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

Developing Best Practices for Fatality Reviews
Part One: A Tool for Planning and Self-Assessment

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SECTION 1. INTRODUCTION

This self-assessment tool provides questions that are designed to guide fatality review teams through a discussion to assist them in:

- assessing how well their processes are working
- identifying where and how fatality review processes could be improved
- enhancing collaborative approaches to achieving greater impact in their communities

Tips for Using the Self-Assessment Tool
Following are three tips for using the self-assessment tool:

1. **Involve Stakeholders—**The tool will be most useful when completed and shared with all the members of the fatality review team. It may also be beneficial to include representatives of other fatality review teams or stakeholder agencies.

2. **Prioritize Areas for Self-Assessment—**The tool can be used to assess one or more areas. A team should choose which areas are most relevant to its needs and priorities. Use of this tool might be most efficient and effective when planning the next year's activities.

3. **Divide Responsibility for the Self-Assessment—**A team may decide to divide up the work to conduct a specific area of self-assessment. If this is done, it will be important for the information to be shared with other team members.

Action Planning
At the end of this tool is a template for developing an action plan for each of the team's priorities, including next steps, responsible persons, and the timeline for action.

SECTION 2. GOVERNANCE AND STRUCTURE

Governance and structure refer to the mandates that guide the work of the fatality team and the organization of the team.

1. What is the source of authority for the team's work? How specific is this authority? What are the key responsibilities that are specified? Is there any pending policy or legislation that may influence the role or impact of the team?

2. Does the team have a responsibility for reporting to a government agency or legislative body? If yes, has this been productive or is it considered a burden? How could reporting be made more effective?

3. Does the team have a specific mandate to coordinate with any other review teams or agencies? If so, how has this mandate been implemented? If not, with which teams would it be beneficial to have formal agreements?

4. Does the team have a written mission and purpose statement? How often is this revisited?

5. Do the goals of the team include identifying child fatalities that may have not have been classified as child maltreatment fatalities by the coroner or medical examiner's office, the police, or other entities involved with child fatalities?

6. Is the team part of a public government agency or a non-profit group? Is the team funded by a public agency or is it dependent upon raising funds from grants and other entities?

7. Is the annual funding sufficient? If not, what are the plans to increase funding?

SECTION 3. TEAM MEMBERSHIP AND TRAINING

The strength of a team depends upon its membership. While some members may have extensive experience with child fatalities, others may need orientation, training, and additional support.

1. Are there any gaps in membership (disciplines, areas of expertise, or stakeholders that are not represented on the team, but should be)? Are these gaps recent or long standing? What steps are being taken to fill these gaps?

2. Does the local or state child welfare agency participate in the reviews? What is its role?

3. Does the team include representatives from other jurisdictions, such as tribal governments or military installations?

4. Is there any training or orientation that new team members are provided to ensure the objectives and process for the reviews is clearly understood? If so, what does that training entail and how often is it provided? Are there continuing education and/or training efforts for longer-term members?

5. Does the team build the capacity of its members in conducting case reviews and developing recommendations? If so, how?

6. Does the team address issues of burnout and the secondary trauma that may be experienced by team members? If so, how?

7. Do the team members have term limits?

8. Do team members participate on other types of fatality review teams? If yes, is there any informal or formal information sharing between teams that have common members?

9. Is there a team leader? What is the job of the team facilitator or leader? How was this position filled?

10. What types of resources and support does the team have? What types of resources and support might be useful?

11. Does the team include specific types of professionals from the community? If yes, what types of professions are involved?

12. Are families included in the team? If not, why?

13. Are any of the meetings held as open public meetings? Are there instances in which people who are not members of the team are invited to a meeting? If yes, under what circumstances?

SECTION 4. CASE INFORMATION AND DATA

A central function for most review teams is to learn from the tragedies that have resulted in deaths or near fatalities of children. In some jurisdictions all deaths are reviewed; in others only selected deaths are reviewed. No matter which deaths are reviewed, there is a need for extensive information and data to complete a comprehensive review.

1. What types of cases does the team review? Are cases grouped by type of death or other characteristic when the team reviews them? Are cases grouped according to when they happened in the calendar year (e.g., all fatalities from the last 3 months)? Has the team experimented with different approaches of case selection?

2. How many fatalities does the team review each year? What proportion of fatalities does this represent?

3. What is the review process? What does it entail and how is it run? Are all members provided with written or oral information? Are they provided this information in advance or at the meeting? Do they have adequate time to prepare their thoughts?

4. Are steps taken to remind reviewers of the objectives of each review to help promote continuity of focus and purpose? If yes, how?

5. Is the information de-identified? If not, how are the data maintained securely?

6. Are the purpose and goals of the case reviews clear?

7. Are sufficient data and information available to meet the goals of the review? Are there common areas of information that would be useful, but is often missing? If yes, what are those gaps or deficiencies? How might the team close this gap?

8. Are there information sharing policies and procedures in place in order to obtain necessary information? Is there a time limit to these agreements?

9. Does the fatality team use automated data or maintain data in an automated format?

10. Does the team have access to data analysts who can conduct more sophisticated analyses of the data? If so, to what extent?

11. Does the team compare its fatality data to data from other similar jurisdictions?

12. Does the team compare its fatality data to national data?

13. How are the team's definitions of types of fatalities similar or different from the definitions used by members of the team, other fatality review teams, and by the community? That is, is there a consistent approach to determining the cause of the fatality (e.g., child maltreatment, SIDS, domestic violence, motor vehicle)?

