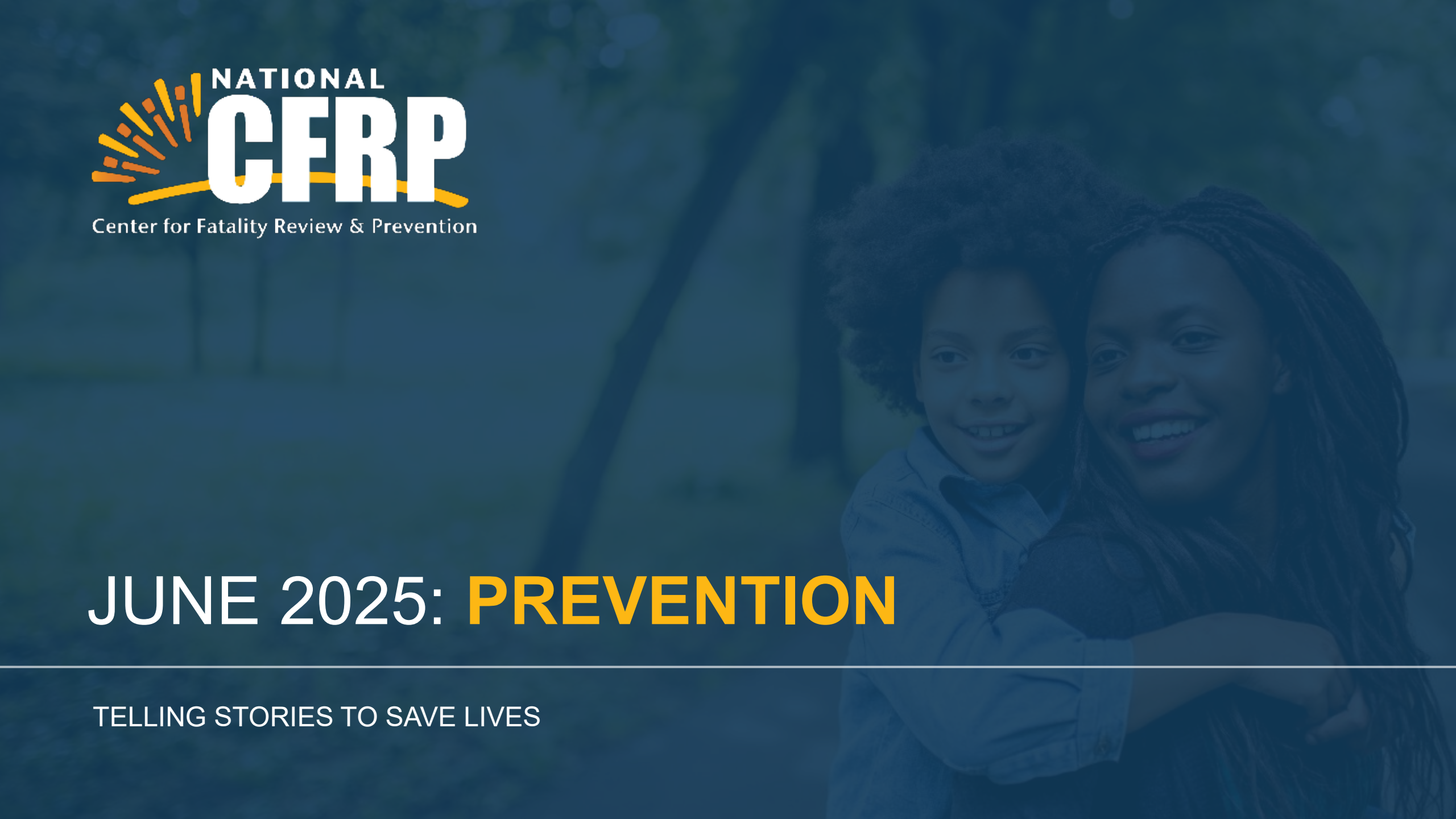
NATIONAL CFRP

Center for Fatality Review & Prevention



JUNE 2025: PREVENTION

TELLING STORIES TO SAVE LIVES

AGENDA

Defining Prevention

Identify how prevention fits into every step of the SMRC process.

