



DOCUMENTING PREVENTION: **OUTCOMES AND IMPACTS OF FATALITY REVIEW**

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).



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



Email the National Center at 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

The speakers have no financial relationships or interests to disclose.



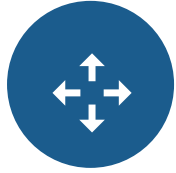
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Define and Operationalize Systems Change

Explore the components of a system, including layers of change.



Describe How Fatality Review Teams Influence Prevention Activities

Describe the different methods that fatality review teams may directly or indirectly influence systems change and outcomes.



Demonstrate National Center Resources for Improving Documentation

Explore the Pediatric NFR-CRS and its resources for documenting outcomes and learn about how the National Center can support documentation.



Discuss Examples of Fatality Review Team and Prevention Outcomes

Practice connecting fatality review work with systems change and outcomes.



OBJECTIVES

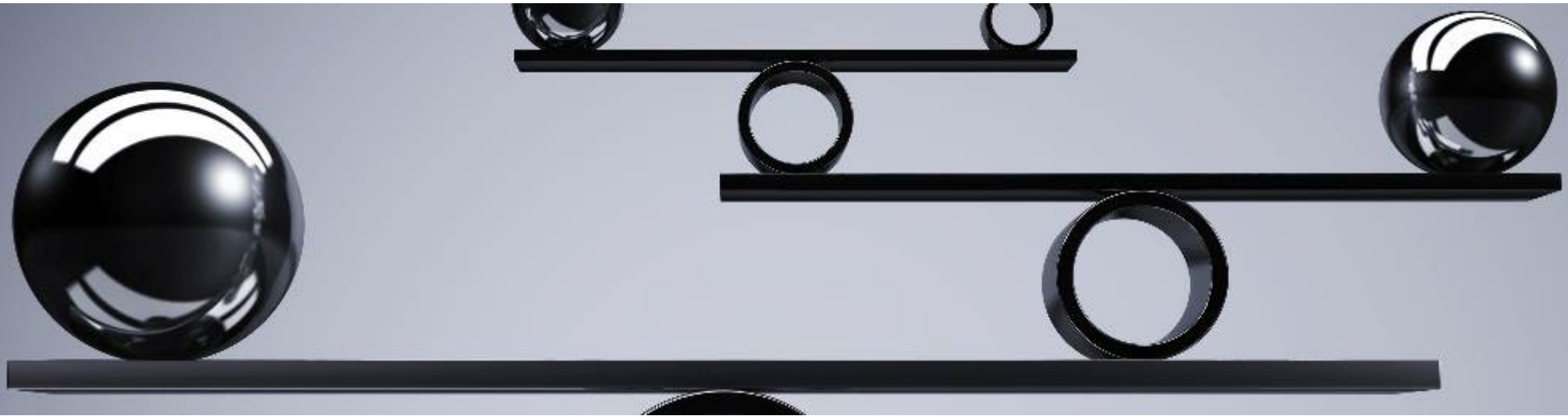


SYSTEMS CHANGE

Defining and Operationalizing

Cause for Concern

DOCUMENTING WHAT IS HAPPENING



PERFORMANCE MEASURES

Many fatality review teams and programs must demonstrate their worth by quantifying change.



SHARE ACTION

Fatality review teams often ask how other programs have navigated all aspects of prevention work.

Systems

A Shared Definition



UNIFIED WHOLE



Interacting or interdependent items that work toward a shared goal or outcome.



ORGANIZED



Method for approaching work in a consistent manner.



LAYERED



Contains many layers of subsystems.



Identifies Root Causes

Identifies and addresses the underlying issues that contribute to and impact health outcomes.



Provides Transformative Changes

Shifts relationships, policies, and resources to remove barriers, resulting in widespread, lasting change.



Uncovers Interconnectedness

Recognizes the multidirectional connections between system components.



Utilizes a Collaborative Approach

Requires a wide variety of partners to identify, implement, and evaluate progress toward shared goals.



