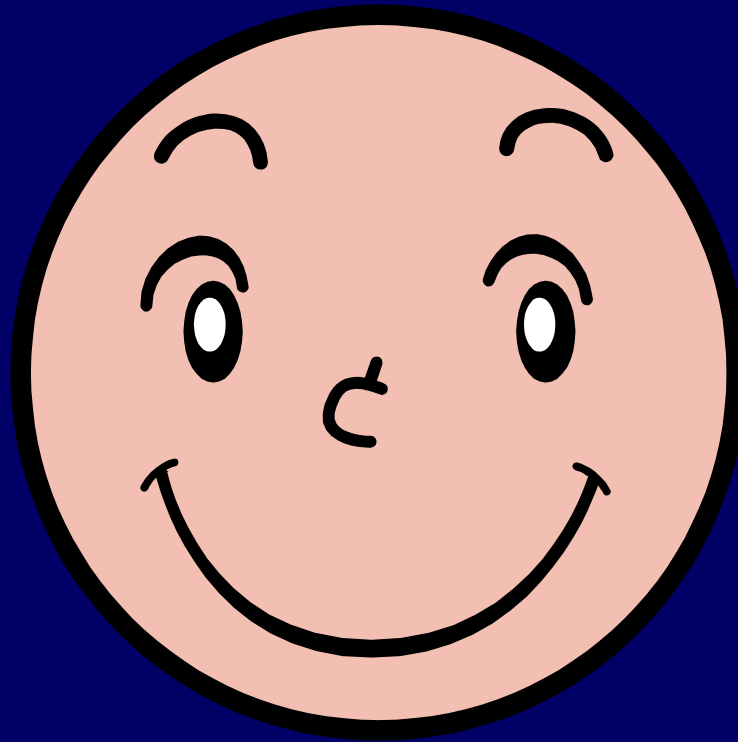


# Effective Meetings



# Preparing for the Meeting

- Have you identified all the deaths? Do you get help from coroner, county clerk, hospitals.
- Are the right people coming to the review?
- Have you looked through your records?
- Do you have enough information for a quality review?
- Are there any concerns from the D.A. or law enforcement?
- Have you identified similar deaths or injuries?

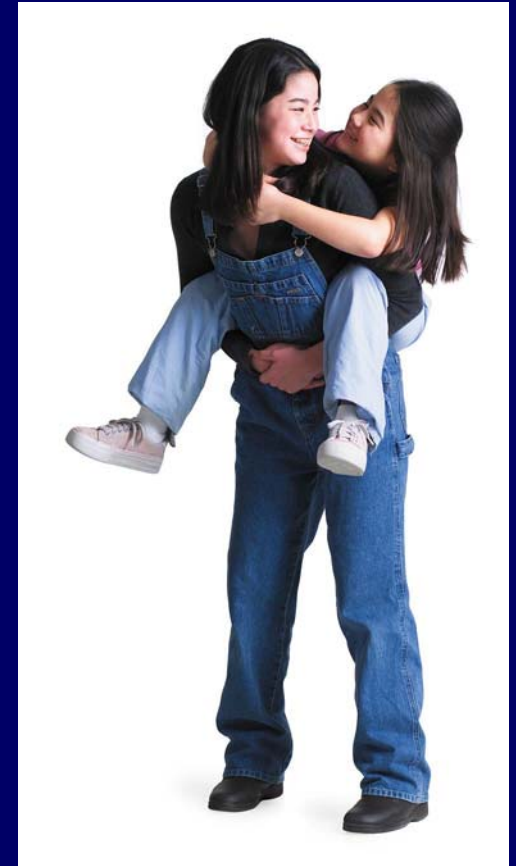


# At Every Meeting

- Bring data or information related to past meeting recommendations.
- Review past meetings' recommendations.
- Ask for reports from persons taking responsibility.
- Document and review actions periodically.
- Celebrate successes.

# At the Review

- People have to bring information.
- Need persons at the review with authority to act on behalf of their agencies.
- Focus is not on blaming systems but on looking forward.
- Review any past cases, information, and updates on proposed recommendations.
- For each case review, members share information in a logical order.
- Members ask questions for clarification.



# Use Your Guide to Effective Reviews

- Prepare for the meeting and collect your records. ■
- To focus reviews by cause.
- To consider comprehensive circumstances.
- To ensure you move to prevention.



# Uncover the Layers



# Sharing Information: the more, the better

- Medical Examiner/Coroner
- EMS/Fire
- Law Enforcement ■
- Health Care Providers
- Social Services
- Public Health
- Prosecuting Attorney
- Others

**You are trying to understand all of the circumstances- for a complete understanding from multiple systems.**

# Information Obtained at a CDR

- Scene Investigation Information
- Medical Examiner/Coroner reports
- EMS Run reports
- CPS Histories
- Public Health Visits/Immunizations
- Medical records from hospitals/physicians
- Fire Marshall Reports
- Suicide Notes sometimes shared
- Some Mental Health
- School Histories
- Court and Juvenile Histories

# SIDS/Suffocation Case

## Records Needed at Review

- Autopsy reports
- Scene investigation reports and photos
- Interviews with family members
- Day Care Licensing investigative reports, if occurred in day care setting
- EMS run reports
- Emergency Department reports
- Prior CPS and DV history on child, caregivers and person supervising child at time of death
- Child's health history
- Criminal background checks on person supervising child at time of death
- Reports of home visits from public health or other services
- Any information on prior deaths of children in family
- Any information on prior reports that child had difficulty breathing
- Downloaded information from apnea monitors

# At Every Review

- Is the investigation complete?
- Are there services that should be provided?
- What were the major risk factors?
- What agency policies and practices need improvement.
- What can be done to change behavior, technology or laws?
- Who will take the lead?
- Who should we talk to?



# Investigation

- Who is the lead investigative agency?
- Was there a scene investigation?
- Was there a scene recreation with photos (especially important for infant sleeping deaths)?
- Were there other investigations conducted?
- What were the key findings of the investigations?
- Does the team feel the investigation was adequate?
- Is the investigation completed?
- What more do we need to know?
- Does the team have suggestions to improve the investigative system?



# SIDS and suffocations

- **Are investigations coordinated with medical examiners, law enforcement and CPS?**
- **Are autopsy protocols in place?**
- **Are comprehensive scene investigations conducted at place of death, as soon as possible, including**

# Services

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- Were there any services that the family was accessing prior to the death?
- Were services provided to family members as a result of the death?
- Were services provided to other children (schoolmates, etc.)?
- Were services provided to responders, witnesses or community members?
- Are there additional services that should be provided to anyone?
- Who will take the lead in following up on these service provisions?
- Does the team have suggestions to improve our service delivery systems?

## **SIDS and Suffocations**

**Bereavement and crisis services for family members and friends.**

**Provision of cribs or other beds for other children still in home.**

**Safety assessment by CPS if neglect was suspected.**

**Burial payments for families needing financial assistance.**

**Critical Incident Stress Debriefing for persons responding to scene.**

**DV services**

# Reviews Can Lead to Immediate Action

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- Other children at immediate risk will be identified, e.g. children removed from a home.
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- Information may lead to criminal charges, usually child abuse or neglect.
- Services may be put in place, such as crisis intervention.