NATIONAL CFRP

Center for Fatality Review & Prevention

Saving Lives Together

Upcoming Events

First all-FIMR Virtual Meetup coming in October!

Join the National Center for the all-FIMR team meet up virtual gathering for FIMR administrators, coordinators, abstractors, interviewers, community action team facilitators, and other key staff. This meeting will replace the five October FIMR regional meetings. Individual regional meetings will resume in January 2022.

WHEN: October 13, 2021, 1:00-5:00 PM EST

***12:30-1:00:** Preconference demonstration of an innovative safe sleep simulator

Sessions topics include:

- Maternal mental health
- Using FIMR to focus on health equity
- Storytelling for social change
- Updates from the National Center
- Interactive, role-specific breakout sessions

Click here to register for all-FIMR Virtual Meetup!

Other important dates

FIMR State Coordinators Call

December 1, 2021, 3:00-4:00 pm EST

Fatality Review Health Equity Learning Collaborative Quarterly Meeting: December 8, 2021, 3:00-4:00 pm EST

For questions regarding either of these opportunities, contact Rosemary Fournier [at rfournie@mphi.org](mailto:rfournie@mphi.org).

The CityMatCH Leadership and MCH Epidemiology Conference is around the corner, December 8-10, 2021. After carefully observing the status of the pandemic across the country and the impact of Hurricane Ida on New Orleans, CityMatCH has determined that this years' conference will be fully virtual. All plenary and breakout sessions, as well as abstract sessions and poster viewing will be available for 90 days post-conference. Registration will open soon at this link: https://www.citymatch.org/conference/registration/.

Field Notes

El Paso County examines decedents' experience of discrimination in death investigations

After the launch of the new *Section I7. Life Stressors* in the NFR-CRS, El Paso County, Colorado's Child Fatality Review Team (CFRT) wanted a concrete way to determine if experiences of discrimination had been present in a deceased child's life. "Sometimes there were questions whether racism had existed in cases we reviewed, and I wanted us to be able to answer that question

accurately, so we incorporated questions regarding all sorts of discrimination into the investigation questionnaire we use to investigate all child deaths," shared Dr. Emily Russell (pictured), the county's Deputy Chief Medical Examiner and co-chair of the CFRT.

As of early 2021, El Paso County's Child Fatality Investigation questionnaire now includes the following question that investigators ask for all child deaths, regardless of cause:

Has discrimination or exclusion based on race, gender, sexual orientation, age, disability or other [cause] impacted the decedent or their community?

"I think my staff do a great job of being both tender and factual," Dr. Russell reflected, acknowledging that these types of questions can be very personal, and are not necessary to determine cause and manner of death—her office's main objective. "It is really above and beyond."

The information from the questionnaires is available to the CFRT in the medical examiner's record. By adding questions to determine if discrimination was present, the team is better able to understand the context in which decedents lived and died, improving CFRT reviews and data quality. With improved data quality, the CFRT is equipped to make more accurate findings and more informed prevention recommendations to improve community safety and wellbeing.

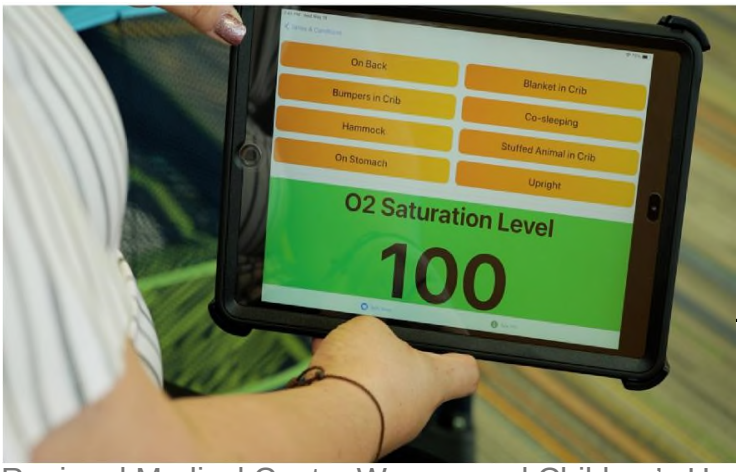
"We were not going to let another year go by saying we don't have any evidence of this happening. There's not going to be debate about whether or not [discrimination] was present," Dr. Russell said, "This is a way to learn more and have better information, to make changes to prevent these deaths." For questions related to *Section I7: Life Stressors,* contact the National Center at info@ncfrp.org.