Crafting Findings and SMARTE Recommendations

Describe how findings and SMARTE recommendations can direct and catalyze prevention.

Using Adult NFR-CRS for Prevention

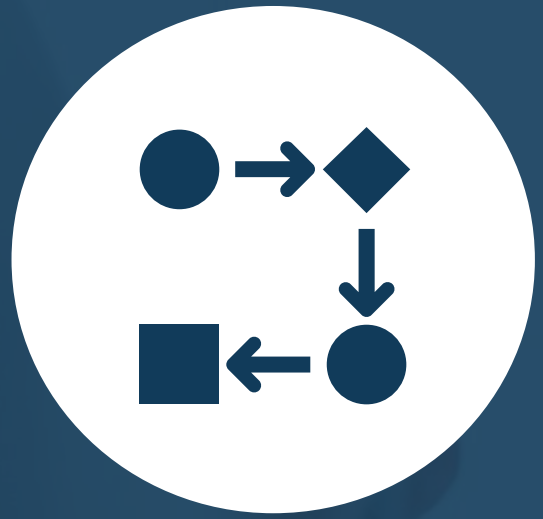
Identify how Adult NFR-CRS can be leveraged to support prevention activities.

Engaging Partners in Prevention

Understand the vital role that partners play throughout the SMRC process.

Identifying Action Steps

Clarify next steps for embedding prevention work into your SMRC.



PREVENTION PROCESS

Create a Plan for Action

SMRC Process

Prevention in Every Step

1. **Notification of Suicide**
   - Source: Coroner or ME
2. **Cases selected for review**
3. Family/Next **of Kin** contact, as applicable
   - Postvention resources **and**/or Release of Information
4. **Data collection**
   - E.g., SCRAP, medical records, police records
   - Used to create and disseminate a case summary
5. Suicide Mortality Review Team **meeting** occurs
   - Risk identification matrix is completed
   - Members share their key records
6. **Individual findings and recommendations** recorded
   - Focus on prevention.
7. **Aggregate findings and recommendations** analyzed for trends
8. **Recommendations** developed and submitted to implementing team

SMRC Process

Prevention in Every Step

1 Notification of Suicide

- Better identification of service members, veterans, and their families.
- Changes in death scene investigation processes.

2 Cases selected for review

- Risk factor-driven decisions based on community needs and priorities.

3 Next of Kin interviews

- Hear how the decedent and their family experienced the systems they navigated.

4 Data collection

- Document what we might "know" about a community.
- Identify data gaps which can tell as much as data trends.

5 Review team meeting

- Thoughtful discussion, exploration of systems, and integrating decedent/family experiences with professional responses.

6 Individual findings and recommendations

- Focus on prevention.
- Use Adult NFR-CRS as a tool.

7 Aggregate findings and recommendations

- Examine trends.
- Requires partners to be engaged in an intentional and consistent method.

8 Recommendations

- Engage partners to catalyze and drive change.

FINDINGS AND RECOMMENDATIONS

Be Intentional and SMARTE

THE SHIFT TO FINDINGS

Moving From Recommendations to Findings

Create Findings

Objective facts about the case that identify key risk and protective factors.

Prevention Activities

Hand-off prevention recommendations to partners and evaluate implementation.

Review Findings

Assemble a broad group of partners to review findings to identify opportunities for prevention.

Write Recommendations

Use that same group of partners to write prevention recommendations.

