CHILD FATALITY REVIEW LOCAL TEAM GUIDELINES

Massachusetts

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Table of Contents

List of Tables

List of Figures

List of Tools and Templates

Appendices

Introduction

Background and Purpose of the Massachusetts CFR Program

In 2000, Massachusetts General Law (M.G.L.) Chapter 38, Section 2A established a Child Fatality Review (CFR) Program to decrease the incidence of preventable fatalities and near-fatalities of children under the age of 18 years. The law created a State Team within the Office of the Chief Medical Examiner chaired by the Chief Medical Examiner and Local Teams in each of the 11 districts headed by a District Attorney (DA) and chaired by a representative from the DA's office.

The purpose of the CFR program is to review child fatalities and near-fatalities from across the state to learn the circumstances of those deaths and find ways to protect the health and safety of children in the Commonwealth in the future. The Local CFR Teams (Local Teams) bring together professionals across agencies and disciplines to conduct individual case reviews of child fatalities and near-fatalities to understand the circumstances and causes of the child's death or near-death. When a Local Team review identifies an opportunity to improve policy or practice across the state, the Local Team formulates a recommendation, which is interpreted as a problem statement by the State Team for the purposes of these guidelines. Those problems statements are sent to the State Team for review.

The State Team reviews all problem statements from Local Teams through the expertise of the members of the State Team and invites other outside experts to State Team meetings to facilitate comprehensive reviews of problem statements. The State Team works to implement some of these changes through the work of its member agencies, and advances others by issuing recommendations to the legislature, Governor, and other entities for statewide action.

Purpose of Local Teams

Under the Massachusetts CFR statute, the purpose of the Local Teams is to reduce the number of child fatalities and near-fatalities by:

- collecting information related to individual fatalities,
- conducting comprehensive multidisciplinary reviews of individual fatalities that highlight how and why the fatality occurred,
- developing actionable problem statements and recommendations for changes in law, policy, and practice that, if implemented, will reduce the number of child fatalities and near-fatalities, and
- promoting collaboration among the agencies that respond to child deaths and provide services to family members experiencing child deaths.

Purpose of these Guidelines

This document is a set of guidelines written to support Local Teams in Massachusetts. This guidance is intended to provide basic operating standards to enhance consistency of local reviews across the Commonwealth.

These guidelines were developed in consultation with the State CFR Team as part of its duty to provide technical assistance and set standards for the CFR Program. They draw on feedback from and expertise

of State Team members, Local Team Members, and program staff, and incorporate materials produced by the National Center for Child Fatality Review and Prevention (NCFRP).

The guidelines begin by describing frameworks and principles that Local Teams should apply to their case reviews. These frameworks help the Local Team members go beyond review of the immediate facts of the case to a broader review of the societal forces that may affect the risks and opportunities surrounding a case. After the frameworks, the guidelines talk about the Local Team members and the roles and functioning of the Local Team. The guidelines then discuss how the Local Team gathers records to enable case reviews and then how the case reviews should occur.

Local Teams are responsible for reviewing fatalities and near-fatalities. As there is no pre-defined pathway for the Local Teams to be notified of near-fatalities, reviewing near-fatalities rarely occurs. Therefore, this document primarily refers to "fatalities" throughout. However, any language in this document that is relevant to fatalities is also relevant to near-fatalities when the Local Team has been made aware of the near-fatality.

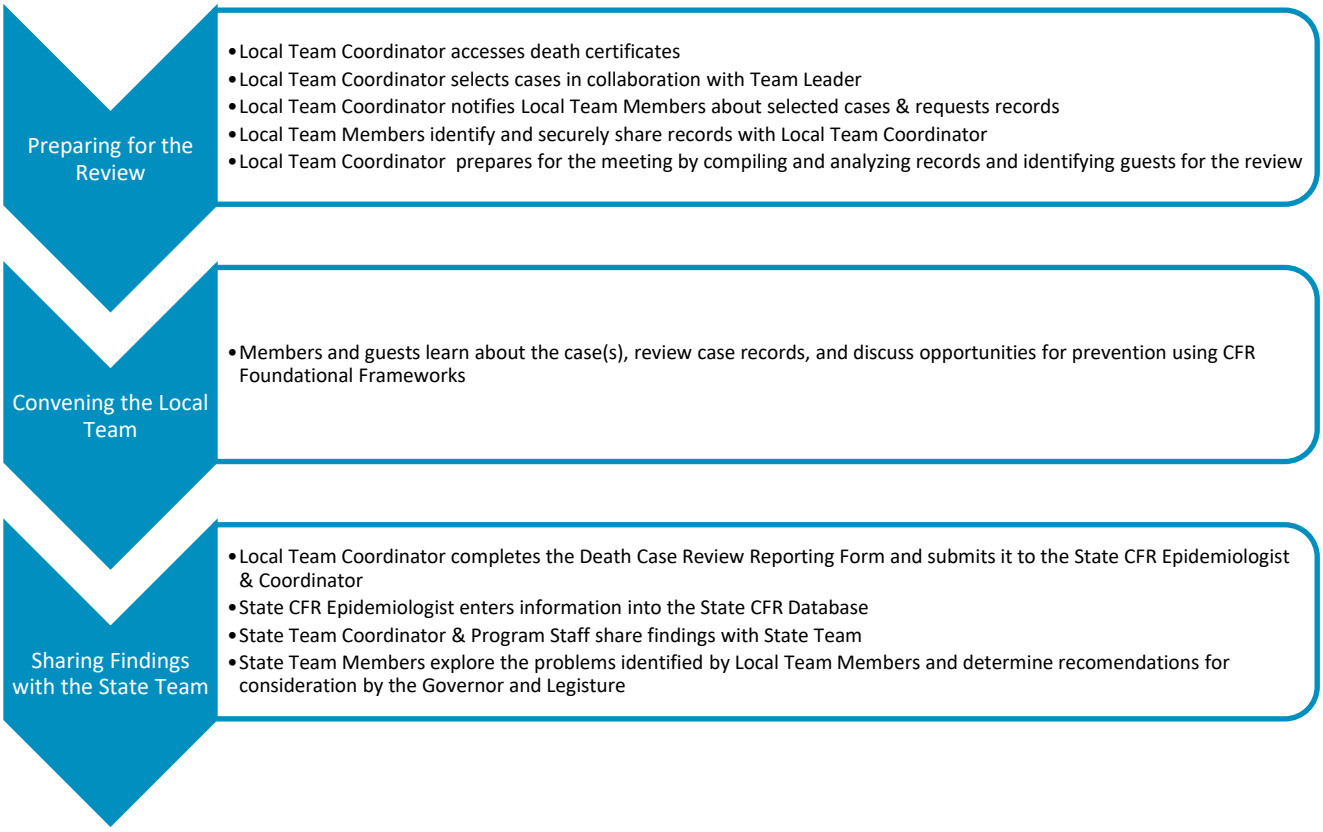
This set of guidelines has some sample letters in the appendix that may be of particular help to Local Teams.

