



# BUILDING COLLABORATION AND COMMUNICATION: **BETWEEN CDR AND CHILD WELFARE**

TELLING STORIES TO SAVE LIVES



# Key Funding Partner

## Federal Acknowledgement

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# Housekeeping

## Before We Get Started



This webinar is being recorded and will be made available on the National Center's webpage ([www.ncfrp.org](http://www.ncfrp.org)).



Participants are muted.  
Use the question-and-answer box to ask questions.



Email the National Center at [info@ncfrp.org](mailto:info@ncfrp.org) if you experience any tech problems.



Complete a brief evaluation of the webinar at the conclusion of the session. Scan the QR code to access.



# Speakers

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The speakers have no financial relationships or interests to disclose.



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# Webinar Objectives

Attendees Will Be Able to:



## REVIEW TYPES



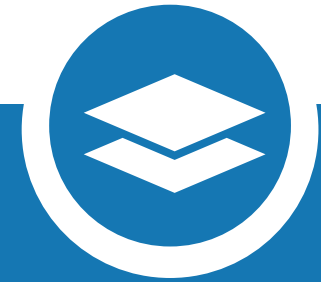
Describe the difference between child death review (CDR) and child-welfare based reviews.



## FOCUS AREAS



Identify effective practices, common challenges, and key facilitator moves.



## SUCCESS STORIES

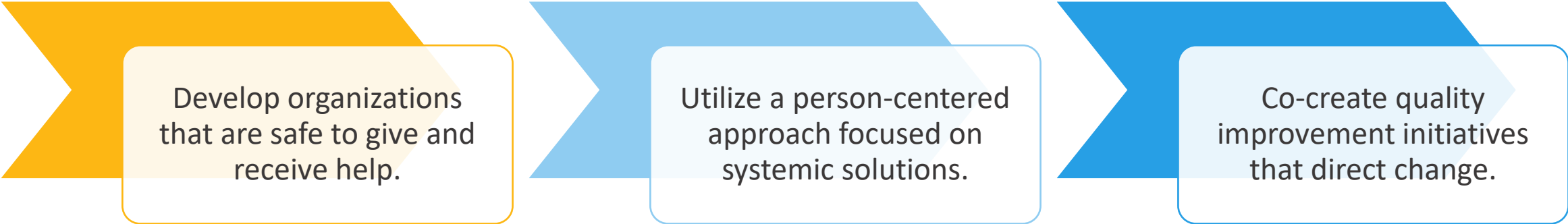


Highlight jurisdictions where successful collaboration has improved safety.

# Center for the Helping Professions

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Goal: Safe, Effective, and Reliable Helping Systems



Develop organizations that are safe to give and receive help.

Utilize a person-centered approach focused on systemic solutions.

Co-create quality improvement initiatives that direct change.



