

**MASSACHUSETTS
CHILD FATALITY REVIEW
PROGRAM**

**FIFTH ANNUAL REPORT
OF PROGRAM ACTIVITY
2005**

**Deval L. Patrick, Governor
Kevin M. Burke, Secretary of Public Safety
JudyAnn Bigby, MD, Secretary of Health and Human Services**

**Office of the Chief Medical Examiner
Henry M. Nields, MD, PhD, Chief Medical Examiner**

**Massachusetts Department of Public Health
John Auerbach, Commissioner of Public Health
Lauren Smith, MD Director of Public Health**

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**Massachusetts Child Fatality Review
FIFTH ANNUAL REPORT OF PROGRAM ACTIVITY - 2005**

Executive Summary

In 2005, a total of 588 Massachusetts resident children ages 0-17 years died. Of this total, 306 (52%) of the deaths were due to congenital anomalies and perinatal conditions, 176 (30%) were from a variety of other medical causes, and 106 (18%) were from intentional and unintentional injuries.

The leading causes of death varied by age group. For infants the leading causes were prematurity, congenital anomalies, sudden infant death syndrome (SIDS) and complications of pregnancy. Cancer, unintentional injuries and congenital anomalies were the leading causes of death among children 1-9 years. Unintentional injuries, cancer, heart disease and suicide were the leading causes for 10 to 14-year olds, and unintentional injuries (predominantly transportation –related), cancer, homicide and suicide were the leading causes among teenagers 15-17 years.

Of the 588 child deaths, 169 were investigated by the Office of the Chief Medical Examiner. The most frequent causes of these deaths were unintentional injuries, including motor vehicle crashes, SIDS, and homicide.

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; that position remained unfilled during 2005¹.

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 three times in 2005 and continued their consideration of a number of issues begun in previous years. In response to ongoing recommendations by Local Teams, members of the State Team continued to discuss how to achieve more standardized statewide guidance on death scene investigations of sudden and unexplained infant death. In addition, State Team members began a discussion to determine whether or not Massachusetts would join a group of states, working under the auspices of the National Center for Child Death Review, to pilot a national electronic data collection system.

¹ In April, 2006 a Child Advocate was appointed to the State Team.

Local Teams varied a great deal in their level of activity during the year. Some of the teams from more populated districts met frequently; other smaller districts had fewer fatalities to review and fewer staff resources with which to conduct the reviews.

During 2005, eight Local Teams reviewed 139 child deaths. Although not all teams submitted recommendations based on their reviews, many of the teams identified a number of causes of child death that they recommended for further attention. These included positional asphyxia, asphyxial deaths due to “the choking game” and other causes, backover accidents, and medical conditions, such as rotavirus, tracheitis and prematurity.

The most serious challenge facing the Massachusetts Child Fatality Review Teams was the continued lack of funding for case review and implementation of recommendations for changes to prevent future child deaths. 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. One of the Teams applied for and was awarded a full-time Coordinator’s position through grant funding. This position was created to assist the team with its mission of reviewing and preventing child deaths.

ANNUAL REPORT - 2005

I. Introduction

The year 2005 was the fifth year of the Child Fatality Review Program 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. This fifth annual report includes:

- a description of the structure of the child fatality review process in the state;
- the fifth year's experience and accomplishments of the State and Local Teams;
- a list of recommendations submitted during the year, as a reflection of the teams' ongoing concerns for particular child safety issues;
- initiatives accomplished or in progress during 2005; and
- ongoing challenges to the continuation and success of the child fatality review process.

The goal of child fatality review is the prevention of future deaths. It is now widely accepted that many child deaths, especially those from injuries, are preventable. As a result, health and safety advocates recognize the importance of the child fatality review team as a critical tool in the prevention of child deaths and injuries. The underlying assumption of the review process is that bringing professionals together from a variety of disciplines and experiences to examine individual fatality 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.

During 2005 several of the same issues of concern were prioritized by more than one Local Team. These 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 insufficient tools for early casefinding, as well as a lack of adequate and appropriate mental health services for teens and pre-teens.

II. Child Deaths Among Massachusetts Residents²

In 2005, a total of 588 Massachusetts children birth through age 17 years of age died (Table 1). Of this total, 306 (52%) of the deaths were due to congenital anomalies and perinatal conditions, 176 (30%) were from a variety of other medical causes, and 106 (18%) were from intentional and unintentional injuries. If congenital anomalies and perinatal conditions are excluded, the causes of the remaining 282 deaths can be broken down into two major categories: medical conditions, accounting for 62% of the deaths and unintentional and intentional injuries, accounting for 38%.

After congenital anomalies and perinatal conditions, the leading causes of child death were unintentional injuries (including transportation-related injuries, drowning and suffocation, among other causes, n=74), cancer (n=35), and intentional injuries (homicide and suicide, combined n=27). A detailed listing of the underlying causes of child deaths for 2005 is presented in Table 1.

² All 2005 data presented in Section II, with the exception of Table 6, are from the Massachusetts Department of Public Health (MDPH), Registry of Vital Records and Statistics.

Table 1. Underlying Cause of Death for Massachusetts Children Ages 0-17, 2005

Cause of Death	Number	Percent of Child Deaths
Perinatal conditions*	227	38.6%
Congenital malformations	79	13.4%
Unintentional Injuries	74	12.6%
Cancer and in situ neoplasms	38	6.5%
SIDS	21	3.6%
Heart Disease	16	2.7%
Homicide	15	2.6%
Suicide	12	2.0%
Other infections	4	0.7%
Stroke	4	0.7%
Injuries of undetermined intent**	4	0.7%
Influenza and pneumonia	3	0.5%
Nephritis	3	0.5%
Septicemia	3	0.5%
Chronic lower respiratory disease	2	0.3%
Other	83	14.1%
Total Number of Deaths	588	100%
Total Deaths from Medical Conditions Under 1 Year of Age	383	65%
Total Deaths from Medical Causes in Children and Youth 1-17 Years	99	17%
Total Deaths from Injuries (0-17 Years)	106	18%

*Perinatal conditions include: newborns affected by maternal conditions which may be unrelated to pregnancy, maternal complications of pregnancy, complications of placenta, prematurity and low birth weight, birth trauma, intrauterine hypoxia and birth asphyxia, respiratory distress and other respiratory conditions of newborn, perinatal infections, neonatal hemorrhage and other and ill-defined conditions of the perinatal period.

