Self-Harm Death Analysis Review Team (SDART) TOOLKIT

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Acknowledgements

Thank you for your interest in initiating an adult death review team in your community. This toolkit was developed and funded under the Healthier Wisconsin Partnership Program, a component of the Advancing a Healthier Wisconsin Endowment at The Medical College of Wisconsin and developed by staff of the Kenosha County Division of Health in Kenosha WI and the Kenosha County SDART Team.

Why hold reviews?

The death review team's goal is to explore missed opportunities for intervention and increase the community's response to end suicide deaths as well as overdose deaths in our community.

The purpose is to improve our understanding of how and why a person died, to develop recommendations to improve our response to deaths, and develop prevention initiatives to take action to improve the health and safety of our community.

Objectives:

1. Determine and report on trends and patterns of adult suicides and overdose deaths.

2. Develop and disseminate an annual report to state officials describing any trends, risk factors, or patterns of deaths, along with any recommendations for changes in law, policy, or practice that will prevent deaths.

3. Identify and evaluate the prevalence of risk factors for suicide overdose deaths.

4. Educate the public, policy makers, and budget authorities about fatalities involving suicide and overdose deaths.

5. Promote collaboration between community agencies.

6. Evaluate and report on high risk factors, current practices, gaps in systematic responses, and barriers to safety and well-being of suicidal adults and accidental overdoses in your County.

How will being a member of the review team benefit my organization or community?

The reviews can provide community agencies with valuable information they can use when they find themselves working with families who lose a loved one to suicide or a drug overdose. The reviews also provides resources that can be shared as well as networking opportunities to create and establish a support network for self-care.

Participating in the review can benefit your organization or community in several different ways such as:

- Improving communication between agencies
- Networking and resource sharing
- Providing accurate and up to date information on key subjects such as suicide or drug prevention

- Identifying areas of strengths as well as areas of improvement needed in the community
- Building your coalition/organization/cause by including review team members in your efforts

Who should be a part of your community's death review team?

Identify a 'champion', defined as a member of the community who is passionate about issues consistent with the needs of your community, such as suicide prevention, grief, or substance abuse issues.
Suggestions of other team members include:

- Medical examiner/Coroner's office
- Law enforcement
- EMS/Fire department
- Adult crisis
- Hospital system(s)
- Colleges
- District Attorney's office
- Department of Corrections
- Social Workers
- Public Health
- Community Agencies
- Mental Health Professionals
- Clergy

What is the role of review team members?

Team members are asked to:

- Contribute information about the decedent from their agency records
- Serve as a liaison to respective professional counterparts
- Provide definitions of professional terminology
- Interpret agency procedures and policies
- Explain the legal responsibilities or limitations of his or her profession

The team members will also be asked their role in responding to the death such as:

- The 911 call
- EMS, Fire, Police (emergency response)
- Hospital physician, public health (medical community)
- Interaction with the family at the hospital
- Police, medical examiner/coroner, investigation
- Notification and death certification
- Bereavement services and burial
- Critical incident debriefing
- Services for family and community
- Prosecution/adjudication
- Follow-up services

Is a death review team needed in your community?

It is important to have several things in place before starting a review team.

- Contact the medical examiner's office to assure participation in the review team. This is vital in providing real time data to the team. Although the medical examiner's presence is encouraged, if unable to do so, it is important to establish a working and trustworthy relationship to aid in the discussion of the review team.
- Look at your local data to determine deaths to review in your community. This data can be found through your medical examiner's office, death certificates and using WISH (Wisconsin Interactive Statistics on Health) https://www.dhs.wisconsin.gov/wish/index.htm

After reviewing the death data, determine if any of the deaths are being addressed by other groups or coalitions, and decide what type of deaths will be a priority to review in your community.

