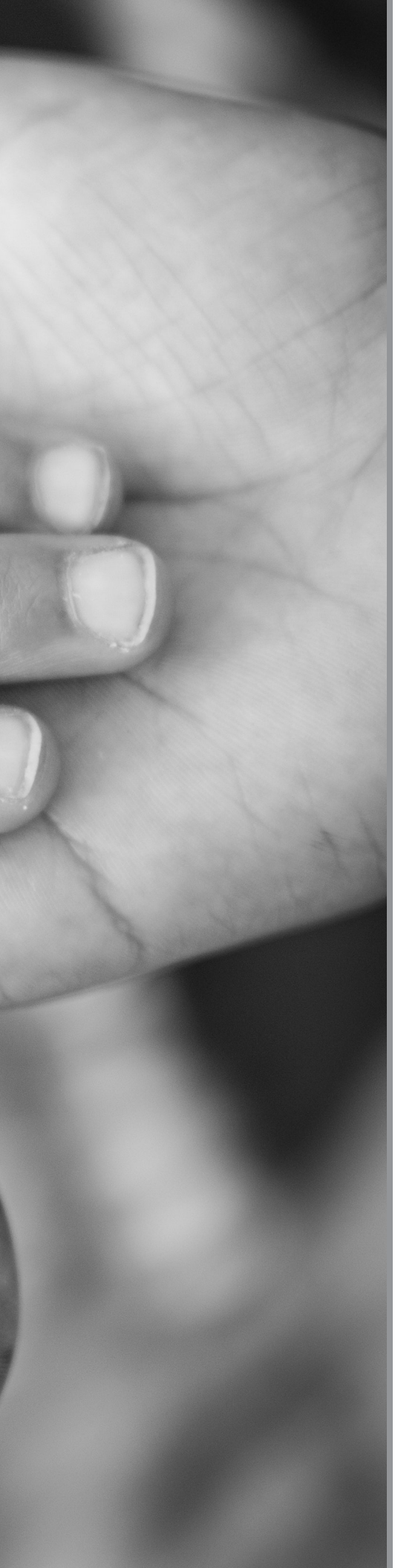
MASSACHUSETTS CHILD FATALITY REVIEW ANNUAL REPORT

January to June 2018 Supplement



MASSACHUSETTS

CHILD FATALITY REVIEW

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MESSAGE FROM **THE CHAIRPEOPLE**

Dr. Mindy Hull
& Rebekah Thomas

Dear Stakeholders:

A child's death is a sentinel event that should urge communities to identify other children at risk for illness or injury[1]. The purpose of Child Fatality Review (CFR) is to conduct a comprehensive, multi-disciplinary review of child deaths, to better understand how and why children die, and to use the findings to take action that can prevent additional deaths and improve the health and safety of children. In Massachusetts, the Child Fatality Review Program is governed by Massachusetts General Laws (MGL) Chapter 38 §2A. Local child fatality review teams examine the circumstances of child deaths under their jurisdiction to determine if the death was preventable and to formulate recommendations outlining education, policy, and prevention action steps that can prevent similar deaths from occurring. These local recommendations inform the statewide prevention efforts of the State CFR Team.

The purpose of the state team shall be to decrease the incidence of preventable child fatalities and near fatalities by: (i) developing an understanding of the causes and incidence of child fatalities and near fatalities; and (ii) advising the governor, the general court and the public by recommending changes in law, policy and practice that will prevent child fatalities and near fatalities.

1 The National Center for the Review & Prevention of Child Deaths, Michigan Public Health Institute. Retrieved on July 16, 2015 from https://www.ncfrp.org/cdr-process/cdr-principles

This annual report is a requirement of MGL Chapter 38 §2A. It reviews the changes that occurred during the reporting time period and the activities conducted by local and state teams. Please note that prior to writing this report, the state team determined that reporting on the state fiscal year (SFY) rather than calendar year is more appropriate. Therefore, the present report covers the gap (January through June 2018) between calendar year 2017 (January-December 2017) and SFY19 (July 2018 – June 2019).

Respectfully,

DR. MINDY HULL
State Team Co-Chair

REBEKAH THOMAS
State Team Co-Chair

CHANGES TO THE **CHILD FATALITY REVIEW** PROGRAM

Several key program changes occurred during the timeframe of the present report. This includes: edits and updates to the Child Fatality Review Program Guidelines and representation from the Department of Public Health to the State and Local Teams.