**Includes deaths where the manner of death (accident, suicide, homicide or natural) is not clear, even after the death investigation.

Tables 2a-e list the causes of death by age group. The leading causes of death for infants were prematurity and low birth weight, congenital anomalies and sudden infant death syndrome (SIDS). Injuries and cancer were the leading causes of death for children 1-4 years, and cancer, unintentional injuries and congenital malformations, the leading causes for children 5-9 years. Among youth 10-14 years and teenagers ages 15-17 years, injuries were, by far, the leading cause of death followed by cancer and heart disease.

Table 2a. Leading Cause of Death, Massachusetts Children Age < 1 Year, 2005

Cause of Death	Number	Percent
Short gestation (prematurity) and low birth weight	80	20.5
Congenital malformations	69	17.6
Sudden Infant Death Syndrome (SIDS)	21	5.4
Pregnancy complications	20	5.1
Complications of placenta	17	4.3
Intrauterine hypoxia	16	4.1
Respiratory distress of newborn	14	3.6
Bacterial sepsis of newborn	10	2.6
Necrotizing enterocolitis	9	2.3
Injuries (including unintentional (n=5), homicide (n=2) and undetermined intent (n=1))	8	2.0
Gastritis	7	1.8
Neonatal Hemorrhage	7	1.8
Circulatory system	7	1.8
Other conditions	106	27.1
Total Number of Deaths	391	100.0

Table 2b. Leading Cause of Death, Massachusetts Children Ages 1-4 Years, 2005

Cause of Death	Number	Percent
Cancer and in situ neoplasms	12	26.7
Injuries (including unintentional (n=8) and homicide (n=3))	11	24.4
Congenital malformations	4	8.9
Heart disease	3	6.7
Other conditions	15	33.3
Total Number of Deaths	45	100.0

Table 2c. Leading Cause of Death, Massachusetts Children Ages 5-9 Years, 2005

Cause of Death	Number	Percent
Cancer	12	38.7
Injuries (all unintentional)	6	19.4
Congenital malformations	4	12.9
Other conditions	9	29.0
Total Number of Deaths	31	100.0

Table 2d. Leading Cause of Death, Massachusetts Children Ages 10-14 Years, 2005

Cause of Death	Number	Percent
Injuries (including unintentional (n=18) and suicide (n=2))	20	54.1
Cancer and in situ neoplasms	4	10.8
Heart disease	2	5.4
Other conditions	11	29.7
Total Number of Deaths	37	100.0

Table 2e. Leading Cause of Death, Massachusetts Children Ages 15-17 Years, 2005

Cause of Death	Number	Percent
Injuries (including unintentional (n=37), suicide (n=10), homicide (n=10), and undetermined intent (n=3) and adverse effect *(n=1))	61	72.6
Cancer	10	11.9
Heart disease	4	4.8
Influenza and pneumonia	2	2.4
Other conditions	7	8.3
Total Number of Deaths	84	100.0

*Adverse effects can be related to medical and surgical care procedures or to the use of therapeutic substances.

Table 3 details the breakdown of the 2005 child deaths by age group and district.

Table 3. Massachusetts Child Deaths by District of Residence, 2005

District	2005 Population Estimate* 0-17 Years	Total Child Deaths (0-17 Years)	Child Death Rate** per 100,000 population	Child Deaths < 1 year	Child Deaths 1-9 yrs.	Child Deaths 10 – 17 yrs.
Berkshire	26,621	5	18.8	3	0	2
Bristol	127,217	55	43.2	38	9	8
Cape & Islands (Includes Barnstable, Dukes and Nantucket Counties)	46,717	13	27.8	9	1	3
Essex	177,867	53	29.8	36	6	11
Hampden	112,786	59	52.3	39	8	12
Middlesex	324,831	111	34.2	76	15	20
Norfolk	151,342	55	36.3	35	9	11
Northwest (Includes Franklin and Hampshire Counties)	41,148	16	38.9	9	3	4
Plymouth	123,436	51	41.3	28	10	13
Suffolk	141,265	74	52.4	52	5	17
Worcester	189,939	96	50.5	66	10	20
Total MA	1,463,169	588	40.2	391	76	121

*National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2006, United States resident population from the Vintage 2006 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Bureau. Available on the Internet from: <http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm>. August 16, 2006.

**Rates based on numbers less than 20 may be unstable and should be interpreted with caution.

Injuries are often thought to be the most preventable of all child deaths. Table 4 lists the leading causes of injury deaths in 2005 by age group and Table 5 shows details on the District of residence of the children and youth who died of injuries. Of the 106 injury deaths among children and youth ages 0-17 years in 2005, 74 (70%) were unintentional, 15 (14%) were homicide, 12 (11%) were suicide, and 5 were undetermined intent or an adverse effect of drugs. Other important findings include:

- Unintentional transportation injuries were the leading cause of injury death among the total 0-17 year population (n=39). Seventy-one percent (n=28) of these were among teens ages 15-17 years. Eighty-

seven percent of the total deaths in this category were to occupants of motor vehicles (including on and off road and motorcyclists) (data not shown).

- Homicide ranked second as the leading category of injury death among the total 0-17 year population (n=15). Two-thirds (n=10) of these were among youth who resided in Suffolk District. Of all homicides among children 0-4 years, at least 80% (4 of 5) were related to child maltreatment. Two-thirds (n=10) of all homicides among children and youth 0-17 years were among teens 15-17 years; 80% of these were due to a firearm.
- Suicide ranked as the third leading category of injury death among the total 0-17 year population (n=12). Hanging/suffocation was the leading mechanism of suicide in youth, accounting for 83% of the suicides in this population.
- Unintentional drowning is another leading cause of injury death among Massachusetts children and youth. In 2005 there were 12 unintentional drowning deaths among children 0-17 years. Over 80% of these were in children 1-4 years of age (n=5) or in youth 15-17 years of age (n=5). One-third (n=4) of all unintentional drowning deaths in children 0-17 years were among youth residing in Plymouth District.
- Unintentional suffocation accounted for 11 deaths among Massachusetts children and ranked as the leading cause of injury death in infants. Five (45%) of the injury deaths in infants less than 1 year of age were caused by unintentional suffocation. Unsafe sleep environments including excessive bedding, crib toys and inadvertent overlay by persons sleeping with the infant can all contribute to these injury deaths.