Seeks Long-Term Change

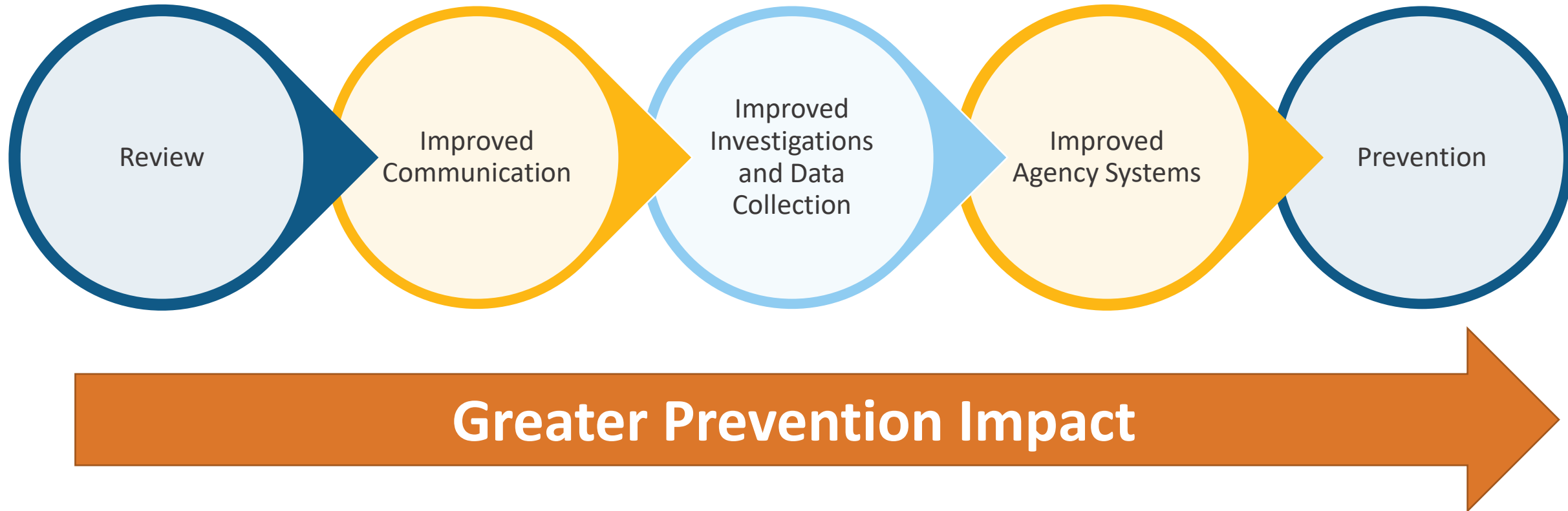
Creates lasting change by addressing root causes through collaboration and layered change.



COMPONENTS OF SYSTEMS CHANGE

System Improvement as Prevention

The Spectrum of Success





Every death is associated with a constellation of risk factors. Prevention efforts seek to improve the factors that drive poor outcomes.

