### Purpose:
The training is designed for all members of a CDR team. The training will provide the team member with current best practice of conducting a review. Learners will hear from experts in various fields pertaining to specific causes of child deaths and the role of each in responding to child deaths. CDR program staff and experienced local review team members will present information regarding the history of CDR in Michigan, examples of prevention initiatives that have come out of the CDR process, and how to run an effective CDR meeting. All sessions are plenary style, and most consist of PowerPoint presentations with verbal accompaniment. Two sessions use videos, and one is an interactive session, where a mock review takes place by incorporating role play.

### Learning Outcome:
The volunteer team member should have knowledge of how to participate in the confidential reviews of children's deaths, knowledge of the history of CDR in Michigan, knowledge of CDR on the national front, knowledge and skills on how to run an effective meeting, and knowledge and skills in conducting death reviews.

<table>
<thead>
<tr>
<th>Session Objectives</th>
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<tbody>
<tr>
<td><strong>Session #:</strong> 1</td>
<td><strong>Session #:</strong> 2</td>
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<tr>
<td><strong>Session Title:</strong> Introduction to Child Death Review (CDR), Citizen Review Panel (CRP), and Sudden Unexpected Infant Death (SUID)</td>
<td><strong>Session Title:</strong> Overview of CDR Team Member Expectations</td>
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<tr>
<td><strong>Presenter(s):</strong> Nicole DeWitt</td>
<td><strong>Presenter(s):</strong> Heidi Hilliard</td>
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<td><strong>Objective 1:</strong> Describe the Michigan Child Death Review Program, SUID Case Registry, and CRP.</td>
<td><strong>Objective 1:</strong> Describe the Child Death Review (CDR) process and how to run an effective meeting.</td>
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<td><strong>Objective 2:</strong> Identify the difference between the local and state CDR teams.</td>
<td><strong>Objective 2:</strong> Identify the roles of the different professional disciplines when a child dies.</td>
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<td><strong>Objective 3:</strong> Discuss the number of reviews completed each year.</td>
<td><strong>Objective 3:</strong> Explain how CDR data is collected and used to drive policy.</td>
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<td><strong>Objective 4:</strong> Describe the statute that covers the CDR process and confidentiality.</td>
<td><strong>Objective 4:</strong> Identify tools and resources to implement injury prevention initiatives in local communities.</td>
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</table>