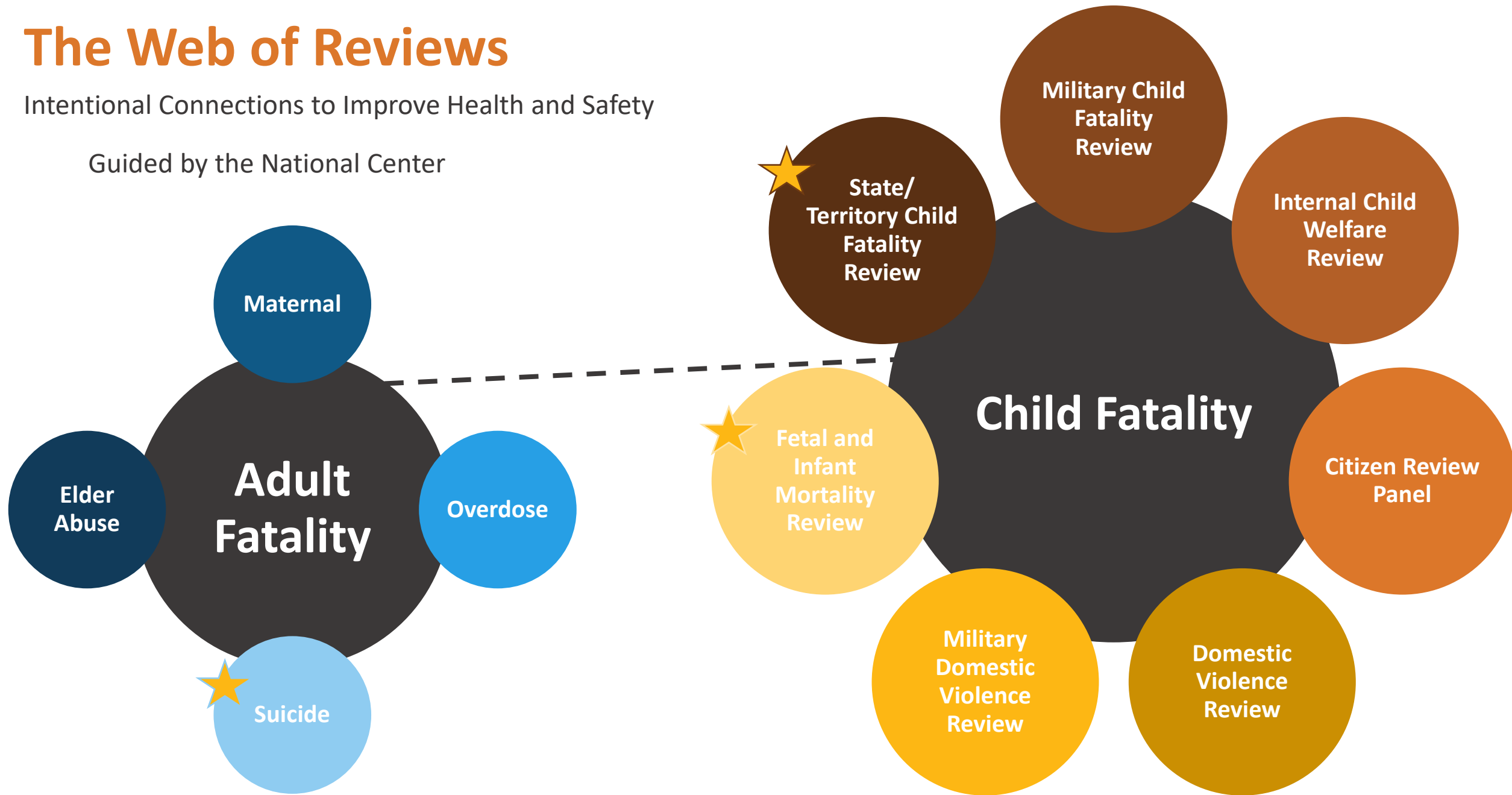
# REVIEW TYPES

Child Death Review and Child Welfare Based Reviews

# The Web of Reviews

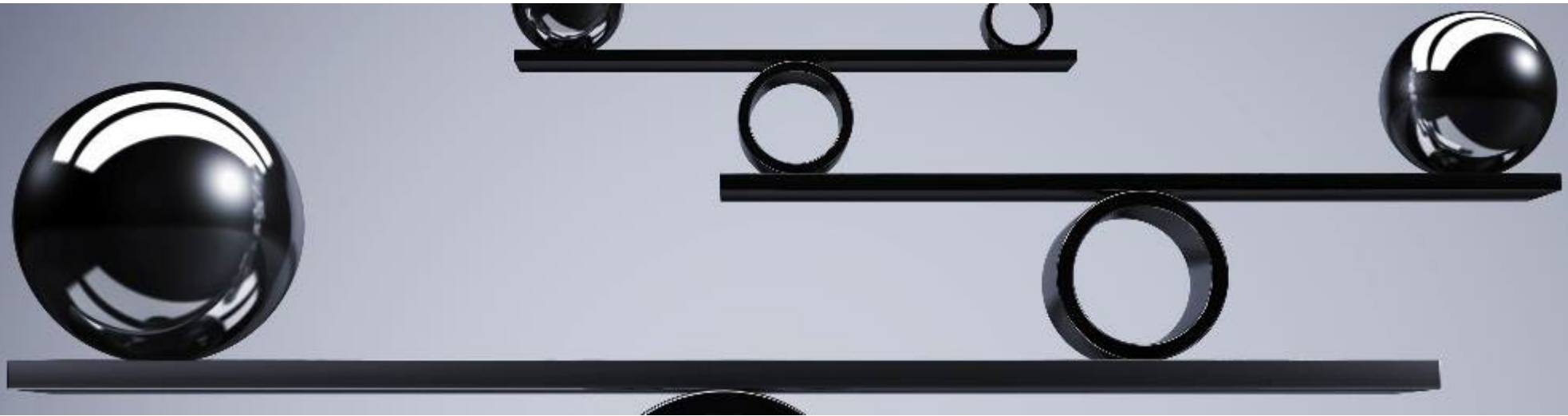
Intentional Connections to Improve Health and Safety

Guided by the National Center



# Review Types

VALUE IN BOTH PRACTICES



## Child Death Review

State, local, or Tribal focused reviews that seek to understand the risk and protective factors surrounding child deaths.



## Child-Welfare Based Reviews

Quality improvement review by the public child welfare agency, often called a Critical Incident Review (CIR).

# How Does CDR Work?

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# How Does CIR Work?

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## Key Components

Case Notes are  
Reviewed

Data are Collected

Quality  
Improvement  
Efforts are  
Identified

Review Team  
Meeting is Held

Patterns are  
Identified

Recommendations  
Shared with Key  
Partners



# FOCUS AREAS

Key Learnings for Fatality Review Teams

# Key Learnings for Fatality Review

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## Focus Areas

**Communication &  
Preparation**

**Engagement  
Beyond Attendance**

**Team Cohesion &  
Leadership**

**Psychological Safety**

**Culture of  
Compassion &  
Shared Purpose**

**Focus on  
Preventions and  
System  
Improvement**

**Cross-System  
Collaboration**

**Continuity Between  
Meetings**

**Cross-Team Pairing**

**Data-Informed,  
Action-Oriented  
Reviews**

# Communication & Preparation

## COMMON CHALLENGES

Team members who are unprepared or underprepared.

A lack of shared understanding about the meeting's purpose.