Case Study: Unintentional Drowning

In order to help Local Teams apply concepts presented in these guidelines to their CFR work, a hypothetical case study of an 11-year-old African American boy who died via an unintentional drowning is presented throughout this document. This topic is presented given the increased risk of drowning among Black Americans in Massachusetts (MA). In 2020 in MA, Black non-Hispanic children were 7 times more likely to die due to drownings compared to White, non-Hispanic children. (MA CFR Annual Report FY20.)

Selected Case: Jamal is an 11-year-old Haitian American boy who lived in a highly segregated, low-income neighborhood. His parents are Haitian immigrants. In his city-run summer camp he recently became friends with another boy who invited him to swim at a local lake, where he drowned.

Figure 1. CFR Process Diagram



Foundational Frameworks, Principles, and Concepts

The following concepts and frameworks underpin the purpose and approach of the Child Fatality Review Program in Massachusetts. These foundational frameworks were identified and implemented by the Department of Public Health which facilitates the CFR programs. Local Team members should have working knowledge of and comfort with these frameworks before engaging in a case review.

Health & Racial Equity

Health equity refers to an ideal state where every person has the opportunity to attain their full health potential and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."[1] In practice, achieving health equity means that "every person has an opportunity to achieve optimal health regardless of: the color of their skin, level of education, gender identity, sexual orientation, the job they have, the neighborhood they live in, [or] whether or not they have a disability."[2] Racial equity is a key component part of health equity and is "a process of eliminating racial disparities and improving outcomes for everyone. It is the intentional and continual practice of changing policies, practices, systems, and structures by prioritizing measurable change in the lives of people of color." (Appendix B. provides definitions for equity-related key terms presented throughout this document.)

In Massachusetts, substantial inequities exist in infant and child fatalities. Boys, children of color, and infants living in urban centers are all at higher risk of fatality than other similarly situated groups.[3] These inequities are not rooted in biological differences between races and ethnicities, nor are they inherent to other aspects of a child's race or ethnicity. Rather, they are linked to social and structural determinants of health, including factors like socioeconomic status and access to health care. The advancement of health and racial equity is both a moral imperative and a critical element to meeting the CFR Program's charge of decreasing preventable fatalities and near-fatalities. All children should be able to live and flourish in Massachusetts. By improving equitable access to healthy and safe conditions for children, Massachusetts can address the social and structural inequities contributing to fatalities and near-fatalities that are disproportionately affecting children with historically marginalized identities. By recommending interventions that support those who are most marginalized, the CFR Program will create better conditions for all to not only survive, but to thrive.

Local Teams are uniquely positioned to identify conditions leading to inequitable fatalities and near-fatalities. Accordingly, the CFR Program is committed to advancing health and racial equity by addressing systemic inequities and oppression related to infant and child fatalities by:

1. ensuring health and racial equity are a central component throughout the case review process, and

[1] Centers for Disease Control and Prevention. (2022, March 1). Health Equity - Office of Minority Health and Health Equity - CDC. Centers for Disease Control and Prevention. https://www.cdc.gov/healthequity/index.html

[2] Centers for Disease Control and Prevention – Division of Community Health. A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease. Atlanta, GA: US Department of Health and Human Services; 2013. Retrieved from: https://www.cdc.gov/nccdphp/dch/pdf/HealthEquityGuide.pdf

[3] Massachusetts Child Fatality Review FY2021 Annual Report

2. developing problem statements or recommendations that advance health and racial equity and seek to address social and structural determinants of health (see more regarding these terms below).

Local Teams must have a thorough understanding of the history, present-day realities, and trends of the communities in which they work to effectively address health equity. The Center for Disease Control's (CDC) *A Practitioner's Guide for Advancing Health Equity* explains:

> Without a clear understanding of existing health inequities, well-intentioned strategies may have no effect on or could even widen health inequities. It is critical to have a clear understanding of what inequities exist, and the root causes contributing to them. Clearly identify and understand health inequities to establish baselines and monitor trends over time, inform partners about where to focus resources and interventions, and ensure strategies account for the needs of populations experiencing health inequities.

The following frameworks and resources support that exploration.

Social and Structural Determinants of Health

Some of the circumstances contributing to a child's death that can be initially seen as individual-level factors are the result of social and structural determinants of health. Social determinants of health are the conditions in which people are born, live, learn, work, play, worship, and age. [4] These conditions impact health outcomes, including infant and child mortality. Social determinants of health include: [5,6,7]

- Built environment and neighborhood
- Education access and quality
- Employment and economic stability
- Housing
- Social environment
- Access to nutritious foods and physical activity opportunities
- Air and water quality
- Language and literacy skills
- Health care access and quality

Social determinants highlight specific social and economic conditions that directly influence health, while structural determinants of health describe underlying structures and systems that create and sustain those social and economic conditions. Structural determinants of health are the "cultural norms, policies, institutions, and practices that define the distribution of social determinants of health."[8] They emphasize the power dynamics, social hierarchies, and institutional arrangements that influence health outcomes. Examples of structural determinants of health include:

[4] U.S. Department of Health and Human Services. Healthy People 2030: Social Determinants of Health. Retrieved from: https://health.gov/healthypeople/objectives-and-data/social-determinants-health
[5] U.S. Department of Health and Human Services. Healthy People 2030: Social Determinants of Health. Retrieved from: https://health.gov/healthypeople/objectives-and-data/social-determinants-health
[6] Mass.gov. PHIT Community Reports. Retrieved from: https://www.mass.gov/phit-community-reports
[7] Centers for Disease Control and Prevention. About Social Determinants of Health (SDOH). Retrieved from: https://www.cdc.gov/socialdeterminants/about.html
[8] Joia Crear-Perry, Rosaly Correa-de-Araujo, Tamara Lewis Johnson, Monica R. McLemore, Elizabeth Neilson, and Maeve Wallace.Journal of Women's Health.Feb 2021.230-235.http://doi.org/10.1089/jwh.2020.8882

