

**MASSACHUSETTS
CHILD FATALITY REVIEW
PROGRAM**

**THIRD ANNUAL REPORT
OF PROGRAM ACTIVITY
2003**

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December 2004

Massachusetts Child Fatality Review THIRD ANNUAL REPORT OF PROGRAM ACTIVITY - 2003

Executive Summary

In 2002, a total of 630 children ages 0-17 died in Massachusetts. Congenital anomalies and perinatal conditions comprise 52.5% of this total. If these causes are excluded, 69% of the 299 remaining deaths can be attributed to medical conditions and 31% to intentional and unintentional injuries.

The child fatality review legislation enacted by the Massachusetts legislature in July 2000 was designed to bring professionals together from a variety of disciplines and experiences to examine individual fatality cases. The objectives of this review are to facilitate interagency networking and collaboration and to produce recommendations for changes that will protect the health and safety of children.

The law establishes the State Team within the office of the Chief Medical Examiner, and the Local Teams within each of 11 District Attorneys' offices. Members of the teams are drawn from state departments of public health, social services, mental health, mental retardation, education, and youth services. There is also representation from the American Academy of Pediatrics, the Massachusetts SIDS Center, the Massachusetts Hospital Association, state and local police, and the juvenile courts. Representation from the child advocacy community is required at the State Team level; to date no one has been appointed.

The common goal of the State and Local Child Fatality Review Teams is to decrease the incidence of preventable child deaths and injuries. The Local Teams collect information on individual cases, discuss case information in team meetings and advise the State Team by making recommendations for changes in law, policy and practice that will prevent child deaths. Through the review process, child fatality review teams promote collaboration among the agencies that respond to child deaths and provide services to family members.

A principal responsibility of the State Team is to provide ongoing advice and support for the Local Teams through training, guidance and the dissemination of information pertinent to the protection of children. A second responsibility is to review Local Team recommendations and combine them with its own research in making final recommendations to the governor, the legislature and the public.

The State Team met four times in 2003 and considered a number of issues that included the adoption of a process for reviewing and evaluating Local Team recommendations, as well as the development of an effective, user-friendly data collection system. By the end of the year, in response to recommendations by several Local Teams, members of the State Team had taken the first steps to determine whether Massachusetts should adopt statewide guidance on death scene investigations of sudden and unexplained infant death. In addition, State Team members joined a multi-state planning group, working under the auspices of the National Center for Child Death Review, to develop a national electronic data collection system.

Local Teams varied a great deal in their level of activity during the year. Some of the teams from more populated districts met frequently, reviewed cases, and sent recommendations to the State

Team. Other smaller districts had fewer fatalities to review and fewer staff resources with which to conduct the reviews.

During 2003, Local Teams reviewed 229 child death cases. Although not all teams submitted recommendations based on their reviews, five of the teams did. These teams reviewed 140 cases and identified a number of causes of child death that they recommended for further attention. Over the past three years, issues of concern identified by more than one Local Team have included:

- ?? Preventable infant deaths: Some infant sleeping practices are increasingly thought to place infants at risk; they may be causing deaths mistakenly identified as SIDS deaths.
- ?? Infant death scene investigation: Local Teams continue to discuss the importance of standardized procedures for the investigation of sudden and unexplained infant deaths.
- ?? Adolescent suicides: they are increasingly seen as directly related to a lack of adequate and appropriate mental health services for this population.
- ?? Reviewing neonatal deaths: Teams in districts without Fetal and Infant Mortality Review Teams remain concerned as to whether they have the expertise, the time or the resources to conduct these reviews.
- ?? Motor vehicle crashes: Discussion continues as to how we can best address the frequency of adolescent fatalities from motor vehicle crashes, including all-terrain vehicles.

The most serious challenge facing the Massachusetts Child Fatality Review Teams was the continued lack of funding for case review and the implementation of recommendations for changes. The lack of any funding attached to the 2000 legislation has forced Local Teams to depend on in-kind staff and other resource contributions; this has limited and will continue to limit all team activity.

A second challenge has been the lack of a data collection system; all 11 Local Teams have expressed frustration at their inability to get back statewide information on case reviews. With the anticipated piloting of a national data collection system, it is expected that this problem will be solved in the foreseeable future.

Goals for the near future include:

- ?? Development of a plan for enhancing resources for child fatality review
- ?? Participation in planning and piloting of a national electronic database for child fatality review
- ?? Continuation of discussion on the need for statewide guidance for death scene investigation of sudden, unexplained infant deaths
- ?? Development of a public education campaign for safe sleeping practices for infants
- ?? Development of a statewide protocol for reviewing premature infant deaths

ANNUAL REPORT - 2003

I. Introduction

The passage of child fatality review legislation by the Massachusetts legislature in July 2000 was the culmination of efforts that began ten years earlier. Because it is widely accepted that many pediatric deaths, especially those from injuries, are preventable, child health and safety advocates and professionals across the state recognized the importance of the child fatality review team as a critical tool in the prevention of death and injuries. The underlying assumption of child fatality review is that bringing professionals together from a variety of disciplines and experiences to examine individual cases can enhance the understanding of all review team participants. The process facilitates interagency networking and collaboration and can produce widely supported recommendations for changes in laws, products, policies and services that impact the health and safety of children.

The year 2003 represented the third year of the review process in Massachusetts. Local Teams continued to meet, review cases and submit recommendations to the State Team. The State Team continued to meet quarterly to review recommendations and discuss the development of a statewide data collection process. The third annual report will include:

- ?? a description of the structure of the child fatality review process in the state;
- ?? the third year's experience and accomplishments of the State and Local Teams;
- ?? a summary of recommendations submitted during the first three years, as a reflection of the teams' ongoing concerns for particular child safety issues;
- ?? initiatives accomplished or in progress since the beginning of Massachusetts child fatality review; and
- ?? ongoing challenges to the continuation and success of the review process.

During the state's first two years of child fatality review activity, teams focused on assembling multi-disciplinary membership, developing a review structure and protocols, reviewing cases and making recommendations for changes to prevent child deaths. During the third year, with membership and protocols in place, Local Teams continued to review cases and to identify patterns in child fatalities that resulted in more focussed recommendations. Over the past three years, issues of concern identified by more than one Local Team have included:

- ?? Preventable infant deaths: Some infant sleeping practices are increasingly thought to place infants at risk; they may be causing deaths mistakenly identified as SIDS deaths.
- ?? Infant death scene investigation: Local Teams continue to discuss the importance of standardized procedures for the investigation of sudden and unexplained infant deaths.
- ?? Adolescent suicides: they are increasingly seen as directly related to a lack of adequate and appropriate mental health services for this population.
- ?? Reviewing neonatal deaths: Teams in districts without Fetal and Infant Mortality Review Teams remain concerned as to whether they have the expertise, the time or the resources to conduct these reviews.
- ?? Motor vehicle crashes: Discussion continues as to how we can best address the frequency of adolescent fatalities from motor vehicle crashes, including all-terrain vehicles.

II. Child Deaths in Massachusetts

In 2002,¹ a total of 630 children from birth through age 17 died in Massachusetts (Table 1). Of this total, 331 (52.5%) of the deaths were due to congenital anomalies and perinatal conditions, 206 (32.7%) were from other medical causes, and 93 (14.8%) were from intentional and unintentional injuries. After congenital anomalies and perinatal conditions, the two highest causes of child death were cancer and other neoplasms and unintentional injuries. If congenital anomalies and perinatal conditions are excluded, the causes of the remaining 299 deaths break down into 69% medical conditions and 31% intentional and unintentional injuries.

Table 1. Causes of Death for Massachusetts Children Ages 0-17, 2002²

| Cause of Death | Number | Percent of Child Deaths |
|--|------------|-------------------------|
| Perinatal Conditions | 249 | 39.5% |
| Congenital Anomalies | 82 | 13.0% |
| Other Medical Conditions | 43 | 6.8% |
| Cancer & Other Neoplasms | 37 | 5.9% |
| Transportation-Related Injuries | 32 | 5.1% |
| Unintentional Injuries – Non-transportation | 29 | 4.6% |
| Diseases of the Circulatory System | 26 | 4.1% |
| Meningitis & other diseases of nervous system | 25 | 4.0% |
| Respiratory Diseases (incl. pneumonia, bronchitis, asthma, respiratory distress) | 20 | 3.2% |
| Homicide | 18 | 2.9% |
| SIDS | 17 | 2.7% |
| Septicemia & Other Infections | 16 | 2.5% |
| Diabetes & other metabolic disorders | 12 | 1.9% |
| Digestive Diseases | 9 | 1.4% |
| Other Injuries | 7 | 1.1% |
| Suicide | 7 | 1.1% |
| HIV Disease | 1 | 0.2% |
| Total Number of Deaths | 630 | 100% |
| Total Deaths excluding Congenital Anomalies & Perinatal Conditions | 299 | 47.5% |
| Total Deaths from Medical Causes excl. Newborn Conditions | 206 | 32.7% |
| Total Deaths from Injuries | 93 | 14.8% |

¹ 2003 data on Massachusetts child deaths were not available from the Dept. of Public Health (DPH), Registry of Vital Records and Statistics at the time of the writing of this report.

² 2002 data on Massachusetts child deaths are from the Dept. of Public Health (DPH), Registry of Vital Records and Statistics.

Table 2 lists the causes of death by age group. The leading causes of death for infants were perinatal conditions and congenital anomalies. Unintentional injuries were the leading causes of death for toddlers, and cancer and injuries (intentional and unintentional), the leading causes for school-age children. Cancer, transport-related injuries and respiratory disease were the leading causes for adolescent deaths, and transport-related injuries, by far the biggest killer of teenagers.

Table 2. Causes of Death for Massachusetts Children Ages 0-17, by Age Group, 2002³

| Cause of Death | < 1 yr | 1 – 4 yrs | 5 – 9 yrs | 10 – 14 yrs | 15 – 17 yrs | Total |
|--|------------------|------------------|------------------|--------------------|--------------------|--------------|
| Perinatal Conditions | 249 | 0 | 0 | 0 | 0 | 249 |
| Congenital Anomalies | 65 | 12 | 3 | 0 | 2 | 82 |
| Other Medical Conditions | 18 | 11 | 3 | 5 | 6 | 43 |
| Cancer & Other Neoplasms | 1 | 7 | 10 | 12 | 7 | 37 |
| Unintentional Injuries - Transport-Related | 0 | 1 | 3 | 3 | 25 | 32 |
| Unintentional Injuries - Nontransport | 4 | 11 | 5 | 7 | 2 | 29 |
| Diseases of the Circulatory System | 9 | 4 | 5 | 3 | 5 | 26 |
| Meningitis & other diseases of nervous system | 8 | 4 | 5 | 8 | 0 | 25 |
| Respiratory Diseases (incl. pneumonia, bronchitis, asthma, respiratory distress) | 10 | 5 | 2 | 2 | 1 | 20 |
| Homicide | 2 | 5 | 2 | 4 | 5 | 18 |
| SIDS | 17 | 0 | 0 | 0 | 0 | 17 |
| Infections | 6 | 3 | 3 | 2 | 2 | 16 |
| Diabetes & other metabolic disorders | 2 | 4 | 1 | 3 | 2 | 12 |
| Other Injuries | 3 | 1 | 0 | 1 | 2 | 7 |
| Suicide | 0 | 0 | 0 | 0 | 7 | 7 |
| Digestive Diseases | 3 | 3 | 1 | 2 | 0 | 9 |
| HIV Disease | 0 | 0 | 0 | 1 | 0 | 1 |
| Total Number of Deaths | 397 | 71 | 43 | 53 | 66 | 630 |

³ 2002 data on Massachusetts child deaths are from the Dept. of Public Health (DPH), Registry of Vital Records and Statistics.

