Improving Child Abuse and Neglect Fatality Reviews

Wednesday, October 24th, 2018

1:00 PM – 2:00 PM ET

NATIONAL CFRP

Saving Lives Together

The National Center for Fatality Review and Prevention

About the National Center for Fatality Review and Prevention

The National Center is funded in part by Cooperative Agreement Numbers UG7MC28482 and UG7MC31831 from the US Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB) as part of an award totaling $1,099,997 annually with 0 percent financed with non-governmental sources. Its contents are solely the responsibility of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

HRSA's Overall Vision for NCFRP

- Through delivery of data, training, and technical support, NCFRP will assist state and community programs in:
  - Understanding how CDR and FIMR reviews can be used to address issues related to adverse maternal, infant, child, and adolescent outcomes
  - Improving the quality and effectiveness of CDR/FIMR processes
  - Increasing the availability and use of data to inform prevention efforts and for national dissemination
- Ultimate Goal:
  - Improving systems of care and outcomes for mothers, infants, children, and families

Housekeeping Notes

- **Webinar is being recorded and will be available within 2 weeks on our website: www.ncfrp.org**
- All attendees will be muted and in listen only mode
- Questions can be typed into the "Questions" pane
  - Due to the large number of attendees, we may not be able to get to all questions in the time allotted
  - All unanswered questions will be posted with answers on the NCFRP website

Guest Speakers

National Center for Fatality Review and Prevention
Abby Collier, MS
Director

National Center for Fatality Review and Prevention
Patricia Schnitzer, PhD
Epidemiologist

Webinar Goals

- Explain the history of child abuse and neglect fatality reviews
- Discuss different models for reviewing child abuse and neglect fatalities
- Identify and apply best practices for child abuse and neglect fatality reviews
- Examine how the unique data collected by fatality review teams impacts the understanding of child abuse and neglect fatalities
- Reference multiple tools for improving child abuse and neglect fatality reviews

Child Maltreatment Fatality Case Reviews: Improving your teams ability to improve agency systems and prevent deaths:

Findings from a national summit of thought leaders in the field

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Poll: What best describes your home agency?

- State/local public health
- State/local child welfare
- Law enforcement
- Mental health provider
- Other

Poll: Do you participate in child abuse and neglect fatality review?

- Yes, on CDR or FIMR
- Yes, internal CPS review
- Yes, internal agency review
- Yes, multiple reviews
- No

Poll: How long have you participated in child abuse fatality review?

- Less than six months
- Six to twelve months
- One to five years
- Five to ten years
- More than ten years

Child Death Review began as:

- A response to the under-reporting and misclassification of child abuse.
- Early reviews focused only on reviews of suspected abuse and neglect.
- Missouri study published Pediatrics led to first state-wide review system.
- Reviews have been effective in improving investigation, diagnosis and reporting of abuse and neglect.
- Teams continue to struggle with using review findings to improve agency practices/policies/services and primary prevention.

National Commission to Eliminate Child Abuse and Neglect Fatalities

- Established by the Protect Our Kids Act (2012)
- Charged with addressing how to identify and track victims of maltreatment as well as identify strategies to better identify and serve at risk families
- Issued final report in 2016
- 114 recommendations

Recommendation 2.1: Support states in improving current CPS practice and intersection with other systems through multi-disciplinary action

1. HHS should provide national standards, proposed methodology and technical assistance to help states analyze their data from the previous five years; review past child abuse and neglect fatalities; and identify the child, family and systemic characteristics associated with child maltreatment deaths.

2. States should undertake a retrospective review of child abuse and neglect fatalities.

3. Using the review findings, every state should be required to develop and implement a comprehensive state plan to prevent child abuse and neglect fatalities.

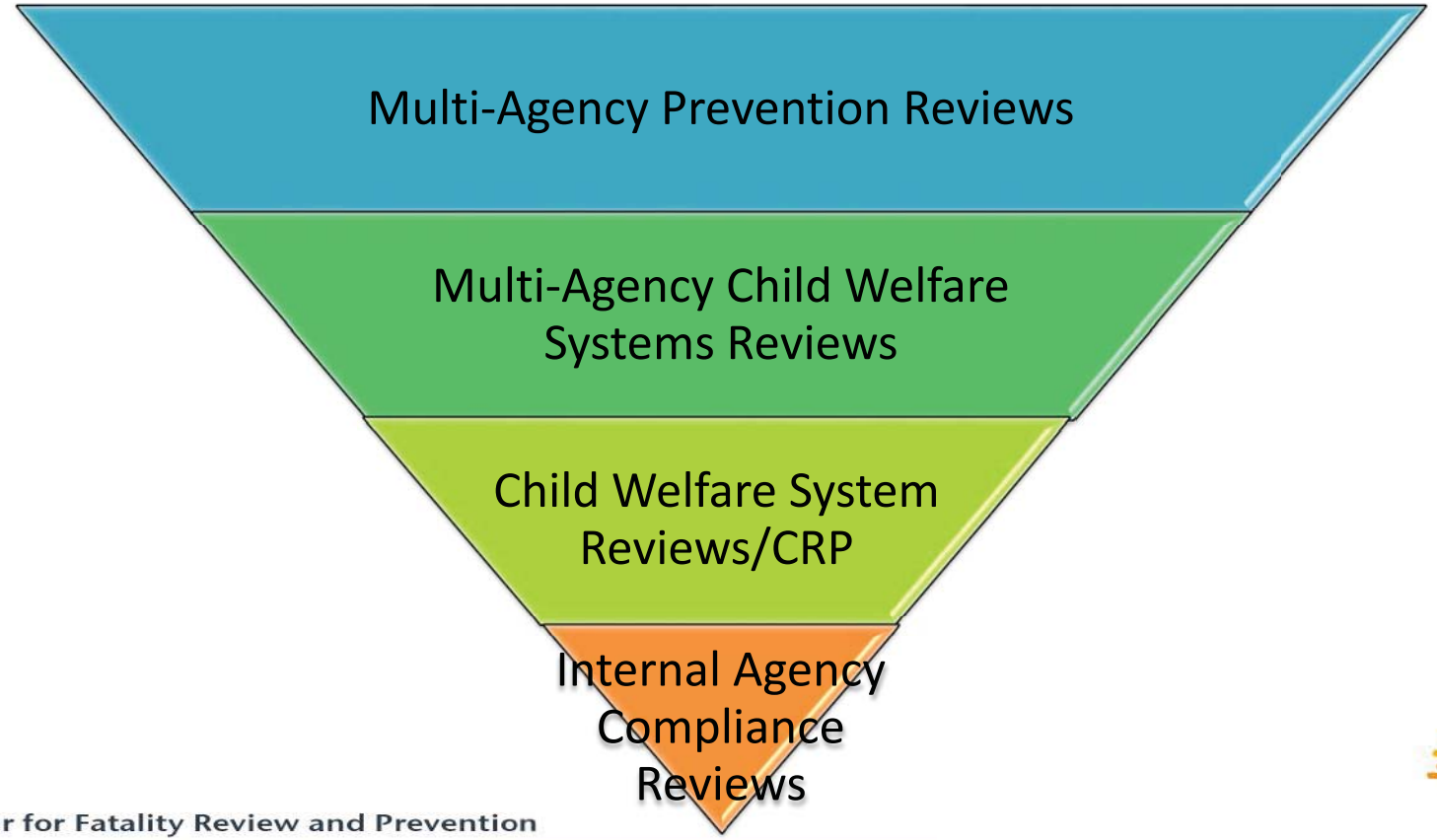
2018 Families First Prevention Services Act

- ''(19) document steps taken to track and prevent child maltreatment deaths by including”
- ''(B) a description of the steps the state is taking to develop and implement a comprehensive, statewide plan to prevent the fatalities that involves and engages relevant public and private agency partners, including those in public health, law enforcement, and the courts''.

