



FATALITY REVIEW: **DEATHS IN CUSTODY**

TELLING STORIES TO SAVE LIVES



Key Funding Partners

Federal Acknowledgements

The National Center is funded in part by Cooperative Agreement Number UG7MC28482 from the U.S. 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 \$5,149,996 annually with 0 percent financed with non-governmental sources. These 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.

About the National Center

Core Functions



Communicate with Fatality Review Teams



Provide Technical Assistance, Training, and Connection



Develop Actionable Resources

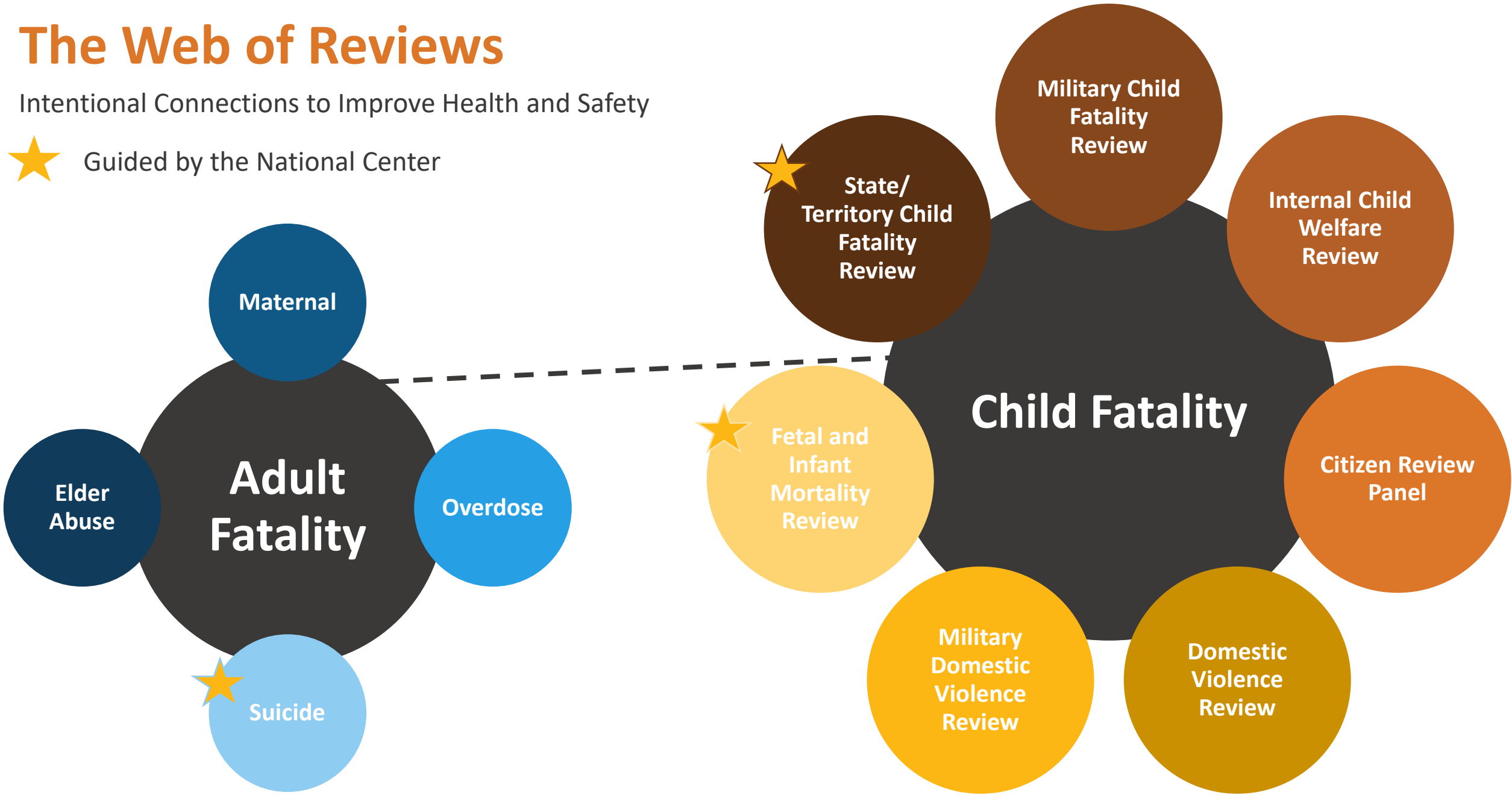


Support the National Fatality Review-Case Reporting System (NFR-CRS)

The Web of Reviews

Intentional Connections to Improve Health and Safety

★ Guided by the National Center



How Does CDR Work?