An innovative approach to infant safe sleep education in Indiana

Specific zip codes in the Allen County, IN area continue to struggle with infant mortality rates that are three times the national average.[1] Suboptimal implementation of safe sleep recommendations contributes to this stagnant number.[2] Data provided to the Allen County, IN FIMR Community Action Team (CAT) noted that unsafe sleep positions were common. Additionally, members of the CAT working in home visitation had noticed that while caregivers were receiving education about back sleeping positions, many didn't appear to be convinced. Telling people what to do is one thing but *showing* them is another.

To address this problem, staff at the Mirro Advanced Medical Simulation Lab with Parkview Health leveraged their knowledge of simulation-based learning and 3D printing to create the Safe Sleep Simulation kit, an innovative solution to the infant sleep-related death problem. Safe Sleep Simulation allows safe sleep educators to deliver education using hands-on, experiential learning in interactive infant sleep scenarios to enhance caregiver understanding of and adherence to safe sleep practices. Safe Sleep Simulation is an education tool kit intended to be used alongside current safe sleep education. **The goal of incorporating this toolkit is to use visual representations and experiential learning to enhance knowledge retention, understanding of why current safe sleep recommendations exist, and ultimately increase adherence to safe sleep practices.**

The Safe Sleep Simulation toolkit includes both a 3D infant model and a mobile application. The 3D infant model allows educators to address the common misconception surrounding infant choking on vomit or spit up in the back to sleep position. The model provides a visual representation of what can happen when an infant spits up while on their back versus what can happen when an infant spits up or vomits while on their belly. Rather than just telling caregivers that back is best, the infant model allows them to see why!



The Safe Sleep Simulation app turns any computer, laptop, tablet, or mobile device into a mock monitor without the need for specialized simulation equipment. The app allows educators to demonstrate potential oxygen saturations in a variety of unsafe sleep positions, engaging caregivers with auditory and visual cues to increase adherence to safe sleep recommendations.

The Mirro Advanced Medical Simulation Lab has partnered with New Tech Academy, the Community Outreach Department at Parkview Regional Medical Center Women and Children's Hospital, Healthier Moms and Babies, to execute the pilot of the program that was funded by the St. Joseph Community Health Foundation. Feedback from our community safe sleep educators, pediatricians, and safe sleep education stakeholders has been instrumental in the continued iterations and refinement of the Safe Sleep Simulation kit.

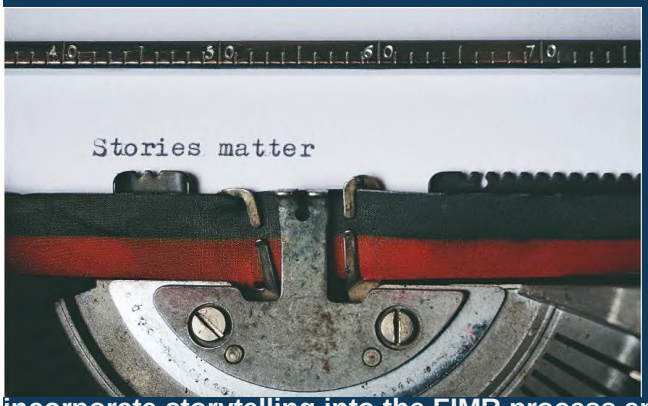
To learn more, visit www.safesleepsimulation.com. For additional information, contact Lisa Clemens at Lisa.Clemens@parkview.com.