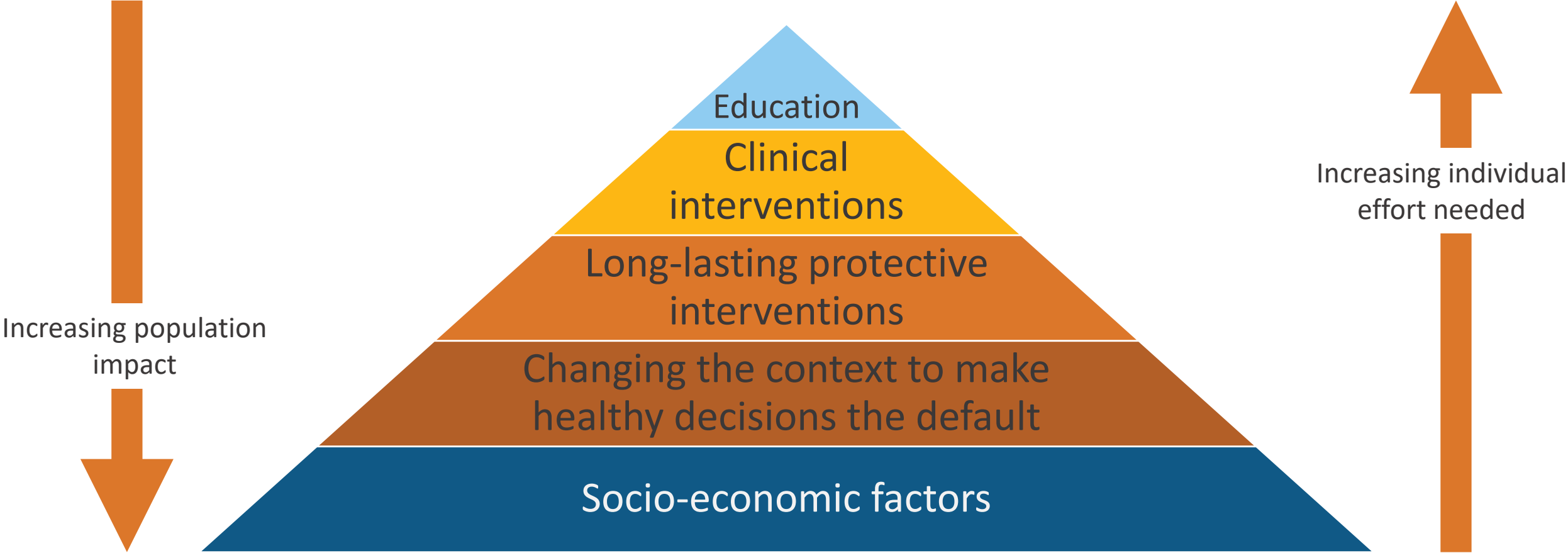


FATALITY REVIEW OUTCOMES

Connecting Prevention Work

Spectrum of Prevention

Individual effort balanced with population impact



Activities, Outcomes, and Impacts

What's the Difference?

ACTIVITIES: Actions or interventions implemented in response to fatality review findings.

OUTCOMES: Measurable changes that suggest the activities are having an effect.

IMPACT: The long-term change in population-level outcomes.

Outcome Attribution

Assessing Connections



DIRECT



Clear relationship between fatality review and the change.



INDIRECT



Anecdotal or semi-clear connection between fatality review and change.



NOT-ATTRIBUTED



Change that was already happening or not connected.

Relationships

THE KEY TO SYSTEMS CHANGE



TEAM MEMBERS

Outcomes are likely to be attributed to fatality review if team members participated in any part of the outcome work.



KEY PARTNERS

Relationships leveraged through fatality review should also be considered in attributing outcomes.



Data

Did fatality review data inform the recommendation or systems change?



If not for participating in fatality review, this outcome might not have happened.

