



Ohio Child Fatality Review

New Chair/Coordinator Training

Agenda

- Introduction to Child Fatality Review (CFR)
- Team composition
- Reviewing Cases
- Tips for success
 - Advice from CFR Coordinators

Scope of CFR

- CFR teams are in all 50 states and Washington D.C.
- ~1,350 local teams and 34 state teams
- Guam
- Military Teams, DOD has own reviews
- Tribal Engagement

Origins of CFR

- Began as a response to under-reporting and misclassification of child abuse.
- Early reviews focused only on suspected abuse and neglect.
- Missouri study published in Pediatrics led to first state-wide review system.
- Reviews have been effective in improving investigation, diagnosis, and reporting of abuse and neglect.

Ohio CFR Legal Mandates

- Ohio House Bill 448 signed July 2000
- Ohio Revised Code 307.621
- Ohio Administrative Code 3701-67-02

CFR Legal Requirements

- Each county must establish a CFR board, or join with other counties to form a regional CFR board.
- Each board must review the deaths of children under 18 years old residing in that county.

CFR Annual Reporting

- Required by April 1st of each year, submitted to the Ohio Department of Health:
 - The data collected for each review
 - The number of child deaths that were not reviewed
 - Recommendations for actions that might prevent other deaths
- Beginning 2015, report for year-of-death 1 year prior (Report Year-of-death 2018 by April 1, 2019)

CFR Annual Report

- By September 30th of each year, the Ohio Department of Health and Ohio Children's Trust Fund prepare and distribute an annual report for the state
- Posted on the ODH Web site at:
<http://www.odh.ohio.gov/odhPrograms/cfhs/cfr/cfrrept.aspx>

State CFR Coordinator

- Can send you a list of ODH vital stats child deaths for your county
- Can provide in state death certificates
- Can set up user accounts for the case report system
- May be able to obtain out of state records
- Theresa.Quaderer@odh.ohio.gov
- 614-728-0773

CFR Mission

***To reduce the incidence of
preventable child deaths***

CFR Goals

- Promote cooperation, collaboration and communication among all groups that serve families and children.
- Maintain a database of all child deaths to develop an understanding of the causes and incidences of those deaths.
- Recommend and develop plans for implementing local service and program changes; and to advise ODH of aggregate data, trends and patterns.

Operating Principles of CFR

- The death of a child is a community responsibility
- A child's death is a sentinel event that should urge communities to identify other children at risk for illness or injury
- A death review requires multidisciplinary participation from the community
- A review of case information should be comprehensive and broad
- A review should lead to an understanding of risk factors

Agenda

- Team composition
 - Essential Elements
 - Membership
 - Expectations

Essential Elements

- Multi-disciplinary
- Telling a story through the sharing of case information from multiple sources
- Focused on improving systems and prevention of deaths; not culpability
- Balance between individual cases and accumulation of fatal and non-fatal data for trends

County CFR Coordinator

1. Determine meeting dates and send meeting notices to team members
2. Obtain names and compile the summary sheet of child deaths to be reviewed and distribute to team members prior to each meeting
3. Ensure that notices of child deaths are available for team review
4. Ensure that new members receive an orientation to the CFR team prior to their first meeting
5. Ensure that all new CFR team members and ad hoc members sign a confidentiality agreement
6. Encourage the sharing of information for effective case reviews

County CFR Coordinator

7. Chair the team meetings and facilitate resolution of agency disputes
8. Complete and submit reports to ODH as directed
9. Ensure that the CFR team operates according to protocols as defined by law
10. Promote CFR team success in following through with recommendations and prevention initiatives and activities
11. Facilitate contacts with the media

CFR Board Members

- Mandated Members
 - County Coroner or designee
 - Chief of Police or Sheriff or designee
 - Executive Director of public children service agency or designee
 - Public Health Official or designee
 - Executive Director of a board of alcohol, drug addiction, and mental health services or designee
 - Pediatrician or Family Practice Physician

CFR Board Members

- Additional members may be included:
 - County Prosecutor
 - Fire/EMS Representative
 - School District Representative
 - Other Child Advocates
 - Hospitals
 - Fire Departments
 - Suicide Prevention Partners
 - Healthy Start
 - LGBT Resource Center

Special Guest Members

- Serve a specific purpose
- Attend only relevant meetings (e.g., fire department comes for fires)
- Signs all confidentiality agreements