The State of Child Maltreatment Reviews in the United States

- All 50 states conduct reviews of child maltreatment through their CDR teams (37 with local teams, rest with state-only teams).
- 33 states have another CAN review system
  - Local child welfare agency conducts internal review of child abuse and neglect deaths: 29
  - Separate multidisciplinary state team which reviews only child abuse and neglect deaths: 10
  - Other state agency(ies) conduct internal review of child abuse and neglect deaths: 10
  - Subcommittee of the state CDR team conducts specialized reviews of child abuse and neglect deaths: 8
  - Separate multidisciplinary local teams which review only child abuse and neglect death: 5
  - Other: 5

Levels of Reviews



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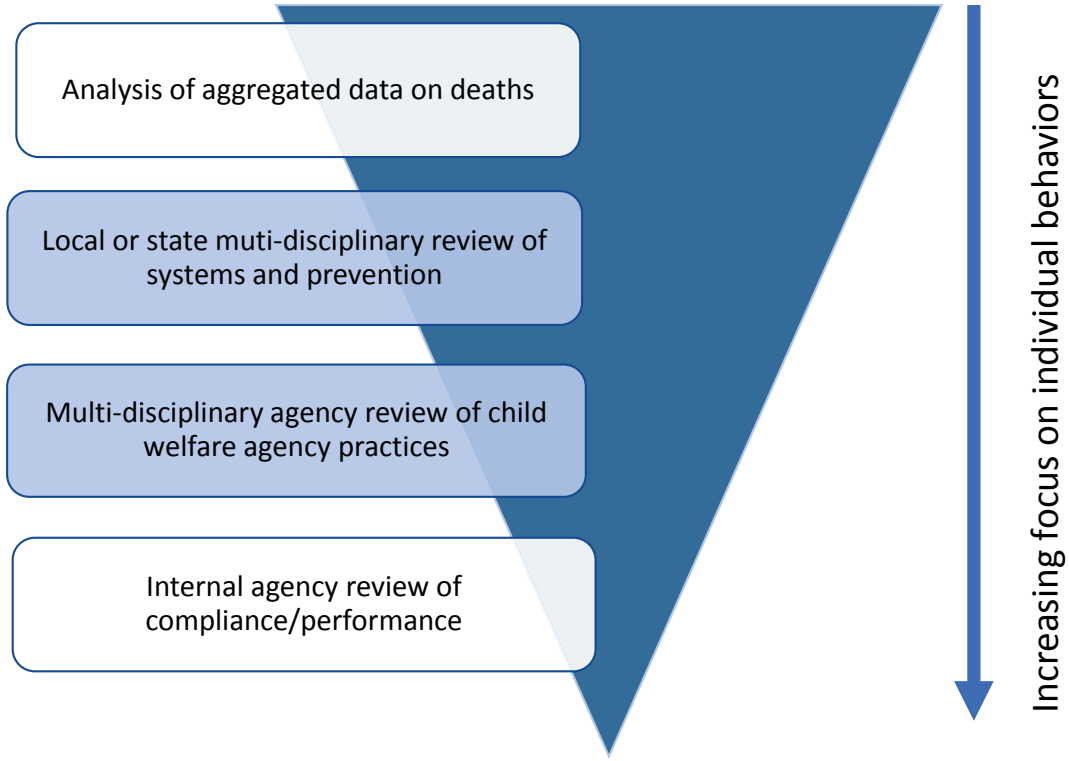
Scope of Reviews



The National Summit to Improve Case Reviews of Child Maltreatment Deaths

- 2.5 days meeting in Colorado a combination of presentations and work groups
- We learned about:
  - Different models of reviews in Michigan, Tennessee, Connecticut, Florida and the United Kingdom.
  - Assortment of tools used during reviews.
- We developed best practice parameters in:
  - Criteria for excellence and core review outcomes.
  - Core processes including case identification, case discussion, findings, recommendations, reporting.
- We identified available and needed tools and resources to help teams.
- We did NOT develop a one size fits all model.

Meeting Attendees

New Guidance

Available at https://www.ncfrp.org/resources/quick-looks/

Criteria for Excellence in Reviews

- Reviews should be family centered and child focused and learning opportunities for agencies.
- Reviews should be objective, forward thinking and not punitive towards agencies.
- Reviews should have a multi-systems focus: broad team membership, case information form many sources, findings and recommendations addressing broad array of systems.
- Case selection of maltreatment should encompass a broad definition.
- Case discussions should be systematic.
- Focus on findings, recommendations and action.
- Expectation should be that review lead to action.

Comparing Approaches

The Traditional 'Bad Apple' Approach	The Systems Approach
Human error is the cause of accidents	Human error is a symptom of trouble deeper inside the system
To explain failure, you must seek failure	To explain failure, do not try to find where people went wrong
You must find people's inaccurate assessments, wrong decision, bad judgements	Instead, find how people's assessments and actions made sense at the time, given the circumstances that surrounded them.