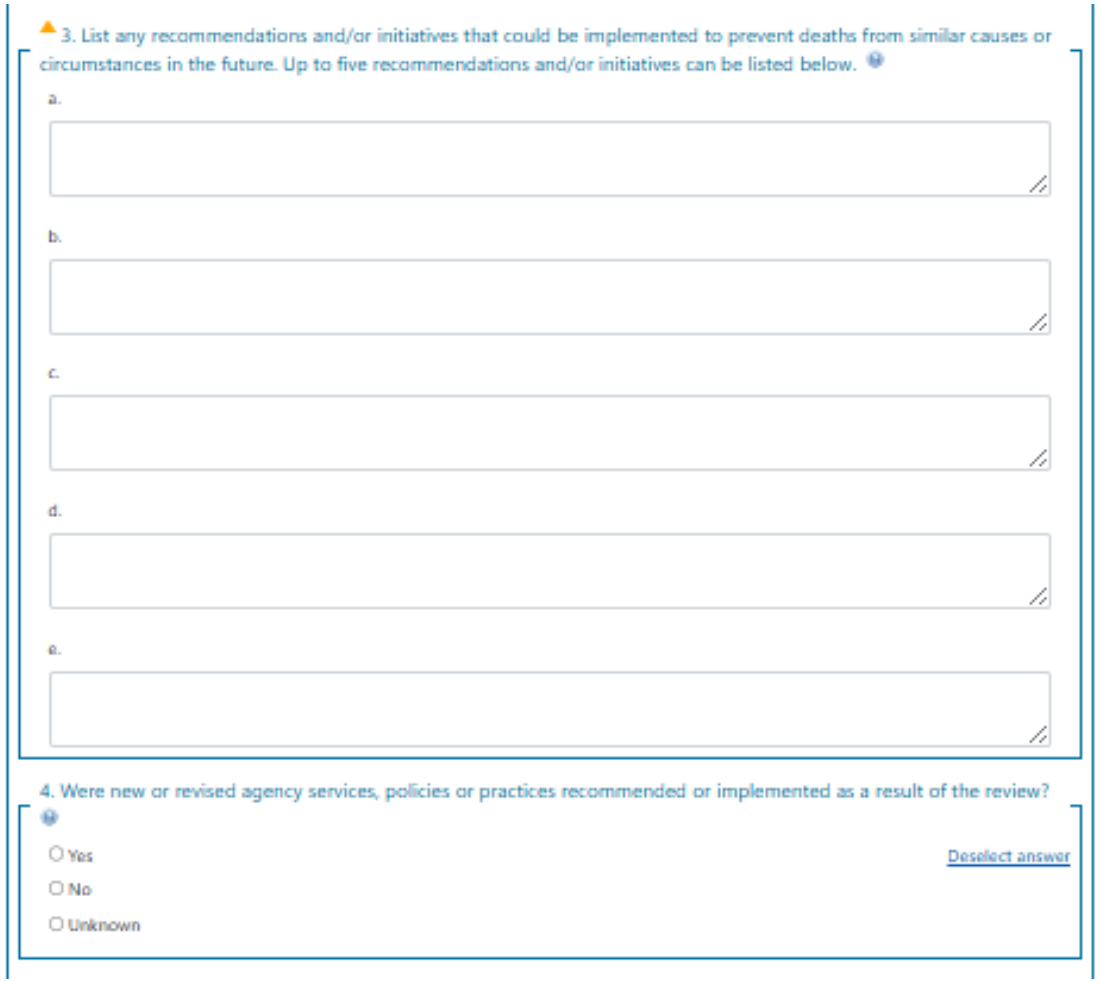
FACTS ABOUT THE CASE

DEFINING FINDINGS

- Objective facts that are tied to key risk and protective factors.
- Focus on how systems interacted and are identified for every case.
- Findings should be used to write formal prevention recommendations.
- Risk Prevention Matrix should be incorporated.

