NATIONAL CFRP
Center for Fatality Review & Prevention

Partnership Engagement **Tips and Tricks**

Learning Together, Protecting Tomorrows

Webinar Recording Availability

This webinar is being recorded and will be made available on the National Center's website.

Participant Guidelines

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

Technical Support Contact

Email the National Center at info@ncfrp.org if you experience tech problems.

Session Evaluation

Complete a brief evaluation 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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About the National Center

Center for Fatality Review and Prevention

Multidisciplinary Teams

Why It Matters

Comprehensive Understanding

Each discipline brings unique insights.

Shared Responsibility

Preventing death is a community effort.

Better Outcomes

Informed, different perspectives lead to stronger recommendations.

Child Death Review Team

Partners Engaged In CDR

MCH Public Health

Healthcare Providers

Schools

District Attorneys

Child Welfare Agencies

Medical Examiners/Coroners

Law Enforcement

Mental Health Professionals

Community Advocacy Organizations

Emergency Response Agencies

Fetal Infant Mortality Review: Case Review Team

Partners Engaged In FIMR CRT

MCH Public Health

Obstetrician-Gynecologists

Doulas

NICU Providers

Child Welfare Agencies

Medical Examiners/Coroners

Home Visiting Programs

Mental Health Professionals

Community Advocacy Organizations

Emergency Response Agencies

Community Action Team

FIMR CAT

Suicide Mortality Review Committee

Partners Engaged In SMRC

Public Health

Crisis Response Agencies

Schools

District Attorneys

Protective Services (Adult/Child)

Medical Examiners/Coroners

Law Enforcement

Suicide Prevention Coordinator

VA/Military

Emergency Response Agencies

Partnerships In Practice

The Added Value

- Essential to effective fatality reviews.
- Partnerships bring unique perspectives.
- Communicating the value of partnerships to address challenges.
- Collaborative partnerships lead to stronger reviews and more impactful outcomes.

Real-World Examples of Impactful Partnerships

Demonstrating How Different Partners Add Value

School Staff – Early Warning Signs

A school counselor identified behavioral changes and absenteeism leading up to a youth suicide, which helped the team focus on mental health prevention in schools.

Military – Service History

Military services shared details of the decedent’s history of service, discharge status, and any veteran services they received.

Law Enforcement – Case Context

A detective shared critical details about a home environment during a sudden unexplained infant death case, helping the team identify unsafe sleep practices.

Health Care Provider – Medical Insight

An OB-GYN explained a mother's preexisting conditions and the social and contextual factors she shared in her prenatal course.

Tips And Tricks

For Engagement

- Complete initial outreach.
- Build the relationship.
- Identify champions.
- Sustain engagement.

Key Takeaways

For Fatality Review Teams

- Multidisciplinary collaboration strengthens fatality reviews.
- Establishing partnerships requires ongoing outreach and relationship-building efforts.
- Engaging partners takes time.
- Clear communication and a shared purpose drive participation.
- The National Center is here to support your team.

Partnering Across Review Types

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Objectives

Learn	why it is important to collaborate across review types
Learn	best practices for partnering across review types
Hear	partnership examples from statewide child death review and suicide death review coordinators