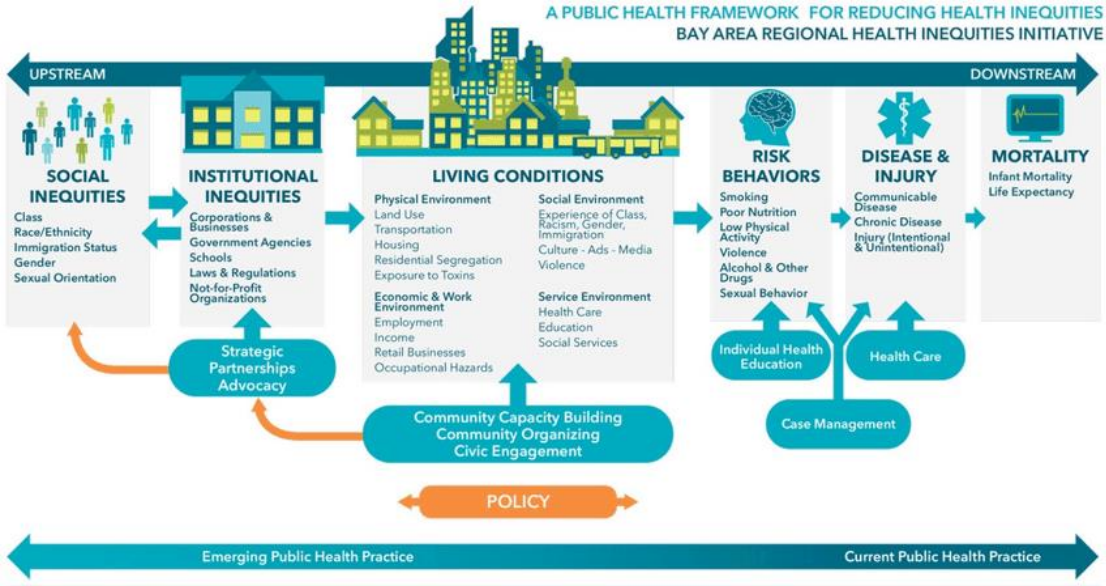
- Discrimination and Social Inequities
- Public Policy, Wealth, and Resource Distribution
- Heath and Insurance Systems
- Licensing and Permitting Systems
- Screening and Referral Systems

Disparate access to social determinants and experience with structural determinants can lead to health inequities.[9] Disparate access, and ultimately disparate health outcomes, often result from systems of privilege and oppression based on social identities. These systems include doctrines, beliefs, or ideologies often referred to as "-isms", such as racism, sexism, nationalism. Each -ism works in combination and can inhibit or prevent access to and experience with structural determinants, which then manifests as social determinants, which vary based on social identity.

It is important to note that individuals' experiences do not differ along each of these identities in isolation, but rather their experiences result from each person's own unique combinations of these identities. This is known as intersectionality. An intersectional approach requires that the Local Team consider the ways individuals uniquely experience discrimination and oppression as a result of each individual's unique combination of numerous and different identities.

Social identities can lead to a person's direct experience of interpersonal discrimination (e.g., racism), however what can be even more harmful is how identities shape individuals' risks for poor health outcomes through social and structural determinants of health.

Figure 2. Root Causes of Health Inequities: BARHII Framework



[9] National Center for Fatality Review and Prevention. Session 13: Using Health Equity in Fatality Review. Retrieved from: https://mediasite.mihealth.org/Mediasite/Play/d0efa7aafc3942e29d9501c07e6f65e91d?catalog=db105963-a5d6-42c9-b623-7f5de124c02a

Appling Concepts: Racial Inequities

Local Teams should also work to understand what contributes to racial inequities in a community to inform their case reviews. As the National Center Guidance Report Improving Racial Equity in Fatality Review explains: "[t]hrough settlement and colonization, slavery, the Oregon Trail, the Trail of Tears, the Great Migration, war, politics, reconstruction, Jim Crow, the war on drugs, wage inequality, and modern-day redlining, each U.S. city has a history of oppression that can be discovered and analyzed." [10]

Through historical and present-day policies U.S. governments and private institutions have developed systems of advantage based on race where white individuals experience power and privilege while people of color face discrimination and oppression.[11] Local Teams should consider how these systems, like health care, education, housing and economic development, child welfare, and juvenile justice affect the well-being of children in their communities.

Case Study: Social and Structural Determinants of Health and Racial Equity

Below is an example of how to apply the lenses of health equity, racial equity, and social and structural determinants of health to the case example.

HISTORICAL FACTORS. Jamal was at increased risk of drowning due to historical factors shaped by anti-Black racism that have consequences that persist to this day. For example, people who were enslaved were prohibited from swimming due to concerns they would escape. In the early 20th century, there was a surge in public swimming pools and private swim clubs that were not accessible to Black residents because of Jim Crow segregation, racially restrictive covenants, and other discriminatory municipal codes.

PRESENT DAY FACTORS. Swim clubs and private pools continue to be largely inaccessible on the basis of race and class. This is at least in part due to the legacy of redlining, and that they are not readily accessible given public transportation policy that often fails to connect low-income inner-city neighborhoods with more affluent communities. Natural water venues, such as lakes or the oceanside, are more easily accessible to some Black communities, however those contain more risk such as currents and underwater hazards. Further, historical factors have shaped cultural attitudes and perceptions that swimming is not safe for African Americans; Blacks are three times more afraid of drowning than whites (USA Swimming Foundation, 2017). Among immigrant populations, these issues are compounded by other factors: many speak languages other than English, further limiting access to swimming lessons and safety warnings; some come from nations where various conditions—like poverty or disaster—prevented them from learning how to swim; and some come from areas where water-safety rules were not enforced.

[10] National Center for Fatality Review & Prevention. National Center Guidance Report: Improving Racial Equity in Fatality Review. August 2019. Retrieved from: https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/Health_Equity_Toolkit.pdf
[11] Wellman, D. T. (1994). Portraits of white racism. Cambridge Univ. Press.

Case Study: Identity & Intersectionality

Below is an example of how to apply the lenses of identity and intersectionality to the case example.

RACISM. The summer before the drowning, a college student in Jamal's community decided to provide swimming lessons to earn some money. While he was considering areas to post flyers, he decided to skip Jamal's neighborhood because he had rarely seen African Americans at the pool and had heard that 'Black people did not and could not swim.'

INTERSECTIONALITY. Because Jamal lived in a neighborhood that is both low-income and predominantly African American, he did not have a community pool, and he never learned to swim. Thus, elements of his intersectional identities (race and socioeconomic status) put him at increased risk.

Power and Privilege

As mentioned, a person's intersectional identity, as impacted by and nested within social and structural determinants of health, can shape health outcomes including the risk of child fatality. Historical and present-day factors have created a social hierarchy whereby some groups (i.e., those who have been marginalized based on their social identities) have less access to power and privilege.

Privilege can be understood as "when one group has something of value that is denied to others simply because of the groups they belong to, rather than because of anything they have done or failed to do."[12] There are many instances in the United States of 'privileges' being withheld from, or inadequately distributed to, groups based on race, ethnicity, and socioeconomic status, including safe and affordable housing and high-quality education. One example of unnoticed privilege is related to handedness. Right-handed people have the privilege of being centered in many elements of design, which largely goes unnoticed except by those who are left-handed.

Power is defined as "access to resources and to decision-makers as well as the ability to influence others and to define reality for yourself and potentially for others."[13] It is important to note that people do not readily identify as having either power or privilege as it is often implicit and difficult to recognize.