PROGRAM GUIDELINE EDITS

In 2016 the Office of the Child Advocate (OCA), as a member of the State CFR Team, agreed to take the lead on a comprehensive needs assessment of the Child Fatality Review program. The project resulted two reports:

1) Findings from the Local Teams (June 2017)
2) Findings from the State Team (March 2018)

The report findings included recommendatins to:

- Provide infromation and resources on common issues to local teams
- Improve communications with local teams
- Provide technical assistance to local teams
- Develop a State Team manual
- Change State Team internal communications
- Add a public policy component to the CFR program
- Develop a budget proposal and identify strategies to obtain funding

In an effort to respond to the findings of the OCA needs assessments and systematize the Massachusetts Child Fatality Review Program operations, a workgroup of State and Local Team members reviewed, revised, and expaned the existing program guidelines. The revised guidelines aim to maximize clarity in roles and responsibilities, improve consistence across teams, leverage existing workflows and operations of the State and Local Team settings, and infuse suggested best practices by the National Center for Child Fatality Review and Prevention.

The revisions and expansions consisted of the following and are elaborated on in subsequent sections:

- Description of the Principles of Prevention
- Updates to the Local Team Guidelines & the creation of tools
- Creation of State Team Guidelines
- Self-Care

It is literally true that you can succeed best and quickest by helping others to succeed.

Napolean Hill

PRINCIPLES OF **PREVENTION**

Because the cornerstone of the child fatality review process is the creation of recommendations that prevent similar fatalities from happening in the future, the CFR program guidelines were amended to include descriptions of three different prevention models. While each model presents the information in different manners, members can familiarize themselves with the frameworks in order to develop action oriented and clear prevention recommendations. The three frameworks include:

THE FOUR E'S

This framework can be used to understand what can be done to prevent injury-related deaths. Each of the categories can be acted on individually but have a symbiotic and compounding benefit when approached in multiples.

Engineering: Modifications to the environment or to products to make them safer.

Enforcement: Implementation or development of laws and policies that prevent death.

Education: Providing information needed to make safe choices by both the public and professionals.

Emergency Medical Services: Assuring that injured individuals receive quality trauma management.

THE SPECTRUM OF PREVENTION

The Spectrum of Prevention was originally developed by Larry Cohen and has six levels of intervention to illustrate the premise that prevention is merely education. While each level can be acted upon individually, the effects are greater when used together.

Alone we can do so little; together we can do so much.

Helen Keller

THE SOCIO-ECOLOGICAL MODEL

Developed by the CDC, the Socio-Ecological Model addresses the factors that influence health outcomes. The structure of this model emphasizes the relatedness of health outcomes across different areas of influence and can help local teams determine where an action or intervention should take place.

UPDATES TO **LOCAL & STATE** TEAMS

LOCAL TEAMS

Using the statute as a template, the guidelines workgroup developed and refined tools that are intended to assist the teams in records collection, case review and developing recommendations. Included in the resources are the following tools:

CLARIFICATION FOR LOCAL TEAM MEMBERSHIP AND EXPECTATIONS

PROCESSES FOR LOCAL TEAM REVIEW AND RECOMMENDATION DEVELOPMENT

SAMPLE ATTENDANCE TRACKING TOOL

MATRIX OF RECORDS TO REQUEST BASED ON THE MANNER OF DEATH

SAMPLE RECORD REQUEST LETTER

SAMPLE CONFIDENTIALITY STATEMENT FOR USE DURING MEETINGS

REVISED CASE DEATH REPORTING FORM

MGL Chapter 38 §2A lists the agencies required to have representation at both the state and local team meetings. In 2018, DPH underwent operational changes which altered the representation provided to state and local teams. Alterations included changing the DPH designee for the state team and designating a single DPH representative to attend all local team reviews, rather than spreading local team representation across numerous different representatives. Because DPH is responsible for the collection of case review information and recommendations, as well as entering this information into the child fatality review database, this change allowed for increased capacity to offer technical assistance to local teams as well as the ability to be a clear conduit of communication between the local and state teams.