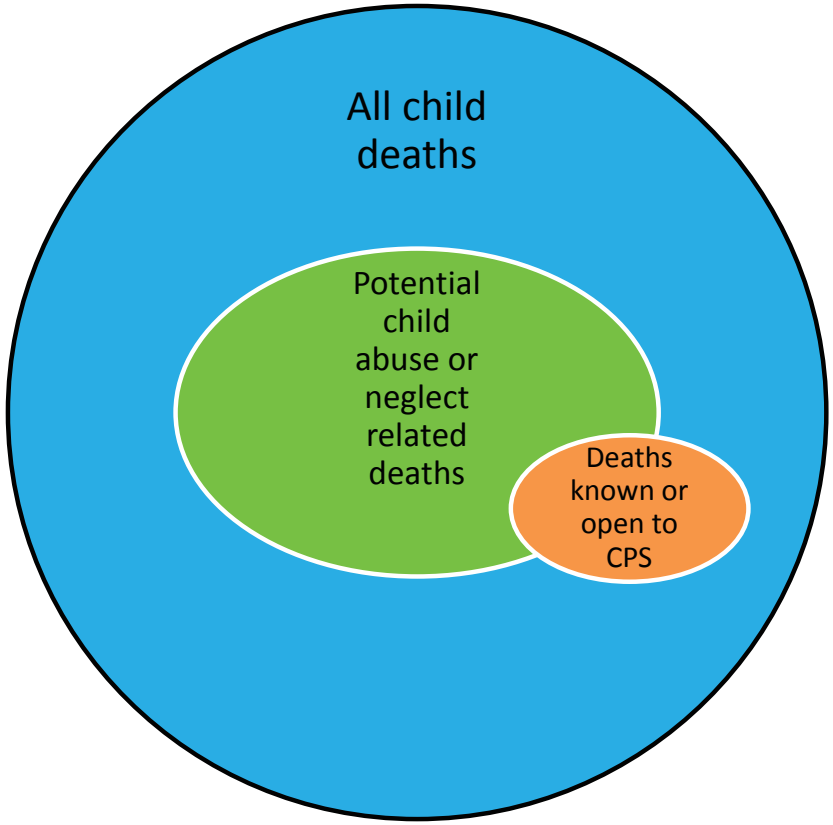
Case Review Outcomes

- The review meeting is not the outcome.
- Outcomes should focus on systems changes/improvements and primary prevention.
- Recommendations should be: objective, measurable, feasible, evidence/best practice based, data driven, identify who is responsible, with ownership to implement, and ensure blameless accountability.
- Reviews should culminate in a written formal report or presentation presented proactively and used for decision making.
- Outcomes should be shared with a variety of audiences, including families.

Of 2,285 maltreatment deaths reviewed, only:

Type of Action	Number of cases with recommended or planned action	Number of cases with implemented action
Agency Systems		
New policy	67	5
Revised policy	50	5
New program	37	1
New service	45	1
Expanded service	39	2
Law/Ordinance		
New law or ordinance	21	0
Amended law or ordinance	12	1
Enforcement of law or ordinance	35	5
Primary Prevention		
Media campaign	116	11
School program	62	2
Community safety project	85	11
Provider education	108	17
Parent education	192	45
Public forum	43	1
Other	56	1
Environmental modification	16	0
Other	36	1

Case Definition, Identification, & Selection



Case Definition, Identification, & Selection

Number of Deaths by Abuse/Neglect Drawn From:

State	NCANDS	State Annual CDR Report	Year for Data
Arizona	11	51	2008
California	30	133	2001
Florida	156	192	2009
Georgia	60	77	2009
Iowa	6	7	2007
Kansas	10	13	2008
Kentucky	22	28	2008
Minnesota	16	19	2001
Missouri	39	109	2009
Nevada	17	37	2008
New Jersey	29	30	2008
Oklahoma	26	50	2006
Oregon	18	20	1999
Pennsylvania	40	98	2009
Washington	36	165	2001
TOTAL	**516**	**1029**	

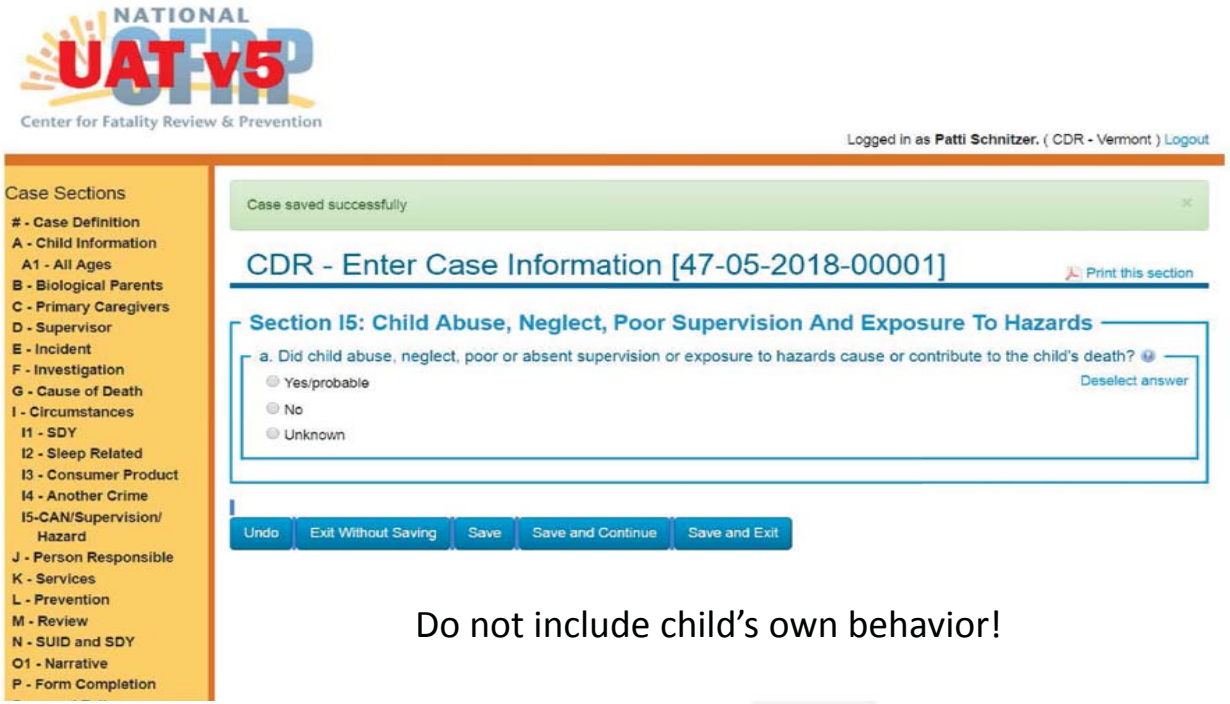
Case Definition, Identification, & Selection

- **Define the population of cases you want to review.** Cast a broad net.
  - If possible, review ALL child deaths. If not possible, consider:
    - All non-natural causes + all natural deaths that when linked to CPS identifies a child or family with a CPS report, or
    - All deaths due to non-natural causes, or
    - All deaths due to non-natural causes that when linked to CPS identifies a child or family with a CPS report.
  - If possible, consider a category with a larger number of deaths but limit those reviewed to children less than age 5
- Involvement in the child protection system should not be the only consideration. This could prevent the team from exploring why children who should have been known to CPS were not, prior to their deaths.

