." For example, in Milwaukee, Wisconsin, one hospital displayed a safe sleeping environment in each birthing unit and also

added questions about safe sleeping to the admissions process. An example of a comprehensive collaborative approach was one devised by Cincinnati, Ohio, where a joint committee to address safe sleeping was created.

> Cincinnati, OH 2010
> In the fall of 2010, a joint committee was formed to address the problem of safe sleep from multiple fronts. The Infant Vitality Initiative of the Cincinnati Police Department invited members of the Cincinnati Health Department, the Hamilton County Health Department, and the Cincinnati Fire Department to joint efforts after a number of police officers recognized their role in identifying unsafe sleeping arrangements among infants in homes the police frequented on other matters.

Improving Public Awareness

One of the underlying common themes of FIMR team reports was publicizing safe sleeping practices. Almost all reports discussed providing additional information to the community on safe sleeping ranging from printed materials in the form of handouts, posters or articles, to radio segments, call-in numbers, and videos.

Addressing the Needs of High-Risk Populations

Many of the reports mentioned conducting prevention efforts focused on specific populations including American Indian, African-American, and Hispanic women. In addition, some reports mentioned a specific standard of information that would be disseminated, namely the American Academy of Pediatrics guidelines on SIDS reduction, safe sleep, and safe sleep environments.[iv]

The FIMR team reports also addressed many other issues related to healthy babies, including breast feeding, preconception nutrition and planning, car safety seats, water safety, and referral to services. While the majority of accomplishments also were related to networking and public awareness (e.g., developing easy-to-understand materials for new mothers or holding events for families), some teams worked with specific agencies to improve organizational capacity under specific conditions, such as disasters.

> Louisiana, 2009
> The coordinator and nurse abstractor conducted educational sessions for the DSS Independent Living Program regarding preparation for parenthood and worked with the American Red Cross Louisiana Chapters Health Committees on care for pregnant women and mothers during disasters.

Some examples indicated working with special high-risk populations such as smokers, substance abusers, and others. These examples are listed below.

Broward County, FL 2008
The Florida Association of Healthy Start Coalitions (FAHSC), under the leadership of the Northeast Florida Healthy Start Coalition, has begun implementation of a three-year statewide consumer education campaign with funding from the March of Dimes Florida Chapter. The campaign, Healthy Babies are Worth the Wait, highlights the importance of the last weeks of pregnancy and the contribution of this period to healthy fetal development and reduced morbidity. The overall goal is to reduce elective deliveries prior to 39 weeks gestation.

Enhancing Organizational Capacity and Improving Service Delivery
FIMR team reports discussed activities that are improving or increasing service delivery and organizational capacity, as illustrated in the examples below.

Milwaukee, WI 2005-2008
Implemented an automated single patient record across the continuum.

Solano, CA 2005-2009
Hold quarterly meetings with Medi-Cal eligibility to trouble shoot barriers OB providers and case management programs are experiencing with their clients regarding their Medi-Cal. Processing times for Medi-Cal applications for pregnant women have been significantly reduced.

Kent, MI 2010
Incorporated a Drug Exposed Infant Group (DEI) into Healthy Kent 2010's I-Team.

Several reports also discussed the use or development of improved data for multiple purposes. These activities most often engaged multiple agencies in cooperative activities to develop new sources of data or to share the use of extant data.

Milwaukee, WI 2005-2008
Collaborated on or evaluated more than 20 research projects and programs including multiple academic publications aimed at examining and addressing factors contributing to infant mortality.

In collaboration with the CDC's PRAMS surveillance system of mothers who recently gave birth, over 1,000 mothers have been surveyed through mailed questionnaires and by telephone, to collect information about their experiences before, during, and after their most recent pregnancy. Mothers are contacted when their babies are about 2-3 months old.

San Francisco, CA 2008
Cooperated with Bay Area Managed Care at Home (MCAH) programs to conduct a regional analysis of most recent linked birth-death cohort files, using large numbers of cases with more complete data to explore relationships suggested by local data, and to suggest epidemiologic patterns, which may be considered in local review processes.

Racine, WI 2007
The state Medicaid HMOs are establishing a system identification process of women who have had previous high risk pregnancies and who are currently pregnant and in the MediCaid system to allow for early referral when there have been multiple fetal/infant deaths.

The following are some examples of activities and achievements associated with improved funding as reported in the selected FIMR team reports.

Missouri, 2007
Offer additional training to health care providers on the Five A's technique, made available through a one-year grant awarded to the St. Louis FIMR program from the March of Dimes in January 2007.

Cincinnati, OH 2010
TriHealth and Cincinnati Children's Hospital Medical Center jointly fund an initiative that works across four communities to develop programs to reduce the prematurity rate; the communities include Price Hill, Over the Rhine/Downtown, The Villages of Roll Hill (formerly known as Fay Apartments), and Butler County.

Humboldt, CA 2008
A number of team members met during 2007 and 2008 to discuss infant/child water safety and design a brochure. The completed brochure is funded by the Child Health and Disability Prevention Program, and is available in English and Spanish. The brochure has been distributed to hospitals, home visiting programs, medical providers, and family resource centers.

Some of the accomplishments were related to formalizing policy at the organizational level or at the State level. For example, Kent County, Michigan (2010), reported working on introducing a bill to the State legislature on a woman's right to breastfeed and also developing a breast feeding policy as part of company health promotion programs.

3.3 ACHIEVEMENTS NOTED IN DVFR REPORTS

Twenty-three DVFR team reports were reviewed. The discussion below provides a snapshot of some of the ways in which DVFR team recommendations have influenced or changed system response, the provision of services, and strategies for protecting victims of domestic violence.

Increasing Collaboration

Some DVFR team reports discussed how agencies and community organizations work together to ensure that agency staff in hospitals, clinics, doctors' offices, schools, and churches provide

consistent messages and relevant information on domestic violence. For example, the New Hampshire Police Standards and Training and the Attorney General's Office are working on developing Web-based and DVD trainings on issues relating to domestic and sexual violence and stalking, which will be distributed statewide.

> Georgia, 2010
> Rev. Steven Saul, Vice-Chair of the Task Force Executive Board, began incorporating the topic of domestic violence into his sermons. Rev. Saul has also held a forum on Domestic Violence: Best Practices for Clergy. Rev. Saul appeared in the local paper, educating the community about the intersection of faith and domestic violence. He appeared on the county cable TV channel discussing this topic and getting the word out to clergy and victims.

Some reports discussed collaboration among county agencies and offices on developing and deploying domestic violence and substance abuse training programs that focus on the relationship between domestic violence fatality and methamphetamine use. Counselors who work with court-ordered substance abuse treatment programs, law enforcement officers, as well as other agency and public staff receive such training. Another example of a comprehensive collaborative approach is illustrated in the example below.