Child Death Review

There are CDR programs in all 50 states, the District of Columbia, Guam, Puerto Rico, and U.S. Virgin Islands

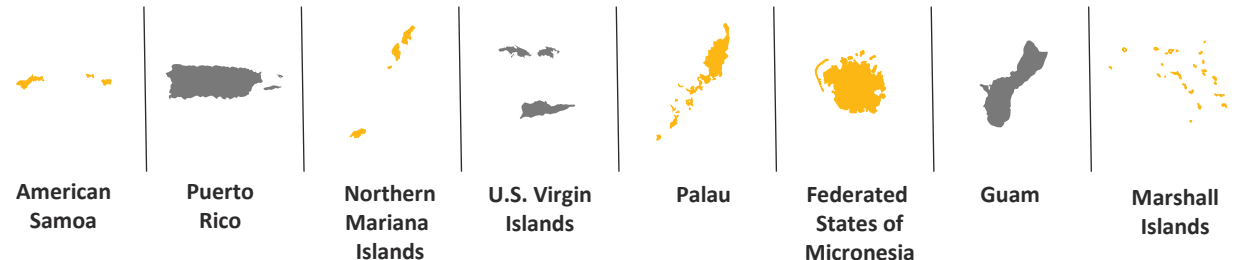
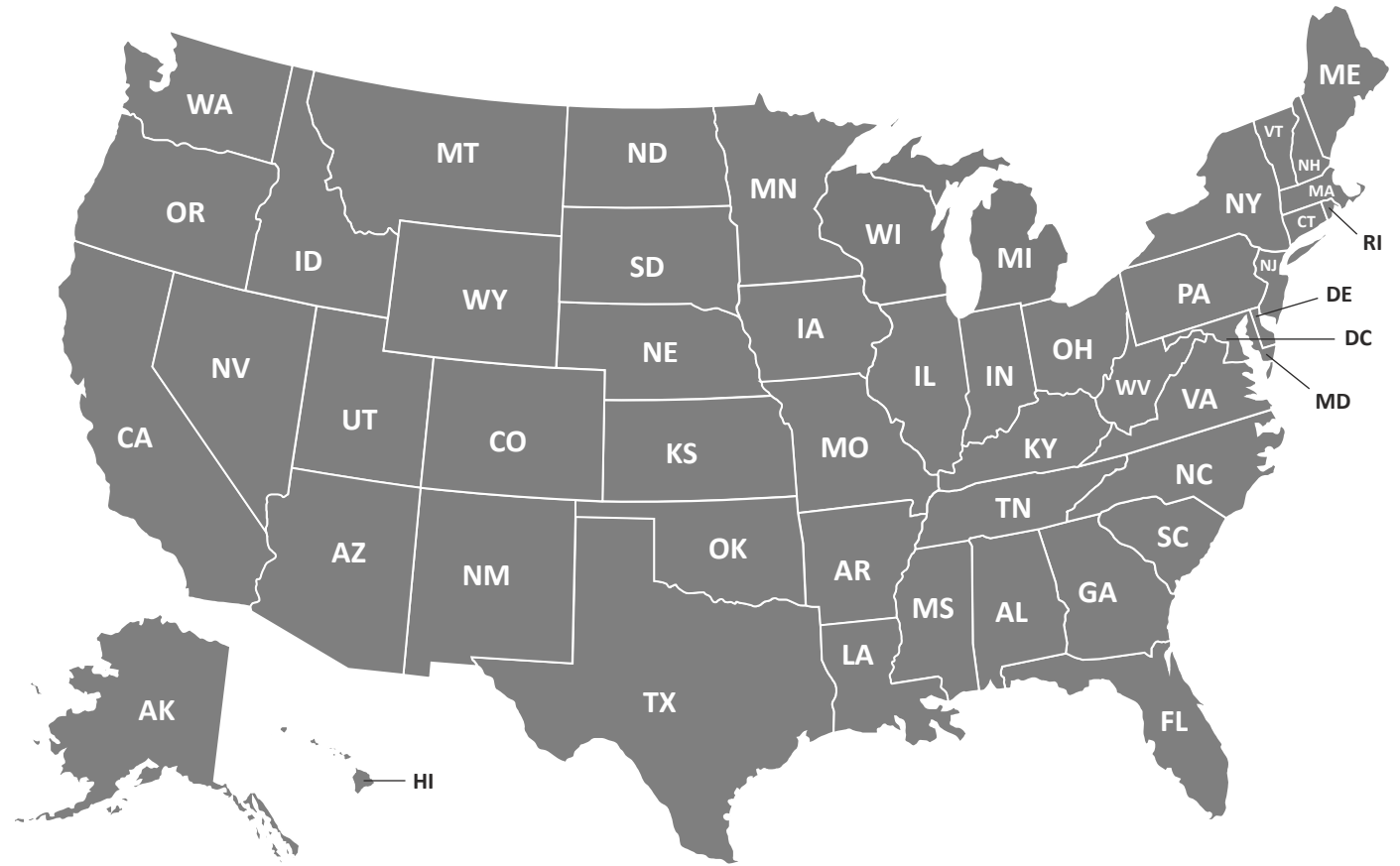
Each state has autonomy to implement CDR in a way that fits their needs. CDR structures are often based on where reviews occur. Reviews commonly occur:

- At the state level
- At the local level
- At the state and local levels

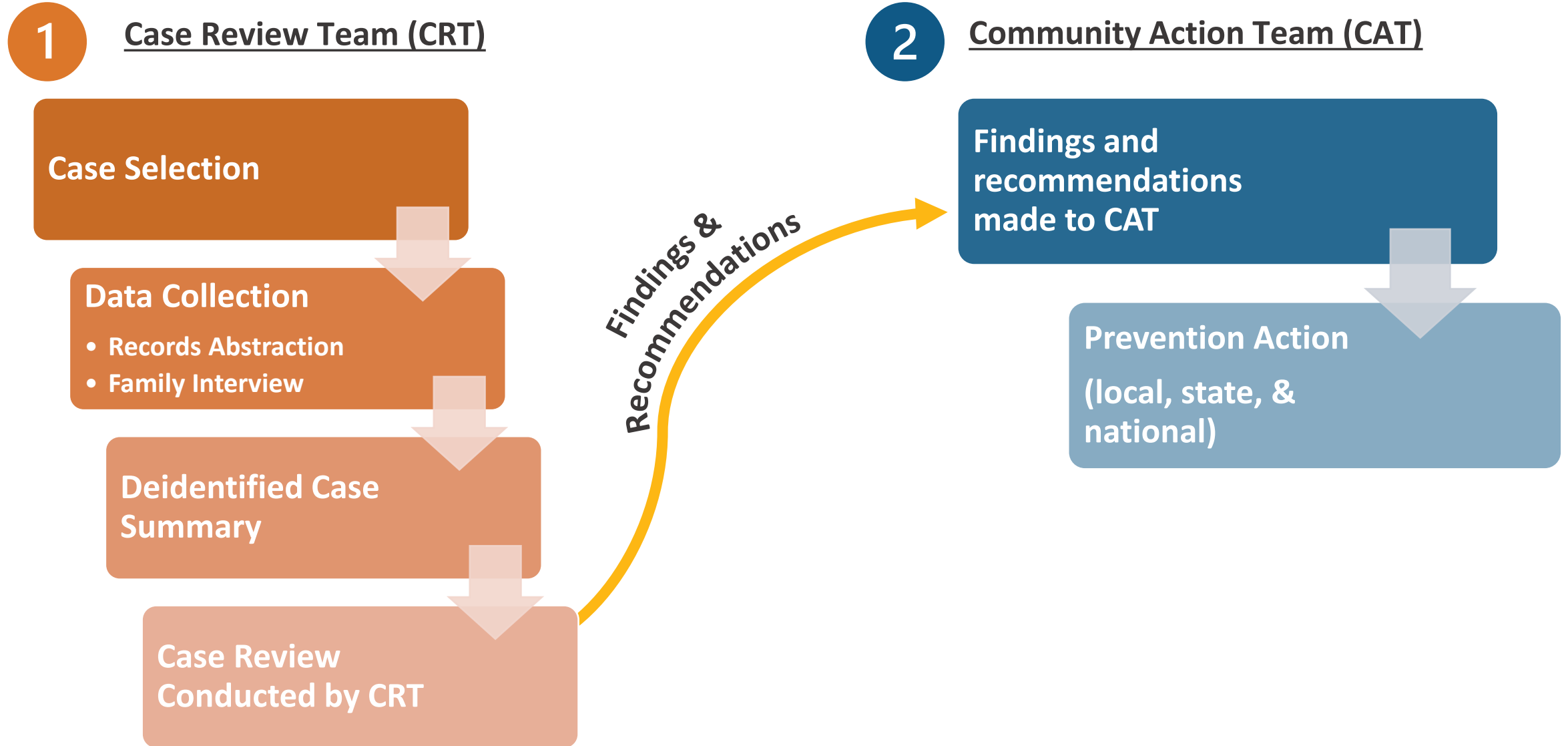
Information about CDR programs is available at

<https://ncfrp.org/cdr-map/>.