Table 4. Seven Leading Causes/Intents of Injury Deaths by Age Group, MA Children 0-17 Years

Rank	Under 1 Year	1-4 Years	5-9 Years	10-14 Years	15-17 Years	All Injury Deaths 0-17 Years
1	Unintentional Suffocation (n=5)	Unintentional Drowning (n=5)	Unintentional – Transport* (n=2)	Unintentional – Transport* (n=8)	Unintentional – Transport* (n=28)	Unintentional – Transport* (n=39)
2	Homicide – Child Maltreatment (n=2)	Unintentional Fire/flame (n=2)	Unintentional Fire/Flame (n=1)	Unintentional Suffocation (n=4)	Suicide – Hanging/ Suffocation (n=8)	Homicide – All Causes (n=15)
3	Poisoning - Undetermined Intent (n=1)	Homicide – Child Maltreatment (n=2)	Unintentional Poisoning (n=1)	Unintentional Drowning (n=2)	Homicide – Firearm (n=8)	Unintentional Drowning (n=12)
4		Homicide – Suffocation (n=1)	Unintentional Suffocation (n=1)	Suicide – Hanging/ Suffocation (n=2)	Unintentional Drowning (n=5)	Suicide – All Causes (n=12)
5		Unintentional -Transport* (n=1)	Unintentional – Unspecified Cause (n=1)	Unintentional Fall (n=1)	Suffocation– Undetermined Intent (n=3)	Unintentional Suffocation (n=11)
6				Unintentional Firearm (n=1)	Suicide – Poison (n=2)	Unintentional Poison (n=3)
7				Unintentional Poisoning (n=1)	Homicide – Cut/stab (n=2)	Unintentional Fire/flame (n=3)
All Other				Other (n=1)	Other (n=5)	Other (n=11)
Total	8	11	6	20	61	106

*Transport includes motor vehicle occupants, motorcyclists, bicyclists, and pedestrians.

Table 5. Leading Causes/Intents of Injury Deaths by District of Residence, MA Children 0-17 yrs, 2005

District	Unintentional Transport	Unintentional Drowning	Homicide – All Causes	Suicide – All Causes	Unintentional Suffocation	Other Injuries	Total Injuries
Berkshire	0	0	0	0	0	0	0
Bristol	3	1	1	1	2	4*	12
Cape & Islands	1	0	0	1	1	1	4
Essex	3	1	2	1	1	0	8
Hampden	5	2	0	1	0	3	11
Middlesex	9	2	1	0	0	3	15
Norfolk	2	1	0	3	2	0	8
Northwest	1	0	0	0	0	1	2
Plymouth	2	4	1	2	2	2	13
Suffolk	2	0	10	1	1	1	15
Worcester	11	1	0	2	2	2	18
Total MA	39	12	15	12	11	17	106

*Includes 2 fire deaths.

The Office of the Chief Medical Examiner accepts jurisdiction in cases of sudden, violent and unexpected deaths and deaths due to therapeutic complications. In accordance with Chapter 38, Section 3 of the Massachusetts General Laws, all deaths of children under the age of 18 years are reportable to the OCME regardless of cause. Of the 588 child deaths reported in 2005, the Medical Examiner's Office accepted jurisdiction in 169 of these cases (Table 6). The most frequent causes of these deaths were unintentional injuries, including motor vehicle crashes, prematurity and natural causes, and SIDS. SIDS deaths include Sudden Infant Death Syndrome, Sudden Unexpected Death and Sudden Unexplained Infant Death Syndrome.

Table 6. Massachusetts Child Deaths Investigated by the Medical Examiner's Office, 2005³

Cause of Death	< 1 yr	1-4 yrs	5-9 yrs	10-14 yrs	15-17 yrs	Total
Other Unintentional Injuries, incl. motor vehicle and maternal trauma	4	4	5	9	31	53
SIDS	17	5	0	0	0	22
Homicide	0	5	2	0	6	13
Undetermined	2	0	0	0	0	2
Drug Related Deaths and Exposures	5	0	0	0	1	6
Drowning	0	3	0	1	3	7
Suicide by hanging and other methods	0	0	0	0	11	11
Co-Sleeping	6	2	0	0	0	8
Unintentional Asphyxia	6	1	0	0	0	7
Prematurity, Congenital Anomalies and other natural causes	10	6	1	2	5	24
Pneumonia, Virus or other infections	6	5	1	0	0	12
Asthma/Bronchitis	0	0	0	0	0	0
Totals	56*	31*	9	12	57	165*

*Four (4) cases are listed as pending; 3 in age group under 1 and 1 in age group 1-4.

III. Structure

The Massachusetts Child Fatality Review law establishes a State Team and 11 Local Teams.⁴ The State Team is under the direction of the Chief Medical Examiner, and the Local Teams are the responsibility of 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

³ Data is from the Office of the Chief Medical Examiner

⁴ A list of Local Teams and Team coordinators can be found in Appendix A.

combined, as are Barnstable, Dukes and Nantucket). Local Teams can meet as frequently as they want but the law mandates a minimum of four meetings per year. There is no meeting requirement for the State Team, but in practice the team meets quarterly.

The make up of the State and Local Teams is also mandated, but not limited, by the law.⁵

Table 7. 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, or designee	Commissioner of Dept. of Social Services, or designee
Commissioner of Dept. of Public Health, 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. District Attorney’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
Representative 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
Representative of the Mass. Hospital Association	
Chief justice of the juvenile division of the trial court, or designee	Chief justice of the juvenile division of the trial court, or designee
President of Mass. Chiefs of Police Association 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 by meeting two objectives established by law:

⁵ A copy of the legislation can be found in Appendix B.

- It develops an understanding of how and why children die based on Local Team experience; 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 prevent future child deaths by meeting four objectives established by law:

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

The Review Process

Notifications to Local Teams: At least on a quarterly basis, each Local Team receives two notifications of child deaths in their districts. One notification consists of copies of death certificates (which, in some cases, may not be finalized) 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 district who died in the district
- deaths of children living in the district who died in another district
- deaths of children living in another district who died in the district

Case Selection: Any death of a child from birth through 17, from any cause, may be chosen for review by the team. 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 accepted by the Office of the Medical Examiner; and
- all cases with previous DSS involvement or cases that have been prosecuted by the District Attorney's office.

Two types usually not reviewed are homicides under investigation and deaths ruled as "pending," both in cause and in manner, by the Medical Examiner. "Pending" as a cause and manner of death is applied to those cases in which further laboratory testing or other investigation is needed and is still incomplete. Although there were such cases in 2005, Local Teams often began review of the case without a finalized death certificate. Local Teams follow up with their review when the investigation by the Medical Examiner's Office has been completed, which may or may not be performed in the same year.