-Source Unknown



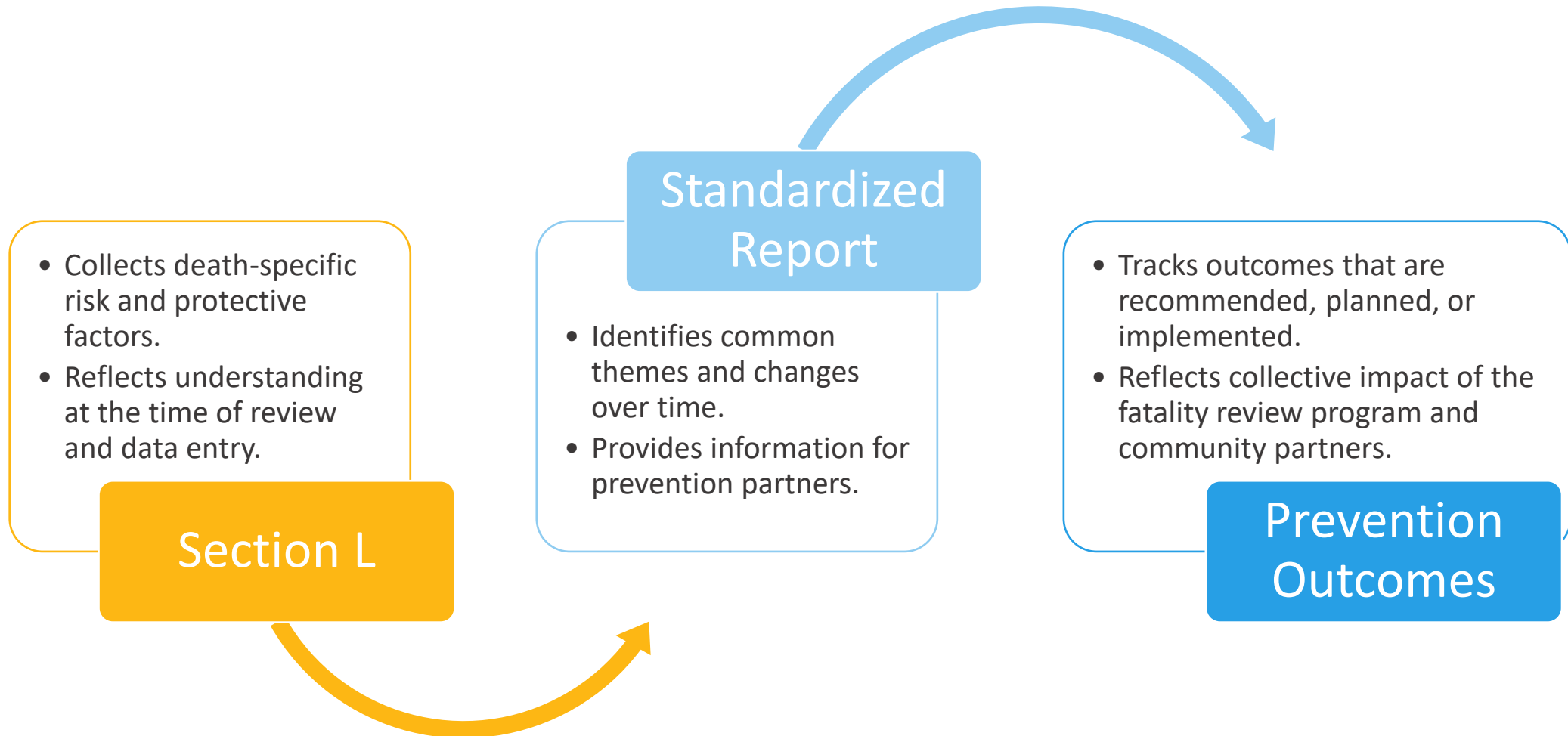


DOCUMENTING OUTCOMES

Pediatric NFR-CRS and National Center Tools

Opportunities for Documenting in Pediatric NFR-CRS

Individual Deaths, Standardized Reports, Prevention Outcomes



Section L: Findings Identified During the Review

Questions L1 – L2: Risk and Protective Factors

Section L: Findings Identified during the Review

Mark this case to edit/add findings at a later date

★1. Describe any significant challenges faced by the child, the family, the systems with which they interacted, or the response to the incident. These could be related to demographics, overt or inadvertent actions, the way systems functioned, or other environmental characteristics (See Data Dictionary for examples).

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

Section L: Findings Identified During the Review

Questions L3 – L4: Recommendations

★★★ 3. List any recommendations and/or initiatives that could be implemented to prevent deaths from similar causes or circumstances in the future: 🗨️

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

Report #30: Findings from Review

Reports

Navigation bar with search and navigation icons. Includes a search box with the number '1' and the text 'of 1', and a search button labeled 'Find | Next'.

Findings From Review

State: Fake State
Local Team: Fake Team A
Cases Selected By: Date Of Death
Death Date From: Not specified
Death Date To: Not specified
For Case Type: Child Death
Review Type: FIMR



Case Number	Age in Years	Manner of Death	Cause of Death	Findings From Review		Risks	Protective Factors	Recommendations
				Policy or Practice Change	Could this death have been prevented			
63-501-2022-00001	0	Natural	Undetermined if medical or external injury	Yes	Team could not determine	Lack of available bereavement and grief resources for family.	Thorough death scene investigation was conducted by local county. Family member seeking treatment for substance use disorder following death of infant.	Community has implemented pregnancy support program. Family member seeks support through program. Local area could benefit from specialized loss and
63-501-2022-00002	0	Natural	MedCond-Congenital Anomaly	Yes	Yes, probably	Infant had extreme congenital anomalies as infant was born 26 weeks gestation. Family did not have access to regular prenatal care due to living in rural area and food	FIMR meeting discussion was extremely robust regarding this case with many agencies participating. This case was discussed at two consecutive CFR meetings to	Local FQ implemented follow up system with childbearing that are prenatal appointments

Prevention Outcomes

Accessible on Homepage and Left Navigation



Logged in as **Gabby Fraley**. (CDR - Fake State - Fake Team A) [Logout](#)

- Main
- Your Account
- Enter New Case
- Manage Cases
- Standardized Reports
- Data Explorer
- Prevention**
- Data Download
- Help
- Logout

Saving Lives Together



Prevention Outcomes

- [+ Enter New Outcome Record](#)
- [+ Download Prevention Outcomes](#)
- [Print Results](#)

Show entries Search: [Print](#)

Unique ID	Last, First Name	Quarter	Year	Description	Cause of Death	Actions
28	Dykstra, Heather	Summer	2024	Life jacket loaner program at Lake Lansing to be funded by Meridian Township Fire Department. Will include 4 adult and 8 children's jackets.	External-Drown	Print Delete

Showing 1 to 1 of 1 entries [Previous](#) **1** [Next](#)

Documenting Prevention Outcomes

Reflects Collective Impact Resulting From Fatality Review

Create New Outcome Record

Added By: _____

User Name	Gabby Fraley
State	Fake State
Team	<input type="text" value="Fake Team A"/>

1. Status of Outcome: _____

Outcome Status	<input type="text"/>
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2. Approximately when this Outcome was implemented:
Quarter _____
Year _____