Of the 630 deaths, 169 were investigated by the Office of the Chief Medical Examiner (Table 3); the most frequent causes of these deaths were unintentional injuries, including motor vehicle crashes, and Other Medical Conditions, followed by SIDS and homicide.

Table 3. Massachusetts Child Deaths Investigated by the Medical Examiner's Office, 2002⁴

| Cause of Death | < 1 yr | 1–4 yrs | 5–9 yrs | 10–14 yrs | 15–17 yrs | Total |
|---|------------------|----------------|----------------|------------------|------------------|--------------|
| Other Unintentional Injuries, incl. motor vehicle | 5 | 11 | 7 | 7 | 26 | 56 |
| Other Medical Conditions | 7 | 12 | 2 | 3 | 5 | 29 |
| SIDS | 20 | 0 | 0 | 0 | 0 | 20 |
| Homicide | 1 | 6 | 2 | 4 | 6 | 19 |
| Undetermined , incl. drug deaths | 6 | 1 | 0 | 0 | 3 | 10 |
| Drowning | 1 | 3 | 3 | 2 | 0 | 9 |
| Suicide by hanging and other methods | 0 | 0 | 0 | 0 | 8 | 8 |
| Co-Sleeping | 4 | 1 | 0 | 0 | 0 | 5 |
| Prematurity, Congenital Anomalies | 3 | 0 | 0 | 0 | 0 | 3 |
| Pneumonia | 3 | 1 | 0 | 0 | 1 | 5 |
| Asthma/Bronchitis | 0 | 2 | 0 | 0 | 0 | 2 |
| Shaken Baby Syndrome | 2 | 0 | 0 | 0 | 0 | 2 |
| Still Pending | 1 | 0 | 0 | 0 | 0 | 1 |
| Total | 53 | 37 | 14 | 16 | 49 | 169 |

The number of child deaths in 2002 varied among the state's counties in direct relation to each county's share of the state's population (Table 4). In several counties, however, the number of child deaths was greater or less than their share of the state's population. These numbers are highlighted in Table 4.

⁴ Data are from the Office of the Chief Medical Examiner.

Table 4. Massachusetts Child Deaths by County, 2002⁵

| County | Population (% of Total Population) | Total Child Deaths (% of Total Child Deaths) | < 1 year (% of <1 yr Deaths) | 1 – 17 yrs. (% of 1-17 yrs Deaths) |
|-----------------|--|--|------------------------------------|--|
| Barnstable | 222,230 (4%) | 17 (3%) | 10 | 7 |
| Berkshire | 134,953 (2%) | 12 (2%) | 8 | 4 |
| Bristol | 534,678 (8%) | 55 (9%) | 36 | 19 |
| Dukes | 14,987 (<1%) | 0 | 0 | 0 |
| Essex | 723,419 (12%) | 67 (11%) | 41 | 26 |
| Franklin | 71,535 (1%) | 6 (1%) | 0 | 6 |
| Hampden | 456,228 (7%) | 67 (11%)* | 44 (11%)* | 23 (10%)* |
| Hampshire | 152,251 (2%) | 16 (3%) | 9 | 7 |
| Middlesex | 1,465,396 (23%) | 117 (19%)* | 74 (19%)* | 43 (18%)* |
| Nantucket | 9,520 (<1%) | 2 (<1%) | 2 | 0 |
| Norfolk | 650,308 (10%) | 52 (8%) | 34 | 18 |
| Plymouth | 472,822 (7%) | 42 (7%) | 22 | 20 |
| Suffolk | 689,807 (11%) | 91 (14%)* | 60 (15%)* | 31 |
| Worcester | 750,963 (12%) | 86 (14%) | 57 | 29 |
| Total MA | 6,349,097 (100%) | 630 (100%) | 397 (100%) | 233 (100%) |

*Note: Numbers are highlighted if they are **more than 2% above or below** the county's share of the state's population.

III. Structure

The Massachusetts Child Fatality Review law establishes a State Team and 11 Local Teams.⁶ The State Team is placed within the Office of the Chief Medical Examiner, and the Local Teams within each of 11 districts headed by a District Attorney. These districts correspond to the state's counties, although two of the districts combine more than one county (Franklin and Hampshire Counties are combined, as are Barnstable, Dukes and Nantucket). Local Teams can meet as frequently as they want but must meet at a minimum four times per year. There is no meeting requirement for the State Team.

The make up of the State and Local Teams is also established, but not limited, by the law.⁷

⁵ 2002 data on Massachusetts child deaths are from the (DPH), Registry of Vital Records and Statistics.

⁶ A list of Local Teams and Team coordinators can be found in Appendix A.

⁷ A copy of the legislation can be found in Appendix B.

Table 5. Mandated Child Fatality Review Team Membership

| Mandated State Team Members | Mandated Local Team Members |
|--|---|
| Chief Medical Examiner (chair) | Chief Medical Examiner, or designee |
| Attorney General, or designee | District Attorney of county (chair) |
| Commissioner of Dept. of Social Services, (DSS) or designee | Commissioner of Dept. of Social Services, or designee |
| Commissioner of Dept. of Public Health (DPH), or designee | Commissioner of Dept. of Public Health, or designee |
| Commissioner of Dept. of Education, or designee | |
| Commissioner of Dept. of Mental Health, or designee | |
| Commissioner of Dept. of Mental Retardation, or designee | |
| Commissioner of Dept. of Youth Services, or designee | |
| Representative of Mass. DA's association | |
| Colonel of State Police, or designee | State law enforcement officer |
| Director of Mass. Center for Sudden Infant Death Syndrome (SIDS), or designee | Director of Mass. Center for Sudden Infant Death Syndrome (SIDS), or designee |
| Rep. of the Mass. chapter of the American Academy of Pediatrics with experience in child abuse and neglect | Pediatrician with experience in child abuse and neglect |
| Rep. of the Mass. Hospital Assoc. | |
| Chief justice of the juvenile division of the trial court, or designee | Chief justice of the juvenile division of the trial court, or designee |
| Pres. of Mass. Chiefs of Police assoc. or designee | Local police officer from the community where the fatality occurred |
| Child Advocate | |
| Anyone else with information relevant to cases under review | Anyone else with information relevant to cases under review |

Responsibilities of the State Team

The common goal of the State and Local Child Fatality Review Teams is to decrease the incidence of preventable child deaths and injuries. The State Team accomplishes the goal of fatality and injury prevention through two objectives:

- ?? It develops an understanding of how and why children die; and
- ?? It advises the governor, the legislature and the public on changes in law, policy and practice that will prevent child deaths.

A principal responsibility of the State Team is to provide ongoing advice and support for the 11 Local Teams through training and the dissemination of information pertinent to the protection of children. A second responsibility is to review Local Team recommendations and combine them

with its own research in making final recommendations to the governor, legislature and the public.

Responsibilities of the Local Teams

The Local Teams have four objectives:

- ?? They collect information on individual child deaths;
- ?? They discuss this case information in team meetings and develop an understanding of the causes and incidence of child deaths;
- ?? Through the review process, they promote collaboration among the agencies that respond to child deaths and provide services to family members; and
- ?? They advise the State Team by making recommendations for changes in law, policy and practice that will prevent child deaths.

The Review Process

Case Selection: At least on a quarterly basis, each Local Team receives two notifications of child deaths. One notification consists of copies of death certificates that originate in the cities and towns of the Commonwealth and are sent to the DPH Registry of Vital Records and Statistics. From DPH, the certificates are sent to the Chief Medical Examiner, who in turn forwards them to the Local Teams. In the case of infants under one year of age, DPH attaches birth certificates to the death certificates; the birth certificate facilitates a review of the infant death by providing critical information on the health status and prenatal care of the mother.

The second notification to the teams is a report from the Department of Public Health, which backs up the death certificates and is organized in the following manner:

- ~~☒~~ deaths of children living in the county who died in the county
- ~~☒~~ deaths of children living in the county who died in another county
- ~~☒~~ deaths of children living in another county who died in the county

Any death of a child from birth to 18, from any cause, may be chosen for review by the team coordinator, who notifies team members of the cases selected for review before the scheduled review meeting. It is recommended that at a minimum, Local Teams review the following:

- ~~☒~~ any death from an injury, intentional or unintentional
- ~~☒~~ any sudden or unexpected deaths, including SIDS
- ~~☒~~ all cases forwarded to the medical examiner
- ~~☒~~ all cases with previous DSS involvement or cases that have been prosecuted by the District Attorney's office.

Local Teams are not expected to determine whether a particular death selected for review was in fact preventable, but case review should focus on the possibility that future deaths of this type are preventable.

A “preventable death” is broadly defined as a death that could have been avoided by a change in clinical care, a change in how a facility, e.g. a hospital, is organized, a change in public health policy or law, a change in community or environmental factors, or a change in individual or group behavior.

Preventable deaths are not limited to child abuse or intentional injury; most unintentional injuries are not “accidents” and can be prevented, as can many illnesses or deaths from illnesses.

Assembling Case Information: To accomplish the mandate of the child fatality review law, the legislature gave each local District Attorney the broad authority to collect all records and information relevant to the death of a child under review by a Local Team. This authority includes records and information relevant to the child and their immediate family from:

- ?? providers of medical or other care, treatment or services, including dental and mental health care;
- ?? state, county or local government agencies; or
- ?? providers of social services.

The legislation also gives the Local Team the authority to obtain information covered under the Health Insurance and Portability and Accountability Act (HIPAA). (See Appendix C.)

Case Review: A case review begins with the presentation of case details, including all information provided by Team members and other sources. Additional participants may be invited to the review if they have information pertinent to the case. The presenter may be the team coordinator or another member with knowledge of the case, but all members who have information concerning the case or the cause of death should contribute to the discussion. At the discretion of the team, a case may be held over to the next meeting if the information provided is unclear, or if more information is needed to complete the review. A case may also be held over if it is under investigation. Reviews are complete when the team agrees that no further information or discussion would add to the investigation of the death.