Section H: Findings

Risk and Protective Factors Impacting Suicides



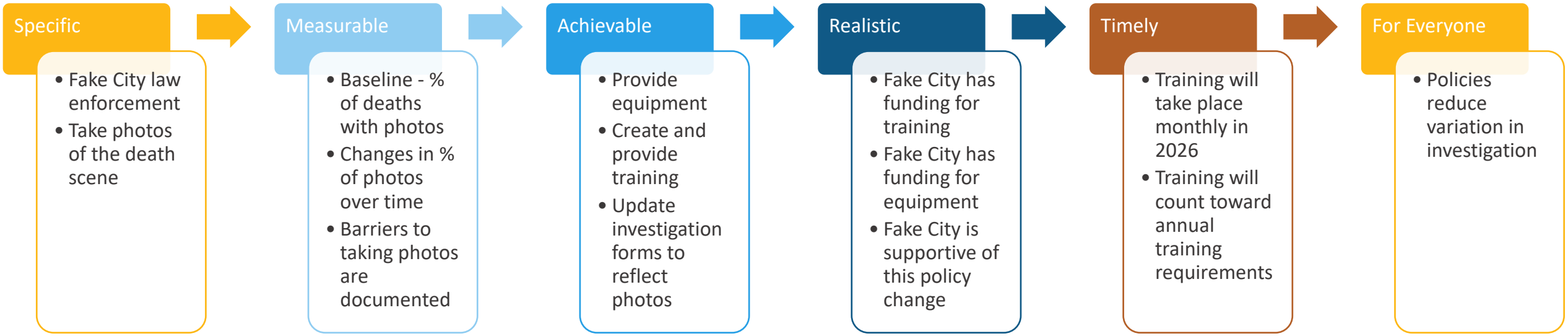
Be SMARTE

A Framework for Consistency and Action

Specific	Measurable	Achievable	Realistic	Timely	For Everyone
• Use numbers • Identify partners by name • Describe the needed resources	• Consider evaluation from the beginning • Define success • Consider a multifaceted approach	• Outline action steps • Identify barriers and potential solutions • Consider if this goal should be broken into smaller goals	• Align the goal with values, community needs, and political will • Compare resources needed to what is available	• Set a deadline • Balance progress with reality • Use measurement goals to help shape a timeline	• Identify if this activity decrease gaps in outcomes? • Identify communities that are at the greatest risk and invite them into the process

Sample Recommendations

Improve Data Collection at the Death Scene



Putting the Pieces Together

Death Scene Investigation

Fake City Law Enforcement will increase the number of death scene investigations that have comprehensive photos documenting substances at the scene by 25 percent by June 30, 2026, by instituting monthly agency wide training and purchasing needed equipment.

Sample Recommendation

Reduce Access to Lethal Means

Specific

- Fake City Health Department
- Fake City Gun Range
- Create process for storing firearms when someone is in a mental health crisis

Measurable

- Baseline – Number of resources in the community for temporary storage
- Number of firearms stored

Achievable

- Fake City Gun Range is willing to partner and create standard policy
- Fake City Health Department is willing to create and distribute resources

Realistic

- Agencies in Fake City are willing to promote this resource
- There is support from firearm advocates to expand temporary storage options

Timely

- Goal date for finishing is June 30, 2026
- Policy will be drafted by December 31, 2025
- Materials will be drafted by March 31, 2026

For Everyone

- Will increase access to safe storage
- Fake City Gun Range is in an area that experiences a higher number of suicides

Putting the Pieces Together

Temporary Storage

Fake City Health Department will work with Fake City Gun Ranges to develop a process for gun ranges to store firearms during mental health crises and will increase the number of participating gun ranges from 10 to 50 by the end of 2026 to help increase access to safe storage in Fake City areas that experience elevated suicide deaths.