1. LeBlanc M. State's infant mortality rate drops in 2019. *The Journal Gazette*. https://journalgazette.net/news/local/20200116/states-infant-mortality-rate-drops-in-2019. Published January 16, 2020. Accessed January 17, 2020.

2. Rubin R. Despite educational campaigns, US infants are still dying due to unsafe sleep conditions. *JAMA*. 2018;319(24):2466-2468. doi:10.1001/jama.2018.6097.

Call for Applications: FIMR Storytelling Collaborative, Cohort 2

The National Center's FIMR program is inviting applications for a second cohort of a dynamic FIMR Storytelling Learning Collaborative. This project seeks to welcome, hear, and elevate the lived experiences of birthing persons, mothers, fathers, and families in new ways for greater impact.



While the parental/family interview is already a critical component of the FIMR process, the FIMR Storytelling Project explores how strategic storytelling can refresh and strengthen current approaches to combining data and community voices to prevent fetal and infant deaths. Stories can help humanize and heal; deepen understanding and motivate action; and catalyze greater impact for systems change.

For the second cohort, the National Center is seeking 4-6 teams that have the appetite and capacity to commit to approximately 15-20 hours of virtual learning between October 2021 and January 2022. Learning teams should have a strong interest in learning about how to incorporate storytelling into the FIMR process and related work in health equity, and they should want to be part of an evolving new national initiative.

All sessions will be facilitated by Magda Peck, PhD (www.magdapeck.com/about), who brings a unique mix of proven public health expertise and experience in maternal and child health, advancing health equity, strategic storytelling, and leadership development. Other guest faculty will be announced.

Please reach out to Rosemary Fournier at rfournie@mphi.org if you have any questions or if you are interested in an applying for this exciting opportunity.

Kudos Corner

Three states dramatically improve data quality

Congratulations to Arkansas, Delaware, and Montana's CDR programs! The National Center's new report, ***Monitoring Data Quality in the National Fatality Review-Case Reporting System: The First Five Years*** *(URL: https://www.ncfrp.org/wp-content/uploads/DataQuality5yearReport.pdf),* found that-- since the National Center's Data Quality Initiative launched in October 2015-- these three programs made the greatest improvements in:

- Reducing the proportion of missing and unknown data elements
- Meeting benchmarks
- Improving timeliness

Arkansas has 11 regional CDR teams covering all 75 of its counties. Delaware has three CDR panels providing fatality review coverage for the whole state; and Montana has 31 Fetal, Infant, Child and Maternal Mortality Review teams serving all 54 counties. State program staff in all three states have diligently supported their teams in records access, data collection, and data entry to improve data quality. The National Center is grateful for their attentive leadership to improve data quality. Great job!

Data Matters

National Center releases five-year report on CDR data quality

The National Center is pleased to release a new report, *Monitoring Data Quality in the National Fatality Review-Case Reporting System: The First Five Years*. In 2015, the National Center began a CDR Data Quality Initiative

(DQI) to help improve the collection and reporting of child death review data. The purpose of the five-year report is to describe the progress made in improving CDR data quality in the NFR-CRS at the conclusion of the first five years of the DQI, comparing 2015 to 2019 and highlighting some success stories.