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 extends to 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?"

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, changes in products available to the public, 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.

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. For example, 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. 2005 Activity

During the state’s fifth year of child fatality review activity, the focus of attention was again on reviewing cases and developing recommendations. Added to these objectives was an enhanced effort on the part of the State Team to respond to recommendations submitted previously that had not been reviewed. The continued lack of any funding appropriated by the state legislature continued to challenge Local and State Teams.

State Team Activity

The State Team met three times in 2005. Accomplishments included:

- Compilation of the 2004 Annual Report;
- Site visits to a number of Local Teams to discuss data collection; 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

The number of cases reviewed by Local Teams has increased steadily over the five years since the passage of child fatality review team legislation in Massachusetts.

<u>Year</u>	<u># of Cases Reviewed</u>	<u>% of All Child Deaths</u>
2001	86	13% (of 648 deaths)
2002	175	27% (of 655 deaths)
2003	260	41% (of 630 deaths)
2004	276	44% (of 629 deaths)
2005	139	24% (of 588 deaths)

As in the previous years, Local Child Fatality Review Teams varied a great deal in their level of activity during 2005. 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. Three of the 11 Local Teams were not able to submit reports. The seven teams that did submit reports reviewed a total of 139 deaths during 2005. Table 8 lists the number of deaths reviewed by each team in broken down by age group.

Table 8. Age Breakdown of Deaths Reviewed by MA Child Fatality Review Teams in 2005

Local Team	< 1 yr	1-4 yrs	5-9 yrs	10-14 yrs	15-17 yrs	Total
Berkshire – no report						n/a
Bristol	8	3	1	1	0	13
Cape and Islands (Barnstable, Duke, Nantucket)	12	3	4	1	4	24
Essex	4	2	0	2	5	13
Hampden	11	5	3	1	1	21
Middlesex	2	2	1	0	1	6
Norfolk*	31	1 (1-6 yrs)	1 (7-10 yrs)	1 (11-13 yrs)	2 (14-17 yrs)	36
Northwest (Franklin, Hampshire)	3	3	1	0	1	8
Plymouth – no report						n/a
Suffolk	12	1	0	3	2	18
Worcester - no report						n/a
					Total	139

*Age categories are slightly different from other teams

Information on each Local Team appears below. The child death data is from 2005, but the team activity in some counties does include 2004 cases, so the numbers are not strictly comparable. In fact, due to the delay in forwarding death certificates to the Local Teams, many of the case reviews conducted in 2005 were for deaths that occurred in 2004. Because the number of child deaths in Massachusetts does not vary that much from year to year, the comparison of cases reviewed in one year to deaths in a previous year is reasonable. Data from the Berkshire, Plymouth and Worcester Counties were not available at the time of this report.

Berkshire Child Fatality Review Team

(No report was submitted.)

Bristol Child Fatality Review Team

Number of child deaths, 2005	55				
Percentage of state child deaths	9%				
Percentage of MA population	9%				
Number of Team meetings in 2005	3				
Number of cases reviewed	13				
Age Breakdown:	<1 yr	1-4 yrs	5-9 yrs	10-14 yrs	15-17 yrs
	8	3	1	1	0
Recommendations to State Team in 2005?	No				

Team Composition:

Mandated Agency	Active Participants	Mandated Agency	Active Participants
District Attorney's Office	5	State Police	2
Medical Examiner	1	Local Police	22
Dept. of Social Services	1	Pediatrician	1
Dept. of Public Health	1	Juvenile Court	2
SIDS Center	1	Others: Judge	1

Case Selection Criteria:

The Bristol Team did not have specific criteria for which cases will be reviewed in place during 2005. The team does review resident child deaths occurring within the county or elsewhere. Not all child deaths are reviewed, but those reviewed include premature and other infant deaths. Deaths under criminal investigation are not reviewed.

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

Number of child deaths, 2005	13										
Percentage of state child deaths	2%										
Percentage of MA population	3%										
Number of team meetings in 2005	3										
Number of cases reviewed	24										
Age Breakdown:	<table border="1"> <thead> <tr> <th><1 yr</th> <th>1-4 yrs</th> <th>5-9 yrs</th> <th>10-14 yrs</th> <th>15-17 yrs</th> </tr> </thead> <tbody> <tr> <td>12</td> <td>3</td> <td>4</td> <td>1</td> <td>4</td> </tr> </tbody> </table>	<1 yr	1-4 yrs	5-9 yrs	10-14 yrs	15-17 yrs	12	3	4	1	4
<1 yr	1-4 yrs	5-9 yrs	10-14 yrs	15-17 yrs							
12	3	4	1	4							
Recommendations submitted to State Team in 2005?	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:	0

Case Selection Criteria: The team reviews all resident and non-resident deaths that occur within their district. All non-investigated child deaths and premature infants will be noted and listed but not reviewed.

Essex Child Fatality Review Team

Number of child deaths, 2005	53										
Percentage of state child deaths	9%										
Percentage of MA population	12%										
Number of team meetings in 2005	4										
Number of cases reviewed	13										
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>0</td> <td>2</td> <td>5</td> </tr> </table>	<1 yr	1-4 yrs	5-9 yrs	10-14 yrs	15-17 yrs	4	2	0	2	5
<1 yr	1-4 yrs	5-9 yrs	10-14 yrs	15-17 yrs							
4	2	0	2	5							
Recommendations submitted to State Team in 2005?	Yes										

Team Composition:

Mandated Agency	Active Participants	Mandated Agency	Active Participants
District Attorney's Office	1	State Police	1
Medical Examiner	1	Local Police	varies
Dept. of Social Services	1	Pediatrician	2
Dept. of Public Health	1	Juvenile Court	1
SIDS Center	1	Others: Child Abuse Project and Family Crimes Unit Attorney's and advocates	8-10

Case Selection Criteria:

The Essex County Child Fatality Review Team will adopt the following criteria in selecting cases for review of children from birth to the age of 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.