STATE TEAM

There were no pre-existing guidelines for the state child fatality review team other than the statute. To improve the functioning and understanding of the roles of the state team members, the workgroup, led by DPH, developed guidelines based on the statute and the needs identified through the OCA state team needs assessment. The needs and objectives of the state team are the following:

IDENTIFY SYSTEMIC RESPONSES TO COMMON ISSUES BY LOCAL TEAMS

IDENTIFY TRENDS OR PATTERNS IN CHILD DEATHS BASED ON LOCAL TEAM RECOMMENDATIONS

SHARE INFORMATION AND RESOURCES FROM AGENCIES THAT THE MEMBERS REPRESENT THAT CAN ADDRESS MATTERS DISCUSSED AT STATE CHILD FATALITY REVIEW MEETINGS

IDENTIFY POLICIES AND PROCEDURES IN RESPECTIVE AGENCIES THAT CAN BE MODIFIED TO REDUCE CHILD DEATHS

ASSIST IN DRAFTING STATEWIDE RECOMMENDATIONS TO THE GOVERNOR AND LEGISLATURE IN THE ANNUAL REPORT

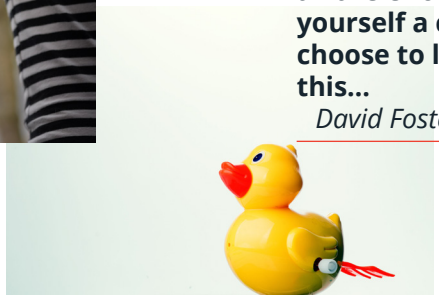
To that effect, the new guidelines consist of the following:

DESCRIPTION OF THE PURPOSE AND OBJECTIVES OF THE STATE TEAM

DESCRIPTION OF STATE TEAM MEMBERSHIP, ROLES, RESPONSIBILITIES, AND EXPECTATIONS

PROCEDURES FOR RECOMMENDATION REVIEW AND ANNUAL REPORT WRITING

> **But most days, if you're aware enough to give yourself a choice, you can choose to look differently at this...**
> *David Foster Wallace*



LOCAL TEAM
MEETINGS & REVIEWS

From January through June 2018, 6 of the 11 local teams met at least once. In total, 9 meetings occurred resulting in the review of 51 cases and 33 recommendations. See Appendix 2 for details on the teams that met, meeting dates, number of cases reviewed, manner of death for those cases, and number of recommendations submitted by the teams.

STATE TEAM
MEETINGS & MINI-RETREAT

From January through June 2018, the state team met three times - January 10th, April 11th and June 6th. The June meeting acted as a half day mini-retreat, to which local and state team members were invited. During the meeting, the OCA presented findings from the state team needs assessment, DPH presented the proposed local and state team guidelines draft and the National Center for Child Fatality Review and Prevention presented on identifying risk factors, applying prevention principles and writing actionable recommendations.

Children are great imitators. So give them something great to imitate.

Anonymous

The purpose of each local team shall be to decrease the incidence of preventable child fatalities and near fatalities by: (i) coordinating the collection of information on fatalities and near fatalities; (ii) promoting cooperation and coordination between agencies responding to fatalities and near fatalities and in providing services to family members; (iii) developing an understanding of the causes and incidence of child fatalities and near fatalities in the county; and (iv) advising the state team on changes in law, policy or practice which may affect child fatalities and near fatalities.

REVIEWS

51 **CASES**

33 **RECOMMENDATIONS**

ANNUAL REPORT
CONCLUSION

MASSACHUSETTS CHILD FATALITY REVIEW

From January through June 2018, the state child fatality review program took important steps to better meet the mandate of Massachusetts General Law Chapter 38 §2A. Those steps included:

RESPONDING TO THE NEEDS ASSESSMENT CONDUCTED BY THE OCA BY REVISING AND EXPANDING PROGRAM GUIDELINES

REFINING REPRESENTATION TO STATE AND LOCAL TEAM MEETINGS

MEETING REGULARLY AND TRACKING INFORMATION

As a result of these program improvements, it is expected that in FY19:

LOCAL TEAMS WILL OPERATE WITH CLEARER GUIDELINES AND MORE CONSISTENCY, THEREFORE DEVELOPING MORE ACTION-ORIENTED AND CONTEXTUAL RECOMMENDATIONS

THE STATE TEAM WILL FOCUS MORE CLOSELY ON RECOMMENDATIONS FROM LOCAL TEAMS

THE OVERALL PROCESS WILL RESULT IN CLEARER AND MORE ACTIONABLE RECOMMENDATIONS TO THE GOVERNOR AND LEGISLATURE

The public health of five million children should not be left to luck or chance.
Jamie Oliver