> Oklahoma, 2009
> The OCADVSA incorporated Battered Immigrant Women training into the OCADVSA CDSVRP training curriculum; sponsored three members of the Battered Immigrant Women Summit team to attend a national training summit; and provided workshops on working with immigrant victims at the OCADVSA Annual Conference.

Two additional examples illustrate innovative and collaborative approaches among community partners in providing domestic violence awareness, information, and direct services within the local community.

> New York, 2010
> OCDV partnered with the Mayor's Office of Adult Education and the City University of New York to create a video that addresses domestic violence for the 'We Are New York' educational series. The 'We Are New York' series is designed to help immigrants learn to speak English and simultaneously learn about vital City services that they can access, including domestic violence services.
>
> San Diego, CA 2007
> Supervisor Pam Slater-Price and District Attorney Bonnie Dumanis introduced an initiative in October 2007, which received unanimous support for the implementation of Cut it Out (CIO) through the County of San Diego. CIO is a nonprofit national domestic violence awareness program that teaches beauty salon professionals and cosmetology students how to recognize the warning signs of domestic violence and safely refer clients through literature to national and San Diego area assistance resources. To date, the beauty schools have distributed over 200 CIO referral cards and have connected.

Improving Public Awareness

Many of the DVFR team reports discussed outreach efforts by the teams and by others in terms of awareness, education and prevention, as well as disseminating contact information for direct help (e.g., clinics, hotlines, community organizations, and resources). These networking and public awareness activities were achieved through participating in presentations, organizing or participating in community service events, staffing informational booths/tables, creating or distributing printed materials, developing posters or articles, conducting radio segments, establishing call or hotline numbers, and developing instructional and informational videos. The examples below illustrate the types of networking activities to increase public awareness that were included in the DVFR team reports.

San Diego, CA 2008

Not To Be Forgotten Rally was established to commemorate the lives of domestic violence victims who were murdered by intimate partners. Members of the DVFRT participate in the rally and provide domestic violence fatalities information.

Kansas, 2011

The FRB has recommended that public awareness initiatives be increased. The FRB collaborated with the Kansas Coalition Against Sexual and Domestic Violence (KCSDV) to implement the public awareness campaign, 'Believe It. Help Change It.' The campaign has consisted of video and radio PSAs, billboards, newspaper ads, online ads, and establishing a website, www.HelpChangeKansas.com. Many of the ads and billboards were displayed across Kansas and had a tremendous impact on drawing attention to the domestic violence issue

New York 2010

In 2010, OCDV developed and launched the Right to a Healthy Relationship public education campaign in the Bronx to inform residents that domestic violence includes physical, emotional, sexual, and financial abuse.

One of the underlying and common themes in the DVFR team reports was publicizing the occurrence of domestic violence and its effects on a child's development even when the child is not a direct target of the abuse. Special presentations, in depth discussions, and increased information dissemination have taken place around this critical issue. In San Diego, CA, domestic violence posters and resource pamphlets addressing this issue were distributed to 44 health clinics and 35 schools. The posters included a countywide (bilingual and 24 hour) domestic violence hotline number and addressed the impact that exposure to domestic violence has on children. In addition, posters that included the adult protective services hotline number and addressed elder abuse were also distributed to the 44 health clinics.

Addressing the Needs of High-Risk Populations

In addition to the effects of domestic violence on infants and children, many of the reports discussed other specific target populations such as teens, immigrants, and elders. Examples of these targeted populations are provided below.

Hillsborough, FL 2007-2009

Recognized that over half of the victims and their perpetrators in reviewed cases were immigrants. Members of the Domestic Violence Fatality Review Team presented the findings at the annual Latino Coalition conference, and also provided training about domestic violence issues.

San Diego, CA 2008

The DVFRT has developed a collaborative relationship with the San Diego Elder Death Review Team (EDRT). The DVFRT and EDRT conducted joint reviews for four cases of intimate partner-related fatalities that involved elders in February and October 2007. Furthermore, the DVFRT Coordinator now participates on the EDRT and many members of the EDRT are on the DVFRT.

Delaware, 2007

Coordinated a Statewide training for Domestic Violence Hotline Workers on Teen Dating Violence. A teen centered social marketing campaign was developed in collaboration with students of Milford High School Communications Technology Department. The students used their research to design informational posters and brochures for distribution during February, Teen Dating Violence Awareness and Prevention Month. Their materials were used to create toolkits for 33 high school wellness centers and their poster design appeared on 30 DART bus taillight ads throughout the month of February.

Enhancing Organizational Capacity and Improving Service Delivery

The DVFR team reports discussed the development or refinement of processes that improve service delivery. For example, in Kansas, the Office of Victim Services (OVS) is working to develop and implement an imminent threat screening process in all offender release plans. This process will screen for serious safety issues to automatically trigger involvement of the OVS for victims who currently are not working with OVS. Other examples included creating a specialized Warrant Squad that is dedicated to serving domestic violence arrest warrants with the goal of increasing the number of served warrants. One such program in Baltimore City, Maryland, reported a 29 percent increase in the number of warrants served between 2008 and 2009.

Minneapolis City, MN 2008

The Minneapolis City Attorney's Office (MCAO) and Police Department launched a pilot project to improve the City's response to domestic violence cases. The pilot proved successful and was expanded citywide as the new Minneapolis misdemeanor domestic violence investigation protocol. The implementation of the protocol has enabled the MCAO's conviction rate for domestic violence cases to rise from 54% to 72% since its implementation.

New Jersey, 2009

The Prosecutor's Office, along with SAFE, created a one of a kind countywide response protocol for domestic violence intervention. This policy integrates police intervention coupled with crises intervention advocacy to provide the highest level of services to domestic violence victims. The Prosecutor's Office provides coordinated training for law enforcement and domestic violence counselors and integrates the services of the county medical center to provide comprehensive service for the victims.

Baltimore, MD 2008

The BCPD centralized the domestic violence (DV) detectives pursuant to a pilot project in the Northeast District. The new Family Crimes Unit (FCU) was housed in the Clarence Mitchell Jr. Courthouse, close to the State's Attorney's Office's Felony Family Violence Division (FFVD). This pilot was so successful that the project was expanded in October 2008 to include the entire city. While it is early for statistical comparisons, the differences between case outcomes before and after the creation of FCU are striking. As of October 1, 2009, 67 'first responder' cases have been investigated and charged by FCU. Thirty-six (36) of these cases are still pending. From the 31 cases, which have been resolved, FFVD has been able to obtain sentences that total in excess of 72 years of incarceration, and 99 years and 9 months of suspended time.

Seeing the need for more accurate data on domestic violence fatalities, San Diego, California, developed a DVFR database for tracking intimate partner-related fatalities and storing case review data. This will increase the data tracked and analyzed and will facilitate reporting of case review data and team findings in San Diego and the local area. This is an example of improved organizational capacity. Other examples discussed in the DVFR team reports include staff training, the development of committees and work groups, streamlining procedures and data collection, and one report of establishing a dedicated domestic violence court that hears all adult domestic violence related criminal cases occurring in Minneapolis.