Changes to the NFR-CRS Support this Model

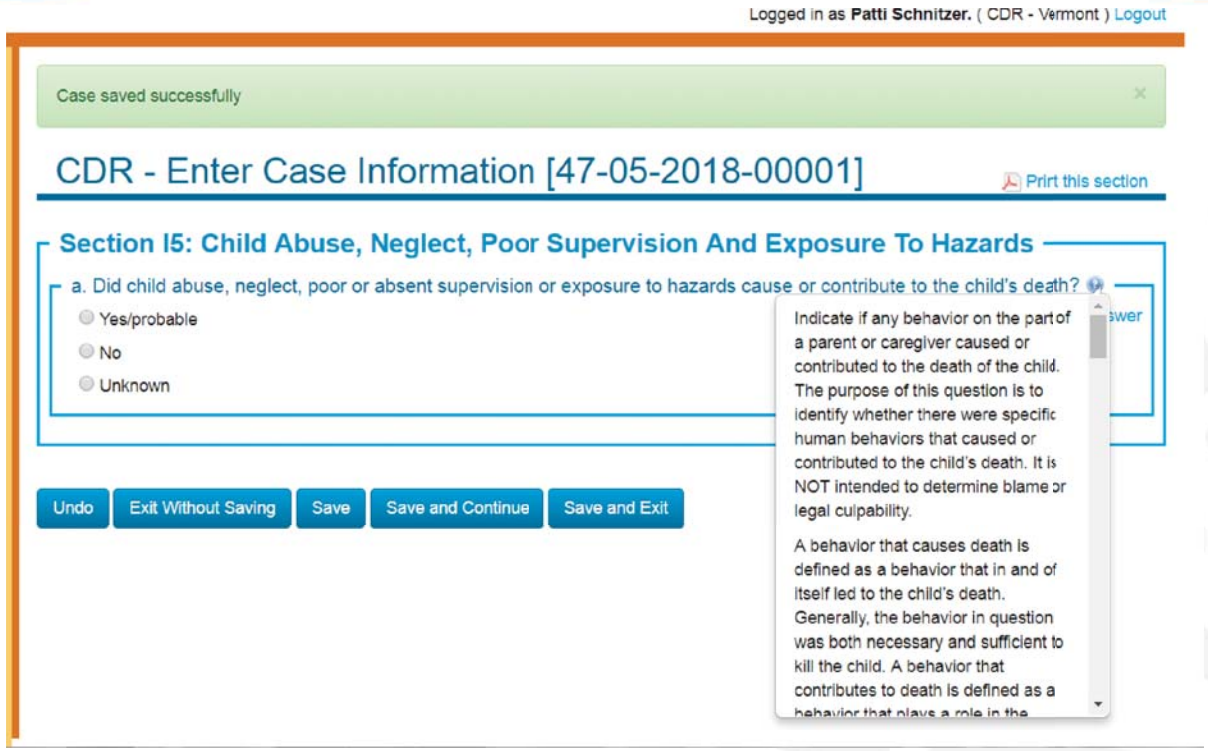
Allowing CDR teams to make determinations of abuse or neglect that might be different than CPS or criminal definitions.

Version 5 Section I5: Child Abuse, Neglect, Poor Supervision and Exposure to Hazards

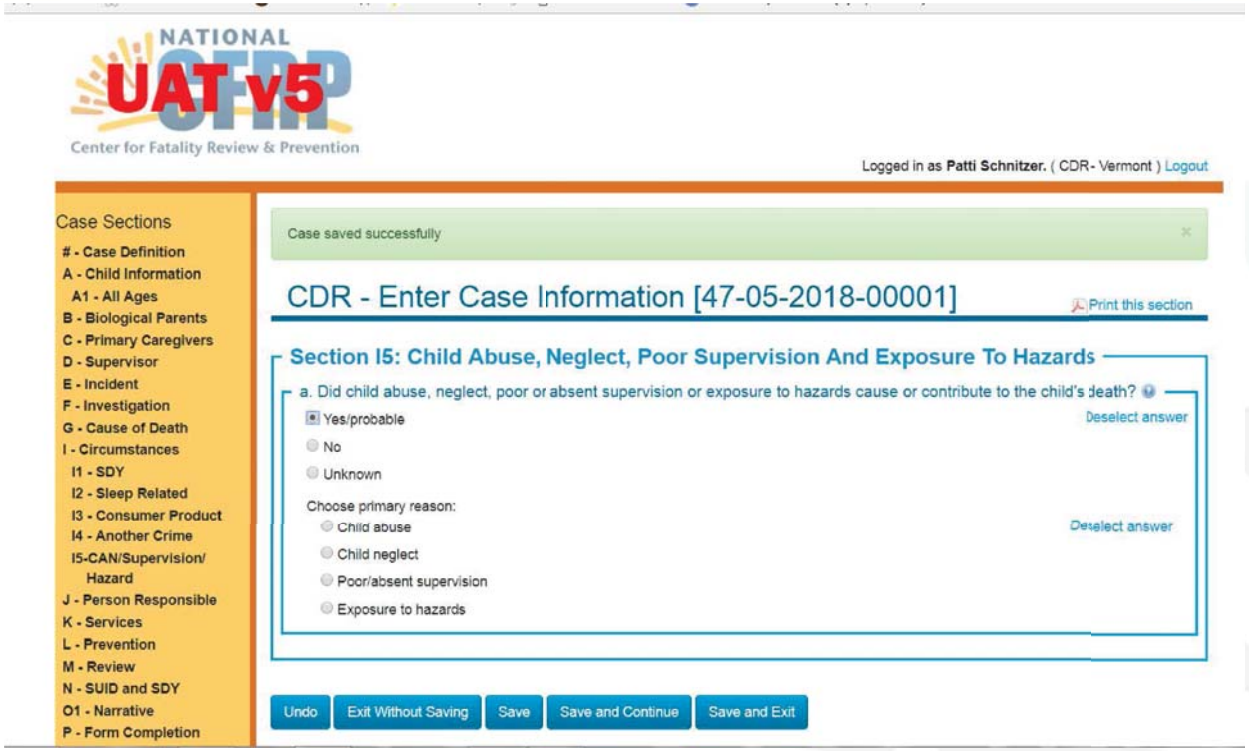


Do not include child's own behavior!

Version 5 Section I5: CAN Definition



Version 5 Section I5: Child Abuse, Neglect, Poor Supervision and Exposure to Hazards



Section I5. Child Abuse, Neglect, Poor Supervision and Exposure to hazards

Section I5 should be considered for all deaths

- Most natural deaths will not be related to child abuse, neglect, poor/absent supervision or exposure to hazards
  - potential for failure to seek or provide medical care, or religious practices to contribute to a death should be considered and documented when appropriate.
- Injury deaths among young children are most likely to be related to child abuse, neglect, poor/absent supervision or exposure to hazards;
  - circumstances of all injury deaths should be reviewed and any identified abuse, neglect, poor supervision, exposure to hazards should be documented when appropriate.
- Undetermined or unknown cause deaths – child abuse, neglect, poor supervision or exposure to hazards that cause or contribute to the death might be identified and when they are, should be documented.

I5a. Did child abuse, neglect, poor/absent supervision or exposure to hazards cause or contribute to the death?