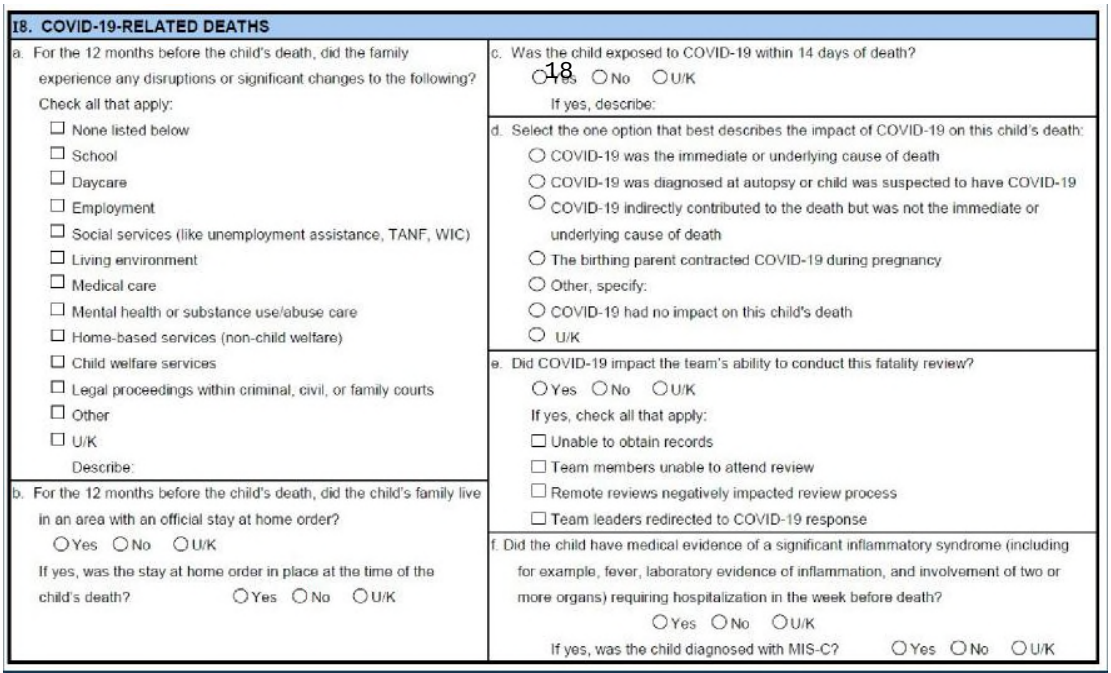
The DQI was comprised of the following components:

- A Data Quality Workgroup to provide overall guidance for the DQI.
- Identification of priority variables in the National Fatality Review-Case Reporting System (NFR-CRS) for monitoring data quality.
- Development of expanded definitions of priority variables in hopes of improving accuracy, completeness, and consistency of data entered for each of the priority variables.
- Development of a Data Quality Summary Report to provide feedback to each state on the priority variables. The first Data Quality Summary Report was issued in September 2016.
- Compilation of best practices for monitoring/improving data quality at the state program level. The Guidance for Improving Child Death Review Data Quality was issued in October 2017.
- Provision of training and technical assistance related to data quality. Numerous webinars have been presented, a Data Quality Training module developed, and technical assistance has been provided in numerous states and delivered in multiple platforms.

Overall, the report demonstrates substantial improvement in data completeness (percent of data reported and not missing or unknown for priority variables) entered in the NFR-CRS. Teams' hard work and attention to detail is making a difference and improving how CDR data can be used at the local, state, and national levels to prevent future deaths! To access the report,

visit: https://www.ncfrp.org/wp-content/uploads/DataQuality5yearReport.pdf. Tolearn more about the DQI, including new efforts to support FIMR NFR-CRS users, visit: https://www.ncfrp.org/data/data-quality-initiative/.

The National Center recommends Section I8 be completed for all deaths occurring after March 1, 2020



I8. COVID-19-RELATED DEATHS

a. For the 12 months before the child's death, did the family experience any disruptions or significant changes to the following? Check all that apply:

- ☐ None listed below
- ☐ School
- ☐ Daycare
- ☐ Employment
- ☐ Social services (like unemployment assistance, TANF, WIC)
- ☐ Living environment
- ☐ Medical care
- ☐ Mental health or substance use/abuse care
- ☐ Home-based services (non-child welfare)
- ☐ Child welfare services
- ☐ Legal proceedings within criminal, civil, or family courts
- ☐ Other
- ☐ U/K

Describe:

b. For the 12 months before the child's death, did the child's family live in an area with an official stay at home order?