Confidentiality

- CFR meetings are not public meetings, and are not subject to “Sunshine Laws”
- All statements, work products, and information related to CFR are confidential
- Each board to develop written policies re: security of confidentiality. OAC - 3701-67-04
Data collection; confidentiality of records
- Violation is a second degree misdemeanor

Member Expectations

- Provide information on specific cases
- Act as a professional liaison
- Participate in data collection
- Collaborate to catalyze prevention activities
- Honor team agreements

Agenda

- Reviewing Cases
 - Identifying cases
 - Process for conducting reviews
 - Developing recommendations

Identifying Cases

- **All** deaths to children younger than age 18

Points to Consider

- Did the death occur in the same county as the child's residence?
- Was the death preventable?
- Was the death particularly sensitive?
- Is there a conflict of interest?

CFR Process

- CFR Board must meet at least once per year to review all deaths of children under 18 years old who at the time of death were residents of the county

CFR Process

1. Share, question, and clarify all case information
2. Discuss the investigation, if appropriate
3. Discuss the delivery of services
4. Identify risk factors
5. Recommend systems improvements
6. Identify and be a catalyst for action to implement prevention recommendations

Share, Question, and Clarify

- Start with the person who has the most information and work to the person with the least.
- Share without interrupting
- Call on all team members
- Once information is shared, clarify inconsistencies
- Ask open-ended, non-judgmental questions

Discuss Investigation

- Be cautious not to place blame
- Identify how systems worked together before, during, and after the investigation
- Identify what additional information is needed
 - Some information may not be available

Identify Service Delivery

- Identify Service Delivery
 - Identify how the child and family intersected with various services
 - Before the death
 - At the time of incident
 - After the death
- Discuss what additional services might be needed for the family, community and professionals
 - Identify existing services
 - Identify service gaps

Identify Risk Factors

- Grouping risk factors into general categories can help guide discussion:
 - Health
 - Social
 - Economic
 - Behavioral
 - Environmental
 - Systemic (Agency Policies and Procedures)
 - Product Safety

Assess Preventability

- Definition: 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.

Assess Preventability

- Examples of Preventable Deaths (List is not exhaustive)
 - Unintentional injury deaths of young children that occur under absent or poor adult supervision
 - Motor vehicle and other transport deaths when fatal injuries are sustained due to failure to use appropriate restraints (child seat, seatbelt) in a motor vehicle, or failure to wear a helmet while riding a bicycle, motorcycle or ATV
 - Deaths due to fire or burns when fire caused by heating residence with a stove or children playing with matches
 - Drowning deaths when infant or toddler left unattended in a bathtub, lack of barriers around swimming pools or other bodies of water, failure to use mandated floatation devices
 - Sleep-related deaths when asphyxia results from bed-sharing or other unsafe infant sleep environment (e.g., place on couch, on pillow)
 - Weapon-related deaths when firearm left loaded and/or unsecured
 - Fall deaths from balconies/windows
 - Poisoning, Overdose, Acute Intoxication unsecured prescription drugs or poisons
 - Suicide If parent or caregiver did not seek care for child when child had history of previous suicide attempts, mental illness, or indicated intent to commit suicide
 - Medical Condition if caregiver does not seek care or delays seeking care for a known medical condition, or fails to follow prescribed care/treatment plan

Assess Preventability

- Examples of Deaths that are Not Typically Preventable
 - Cardiovascular disease
 - Congenital anomalies (birth defects)
 - Prematurity and other perinatal conditions
 - Other chronic medical conditions

Recommend Systems Improvements

- Identify at least one systems gap and one systems success
- Track findings on every case
- Write SMART recommendations
- Review findings and recommendations at least once a year
- Indicate if any recommendations regarding education, law, or environment were made as a result of the fatality review

Identify and Take Action to Implement Prevention Recommendations

- Identify prevention partners.
- Share findings and recommendations.
- Build accountability into sharing recommendations.

Agenda

- Tips for Success

Helpful Tips for Effective Reviews

1. Be prepared
2. Offer training
3. Clarify purpose
4. Utilize share, question, and clarify process
5. Focus on prevention

Helpful Tips for Effective Reviews


6. Follow through
7. Address conflict
8. Seek education
9. Practice self-care
10. Enter data

CFR Data Collection

- For each child death reviewed:
 - Age
 - Sex
 - Race
 - Ethnicity
 - Year of Death
 - Cause of Death
 - Geographic Location of Death
 - Factors Contributing to Death

National Center for Child Fatality Review and Prevention

- <https://www.ncfrp.org/>



Home | About Us | Programs | CDR Process | FIMR Process | Data | Causes | **Tools and Resources** | News / Events

Search ...