- Indicate if any behavior on the part of a parent/caregiver/supervisor caused or contributed to the death of the child.
- The purpose of this question is to identify whether there were specific human behaviors by a parent/caregiver/supervisor that caused or contributed to the child's death.
- The purpose of this section (and CDR more broadly) is to document circumstances and identify risk factors for use in developing prevention strategies, NOT to determine legal culpability or substantiate child maltreatment.
- Consequently, although legal definitions for some categories (e.g., child abuse, neglect, negligence) may be available, they should not be used as criteria for completing this section.

I5a. Did child abuse, neglect, poor/absent supervision or exposure to hazards cause or contribute to the death?

Examples include (but are not limited to):

- A caregiver shaking an infant so hard to cause severe head trauma and death.
- A caregiver that withholds lifesaving medical care or prescribed treatment.
- An unsupervised toddler falling into an open residential pool and drowning.
- A child left in a closed car on a hot day who dies from hyperthermia.
- A caregiver who unintentionally rolls onto an infant in an adult bed and the infant suffocates.
- An infant suffocates due to thick blankets in the sleep environment.

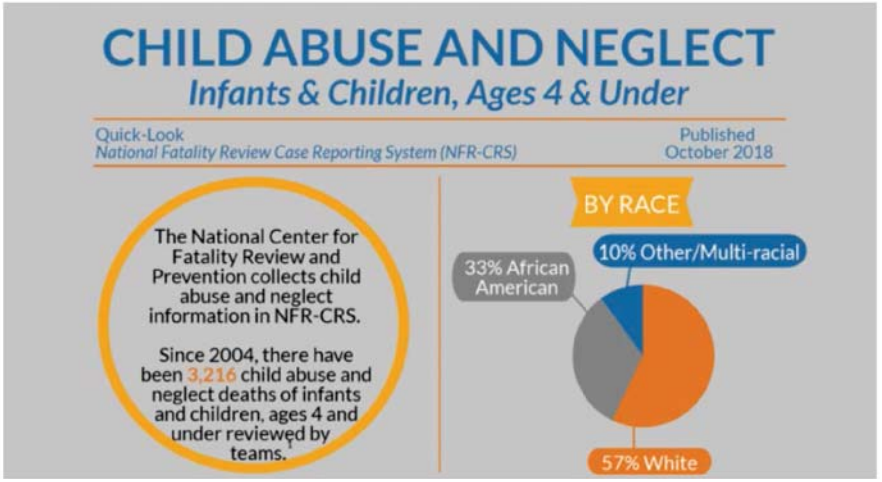
Case Definition, Identification, & Selection

- **Define the population of cases you want to review.** Cast a broad net.
- **Minimum records required for quality review.** Although there are different purposes for reviews, these four sources are considered required for a quality review for ANY purpose.
  - Records from the medical examiner/coroner.
  - Medical records.
  - Law enforcement reports/records.
  - Child welfare records.

Involvement in the child protection system should not be the only consideration. This could prevent the team from exploring why children who should have been known to CPS were not, prior to their deaths.

Child Abuse and Neglect Quick-Look

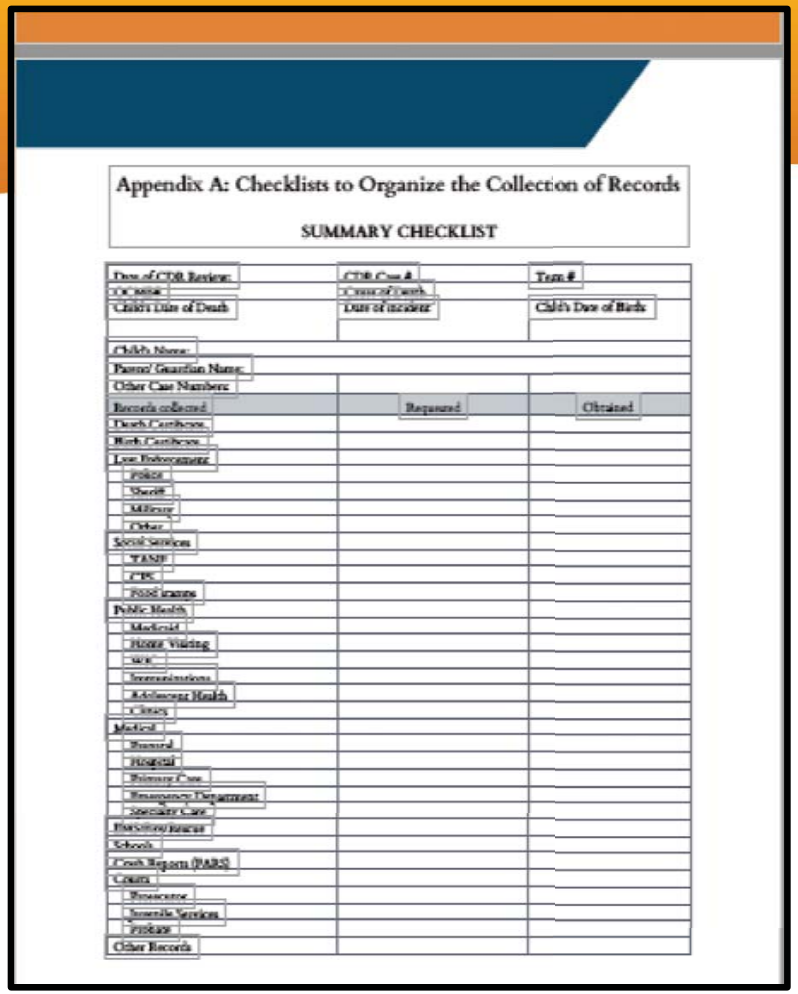
Access the quick-look https://www.ncfrp.org/resources/quick-looks/