## EFFECTIVE PRACTICES

Send meeting materials ahead of time which should include the agenda, one-page summary, key questions, and a reminder that the goal is learning, not fault-finding.

Use standardized tools/templates so team members share a common frame and expectations.

## FACILITATOR MOVES

- Circulate meeting materials 3–5 days ahead and open with a 60-second purpose refresh.
- Clarify timelines, with special attention on cases pending agency or criminal investigation.

# Engagement Beyond Attendance

## COMMON CHALLENGES

Team members who attend but are not engaged, sometimes called passive attendance.

Dominant voices that suppress insights and learning.

## EFFECTIVE PRACTICES

Open with a quick prompt to surface current challenges; close by collecting feedback for continuous improvement.

Ensure there is space for all voices and viewpoints, so quieter disciplines are heard and valued.

## FACILITATOR MOVES

- Institute an optional round-robin opener.
- Use a two-question exit survey.

# Team Cohesion & Leadership

## COMMON CHALLENGES

Misaligned expectations.

Lack of succession planning for team member attrition.



## EFFECTIVE PRACTICES

Utilize skilled facilitation to set an effective tone and focus, by cultivating an environment where psychological safety is present. Foster discussions on learning.

Address knowledge gaps (e.g., acronyms) and build community within and between meetings.



## FACILITATOR MOVES

- Always utilize a skilled facilitator. This includes having a backup plan if the usual facilitator is unable to attend.
- Create a glossary of shared terms and acronyms.

# Psychological Safety

## COMMON CHALLENGES

Fear of being blamed.