**NATIONAL CDRP**
Saving Lives Together

The National Center for Fatality Review and Prevention

Tools for CDR Teams

Many of the tools and resources listed below were developed by child death review team coordinators and advocates across the country. Their experiences should help assist you in your efforts to develop and maintain an effective team. Several of the tools come directly from [A Program Manual for Child Death Review](#) which was prepared by The National Center for Child Death Review and child death review leaders and advocates throughout the U.S.

If there is a tool or resource that you are interested in that is not listed, please send us your suggestions.

- Planning Tools
- State Program Tools
- CDR Administration Tools
- Meeting Tools
- CDR Coordinator Tools
- Investigation Tools
- CDR Reporting Tools
- Prevention Tools
- Sample Information Request Forms
- Sample Welcome Packets

A peer-reviewed professional reference devoted to child fatality review
Child Fatality Review

ODH CFR Website



- WHAT IS ODH?
ABOUT US
- KNOW OUR
PROGRAMS
- HEALTH RULES
LAWS & FORMS
- EXPLORE
DATA & STATS
- FIND LOCAL
HEALTH
DISTRICTS

A→Z
INDEX

?

Q

ODH / Know Our Programs / Child Fatality Review



Child Fatality Review

WELCOME

NEWS & EVENTS

QUESTIONS

ABOUT US

RESOURCES

FORMS

Child Fatality Review

Child deaths are often regarded as an indicator of the health of a community. While mortality data provide us with an overall picture of child deaths (by number and cause), it is from a careful study of each and every child's death that we can learn how best to respond to a death and how best to prevent another.

Recognizing the need to better understand why children die, the Ohio General Assembly passed Substitute House Bill Number 448 (HB 448) in July, 2000, mandating Child Fatality Review (CFR) Boards in each of Ohio's counties (or regions) to review the deaths of children under eighteen years of age.

Purpose:

The ultimate purpose of the local review boards, as clearly described in the law, is to reduce the incidence of preventable child deaths. To accomplish this, it is expected that local review boards will:

1. Promote cooperation, collaboration and communication between all groups that serve families and children;
2. Maintain a database of all child deaths to develop an understanding of the causes and incidence of those deaths;
3. Recommend and develop plans for implementing local service and program changes; and advise the department of health of aggregate data, trends and patterns found in child deaths.

Mailing Address:

Ohio Department of Health
Child Fatality Review Program
246 North High Street, 6th Floor
Columbus, Ohio 43215



Advice from CFR Coordinators

- Lorrie Considine (Cuyahoga County)
- Tom Boeshart (Hamilton County)
- Deb Hattery-Roberts (Allen County)

Advice from CFR Coordinators

- Tips on the Case Reporting System
- Tips on running review meetings
- Tips on forming relationships
- Barriers in CFR

Tips on the Case Reporting System

- Permissions
 - Local-level users can enter and view data for their county only
 - State-level users can view all data for all teams in the state
 - National Center staff can view only de-identified data across all states

Main
Administration
Your Account
Deleted Cases
Enter New Case
Manage Cases
Standardized Reports
My CDR Outcomes
Data Download
Help
Logout

Saving Lives Together



Welcome, Ohio

HIPAA Reminder:

Names, dates, and county fields:

Enter identifiable information online if your state/local policy allows. Please check with your state CDR coordinator if you are unsure.

Any other text field, such as the Narrative section, any 'specify' or 'describe' fields:

Do not include specific names, dates of birth, dates of death, references to specific counties, practitioners, or facility names in these text fields.

Examples: "Evans County EMS" should be "EMS"; "Evans County Children's Hospital" should be "the children's hospital."

Why this reminder?

Text fields may be shared with approved researchers as noted in our Data Use Agreements and therefore entering identified data into those fields would compromise your responsibility to HIPAA.

Child deaths are often regarded as an indicator of the health of a community. While mortality data provide us with an overall picture of child deaths (by number and cause), it is from a careful study of each and every child's death that we can learn how best to respond to a death and how best to prevent another.

Recognizing the need to better understand why children die, the Ohio General Assembly passed Substitute House Bill Number 448 (HB 448) in July, 2000, mandating Child Fatality Review (CFR) Boards in each of Ohio's counties (or regions) to review the deaths of children under eighteen years of age.