Tips for conducting reviews

Core Review Processes

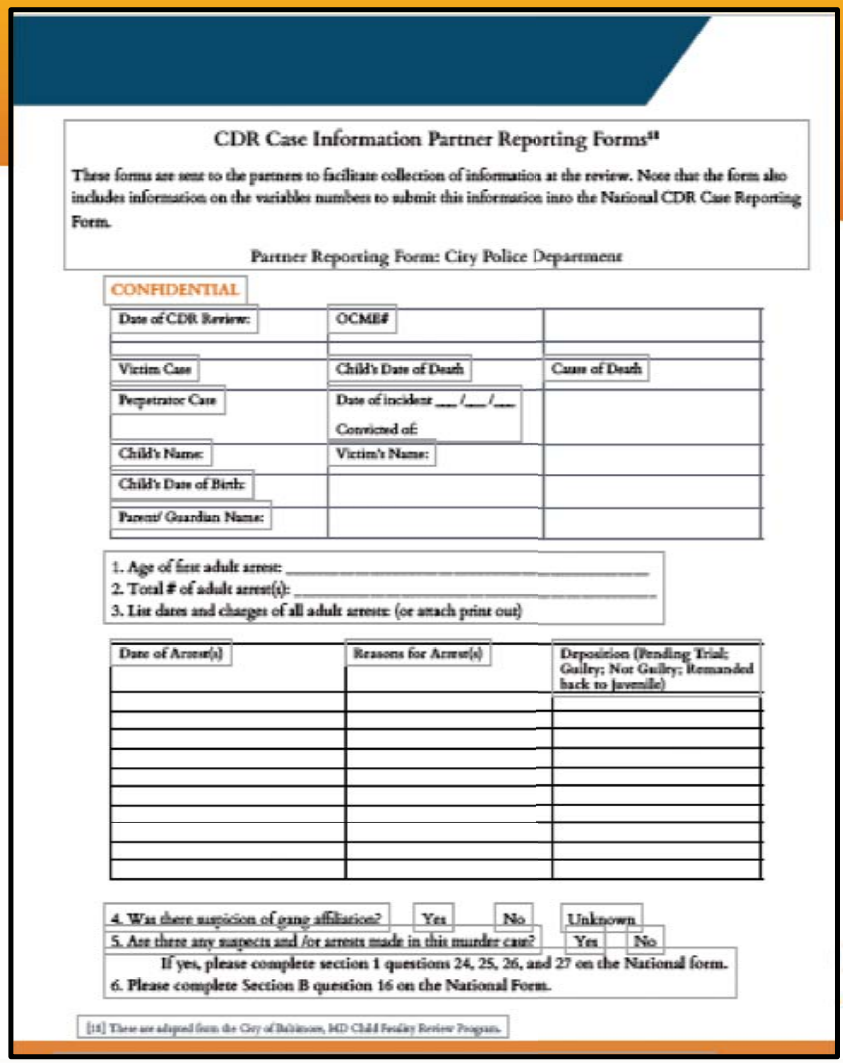
- Case Definition
- Case Identification
- Case Selection
- Data Tool Development
- Team Membership
- Gathering and Disseminating Case Information
- Case Preparation
- Conducting Meetings
- Recommendation development
- Reporting
- Team Support



Appendix A: Checklists to Organize the Collection of Records

SUMMARY CHECKLIST

Date of CDR Review:	CDR Case #	Team #
OCME#	Cause of Death	
Child's Date of Death	Date of Incident	Child's Date of Birth
Child's Name:		
Parent/ Guardian Name:		
Other Case Numbers:		
Records collected	Requested	Obtained
Death Certificate		
Birth Certificate		
Law Enforcement		
Police		
Sheriff		
Military		
Other		
Social Services		
TANF		
CPS		
Food stamps		
Public Health		
Medicaid		
Home Visiting		
WIC		
Immunizations		
Adolescent Health		
Clinics		
Medical		
Prenatal		
Hospital		
Primary Care		
Emergency Department		
Specialty Care		
Psychiatric/Mental		
Schools		
Crash Reports (PARS)		
Courts		
Prosecutor		
Juvenile Services		
Probate		
Other Records		



CDR Case Information Partner Reporting Forms[11]

These forms are sent to the partners to facilitate collection of information at the review. Note that the form also includes information on the variables numbers to submit this information into the National CDR Case Reporting Form.

Partner Reporting Form: City Police Department

CONFIDENTIAL

Date of CDR Review:	OCME#	
Victim Case	Child's Date of Death	Cause of Death
Perpetrator Case	Date of incident ___ /___ /___ Convicted of:	
Child's Name:	Victim's Name:	
Child's Date of Birth:		
Parent/ Guardian Name:		

1. Age of first adult arrest: _____
2. Total # of adult arrest(s): _____
3. List dates and charges of all adult arrests: (or attach print out)

Date of Arrest(s)	Reasons for Arrest(s)	Deposition (Pending Trial; Guilty; Not Guilty; Remanded back to Juvenile)

4. Was there suspicion of gang affiliation? Yes No Unknown
5. Are there any suspects and /or arrests made in this murder case? Yes No
   If yes, please complete section 1 questions 24, 25, 26, and 27 on the National form.
6. Please complete Section B question 16 on the National Form.

[11] These are adapted from the City of Baltimore, MD Child Fatality Review Program.

Case Preparation

- A case narrative should be prepared based on all records available and shared in advance with members of the review team.
- In addition, a timeline showing contacts with all agencies and organizations prior to the death should be created and shared in advance.
- For cases with complex family compositions, a family genogram is recommended.

Appendix B: Timeline of Circumstances Leading to a Maltreatment Fatality

Note: This is a fictitious case developed for training purposes only

Isaac Jones
Date of Report: November 2010

DOB: 10/18/2006
Date of injury: 5/25/2010

Parents: Bio-mother: Jennifer Smith, 22
Bio-father: Andrew Jones, 22

Other Adult(s): Erica Jones, 21, Step-mother to Isaac
Kendrell Green, 21, Jennifer Smith's fiancé

Placement at time of injury: Living with Father and Step-mother

Siblings/Children: Samuel (Smith) 7 years
Kendrell Green, Jr., 1 y/o
Jonathon Jones, 10 m/o.

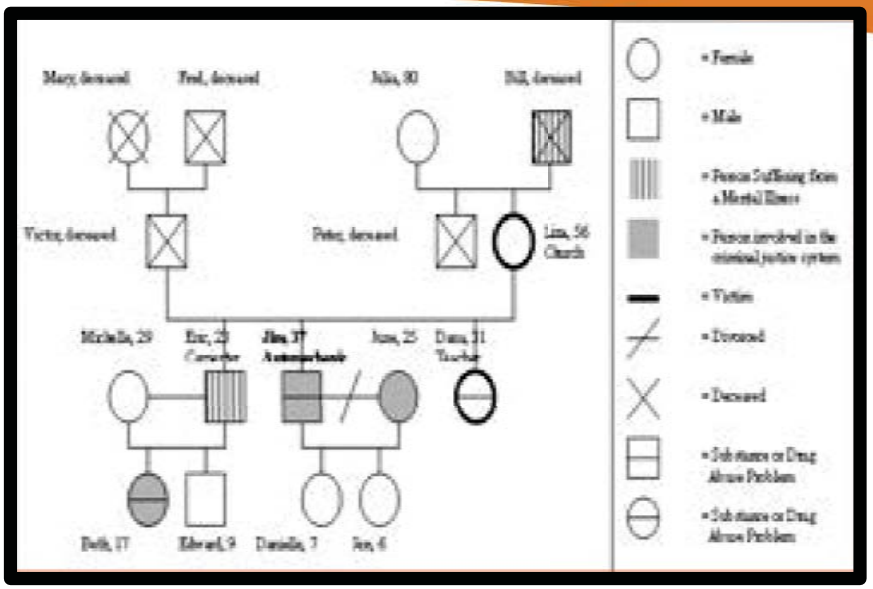
INVESTIGATION HISTORY: Three-year-old Isaac was brought to the community hospital ER, by his bio-father, Andrew Jones and step-mother, Erica Jones, unresponsive. He was airlifted to the trauma center. Medical diagnosis is:

- Diffuse axonal injury
- Cerebral edema
- Acute cerebral hypoxic-ischemic injury
- Subacute to remote traumatic central nervous system injuries
- Bilateral subdural neomembranes
- Subacute contusion, left optical lobe
- Vision and hearing loss
- Numerous contusions on the body and scarring on the back tissue; old pattern injuries on the leg
- Healing and old rib fractures

The long-term prognosis is that he will not fully recover and will be blind, have limited cognitive abilities, require a feeding tube and have paralysis.