Jurisdiction Without CDR



Fetal and Infant Mortality Review (FIMR)



FIMR Profile Survey: 2021 Activities

Fetal and Infant Mortality Review (FIMR) is a community-based, action-oriented process to review fetal and infant deaths and make recommendations that spark systems-level changes and prevent future deaths.

FIMR programs differ in multiple factors, including:

- Scope and composition
- Supporting legislation
- Level of state support
- Case selection methods
- Administrative leadership
- Reporting systems used

To better understand these similar but diverse programs, the National Center for Fatality Review and Prevention (National Center) conducts a bi-annual survey of FIMR program leaders to collect additional team-specific profile data.

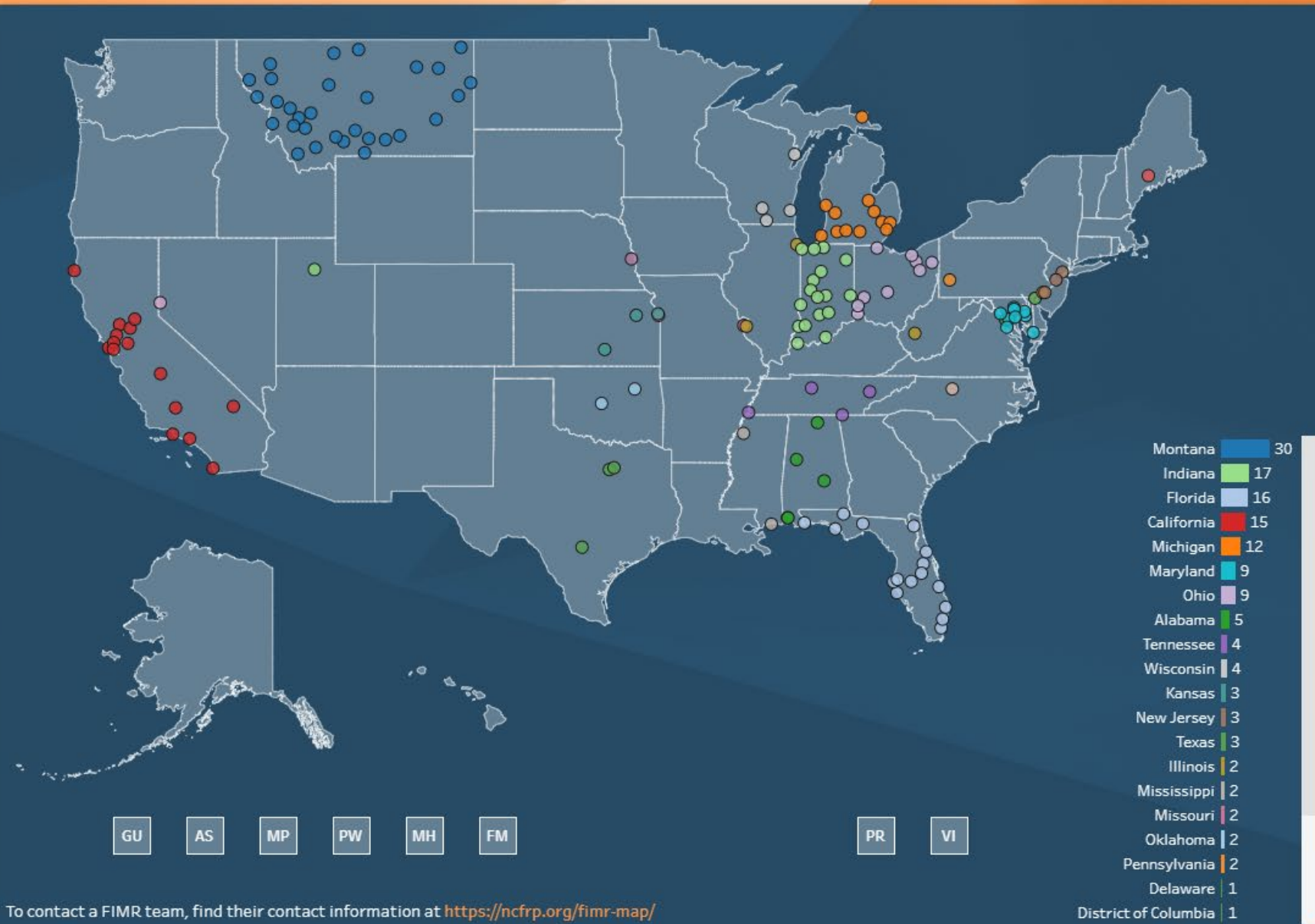
The following dashboards contain survey data from FIMR programs that were actively reviewing cases in 2021. If an active team's response was received in a previous year's survey, but not the survey for activities in 2021, the most recent response is reported.