Paths to Prevention

CATALYZING PARTNERSHIPS TOWARD ACTION

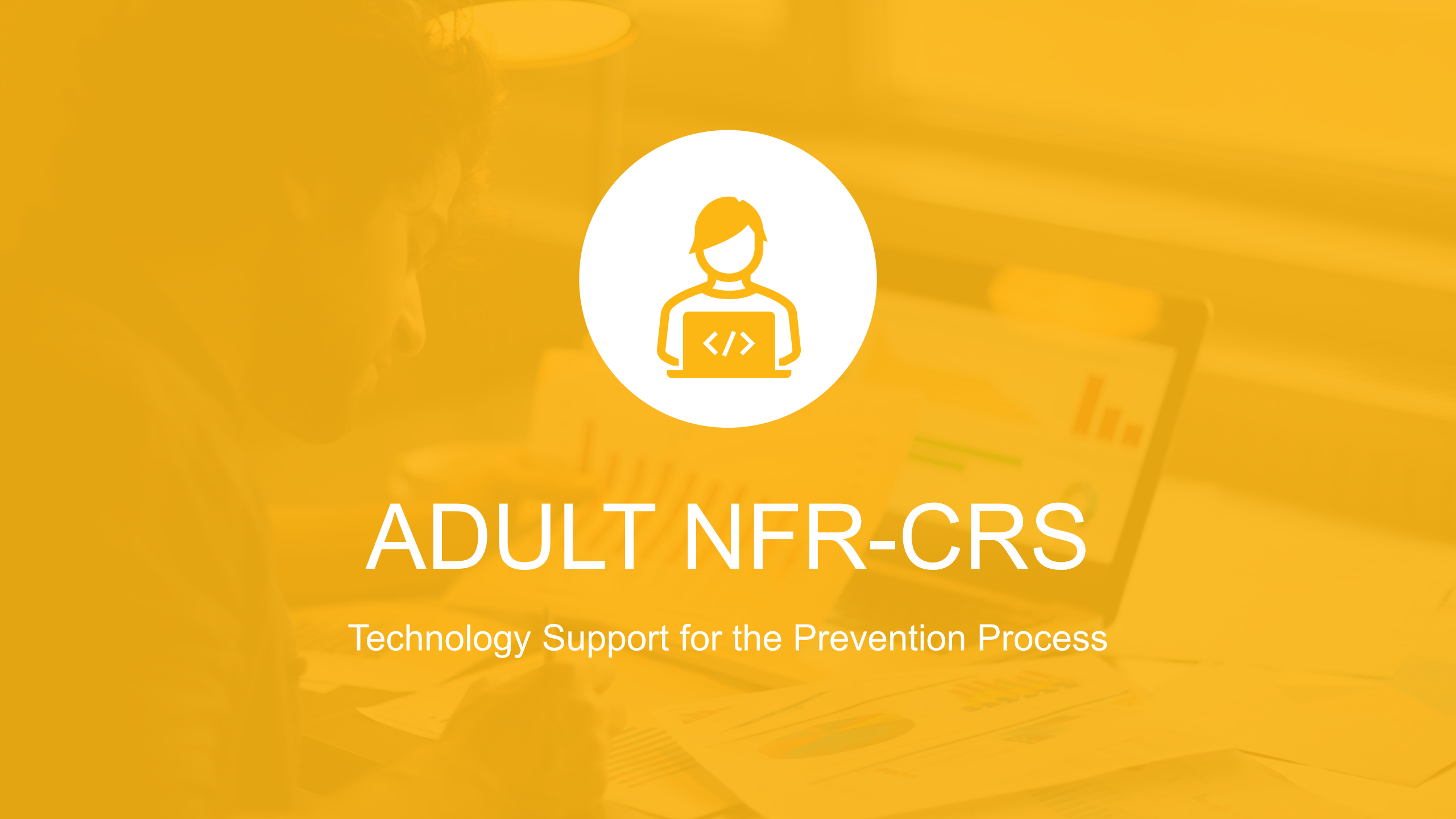
ACTION TEAM

Receives aggregate findings and draft recommendations to finalize recommendations.

Existing partners already engaged in prevention work.

DIRECT IMPACT

SMRC directly finalizes prevention recommendations and directly does the work to implement and evaluate prevention.