A child fatality review team does not function as a mechanism for criticizing or second-guessing any family or agency decisions. Rather it is a forum for sharing and discussing information essential to the improvement of the state’s ability to protect its children. The critical question being answered by the review is not “Could this death have been prevented?” but “How can we prevent a death like this from occurring again?”

Recommendations: Once a case has been reviewed, team members may reach conclusions about the child’s death that lead them to recommend changes to prevent similar deaths in the future. The death might point to a problem with a particular consumer product or a lapse or delay in medical care received by the child before they died. The death might also suggest changes in policies or services offered by team members’ or other agencies that could help prevent future deaths. These recommendations for change can be forwarded to the State Team, which considers them and can pass them on to the governor, legislature and the public for their consideration and response. Recommendations can also be directed to the appropriate agencies

or individuals at the community level, if this course of action seems most appropriate to Local Team members.

Confidentiality

The Child Fatality Review law makes the following provisions for maintaining confidentiality:

- ?? The Chair will make sure that no information submitted for case review is given to anyone outside the Local Team.
- ?? Team members may not violate confidentiality.
- ?? Team members may not disclose team business, except as necessary to carry out their duties and responsibilities.
- ?? Team meetings are closed to the public.
- ?? All information and records acquired by the team for case review are confidential and may be disclosed only as necessary to carry out team duties.
- ?? Statistical compilations of data may be disclosed to the public, provided they contain no identifying information.
- ?? Team members or anyone else attending team case review meetings may not be questioned in any civil or criminal proceeding regarding information presented or opinions formed during reviews.
- ?? Information or records of State and Local Teams will not be subject to subpoena, discovery, or introduction into evidence of civil or criminal proceedings. However, information obtained from other sources for the review may be subject to subpoena, discovery, or introduction into evidence.

Some Local Teams begin each case review session by signing a confidentiality form; others sign the form once, at their first meeting

IV. 2003 Activity

During the state's third year of child fatality review activity, the focus of attention was on reviewing cases and developing recommendations. The lack of any funding appropriated by the state legislature continued to challenge Local and State Teams, but one of the Local Teams (Essex County) was able to organize a regional conference on adolescent mental health, in response to a number of suicides (see the Essex Team report below).

State Team Activity

The State Team met three times in 2003; accomplishments included:

- ?? Production of the 2002 Annual Report;
- ?? Organization of a statewide CFRT Forum, attended by 92 people;
- ?? Site visits to a number of Local Teams to discuss data collection;
- ?? Participation in the first national CFRT conference, sponsored by the Maternal and Child Health Bureau-funded National Resource Center for Child Death Review; and
- ?? Ongoing discussion of Local Team recommendations and organization of a recommendations committee to develop a process for expediting the analysis and disposition of submitted recommendations.

Local Team Activity

As in the previous years, Local Child Fatality Review Teams varied a great deal in their level of activity during 2003. Information on Local Team activity was obtained from written reports submitted by each Local Team to the State Team, and is included in this report. A total of 260 deaths were reviewed by the 10 Local Teams submitting reports. Table 5 lists the number of deaths reviewed by each team in 2003, broken down by age group

Table 5. Age Breakdown of Deaths Reviewed by MA Child Fatality Review Teams in 2003

| Local Team | < 1 yr | 1–4 yrs | 5–9 yrs | 10–14 yrs | 15–17 yrs | Total |
|--|------------|-----------|-----------|-----------|-----------|------------|
| Barnstable, Martha’s Vineyard, Nantucket (Cape and Islands CFRT) | 17 | 1 | 1 | 1 | 4 | 24 |
| Berkshire | | | | | | No Report |
| Bristol | 4 | 1 | 0 | 0 | 2 | 7 |
| Essex | 4 | 2 | 3 | 3 | 2 | 14 |
| Franklin & Hampshire (Northwestern CFRT) | 5 | 1 | 1 | 1 | 0 | 8 |
| Hampden | 17 | 9 | 2 | 6 | 5 | 39 |
| Middlesex | 4 | 1 | 2 | 1 | 4 | 12 |
| Norfolk | 22 | 5 | 4 | 4 | 0 | 35 |
| Plymouth | 26 | 8 | 4 | 7 | 1 | 46 |
| Suffolk | 8 | 2 | 2 | 1 | 1 | 14 |
| Worcester | 43 | 2 | 8 | 5 | 3 | 61 |
| Total | 150 | 32 | 27 | 29 | 22 | 260 |

Information on each Local Team appears below. Child death data are from 2002, and team activity from 2003. In fact, due to the delay in forwarding death certificates to the Local Teams, most case reviews conducted in 2003 were for deaths that occurred in 2002.

**Barnstable, Dukes & Nantucket Counties
(Cape and Islands Child Fatality Review Team)**

| | | | | | | | | | | | |
|--|---|---------|-----------|-----------|-----------|-----------|----|---|---|---|---|
| Number of child deaths, 2002 | 19 | | | | | | | | | | |
| Percentage of state child deaths | 3% | | | | | | | | | | |
| Percentage of MA population | 4% | | | | | | | | | | |
| Number of team meetings in 2003 | 4 | | | | | | | | | | |
| Number of cases reviewed | 24 | | | | | | | | | | |
| Age Breakdown: | <table border="1"> <tr> <td><1 yr</td> <td>1-4 yrs</td> <td>5-9 yrs</td> <td>10-14 yrs</td> <td>15-17 yrs</td> </tr> <tr> <td>17</td> <td>1</td> <td>1</td> <td>1</td> <td>4</td> </tr> </table> | <1 yr | 1-4 yrs | 5-9 yrs | 10-14 yrs | 15-17 yrs | 17 | 1 | 1 | 1 | 4 |
| <1 yr | 1-4 yrs | 5-9 yrs | 10-14 yrs | 15-17 yrs | | | | | | | |
| 17 | 1 | 1 | 1 | 4 | | | | | | | |
| Does the team collect data on cases reviewed | Yes | | | | | | | | | | |
| Recommendations submitted to State Team in 2003? | No | | | | | | | | | | |

Team Composition:

| Mandated Agency | Active Participants | Mandated Agency | Active Participants |
|----------------------------|---------------------|----------------------------|---------------------|
| District Attorney's Office | 1 | State Police | 1 |
| Medical Examiner | 1 | Local Police | 0 |
| Dept. of Social Services | 1 | Pediatrician | 1 |
| Dept. of Public Health | 1 | Juvenile Court | 1 |
| SIDS Center | 1 | Others: Regional Counselor | 0 |

Case Selection Criteria: The team reviews all resident and non-resident deaths that occur within their counties, including premature and other infant deaths.

Berkshire County Child Fatality Review Team (No report was submitted.)

| | | | | | | | | | | | |
|--|--|---------|-----------|-----------|-----------|-----------|---------------------|--|--|--|--|
| Number of child deaths, 2002 | 12 | | | | | | | | | | |
| Percentage of state child deaths | 2% | | | | | | | | | | |
| Percentage of MA population | 2% | | | | | | | | | | |
| Number of team meetings in 2003 | No report from team | | | | | | | | | | |
| Number of cases reviewed | No report from team | | | | | | | | | | |
| Age Breakdown: | <table border="1"> <tr> <td><1 yr</td> <td>1-4 yrs</td> <td>5-9 yrs</td> <td>10-14 yrs</td> <td>15-17 yrs</td> </tr> <tr> <td colspan="5">No report from team</td> </tr> </table> | <1 yr | 1-4 yrs | 5-9 yrs | 10-14 yrs | 15-17 yrs | No report from team | | | | |
| <1 yr | 1-4 yrs | 5-9 yrs | 10-14 yrs | 15-17 yrs | | | | | | | |
| No report from team | | | | | | | | | | | |
| Does the team collect data on cases reviewed | No report from team | | | | | | | | | | |
| Recommendations submitted to State Team in 2003? | No | | | | | | | | | | |

Bristol County Child Fatality Review Team

| | | | | | | | | | | | |
|--|--|---------|-----------|-----------|-----------|-----------|---|---|--|--|---|
| Number of child deaths, 2002 | 55 | | | | | | | | | | |
| Percentage of state child deaths | 9% | | | | | | | | | | |
| Percentage of MA population | 8% | | | | | | | | | | |
| Number of Team meetings in 2003 | 4 | | | | | | | | | | |
| Number of cases reviewed | 7 | | | | | | | | | | |
| Age Breakdown: | <table border="1"> <tr> <td><1 yr</td> <td>1-4 yrs</td> <td>5-9 yrs</td> <td>10-14 yrs</td> <td>15-17 yrs</td> </tr> <tr> <td>4</td> <td>1</td> <td></td> <td></td> <td>2</td> </tr> </table> | <1 yr | 1-4 yrs | 5-9 yrs | 10-14 yrs | 15-17 yrs | 4 | 1 | | | 2 |
| <1 yr | 1-4 yrs | 5-9 yrs | 10-14 yrs | 15-17 yrs | | | | | | | |
| 4 | 1 | | | 2 | | | | | | | |
| Does the team collect data on cases reviewed | Yes | | | | | | | | | | |
| Recommendations to State Team in 2003? | No | | | | | | | | | | |

Team Composition:

| Mandated Agency | Active Participants | Mandated Agency | Active Participants |
|----------------------------|---------------------|--|---------------------|
| District Attorney's Office | 4 | State Police | 2 |
| Medical Examiner | 1 | Local Police | 18 |
| Dept. of Social Services | 1 | Pediatrician | 1 |
| Dept. of Public Health | 1 | Juvenile Court | 1 |
| SIDS Center | 1 | Others: Regional Counsel and Mass. SIDS Center | 2 |

Case Selection Criteria:

The team reviews resident child deaths occurring within the county. Not all child deaths are reviewed, but those reviewed include premature and other infant deaths. Deaths under criminal investigation are not reviewed.