Purpose:

The ultimate purpose of the local review boards, as clearly described in the law, is to reduce the incidence of preventable child deaths. To accomplish this, it is expected that local review boards will:

- Promote cooperation, collaboration and communication between all groups that serve families and children;
- Maintain a database of all child deaths to develop an understanding of the causes and incidence of those deaths;
- Recommend and develop plans for implementing local service and program changes; and advise the department of health of aggregate data, trends and patterns found in child deaths.

Mailing Address:

Ohio Department of Health
Child Fatality Review Program
246 North High Street, 6th Floor
P.O. Box 118
Columbus, Ohio 43216-0118

Telephone: (614) 466-8968

Fax: (614) 564-2443

Email: cfr@odh.ohio.gov

When Entering a Case

- Case number assigned on first data entry page
 - State and County are assigned
 - Can edit Year of Review and Sequence
 - Year of Review default is current year
- Data Dictionary is available on all data pages

When Entering a Case

Entering a case:

Enter New Case

Case Definition:

36

State

Team/County *

2018

Year of Review

00001

Sequence of Review *

Case Type *

Death

Death Certificate #

Birth Certificate #

Medical Examiner/Coroner #

Date Team Notified of Death



Child never left hospital following birth

☐

Undo

Exit Without Saving

Save

Save and Continue

Save and Exit

When Entering a Case



- Navigate to any of the data pages using the navigation bar or go to the next section using “Save and Continue”
- Data are saved as you moved from page to page
- Do not use the “Back” button
- Time-out for inactivity is 60 minutes


Main
Administration
Your Account
Deleted Cases
Enter New Case
Manage Cases
Standardized Reports
My CDR Outcomes
Data Download
Help
Logout

Case Sections

- Case Definition
A - Child Information
For Infants
IEM
B - Primary Caregivers
C - Supervisor
D - Incident
E - Investigation
F - Cause of Death
G10 - Medical Condition
H - Circumstances
H1 - SDY
H2 - Sleep Related
H3 - Consumer
Product
H4 - Another Crime
I - Acts
J - Services
K - Prevention
L - Review
M - SUID and SDY
N - Narrative
O - Form Completion
Save and Exit

Manage Cases

-  Enter New Case
-  Import Vital Records

 Print Results

Search Cases:

Last Name / Number

Case Type

All Case Types



Team



Manner of Death



Cause of Death



Toggle Advanced Search Options

Date of Entry Complete (Section P)

From



To



Date of Death

From



To



Data Entry (Section P)

Data Entry Incomplete

☐

Quality Assurance by State Incomplete

☐

Misc.

Prevention Updates (Section L)

☐



Out of State Resident Review

☐

Search Cases

Reset Search

Manage Cases

-  Enter New Case
-  Import Vital Records

 Print Results

Case Number	Last Name	First Name	Death Date	Manner of Death	Cause of Death	Local Team	Data Entry Complete	QA Complete	Actions
36-00-2003-00001			05/25/2002	Natural	no response	None specified	Yes	No	Print Delete
36-00-2003-00002			07/01/2002	Natural	MedCond-Prematurity	None specified	Yes	No	Print Delete
36-00-2003-00003			01/01/2002	Natural	MedCond-Unknown	None specified	Yes	No	Print Delete
36-00-2003-00004			01/01/2002	Natural	MedCond-Other medical	None specified	Yes	No	Print Delete
36-00-2003-00005			03/01/2002	Natural	MedCond-Other medical	None specified	Yes	No	Print Delete
36-00-2003-00006			11/15/2002	Natural	MedCond-Other medical	None specified	Yes	No	Print Delete
36-00-2003-00007			03/01/2002	Accident	External-Motor Vehicle	None specified	Yes	No	Print Delete
36-00-2003-00008			05/01/2002	Accident	External-Motor Vehicle	None specified	Yes	No	Print Delete
36-00-2003-00009			04/03/2002	Natural	MedCond-Prematurity	None specified	Yes	No	Print Delete
36-00-2003-00010			06/20/2002	Natural	MedCond-SIDS	None specified	Yes	No	Print Delete

< Previous | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Next >



Help

Contact Information for the National Center for Fatality Review and Prevention

1825 K Street, NW
Suite 600
Washington, DC 20005

Phone: 1-800-656-2434
Fax: (517) 324-7365
Email: info@ncfrp.org

Webinars/Tutorials

What's New in Version 5.0 of the National Fatality Review Case Reporting System (presented March 21, 2018):
<https://vimeo.com/261476160> (passcode NCFRP)