○ Yes ○ No ○ U/K

If yes, was the stay at home order in place at the time of the child's death? ○ Yes ○ No ○ U/K

c. Was the child exposed to COVID-19 within 14 days of death?

○ Yes ○ No ○ U/K

If yes, describe:

d. Select the one option that best describes the impact of COVID-19 on this child's death:

- ○ COVID-19 was the immediate or underlying cause of death
- ○ COVID-19 was diagnosed at autopsy or child was suspected to have COVID-19
- ○ COVID-19 indirectly contributed to the death but was not the immediate or underlying cause of death
- ○ The birthing parent contracted COVID-19 during pregnancy
- ○ Other, specify:
- ○ COVID-19 had no impact on this child's death
- ○ U/K

e. Did COVID-19 impact the team's ability to conduct this fatality review?

○ Yes ○ No ○ U/K

If yes, check all that apply:

- ☐ Unable to obtain records
- ☐ Team members unable to attend review
- ☐ Remote reviews negatively impacted review process
- ☐ Team leaders redirected to COVID-19 response

f. Did the child have medical evidence of a significant inflammatory syndrome (including for example, fever, laboratory evidence of inflammation, and involvement of two or more organs) requiring hospitalization in the week before death?

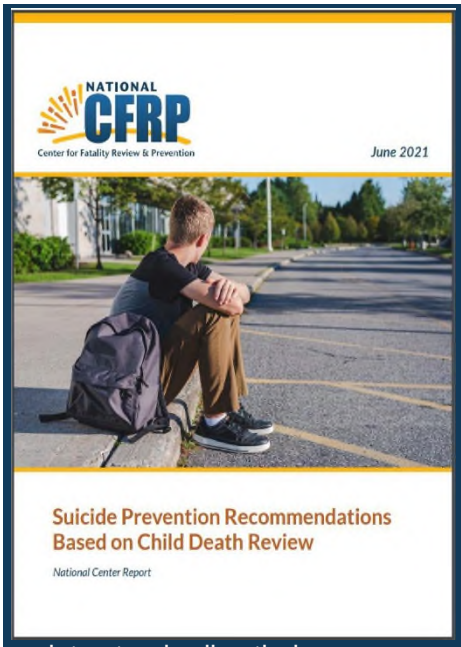
○ Yes ○ No ○ U/K

If yes, was the child diagnosed with MIS-C? ○ Yes ○ No ○ U/K

Section I8, *COVID-Related Deaths*, was added to the National Fatality Review-Case Reporting System (NFR-CRS) earlier this year to capture data about all deaths during the COVID-19 pandemic. The questions seek to identify barriers that were experienced and how systems changed. Revisiting completed cases is a shift in practice. However, given the importance of this information and how fatality review is uniquely situated to identify systems gaps and barriers, we encourage all fatality review teams to revisit deaths occurring after March 1, 2020, and update Section I8 NFR-CRS data.

For support completing this section, refer to the National Center's ***Introduction & Supplemental Guidance for Section I8: COVID-19 Related Deaths***:
https://www.ncfrp.org/wp-content/uploads/Supplemental-Guidance-on-Reviewing-Deaths-During-COVID-19.pdf

Resources for Prevention



For the first time, the National Center released a set of national-level recommendations based on information from fatality review partners across the country. *Suicide Prevention Recommendations Based on Child Death Review* (URL:https://www.ncfrp.org/wp-content/uploads/Suicide_Prevention_Report.pdf) was released in June to support the effort and impact of suicide fatality reviews. It provides and overview of CDR, youth suicide data from the NFR-CRS, and finally shares the following recommendations to support more effective understanding of child and youth suicide:

- Incorporate diversity, equity, and inclusion into all aspects of fatality review
- Comprehensive funding for suicide reviews
- Consistent access to information in records
- Death scene investigation standards for suicide
- Support for professionals participating in CDR