DVFR team reports addressed how funding has been obtained for domestic violence focused programs and activities. For example, grants were awarded to schools and other community agencies for the development and dissemination of informational and awareness materials, as well as media campaigns. The Violence Against Women Recovery Act funding is being used to develop pilot projects, dedicate staff to domestic violence work, implement training curriculum, and create partnerships.

New Hampshire, 2011

The Attorney General's Office received a US Department of Justice VAWA grant, which created the New Hampshire Partnership for the Protection of Older Adults, under the leadership of the Attorney General.

DVFR team reports also discussed how they supported policy and legislative changes by drafting legislation, lobbying the State legislature to pass domestic violence and victim's rights laws, and assist in the revision of policies and procedures to help ensure the safety of victims when perpetrators are released from custody.

Minnesota, 2011

Through legislative lobbying efforts of the MCAO, the Minnesota State Legislature passed a law that doubled the amount of time police have to arrest defendants who flee the scene of misdemeanor domestic violence cases from 12 to 24 hours.

SECTION 4. SUMMARY AND CONCLUSIONS

There is great variation among the reports produced by fatality review teams. This review of recently released reports found that many reports did not include recommendations or that the recommendations were not entirely clear in the reports. Many reports categorized recommendations by the cause of the fatality (e.g., CAN, SIDS, drowning). Fewer teams categorized the information by the agency or organizations targeted to implement the recommendations. Many team reports did not include a discussion of their achievements in effecting practice and policy changes though recommendations and most did not link the achievements to specific recommendations. Most of the recommendations made by the fatality review teams were for:

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

All teams acknowledged that collaboration among many agencies and providers was necessary to effectively implement most recommendations. There were few recommendations for increased funding to facilitate collaboration among agencies despite that fact that it is well documented that lack of time and resources are often barriers to interagency collaboration. There was no mention in the reports reviewed of how the different fatality review teams within a State may collaborate to enhance injury prevention despite the fact that both CDR and FIMR teams made many recommendations for preventing SIDS-related deaths. It is also notable that none of the DVFR team reports addressed child deaths given that some have estimated that as many as 70 percent of homes where child abuse or neglect has occurred involve domestic violence, and 40 percent of cases result in critical injury or death of a child.[v]

Identifying the specific individuals and agencies and organizations that can make the needed changes leading to the prevention of child deaths is an important component of writing effective recommendations.[vi] All three types of fatality review teams identified child welfare agencies as one of the top four types of agencies for implementing the recommendations. The medical community was identified in the top four agencies by two of the three types of fatality review teams. Many of the identified agencies did not fall within the nine specified categories of agencies and organizations that should be responsible for implementing the recommendations. Many teams made global statements indicating that parents should make specific changes in their behavior or communities should provide particular supports or services.

Implementation of strategies to promote public awareness and education was the primary type of achievement reported by the CDR, FIMR, and DVFR review teams. The types of strategies for public awareness and education included the development of brochures, websites, videos for distribution in movie theatres and hospitals, conducting radio segments, participating in community service events, and establishing hotline or call in numbers for information. Each type of review team also identified achievements in implementing strategies that were focused on high risk populations. These included infants and young children, teen mothers, teenagers, parents with substance abuse issues, and minority women. Another common theme of accomplishments is the development, tracking, and sharing of data to inform program

development and efforts to improve organizational capacity. Efforts to collaborate among varied organizations and agencies were often discussed in terms of getting specific types of recommendations implemented, particularly public awareness and education efforts and advocating for new policies or legislation.

Making recommendations for change in social and agency programs and policies is only one objective of most fatality teams. Achieving a broader consensus of knowledge and critical community action is another. While it is unclear how many deaths can be prevented through these activities, it can be argued that community responsiveness in terms of social equity and appropriateness can be influenced by fatality review teams. It appears that each type of fatality team is making contributions in the areas of recommendations and achievements. Notably, however, collaboration among teams is not highly evident in the reports reviewed.

Tracking whether the recommendations are being heard and acted on can be important information for fatality review teams. It has been suggested that it is important that teams assess their processes and strategies to ensure that their work continues to be relevant for prevention advocacy.[vii] It is also important that teams continue to assess their intermediate outcomes or achievements, which can inform the appropriate strategies for impacting the number of children who die from preventable injuries or actions.[viii] However, it cannot be concluded solely from the review of these reports whether fatality review teams are conducting assessments of their processes and outcomes.

BIBLIOGRAPHY

Alabama
Alabama Department of Public Health. (2007). *Alabama child death review system annual report.* Retrieved from http://www.childdeathreview.org/reports/AL_CDR2007.pdf

Alabama Department of Public Health. (2009). *Fetal and infant mortality review 2009 annual report.*

Alaska
Alaska Division of Public Health. (2011). *Alaska maternal-infant mortality review and child death review annual report: 2011.* Retrieved from http://www.epi.hss.state.ak.us/mchepi/default.stm

Arizona
Arizona Coalition against Domestic Violence. (2010). *Arizona domestic violence fatality report 2010.*

Arizona Department of Health Services. (2011). *Arizona child fatality review team eighteenth annual report.* Retrieved from http://www.childdeathreview.org/spotlightAZ.htm

California
County of Humboldt, Fetal-Infant Mortality Review & Child Death Review Team. (2010). *Fetal-infant mortality review & child death review team recommendations report: 2007-2008.* Retrieved from http://www.childdeathreview.org/spotlightCA.htm

County of Sacramento. (2008). *Fetal infant mortality review team 2005-2007, program report.*

Colorado
Colorado Child Fatality Prevention System. (2010). *Colorado child fatality prevention system Annual Report 2010.* Retrieved from http://www.childdeathreview.org/spotlightCO.htm

Connecticut
Connecticut Domestic Violence Fatality Review Committee. (2011). *Upon further examination: findings and recommendations from the Connecticut domestic violence fatality review committee*.

