

*This form should only be used for full team reviews of deaths of children born alive and under the age of 18 at time of death. **Please address all questions Please write the death certificate number at the top of each page.***

Note: The death certificate number begins with **the last two digits in the year** and should not be shorter or longer than 8 characters. Please confirm that you enter the correct and full number on all pages of this report form.

- First and Final Review
- Initial Review (more info needed)
- Completed Review (After all info)

Preparation Time (info gathering by review coordinator): \_\_\_\_\_ minutes

Actual Review Time (length of review during meeting): \_\_\_\_\_ minutes

County Number \_\_\_\_\_ Quarter \_\_\_\_\_ Date of Death: \_\_\_\_/\_\_\_\_/\_\_\_\_

1a. Review Date (MM/DD/YYYY) \_\_\_\_\_ 1b. Follow-up Date (if applicable; MM/DD/YYYY) \_\_\_\_\_

2. Was this case previously reviewed by CCPT?  Yes  No

3. Please use this space to provide a brief description of the circumstances surrounding this child’s death.

4. Please check the boxes next to the agency name if a member from that agency was present for this review:

<u>Agency or Position Represented (DO NOT USE PERSON’S NAME)</u>	<u>MANDATED appointed members PRESENT (no need to ask about absent)</u>	<u>Commissioner appointed PRESENT (5 total)</u>	<u>Number of NON MEMBERS PRESENT</u>
Dept. of Social Services (DSS) Director			
DSS Staff Member			
DSS Board Member			
Law Enforcement Office			
District Attorney’s Office			
Community Action			
Schools			
Mental Health			
Guardian ad Litem			
Health Director			
Health Care Provider			
EMS/Firefighter			
District Court Judge			
Medical Examiner			
Day Care/Head Start			
Parent			
Other			
Describe the ‘Other’ if applicable			

5. Please complete the table below. **System problems** are existing policies/rules or gaps in services that may contribute to child deaths. **Recommendations** should be specific and include: which agency(ies) would carry out the recommendation; which population(s) will be targeted; and what resources should be required. **Actions** should be specific and include actions taken to improve service delivery problems. **If a system problem is identified, a recommendation must accompany it.**

- System problem identified       No system problem identified

If a system problem (s) was identified, list the specific problem(s) below and provide a detailed statement about each problem that your team identifies. If not, please indicate "None."	If a system problem(s) was identified, what are the recommendations? <i>Please number to match the number of the system problem(s) identified.</i>	Record the action(s) taken or to be taken. <i>Please number to match the number of the system problem(s) identified.</i>

6. Please list any comments about the review process, including problems that require assistance from the CFPT Program Coordinator (i.e.: attendance, record access, team training, etc.).

7. Please list any comments about prevention activities initiated by your Team.

_____ Name of Chairperson	_____ Chair's Title
_____ Chair's Agency	_____ Chair's Phone Number
_____ Name of Person Completing this Form	_____ Title
_____ Agency (include County)	_____ Phone Number

Purpose:	General Statute 7B-1400 states that reports of child death reviews shall contain a listing of system programs identified through the review process, recommendations for preventive actions, any changes that resulted from the recommendations, and information about each death reviewed. This form will be used as the report specified above.
Preparation:	<p>The Review Coordinator of the Local Child Fatality Prevention Team (CFPT) shall complete this report every time the full CFPT reviews a child death. For help completing this form, please call (919) 707-5623. Because of the confidential nature of this report, facsimile transmission is prohibited. Prepare an original and one copy and mail original within 45 days of completed review. Maintain a copy for your files.</p> <ol style="list-style-type: none"> <li>1. Email word document to <a href="mailto:CFPTreports@dhhs.nc.gov">CFPTreports@dhhs.nc.gov</a></li> <li>2. Keep the original for the local CFPT files. Copies are to be kept for 5 years from the date of the review and then destroyed.</li> </ol>
Disposition: This form may be destroyed in accordance with the <i>Records Disposition Schedule</i> published by the NC Division of Archives and History. February 2012	