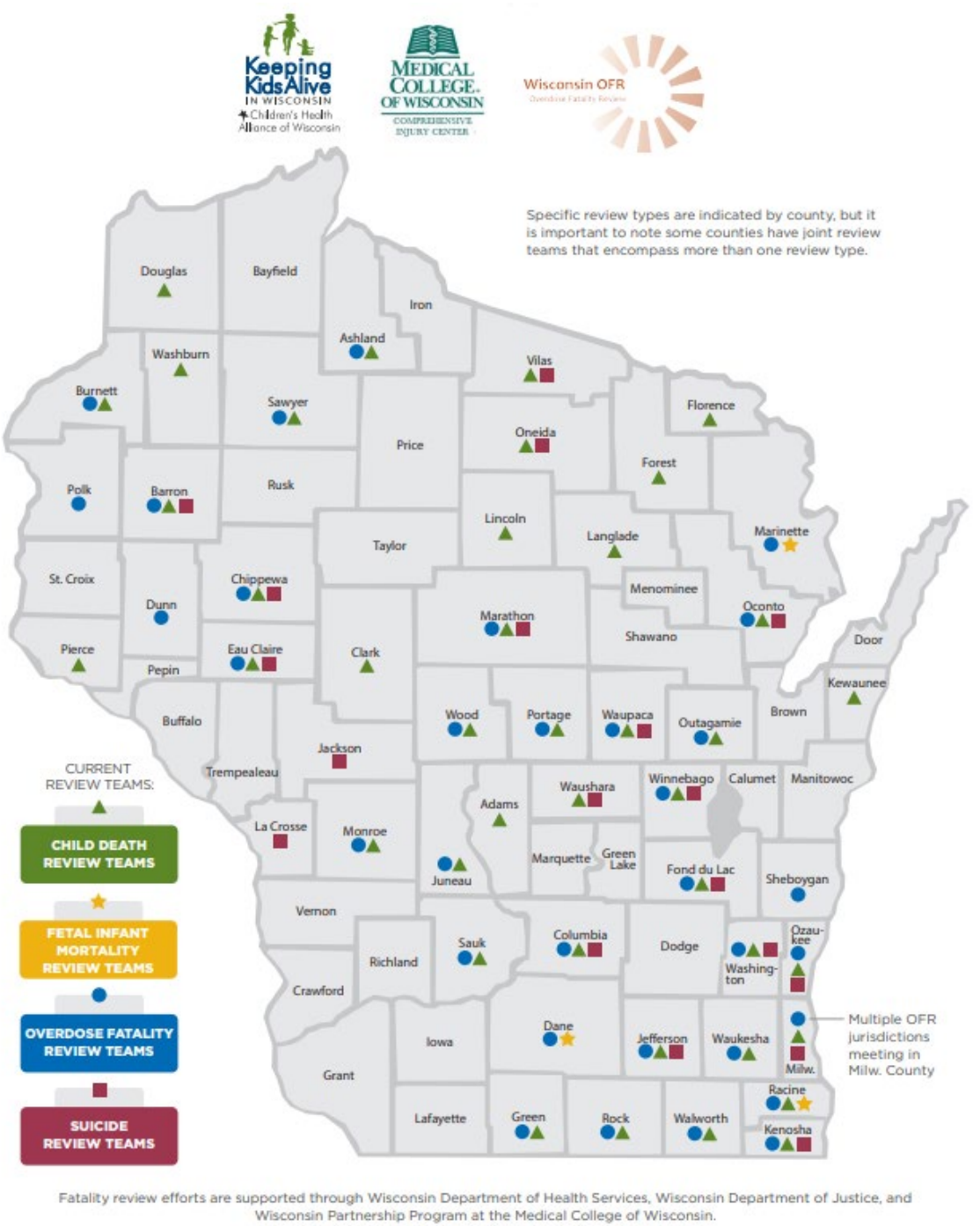
Fatality Review Model

Shared purpose: Multi-agency, in-depth case review will identify risk factors and opportunities to prevent future deaths of similar circumstances.

Fatality review in Wisconsin

- Child Death Review
- Fetal & Infant Mortality Review
- Critical Incident Reviews
- Suicide Reviews
- Homicide Reviews
- Overdose Fatality Review

Map of Fatality Review Teams by County



Importance of Partnerships Across Review Types

Many of the same partners

Overlap in risk and protective factors

Prevention collaboration opportunities

Engaging Partners

Explain project goals

Define partnership needs

Set realistic expectations

Working Together in Wisconsin

Fatality review coordinators meet quarterly

Presenting at conferences

Joining partner meetings

Joint review meetings

Resource sharing

Fatality Review Legislation

Purpose of CDR

- Improve our understanding of how and why children die
- Identify the need to influence policies and programs that promote child safety
- Engage partners to increase collaboration opportunities
- Implement actionable prevention aimed at improving health, safety, and protections for children
- Use what is learned to prevent other child deaths

Ultimate goal is to take action to improve child safety, prevent deaths and make communities safer

Intensive Technical Support

Trainings

Initial team implementation

Refresher

Data

Ongoing

Technical Support Calls

Quarterly Connection Calls

Individual or as needed outreach

Additional

Conferences

Newletters

Data Support

Website Resources

Purpose and Goals of Suicide Review

Group of multi-disciplinary organizational representatives who come together to discuss circumstances surrounding a suicide.