Lack of empathy when discussing individual or systems gaps.

## EFFECTIVE PRACTICES

Acknowledge the depth and complexity of the fatality review topics, membership, and data.

Model empathy and curiosity to enable honesty and deeper learning.

## FACILITATOR MOVES

- Create and utilize community agreements.
- Redirect personalizing comments back to system factors.

# Culture of Compassion & Shared Purpose

## COMMON CHALLENGES

Drifting from the team's core purpose.  
Loss of team cohesion.

Minimizing the team's impact on policy  
and systems change.



## EFFECTIVE PRACTICES

Create a shared purpose that intends to  
increase resilience, engagement, and  
humility.

Pause to highlight insights by  
connecting them to system learning  
and team goals.



## FACILITATOR MOVES

- End each meeting by restating the shared aim and one observed system insight.
- Systematically collect policy and systems changes resulting from team participation.

# Focus on Preventions and System Improvement

## COMMON CHALLENGES

Focusing on individual actions.

Narrowing learning to only finding faults.



## EFFECTIVE PRACTICES

Reframe from 'why didn't they?' to 'why couldn't they?' to invite openness and curiosity about systems gaps.

Remove blame from all conversations.



## FACILITATOR MOVES

- Start with a systems-thinking prompt to anchor analysis on processes.
- Utilize community agreements to redirect blaming discussions.

# Cross-System Collaboration

## COMMON CHALLENGES

Siloed processes that focus on individual agency needs.

Informal processes for accessing data result in slower reviews.



## EFFECTIVE PRACTICES

Align team consensus across agencies. Clarify what information each agency can share to reduce fragmentation.

Institutionalize sharing through formal processes such as data sharing agreements.



## FACILITATOR MOVES

- Schedule recurring interagency coordination meetings.
- Utilize a standing agenda that features subject matter expertise and data.

# Continuity Between Meetings

## COMMON CHALLENGES

Inconsistent follow-up.

Overreliance on a few people.

Disrupted momentum through cancelled meetings.

## EFFECTIVE PRACTICES

Adhere to community agreements about communication frequency.

Provide accessible shared tools so all members stay aligned between sessions.

Maintain momentum with brief highlights, upcoming topics, and 'wins' on a shared platform.

## FACILITATOR MOVES

- Post a 5-bullet recap, highlighting action items within 48 hours.
- Track follow-up actions.

# Cross-Team Pairing

## COMMON CHALLENGES

Limited cross-disciplinary understanding.

Siloed prevention work.

Team member attrition.

## EFFECTIVE PRACTICES

Pair members across disciplines for informal “coffee chats” and flash mentoring to build trust.

Share training opportunities.

Provide orientation and training.

## FACILITATOR MOVES

- Create intentional and productive opportunities for collaboration.
- Rotate quarterly relationship pairings.
- Provide a reflection prompt focused on gathering learning.

# Data-Informed, Action-Oriented Reviews

## COMMON CHALLENGES

Delayed records and unclear timing hinder progress.

Broad recommendations that do not provide a framework for action.

Lack of documentation for team member insights.

## EFFECTIVE PRACTICES

Formalize processes for accessing data.

Link findings to team insights.

Share findings and insights with partners who can craft actionable recommendations.

## FACILITATOR MOVES

- Assign a small group to synthesize 2–3 findings per meeting and document in the Pediatric National Fatality Review-Case Reporting System.
- Proactively identify and establish prevention partners.
- Create a feedback loop to ensure the team is aware of prevention activities.

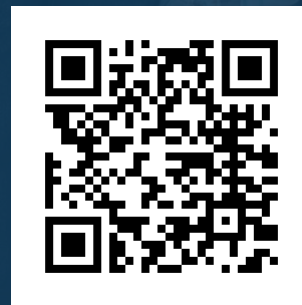


# SUCCESS STORIES

Collaboration in Action

# THANK YOU

Complete an evaluation  
through the link in chat or  
by scanning this QR code:





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