Essex County (Eastern District Child Fatality Review Team)

| | | | | | | | | | | | |
|--|--|---------|-----------|-----------|-----------|-----------|---|---|---|---|---|
| Number of child deaths, 2002 | 67 | | | | | | | | | | |
| Percentage of state child deaths | 11% | | | | | | | | | | |
| Percentage of MA population | 12% | | | | | | | | | | |
| Number of team meetings in 2003 | 4 | | | | | | | | | | |
| Number of cases reviewed | 14 | | | | | | | | | | |
| Age Breakdown: | <table border="1"> <tr> <td><1 yr</td> <td>1-4 yrs</td> <td>5-9 yrs</td> <td>10-14 yrs</td> <td>15-17 yrs</td> </tr> <tr> <td>4</td> <td>2</td> <td>3</td> <td>3</td> <td>2</td> </tr> </table> | <1 yr | 1-4 yrs | 5-9 yrs | 10-14 yrs | 15-17 yrs | 4 | 2 | 3 | 3 | 2 |
| <1 yr | 1-4 yrs | 5-9 yrs | 10-14 yrs | 15-17 yrs | | | | | | | |
| 4 | 2 | 3 | 3 | 2 | | | | | | | |
| Does the team collect data on cases reviewed | No | | | | | | | | | | |
| Recommendations submitted to State Team in 2003? | Yes | | | | | | | | | | |

Team Composition:

| Mandated Agency | Active Participants | Mandated Agency | Active Participants |
|----------------------------|---------------------|--------------------------|---------------------|
| District Attorney's Office | 8 | State Police | 2 |
| Medical Examiner | 1 | Local Police | 1-3 |
| Dept. of Social Services | 2 | Pediatrician | 2 |
| Dept. of Public Health | 1 | Juvenile Court | 3 |
| SIDS Center | 1 | Others: Child Psychiatry | 1 |

Case Selection Criteria:

The Essex County Team reviews the following deaths of children up to age 18:

- ☞☞ All homicides
- ☞☞ All deaths from unintentional injuries
- ☞☞ All sudden or unexpected deaths, including suicides and SIDS
- ☞☞ Cases where there is a known DSS history, when deemed appropriate after consultation with the Medical Examiner.
- ☞☞ All deaths of children who are residents of Essex County, regardless of place of death, when case review criteria are met.
- ☞☞ Deaths of children who are not residents of Essex County, but who died in Essex County, at the discretion of members of the Team. In these instances, every effort will be made to contact the Chair of the Child Fatality Review Team where the child resided, if such a team exists.
- ☞☞ Cases involving deaths due to medical causes, when there are unique circumstances or noted patterns that warrant review.
- ☞☞ Cases, for which individual agencies represented on the Team request a formal review, based on their knowledge of the case or noted cause of death. The request for review should be made to the Chair for consideration.
- ☞☞ Any other case deemed appropriate for review by the Team after consultation with the Medical Examiner.

The team does not review all Essex County child deaths, nor does it review premature or other infant deaths.

2003 Accomplishments:

- ?? As a result of teen suicides, a multidisciplinary subcommittee was formed to look at adolescent mental health issues. The subcommittee has met periodically to define issues and consider solutions.
- ?? A training on adolescent mental health was planned for 2004.
- ?? Case selection and review protocols were developed and adopted in July 2003 (See Appendix D.)

Major Challenges:

- ?? Difficulties obtaining case-related information from hospitals and other sources

The Essex Co. Team has had varied responses from its requests to clinics and physicians' offices. Copies of the Child Fatality Review legislation are sent to document the authorization of the request, but sometimes numerous calls are needed to get records sent in a timely manner. It has been particularly difficult to get records sent from another state.

?? Available staffing resources continue to be inadequate.

Franklin and Hampshire Counties (Northwestern Child Fatality Review Team)

| | | | | | | | | | | | |
|--|--|---------|-----------|-----------|-----------|-----------|---|---|---|---|---|
| Number of child deaths, 2002 | 22 | | | | | | | | | | |
| Percentage of state child deaths | 3.5% | | | | | | | | | | |
| Percentage of MA population | 3.5% | | | | | | | | | | |
| Number of team meetings in 2003 | 4 | | | | | | | | | | |
| Number of cases reviewed | 8 | | | | | | | | | | |
| Age Breakdown: | <table border="1"> <tr> <td><1 yr</td> <td>1-4 yrs</td> <td>5-9 yrs</td> <td>10-14 yrs</td> <td>15-17 yrs</td> </tr> <tr> <td>5</td> <td>1</td> <td>1</td> <td>1</td> <td>0</td> </tr> </table> | <1 yr | 1-4 yrs | 5-9 yrs | 10-14 yrs | 15-17 yrs | 5 | 1 | 1 | 1 | 0 |
| <1 yr | 1-4 yrs | 5-9 yrs | 10-14 yrs | 15-17 yrs | | | | | | | |
| 5 | 1 | 1 | 1 | 0 | | | | | | | |
| Does the team collect data on cases reviewed | Yes | | | | | | | | | | |
| Recommendations submitted to State Team in 2003? | No | | | | | | | | | | |

Team Composition:

| Mandated Agency | Active Participants | Mandated Agency | Active Participants |
|----------------------------|----------------------------|--|----------------------------|
| District Attorney's Office | 3 | State Police | 1 |
| Medical Examiner | 1 | Local Police | as needed |
| Dept. of Social Services | 1 | Pediatrician | 1 |
| Dept. of Public Health | 1 | Juvenile Court | 1 |
| SIDS Center | 1 | Others: Children's Advocacy Center; Western Mass. EMS | 2 |

Case Selection Criteria:

The team reviews deaths of all children under 18 who resided or died in county, except those deaths under investigation. Premature infant deaths are reviewed.

2003 Accomplishments:

- ?? Development of a protocol
- ?? Addition of the Assistant Director of the Western Massachusetts EMS Council to Child Fatality Review Team to provide a broader base of expertise for case review

Major Challenges:

- ?? Difficulties obtaining case-related information from hospitals and other sources
The team has experienced difficulties obtaining the mother’s records that are relevant to the cases involving prematurity, newborns, and some infants.
- ?? Lack of database to consolidate all information obtained.

Hampden County Child Fatality Review Team

| | | | | | | | | | | | |
|--|---|---------|-----------|-----------|-----------|-----------|----|---|---|---|---|
| Number of child deaths, 2002 | 67 | | | | | | | | | | |
| Percentage of state child deaths | 11% | | | | | | | | | | |
| Percentage of MA population | 7% | | | | | | | | | | |
| Number of team meetings in 2003 | 11 | | | | | | | | | | |
| Number of cases reviewed | 39 | | | | | | | | | | |
| Age Breakdown: | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"><1 yr</td> <td style="text-align: center;">1-4 yrs</td> <td style="text-align: center;">5-9 yrs</td> <td style="text-align: center;">10-14 yrs</td> <td style="text-align: center;">15-17 yrs</td> </tr> <tr> <td style="text-align: center;">17</td> <td style="text-align: center;">9</td> <td style="text-align: center;">2</td> <td style="text-align: center;">6</td> <td style="text-align: center;">5</td> </tr> </table> | <1 yr | 1-4 yrs | 5-9 yrs | 10-14 yrs | 15-17 yrs | 17 | 9 | 2 | 6 | 5 |
| <1 yr | 1-4 yrs | 5-9 yrs | 10-14 yrs | 15-17 yrs | | | | | | | |
| 17 | 9 | 2 | 6 | 5 | | | | | | | |
| Does the team collect data on cases reviewed | Yes | | | | | | | | | | |
| Recommendations submitted to State Team in 2003? | Yes | | | | | | | | | | |

Team Composition:

| Mandated Agency | Active Participants | Mandated Agency | Active Participants |
|----------------------------|---------------------|---|---------------------|
| District Attorney’s Office | 2 | State Police | 2 |
| Medical Examiner | 2 | Local Police | 2 |
| Dept. of Social Services | 1 | Pediatrician | 1 |
| Dept. of Public Health | 1 | Juvenile Court | 1 |
| SIDS Center | 1 | Others: Data Collector (DA’s Office); Pediatric Trauma Coordinator, Baystate Med. Ctr; Ass’t. Director, Western Mass. EMS | 3 |

Case Selection Criteria:

The team reviews any case involving a child under 18 that was a resident of Hampden County and whose death occurred in Hampden County, unless:

- ?? the case is under a pending investigation as a crime
- ?? the case is assigned for prosecution that has not been completed; and
- ?? in the case of a premature infant, the death occurred prior to the fetus’ viability, and there is nothing to suggest that a closer look is warranted.

2003 Accomplishments:

- ?? Team members applied for a grant to provide public education on window safety and to buy window guards. The grant was not funded, but they were successful in getting the hospital's commitment to continue the project.
- ?? Team members provided public education on window safety and developed a strategy to effectively distribute the window guards.
- ?? The team researched whether window guard regulations could be established.
- ?? The team coordinator reached out to local hospitals and gained commitments to report all sudden and unexplained infant deaths to the Department of Social Services.
- ?? The team published an article in the state newsletter on organizing a child fatality review.

Major Challenges: Lack of database to consolidate all information obtained.

Middlesex County Child Fatality Review Team

| | | | | | | | | | | | |
|--|--|---------|-----------|-----------|-----------|-----------|---|---|---|---|---|
| Number of child deaths, 2002 | 117 | | | | | | | | | | |
| Percentage of state child deaths | 19% | | | | | | | | | | |
| Percentage of MA population | 23% | | | | | | | | | | |
| Number of team meetings in 2003 | 4 | | | | | | | | | | |
| Number of cases reviewed | 12 | | | | | | | | | | |
| Age Breakdown: | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"><1 yr</td> <td style="text-align: center;">1-4 yrs</td> <td style="text-align: center;">5-9 yrs</td> <td style="text-align: center;">10-14 yrs</td> <td style="text-align: center;">15-17 yrs</td> </tr> <tr> <td style="text-align: center;">4</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">1</td> <td style="text-align: center;">4</td> </tr> </table> | <1 yr | 1-4 yrs | 5-9 yrs | 10-14 yrs | 15-17 yrs | 4 | 1 | 2 | 1 | 4 |
| <1 yr | 1-4 yrs | 5-9 yrs | 10-14 yrs | 15-17 yrs | | | | | | | |
| 4 | 1 | 2 | 1 | 4 | | | | | | | |
| Does the team collect data on cases reviewed | Yes | | | | | | | | | | |
| Recommendations submitted to State Team in 2003? | Yes | | | | | | | | | | |

Team Composition:

| Mandated Agency | Active Participants | Mandated Agency | Active Participants |
|----------------------------|---------------------|----------------------------------|---------------------|
| District Attorney's Office | 6 | State Police | 1 |
| Medical Examiner | 1 | Local Police | 57 |
| Dept. of Social Services | 2 | Pediatrician | 2 |
| Dept. of Public Health | 2 | Juvenile Court | 0 |
| SIDS Center | 1 | Others: Middlesex County Sheriff | 1 |

Case Selection Criteria:

Team members review all Middlesex resident death certificates at each meeting and select those deaths that raise concerns or issues or demonstrate a pattern that should be addressed. These deaths are then reviewed at the following meeting. Premature infant deaths are reviewed; cases under criminal investigation are not.

2003 Accomplishments:

The team was able to provide training to ad hoc members from a number of local first response agencies (who are invited to attend to review a particular case) on the purpose, goals and methodology of child fatality review. The response to this training was excellent, and as a result, the attendance and participation of ad hoc members has increased significantly.