Purpose

- **Improve our understanding** of how and why a person dies by suicide
- **Develop recommendations** to improve our response to suicide deaths
- **Develop prevention initiatives** to take action to improve the health and safety of our community

Goal

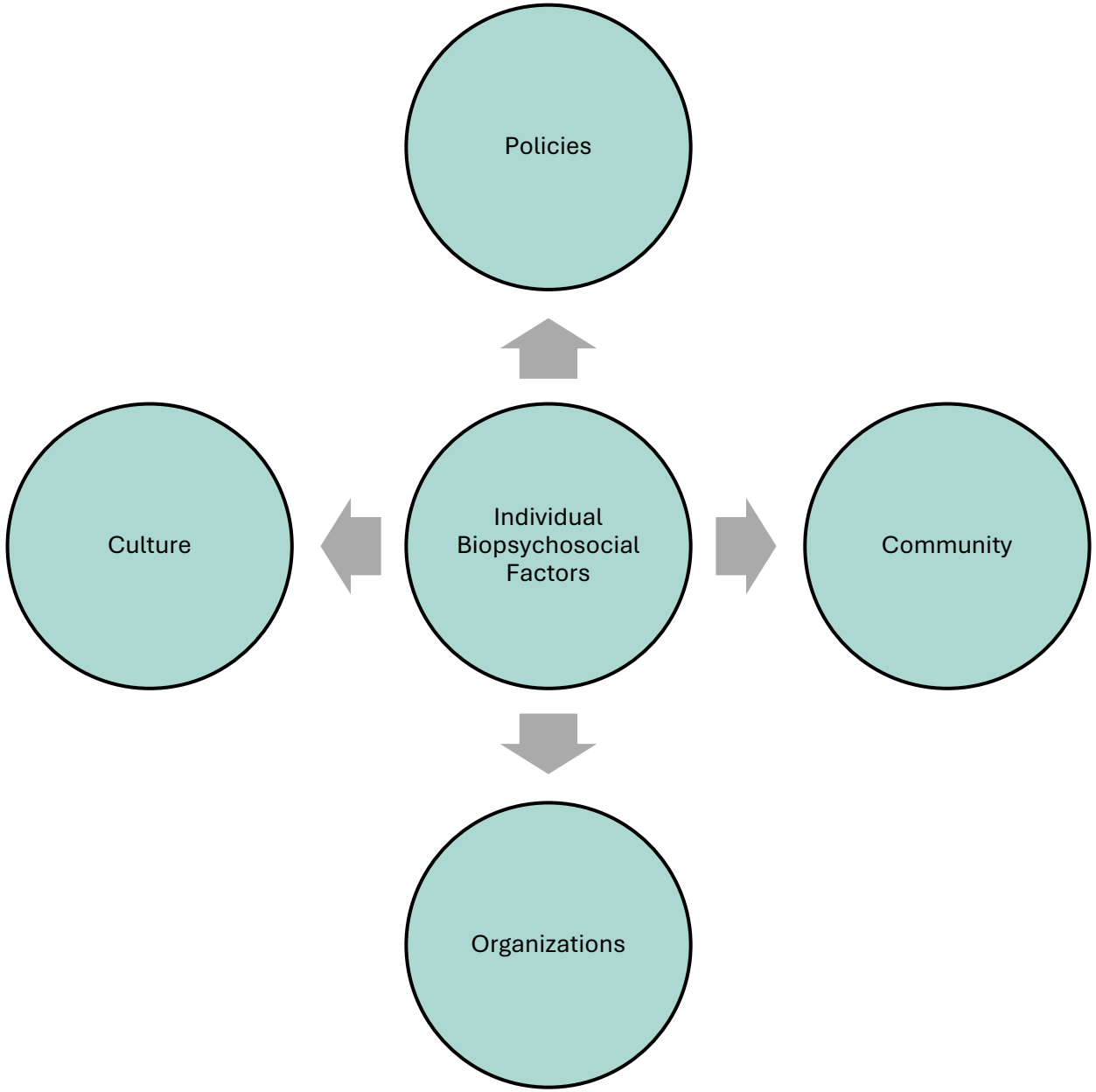
- **Explore** missed opportunities for intervention and **enhance** the community's ability to respond to prevent future suicide deaths