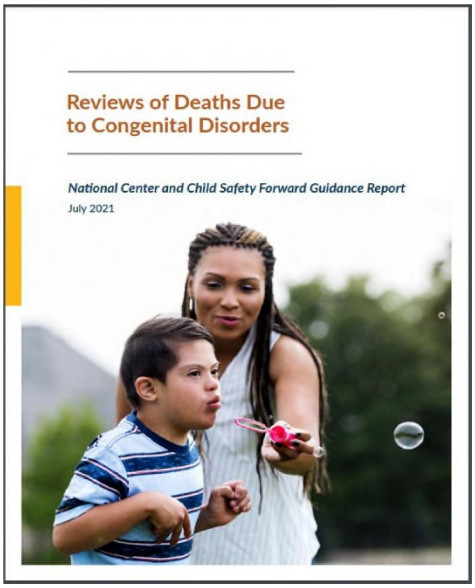
These recommendations may be helpful to local and state CDR teams as they work to standardize their processes, seek funding, or advocate for team member wellbeing.

The National Center releases *Review of Deaths Due to Congenital Disorders*

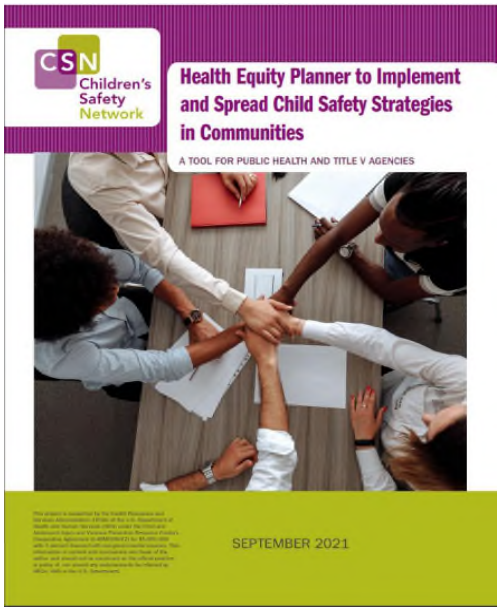
In July, the National Center released a new guidance resource focused on reviewing fatalities due to congenital disorders. Effective review of fetal, infant, and child deaths by fatality review teams can lead to an increased understanding of the causes and contributing factors placing parents and families at risk for the tragedy of a death due to congenital disorders. Case review findings and team recommendations can inform effective prevention efforts and improvements in the community and healthcare systems that serve all families.

The resource includes an overview of common factors contributing to congenital disorders; an overview of common conditions, screening and diagnostic tests; key questions to ask in these types of case reviews, and opportunities for prevention. *Reviews of Death Due to Congenital Disorders* can be found at

https://www.ncfrp.org/wp-content/uploads/Report_Congenital_Disorders_Guidance.pdf .



Children's Safety Network releases Health Equity Planner



Children's Safety Network has released *Health Equity Planner to Implement and Spread Child Safety Strategies in Communities (URL: https://www.childrenssafetynetwork.org/sites/default/files/Health-Equity-Planner-2021.pdf*), a resource for public health and Title V agencies. The Health Equity Planner is intended to be used at the departmental, programmatic, or work unit level to assess the integration of health equity approaches in child safety initiatives using a 3-step process:

- Assess
- Plan and test
- Monitor, revise, and adapt

It is meant to be used as a stand-alone tool, or in conjunction with the CSN Framework for Quality Improvement and Innovation in Child Safety

(URL: Framework for Quality Improvement and Innovation in Child Safety: A Guide to Implementing Injury and Violence Prevention Strategies and Programs | Children's Safety Network (childrenssafetynetwork.org). This tool can be used to facilitate planning with key partners on how health equity can be addressed at all levels of the social-ecological model.

If you have a training need, the National Center will be happy to connect with you to find a creative solution and provide technical assistance or training to your program. Reach out to us at info@ncfrp.org!

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