Major Challenges:

- ?? Lack of database to consolidate all information obtained
- ?? Need for more active attendance and participation from the Medical Examiner’s Office
- ?? Need to have recommendations implemented through legislative action and/or community outreach

Norfolk County Child Fatality Review Team

| | | | | | | | | | | | |
|--|---|---------|-----------|-----------|-----------|-----------|----|---|---|---|---|
| Number of child deaths, 2002 | 52 | | | | | | | | | | |
| Percentage of state child deaths | 8% | | | | | | | | | | |
| Percentage of MA population | 10% | | | | | | | | | | |
| Number of team meetings in 2003 | 4 | | | | | | | | | | |
| Number of cases reviewed | 35 | | | | | | | | | | |
| Age Breakdown: | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; text-align: center;"><1 yr</td> <td style="width: 20%; text-align: center;">1-4 yrs</td> <td style="width: 20%; text-align: center;">5-9 yrs</td> <td style="width: 20%; text-align: center;">10-14 yrs</td> <td style="width: 20%; text-align: center;">15-17 yrs</td> </tr> <tr> <td style="text-align: center;">22</td> <td style="text-align: center;">5</td> <td style="text-align: center;">4</td> <td style="text-align: center;">4</td> <td style="text-align: center;">0</td> </tr> </table> | <1 yr | 1-4 yrs | 5-9 yrs | 10-14 yrs | 15-17 yrs | 22 | 5 | 4 | 4 | 0 |
| <1 yr | 1-4 yrs | 5-9 yrs | 10-14 yrs | 15-17 yrs | | | | | | | |
| 22 | 5 | 4 | 4 | 0 | | | | | | | |
| Does the team collect data on cases reviewed | No | | | | | | | | | | |
| Recommendations submitted to State Team in 2003? | No | | | | | | | | | | |

Team Composition:

| Mandated Agency | Active Participants | Mandated Agency | Active Participants |
|----------------------------|---------------------|-----------------|---------------------|
| District Attorney’s Office | 4 | State Police | 1 |
| Medical Examiner | 1 | Local Police | 0 |
| Dept. of Social Services | 2 | Pediatrician | 3 |
| Dept. of Public Health | 1 | Juvenile Court | 1 |
| SIDS Center | 1 | Other: Nurse | 1 |

Case Selection Criteria:

All resident child deaths are reviewed including neonatal deaths. Cases under investigation are not reviewed.

Major Challenges:

- ?? Not all hospitals are equally responsive to request for data on premature infant deaths.
- ?? Lack of statewide protocol for review of premature infant deaths
- ?? Funding for this effort is inadequate.

Plymouth County Child Fatality Review Team

| | | | | | | | | | | | |
|--|--|-----------------|------------------|------------------|------------------|------------------|----|---|---|---|---|
| Number of child deaths, 2002 | 42 | | | | | | | | | | |
| Percentage of state child deaths | 7% | | | | | | | | | | |
| Percentage of MA population | 7% | | | | | | | | | | |
| Number of team meetings in 2003 | 4 | | | | | | | | | | |
| Number of cases reviewed | 46 | | | | | | | | | | |
| Age Breakdown: | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;"><u><1 yr</u></td> <td style="text-align: center;"><u>1-4 yrs</u></td> <td style="text-align: center;"><u>5-9 yrs</u></td> <td style="text-align: center;"><u>10-14 yrs</u></td> <td style="text-align: center;"><u>15-17 yrs</u></td> </tr> <tr> <td style="text-align: center;">26</td> <td style="text-align: center;">8</td> <td style="text-align: center;">4</td> <td style="text-align: center;">7</td> <td style="text-align: center;">1</td> </tr> </table> | <u><1 yr</u> | <u>1-4 yrs</u> | <u>5-9 yrs</u> | <u>10-14 yrs</u> | <u>15-17 yrs</u> | 26 | 8 | 4 | 7 | 1 |
| <u><1 yr</u> | <u>1-4 yrs</u> | <u>5-9 yrs</u> | <u>10-14 yrs</u> | <u>15-17 yrs</u> | | | | | | | |
| 26 | 8 | 4 | 7 | 1 | | | | | | | |
| Does the team collect data on cases reviewed | Yes | | | | | | | | | | |
| Recommendations submitted to State Team in 2003? | No | | | | | | | | | | |

Team Composition:

| Mandated Agency | Active Participants | Mandated Agency | Active Participants |
|----------------------------|---------------------|---------------------------|---------------------|
| District Attorney’s Office | 3 | State Police | 1 |
| Medical Examiner | 1 | Local Police | 1 |
| Dept. of Social Services | 2 | Pediatrician | 3 |
| Dept. of Public Health | 1 | Juvenile Court | 1 |
| SIDS Center | 1 | Others: Physicians, MSPCC | 2 |

Case Selection Criteria:

The team reviews all deaths of children living or dying in Plymouth County, including premature infants; deaths under criminal investigation or prosecution are not reviewed.

Suffolk County Child Fatality Review Team

| | | | | | | | | | | | |
|--|--|---------|-----------|-----------|-----------|-----------|---|---|---|---|---|
| Number of child deaths, 2002 | 91 | | | | | | | | | | |
| Percentage of state child deaths | 14% | | | | | | | | | | |
| Percentage of MA population | 11% | | | | | | | | | | |
| Number of team meetings in 2003 | 8 | | | | | | | | | | |
| Number of cases reviewed | 14 | | | | | | | | | | |
| Age Breakdown: | <table border="1"> <tr> <td><1 yr</td> <td>1-4 yrs</td> <td>5-9 yrs</td> <td>10-14 yrs</td> <td>15-17 yrs</td> </tr> <tr> <td>8</td> <td>2</td> <td>2</td> <td>1</td> <td>1</td> </tr> </table> | <1 yr | 1-4 yrs | 5-9 yrs | 10-14 yrs | 15-17 yrs | 8 | 2 | 2 | 1 | 1 |
| <1 yr | 1-4 yrs | 5-9 yrs | 10-14 yrs | 15-17 yrs | | | | | | | |
| 8 | 2 | 2 | 1 | 1 | | | | | | | |
| Does the team collect data on cases reviewed | Yes | | | | | | | | | | |
| Recommendations submitted to State Team in 2003? | Yes | | | | | | | | | | |

Team Composition:

| Mandated Agency | Active Participants | Mandated Agency | Active Participants |
|----------------------------|---------------------|---|---------------------|
| District Attorney's Office | 3 | State Police | 0 |
| Medical Examiner | 1 | Local Police | 0 |
| Dept. of Social Services | 2 | Pediatrician | 1 |
| Dept. of Public Health | 1 | Juvenile Court | 1 |
| SIDS Center | 1 | Others: Boston Public Health Commission | 1 |

Case Selection Criteria:

Not all child deaths in Suffolk County are reviewed. The entire team examines all child death certificates and determines which cases should be reviewed more extensively. Cases selected are children who resided in Suffolk County, regardless of place of death. Infant deaths are not reviewed; deaths under investigation or prosecution are not reviewed.

2002 Accomplishments:

- ?? The team created a case checklist to track documents needed for case review.
- ?? The team initiated a statewide discussion with other teams regarding consistent death scene investigation protocols and practices for sudden and unexplained infant deaths.

Major Challenges:

- ?? Consistent police representation at team meetings
- ?? Difficulty in obtaining hospital or other medical records requested
- ?? Inadequate staff resources needed to track all necessary case review information
- ?? Inadequate staff and other resources needed to make effective change
- ?? Lack of standardized electronic data collection

Worcester County Child Fatality Review Team

| | | | | | | | | | | | |
|--|---|---------|-----------|-----------|-----------|-----------|----|---|---|---|---|
| Number of child deaths, 2002 | 86 | | | | | | | | | | |
| Percentage of state child deaths | 14% | | | | | | | | | | |
| Percentage of MA population | 12% | | | | | | | | | | |
| Number of team meetings in 2003 | 5 | | | | | | | | | | |
| Number of cases reviewed | 61 | | | | | | | | | | |
| Age Breakdown: | <table border="1"> <tr> <td><1 yr</td> <td>1-4 yrs</td> <td>5-9 yrs</td> <td>10-14 yrs</td> <td>15-17 yrs</td> </tr> <tr> <td>43</td> <td>2</td> <td>8</td> <td>5</td> <td>3</td> </tr> </table> | <1 yr | 1-4 yrs | 5-9 yrs | 10-14 yrs | 15-17 yrs | 43 | 2 | 8 | 5 | 3 |
| <1 yr | 1-4 yrs | 5-9 yrs | 10-14 yrs | 15-17 yrs | | | | | | | |
| 43 | 2 | 8 | 5 | 3 | | | | | | | |
| Does the team collect data on cases reviewed | Yes | | | | | | | | | | |
| Recommendations submitted to State Team in 2003? | Yes | | | | | | | | | | |

Team Composition:

| Mandated Agency | Active Participants | Mandated Agency | Active Participants |
|----------------------------|---------------------|--|---------------------|
| District Attorney's Office | 1 | State Police | 1 |
| Medical Examiner | 1 | Local Police | 4 |
| Dept. of Social Services | 3 | Pediatrician | 2 |
| Dept. of Public Health | 1 | Juvenile Court | 0 |
| SIDS Center | 1 | Others: pediatric surgeon; pediatric trauma RN; child care facility director | 3 |

Case Selection Criteria:

The team reviews all resident and non-resident child deaths that occur within the county, including premature and other infant deaths.

Major Challenges: Need for a standardized electronic data collection system

V. Recommendations from Local Teams

As in previous years, Local Teams continued to make recommendations for changes based on their ongoing review of child deaths in their districts. A number of issues produced recommendations from more than one team and from more than one case. These recommendations involved concerns about safe sleeping practices for infants, standardizing infant death scene investigation, ATV and motor vehicle-related fatalities for teenagers, domestic violence and homicide prevention, and mental health problems and lack of services leading to adolescent suicide. Table 6 is a list of recommendations submitted to the State Team in 2003. A list of recommendations submitted from Local Teams to the State Team in previous years is included in Appendix D.