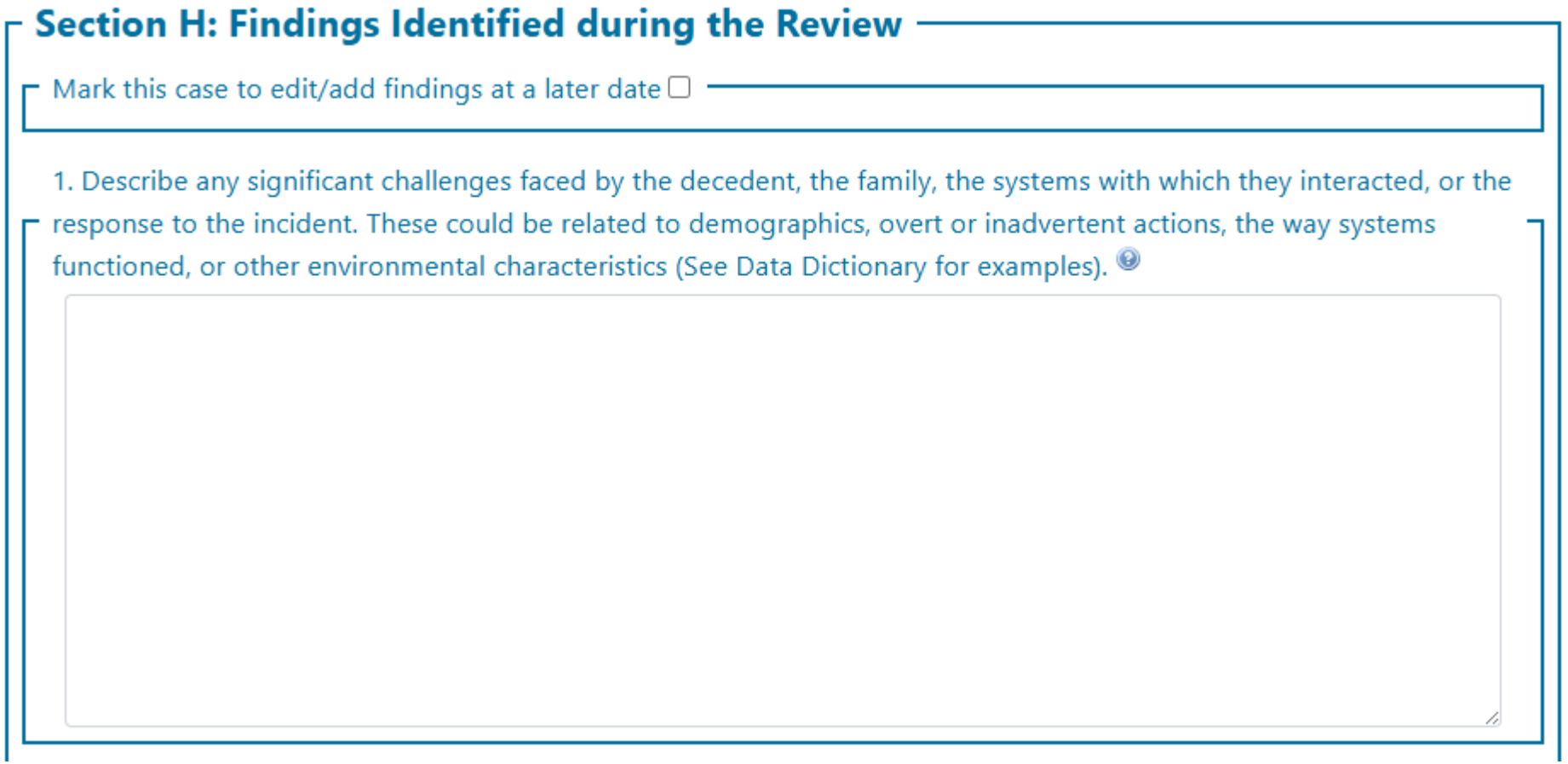


ADULT NFR-CRS

Technology Support for the Prevention Process

Section H: Findings

Risk and Protective Factors Impacting Suicides



Section H: Findings

Risk and Protective Factors Impacting Suicides

2. Describe any notable positive elements in this case. They could be demographic, behavioral, or environmental characteristics that may have promoted resiliency in the decedent or family, the systems with which they interacted or the response to the incident (See Data Dictionary for examples).