Hampden County Child Fatality Review Team

Number of child deaths, 2005	59										
Percentage of state child deaths	10%										
Percentage of MA population	8%										
Number of team meetings in 2005	12										
Number of cases reviewed	21										
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>11</td> <td>5</td> <td>3</td> <td>1</td> <td>1</td> </tr> </table>	<1 yr	1-4 yrs	5-9 yrs	10-14 yrs	15-17 yrs	11	5	3	1	1
<1 yr	1-4 yrs	5-9 yrs	10-14 yrs	15-17 yrs							
11	5	3	1	1							
Recommendations submitted to State Team in 2005?	Yes										

Team Composition:

Mandated Agency	Active Participants	Mandated Agency	Active Participants
District Attorney's Office	2	State Police	1
Medical Examiner	2	Local Police	2
Dept. of Social Services	1	Pediatrician	1
Dept. of Public Health	2	Juvenile Court	1
SIDS Center	1	Others: Data Collector (DA's Office); Pediatric Trauma Coordinator, Baystate Med. Ctr; Ass't. Director, Western Mass. EMS, Springfield Dept. of Health and Human Services	4

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.

The cases reviewed are separated into three categories:

- a. if there is a question of abuse, a 51 A/B submitted or a police investigation is initiated;
- b. notice of any non-suspicious death; and
- c. receipt of a death certificate from the Medical Examiner's Office.

Middlesex County Child Fatality Review Team

Number of child deaths, 2005	111										
Percentage of state child deaths	19%										
Percentage of MA population	22%										
Number of team meetings in 2005	2										
Number of cases reviewed	6										
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>2</td> <td>2</td> <td>1</td> <td>0</td> <td>1</td> </tr> </table>	<1 yr	1-4 yrs	5-9 yrs	10-14 yrs	15-17 yrs	2	2	1	0	1
<1 yr	1-4 yrs	5-9 yrs	10-14 yrs	15-17 yrs							
2	2	1	0	1							
Recommendations submitted to State Team in 2005?	Yes										

Team Composition:

Mandated Agency	Active Participants	Mandated Agency	Active Participants
District Attorney's Office	7	State Police	0
Medical Examiner	1	Local Police	0
Dept. of Social Services	2	Pediatrician	2
Dept. of Public Health	2	Juvenile Court	0
SIDS Center	1	Others: Middlesex County Sheriff's Dept. Ad Hoc members invited on a case by case basis	1 7

Case Selection Criteria:

The types of cases the team reviews are resident death occurring within the county and residents of the county whose deaths occurred elsewhere. The permanent team members review all Middlesex County death certificates at each meeting and select those deaths that raise concerns, issues or demonstrate a pattern that warrant an in-depth review. These cases are then reviewed at each subsequent meeting. The team does not review cases that are under criminal investigation.

Norfolk County Child Fatality Review Team

Number of child deaths, 2005	55												
Percentage of state child deaths	9%												
Percentage of MA population	10%												
Number of team meetings in 2005	4												
Number of cases reviewed	36												
Age Breakdown*:	<table border="1"> <tr> <td><1 yr</td> <td>1-2 yrs</td> <td>3-6 yrs</td> <td>7-10 yrs</td> <td>11-13 yrs</td> <td>14-17 yrs</td> </tr> <tr> <td>31</td> <td>0</td> <td>1</td> <td>1</td> <td>1</td> <td>2</td> </tr> </table>	<1 yr	1-2 yrs	3-6 yrs	7-10 yrs	11-13 yrs	14-17 yrs	31	0	1	1	1	2
<1 yr	1-2 yrs	3-6 yrs	7-10 yrs	11-13 yrs	14-17 yrs								
31	0	1	1	1	2								
Recommendations submitted to State Team in 2005?	No												

*Age categories are slightly different than other teams

Team Composition:

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

Case Selection Criteria:

All resident deaths occurring within the county and residents whose deaths occurred elsewhere.

Northwestern Child Fatality Review Team
(Franklin and Hampshire Counties)

Number of child deaths, 2005	16										
Percentage of state child deaths	3%										
Percentage of MA population	3%										
Number of team meetings in 2005	4										
Number of cases reviewed	8										
Age Breakdown:	<table border="1"> <thead> <tr> <th><1 yr</th> <th>1-4 yrs</th> <th>5-9 yrs</th> <th>10-14 yrs</th> <th>15-17 yrs</th> </tr> </thead> <tbody> <tr> <td>3</td> <td>3</td> <td>1</td> <td>0</td> <td>1</td> </tr> </tbody> </table>	<1 yr	1-4 yrs	5-9 yrs	10-14 yrs	15-17 yrs	3	3	1	0	1
<1 yr	1-4 yrs	5-9 yrs	10-14 yrs	15-17 yrs							
3	3	1	0	1							
Recommendations submitted to State Team in 2005?	No										

Team Composition:

Mandated Agency	Active Participants	Mandated Agency	Active Participants
District Attorney's Office	5	State Police	2
Medical Examiner	1	Local Police	as needed
Dept. of Social Services	1	Pediatrician	1
Dept. of Public Health	2	Juvenile Court	1
SIDS Center	1	Others:	1

Case Selection Criteria:

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

Plymouth Child Fatality Review Team

No report was submitted.

Suffolk Child Fatality Review Team

Number of child deaths, 2005	74										
Percentage of state child deaths	13%										
Percentage of MA population	10%										
Number of team meetings in 2005	10										
Number of cases reviewed	18										
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>12</td> <td>1</td> <td>0</td> <td>3</td> <td>2</td> </tr> </table>	<1 yr	1-4 yrs	5-9 yrs	10-14 yrs	15-17 yrs	12	1	0	3	2
<1 yr	1-4 yrs	5-9 yrs	10-14 yrs	15-17 yrs							
12	1	0	3	2							
Recommendations submitted to State Team in 2005?	No										

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	3	Pediatrician	2
Dept. of Public Health	2	Juvenile Court	1
SIDS Center	1	Others including Ad Hoc Members	3

Case Selection Criteria:

All resident deaths due to:

- Homicides
- Suicides
- Unintentional Injuries
- Sudden or unexpected deaths, including SIDS
- Some medical deaths, and
- All deaths resulting from abuse and/or violence.

Non-resident deaths are reviewed if the death is related to incident or event which occurred in Suffolk County (i.e. abuse, automobile incident).

Worcester County Child Fatality Review Team

(No report was submitted.)

V. Recommendations from Local Teams

In 2005, three Local Teams submitted a total of 11 recommendations to the State Team for changes based on their ongoing review of child deaths in their districts. This number was about the same as the previous year in which two teams submitted 12 recommendations. Table 9 lists recommendations submitted to the State Team in 2005. A list of recommendations submitted from Local Teams to the State Team in previous years is included in Appendix D.