Table 6. Recommendations Submitted by Local Teams

| Recommendation | Team Submitting | Submitted in 2003? | Submitted Previously? |
|--|---|--------------------|-----------------------|
| Infants < 1 yr | | | |
| Unexplained Infant Deaths: ?? Standardized guidance regarding infant death scene investigation and standardized cause of death classification are needed to facilitate case review. | Essex, Hampden, Middlesex, Suffolk, Plymouth | Yes | Yes |
| ?? Public education is needed on safe sleeping practices. | Essex, Middlesex, Suffolk, Worcester, Hampden | Yes | Yes |
| 1- 4 years | | | |
| Homicide/Child Abuse-Related Deaths: ?? Interagency coordination should be improved between the time a DSS investigation occurs and the hearing. Police investigators and MDs should testify at hearings. | Essex | Yes | No |
| ?? Enhance broad-based screening for domestic violence. | Middlesex, Suffolk | Yes | Yes |
| ?? Include age of parents on death certificates. Young parents may be at particular risk for child abuse. | Essex, Hampden | Yes | Yes |
| Unintentional Injury Deaths: ?? Conduct public education campaign on importance of window guards to prevent falls. | Hampden, Worcester, Middlesex | Yes | Yes |
| ?? DSS should conduct home safety inspections for children on its caseload. | Hampden | Yes | No |
| 5 – 9 years | | | |
| Drowning Deaths: ?? Education of youth and families should be carried out regarding the dangers of ice covering bodies of water. | Essex | Yes | No |
| ?? Carry out public education regarding child drowning prevention. | Worcester | Yes | No |
| Homicide Deaths/Child Abuse-Related Deaths: ?? Enhance broad-based screening for domestic violence. | Middlesex, Suffolk | Yes | Yes |
| ?? Enhance public education on domestic violence. | Middlesex, Suffolk | Yes | Yes |
| Fire Death: ?? Conduct public education to prevent smoking while using supplemental oxygen. ?? Pass legislation making it a misdemeanor to smoke while using oxygen, which would impact DSS regulations. | Suffolk | Yes | No |
| | Suffolk | Yes | No |

Table 6. Recommendations Submitted by Local Teams (cont.)

| Recommendation | Team Submitting | Submitted in 2003? | Submitted Previously? |
|---|--|--------------------|-----------------------|
| 10 - 14 years | | | |
| Homicide Deaths: ?? Enhance broad-based screening for domestic violence. ?? Enhance public education on domestic violence. | Middlesex, Suffolk, Worcester Middlesex, Suffolk, Worcester | Yes Yes | Yes Yes |
| Suicide: ?? Mental health services are inadequate and should be addressed | Essex, Middlesex | Yes | Yes |
| Child Abuse-Related Deaths: ?? Interagency coordination should be improved between the time a DSS investigation occurs and the hearing. Police investigators and MDs should testify at hearings. | Essex, Worcester. Hampden | Yes | Yes |
| 15 – 17 years | | | |
| Suicide: ?? Mental health services are inadequate and should be addressed | Essex, Middlesex | Yes | Yes |
| All-Terrain Vehicle Deaths: ?? Individual localities should establish by-laws for operation of ATVs. | Essex, Middlesex, Hampden | Yes | Yes |
| Teen Homicide: ?? The State Team should begin a statewide discussion on how underage social clubs are regulated in MA cities and towns. | Essex | Yes | No |
| Motor Vehicle -Related Deaths: ?? Pass a primary seat belt law. ?? Amend junior driver law to prohibit cell phone use while driving ?? Conduct a seatbelt education campaign | Middlesex Middlesex Worcester | Yes Yes Yes | No No No |

VI. Summary of Accomplishments and Challenges in 2003

During 2003, Local Teams reviewed 260 child death cases. Although not all teams submitted recommendations based on their reviews, five of the teams did. These teams reviewed 140 cases and identified a number of causes of child death that they recommended for further attention. These causes were motor vehicle-related deaths, adolescent suicide, unexplained infant death related to unsafe sleeping practices, and domestic violence and child abuse leading to homicide.

One of the teams, the Essex County Child Fatality Review Team, planned a regional conference of professionals concerned with adolescent mental health services and suicide prevention that was scheduled for early in the following year. The State Team sponsored a second statewide forum for the review teams and other interested professionals in December 2003. Other teams reached out to include Emergency Medical Service providers on their teams and to offer outreach and training to public safety first responders invited to participate in case review on an ad hoc basis.

There was ongoing discussion by State Team members on how to best respond to the variety of recommendations submitted by the Local Teams. By the end of the year, the State Team was able to determine that while some recommendations were suitable for statewide action, others were more suitable for action at the community level, and still others were determined to be already accomplished, tried unsuccessfully in the past, or unfeasible. Among the recommendations considered suitable for statewide action was the suggestion that uniform guidelines be developed for investigating the death scene of infants who die suddenly and unexpectedly. How best to accomplish this was still under discussion at the end of 2003.

Two State Team members were able to attend the first national conference of child fatality review teams held in Chicago in September 2003. The conference was sponsored by the new National Center for Child Death Review that was funded by the federal Maternal and Child Health Bureau to provide resources and technical assistance to the states. Massachusetts became one of 17 states to participate in the planning of a national electronic data collection system to be piloted during 2004-2005.

The most serious challenge facing the Massachusetts Child Fatality Review Teams was the continued lack of funding for case review and the implementation of recommendations for changes. The lack of any funding attached to the 2000 legislation has forced Local Teams to depend on in-kind staff and other resource contributions; this has limited and will continue to limit all team activity.

A second challenge has been the lack of a data collection system; all 11 Local Teams have expressed frustration at their inability to get back statewide information on case reviews. With the anticipated piloting of a national data collection system, it is expected that this problem will be solved in the foreseeable future.

VII. Objectives for Future Activity

?? Development of a plan for enhancing resources for child fatality review

From the beginning, child fatality review in Massachusetts has been an unfunded mandate. Local Teams, operating out of the District Attorneys' Offices, have been given responsibility for reviewing child deaths but have not been given any funding to support their work. Instead, the work has been done with in-kind contributions, placing a limit on what can be accomplished. During the next few years, the State and Local Teams will attempt to identify statewide and regional funding sources to enhance case review and the implementation of team recommendations.

?? Participation in the planning and piloting of a national electronic data collection system for child fatality review

Massachusetts will continue to participate in the planning for a new national database so as to expedite the reporting of local and statewide activity to team members and other interested professionals.

?? Continuation of discussion on the need for statewide guidance for death scene investigation of sudden, unexplained infant deaths

There is a growing concern among Local Teams that many of the infant deaths attributed to SIDS are in fact caused by unsafe sleeping practices. The variety of death scene investigation practices across the state has made the review of these deaths especially difficult. Several teams have recommended changes in sudden, unexplained infant death scene investigation protocols; discussion about standardizing these investigations is underway by the State Team.

?? Development of a public education campaign for safe sleeping practices for infants

Almost all Local Teams reviewing infant deaths have noticed a significant number of deaths that might be caused by unsafe sleeping practices; these teams have recommended that the State Team undertake a public education campaign on safe sleeping practices.

?? Development of a statewide protocol for reviewing premature infant deaths

There are three Massachusetts counties with active Fetal and Infant Mortality Review (FIMR) Teams: Hampden, Worcester, and Suffolk. The rest of the counties either do not review infant deaths or review them through their Child Fatality Review Teams. These teams have raised questions as to whether they have the resources and appropriate protocols to do an adequate review of premature infant deaths. In the near future, the State Team will undertake to enlist the assistance of the FIMR Teams to draft protocols for review of these child deaths.

APPENDICES

Appendix A:

**Massachusetts Child Fatality Review Teams
2003**

| District | District Attorney's Office/Contact Information |
|--|---|
| Berkshire | <p>David Capeless Berkshire County District Attorney's Office 7 North Street, P. O. Box 1969 Pittsfield, MA 01201 Main Phone: (413) 443-5951 Contact: David Capeless Medical Examiners: Joann Richmond, MD Loren Mednick, MD</p> |
| Bristol | <p>Paul F. Walsh, Jr. Bristol County District Attorney's Office 888 Purchase Street New Bedford, MA 02740 Main Phone: (508) 997-0711 Contact: Renee Dupuis Medical Examiner: William Zane, MD</p> |
| Cape & Islands (Barnstable, Dukes, and Nantucket Cos.) | <p>Michael O'Keefe Cape & Islands District Attorney's Office 3231 Main Street Barnstable, MA 02630 Main Phone: (508) 362-8113 Contact: Brian Glennly Medical Examiner: William Zane, MD</p> |
| Essex | <p>Jonathan W. Blodgett Essex County District Attorney's Office Museum Place, 2 East India Square Salem, MA 01970 Main Phone: (978) 745-6610 Contact: Pat Snyder-Matthews Medical Examiner: Richard Evans, MD</p> |
| Hampden | <p>William M. Bennett Hampden County District Attorney's Office 50 State Street Springfield, MA 01103 Main Phone: (413) 747-1000 Contact: Maria Rodriguez Medical Examiners: Joann Richmond, MD Loren Mednick, MD</p> |

| District | District Attorney's Office/Contact Information |
|--|---|
| Middlesex | <p style="text-align: center;">Martha Coakley Middlesex County District Attorney's Office Middlesex Superior Courthouse 40 Thorndike Street 2nd. Floor Cambridge, MA 02141 Main Phone: (617) 591-7700 Fax: (617)628-8733 Contact: Anna Rufo Medical Examiner: Richard Evans, MD</p> |
| Norfolk | <p style="text-align: center;">William R. Keating Norfolk County District Attorney's Office 45 Shawmut Road Canton, MA 02021 Main Phone: (781) 830-4800 Contact: Jeanmarie Carroll Medical Examiner: Marie Cannon, MD</p> |
| Northwestern (Franklin and Hampshire Counties) | <p style="text-align: center;">Elizabeth D. Scheibel Northwestern District Attorney's Office 1 Gleason Plaza Northampton, MA 01060 Main Phone: (413) 586-9225 Contact: Priscilla Marion-Robare Medical Examiners: Joann Richmond, MD Loren Mednick, MD</p> |
| Plymouth | <p style="text-align: center;">Timothy J. Cruz Plymouth County District Attorney's Office 32 Belmont Street Post Office Box 1665 Brockton, MA 02303 Main Phone: (508) 584-8120 Contact: Karyn Clifford Medical Examiner: William Zane, MD</p> |
| Suffolk | <p style="text-align: center;">Daniel F. Conley Suffolk County District Attorney's Office 1 Bulfinch Place Boston, MA 02114 Main Phone: (617) 619-4000 Contact: Susan Goldfarb Medical Examiner: Faryl Sandler, MD</p> |

| District | District Attorney's Office/Contact Information |
|-----------|---|
| Worcester | <p style="text-align: center;"> John Conte Worcester County District Attorney's Office Court House 2 Main Street Worcester, MA 01608 Main Phone: (508) 755-8601 Contact: Mary Sawicki Medical Examiner: Richard Evans, MD </p> |

| | |
|------------|---|
| State Team | <p style="text-align: center;"> Richard Evans, MD Office of the Chief Medical Examiner 720 Albany St. Boston, MA 02118 Main Phone: (617) 267-6767 Contact: Janet Shea </p> |
|------------|---|

Appendix B: Child Fatality Review Legislation

Chapter 247 of the Acts of 2000

AN ACT RELATIVE TO THE ESTABLISHMENT OF A CHILD FATALITY REVIEW TEAM.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Chapter 38 of the General Laws is hereby amended by inserting after section 2 the following section:

Section 2A. As used in this section, the following words shall have the following meanings:

"Child", any person under the age of 18.