Reporting Child Abuse and Neglect in Version 5.0 of the National Fatality Review Case Reporting System (presented April 4, 2018):
<https://vimeo.com/264255905> (passcode NCFRP)

Supporting Documentation

Guide for Effective Reviews	pdf
CDR Program Manual	pdf
CDR Case Report Form	pdf
User Manual	pdf
How to Import Vital Stats	pdf
Import Vital Records Template	xlsx
Data Dictionary	pdf
Data Download Codebook	pdf
Data Download Codebook	xlsx
Pared Down Flat File Codebook	pdf
Standardized Reports Documentation	pdf
Macro to Import Data into Microsoft Access	mdb

Important Data System Tips

- Do not use the “BACK” or “FORWARD” arrows! Only use the navigation spots on the site.
- Do not “X” out when done. Log off when leaving the site.
- Log off if you will be interrupted or delayed.

What to do with your data?



INTRODUCTION

This data snapshot is a summary of the deaths of 440 children (under the age of 18 years) residing in Franklin County, Ohio that occurred during 2015-2016. It provides demographic, as well as cause of death, information to identify common themes that might help our community prevent future deaths.

Information presented is gathered and discussed through the Franklin County Child Fatality Review (FCCFR), an on-going community planning process, in which a team of community experts from various systems and agencies convenes to review the circumstances around the deaths of children residing in Franklin County. A list of organizations who participate in the FCCFR process can be found on page 4.

DEMOGRAPHICS OF FRANKLIN COUNTY CHILD DEATHS, 2015-2016

Infants (< 1 year), non-Whites and males have higher death rates than other subpopulations.

	Number	Percent	Rate ¹
Age (n=440)			
< 1 year	311	70.7	821.0
1-4 years	40	9.1	27.6
5-9 years	22	5.0	13.3
10-14 years	34	7.7	22.0
15-17 years	33	7.5	36.2
Race (n=440)			
White, Non-Hispanic	159	36.1	49.0
Black, Non-Hispanic	196	44.5	106.9
Hispanic	39	8.9	74.1
Other	46	10.5	n/a
Sex (n=440)			
Male	250	56.8	83.0
Female	190	43.2	65.0
ZIP Code (n=439)			
CelebrateOne ² Areas	207	47.2	n/a
Non-CelebrateOne ² Areas	232	52.8	n/a

Create Standardized Reports

State: Ohio

1. Select Criteria

Case Type

Death ▼

Data Range*

☒ Year Of Review

☐ Date of Death

2017 ▼



2017 ▼



Data Entry

☒ Only Cases Marked as Data Entry Complete (Section P)

☐ Only Cases Marked as QA Complete (Section P)

☐ Only SUID and SDY Cases (Section N)

Constrain by Local Team: *

All Of Ohio ▼

2. Select A Report*

Infant/Child Information


☐ 1. Demographics (Ethnicity/Race and Age Group by Sex)

☒ 2. Infant Death Information

☐ 3. Manner and Cause of Death by Age Group

Standardized Reports

Infant Death Information

State: Ohio
 Local Team: 
 Cases Selected By: Review Year
 Review Year From: 2017
 Review Year To: 2017
 Cases With Data Entry Complete Only
 For Case Type: Child Death
 Review Type: CDR



Category	Manner Of Death						Total
	Natural	Accident	Homicide	Undetermined	Pending	Unknown	
Deaths Reviewed	15	1	1	3	0	0	20
Premature (<37 Weeks)	10	0	0	0	0	0	10
Low Birth Weight (<2500 grams)	8	0	0	0	0	0	8
Intrauterine Smoke Exposure	5	0	1	1	0	0	7
Intrauterine Alcohol Exposure	0	0	0	0	0	0	0
Late (> 6 months) or No Prenatal Care	1	0	0	0	0	0	1
Infant Born Drug Exposed	0	0	0	1	0	0	1
Neonatal Abstinence Syndrome	0	0	0	0	0	0	0
NICU Stay of More than 1 Day	0	0	0	0	0	0	0
Infant Ever Breastfed	5	1	0	2	0	0	8

Footnote: Columns do not add up to total deaths because the factors are not mutually exclusive. Infants should not have a manner of death suicide, so this manner is not included in this table. NAS and NICU questions were not added until Version 5

Advice from CFR Coordinators

- Tips on running review meetings
- Tips on forming relationships
- Barriers in CFR

Q & A

Contact Information

Theresa Quaderer
Public Health Consultant,
Ohio Department of Health
(614) 728-0773

Theresa.Quaderer@odh.ohio.gov