Section H: Findings

Recommendations

3. List any recommendations and/or initiatives that could be implemented to prevent deaths from similar causes or circumstances in the future. Up to five recommendations and/or initiatives can be listed below.

a.

b.

c.

d.

e.

Section H: Findings

Recommendations

4. Were new or revised agency services, policies or practices recommended or implemented as a result of the review?

- ○ Yes
- ○ No
- ○ Unknown

Deselect answer

Standardized Report

Standardized Report 15: Findings Identified During the Review

Findings Identified during the Review

State: Fake State
Local Team: Team A
Age: All Ages
Sex: All Sexes
Hispanic or Latino/a origin: All Origins
Military Status: All Deaths (Military and Non-Military)
Cases Selected By: Review Year
Review Year From: 1995
Review Year To:2025

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Findings Identified during the Review							
Case Number	Age	Manner	Cause	Policy or Practice Change	Risks	Protective Factors	Recommendations
63-001-2025-00001	35	Suicide	External-Poison	No	Decedent was not seen for menta health issues in the 2 weeks preceding death. The decedent's established therapist was out of town, and the decedent was not willing to see an alternative practitioner.	The death scene investigation was thorough (all investigative parties were present) and included a family interview the decedent's spouse and adult children.	Zoning to limit the location and density of alcohol outlets in the decedent's community.

PARTNER ENGAGEMENT

Meaningful Relationships Start at the Beginning

BENEFITS OF PARTNERSHIP

Comprehensive Understanding

Well rounded partnerships promote improved understanding of how systems function.

Transparency and Trust

Long-term partnerships can foster a willingness to share gaps.

Improved Decision-Making

Insights from a multifaceted group of partners can improve decision-making.

Policy Development

Policies are best developed with those impacted.

Accountability and Quality Improvement

Creates layered opportunities for improvement and shares accountability.

Identify Key Partners

Identify the individuals, organizations, and groups that have an interest in fatality reviews and represent the populations being reviewed. This could include professionals, community members, advocacy groups, and more. Make sure to include the agencies involved in the planning meeting discussed in May.