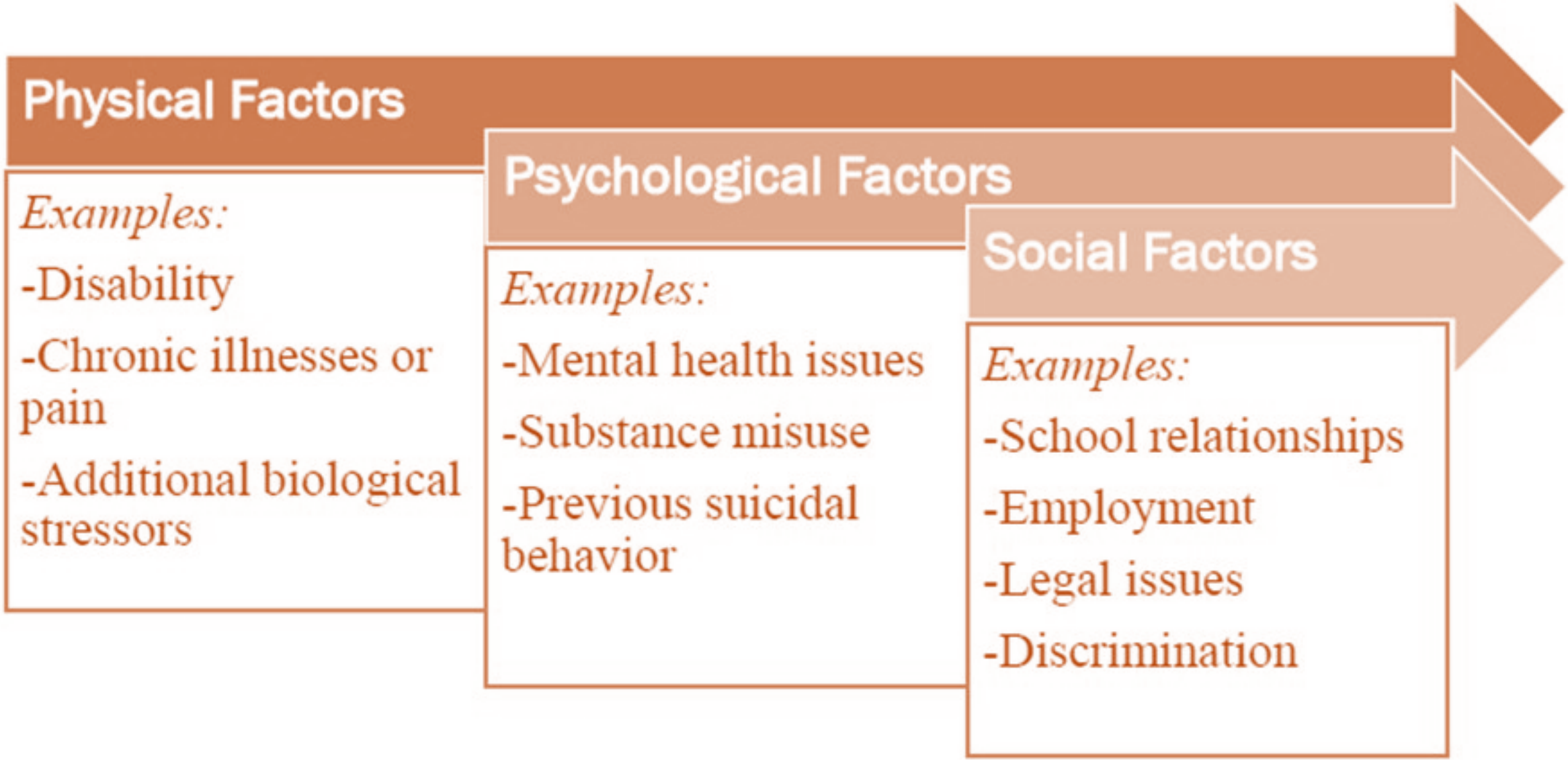
The Work of Suicide Review

- Why suicide?
- Why now?
- Why this method?
- Develop systems-level recommendations for prevention

SMR Considerations

Teams should consider the multiple factors that were present in the life of the decedent **prior** to the suicide.




Physical Factors
Examples:
-Disability
-Chronic illnesses or pain
-Additional biological stressors
Psychological Factors
Examples:
-Mental health issues
-Substance misuse
-Previous suicidal behavior
Social Factors
Examples:
-School relationships
-Employment
-Legal issues
-Discrimination

Example Structure for Recommendations

Haddon's Matrix

	Host	*Agent*	*Physical Environment*	*Social Environment*
Pre-event				
Event				
Post-event				

Statewide Collaboration Opportunities

Resilience: Vicarious Trauma Prevention

- Learn how this work can expose members to vicarious trauma
- Understand how vicarious trauma can affect you and others
- Provide vicarious trauma prevention strategies

Community of Practice

- Suicide review community practice meets every other month
  - All suicide review teams across the state are invited
  - Technical assistance
  - Lessons learned
  - Developing statewide recommendations

Review

- Get to know your state coordinators
- Find opportunities to collaborate
- Share resources
- Take care of yourself and your team

Thank you

Questions

Q&A For Speakers

Please complete an evaluation using the link in the chat, or by scanning the QR code above.

Thank You for Your Time!

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