The explanation given by parents was that he had fallen out of bed while taking a nap. According to the step-mom, she had dropped Isaac's dad off at work around 6:50 p.m. Isaac had been put down to sleep in an adult bed at 7 pm. When she checked on him at 9:00 pm,, she discovered him on the floor. She called the dad and they brought the child to ER.

The examining doctor at the trauma center found extensive swelling to the left side of the child's head, his eyelid was



Case Discussion

To help ensure that their reviews remain child focused, one state always displays the child's photo on a screen during their discussion

- The personal story of children should be a part of reports and discussions
- Be systematic and use a discussion guide. This can serve as a reminder for whether or not the team has reviewed the richness and complexity of the child's life as well as their death.
- Child welfare cases should have a comprehensive case summary narrative when cases are closed.
- Create ways to "remember the past" but also move forward in terms of the totality of the work.
- Use science/evidence based reasoning in their discussion.
- It is important that good group management is practiced, and that facilitators keep the group on track.

Case Findings and Recommendations

- Best practices for reaching conclusions based on the case review process.
  - Be impartial and objective.
  - Move the discussion from the circumstances of an individual case to what the findings are (missed opportunities, systems improvements, and prevention strategies/ideas).
  - Draw conclusions from the case(s) review discussion.
  - Have a systematic way to record findings or recommendations.
  - Apply a health equity lens and include social determinants as part of the discussion.
  - Discuss findings on every case, compile and meet separately for recommendation: Delaware example.
- Before full findings are made, no ideas are bad, but there needs to be a narrowing down process to get from case discussion to findings to recommendations.
- There needs to be a prioritization process for the key findings and the recommendations.

Allow opportunity for immediate staffing on critical findings

Case Findings and Recommendations

Findings

- Discuss strengths.
- Talk about what is unique to come up with findings.
- Not every finding should lead to a recommendation.
- Use a systematic approach to document and track findings.

Recommendations

- Create Specific, Measurable, Actionable, Realistic, Time-Bound (SMART) recommendations, make sure they are not DUMB = Delusional, Unrelated, Murky, Biased.
- Involve partners in the development of recommendations to encourage buy in.
- Prioritize recommendations.

Does multidisciplinary case review lead to Improving Systems-Agency Policies and Practices

- Did agencies follow acceptable practice/policies in meeting the needs of the child before, at time of and after death?
- Are there gaps in delivery of services to family/child?
- Are there specific agency policies or practices that should be changed, improved on, implemented?
- How can we best notify the agenc(ies) about our findings?

Major Policy Changes Made Following Reviews

186 deaths in 1999-2001

↓

170 deaths in 2002-2004

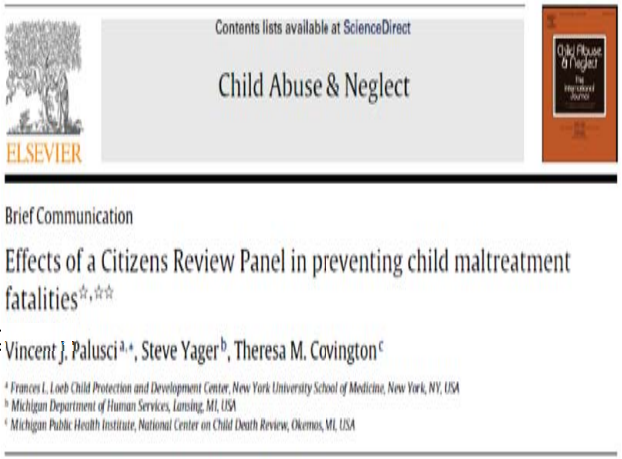
9% drop in deaths

264 findings

↓

172 findings

35% drop in findings



Vincent J. Palusci, Steve Yager, Theresa M. Covington. Effects of a Citizens Review Panel in preventing maltreatment fatalities, C*hild Abuse and Neglect, 09: September*

Table 3
Case review findings and changes: CPS investigation, assessment and services.

Finding	Problem area	Annual # Cases: Period I	Period II	% Change (decrease)	System changes
5. Inappropriate screening-out of complaints and delay in acceptance of complaints and case assignment	Non-compliance	6.7	1.0	(85.1)*	New CPS peer review program
6. Incomplete and insufficient complaint investigation by MDHS staff. ("Incomplete" refers to concluded investigations, but no supervisory sign-off; "insufficient" refers to the apparent omission of required tasks.)	Non-compliance	9.0	6.0	(33.3)	New training at CPS training institute for new hires
7. Unacceptable time lapses between assignment and contact with families	Non-compliance	4.0	0.7	(82.5)*	New CPS peer review program
8. Failure of CPS supervisor to sign off on child abuse/neglect assessments and/or properly review the case materials, in accordance with established procedures	Non-compliance	2.5	1.3	(48.0)	New mandatory CPS supervisor training
9. Poor communication among law enforcement and MDHS and failure to perform joint investigation resulted in the whole picture of the child and family's condition not being properly investigated	Poor practice	2.7	2.3	(14.8)	New protocol for joint investigation Development of Child Advocacy Centers
10. Inaccurate assessment and improper coding of the five-tiered system	Poor practice	11.7	8.7	(25.6)	New training at CPS training institute for new hires
11. Failure to perform complete investigations regarding medically fragile children	Poor practice	1.7	0.3	(82.4)	New protocol and training sessions for medically fragile infants and Munchausen by Proxy
12. Failure to comply with policy requiring that positive drug screens in newborns result in automatic finding of preponderance of evidence of failure to protect	Non-compliance	1.0	0.3	(66.7)	New birth match system linking birth certificates with CPS records
13. Failure to properly investigate for complaints when otherwise indicated because of inability to contact parents without evidence of due diligence	Non-compliance	1.7	2.0	+17.6	New protocol for joint investigation
14. Failure of worker to properly assess well-being of child(ren) in the home or recognize imminent danger and take protective custody	Poor practice	3.0	1.3	(56.7)	New protocol for joint investigation
15. Failure to recognize and respond to parents' repeated and clear indications that they do not want the child/children	Poor practice	2.5	0.7	(72.0)	Passage of "Safe Delivery Act" allowing parents to safely leave infants at hospitals and other facilities
16. Safety Assessment completed incorrectly or not at all	Non-compliance	6.5	1.3	(80.0)	Statewide CPS training on assessment tools Data system upgrades
17. Risk Assessment completed incorrectly or not at all	Non-compliance	9.5	1.3	(86.3)*	Statewide CPS training on assessment tools

Reporting

- *What should be included in a report?*
  - A listing of key findings and a description of the evidence that supports them, as well as the recommendations and/or action plans that emerge from them.
- *When/where should reports be presented?*
  - Most states must at minimum produce a report annually. If an emerging issue is identified, more immediate reporting is recommended.
- *Who should be involved in preparing your report?*
  - An individual usually serves as the lead for the production of the report. But other team members and stakeholders should be involved, the earlier in the process the better.
- What format?
  - Consider fact sheets, full reports or shorter Executive Summaries.

