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## Colorado Child Fatality Prevention System (CFPS): Meeting Facilitation Guidance

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# 10 STEPS

## to facilitating a Child Fatality Review

June 5, 2014

Created by Leah Emerick Anderson

Child Fatality Prevention Team Coordinators,

This document is intended to serve as a guide for facilitating Child Fatality Review. Because each local team will develop a unique structure, it is understood that this guidance may not be the best model for all teams. As such, teams are welcome to adapt from this model to accommodate the needs of their individual team.

We appreciate all of the time that you are investing in the Child Fatality Prevention System. I would like to remind you that Technical Assistance is always available to help teams navigate this system.

Thank you,



Leah Emerick Anderson  
Technical Assistance and Child Fatality Prevention Coordinator

For technical assistance, e-mail:  
[support@cfps.freshdesk.com](mailto:support@cfps.freshdesk.com)  
or call: (o) 303.692.2947



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Colorado Department  
of Public Health  
and Environment

# 10 STEPS

## to facilitating a Child Fatality Review

- 1 EXECUTIVE SESSION.**

At the start of each meeting, have new or ad hoc members sign confidentiality agreements before initiating executive session.
- 2 SUMMARIZE.**

Allow team members to read through the case summary as presented by the team Coordinator (when available).
- 3 SHARE.**

Allow any team member who played a direct role in responding to the case to share knowledge of the case.
- 4 ASK.**

Allow team members to ask any questions they may have about the events surrounding the fatality. Use the case records and team members' recollections of the event to address these questions.
- 5 ACTS.**

Discuss Section I., Acts of Omission/Commission, with the team and enter results into the National Center Data Collection Website.
- 6 SERVICES.**

Discuss Section J., Services to Family and Community, with the team and enter results into the National Center Data Collection Website.
- 7 INITIATIVES.**

Discuss Section K., Prevention Initiatives Resulting from the Review, with the team and enter results into the National Center Data Collection Website.
- 8 PREVENTION.**

Discuss Section L., Review Meeting Process, with the team, focusing on questions 6-12. Enter results into the National Center Data Collection Website.
- 9 NARRATE.**

Cut and paste the case summary into Section M., Narrative, in the National Center Data Collection Website. Exclude any identifiers. Add any notes from the review meeting that may be relevant.
- 10 SHRED.**

Collect and shred all case summaries, notes taken during the discussion, and other confidential materials that were handed out during the meeting. Conclude executive session.

# 1

## EXECUTIVE SESSION.

### Confidentiality forms.

Ensure that all team members and participants have signed a confidentiality form prior to starting the meeting.

### Executive session format.

*Start recording session.*

Team coordinator:

“

The next item on the agenda is to discuss child fatality cases in executive session for the purpose of developing child fatality prevention recommendations. The legal authority for closing this portion of the meeting is Colorado Revised Statute §24-6-402(3)(a)(III). The purpose of this executive session is to discuss confidential information pertaining to child fatalities obtained from departments of social services, coroner and medical examiner investigations, and other similar confidential sources. The topics being discussed are confidential in nature and are protected under Colorado Revised Statute §25-20.5-408(3)(c)(II). At this time, a motion would be needed in order to discuss the next topic in the executive session rather than in an open meeting. Is there such a motion? . . .

Team member: so moved.

Team coordinator: any second? . . .

Team member(s): second.

Team coordinator: any discussion on the motion? . . .

Team member(s): *(no response required)*.

Team coordinator: motion carried.

The executive session will be recorded and all members of the governing body are reminded to limit their discussion during the executive session to the announced topic(s). Any collective decision, collective commitment, or other final action by the governing body must occur after it reconvenes in an open meeting, unless final action is specifically required by law to be taken during the executive session. We will now ask the members of the public who are attending the meeting to leave the room. We anticipate adjourning the executive session, and reconvening the open portion of the meeting, at approximately *(state time)*. The minutes will show that the executive session began at *(state time)* and was attended by *(state the names of each attendees)*.

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# 2

## SUMMARIZE.

### Before the meeting.

- ☐ Request case records for review (e.g. law enforcement report, autopsy report, medical records, TRAILS report, etc...).
- ☐ Review case records, abstracting the following data:
  - Death Certificate number
  - Date of death
  - Child's age
  - Manner and Cause of death
  - Case and Circumstance details
- ☐ Write a case summary to include the following information:
  - Manner of death  
(this is determined as accidental, homicide, suicide or undetermined)
  - Cause of death  
(this is the specific reason the child died (e.g. car crash, gunshot, blunt force head injury, etc.))
  - Synopsis of incident/timeline of events surrounding the death
  - Demographics, including county, age, medical history of child and caretaker, if relevant
  - Social history
  - School history, if relevant
  - Investigation information
  - Autopsy information



Include details that you feel would help the team determine prevention strategies. You may write in paragraph or bullet point format, but the reader must be able to quickly understand all important circumstances of the case.