Connecticut Office of the Child Advocate. (2011) *An examination of Connecticut child fatalities, a ten year review, January 1, 2001 to January 1, 2011.*

Delaware
Delaware Child Death, Near Death and Stillbirth Commission. (2010). *Delaware preventing child deaths in the first state, child death, near death and stillbirth commission annual report for fiscal year 2010.* Retrieved from http://www.childdeathreview.org/spotlightDE.htm

Delaware Domestic Violence Coordinating Council. (2010). *2010 Annual report and fatal incident review team report.*

District of Columbia
Office of the Chief Medical Examiner. (2007). *District of Columbia child fatality review committee 2007 annual report.*

Florida
Broward County Fetal Infant Mortality Review. (2010). *FIMR.*

Child Abuse Death Review Committee. (2011). *Death review annual report.* Retrieved from http://www.childdeathreview.org/spotlightFL.htm

Florida Department of Law Enforcement. (2007). *Florida domestic violence fatality review team 2007 annual report executive summary.*

Georgia
Georgia Child Fatality Review Panel. (2009). *Georgia child fatality review panel 2009 annual report.* Retrieved from http://www.childdeathreview.org/spotlightGA.htm

Georgia's CAPTA Citizen Review Panel. (2010). *Georgia's CAPTA citizen review panels annual report 2010.*

Georgia Commission on Family Violence & Georgia Coalition against Domestic Violence. (2010). *2010 Georgia domestic violence fatality review annual report.*

Indiana
Indiana Child Fatality Review Team. (2010). [Summary of activities of CFRT for 2009]. Retrieved from http://www.childdeathreview.org/spotlightIN.htm

Iowa
Iowa Domestic Abuse Death Review. (2009). *Iowa domestic abuse death review team biennial report, calendar years 2007-2008.*

Iowa Office of the State Medical Examiner and Iowa Department of Public Health. (2011). *Iowa's child death review team report to the Governor and General Assembly: annual report for years 2008 and 2009.* Retrieved from http://www.childdeathreview.org/spotlightIA.htm

Kansas
Governor's Domestic Violence Fatality Review Board. (2011). *State of Kansas Governor's domestic violence fatality review board 2010 report.*

Kansas Attorney General. (2011). *Kansas cares about kids: 2011 annual report.* Retrieved from http://www.childdeathreview.org/spotlightKS.htm

Kentucky
Department for Public Health. (2010). *Kentucky child fatality review system 2010 annual report.* Retrieved from http://www.childdeathreview.org/spotlightKY.htm

Louisiana
Louisiana Coalition against Domestic Violence. (2010). *The killing must stop: death at the hands of the person you love findings and recommendations of the Louisiana domestic violence fatality review project.*

Louisiana Office of Public Health. (2009). *Louisiana fetal and infant mortality review 2009 annual report.*

Maine
Maine Department of Health and Human Services. (2009). *Report of the State of Maine child death and serious injury review panel: 2007-2008.* Retrieved from http://www.childdeathreview.org/spotlightME.htm

Maine Domestic Abuse Homicide Review Panel. (2010). *"He wants to see me dead:" the 8th report of the Maine domestic abuse homicide review panel January 2010.*

Maryland
Maryland State Child Fatality Review Team. (2009). *2009 Annual legislative report.*

Maryland Network against Domestic Violence. (2009*). Taking a closer look: domestic violence fatality review statewide report 2009.*

Michigan
Kent County Fetal Infant Mortality Review. (2010). *2010 Annual report: nine years of FIMR/Kent County, Michigan.*

Michigan Department of Human Services. (2010). *Michigan citizen review panels 2010 annual report.*

Michigan Department of Human Services. (2011). *Michigan child death state advisory team eighth annual executive report.* Retrieved from http://www.childdeathreview.org/spotlightMI.htm

Muskegon County Public Health. (2010). *Infant mortality reduction 2010 annual report.*

Minnesota
Minnesota Fourth Judicial District Domestic Fatality Review Team. (2010). *A matter of life and death.*

Mississippi
Mississippi State Department of Health. (2010). *Mississippi's children . . . our most precious resource, Mississippi child death review panel annual report.* Retrieved from http://www.childdeathreview.org/spotlightMS.htm

Missouri
Maternal, Child and Family Health Coalition. (2007). *2007 Annual report, St. Louis fetal infant mortality review program.*

Missouri Department of Social Services. (2010). *Preventing child deaths in Missouri, the Missouri child fatality review program annual report for 2010.* Retrieved from http://www.childdeathreview.org/spotlightMO.htm

Montana
Montana Department of Justice. (2011). *Report to the legislature: Montana domestic violence fatality review commission.*

Montana Department of Public Health and Human Services. (2009). *Fetal, infant, and child deaths in Montana, a summary of mortality reviews conducted in 2005 and 2006.* Retrieved from http://www.childdeathreview.org/spotlightMT.htm

Nebraska
Nebraska Department of Health & Human Services. (2011). *Nebraska child death report for 2007 and 2008.* Retrieved from www.dhhs.ne.gov/CDRteam

Nevada
Child Death Review Team in Clark County. (2010). *2009 Annual report of child deaths in Clark County, Nevada.*

New Hampshire
New Hampshire Department of Justice. (2011). *Twelfth report of the child fatality review committee.* Retrieved from http://www.childdeathreview.org/spotlightNH.htm

New Hampshire Governor's Commission on Domestic and Sexual Violence. (2011). *State of New Hampshire Governor's commission on domestic and sexual violence, eighth report of the domestic violence fatality review committee.*

New Jersey
New Jersey Child Fatality & Near Fatality Review Board. (2011). *2010 annual report*. Retrieved from http://www.childdeathreview.org/spotlightNJ.htm

New Jersey Domestic Violence Fatality and Near Fatality Review Board. (2009). *Findings and recommendations of the New Jersey domestic violence fatality & near fatality review board.*

New York
New York City Department of Health and Mental Hygiene. (2011). *2011 Report from the child fatality review team, understanding child injury deaths*. Retrieved from http://www.childdeathreview.org/spotlightNY.htm

New York City Mayor's Office to Combat Domestic Violence. (2010). *New York City domestic violence fatality review committee annual report 2010.*

North Carolina
Mecklenburg Domestic Violence Fatality Prevention and Protection Review Team. (2011). *Interim report of the Mecklenburg County domestic violence fatality prevention and protection review team to the Mecklenburg County commissioners, the North Carolina domestic violence commission, and the Governor's crime commission.*

North Carolina Department of Health and Human Services. (2007). *North Carolina state child fatality review report.* Retrieved from http://www.childdeathreview.org/spotlightNC.htm

Ohio
Ohio Department of Health. (2011). *Ohio child fatality review eleventh annual report.* Retrieved from http://www.childdeathreview.org/spotlightOH.htm

Oklahoma
Oklahoma Office of the Attorney General. (2009). *Domestic violence homicide in Oklahoma: domestic violence fatality review board annual report 2009.*

Rhode Island
Rhode Island Department of Health. (2010). *Rhode Island child death review: sudden infant death and sudden unexpected infant deaths, 2008-2009.* Retrieved from http://www.childdeathreview.org/spotlightRI.htm

South Dakota
Randall, B., Wilson, A., & Regional Infant and Child Mortality Review Committee. (2010). *Regional infant and child mortality review committee: 2009 final report.* Retrieved from http://www.childdeathreview.org/spotlightSD.htm

Tennessee
University of Tennessee College of Social Work. (2011). *Tennessee citizen review panels annual report & recommendations.*

Texas
Tarrant County Public Health. (2009). *Fetal infant mortality review Tarrant County, study findings and recommendations from the Tarrant County FIMR case review team.*