SECTION 5. TYPES OF RECOMMENDATIONS

Following the reviews of a death or the analysis of many deaths, the major task of a review team is to develop recommendations for improving agency systems and implementing prevention strategies. The results of the knowledge that is gained through fatality reviews are often shared through meetings of concerned professionals and other citizens, reports, and testimony, all of which commonly contain recommendations the review body has formed as the result of those reviews.

1. Does the team have an objective to make recommendations about specific topics or issues?

2. How does the team select the specific topics for recommendations?

3. Does the team assess the impact of earlier recommendations before choosing to make new ones?

4. Does the team have a standard approach for gathering the data and information in order to determine if recommendations will be useful?

5. What criteria are applied in deciding the areas to examine?

6. Are there processes in place to determine the audience for the recommendations? What are they? Does the team discuss how to tailor recommendations to effectively reach specific audiences/ recipients?

7. Does the team identify the agencies or organizations that are expected to implement the recommendations and work with them early on in the process?

8. Does the team approach these agencies and organizations to get their input and buy-in or before drafting or issuing a recommendation? If yes, at what stage in the process, and how?

9. Has the team designed a process or identified steps for obtaining agency buy-in for implementing team recommendations?

10. Does the fatality review team expect to work on implementing the recommendations which are made?

SECTION 6. DEVELOPING RECOMMENDATIONS

Once a team decides to develop recommendations, there are many considerations in developing useful recommendations.

1. How does the team determine the amount of time that will be dedicated to developing recommendations? Is this time sufficient?

2. Does the team routinely assess prior recommendations in order to improve the quality of the recommendations or to determine which recommendations are important enough to continue to issue and advocate for their implementation?

3. What is the range of expertise needed to develop strong recommendations? How does the team obtain the appropriate expertise?

4. Does the team review recommendations from other fatality review teams to strengthen their own and identify overlapping or related recommendations?

5. Has the team developed joint recommendations with another type of review team? Would it be useful to implement a process for developing joint recommendations?

6. Has the team established criteria for drafting strong recommendations? Do the recommendations clearly identify the intended audience and include concrete steps that are measurable?

7. Does the team have a framework for developing multifaceted approaches to injury prevention such as the Spectrum of Prevention(Wirtz, Foster, & Lenart, 2011) that includes:

    - strengthening individual knowledge and skills
    - promoting community education
    - educating providers/others
    - changing organizational practices
    - fostering coalitions and networks
    - mobilizing neighborhoods and communities
    - influencing policy and legislation?

8. In developing the recommendations, does the team:

    - formulate the justification for each recommendation
    - include a discussion of the resources that would be needed to implement the prevention strategies identified
    - provide a link between the number of deaths and the recommendation itself
    - clearly specify the intervention focus, that is, the recipient of the intended prevention strategy?

9. In developing the recommendations does the team develop both a short, succinct form of each recommendation and a longer more detailed form that identifies the steps required for implementing the recommendation?

10. Does the team estimate the resources or funds that will be needed to implement each recommendation?

11. Does the team make any estimates as to the potential impact of a recommendation?

12. In developing recommendations, does the team include a problem description that references local, State, and national data, and the relevant risk and protective factors?

13. Does the team make recommendations that demonstrate knowledge of evidence based or promising practices for addressing the issue?

SECTION 7. PRESENTING AND DISSEMINATING RECOMMENDATIONS

Once a recommendation is drafted, there are several steps to ensure that it is shared with other stakeholders.

1. Does the team create a dissemination plan for recommendations? If yes, what does it typically entail and are certain recommendations prioritized or given more attention than others?

2. What format(s) does the team use to disseminate the recommendations? Does the team assess the effectiveness of the format(s) chosen?

3. Does the team identify and develop partners for disseminating recommendations?

4. Does the team try to build support for and/or share ownership of the ideas that are disseminated?

5. Does the team establish follow-up steps to the recommendations?

6. Is the impact of the implementation of the recommendation measured?

7. Does the team let the public know about the successful recommendations?

SECTION 8. COOPERATION, COORDINATION, AND COLLABORATION

Fatality teams do not work in isolation. There is a wide range of activities that can be undertaken by the different agencies represented on the team and among the different fatality review teams. Cooperation represents a basic level of working together, while coordination and collaboration entail more joint work and shared objectives.

1. What other reviews are occurring in the community/State?

2. Which other groups are the most important partners in the work of the team? Does the team need to develop new partners?

3. What are the existing barriers to improving working with the partners? How will the team resolve these barriers?

4. What resources, supports, or leadership is required to make collaboration happen?

5. Does the team have goals to cooperate (work together), coordinate (joint planning and assigning of roles), or to collaborate (sharing resources, decision making, and establishing agreements on how to reach end goals through consensus and compromise) with other groups?

6. What mechanisms are needed to facilitate cooperation, coordination, or collaboration among the different fatality review teams (e.g., MOUs, policies, legislative mandates)?

7. Does the team make efforts to determine its role within the larger political and fiscal context of the community and its leadership?

8. Does the team review recommendations from other fatality review teams to strengthen the team's recommendations and identify overlapping or related recommendations?

9. Has the team built partnerships to help ensure the implementation of the recommendations? What partners does the team need to assist in implementation of recommendations?

ACTION PLANNING			
Priority	**Next Steps**	**Who is Taking the Lead**	**Timeline**