### During the meeting.

Present the case summary to the team, allowing them to read the entire document.

# 3

## SHARE.

### Team Member Accounts.

- ☐ If any team members played a direct role in responding to the case, allow members time to share their knowledge of the event.
- ☐ If any information was unclear in the case records and/or the Coordinator was unable to find answers to questions in the National Center Data Collection Website, use the expertise and knowledge of team members to fill in the gaps.

# 4

## ASK.

### Start the Conversation.

Allow team members to ask any questions they may have about the events surrounding the fatality. Have case records on hand so that you can quickly look up information in response to team members' questions.

The following is a good starter question:

“ What information do you wish you had to help explain the circumstances that led up to the death of this child? ”

# 5

## ACTS.

### Acts of Omission or Commission.

Open Section I. in the National Center Data Collection Website and lead the team through all applicable questions. Completion of this section is especially important because it provides information about any human behaviors that may be involved in a child's death.

Share definition with the Team:

“ Acts of omission or commission are defined as any act or failure to act which causes and/or substantially contributes to the death of a child. ”

Teams may have different standards that apply, but they should be based on evidence and professional judgments. Legal definitions may serve as a baseline, although they need not be used as a strict criteria.

This is not a determination of blame, but rather an identification of whether there were specific human behaviors involved that caused or contributed to the child's death.

# 6

## SERVICES.

### Services to Family and Community.

Open Section J. in the National Center Data Collection Website and lead the team through all applicable questions. Services are any type of supportive resources that the family and community were offered and/or utilized as a direct result of a child's death. In order to accommodate all types of services, the categories listed are general. To note a specific service, select 'Other' and write the service in the 'Specify' text box.

# 7

## INITIATIVES.

### Prevention Initiatives Resulting from the Review.

Open Section K. in the National Center Data Collection Website and lead the team through all applicable questions.

#### K1. Could this death have been prevented?

Please enter the team's conclusions regarding the preventability of the death. A child's death is considered to be preventable if an individual or the community could reasonably have done something that would have changed the circumstances that led to the child's death.

#### K2. What recommendations and/or initiatives resulted from the review?

This section is relevant now that child fatality reviews are being conducted at the local level. Teams have the opportunity to indicate specific prevention strategies that were developed during the review process.

### Edit Local Prevention Initiatives Later...



**Mark this case to edit/add prevention actions at a later date**

Teams have the option to edit/add prevention actions at a later date: Select this option if you would like to complete this section after you have more information. This section may be edited at a future team meeting or by the coordinator at a future date.

To identify these cases when you are ready to edit, use the 'Search for Prevention Updates' under 'Search for Case' on the navigation menu of your state welcome page.



## The Review Meeting Process.

Open Section L. in the data collection website and lead the team through all applicable questions. Please pay special attention to the following questions:

### L7. Review meeting outcomes, check all that apply.

This section allows teams to indicate outcomes of the meeting. Please note that there are options for the team to state that they disagreed with official manner and/or cause of death. Please specify the team's decision regarding the manner and/or cause of death.

The following questions, L8 and L9, will help facilitate the discussion around prevention recommendations.

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### L8. Describe the factor(s) that directly contributed to this death.

This is a subjective question and asks which factors the team feels directly and more immediately contributed to this child's death. Although it is worded in the data collection website as "factors that directly contributed," please list instead ANY RISK FACTORS that may have caused and/or contributed to the death.

### L9. Describe the factor(s) that directly contributed to this death that are modifiable.

This is a subjective question and asks the team what factors listed in L8 are able to be changed. As with L8, please list ANY RISK FACTORS, not only those that directly contributed to the death.

The following question is the heart of this Child Fatality Review Process. These recommendations will be aggregated and used in the State's Annual Legislative Report.

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### L10. List any prevention recommendations to prevent deaths from similar causes in the future.

Collaborate with your team to develop prevention recommendations that are feasible and specific. Recommendations should include changes to practices, policies and procedures, as well as potential improvements to current prevention activities. It may be helpful to think of this as a "wish list" for prevention so that team members don't limit their ideas based on scope or cost. For this field, the sky is the limit!

# 9

## NARRATE.

### The Narrative.

Open Section M. in the National Center Data Collection Website. Often, the circumstances of a death are not entirely evident from the case report tool alone. Providing a description of the incident involving the child is helpful in understanding how a death occurred. Include information on past history involving CPS, law enforcement, public health and other organizations. If you would like to add text to the narrative from another document, such as a case summary, you may copy the text and paste it into the National Center Data Collection Website.

**DO NOT INCLUDE IDENTIFIERS IN THE NARRATIVE.**

# 10

## SHRED.

### Collect & Shred.

Collect and shred all case summaries, notes taken during discussion, and other confidential materials that were handed out during the meeting.

### Conclude Executive Session.

Team Coordinator:

“ The minutes will show that an executive session was adjourned at (*state time*). The public has been invited to return to the meeting room and we are now back in open session. ”



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**Colorado Department  
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