Texas Council on Family Violence. (2010). *Honoring Texas victims, family violence fatalities in 2010.*

Texas Department of Family and Protective Services. (2009). *2009 Citizen review team report.*

Texas Department of State Health Services. (2010). *Texas state child fatality review team annual report 2010.* Retrieved from http://www.childdeathreview.org/spotlightTX.htm

Utah
Utah Department of Health. (2008). *Domestic violence fatalities in Utah 2003-2008.*

Vermont
Vermont Domestic Violence Fatality Review Commission. (2011). *State of Vermont domestic violence fatality review commission report.*

Virginia
Commonwealth of Virginia Citizen Review Panels. (2011). *Child abuse prevention and treatment act report of the citizen review panels, June 2011.*

Washington
Fawcett, J. (2010) for the Washington Coalition against Domestic Violence. (2010). *Up to us: lessons learned and goals for change after thirteen years of the Washington state domestic violence fatality review.*

Wisconsin
City of Milwaukee Health Department. (2010). *2010 City of Milwaukee fetal infant mortality review (FIMR) report: understanding and preventing infant death and stillbirth in Milwaukee, 2005-2008 stillbirths and infant deaths.*

Keeping Kids Alive Wisconsin. (2010). *A window into prevention – 2010.* Retrieved from http://www.childdeathreview.org/Reports/WI_First_Rpt2010.pdf

Wisconsin Coalition against Domestic Violence. (2010). *Domestic violence claimed 58 lives in Wisconsin in 2010 - Wisconsin domestic violence homicide report 2010.*

Wyoming
Child Major Injury and Fatality Review Team. (2008). *Ninth annual report*. Retrieved from http://www.childdeathreview.org/spotlightWV.htm

APPENDIX A. METHODS

The following is a summary of the processes for selecting reports for review, reviewing and analyzing the reports, and the definitions of "recommendations" and "outcomes."

Selection of Reports
An online search was conducted to identify reports issued by CDR, CRP, FIMR, and DVFR teams from all States and the District of Columbia. The websites of the following resource centers were reviewed to identify reports or links to State websites, which may include reports. The resource center websites also provided information on available State websites, where additional reports were found.

- National Center for the Review and Prevention of Child Death (http://childdeathreview.org)
- National Citizens Review Panels Virtual Community (http://www.uky.edu/SocialWork/crp)
- National Fetal-Infant Mortality Review Program (http://www.nfimr.org/)
- National Domestic Violence Fatality Review Initiative (http://www.ndvfri.org/)

For each State and the District of Columbia, the most recent fatality review team reports were collected. Some fatality review teams issue annual reports, while others issue multi-year reports. Local teams issued many of the DVFR and FIMR reports. The majority of the citizen review panel reports did not include reviews of child fatalities as many CDR teams also serve as the citizen review panel for the review of fatalities of children involved with child welfare.

In order to be selected for review, the reports had to include information from reviews within the last five years (2007–2011). Priority was given to State level reports, but reports from selected local jurisdictions were also included. Local reports were reviewed if the jurisdiction was identified as a possible site visit location. Sixty-seven reports were reviewed. Table 1, on the next page, provides a summary of the types of reports by State, reviewed to determine the prevalence and types of recommendations issued by State and local fatality teams and the reported accomplishments of the teams. Additional local reports were reviewed to identify additional achievements.

Table A-1. Review of Reports

STATE	CDR Reports	CRP Reports	FIMR Reports	DVFR Reports
Alabama	■		■	
Alaska	■			
Arizona	■			■
Arkansas				
California	■		■	■
Colorado	■			
Connecticut	■			■
Delaware	■			■
District of Columbia	■			
Florida	■		■	■
Georgia	■	■		■
Hawaii				
Idaho				
Illinois				
Indiana	■			
Iowa	■			■
Kansas	■			■
Kentucky	■			
Louisiana			■	■
Maine	■			■
Maryland	■			■
Massachusetts				
Michigan	■	■	■	
Minnesota				■
Mississippi	■			
Missouri	■		■	
Montana			■	■
Nebraska	■			
Nevada	■			
New Hampshire	■			■
New Jersey	■			■
New Mexico				
New York	■			■
North Carolina				■
North Dakota				
Ohio	■			
Oklahoma				■
Oregon				
Pennsylvania				
Rhode Island	■			
South Carolina				
South Dakota	■			
Tennessee		■		
Texas	■	■	■	■
Utah				■
Vermont				■
Virginia		■		
Washington				■
West Virginia				
Wisconsin	■		■	■
Wyoming	■			
TOTAL	30	5	9	23

Review of Reports

A template was developed and used document the prevalence and types of recommendations made by fatality review teams and the agencies identified to implement the recommendations. The template was also used to document examples of recommendations (see appendix B). It is important to acknowledge that not all recommendations were classified. For each cause of death, the reviewer noted if a recommendation was made in one of the seven categories of recommendations. This approach was adopted since the number of recommendations in the reports varied greatly. Data on the number of recommendations made by the fatality review teams in each category were not collected. This study did not try to capture the total number of recommendations made by fatality review teams. The recommendations were sorted by the following causes of death:

- child abuse and neglect (CAN)
- drowning
- fire/burns/electrocution
- fire arms/weapons
- homicide
- motor vehicle/other means of transportation
- poisoning/overdose/alcohol
- sudden infant death syndrome (SIDS)
- suffocation (asphyxia)
- suicide
- other
- unspecified

Recommendations were classified using the following seven 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

For each cause of death, information regarding the agencies and organizations involved in the implementation of the recommendations was collected. Data were not collected for the total number of times a specific category of agency or organizations was identified. Agencies/organizations were classified using 10 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

An analysis of all the recommendations and the agencies identified for implementing the recommendations was conducted for each type of fatality review team report. A sub sample of recommendations and agencies was selected for discussion in this report. For each cause of death, there had to be a pattern of similar types of recommendations and agencies in order to be discussed in this report. This approach ensures that common themes could be discussed further. Given that there were so few recommendations in the CRP reports, the data regarding recommendations for these reports were combined with the data from the CDR reports for purposes of analysis.