APPENDIX 1:
CHILD FATALITY REVIEW
TEAM MEMBERS

STATE TEAM

CHIEF MEDICAL EXAMINER (CO-CHAIR)

COMMISSIONER OF THE DEPARTMENT OF PUBLIC HEALTH, OR DESIGNEE (CO-CHAIR)

ATTORNEY GENERAL, OR DESIGNEE

COMMISSIONER OF THE DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION, OR DESIGNEE

COMMISSIONER OF THE DEPARTMENT OF MENTAL HEALTH, OR DESIGNEE

COMMISSIONER OF THE DEPARTMENT OF DEVELOPMENTAL SERVICES, OR DESIGNEE

COMMISSIONER OF THE DEPARTMENT OF CHILDREN AND FAMILIES, OR DESIGNEE

COMMISSIONER OF THE DEPARTMENT OF YOUTH SERVICES, OR DESIGNEE

REPRESENTATIVE OF THE MASSACHUSETTS DISTRICT ATTORNEYS ASSOCIATION

COLONEL OF THE MASSACHUSETTS STATE POLICE, OR DESIGNEE

DIRECTOR OF THE MASSACHUSETTS CENTER FOR UNEXPECTED INFANT AND CHILD DEATH, OR DESIGNEE

REPRESENTATIVE OF THE MASSACHUSETTS CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS WITH EXPERIENCE IN CHILD ABUSE AND NEGLECT

REPRESENTATIVE OF THE MASSACHUSETTS HOSPITAL ASSOCIATION

CHIEF JUSTICE OF THE JUVENILE DIVISION OF TRIAL COURT, OR DESIGNEE

THE CHILD ADVOCATE, OR DESIGNEE

OTHER INDIVIDUALS WITH INFORMATION RELEVANT TO CASES UNDER REVIEW

LOCAL TEAMS

DISTRICT ATTORNEY OF COUNTY (CHAIR)

CHIEF JUSTICE OF THE JUVENILE DIVISION OF TRIAL COURT, OR DESIGNEE

CHIEF MEDICAL EXAMINER, OR DESIGNEE

COMMISSIONER OF THE DEPARTMENT OF PUBLIC HEALTH, OR DESIGNEE

COMMISSIONER OF THE DEPARTMENT OF CHILDREN AND FAMILIES, OR DESIGNEE

DIRECTOR OF THE MASSACHUSETTS CENTER FOR UNEXPECTED INFANT AND CHILD DEATH, OR DESIGNEE

PEDIATRICIAN WITH EXPERIENCE IN CHILD ABUSE AND NEGLECT

LOCAL POLICE OFFICER FROM THE COMMUNITY WHERE THE FATALITY OCCURRED

STATE LAW ENFORCEMENT OFFICER

OTHER INDIVIDUALS WITH INFORMATION RELEVANT TO CASES UNDER REVIEW

APPENDIX 2: **LOCAL TEAM** MEETINGS, REVIEWS, AND RECOMMENDATIONS

Team	Meeting Dates	Case Review Forms Submitted	Manner of Death						Unique Recommendations
			Accident	Homicide	Natural	Suicide	Undetermined	Missing	
Berkshire	-	-	-	-	-	-	-	-	-
Bristol	-	-	-	-	-	-	-	-	-
Cape & Islands	-	-	-	-	-	-	-	-	-
Essex	04/18/2018	-	3	-	1	-	-	-	0
Hampden	06/20/2018	7	-	-	3	-	4	-	7
Middlesex	03/29/2018 06/15/2018	3 4	1 1	- -	- -	1 -	- 1	1 2	17
Norfolk	01/10/2018 03/21/2018 06/20/2018	9 4 2	- - -	- - 1	9 3 1	- 1 -	- - -	- - -	3
Northwest	-	-	-	-	-	-	-	-	-
Plymouth	04/26/2018	3	1	-	-	1	1	-	6
Suffolk	-	-	-	-	-	-	-	-	-
Worcester	02/22/2018	19	7	-	9	2	1	-	0
TOTAL	9	51	13	1	26	5	7	3	33

ACKNOWLEDGEMENT

We would like to take a moment to acknowledge the hard work and dedication that every participant of both the State and Local teams contributes to the efforts of child fatality review. Reviewing circumstances surrounding any death is never easy and it is that much more difficult when it is a child.

Through your commitment to this program, recommendations are created in an effort to prevent similar unfortunate circumstances from occurring again.

Thank you.

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