Table 9. Recommendations Submitted by Local Teams

Recommendation	Team Submitting
<p>1. That DPH provide statistics and education resources on premature deaths of infants, backover accidents with young children, and The Choking Game and other asphyxial deaths of youth to better inform the local teams.</p>	Essex
<p>2. Referrals to the Massachusetts Center for SIDS/Massachusetts Infant and Child Death Bereavement Program.</p> <ul style="list-style-type: none"> - Based on a number of deaths of children under two years of age, our team noted that all hospitals do not have a regular protocol of referring families of the SIDS Center. This results in families often not accessing follow-up bereavement services of any type once they leave the hospital environment. The team also recognizes the value of referring these cases as it allows the SIDS Center to gather data on these deaths for the national database. <p>The local team will make a recommendation therefore to our local hospitals to include a referral to the SIDS Center as part of their protocol in all deaths of children under two years of age.</p>	Hampden
<p>3. SIDS Training</p> <ul style="list-style-type: none"> - That the State Team support the mission of the Massachusetts Center for Sudden Infant Death Syndrome to provide statewide education on the issues around SIDS deaths, including training for the Department of Social Services, day care providers, home visiting nurses, early intervention workers and law enforcement in an effort to raise awareness of the risks related to SIDS deaths and to identify best practices in child care and death investigations. 	Hampden
<p>4. Training for local law enforcement on the fire starter program.</p> <ol style="list-style-type: none"> a. The Hampden County Child Fatality Review Team recommends that training be made available to all local law enforcement and the public at large with respect to the fire starter program so that this type of intervention be made the subject of referral in appropriate cases as a preventative measure. b. The local Hampden County Juvenile Court will host training for court personnel, particularly attorneys and the probation department to make them aware of the availability and appropriateness of the fire starter program in juvenile cases. <ul style="list-style-type: none"> - In response to this recommendation the Honorable Justice Daniel J. Swords agreed to work with the Fire Marshals office to organize a brown-bag lunch to educate court personnel about the fire starter program and related issues. 	Hampden
<p>5. The Massachusetts paramedics should be required to have and keep current certification in either Pediatric Advance Life Support (PALS) or Pediatric Education for Pre-Hospital Professionals (PEPP).</p> <ul style="list-style-type: none"> - During the review process it has been noted that when ALS is 	Hampden

called, there have been several incidents where the ALS protocol for pediatric cardiac arrest were not followed.	
6. There should be “100% quality improvement” review in all pediatric deaths by ambulance service medical director. - Treatment protocols for pediatric cardiac arrest require ambulance call for ALS if available. However, this recommendation is not consistently followed in all jurisdictions.	Hampden
7. Educate first responders how to properly preserve death scenes. - This recommendation was based on a case involving the death of a 1 ½ month old male infant, otherwise healthy, who was found sleeping on his back.	Middlesex
8. Provide multi-lingual versions of safe sleep brochures to families. - see recommendation #7.	Middlesex
9. Education and training for mothers pertaining to safe sleep practices. - This recommendation was based on a case of a two month old found sleeping in a bed between the mother and a 9 year old.	Middlesex
10. Enact a law that would require home safety audits and the home inspection of pools. - This recommendation was based on a 1 year old drowning in a family pool.	Middlesex
11. Enact a law that would require the purchase of a helmet with the purchase of a bicycle. - This recommendation was based on the review of a 7 year old hit by a car while riding her bike.	Middlesex

VI. Summary of Accomplishments and Challenges in 2005

During 2005, eight Local Teams reported reviewing 139 child death cases. Although not all teams formally submitted recommendations to the State Team, based on the surveys of activity completed by the local coordinators, many of the teams provided training, discussed issues and made local recommendations based on their case reviews.

Bristol County noted that in 2005 the team began to develop a better understanding of what they wanted to accomplish and what types of cases should be reviewed. Their goal was to gain knowledge about certain child deaths such as positional asphyxia and medical conditions (i.e. Rotavirus and Tracheitis).

Statistical inquiries into premature deaths of infants, The Choking Game and other asphyxial deaths of youth, and backover accidents with young children were discussed at the Essex County Team meetings.

The Hampden County Team provided training during the Hampden County Annual Victim Rights Conference entitled "Why Kids Act that Way" which included a workshop of Juvenile Fire Setting. In 2005, the team also sponsored two additional presentations on "*Substance Abuse and Community Resources Available*", and "*Fire Setting Programs*".

The Norfolk Child Fatality Team sponsored a Suicide Prevention Training. The Northwestern Team listed the support and commitment of all of the professionals on their team as a major accomplishment. The team also notes that due to a lower number of deaths in their district it allows the group to spend equal time reviewing each case.

The Suffolk County Team was awarded a grant in December 2005 which provided funds for a full-time coordinator. This position was created to assist the Suffolk County Child Fatality Review Team in its mission to improve the understanding of how and why children die; to demonstrate the need for and to influence policies and programs to improve child health, safety and protection; and to ultimately achieve the common goal of decreasing the incidence of preventable child death and injuries. The Suffolk Team also discussed the appropriateness of reviewing premature deaths of infants. The protocol in these cases will now reflect more input from the pediatrician on the team to determine the appropriateness of full team review. There was express concern from DPH and the pediatrician that there are reviews of these cases within hospitals.

Challenges preventing the teams from accomplishing their work include lack of resources, time and money. Bristol County went further to note that the lack of resources is detrimental to the coordination and extensive review of cases. Local Teams are unable to perform the extensive investigation into the cases from their county due to these factors. In 2005, the State Team discussed at their meetings alternative ways of providing personnel assistance to the local teams. Reaching out to Universities to recruit interns was suggested, but dismissed due to the sensitivity of the information being collected. Other funding sources, such as small contributions from other agencies, were also discussed at the State Meetings.

At the Local Team meetings, a Medical Examiner is requested to be present for case discussions. Several teams noted that Medical Examiners no longer attended the meetings. The Chief Medical Examiner agreed that a presence by the OCME at the Local Team Meetings is important; therefore a representative from the office in place of a Medical Examiner will attend.

Also discussed at the State Team Meeting was death investigation into child deaths. In the past, local teams recommended improving and standardizing child death scene investigations. The Chief Medical Examiner wholeheartedly supported this concept and is currently creating an investigative division in the OCME which will in part address this issue.