These dashboards provide the opportunity for FIMR programs, policymakers, and other interested parties to explore how programs compare across a range of factors and to see how these teams work to decrease fetal and infant deaths.

The goal of these dashboards is to facilitate process improvement within the FIMR program nationwide and to help policymakers develop agendas and shape the debate around eliminating the disparities in maternal and infant mortality.

If you have questions, contact info@ncfrp.org.

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To contact a FIMR team, find their contact information at <https://ncfrp.org/fimr-map/>

Pediatric National Fatality Review-Case Reporting System (Pediatric NFR-CRS)

A National Tool for CDR Teams

- First created in 2005.
- Allows users to enter case data, summarize findings, review recommendations, and access/download data.
- Over 2,500 variables collected, including:
 - Demographic and social characteristics of the child, family, and supervisor.
 - Circumstances of the death, including the incident and death investigation.
 - Risk and protective factors.

CDR REPORT FORM

Version 6.2

National Fatality Review Case Reporting System

Data Entry Website: data.ncfrp.org

Phone: 800-656-2434

Email: info@ncfrp.org

ncfrp.org



@nationalcfrp



Pediatric NFR-CRS Utilization

There are currently 49 states using the Pediatric NFR-CRS

- 49 use NFR-CRS for CDR
- 20 use NFR-CRS for FIMR

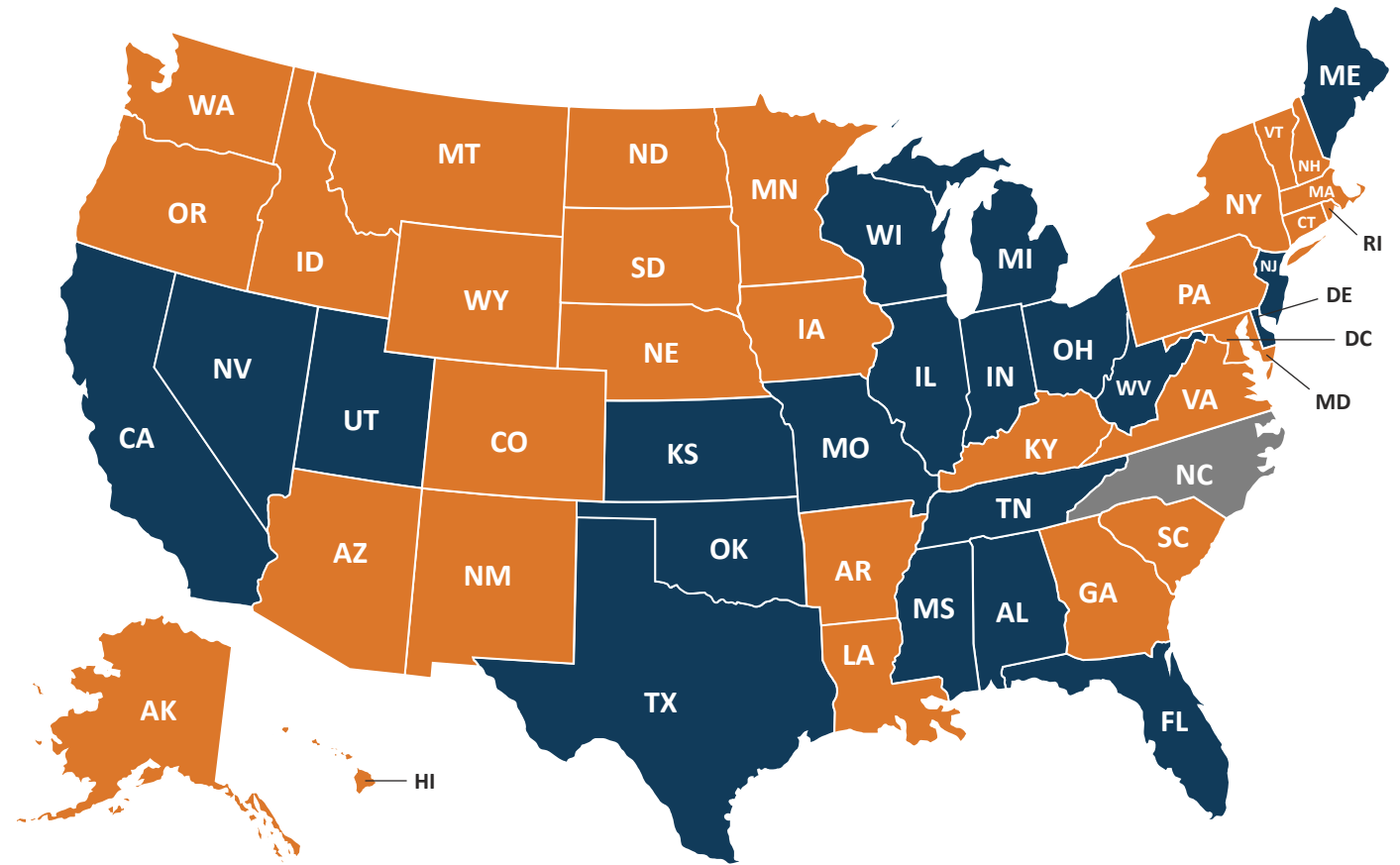
Each state uses Pediatric NFR-CRS differently. Some have comprehensive reviews whereas others may only use NFR-CRS in one jurisdiction.