This is an important concept for the work of the Local Teams both in case reviews and problem statement development, and for understanding the importance of Local Team Members' roles. Including considerations of how power and privilege might have impacted a child fatality or near-fatality can ensure a more accurate review, and result in a deeper understanding of systemic changes necessary to prevent fatalities and near-fatalities. Local Team Members understanding their own power and privilege as part of the CFR team can also help illuminate the ways in which their roles, and voices are critically important for advancing effective, equitable prevention strategies.

[12] The Health. Collaborative Glossary. Retrieved from: https://www.thehealthcollab.com/our-approach/collaborative-glossary
[13] The Health Collaborative. Collaborative Glossary. Retrieved from: https://www.thehealthcollab.com/our-approach/collaborative-glossary

Case Study: Power and Privilege

Below is an example of how to apply the lenses of power and privilege to the case example.

Power and privilege in this case study can be seen in the ways that historical and present-day factors intersect with "-isms" and risk factors based on Jamal's demographic characteristics. Jamal did not have the privileges of learning water safety and swimming skills. Further, community members in Jamal's chronically disinvested neighborhood had limited formal power to ensure their community or schools had a public pool and their children had access to swim lessons.

Know The Community

The State Team recommends Local Teams conduct the following activities to get to know their communities' history, present-day realities, social and structural determinants of health, and inequities. For technical assistance carrying out any of these activities, contact the State CFR Coordinator.

1. **Collect, review, and share community-level data** to understand what is happening in your community, and identify patterns and themes. Data sources include:
    a. A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease - Appendix C in the guide lists population-level data resources Local Teams can explore to identify and understand health inequities in their communities.
    b. Massachusetts's Population Health Information Tool (PHIT) - presents health data that enable Local Teams to explore issues, map their communities, and compare hundreds of health measures. Of particular note are PHIT's community reports, which present community-specific health data framed by six Social Determinants of Health: built environment, education, employment, housing, social environment, and violence.
    c. Massachusetts's Race and Hispanic Ethnicity Health Equity Dashboard – provides health outcome data from across the Department of Public Health in a centralized location. Key findings supplement charts to help viewers gain introductory level understanding of the impact of race on the health of Massachusetts residents.
    d. The Opportunity Index provides data on what opportunity looks like in the U.S. through four dimensions of community well-being: economy, education, health, and community.
    e. The Department of Public Health. The State CFR Coordinator can assist in identifying, retrieving, and interpreting data.

2. **Explore the community's social, economic, and physical environments to develop a deeper understanding of inequities.** The CDC Division of Community Health notes that "[p]artners such as local public works, transportation, and police departments may have access to other data sources (e.g., water quality, street conditions, crime statistics) which may reveal inequities related to social, economic, and physical environments."[14]

[14] Centers for Disease Control and Prevention – Division of Community Health. A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease. Atlanta, GA: US Department of Health and Human Services; 2013.

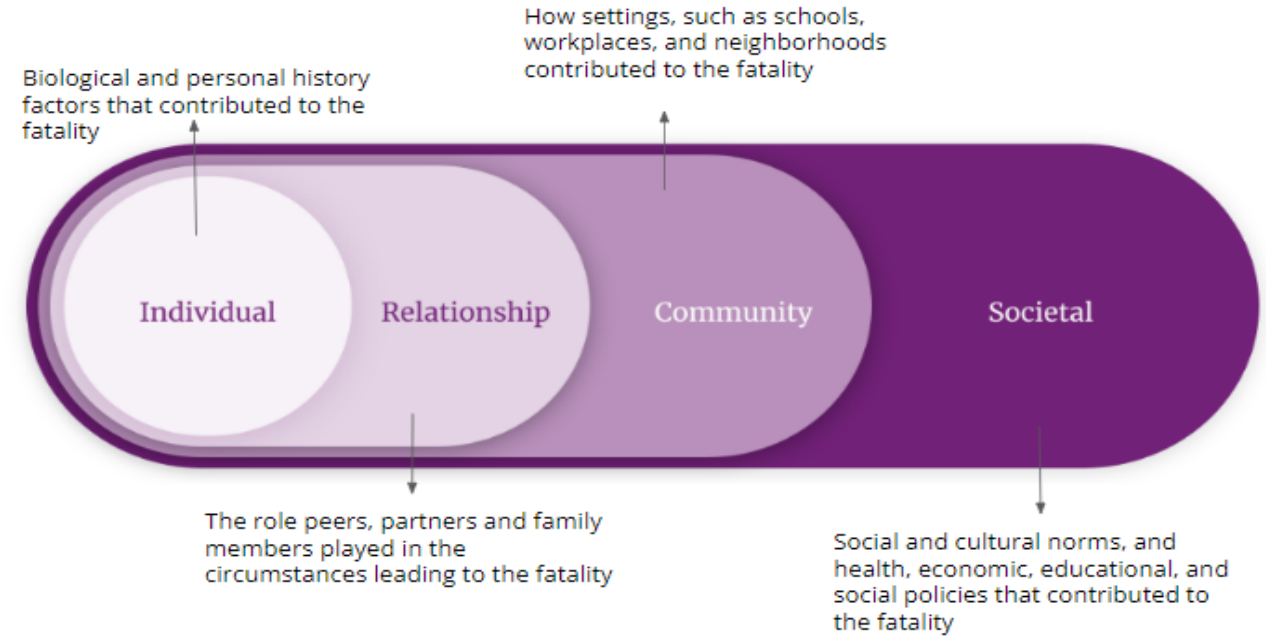
3. **Investigate the community's history and context, including long-standing policies, cultural norms, and values.** There is an array of sources that can provide detailed insights into local history that may shape the factors contributing to a fatality or near fatality:
    - Local libraries sections devoted to local history.[15]
    - Local newspapers with insights into current community activities, issues, and leaders. [16]
    - Long-time residents, professionals, or businesspeople with deep knowledge of the community.[17]
    - Historical societies, like the Massachusetts Historical Society
    - The FamilySearch Blog's 3 Websites for Finding Local History
    - The Southern Rural Development Center's guide, Community Leadership for the 21st Century: Understanding Your Community

Explore Case Complexity

Numerous factors influence health outcomes, with infant and child fatality being one such outcome. The CDC uses a four-level social-ecological model to demonstrate the effect of the various factors that put children at risk or protect them.[18] The concentric circles of the Socio-Ecological Model (Figure 2) demonstrate that each layer influences the other layers. Therefore, when reviewing child fatality and near-fatality cases, Local Teams should consider and review information at all levels of the Social-Ecological Model. Reviewing information at all levels of the model is ultimately important to inform problem statement development because sustainable prevention requires prevention approaches across all levels of the model.