The resources below should also be reviewed before putting together a local review team.

https://www.cdc.gov/violenceprevention/pdf/self-directed-violence-a.pdf

http://c.ymcdn.com/sites/www.cste.org/resource/resmgr/injury/isw7.pdf

http://www.nsc.org/RxDrugOverdoseDocuments/900006595_SCA_2015_Madison_Dane_County_Case_Study.pdf

How is a review team formed? Where do I start?

STEP 1: Form the review team

After reviewing the above resources, the next step is to determine who the main contact person will be for the review team. The main contact will send out the meeting reminders and the meeting minutes.

Questions to answer before the first meeting:

- Who will be the chairperson? What will their duties be? (i.e. put summaries together, input data, put agenda together, lead the meeting, take minutes or will these duties be divided among team members?)
- What date and time will the review team meet? What is the date for the 2nd meeting?
- Where will the meeting be held? Will it be at the same place each time or location be rotated?
- Who should be invited to the meeting? Will you have team members RSVP to the meeting? For on-line registration, consider using a free online form builder like www.jotform.com or www.eventbrite.com. You can post the link in a meeting reminder e-mail.

- What deaths do you want to review (suicides, overdoses, motor vehicle fatalities, homicides, drownings, etc.)
- Decide what age ranges you will cover?
- Do you have a confidentiality agreement? Will legal counsel need to review and approve it? How long will this process take?
- How long will the meetings be?
- How often will the team meet (monthly, bimonthly, quarterly)?
- How will meetings be documented?
- Will refreshments, snack, or lunch be provided?

STEP 2: Where can information be gathered to prepare case summaries for the review?

- Autopsy, toxicology report, and scene investigation (from the medical examiner's office)
- Death certificate
- Obituary (if available)—found in the local paper or from www.legacy.com
- Criminal record reports—utilize local inmate search through Sheriff's Department or State database
- Social media (Facebook, Twitter, Instagram, etc.). This may provide some insight into the thought process of the decedent at time of death
- Case summary to include:
    - Demographic information – Name, DOB, Age, DOD, Gender, Race
    - Cause of death—determined by the medical examiner's office
    - Manner of death—determined by the medical examiner's office
    - Brought to the Emergency Room?
    - Time pronounced dead
    - History of decedent
        - Recent history
        - Medical history
        - Social history
        - Criminal history
        - Autopsy report – includes final diagnoses and toxicology screen

STEP 3: What does the agenda include for the review?

- Introductions/Updates and Information Sharing
- Receive update report/numbers from the medical examiner's office
- Review cases (number of cases reviewed can be dependent on how often meetings take place and for what length of time)
- Next meeting date, time, and location

STEP 4: What information will be documented at and after the review?

- Sign in sheet
- Confidentiality agreements
- Answer these three questions
    - What steps could have been taken to prevent this death?
    - What questions could another individual have asked the decedent to save their life?

        - What community resources, other than the ones offered to this individual, could have made a difference?
- Document your findings from the review.
    - Decide what database will best suit your community's needs for tracking findings and recommendations.
    - De-identify all information.
    - Keep the chosen database password protected and limit those who have access to it

HELPFUL TIPS:

BEFORE THE REVIEW

- Send a reminder e-mail to remind attendees of the review.
- Include the agenda and names of the decedents that will be reviewed. Providing names allows time for community agencies to bring information about the decedent to the meeting.

WHAT SHOULD BE BROUGHT TO THE REVIEW?

- Signage-Place clear signs outside the building and place signs in the building directing attendees to the location
- Sign in sheet
- Confidentiality Agreement
- Table tent or name tags
- Copies of the summaries of the deaths to be reviewed or AV Equipment (if needed)
- Prepare opening comments—Plan a short welcome to explain the purpose of the reviews and give an overview of what attendees can expect
- Food—If you are providing, will it be delivered or picked up?

AFTER THE REVIEW

- Be sure to collect the case summaries after each meeting to keep reviews confidential
- Send out a save the date for the next review and the meeting minutes and resources that were shared
- Document what cases were reviewed, findings, and prevention ideas

CONTACT INFORMATION

If you have any questions about the materials or would like to offer feedback, please contact:

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