	<input type="text" value="Planning"/> <input type="text" value="In Process"/> <input type="text" value="Completed"/> <input type="text" value="Re-prioritized"/>
--	---

3. A short description of the Outcome implemented (less than 5000 characters): _____

Documenting Prevention Outcomes

Reflects Collective Impact Resulting From Fatality Review

4. Lead person to contact for more information: _____

First Name

Last Name

Contact Phone or Email

5. One cause of death for this initiative (if it applies across multiple causes, select 'no response'): _____

Cause of Death

no response



6. Approximately how many case reviews led to this recommendation or implementation: _____

Approximate number of case reviews



Long Term Plan

Modify Data Use Agreements (DUA) to allow for National Center documentation within Pediatric NFR-CRS. Given that a DUA amendment takes time, the National Center will begin capturing this information in an internal activity tracker.



LEARN TOGETHER

Practice on Mock Deaths

Scenario 1: Built Environment

Pedestrian-Vehicle Collision

A 6-year-old child was struck and killed by a vehicle while crossing an unmarked intersection near a park in a high-traffic, low-income neighborhood. The review team noted the absence of crosswalks and traffic calming measures. Community members had previously raised concerns, but no action had been taken. The fatality review led to a recommendation to the city's public works department to implement safety improvements in the area.



RECOMMENDATION: Install marked crosswalks, speed bumps, and signage near schools and parks in high-risk neighborhoods.



OUTCOME: A neighborhood with historically high rates of child pedestrian injuries had new crosswalks, speed bumps, and signage installed near schools and parks. Within 18 months, zero child pedestrian deaths or serious injuries were reported in that area.

Scenario 2: Policy/Legislation

House Fire

A toddler died in a house fire that started overnight in a rental unit. During the review, it was discovered that there were no properly functioning smoke alarms and that prior citations for fire safety violations in the complex had gone unaddressed. The CDR team escalated this finding to the city housing office, which prompted the city council to pass a mandatory smoke alarm ordinance for all rental properties.



RECOMMENDATION: Pass a policy requiring regular smoke alarm inspections and penalties for noncompliance in rental housing.



OUTCOME: A local ordinance mandating regular smoke alarm inspections in rental housing led to a 75% increase in compliance among units previously cited for fire hazards, with no child deaths from residential fires in those neighborhoods over the next two years.

Scenario 3: Education

Positional Asphyxia

An infant died from positional asphyxia after being placed to sleep on a couch. The caregiver, whose primary language was not English, reported never receiving clear safe sleep instructions at the hospital. The FIMR team recognized a lack of linguistically appropriate discharge education materials and worked with hospital leadership to implement a multilingual education policy across all maternity units.



RECOMMENDATION: Develop and distribute community and linguistically appropriate safe sleep materials, accompanied by face-to-face education.



OUTCOME: After implementation of multilingual safe sleep education in birthing hospitals, 95% of families—regardless of primary language—demonstrated correct understanding of infant sleep practices before discharge.

Scenario 4: Equipment and Technology

Motor Vehicle Crash

A fatal car crash involving a 4-year-old child occurred in a rural area. The child was not restrained in a booster seat, and the caregiver shared that they were unaware of the requirement and couldn't afford one. The review team identified multiple similar cases in rural counties and partnered with EMS and community coalitions to launch a traveling booster seat distribution and education program.



RECOMMENDATION: Launch a rural outreach campaign with free booster seat distribution and parent education.



OUTCOME: A free booster seat program in rural areas resulted in a 60% rise in proper child restraint use during roadside safety checks, with observed usage rates now on par with suburban communities.

Scenario 5: Treatment and Recovery

Suicide

A 16-year-old female who was three months postpartum, died by suicide. The mother had shown symptoms of depression during her 6-week follow-up but lived in an area without local mental health providers and had no transportation to appointments. The CDR team partnered with a local FIMR team to identify gaps in follow-up care and collaborated with a regional health system to deploy mobile mental health teams to expand access to postpartum support in underserved communities.



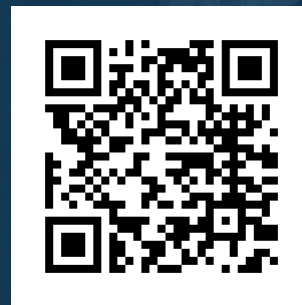
RECOMMENDATION: Increase access to home-based maternal mental health care in medically underserved areas.



OUTCOME: A mobile care team launched in areas with limited access to behavioral health services completed over 300 home-based maternal mental health visits in the first year, leading to earlier identification and support for postpartum individuals.

THANK YOU

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





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