[15] Pigg, Kenneth. Community Leadership for the 21st Century: Understanding Your Community. Retrieved from: http://srdc.msstate.edu/community/Understanding%20Your%20Community%20268.pdf
[16] Pigg, Kenneth. Community Leadership for the 21st Century: Understanding Your Community. Retrieved from: http://srdc.msstate.edu/community/Understanding%20Your%20Community%20268.pdf
[17] Pigg, Kenneth. Community Leadership for the 21st Century: Understanding Your Community. Retrieved from: http://srdc.msstate.edu/community/Understanding%20Your%20Community%20268.pdf
[18] Centers for Disease Control and Prevention. The Social-Ecological Model: A Framework for Prevention. January 2022.

Figure 3. Social-Ecological Model



Case Study: Factors that Contributed to the Drowning Across all Levels of the Social-Ecological Model

- **Individual-level**: Jamal did not have water safety or swimming skills.
- **Relationship-level**: Jamal's parents did not know how to swim and, therefore, were not able to pass along to Jamal key water safety and swimming skills and did not discuss the dangers of bodies of water.
- **Community-level**: Community members in Jamal's chronically disinvested neighborhood had limited formal power to ensure their community or schools had a public pool and their children had access to swim lessons.
- **Societal-level**: Historical disinvestment in low-income, African American communities and cultural attitudes and perceptions that swimming is not safe for African Americans.

Trauma Informed and Responsive

Reviewing child fatalities and near-fatalities is psychologically challenging work that can cause vicarious trauma and lead to burnout. [19] It is important for Local Teams to support members in practicing self-care.

Vicarious trauma refers to "elevated levels of exhaustion from the cumulative, repeated, pervasive, long-term stress to others' traumatic experiences."[20] This is often experienced along with compassion fatigue, where people take on the suffering of others who have experienced extreme stress or trauma, and which can be experienced as physical and mental exhaustion, and emotional numbing or withdrawal. When left unaddressed, vicarious trauma and compassion fatigue can contribute to burnout, which is characterized by feelings of defeat, pessimism, detachment, and feeling empty. Burnout leaves many feeling that the only way to relieve symptoms is to stop engaging in the work where the person is exposed to trauma. Burnout can be difficult to overcome but is more easily prevented by addressing warning signs when they initially arise. Below are guidelines for preventing and addressing burnout and fostering resiliency among Local Team members.

Home organizations[21] must assure their Local Team representative has someone with whom they can check-in about their needs and the toll of the work. This person should have the authority to approve accommodations such as periodic mental health days as paid sick leave or short-term reduced workload.

Local Team leaders and coordinator must establish and document protocols for reviewing explicit materials such as recordings of 911 calls or scene photos. See the :Reviewing Potentially Traumatizing Material" section for more information.

Local Team Leaders' and Coordinators' role is to foster a culture that encourages checking-in on one another's wellbeing, and encouraging open dialogue about vicarious trauma, compassion fatigue, and burnout. For example, Local Teams can:

- provide space in the meeting agenda to have such conversations,
- start or end meetings with a mindful moment (see How to start a meeting with a mindful minute (with video and script) as an example),
- check-in at the start and/or during a meeting with how members are feeling (for example, using an emotions wheel or a two-word check-in),
- build in breaks during the reviews for members to step away and center themselves, and
- regularly share these tips with team members.

Build in opportunities to celebrate the strength and resilience of individuals and communities, and to celebrate any Team or individual successes.

Immediately following a CFR team meeting, individuals are advised to actively practice self-care. This can include scheduling "cool down" time the hour following a CFR meeting and taking time to:

[19] National CFP, 2016 - https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/GuidanceVicariousTrauma.pdf
[20] National CFP, 2016 - https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/GuidanceVicariousTrauma.pdf
[21] Home Organization refers to the organization which the Local Team Member works for or represents in an official capacity

- meditate (e.g., 30 Meditation Exercises and Activities to Practice Today) or practice deep breathing (e.g., Take 5 Breathing)
- talk to a trusted source[22]
- take a short walk
- listen to binaural beats or music
- practice chair yoga (e.g., 11 Chair Yoga Poses to Try).

The National Institutes of Health have an Emotional Wellness Toolkit that includes other recommended activities for self-care.

Resources to Learn More about Self-Care:

- Beyond the Cliff: Laura van Lipsky examines the cumulative toll that can occur when people are exposed to the suffering, hardship, crisis or trauma of humans, other living beings, or the planet itself. The talk explores how to work toward reconciling such challenges, both individually and collectively, in the context of systematic oppression and liberation theory.
- Drowning in Empathy: The Cost of Vicarious Trauma: Amy Cunningham discusses steps for treating compassion fatigue.
- The Edge of Compassion: Françoise Mathieu explores ways to find the right balance between caring for others while staying healthy and empathic.
- Trauma Stewardship Institutes: Focuses on raising awareness of and responding to the cumulative toll on those who are exposed to suffering, hardship, crisis, or trauma. The organization provides free downloadable documents and recordings to assist with self-care, including a Tiny Survival Guide, a Map for Managing One's Day, and a Gratitude Log.

[22] When choosing a trusted source to talk with, please be respectful of the confidentiality and privacy expectations laid out in these guidelines and issued by the Local Team components.

Spectrum of Prevention

The Spectrum of Prevention is a broad framework of strategies that are used to address complex public health problems. It identifies seven complementary and synergistic levels of intervention (see image below), listed in order of most powerful to least powerful, and helps people move beyond education as the sole means of prevention. When used together the levels have a greater effect than would be possible from a single activity or initiative.[23] NCFRP's *A Program Manual for Child Death Review* (pg. 57) defines each level as follows:

1. **Influencing policy and legislation.** "Work to change laws or regulations at the local, state, and national levels. Sometimes the greatest improvement in prevention, affecting the largest number of people, can be accomplished by attention to policy issues and regulation."
2. **Mobilizing neighborhoods and communities.** "Engage community members in the process of identifying, prioritizing, planning, and making changes. The provision of technical assistance to facilitate this process can be a catalyst for neighborhoods and communities to be empowered to make a difference."
3. **Changing organizational practices.** "Change internal business and agency policies, regulations, practices, and norms. Looking at the practices of key groups, such as law enforcement health departments and schools has potential for affecting the health, safety, and satisfaction of the greater community. Also, every organization should look at its own practices and see what could be changed or strengthened."
4. **Fostering coalitions and networks.** "Creating or strengthening the ability of people and organizations to join together to work on a specific problem is useful for accomplishing a broad range of goals that reach beyond the capacity of any individual member or agency. These goals may range from information sharing to coordination of services to community education or advocacy for major regulatory or legislative changes."
5. **Training providers.** "Providers can influence others. They can be professionals, paraprofessionals, community activists or peers. It is critical to ensure that those who provide training, advice or serve as role models have the information, skills, capacity, and motivation to effectively promote prevention with youth, parents, colleagues, and policy makers."
6. **Promoting community education.** "Reach groups of people with information and resources to build support for healthier behavior and community norms. Since the media is so predominant in our society, skillful attention to the media can advance community education efforts."
7. **Strengthening individual knowledge and skills.** "Assisting individuals to increase their knowledge and capacity to act can lead to behavior change. Many health providers and community agencies currently apply this strategy through education, counseling, and other individual services to encourage individuals to change their behavior."