A review of State and local reports was conducted to identify accomplishments. Accomplishments were then extracted and coded using the primary categories for which accomplishments were reported. These categories included:

- collaboration
- increased public awareness
- addressing the needs of high risk populations
- enhanced organizational capacity and improved service delivery

APPENDIX B. TABLE OF REPORTS REVIEWED BY STATE

STATE	CDR Reports	CRP Reports	FIMR Reports	DVFR Reports
Alabama	Publication: 2010 Years covered: 2003-2007		Publication: 2009 Years covered: 2009	
Alaska	Publication: 2011 Years covered: 1992-2007			
Arizona	Publication: 2011 Years covered: 2010			Publication: 2010 Years covered: 2010
Arkansas				
California	Publication: 2010 Years covered: 2007-2008		Publication: 2008 (Sacramento County Only) Years covered: 2005-2007	Publication: 2010 Years covered: 2010 (Sacramento County)
Colorado	Publication: 2010 Years covered: 2010			
Connecticut	Publication: 2011 Years covered: 2001-2011			Publication: 2011 Years: 2000-2009
Delaware	Publication: 2011 Years covered: 2010			Publication: 2010 Years covered: 2009
District of Columbia	Publication: 2008 Years covered: 2007			
Florida	Publication: 2011 Years covered: 2010		Publication: 2010 Years covered: 2010	Publication: 2007 Years covered: 2007
Georgia	Publication: 2010 Years covered: 2009	Publication: 2010 Years covered: 2009		Publication: 2010 Years covered: 2010
Hawaii				
Idaho				
Illinois				
Indiana	Publication: 2010 Years covered: 2007-2009			
Iowa	Publication: 2008 Years covered: 2007			Publication: 2009 Years covered: 2007-2008
Kansas	Publication: 2011 Years covered: 2009			Publication: 2011 Years covered: 2010
Kentucky	Publication: 2010 Years covered: 2008			

STATE	CDR Reports	CRP Reports	FIMR Reports	DVFR Reports
Louisiana			Publication: 2009 Years covered: 2009	Publication: 2010 Years covered: 1997-2009
Maine	Publication: 2009 Years covered: 2007-2008			Publication: 2010 Years covered: 2006-2008
Maryland	Publication: 2009 Years covered: 2004-2008			Publication: 2009 Years covered: 2003-2009; 2008-2009
Massachusetts				
Michigan	Publication: 2009 Years covered: 2007-2008	Publication: 2010 Years covered: 2010	2 local reports: Muskegon (Pub 2010, cvrs 2006-2008 Kent County Pub 2010, Cvrs 2001-2009)	
Minnesota				Publication: 2010 Years covered:1996-2008
Mississippi	Publication: 2010 Years covered: 2009			
Missouri	Publication: 2010 Years covered: 2010		Publication: 2007 Years covered: 2004-2007	
Montana			Publication: 2009 Years covered: 2005-2006	Publication: 2011 Years covered: 2000-2010
Nebraska	Publication: 2011 Years covered: 2007-2008			
Nevada	Publication: 2010 Years covered: 2009			
New Hampshire	Publication: 2011 Years covered: 2003-2008			Publication: 2011 Years covered: 2009-2010
New Jersey	Publication: 2011 Years covered: 2010			Publication: 2009 Years covered: 2003-2007
New Mexico				
New York	Publication: 2011 Years covered: 2001-2009			Publication: 2010 Years covered: 2002-2009
North Carolina				Publication: 2011 Years covered: 2011
North Dakota				

STATE	CDR Reports	CRP Reports	FIMR Reports	DVFR Reports
Ohio	Publication: 2011 Years covered: 2009			
Oklahoma				Publication: 2009 Years covered: 2009
Oregon				
Pennsylvania				
Rhode Island	Publication: 2010 Years covered: 2008-2009			
South Carolina				
South Dakota	Publication: 2010 Years covered: 2009			
Tennessee		Publication: 2011 Years covered: 2011		
Texas	Publication: 2010 Years covered: 2010	Publication: 2009 Years covered: 2008-2008	Publication: 2009 Years covered: 2008	Publication: 2010 Years covered: 2010
Utah				Publication: 2008 Years covered: 2003-2008
Vermont				Publication: 2011 Years covered: 2010
Virginia		Publication: 2011 Years covered: July 2010-June 2011		
Washington				Publication: 2010 Years covered: 2006-2008
West Virginia				
Wisconsin	Publication: 2010 Years covered: 2007-2008		Publication: 2010 Years covered: 2005-2008	Publication: 2010 Years covered: 2010
Wyoming	Publication: 2008 Years covered: 2007			

APPENDIX C. REVIEW TEMPLATE

Recommendation and Agency Categories by Cause of Death
State
County *(identify names of counties reviewed, if applicable)*
Type of Report
Year of Publication
Years Covered (*if provided*)

Cause or Manner of Death	Recommendations (select one or more per cause or manner of death)							Agencies and Organizations Involved (select one or more per cause or manner of death)									
	Improved Collaboration	Increased Funding	Strengthened Organizational Capacity	Improved Policies/ Legislation	Increased Public Awareness/ Education	Improved Service Delivery	Other	Child Welfare Agency/ Providers	Education	Domestic Violence Providers	Law Enforcement/Justice	Medical Examiner/Coroner's Office	Medical Community	Mental Health	Public Health Agency/ Providers	Substance Abuse	Other
CAN																	
Drowning																	
Fire/Burns/Electrocution																	
Fire Arms/ Weapons																	
Homicide																	
Motor Vehicle/ Other Means of Transportation																	
Poisoning/Overdose/Alcohol																	
SIDS																	
Suffocation (asphyxia)																	
Suicide																	
Other																	
Unspecified																	
Examples of Collaboration Strategies for Best Practices Discussion:																	
Examples of Other Recommendations for Best Practices Discussion:																	

APPENDIX D. SUPPORTING TABLES

The following tables are provided:

- Table D-1. CDR CAN Recommendations by State
- Table D-2. Agencies/Organizations Identified by CDR teams for CAN by State
- Table D-3. CDR SIDS Recommendations by State
- Table D-4. Agencies/Organizations Identified by CDR teams for SIDS by State
- Table D-5. CDR Motor Vehicle/Other Means of Transportation Recommendations by State
- Table D-6. CDR Drowning Recommendations by State
- Table D-7. FIMR SIDS Recommendations by State
- Table D-8. DVFR Homicide Recommendations by State
- Table D-9. Agencies/Organizations Identified by DVFR for Homicide by State

Table D-1. CDR CAN Recommendations by State

STATE	CAN Recommendations						
	Improved Collaboration	Increased Funding	Strengthened Organizational Capacity	Improved Policies/ Legislation	Increased Public Awareness/ Education	Improved Service Delivery	Other
Alabama							
Alaska							
Arizona		■	■				
Arkansas							
California	■			■		■	
Colorado		■				■	
Connecticut							
Delaware			■	■	■	■	
District of Columbia	■		■	■			
Florida		■	■	■	■	■	
Georgia	■			■	■		
Hawaii							
Idaho							
Illinois							
Indiana	■	■	■		■	■	
Iowa			■				
Kansas							
Kentucky	■	■	■	■	■	■	
Louisiana							
Maine	■		■	■		■	
Maryland		■			■		■
Massachusetts							
Michigan	■		■	■			■
Minnesota							
Mississippi				■	■	■	■
Missouri		■	■	■	■	■	
Montana							
Nebraska	■		■	■		■	
Nevada			■		■		
New Hampshire			■		■	■	
New Jersey			■				
New Mexico							
New York			■	■			
North Carolina							
North Dakota							
Ohio							
Oklahoma							
Oregon							
Pennsylvania							
Puerto Rico							
Rhode Island							
South Carolina							
South Dakota							
Tennessee			■	■			
Texas	■	■	■	■	■		
Utah							
Vermont							
Virginia			■	■			
Washington							
West Virginia							
Wisconsin			■	■	■	■	
Wyoming	■		■				
TOTAL	10	8	20	16	12	12	3