VIII. Objectives for Future Activity

- **Participation in piloting and ongoing development of a national electronic data collection system for child fatality review**

Massachusetts will join the 14 states that are participating in the data system pilot. Final agreements are being worked out between the parties for an anticipated start date of January 2006. This reporting system will make it possible for reporting of local and statewide activity to all team members and other interested professionals.

- **Development of a public education campaign for safe sleeping practices for infants**

As discussed in the previous year, local teams have expressed concern in the growing number of deaths caused by unsafe sleep practices. The State Team considered ways of distributing the Department of Public Health pamphlet to a variety of locations, such as WIC sites, community health centers and birthing hospitals. The pamphlet is available in multiple languages. While this concept is a great start in reaching parents, creative ways of enforcing these safe sleep practices is still a critical need.

**Appendix A: Massachusetts Child Fatality Review Teams
2005**

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: Randy Moshos, PA-C Lt. Edith Platt</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: Cynthia Brackett Medical Examiner: Randy Moshos, PA-C Lt. Edith Platt</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 Glenn Medical Examiner: Randy Moshos, PA-C Lt. Edith Platt</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: Randy Moshos, PA-C Lt. Edith Platt</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: Randy Moshos, PA-C Lt. Edith Platt</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: Randy Moshos, PA-C Lt. Edith Platt</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: Randy Moshos, PA-C Lt. Edith Platt</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: Randy Moshos, PA-C Lt. Edith Platt</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: Sharon Donatelle Medical Examiner: Randy Moshos, PA-C Lt. Edith Platt</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: Randy Moshos, PA-C Lt. Edith Platt</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: Randy Moshos, PA-C Lt. Edith Platt</p>

State Team	<p style="text-align: center;">Mark Flomenbaum, MD Office of the Chief Medical Examiner 720 Albany St. Boston, MA 02118 Main Phone: (617) 267-6767 Contact: Randy Moshos, PA-C Janet Shea</p>
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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, 2001-2004

Recommendation	Team Submitting
Infants < 1 yr	
<p>Unexplained Infant Deaths:</p> <ol style="list-style-type: none"> Standardized guidance regarding infant death scene investigation and standardized cause of death classification are needed to facilitate case review. Public education is needed on safe sleeping practices. Standard RSV nasal swab testing for SIDS deaths of children <1 yr. Requirements for registering home births with penalties for failure to report. Review pending legislation regarding midwives. 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. All day care providers should be required to attend SIDS prevention trainings. Include sensitivity training for EMS and medical providers. 	<ol style="list-style-type: none"> Essex, Hampden, Suffolk, Middlesex, Plymouth Essex, Middlesex, Suffolk, Worcester, Hampden, Plymouth Plymouth Middlesex Hampden Middlesex, Plymouth, Suffolk, Hampden
<p>Homicide/Abuse/Neglect:</p> <ol style="list-style-type: none"> For all unexpected deaths of infants, a protocol should be established requiring a post mortem radiological skeletal survey at the hospital, interpreted by a radiologist familiar with child abuse, and not at the expense of the family. There should be a mandate to report the existence of drugs in the child at birth. 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. 	<ol style="list-style-type: none"> Hampden Hampden Hampden
<p>Illness-Related Deaths:</p> <ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> Middlesex, Hampden Middlesex, Hampden Middlesex, Hampden
1- 4 years	
<p>Homicide/Abuse/Neglect:</p> <ol style="list-style-type: none"> Interagency coordination should be improved between the time a DSS investigation occurs and the hearing. Police investigators and MDs should testify at hearings. Enhance broad-based screening for domestic violence. Include age of parents on death certificates. Young parents may be at particular risk for child abuse. Increased cross-disciplinary training on co-occurrence of domestic 	<ol style="list-style-type: none"> Essex Middlesex, Suffolk Essex, Hampden Suffolk

<p>violence and child</p> <ol style="list-style-type: none"> 5. 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? 6. Training of DSS staff on early development issues 	<ol style="list-style-type: none"> 5. Middlesex 6. Hampden
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Appendix D: LOCAL TEAM RECOMMENDATIONS, 2001-2004 (cont.)

Recommendation	Team Submitting
1- 4 years (cont.)	
<p>Unintentional Injury Deaths:</p> <ol style="list-style-type: none"> 1. Conduct public education campaign on importance of window guards to prevent falls. 2. DSS should conduct home safety inspections for children on its caseload. 3. Changes in codes for securing bike racks to ground are needed. 4. Fire alarms should be periodically inspected, difficult to shut off. There should be separate breakers for alarms; they should be hard wired. 5. Look into whether building materials for decks are contributing to heatstroke fatalities. 6. Investigate whether car seats are contributing to deaths of children with respiratory problems that are put to sleep in them. 7. 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? 8. All day care providers should be required to attend SIDS prevention trainings. Include sensitivity training for EMS and medical providers. 9. Amend codes to require child-resistant safety screens or window guards in homes with children. 10. Implement public awareness campaign similar to “Kids Can’t Fly” throughout MA. 11. Investigate whether non-English-speaking communities know about the dangers of balloons to young children. Consider tracking data on balloon deaths. 12. Educate non English speakers to call 911 for emergencies 	<ol style="list-style-type: none"> 1. Hampden, Worcester, Middlesex 2. Hampden 3. Plymouth 4. Essex 5. Essex 6. Hampden, Suffolk, Plymouth 7. Middlesex 8. Middlesex, Plymouth, Suffolk, Hampden 9. Middlesex 10. Middlesex 11. Middlesex 12. Middlesex
5 – 9 years	
<p>Homicide/Abuse/Neglect:</p> <ol style="list-style-type: none"> 1. Enhance broad-based screening for domestic violence. Enhance public education on domestic violence. 	<ol style="list-style-type: none"> 1. Middlesex, Suffolk
<p>Unintentional Injury Deaths:</p> <ol style="list-style-type: none"> 1. 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. 2. Fire alarms should be periodically inspected, and?? difficult to shut off. There should be separate breakers for alarms; they should be hard wired. 3. We recommend a public education campaign aimed at informing parents about the dangers of any chests or storage containers with locking mechanisms. 4. Education of youth and families should be carried out regarding the dangers of ice covering bodies of water. 5. Carry out public education regarding child drowning prevention. 	<ol style="list-style-type: none"> 1. Suffolk 2. Essex 3. Hampden 4. Essex 5. Worcester

Appendix D: LOCAL TEAM RECOMMENDATIONS, 2001-2004 (cont.)