To learn more about the Spectrum of Prevention, visit the Prevention Institute's The Spectrum of Prevention or Contra Costa Health Services' The Spectrum of Prevention.

[23] Prevention Institute. (n.d.). The Spectrum of Prevention. Retrieved from: https://www.preventioninstitute.org/tools/spectrum-prevention-0

Confidentiality & Respect

CFR involves peering into the life of a child on what was likely their caregiver's worst day of their life. This must be approached with respect and consideration for the family's privacy. All the information collected by the Local Team for the purposes of child fatality review is legally protected from disclosure.[24] Local Team Coordinators are required to provide each team member with a confidentiality statement to which each team member must adhere, including instructions for destroying records. In no case should any team member or designee disclose any information regarding the Local Team's findings or decisions outside the Team, other than pursuant to Team confidentiality guidelines. If you have any knowledge leading you to believe the confidentiality of a case has been compromised, take the matter to your supervisor immediately to determine appropriate next steps.

[24] Some information reviewed by the Local Teams may be disclosed through other means and mechanisms. For example, a police record reviewed in the Local Team cannot ever be disclosed to anyone by the Local Team itself, but it may be disclosed by a police department as the result of a duly issued subpoena.

Local Team Membership & Roles

The CFR statutes names the 11 Local District Attorney's offices as the lead for each Local Child Fatality Review Team (referred to as Local Team). Multi-sector participation is also spelled out in the statute.

Leaders & Coordinators

Local Team Leader

Typically, an Assistant District Attorney serves as the Local Team Leader. Local Team Leaders provide direction and oversight to the Local Team. They are expected to:

- Direct and approve case selection and agenda development
- Facilitate case reviews
- Set Local Team practice, in alignment with these guidelines, including but not limited to
    - Record sharing and destruction protocols
    - Decide whether Ad Hoc Members should stay for all cases reviewed during the meeting, or only select cases or portions of the review
    - Determine meeting frequency and modality
- Identify and engage Local Team Members
- Seek approval from the state team for appointment of a pediatrician with experience in child abuse and neglect
- Create a team culture that promotes mental health
- Liaise with the State CFR Team through the State CFR Coordinator
- Communicate State Team updates to Local Team Members
- Supervise the Local Team Coordinator

Local Team Coordinator

It is optimal to have a Local Team Coordinator in addition to a Team Leader. Local Team Coordinators are expected to collaborate with Local Team Leaders to carry out the following duties:

- Select cases and prepare for case review
    - Support case selection, for which the Local Team Leader has final say
    - Notify Local Team Members about cases up for review
    - Support case materials collection
    - Collect and analyze relevant records
- Support case review meetings
    - Manage case review meeting scheduling, calendar invitations, and logistics to ensure team meetings are held
    - Set case review meeting agendas
    - Identify and invite ad hoc members
    - Ensure meeting participants are aware of and sign the confidentiality statement, and
    - Instruct participants on how to share and destroy records collected
    - Present case materials
- Conduct follow-up work after a case review

    - Support the Local Team in completing the Death Case Review Reporting Form
    - Submit completed Death Case Review Reporting Forms to the State CFR Coordinator
    - Support the Local Team Leader in liaising and communicating with the State CFR Team through the State CFR Coordinator
- Maintain Local CFR Records including:
    - Team rosters & participation (see below for a sample team roster)
    - Protocols & Practices
    - A record of which Records were collected for each case reviewed
    - Signed confidentiality statements
- Orient new team members and ad hoc members to the CFR purpose, foundational frameworks, concepts, and process

Local Team Coordinators and Leaders are also responsible for facilitating a case review.

Mandated Team Members

Local Teams are multidisciplinary and are composed of professionals who bring their expertise and knowledge to case reviews. Local Team Membership is defined in the CFR statute. The law requires that Local Teams include the following individuals or their designees:

- Chief Medical Examiner
- Pediatrician with experience in diagnosing or treating child abuse and neglect[25]
- Local police officer from the city or town where the fatality or near fatality occurred
- State Law Enforcement Officer
- Chief Justice, Juvenile Court
- Commissioner, Department of Children and Families
- Director, Massachusetts Center for Unexpected Infant and Child Death
- Commissioner, Department of Public Health

To ensure that Local Teams are effective and productive, team members are expected to:

- Regularly attend meetings and come prepared to discuss the cases selected for review,
- Contribute records related to the case that their agency holds,
- Serve as a liaison to respective professional counterparts,
- Interpret and explain agency procedures and policies, and
- Explain the capacities, responsibilities, and limitations—legal and otherwise--of their profession and their agency.

[25] The CFR Statute requires that the pediatrician be appointed by the State Team. To seek an appointment, send the pediatrician's name to the State CFR Coordinator. The State CFR Coordinator will bring the appointment recommendation to the State Team and follow up regarding the approval. Local Team Leaders determine the process for identifying, engaging, and recommending a physician. It is recommended that member of the Local Team participate in the selection process.

Ad Hoc Members of the Team

Local Teams may invite ad hoc members with expertise or information relevant to a specific review. The expertise and knowledge of ad hoc members may relate either directly to the deceased or nearly deceased individual's life or to a subject matter relevant to the case. For example, Local Teams might invite emergency services experts; national, state, and local organization representatives; behavioral experts; engineering experts; or the child's physician, guidance counselor or other service provider. These ad hoc members can illuminate certain aspects of a case or support the team in developing actionable problem statements. The leader of the Local Team has the final say in which ad hoc member can attend and for which portions of the review. Ad hoc members must follow all the rules of any regular Local Team member. The State Team recommends dismissing ad hoc members after they provide their relevant insight and discourages reviewing or discussing unrelated cases in front of ad hoc members.

The Office of the Child Advocate operates as a permanent ad hoc member to all local child fatality review teams for all case reviews. The Office of the Child Advocate ad hoc members bring content expertise as well as policy expertise to the Local Teams.

For support in identifying experts as needed, Local Teams should reach out to State CFR Coordinator.

Recommended Ad Hoc Representation

Although not required by the Massachusetts CFR statue, Local Teams should consider including the following types of individuals as part of their team composition:

- **Community representatives** (at least two; racially/ethnically concordant whenever possible)**.** Community representatives may be able to provide details and information that contextualize factors surrounding a death, especially in cases where a cause of death reflects a pervasive racial, ethnic, or other inequity. These can be individuals knowledgeable about a specific sub-community, or individuals who provide services within a geographic region who can speak to social and structural determinants of health within the community.
- **Academic scholar or researcher.** Academic scholars and researchers are also key members as they may be able to connect local patterns to larger trends and may be abreast of research on potential preventative strategies that have been shown to be effective. Taken together, these perspectives can ensure more culturally responsive and evidence-informed reviews, resulting in more appropriate and effective strategies to prevent infant and child death.