Table D-2. Agencies/Organizations Identified by CDR teams for CAN by State

STATE	CAN									
	Agencies/Organizations Involved									
	Child Welfare Agency/ Providers	Education	Domestic Violence Providers	Law Enforcement/Justice	Medical Examiner/Coroner's Office	Medical Community	Mental Health	Public Health Agency/ Providers	Substance Abuse	Other
Alabama										
Alaska										
Arizona	■			■						■
Arkansas										
California	■			■		■		■		
Colorado										
Connecticut										
Delaware	■			■		■				■
District of Columbia	■					■		■	■	
Florida	■	■		■		■		■		■
Georgia										
Hawaii										
Idaho										
Illinois										
Indiana	■			■	■	■		■		■
Iowa	■	■								
Kansas										
Kentucky	■							■		■
Louisiana										
Maine	■			■		■				
Maryland								■		■
Massachusetts										
Michigan	■	■		■		■		■		■
Minnesota										
Mississippi										
Missouri										■
Montana										
Nebraska	■			■				■		■
Nevada										
New Hampshire	■					■				■
New Jersey	■						■			
New Mexico										
New York						■				■
North Carolina										
North Dakota										
Ohio										
Oklahoma										
Oregon										
Pennsylvania										
Puerto Rico										
Rhode Island										
South Carolina										
South Dakota										
Tennessee	■	■								
Texas	■						■	■		■
Utah										
Vermont										
Virginia	■		■	■						
Washington										
West Virginia										
Wisconsin						■				■
Wyoming	■			■		■	■	■		■
TOTAL	17	4	1	1	1	11	3	1	1	14

Table D-3. CDR SIDS Recommendations by State

STATE	SIDS Recommendations						
	Improved Collaboration	Increased Funding	Strengthened Organizational Capacity	Improved Policies/ Legislation	Increased Public Awareness/ Education	Improved Service Delivery	Other
Alabama			■		■		
Alaska			■		■		
Arizona					■		
Arkansas							
California					■		
Colorado							
Connecticut					■		
Delaware				■	■		
District of Columbia							
Florida	■	■	■	■	■	■	
Georgia		■	■	■	■		
Hawaii							
Idaho							
Illinois							
Indiana			■		■	■	
Iowa					■		
Kansas	■				■		
Kentucky	■		■		■		
Louisiana							
Maine	■				■		
Maryland					■		
Massachusetts							
Michigan	■		■	■	■		
Minnesota							
Mississippi		■	■	■	■		
Missouri			■		■	■	■
Montana							
Nebraska				■			
Nevada					■		
New Hampshire							
New Jersey	■		■		■		■
New Mexico							
New York				■	■		■
North Carolina							
North Dakota							
Ohio							
Oklahoma							
Oregon							
Pennsylvania							
Puerto Rico							
Rhode Island					■		
South Carolina							
South Dakota							
Tennessee							
Texas							
Utah							
Vermont							
Virginia							
Washington							
West Virginia							
Wisconsin			■		■		■
Wyoming							
TOTAL	6	3	11	7	22	3	4

Table D-4. Agencies/Organizations Identified by CDR teams for SIDS by State

STATE	SIDS									
	Agencies/Organizations Involved									
	Child Welfare Agency/ Providers	Education	Domestic Violence Providers	Law Enforcement/Justice	Medical Examiner/Coroner's Office	Medical Community	Mental Health	Public Health Agency/ Providers	Substance Abuse	Other
Alabama										
Alaska										
Arizona						■				■
Arkansas										
California	■							■		■
Colorado										
Connecticut						■				
Delaware										
District of Columbia										
Florida	■			■	■					■
Georgia						■				■
Hawaii										
Idaho										
Illinois										
Indiana										■
Iowa						■				■
Kansas								■		■
Kentucky						■		■		■
Louisiana										
Maine								■		■
Maryland										
Massachusetts										
Michigan	■	■		■	■			■		
Minnesota										
Mississippi					■					
Missouri				■	■	■				■
Montana										
Nebraska	■									
Nevada										
New Hampshire										
New Jersey	■					■		■		■
New Mexico										
New York						■				■
North Carolina										
North Dakota										
Ohio										
Oklahoma										
Oregon										
Pennsylvania										
Puerto Rico										
Rhode Island						■				
South Carolina										
South Dakota										■
Tennessee										
Texas										
Utah										
Vermont										
Virginia										
Washington										
West Virginia										
Wisconsin								■		■
Wyoming										
TOTAL	5	1	0	3	4	9	0	7	0	14

Table D-5. CDR Motor Vehicle/Other Means of Transportation Recommendations by State

STATE	Motor Vehicle/Other Means of Transportation						
	Recommendations						
	Improved Collaboration	Increased Funding	Strengthened Organizational Capacity	Improved Policies/ Legislation	Increased Public Awareness/ Education	Improved Service Delivery	Other
Alabama		■		■	■		
Alaska							
Arizona				■			
Arkansas							
California							
Colorado				■			
Connecticut							
Delaware				■	■		
District of Columbia							
Florida			■	■	■		
Georgia				■			
Hawaii							
Idaho							
Illinois							
Indiana						■	
Iowa			■				
Kansas			■	■		■	
Kentucky			■		■		
Louisiana							
Maine							
Maryland	■		■		■		
Massachusetts							
Michigan	■		■	■			
Minnesota							
Mississippi				■	■		■
Missouri				■	■		
Montana							
Nebraska	■			■	■		
Nevada				■	■		
New Hampshire			■	■	■		
New Jersey							
New Mexico							
New York				■			■
North Carolina							
North Dakota							
Ohio							
Oklahoma							
Oregon							
Pennsylvania							
Puerto Rico							
Rhode Island							
South Carolina							
South Dakota							
Tennessee							
Texas				■	■		
Utah							
Vermont							
Virginia							
Washington							
West Virginia							
Wisconsin				■	■		■
Wyoming							
TOTAL	3	1	7	16	12	2	3