"Fatality", any death of a child.

"Local team", a local multidisciplinary and multi-agency child fatality review team in each of the 11 districts headed by a district attorney. Notwithstanding the provisions of section 172 of chapter 6, members of the local team shall be subject to criminal offender record checks to be conducted by the district attorney. All members shall serve without compensation for their duties associated with membership on said team. Each local team shall be comprised of at least the following members:

- (1) the district attorney of the county, who shall chair each local team;
- (2) the chief medical examiner or his designee;
- (3) the commissioner of the department of social services or his designee;
- (4) a pediatrician with experience in diagnosing or treating child abuse and neglect, appointed by the state team;
- (5) a local police officer from the town or city where the child fatality occurred, appointed by the chief of police of said municipality;
- (6) a state law enforcement officer, appointed by the colonel of state police;
- (7) the chief justice of the juvenile division of the trial court or his designee;
- (8) the director of the Massachusetts center for sudden infant death syndrome, located at the Boston Medical Center or his designee;
- (9) the commissioner of the department of public health or his designee; and
- (10) any other person with expertise or information relevant to individual cases who may attend meetings on an ad hoc basis, by agreement of the permanent members of each local team. Such persons may include, but shall not be limited to, local or state law enforcement officers, hospital representatives, medical specialists or subspecialists, or designees of the commissioners of the departments of mental retardation, mental health, youth services and education.

"State team", a child fatality review team within the office of the chief medical examiner. Notwithstanding the provisions of section 172 of chapter 6, members of the state team shall be subject to criminal offender record checks to be conducted by the colonel of the state police, on behalf of the chief medical examiner. All members shall serve without compensation for their duties associated with membership on said team. The state team shall consist of at least the following members:

- (1) the chief medical examiner, who shall chair the state team;
- (2) the attorney general or his designee;

- (3) the commissioner of the department of social services or his designee;
- (4) the commissioner of the department of public health or his designee;
- (5) the commissioner of the department of education or his designee;
- (6) a representative of the Massachusetts District Attorney's Association to be selected by said association;
- (7) the colonel of the state police or his designee;
- (8) the commissioner of the department of mental health or his designee;
- (9) the commissioner of the department of mental retardation or his designee;
- (10) the director of the Massachusetts center for sudden infant death syndrome or his designee;
- (11) the commissioner of the department of youth services or his designee;
- (12) a representative of the Massachusetts chapter of the American Academy of Pediatrics, with experience in diagnosing or treating child abuse and neglect to be selected by said chapter;
- (13) a representative from the Massachusetts Hospital Association to be selected by said association;
- (14) the chief justice of the juvenile division of the trial court or her designee;
- (15) the president of the Massachusetts Chiefs of Police Association or his designee;
- (16) a child advocate appointed by a majority vote of the members of the state team; and
- (17) any other person selected by the chair, or by majority vote of the members of the state team, with expertise or information relevant to individual cases.

(1) There shall be established within the office of the chief medical examiner the state child fatality review team. The purpose of the state team shall be to decrease the incidence of preventable child deaths and injuries by:

- (i) developing an understanding of the causes and incidence of child death; and
- (ii) advising the governor, the general court and the public by recommending changes in law, policy and practice that will prevent child deaths.

(2) To achieve its purpose, the state team shall:

- (i) develop model investigative and data collection protocols for local child fatality teams;
- (ii) provide information to local teams and law enforcement agencies for the purpose of the protection of children;
- (iii) provide training and written materials to the local teams to assist them in carrying out their duties;
- (iv) review reports from local teams;
- (v) study the incidence and causes of child fatalities in the commonwealth;
- (vi) analyze community, public and private agency involvement with the decedents and their families prior to and subsequent to the deaths;
- (vii) develop a protocol for the collection of data regarding child deaths and provide training to local teams on the protocol;
- (viii) develop and implement such rules and procedures as are necessary for its own operation; and
- (ix) provide the governor, the general court and the public with annual written reports, subject to confidentiality restrictions, which shall include, but not be limited to, the state team's findings and recommendations.

(c)(1) A local child fatality review team shall be established in each of the 11 districts headed by a district attorney. The purpose of each such local team shall be to decrease the incidence of preventable child deaths and injuries by:

- (i) coordinating the collection of information on child deaths;
- (ii) promoting cooperation and coordination between agencies responding to child deaths and in providing services to family members;
- (iii) developing an understanding of the causes and incidence of child deaths in the county; and

(iv) advising the state team on changes in law, policy or practice which may affect child deaths and injuries.

(2) To achieve its purpose, the local team shall:

- (i) review, establish and implement model protocols from the state team;
- (ii) review, subject to the approval of the local district attorney, all individual child deaths in accordance with the established protocol;
- (iii) meet periodically, but at least four times per calendar year, to review the status of child death cases and recommend methods of improving coordination of services between member agencies;
- (iv) collect, maintain and provide confidential data as required by the state team; and
- (v) provide law enforcement or other agencies with information for the purposes of the protection of children.

(3) At the request of the local district attorney, the local team shall be immediately provided with:

- (i) information and records relevant to the cause of death of a child whose death is being reviewed by the local team, by providers of medical or other care, treatment or services, including dental and mental health care;
- (ii) information and records relevant to the cause of death maintained by any state, county or local government agency including, but not limited to, birth certificates, medical examiner investigative data, parole and probation information records, and law enforcement data post-disposition, except that certain law enforcement records may be exempted by the local district attorney;
- (iii) information and records of any provider of social services, including the state department of social services, to the child or his family, that the local team deems relevant to the review; and
- (iv) demographic information relevant to the decedent and his immediate family including but not limited to, address, age, race, gender, and economic status. The district attorney may enforce this paragraph by seeking an order of the superior court.

(d)(1) The following provisions shall apply to both the state and local teams:

Any privilege or restriction on disclosure established pursuant to chapter 66A, section 70 of chapter 111, section 11 of chapter 111B, section 18 of 111E, chapters 112, 123, or sections 20B, 20J or 20K of chapter 233 or any other law relating to confidential communications shall not prohibit the disclosure of this information to the chair. Any information considered to be confidential pursuant to the aforementioned statutes may be submitted for the team's review upon the determination of the chair that the review of said information is necessary. The chair shall ensure that no information submitted for the team's review is disseminated to parties outside the team. Under no circumstances shall any member of this team violate the confidentiality provisions set forth in the aforementioned statutes.

(2) Except as necessary to carry out a team's purpose and duties, members of a team and persons attending a team meeting may not disclose any information relating to the team's business.

(3) Team meetings shall be closed to the public. Any and all information and records acquired by the state team or by a local team, in the exercise of its purpose and duties pursuant to this chapter, shall be confidential, exempt from disclosure under chapter 66, and may only be disclosed as necessary to carry out the teams' duties and purposes.

(4) Statistical compilations of data which do not contain any information that would permit the identification of any person may be disclosed to the public.

(5) Members of a team, persons attending a team meeting and persons who present information to a team may not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a team meeting.

(6) Information, documents and records of the state team or of a local team shall not be subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding; provided, however, that information, documents and records otherwise available from any other source shall not be immune from subpoena, discovery or introduction into evidence through these sources solely because they were presented during proceedings of the team or are maintained by a team.

(d) Nothing in this section shall be construed or interpreted to limit the powers and duties of the chief medical examiner or district attorneys.

SECTION 2. Section 3 of chapter 38 of the General Laws, as appearing in the 1998 Official Edition, is hereby amended by striking out, in line 35, the word "two" and inserting in place thereof the following figure:- 18.

SECTION 3. Said section 3 of said chapter 38, as so appearing, is hereby further amended by inserting after the word "nurse", in line 42, the following words:- , department of social services social worker.

SECTION 4. The last paragraph of section 4 of said chapter 38, as so appearing, is hereby amended by adding the following sentence:- The chief medical examiner shall notify the local district attorney of the death of a child immediately following receipt of a report that such a death occurred.

SECTION 5. Section 51F of chapter 119 of the General Laws, as appearing in the 1998 Official Edition, is hereby amended by inserting after the first paragraph the following paragraph:

Nothing in this section shall prevent the department from keeping information on unsubstantiated reports to assist in future risk and safety assessments of children and families.

Approved August 10, 2000.

Appendix C: Local Team Request for Case Information

ANYWHERE COUNTY DISTRICT ATTORNEY’S OFFICE

Date

Medical Records Department
Name of Hospital
Address, etc.

Dear (Your contact person in Medical Records):

Pursuant to M.G.L. c, 38, §2A, a Child Fatality Review Team is established in every county in the Commonwealth. Please see a copy of the law, which is attached. Each interdisciplinary team is charged with examining child fatalities to better understand their causes and to prevent similar deaths in the future. To accomplish this mandate, the legislature gave each local district attorney the broad authority to collect all records and information relevant to the cause of death of a child whose death is under review by the local team, including records and information relevant to the decedent and immediate family. This includes information from:

- ??providers of medical or other care, treatment or services, including dental and mental health care;
- ??state, county or local government agencies; or
- ??providers of social services.

The law states that at the request of the local district attorney, a provider of medical or social services, or another governmental agency, shall send to the Team all records identified as relevant to the cause of death of the child whose death is under review.

If you are a covered entity under the Health Insurance Portability and Accountability Act (HIPAA) and question whether you are authorized to disclose this information to the Child Fatality Review Team, please note that HIPAA allows for disclosures required by law, without the need for an individual authorization. See, 45 CFR §164.512(a). Once the district attorney identifies records necessary for the review, M.G.L. c. 38, §2A (c)(3) requires that such information be immediately provided to the Child Fatality Review Team.

Listed below are the records identified as needed for the Child Fatality Review Team’s current review of

_____ (child’s name) _____ (child’s date of birth) _____ (child’s date of death) _____

- ___ Ambulatory care records on the child;
- ___ Inpatient care records on the child;
- ___ Birth Certificate worksheets on the child;
- ___ Discharge Summary and prenatal history for child’s mother _____ (name of mother) _____
- ___ Other pertinent information on child and family: _____

Please deliver the records to _____ (name) _____ by _____ (date) _____

If you have any questions or would like additional information, please contact the Team Coordinator, _____ (name) _____ at (617) 123-4567.