| **Session #:** 3 | **Session #:** 4 |
| **Session Title:** EMS Responds to a 911 Call | **Session Title:** The Role of CPS in a Child’s Death |
| **Presenter(s):** Rick Dupon | **Presenter(s):** Colin Parks |
| **Objective 1:** Identify the optimal actions in response to a child’s death. | **Objective 1:** Define the responsibilities that DHS has in investigating a child’s death. |
| **Objective 2:** Define the role of EMS in responding to a child’s death. | **Objective 2:** Describe what it means to be a mandated reporter, who is responsible for making a report and the consequences of not doing so. |
| **Objective 3:** Identify the roles different responding agencies can and should play, individually and collectively. | **Objective 3:** Identify the policies in place for substantiating abuse and neglect. |
| **Objective 4:** Discuss the importance of the contribution that EMS personnel can have in the CDR process. | **Objective 4:** Discuss how a DHS team member interacts with CPS staff. |
| Session #: 5 | Session Title: The Role of the Medical Examiner  
Presenter(s): Dr. Carl Schmidt  
Objective 1: Describe the history of the evolution of the ME system, globally and in Michigan.  
Objective 2: Identify roles various agencies can play individually and collectively in a coordinated scene investigation, including medical examiners, first responders, law enforcement officers, public health, prosecutors and social services.  
Objective 3: Identify all of the procedures necessary to accurately determine cause and manner of death.  
Objective 4: Explain how a complete post mortem exam helps to determine cause of death.  
Objective 5: Identify the importance of the contribution that MEs have in the CDR process. |
|---|---|
| Session #: 6 | Session Title: The Role of Law Enforcement: Death Scene Investigation  
Presenter(s): Det Amy Hicok (Ret)  
Objective 1: Identify the various components of a thorough child death scene investigation.  
Objective 2: Describe how scene investigation is crucial to differentiate causes of death (SIDS vs suffocation, accidental injury vs abuse, etc)  
Objective 3: Define the duties and responsibilities that law enforcement agencies have in investigating a child’s death.  
Objective 4: Identify ways in which agencies should be working together for a more coordinated response.  
Objective 5: Demonstrate the important contribution that law enforcement personnel have in the process. |
| Session #: 7 | Session Title: The Legal System's Response to a Child's Death  
Presenter(s): Lora Weingarden  
Objective 1: Provide definitions to the legal terms used in describing child fatalities.  
Objective 2: Describe relevant Michigan laws.  
Objective 3: Define the roles of the courts, including probate and criminal courts, in child fatalities.  
Objective 4: Define how a prosecutor builds a case and how a thorough investigation leads to better prosecutions in cases of intentional child deaths.  
Objective 5: Identify the importance of the contribution that Prosecutors have in the CDR process. |
| Session #: 8 | Session Title: Effective CDR Meetings: Mock Review  
 Presenter(s): County Review Team  
Objective 1: Describe the characteristics of a high quality review.  
Objective 2: Identify the types of information shared by various team members at a review.  
Objective 3: Discuss the value of a multi-disciplinary discussion and team problem solving in understanding child fatalities.  
Objective 4: Identify the importance of asking questions about the investigation, services provided to the family before and after the death.  
Objective 5: Describe what can be done to improve response at the local level.  
Objective 6: Discuss potential problems and solutions in conducting local reviews and how to address these problems at the county level. |
| Session #: 9 | Session Title: Medically Fragile Deaths  
Presenter(s): Dr. Debra Simms  
Objective 1: Describe the epidemiology of medical deaths.  
Objective 2: Identify the causes of deaths of children with chronic medical conditions.  
Objective 3: Describe the risk factors that can contribute to natural child deaths.  
Objective 4: Discuss how to conduct effective reviews of natural child deaths, with a special emphasis on risk factor identification. |
| Session #: 10 | Session Title: Child Abuse and Neglect Deaths  
Presenter(s): Dr. Debra Simms  
Objective 1: Define the injuries from child abuse and neglect which can lead to death, especially abdominal injuries, head injuries, failure to thrive, medical neglect and Munchausen's Syndrome by Proxy.  
Objective 2: Describe how a diagnosis of child maltreatment is made.  
Objective 3: Describe the risk factors associated with abuse and neglect deaths.  
Objective 4: Discuss associated prevention strategies for communities. |
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<th>Session #</th>
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</table>
| Session # 11 | Abusive Head Trauma (Shaken Baby Syndrome)  
Session Title:  
Presenter(s): Dr. Carl Schmidt  
Objective 1: Describe the physical parameters of SBS.  
Objective 2: Identify the clinical and autopsy findings that support an SBS diagnosis. |
| Session # 12 | Youth Suicide/Risk Taking Behaviors  
Session Title:  
Presenter(s): Seth Persky, Ellen Pare  
Objective 1: List two ways that suicide death review can contribute to suicide prevention.  
Objective 2: List three ways that professionals can support a suicidal youth.  
Objective 3: Describe the prevalence of suicidality in our state’s youth. |
| Session # 13 | Reviewing Perinatal Deaths  
Session Title:  
Presenter(s): Sandy Nicolas, Sharon VanDam  
Objective 1: Describe the impact of perinatal deaths on the overall infant/child mortality rate for Michigan.  
Objective 2: Identify risk factors contributing to infant deaths due to conditions originating in the perinatal period.  
Objective 3: Explain how to conduct more effective reviews of perinatal deaths, with a special emphasis on risk factor identification. |
| Session # 14 | SIDS and Sudden Unexpected Infant Deaths  
Session Title:  
Presenter(s): Dr. Carl Schmidt  
Objective 1: Define what Sudden Infant Death Syndrome and Sudden Unexplained Infant Death are and are not.  
Objective 2: Discuss how diagnosis is made.  
Objective 3: Describe the problems associated with the reporting and surveillance of SIDS/SUID and related controversies.  
Objective 4: Define the risk factors associated with SIDS/SUID deaths.  
Objective 5: Identify current research initiatives to determine etiology. |
| Session # 15 | Best Practices in Death Scene Reenactments  
Session Title:  
Presenter(s): Patricia Tackitt  
Objective 1: Identify the components of a thorough child death investigation.  
Objective 2: Explain why child death investigation and re-enactments are critical in differentiating the various causes of SUIDs.  
Objective 3: Demonstrate how to document what the family showed by digital photography or video.  
Objective 4: Discuss the importance of providing the Medical Examiner with a copy of the death scene investigation, scene/re-enactment photos, in determination of cause and manner of death. |
| Session # 16 | Understanding Secondary Traumatic Stress and the Importance of Professional Well-being  
Session Title:  
Presenter(s): Stephanie McCann  
Objective 1: Identify symptoms of Secondary Traumatic Stress  
Objective 2: Discuss levels of secondary trauma exposure in the workplace.  
Objective 3: Identify mindfulness techniques to reduce symptoms of secondary traumatic stress including mindfulness-based self-care.  
Objective 4: Describe self-care strategies for professional wellness. |

**Disclosures:**

CRITERIA FOR COMPLETION  
Criteria for obtaining continuing education hours is 100% attendance of the event and completion of the following: Sign Out Sheet, Evaluation Survey.  
Please Note: NO late forms will be accepted.

The Planning Committee members declare no relevant financial conflict of interest or financial interests in any product or service mentioned in this program, including grants, research support, consultant, stock holdings or other financial and material support.

The presenters, have declared no conflict of interest or financial interest in this program. All presenters have signed an attestation that they will present fairly and without bias.
### Purpose, Objectives, and Disclosure(s)

<table>
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<tr>
<th><strong>Nursing Contact Hours Designation</strong></th>
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<tbody>
<tr>
<td>A total of <strong>12.00</strong> Nursing contact hours have been awarded for this activity by the Michigan Public Health Institute – Continuing Education Solutions (MPHI_CES #6210).</td>
</tr>
<tr>
<td><em>Michigan Public Health Institute is approved as a provider of continuing nursing education by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation.</em> (OBN-001-91)</td>
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<td>A total of <strong>12.00</strong> social work clock hours have been awarded for this activity by the Michigan Public Health Institute – Continuing Education Solutions.</td>
</tr>
<tr>
<td><em>MPHI-CES is an Unlimited Approved Provider (MICEC-0042) with the Social Work Continuing Education Collaborative and is recognized by the State of Michigan, Department of Community Health, Licensing Division for Social Work Continuing Education.</em></td>
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<th><strong>Continuing Medical Education Designation – Category 2</strong></th>
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<td>Application has been made to The Michigan Board of Medicine for the above mentioned continuing education program for <strong>12.00</strong> Category 2 hours. Please keep a copy of the agenda for your records.</td>
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</table>

All participants have been provided with a copy of the event purpose statement, event objectives, session descriptions, session objectives, and disclosure statements prior to the start of this event.