Recording Findings: Appendix C - Templates

Appendix C: Templates to Record Findings

Template One

ires findings and recommendations on a continuum of services and activities that usually occur when ying at risk children and responding to the deaths. This template can be used for every case, and then gs can be aggregated and tabulated." Below is the template with a couple of examples included:

Case summary: 6-month-old child found unresponsive while sleeping on floor with mother. Mother was using heroin evening before death. Two siblings living at grandmothers. Two prior referrals for neglect, unsubstantiated with voluntary safe sleep information and home visit provided.					
Services/Activities	Findings				Recommendation
	Agency	Before death	At time of death	After death	
Investigation of and reporting to CPS of suspected maltreatment	Birth hospital did not report substance exposed infant to CPS	X			Require and provide education to all area birth hospital staff on an annual basis on mandatory reporting
Investigation and response by law enforcement					
Investigation and response by coroner/medical examiner	Skeletal surveys were not completed at autopsy		X		Ensure all infants receive full x rays upon autopsy at forensic center
Case intake and investigation by CPS	Siblings were not assessed because they were away at grandmother at time of death		X		Change policy to require siblings of deceased children who have prior CPS histories are assessed within 136 hours after child death
Provision of services by CPS					
Provision of other services	Mother had refused health department home visiting services after birth	X			Conduct an assessment of all HV refusals, and develop a plan to improve rate of acceptance
Actions taken by civil and criminal divisions of DA/ courts					
Other					

Template Two

This template was borrowed from the state of Tennessee's Safety Systems Map. It works to identify systems issues and then links these issues to outcomes. This template is particularly focused on child welfare systems practice and staff to guide improvements in their safety culture. Again, tabulating findings after a period prior to making recommendations is most effective.

Case summary: 6-month-old child found unresponsive while sleeping on floor with mother. Paramour sleeping in bed. Mother was using heroin evening before death. Two siblings staying overnight at grandmothers not assessed for safety after death. Two prior referrals for neglect, unsubstantiated, with voluntary safe sleep information and home visit provided. Death ruled accidental, not substantiated.					
Actor	Findings				Recommendations
Government/Regulatory bodies	Investigation mandated by law, multi-agency response is not	Rules for Plans of Safe Care not completed by legislature			
External entities	Intense media attention	Birth hospital did not report substance exposed infant to CPS	Law enforcement did not conduct reenactment of sleep scene		
Organizational Factors (Central Office)	Hotline decision making tool does not include unsafe sleep situations				
Organizational Factors (regional office)	Supervisor did not review prior neglect reports				
Conditions, processes and actor activities	Prior CPS visit did not assess sleep environment	Referral for substance abuse treatment not followed up by caseworker	Worker distraught and left agency following death.	Mother's paramour was not interviewed or investigated	
Outcome					

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Team Member Supports

- Training
- Coaching
- Secondary trauma supports
- Team facilitation support
- Building up critical thinking skills

Key Contacts

- For more information contact:
  - Abby Collier, Director, NCFRP acollier@mphi.org
  - Teri Covington, Director, Within Our Reach tcovington@alliance1.org
  - Patti Schnitzer, epidemiologist, NCFRP, pschnitzer@outlook.com

Questions

- As a reminder:
  - Questions can be typed into the “Questions” pane
  - Due to the large number of attendees, we may not be able to get to all questions in the time allotted
  - All unanswered questions will be posted with answers on the NCFRP website
  - **Recording of webinar and copy of slides will be posted within 2 weeks on the NCFRP website: www.ncfrp.org**

NCFRP is on Social Media: NationalCFRP

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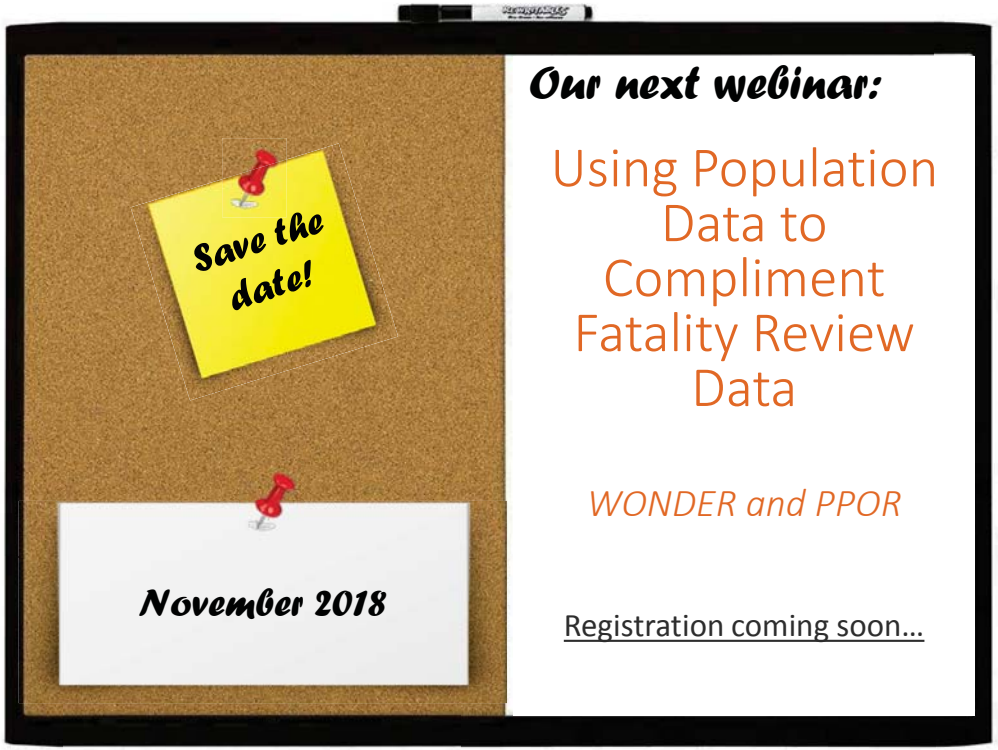
What's Next?



Our next webinar:

Using Population Data to Compliment Fatality Review Data

WONDER and PPOR

Registration coming soon…