Table D-6. CDR Drowning Recommendations by State

STATE	DROWNING						
	Recommendations						
	Improved Collaboration	Increased Funding	Strengthened Organizational Capacity	Improved Policies/ Legislation	Increased Public Awareness/ Education	Improved Service Delivery	Other
Alabama				■	■		
Alaska							
Arizona					■		
Arkansas							
California							
Colorado							
Connecticut					■		
Delaware				■	■		
District of Columbia							
Florida	■			■	■	■	
Georgia							
Hawaii							
Idaho							
Illinois							
Indiana			■	■	■	■	
Iowa							
Kansas	■				■		■
Kentucky				■	■		
Louisiana							
Maine							
Maryland							
Massachusetts							
Michigan							
Minnesota							
Mississippi					■		
Missouri			■	■	■	■	
Montana							
Nebraska				■	■		
Nevada				■	■		
New Hampshire				■	■		
New Jersey							
New Mexico							
New York							
North Carolina							
North Dakota							
Ohio							
Oklahoma							
Oregon							
Pennsylvania							
Puerto Rico							
Rhode Island							
South Carolina							
South Dakota							
Tennessee							
Texas				■			
Utah							
Vermont							
Virginia							
Washington							
West Virginia							
Wisconsin			■	■	■	■	
Wyoming							
TOTAL	2	0	3	11	14	4	1

Table D-7. FIMR SIDS Recommendations by State

STATE	SIDS Recommendations						
	Improved Collaboration	Increased Funding	Strengthened Organizational Capacity	Improved Policies/ Legislation	Increased Public Awareness/ Education	Improved Service Delivery	Other
Alabama							
Alaska							
Arizona							
Arkansas							
California					■		
Colorado							
Connecticut							
Delaware							
District of Columbia							
Florida			■			■	
Georgia							
Hawaii							
Idaho							
Illinois							
Indiana							
Iowa							
Kansas							
Kentucky							
Louisiana			■		■		
Maine							
Maryland							
Massachusetts							
Michigan							
Minnesota							
Mississippi							
Missouri	■		■		■		
Montana							
Nebraska							
Nevada							
New Hampshire							
New Jersey							
New Mexico							
New York							
North Carolina							
North Dakota							
Ohio							
Oklahoma							
Oregon							
Pennsylvania							
Puerto Rico							
Rhode Island							
South Carolina							
South Dakota							
Tennessee							
Texas							
Utah							
Vermont							
Virginia							
Washington							
West Virginia							
Wisconsin							
Wyoming							
TOTAL	1	0	3	0	3	1	0

Table D-8. DVFR Homicide Recommendations by State

STATE	Homicide						
	Recommendations						
	Improved Collaboration	Increased Funding	Strengthened Organizational Capacity	Improved Policies/ Legislation	Increased Public Awareness/ Education	Improved Service Delivery	Other
Alabama							
Alaska							
Arizona	■	■	■	■	■		
Arkansas							
California	■		■				
Colorado							
Connecticut	■		■	■	■	■	
Delaware							
District of Columbia							
Florida							
Georgia	■		■		■		
Hawaii							
Idaho							
Illinois							
Indiana							
Iowa	■	■	■	■	■	■	
Kansas	■			■	■		
Kentucky							
Louisiana	■		■	■	■	■	
Maine			■	■	■	■	
Maryland	■		■	■	■	■	
Massachusetts							
Michigan							
Minnesota	■		■		■		
Mississippi							
Missouri							
Montana			■		■	■	
Nebraska							
Nevada							
New Hampshire			■	■	■	■	
New Jersey	■		■	■	■	■	
New Mexico							
New York						■	
North Carolina			■		■	■	
North Dakota							
Ohio							
Oklahoma		■	■	■	■	■	
Oregon							
Pennsylvania							
Puerto Rico							
Rhode Island							
South Carolina							
South Dakota							
Tennessee							
Texas							
Utah	■		■	■	■	■	■
Vermont							
Virginia							
Washington							
West Virginia							
Wisconsin							
Wyoming							
TOTAL	11	3	15	11	15	12	1

Table D-9. Agencies/Organizations Identified by DVFR for Homicide by State

STATE	Homicide									
	Agencies Involved									
	Child Welfare Agency/ Providers	Education	Domestic Violence Providers	Law Enforcement/Justice	Medical Examiner/Coroner's Office	Medical Community	Mental Health	Public Health Agency/ Providers	Substance Abuse	Other
Alabama										
Alaska										
Arizona	■		■	■						
Arkansas										
California				■		■	■			■
Colorado										
Connecticut	■		■	■						
Delaware										
District of Columbia										
Florida										
Georgia			■							
Hawaii										
Idaho										
Illinois										
Indiana										
Iowa	■	■	■	■				■	■	
Kansas	■	■	■	■						
Kentucky										
Louisiana		■	■	■						
Maine							■	■		
Maryland			■	■				■		
Massachusetts										
Michigan										
Minnesota	■	■	■	■			■			■
Mississippi										
Missouri										
Montana		■		■						■
Nebraska										
Nevada										
New Hampshire				■						■
New Jersey			■	■			■	■	■	
New Mexico										
New York										
North Carolina	■		■	■				■		■
North Dakota										
Ohio										
Oklahoma		■	■	■		■	■	■	■	
Oregon										
Pennsylvania										
Puerto Rico										
Rhode Island										
South Carolina										
South Dakota										
Tennessee										
Texas										
Utah	■		■	■		■		■		■
Vermont										
Virginia										
Washington										
West Virginia										
Wisconsin										
Wyoming										
TOTAL	7	6	12	14	0	3	5	7	3	6

ENDNOTES

[i] Wirtz, S. J., Foster, V., & Lenart, G. A. (2011). Assessing and improving child death review team recommendations. *Injury Prevention, 17,* 64-70; Covington, T., Foster, V. & Rich, S. (Eds.). (2005). A program manual for child death review. Okemos (MI): The National Center for Child Death Review; Alexander, R. (2007). Child death review team recommendations. *Child Fatality Review: An Interdisciplinary Guide and Photographic Reference* (pp. 719-739). St. Louis, MO: G.W. Medical Publishing.

[ii] Alexander, S. P. (2007). Preventing future deaths through effective prevention recommendations and actions. *Child Fatality Review: An Interdisciplinary Guide and Photographic Reference* (pp. 693-707). St. Louis, MO: G.W. Medical Publishing, Inc.

[iii] *U.S. Preventive Services Task Force Grade Definitions. May 2008.* Retrieved March 30, 2012 from http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm

[iv] American Academy of Pediatrics, Task Force on Sudden Infant Death Syndrome.(2011). SIDS and other sleep-related infant deaths; Expansion of recommendations for a safe sleeping environment. Pediatrics, originally published online October 17, 2011, DOI: 10.1542/peds.2011-2284.

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

[vi] Wirtz, S. J., Foster, V., & Lenart, G. A. (2011). Assessing and improving child death review team recommendations. *Injury Prevention, 17,* 64-70.

[vii] Alexander, S. P. (2007). Preventing future deaths through effective prevention recommendations and actions. *Child Fatality Review: An Interdisciplinary Guide and Photographic Reference* (pp. 693-707). St. Louis, MO: G.W. Medical Publishing, Inc.

[viii] Coffman, J. (2007). What's different about evaluating advocacy and policy change? *The Evaluation Exchange,* Vol. XIII, No. 1, 1-33.