Sample Team Roster

Team Roster	
District	
Fiscal year	

Coordinators Name	**Role**	**Official Title**	**Phone Number**	**Email**
[Team Leader]	Leader			
[Coordinator 1]	Coordinator			

Member Name	**Agency**	**Role**	**Phone Number**	**Email**
Sample 1	OCME	Mandated Member	xxx-xxx-xxxx	Sample@mass.gov
Sample 2	Riverside Trauma Center	Guest	xxx-xxx-xxxx	Sample2@riverside.org

Preparing for a Case Review

Death Certificate Dissemination

Birth and death certificates are disseminated monthly through a SharePoint folder maintained by the Department of Public Health (DPH). Access to the SharePoint site is provided by the State CFR Epidemiologist. Local Team Coordinators will be notified when new records are added to the site.

Local Teams should notify the CFR epidemiologist and State CFR Coordinator for access to the folder or if any questions about the process and contents of the folder arrive. If the Local Team is not reviewing a case because the death occurred outside the district, the Local Team Coordinator must send the death certificate to the appropriate Local Team (see *Responsibility for Case Review* below)

Case Selection

Once death certificates are received, the CFR coordinator, in collaboration with the Team Leader, should review the records and decide which ones to have the full Local Team review. The CFR statute requires that Local Teams study the fatalities and near-fatalities of any person in their county under the age of 18 years. Therefore, ideally, all child fatalities should be reviewed. The State Team acknowledges that this may not be possible, especially for districts with large populations or high death rates. As such, the state team recommends that Local Teams review cases that The Office of the Chief Medical Examiner (OCME) has closed and for which the death certificate is final. The cases should also meet the following criteria, please note, these criteria are not mutually exclusive and should be used only as a guide:

- The Death occurred in the two years preceding the meeting date,
- The cause/manner of death is unintentional injury[26], suicide, sudden or unexpected (including SIDS),
- The child was previously involved with the Department of Children and Families (DCF), Department of Mental Health (DMH), or Department of Youth Services (DYS).

Local Teams can advance equity using targeted case selection strategies. Teams may select additional relevant cases based on local data reflecting a specific, long-standing cause of inequitable death, a recent uptick in a cause of death that is experienced inequitably, or if there are strategic opportunities to inform relevant policy change or program design, such as growing momentum around a policy change where data is needed to contextualize the need for or possible impact of such a policy.

Responsibility for Case Review

Which Local Team will conduct a review depends on the cause of death and circumstances surrounding the death or near-fatality. If the fatality or near fatality occurred outside of a child's town of residence, then the Local Teams will have to determine whether or not to review that case. If the cause of death or near-fatality relates more to the residence of the deceased or nearly deceased child, the Local Team that represents their town of residence shall conduct the review. If physical infrastructure impacted the fatality, the team that represents the location where the event took place

[26] Unintentional injury is defined as physical harm to a person that was not purposeful. For example, a car crash or fall is typically unintentional, but can also be intentional as in the case of homicide or suicide.

shall conduct the review. Table 1. describes the most frequently occurring causes of death, whether residency or place of event should review, and any additional consideration for the review.

Table 1. Local Teams Responsible for Review Based on Cause of Death

Cause	County Team that Should Review	Notes
Gestational & Congenital Malformation	Residency	Note pre-natal, peri-natal and support service location if different
SUID	Residency	Note if infant died in a county other than the one in which they resided. Inform that team.
Unintentional Injury	Place of Event	This includes car crashes, falls, poisoning
Suicide	Residency & Place of Event	Multi Team reviews are encouraged
Homicide	Residency & Place of Event	Multi Team reviews are encouraged
Illness (Chronic health conditions, cancer, and infectious diseases)	Residency	Note if contagion or exposure is suspected to have happened outside the county of residency

In instances where a Local Team Leader decides not to review a case for which they have received a death certificate based on the above criteria, the Local Team Coordinator should send the death certificate to the appropriate Local Team and determine whether or not to send a representative to that Local Team review. In instances where the review findings impact prevention efforts in another district, Local Teams should share findings and information with that district.

Near-Fatalities

With the amendment of the CFR statute in 2008, the purpose of the program was expanded to include the review of near-fatalities.[27] The statute defines a near-fatality as "an act that, as certified by a physician, places a child in serious or critical condition."[28] There is no system in place for Local Teams to be notified of near-fatalities.

However, Local Teams are encouraged to review near-fatalities when:

- A Local Team is notified in any way of a near-fatality
- A Local Team case review reveals a near-fatality of another child, or
- The Local Team Leader or Coordinator becomes aware of a near-fatality, and decides it is important to include in the review process.

To accomplish this mandate, the Local Team can also request aggregate data on non-fatal health outcomes from the DPH CFR Epidemiologist.

[27] Chapter 176 of the Acts of 2008, "An Act Protecting Children in the Care of the Commonwealth."
[28] MGL Chapter 38 Section 2A

Records Identification and Collection

Local Team Leaders and Coordinators often do not have pre-existing access to the records necessary to conduct a comprehensive review. It is the role of the Local Team Members to identify and supply appropriate records in a timely fashion.

Once cases are selected, the Local Team Coordinator should notify all Local Team Members about which cases will be reviewed and request relevant records from team members. This notification should include guidance on how and by when to send the records to the Local Team Coordinator.

This notification should be sent a minimum of three weeks prior to the meeting date so relevant agency/department records can be collected, compiled, shared and/or analyzed as part of the review process.

This case notification list should only include the following information about the deceased child:

- Name
- Date of birth
- Date of death
- Cause of death

Records to Collect

CFR has far-reaching records collection privileges, and the Local Team Coordinator is responsible for collecting and compiling relevant provider records. Based on the notification they receive from the Coordinator, Local Team Members will collect relevant case materials from their respective agencies. For medical records, school records, and other records that are not specific to an organization represented on the local team, the Local Team Coordinator is expected to reach out to the record holder.