Jurisdiction Using NFR-CRS for CDR

Jurisdiction Using NFR-CRS for CDR and FIMR

Jurisdiction Not Using NFR-CRS

Jurisdiction Without Fatality Review



American Samoa

Puerto Rico

Northern Mariana Islands

U.S. Virgin Islands

Palau

Federated States of Micronesia

Guam

Marshall Islands

Adult Data Collection

Adult National Fatality Review – Case Reporting System



COLLECTION



A web-based interface is
available at no cost.



REPORTING



Flat file downloads,
standardized reports, and
data visualizations.



AGREEMENT



A data use agreement will be
negotiated and executed.

Organization of Adult NFR-CRS

Organized by Cause of Death

▲ 6. Primary cause of death: Choose only 1 of the 4 major categories, then a specific cause. For pending, choose most likely cause. ⓘ

- ☒ From an external cause of injury
- ☐ From a medical condition
- ☐ Undetermined if injury or medical cause
- ☐ Unknown

[Deselect answer](#)

- ☐ Motor vehicle and other transport
- ☐ Fire, burn, or electrocution
- ☐ Drowning
- ☐ Asphyxia
- ☒ Weapon or Bodily Force
- ☐ Fall or crush
- ☐ Poisoning, overdose or acute intoxication
- ☐ Undetermined injury
- ☐ Other cause
- ☐ Unknown

[Deselect answer](#)

Detailed Cause of Death

Firearm Section E5

Section E5: Weapon or Bodily Force

▲ a. Was the death a result of a weapon (e.g., firearm, sharp object, etc.)? * ⓘ

- ☒ Yes
- ☐ No, death due to bodily force
- ☐ Unknown

[Deselect answer](#)

▲ b. Type of weapon: * ⓘ

- ☐ Firearm
- ☐ Knife/sharp instrument
- ☐ Rope
- ☐ Other
- ☐ Unknown

[Deselect answer](#)

Priority Variables in Adult NFR-CRS

Designated with a Yellow Triangle

Section A: Decedent Information

1. Decedent's name ☐ Unknown 

First

Middle

Last

John

Doe Test2

Chosen name (if different from above)

 2. Decedent's date of birth ☐ Unknown 



 3. Decedent's date of death ☐ Unknown 



Life Stressors in Adult NFR-CRS

Contextual Information about the Decedent

▲ c. Life stressors/Risk factors - Relationships

Had the decedent ever experienced any of the following life stressors:

Family relationship stress

Yes



In 90 days before death?

Yes



Did it contribute to the death?

Yes



Divorce/separation



Intimate partner problem

Yes



In 90 days before death?

Yes



Did it contribute to the death?

Yes





CONTACT INFORMATION



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