Mutually Agreed Upon Process for Sharing Information

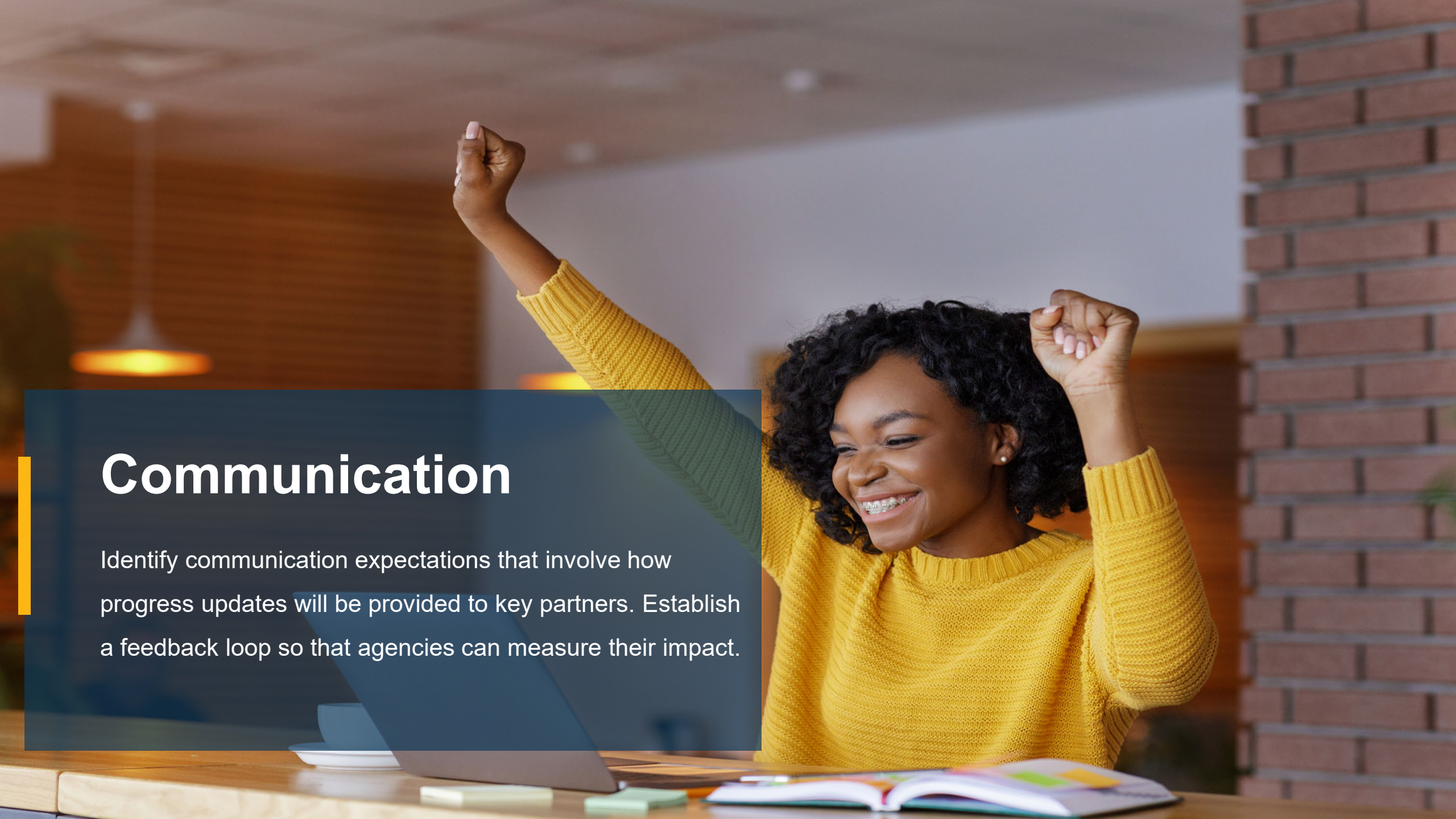
ESTABLISH THE “HANDOFF”

- What information is needed to transition the recommendation to the party?
- Are there other partners that should participate in the transition discussion?
- How should the information be transitioned?

CULTIVATING BELONGING

Ensuring All Voices Are Valued

- Acknowledge the individuals in the group first.
- Recognize that each person has different circumstances, professional orientations, and different participation needs.
- Establish what everyone needs to participate in a group.
- Implement facilitation methods to ensure all involved are afforded the opportunity to influence the intended outcome.



Communication

Identify communication expectations that involve how progress updates will be provided to key partners. Establish a feedback loop so that agencies can measure their impact.

ACTION STEPS

Finding a Tangible Starting Point

Setting a Strong Foundation

Action Steps if Fatality Review is Establishing

COMMUNITY SCAN

Conduct a scan of partners working in and around suicide prevention.

LISTEN

Engage with a broad group of partners and listen to their insights.

BUILD RELATIONSHIPS

Cultivate and develop relationships with and between partners.

Review Findings and Craft Recommendations

PRACTICE REFINES PROCESSES

FINDINGS

Review the findings that your team has compiled since its inception. This can be an opportunity to conduct QI on the SMRC process.

RECOMMENDATIONS

Convene partners to use the findings that have been documented to practice writing recommendations.

CONTACT INFORMATION

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