Recommendation	Team Submitting
10 - 14 years	
<p>Homicide/Abuse/Neglect Deaths:</p> <ol style="list-style-type: none"> 1. Enhance broad-based screening for domestic violence. Enhance public education on domestic violence. 2. Interagency coordination should be improved between the time a DSS investigation occurs and the hearing. Police investigators and MDs should testify at hearings. 	<ol style="list-style-type: none"> 1. Middlesex, Suffolk, Worcester 2. Essex, Worcester, Hampden
<p>Suicide:</p> <ol style="list-style-type: none"> 1. Mental health services are inadequate and should be addressed 2. Amend CFRT Act to authorize release of adoption and pre-adoption records of children whose deaths are being reviewed. 3. 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. 4. Child Fatality Review Act should be amended to require Local Teams to include a mental health professional. 5. State should have a central fund of money to cover therapeutic school placements rather than requiring cities or towns to cover the costs. 	<ol style="list-style-type: none"> 1. Essex, 2. Middlesex 3. Middlesex 4. Middlesex 5. Middlesex
<p>Unintentional Injury Deaths:</p> <ol style="list-style-type: none"> 1. Legislation for mandatory helmet & other protective gear for skateboarders. Provide safe spaces for skateboarders. Distribute safety instructions at schools. 2. Fire alarms should be periodically inspected, difficult to shut off, with separate breakers for alarms, and hard wired. 3. We recommend a public education campaign aimed at informing parents about the dangers of any chests or storage containers with locking mechanisms. 4. We recommend a public education campaign on the dangers of recreational vehicles and snowmobiles in the hands of children. 5. We recommend mandatory headgear, at least for children, driving or riding recreational vehicles and snowmobiles. 	<ol style="list-style-type: none"> 1. Plymouth 2. Essex 3. Hampden 4. Hampden 5. Hampden
<p>Illness-Related Deaths:</p> <ol style="list-style-type: none"> 1. Review of school protocols on food allergies 	<ol style="list-style-type: none"> 1. Essex
15 – 17 years	
<p>Homicide/Abuse/Neglect:</p> <ol style="list-style-type: none"> 1. The State Team should begin a statewide discussion on how underage social clubs are regulated in MA cities and towns. 	<ol style="list-style-type: none"> 1. Essex
<p>Suicide:</p> <ol style="list-style-type: none"> 1. Mental health services are inadequate and should be addressed. 2. An alliance should be developed between mental health and medical communities for suicide prevention and risk detection. 	<ol style="list-style-type: none"> 1. Essex, Middlesex 2. Essex

Appendix D: LOCAL TEAM RECOMMENDATIONS, 2001-2004 (cont.)

Recommendation	Team Submitting
15 – 17 years (cont.)	
<p>Unintentional Injury Deaths:</p> <ol style="list-style-type: none"> 1. Fire alarms should be periodically inspected, difficult to shut off, have separate breakers and be hard wired 2. Individual localities should establish by-laws for operation of ATVs. 3. Is there an E Code for dirt bikes/ATVs? Implement public awareness campaign 4. Pass a primary seat belt law. 5. Amend junior driver law to prohibit cell phone use while driving 6. Conduct a seatbelt education campaign 	<ol style="list-style-type: none"> 1. Essex 2. Essex, Middlesex, Hampden 3. Middlesex 4. Middlesex 5. Worcester
Recommendations for All Age Groups:	
<p>Homicide/Abuse/Neglect:</p> <ol style="list-style-type: none"> 1. Legislation should be passed mandating that DSS immediately notify police in any fatality of a child under their jurisdiction. 2. 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. 3. To rule out abuse, 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. 	<ol style="list-style-type: none"> 1. Hampden 2. Middlesex 3. Hampden
<p>Unintentional Injury Deaths:</p> <ol style="list-style-type: none"> 1. Develop PSAs and public education at beginning of winter about car grills and tailpipes covered with snow. 2. Hospitals and pediatricians should provide literature and education about products that have been recently removed from market. 3. Ask NHTSA to open investigation into Ford Windstar for possible defects in the van door (which slid closed, struck a child’s head and killed him). NHTSA should be asked to review all minivan doors for safety concerns. 4. Extend bicycle helmet law to all persons regardless of age. Amend law to include enforcement mechanism. Implement public awareness campaign. 	<ol style="list-style-type: none"> 1. Essex 2. Middlesex 3. Middlesex 4. Middlesex
<p>Procedural Recommendations:</p> <ol style="list-style-type: none"> 1. 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. 2. The State CFR Team should send letter to hospitals encouraging the reporting of deaths to the Medical Examiner. 3. Develop consistent investigating and reporting of unexplained deaths through development of statewide protocols 4. The State Team should develop written materials to inform and educate physicians regarding their obligations to fill out death certificates in a timely manner. 5. Hospitals need to initiate protocols, which include provider cooperation with police to assist them in speaking with family members as soon as 	<ol style="list-style-type: none"> 1. Hampden 2. Hampden 3. Plymouth, Suffolk 4. Hampden 5. Hampden

possible and getting statements from them in a sensitive manner regarding the death.	
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Appendix E: Mandated Team

Mandated State Team Members - 2005	Name
Chief Medical Examiner (chair)	Mark Flomenbaum
Attorney General, or designee	Emily Paradise
Commissioner of Dept. of Social Services, (DSS) or designee	Scott Scholefield
Commissioner of Dept. of Public Health, (DPH) or Designee	Sally Fogerty
Commissioner of Dept. of Education, or designee	John Bynoe
Commissioner of Dept. of Mental Retardation, or designee	Mark Fridovich
Commissioner of Dept. of Mental Health, or designee	Gordon Harper
Commissioner of Dept. of Youth Services, or designee	Susan Campbell
Representative of Mass. DA's Association	Kim Aliprantis
Colonel or State Police, or designee	Laura Beurman Ellison Brian X. Lilly Mary McClain
Director of Mass. Center for Sudden Infant Death Syndrome (SIDS), or designee	
Rep. of Mass. Chapter of the American Academy of Pediatrics with experience in child abuse and neglect	Ed Bailey
Rep. of the Mass. Hospital Association	Anuj Goel
Chief justice of the juvenile division of the trial court, or designee	Martha Grace
Pres. of Mass. Chiefs of Police Association, or designee	Tom O'Loughlin
Child Advocate	Not filled
Anyone else with information relevant to cases under Review	