Thank you for your assistance.
(Name)
Anywhere County District Attorney

Appendix D: LOCAL TEAM RECOMMENDATIONS, 2001 and 2002

| Summary of Case or Problem | Recommendation |
|--|---|
| 1. 13-yr old Skateboarder struck by car. <i>Plymouth</i> | ?? Legislation for mandatory helmet & other protective gear for skateboarders ?? Safe spaces for skateboarders ?? Safety instructions distributed at schools |
| 2. 4 yr old blunt trauma to chest by bike rack <i>Plymouth</i> | Changes in codes for securing bike racks to ground |
| 3. SIDS deaths: 3 mo old, 2+ mo old <i>Plymouth</i> | Standard RSV nasal swab testing for unexplained deaths of children <1 yr. |
| 4. Substance abuse, domestic violence; 16 mo old <i>Suffolk</i> | Increased cross-disciplinary training on co-occurrence of domestic violence and child abuse |
| 5. Fire fatalities <i>Essex</i> | Fire alarms should be - periodically inspected - difficult to shut off - separate breakers for alarms - hard wired |
| 6. Boating death <i>Essex</i> | ?? Mandatory use of flotation devices ?? Posting of hazardous bodies of water |
| 7. Heat stroke death of toddler <i>Essex</i> | Look into whether building materials for decks are contributing to these fatalities. |
| 8. Deaths of children with respiratory problems placed in car or other seats for sleep <i>Hampden, Suffolk, Plymouth</i> | ?? Investigate whether equipment is contributing to deaths ?? Police should do a thorough investigation of circumstances surrounding child deaths. |
| 9. It may take one team countless similar cases before an issue is identified. By being informed of statewide information each team can have focus and explore common problems more readily – i.e. are there infants dying across the state in an upright position such as a car seat? <i>Hampden</i> | We recommend that the State Team compile and categorize the information on the cause of death and surrounding circumstances from all the local teams and distribute the information quarterly to the local teams so that teams can review where they overlap. |
| 10. 13 year old and 6 year old suffocate in family owned cedar chest. <i>Hampden</i> | We recommend a public education campaign aimed at informing parents about the dangers of any chests or storage containers with locking mechanisms. |
| 11. Most infant deaths seem to occur to parents who are very young. <i>Hampden</i> | We recommend that the date of birth of parents be documented on death certificates. This information would be helpful in confirming if that is true and targeting future public education. |
| 12. 1 day old, cause of death was acute aspiration pneumonia. Child delivered at home by a midwife; delivery was normal; birth cert. never filed <i>Middlesex</i> | ?? Requirements for registering home births with penalties for failure to report. ?? Review pending legislation regarding midwives. |

| Summary of Case or Problem | Recommendation |
|--|--|
| 13. 14 yr old death from asphyxiation <i>Middlesex</i> | <p>?? Amend CFRT Act to authorize release of adoption and pre-adoption records of children whose deaths are being reviewed.</p> <p>?? All insurance companies should be required to include mental health services as part of insurance package. Mental health providers should also be included on insurance co. panels.</p> <p>?? Child Fatality Review Act should be amended to require Local Teams to include a mental health professional.</p> <p>?? State should have a central fund of money to cover therapeutic school placements rather than requiring cities or towns to cover the costs.</p> |
| 14. 10 mo. old, asphyxia from fall from crib into trash basket with a plastic liner. <i>Middlesex</i> | ?? Review deaths of all children <18 mos from suffocation, falls, drowning, for correlations between deaths and development milestones. Do we need a public awareness campaign? |
| 15. Teen drug overdose fatality <i>Essex</i> | Alliance between mental health and medical communities for prevention and risk detection |
| 16. Nut allergy at school <i>Essex</i> | Review of school protocols on food allergies |
| 17. Death from neglect not picked up by DSS <i>Hampden</i> | Training of DSS staff on early development issues |
| 18. Judge Baker Hotline not effective in starting multi-disciplinary response to life-threatening injury <i>Hampden</i> | Seek input from all disciplines and state areas on how to improve the Hotline. |
| 19. DSS does not always involve police in child fatality investigation <i>Hampden</i> | Legislation requiring immediate police notification in any DSS child fatality case. |
| 20. Not all child deaths are reported to the Medical Examiner by hospital <i>Hampden</i> | State CFR Team should send letter to hospitals regarding reporting deaths to ME. |
| 21. The death of a child is a profound tragedy for families and caregivers. The Massachusetts Center for SIDS/Massachusetts Infant and Child Death Bereavement Program is available to provide compassionate care to those in need - parents, sibling, care providers as well as professionals who are in contact with families at the time of a child's death. <i>Hampden</i> | We recommend that healthcare organizations and clinicians involved with families be advised to refer families who have experienced the death of an infant or young child (0-3 years of age) for bereavement counseling to the Massachusetts Center for SIDS/Massachusetts Infant and Child Death Bereavement Program, notwithstanding any other referral. |
| 22. 10 yr old blunt head trauma from MVC pedestrian injury <i>Middlesex</i> | <p>?? State should set standards for public playing fields and parks with regard to MV proximity.</p> <p>?? Improved signage at parks</p> |

| Summary of Case or Problem | Recommendation |
|---|---|
| <p>23. 3-week old baby possible rollover (sleeping w/parent). The Team has reviewed several alleged SIDS deaths that present other possible causes such as rollover, asphyxiation, etc. Team is concerned that SIDS deaths maybe improperly characterized and would like to see these types of deaths documented in more detail. <i>Hampden</i></p> | <p>?? All teams should document cases where rollover or other possible cause of death could exist in cases currently categorized as a SIDS death. ?? For all unexpected deaths of infants, a protocol should be established requiring a post mortem radiological skeletal survey be done at the hospital, interpreted by a radiologist familiar with child abuse, and not at the expense of the family.</p> |
| <p>24. SIDS death at day care <i>Middlesex, Plymouth, Suffolk, Hampden</i></p> | <p>?? All day care providers should be required to attend SIDS prevention trainings. ?? Sensitivity training for EMS and medical providers</p> |
| <p>25. 3 yr. old, blunt head trauma from a 2nd story window fall. <i>Middlesex</i></p> | <p>?? Amend codes to require child-resistant safety screens or window guards in homes with children. ?? Implement public awareness campaign similar to “Kids Can’t Fly” throughout MA.</p> |
| <p>26. 15 yr old from multiple trauma; driving ATV and struck tree. <i>Middlesex</i></p> | <p>?? Is there an E Code for dirt bikes/ATVs? ?? Implement public awareness campaign</p> |
| <p>27. 23 mo. old from asphyxia from choking on balloon. <i>Middlesex</i></p> | <p>?? Investigate whether non-Eng. speaking communities know about the dangers of balloons to young children. ?? Consider tracking data on balloon deaths. ?? Educate non Eng. speakers to call 911 for emergencies</p> |
| <p>28. 13 yr old from strangulation and 5 yr old from multiple gunshot wounds. <i>Middlesex</i></p> | <p>?? Educate community health centers and schools to conduct screening for domestic violence and sexual abuse. ?? Train mandated reporters to file 51A reports on children who are part of domestic violence.</p> |
| <p>29. SIDS deaths: 2-mo old, 3+ mo old <i>Plymouth, Suffolk</i></p> | <p>Consistent investigating and reporting of unexplained deaths through development of statewide protocols</p> |
| <p>30. Co-sleeping deaths: 1 mo old, 2 mo. old <i>Suffolk, Hampden</i></p> | <p>Increased risk reduction education on safe sleeping</p> |
| <p>31. Co-sleeping, with homelessness, maternal age and substance abuse <i>Suffolk, Hampden</i></p> | <p>Increased support services, e.g. Healthy Start</p> |
| <p>32. Carbon monoxide poisoning <i>Essex</i></p> | <p>PSAs and public education at beginning of winter about car grills and tailpipes covered with snow.</p> |
| <p>33. [No particular case] <i>Essex</i></p> | <p>Add ages of parents to death certs</p> |
| <p>34. There is a delay in having death certificates filled out by physicians in a complete and accurate manner regarding cause of death. <i>Hampden</i></p> | <p>The State Team should develop written materials to inform and educate physicians regarding their obligations to fill out death certificates in a timely manner.</p> |

| Summary of Case or Problem | Recommendation |
|--|--|
| 35. When a death occurs and the child is in the hospital, police are often prevented from taking timely statements from family members who are mourning their loss. <i>Hampden</i> | Hospitals need to initiate protocols, which include cooperation with police to assist them in speaking with family members as soon as possible and getting statements from them regarding the death in a sensitive manner. |
| 36. Positional asphyxia, 1-mo. old <i>Middlesex, Plymouth, Hampden, Suffolk</i> | ?? CPR training & certif. for all 911 dispatchers ?? Home visits for all families with prior SIDS deaths ?? Safe-sleeping education ?? Pre-discharge evaluations by social workers for home visits to new mothers |
| 37. Police hold evidence like diapers, bottles etc. for long periods of time awaiting the decision on whether the case will be prosecuted. The decision cannot be made without an autopsy being performed and a report issuing. Often the ME is awaiting Toxicology reports, which take from 4 weeks to 3 months in completing. <i>Hampden</i> | There is a need to fully fund the Toxicology lab so this work can be performed more expediently. |
| 38. Drugs in the fetal blood stream can be found at time of birth and may be connected with the child death at a later time, however, the existence of drugs in the child is not reported. <i>Hampden</i> | There should be a mandate to report the existence of drugs in the child at birth. |
| 39. In assessing an infant death, there is no uniform practice regarding the type of X-Ray which should be used. <i>Hampden</i> | There should be a uniform practice regarding the X-ray of infants who have died and there should be facilities accessible across the state to accommodate the need. |
| 40. 14 year old fell off a moving all-terrain-vehicle, injuries to head caused death. <i>Hampden</i> | ?? We recommend a public education campaign on the dangers of recreational vehicles and snowmobiles in the hands of children. ?? We recommend mandatory headgear, at least for children, driving or riding recreational vehicles and snowmobiles. |
| 41. 4-mo. old, cardiac arrest, failure to thrive, inadequate nutrition <i>Middlesex 6/01 Hampden</i> | ?? Home visits should have a medical component built in. ?? Home visits should be required to include a risk assessment. ?? Training should include weighing and measuring on a regular basis |
| 42. Death of 9 mo. old from subdural hematoma. Child fell down a flight of stairs while in a baby walker. <i>Middlesex</i> | Hospitals and pediatricians should provide literature and education about products that have been recently removed from market. |
| 43. 8 yr. old fatality from blunt head trauma. Sliding minivan door struck child's head. <i>Middlesex</i> | Ask NHTSA to open investigation into Ford Windstar for possible defects. NHTSA should be asked to review all minivan doors for safety concerns. |
| 44. 13 yr old fatality from blunt head trauma, struck by car, not wearing a helmet. <i>Middlesex</i> | ?? Extend bicycle helmet law to all persons regardless of age. Amend law to include enforcement mechanism. ?? Implement public awareness campaign. |