Ideally, death reviews should at a minimum include the following records:

Table 2. Records to Collect

Record	Record Holder	Notes
Finalized death certificates	Vital Statistics	Provided to Local Teams by the Department of Public Health
Death investigation reports, including scene reports, interviews, information on prior criminal activity related to the selected case	DA	
Autopsy & Toxicology reports	OCME	

Complete Medical records, including mental health	Medical Provider	HIPAA allows for disclosures required by law, such as M.G.L. c. 38 §2A which requires that medical records be immediately provided to the Child Fatality Review Team. See Sample Letter
Mother's prenatal health records (if infant or young child)	Medical Provider	This may not be feasible but can and should be considered.
EMS records if child was transported, including recorded 911 calls and Patient Care Reports		
DCF Case Records and Case History	DCF	DCF representatives to the Local Team should determine which records are most relevant, recommended records include 51A and B. DCF representatives should not share Worker Dictation, and should be ready to provide an oral case summary if necessary
Social Service records, such as WIC, Early Intervention, etc.	DPH, MRC, DYS, DMH, EOHHS, DTA	
Court Records		
Relevant family information including siblings, biological and stepparents, extended family, living conditions, neighborhood, prior child deaths, etc.	Service Providers and Personal Contacts	
Educational Records	Parents/Guardians of the Deceased Child	Protected under the Family Education Rights and Privacy Act (FERPA). To receive and review the materials, Local Teams must acquire consent from the parent or guardian of the deceased child. Alternatively, Local Teams may consider inviting school officials to a case review as ad hoc members to discuss a child's schooling. For support around inviting school officials to case reviews. See sample Letter

Law enforcement records, including Local and State Police report, Crime Lab records, and 51A/51B forms	DA	

The State team recommends that the Local Team attempt to gather additional records for specific causes or manners of death such as relevant regulatory or statutory information, or additional investigation records. Examples of such information include:

Table 3. Cause and Manner Specific Records to Collect

Record	Record Holder	Notes
Licensing requirements and history of past violations for childcare providers	EEC, DPH	Collect if death occurred at a childcare facility
Local pool regulations, building codes, playground regulations or other relevant ordinances	Municipality	Collect if the death related to a regulated body
Product safety information	Consumer Product Safety Commission	Collect if the death related to a consumer product
Motor vehicle crash reconstruction reports	State Police, Crash Reconstruction Unit	Collect if the death related to a car crash
SUID Investigation forms	State or local police, depending on jurisdiction	Collect for SUID cases
Scene investigations reports	Department of Fire Services	Collect for fire-related death

Record Confidentiality

Local Team Coordinators must provide record holders with guidance on how to protect confidentiality of the records shared with the coordinator. Strategies to maintain confidentiality depending on meeting modality. Please know that due to confidentiality restraints, materials shared during Local Team meetings are for review during the scheduled meeting only.[29]

In-Person

If the meeting is held in-person, Local Team Coordinators can print and distribute case material packets in hard copies to members and ad hoc members the day of the meeting. At the end of each meeting, Coordinators should collect all packets back from members and ad hoc members and dispose of them by shredding the materials.

Virtual

If the meeting is held virtually, Local Team Coordinators are to confirm with all members and ad hoc members that only the members and ad hoc members can see the screen and hear the audio. Options for securely sharing records during the meeting include the following:

- Creating a secure on-line portal, such as SharePoint, where materials are kept.
  - Make sure these materials are not downloadable.
  - Consider adding and removing the files at the beginning and end of the meeting
- Sharing records on the screen during the meeting (either the coordinator or the record holder can share their screen). Please note, this option is time-consuming.

If members and ad hoc members are allowed to download records, the Local Team Coordinator must provide guidance on removing electronic from the Local Team's device including how to do it and by when it must be complete.

[29] National Center for Child Death Review. A Program Manual for Child Death Review: Strategies to Better Understand Why Children Die and Taking Action to Prevent Child Deaths. 2005. Retrieved from: https://ncfrp.org/wp-content/uploads/NCRPCD-Docs/ProgramManual.pdf

Analyzing and Presenting Records

In preparation for the review, the Local Team lead and coordinator should familiarize themselves with the records collected. This will help facilitate the discussion with the Local Team. If the coordinator has sufficient capacity, create a presentation with relevant case information, including but not limited to:

- The child's intersecting identities
- Facts of the case
- Records received and reviewed

During a case review the coordinator must provide a list of records collected in preparation for the review. This allows Local Team Members to ensure appropriate records were collected. The records about which the presentation is provided should be made available throughout the meeting.

The records collected for the case review must be made available to Local Team Members during the case review meeting. This allows Local Team Members to review something in more detail, leveraging their expertise.

Case materials should be relevant to the prevention of the future fatalities and near-fatalities. Before a case review, determine whether the inclusion of potentially traumatizing materials, such as call recordings or pictures, are necessary for developing actionable problem statements about the prevention of child fatalities and near-fatalities. Consider calling upon subject matter experts to provide expert opinions on specific records, such as 911 calls or autopsy, rather than expecting team members to review the content. If such materials are shared or presented, assure a trigger warning is provided with sufficient opportunity to opt out of that portion of the review and resources to support self-care.

See Appendix C. pg. 52 for sample case summaries

Meeting Frequency & Case Load

The CFR statute requires Local Teams to meet at least four times per calendar year. Teams with a large number of cases to review may need to meet more frequently to ensure there is sufficient time for in-depth reviews of all selected cases. (See Case Selection section.)

Teams with a small number of cases are encouraged to use their four meetings as an opportunity to conduct more extensive case reviews. There is no minimum number of cases required to hold a Local Team meeting; if there is at least one case identified for review, the Local Team should meet. Coordinators should ensure that there is sufficient time to conduct adequate review of all the cases presented on the agenda. Reviewing fewer cases per meeting offers an opportunity for teams to conduct a richer review and develop more comprehensive problem statements. However, reviewing too few cases with different causes reduces the generalizability of problem statements.

Because there are 11 Local Teams, and often Local Team Members participate in several local teams, every effort should be made to coordinate scheduling of team meetings among the various Teams.

Meeting Modality: In-person or Virtual

Local Teams may meet in-person or virtually. There are numerous advantages and disadvantages to either meeting modality, which Local Teams should weigh. When considering a virtual meeting, Local Team Coordinators should address the following questions:

- Do team members have reliable internet access?
- Do team members have access to a private space to participate in virtual team discussions?
- Are team members able to store records in compliance with any relevant state and federal laws?
- Do team members have the equipment and skills to use a teleconferencing/web conferencing platform?
- Can team members sign and return confidentiality agreements? This could be accomplished via email, in the chat box within a webinar platform, or verbally.

If the answer to any of the above questions is no, Local Teams should meet in-person or address the issues prior to meeting virtually.

For further guidance on virtual meetings, Local Team Leaders and Coordinators can consult NCFRP's Planning for Remote Fatality Reviews.

Instructions on how to share and destroy records collected may also vary depending on meeting modality.

Conducting a Case Review

Sign-In and Confidentiality

Local Team meetings are closed to the public because sensitive and confidential information, data, and records of the deceased are discussed. At the outset of the review, Local Team Members and invited ad hoc members must be reminded that reviews are confidential and that materials shared during the meetings may not be taken from or discussed outside of the meeting. Coordinators should implement a sign-in process that clearly explains the confidentiality provisions and allows members and ad hoc members to endorse that statement (see Sample Confidentiality Statement & sign-in Sheet below). For in-person meetings, Local Teams could use a physical sign in sheet; for virtual meetings, Teams could use email, the chat function of a webinar platform, or verbal acknowledgement to accomplish the same end.[30]

To assure members are adhering to the participation expectations laid out in the Mandated Agency and Organization Representatives section of this document, coordinators should periodically review sign-in sheets or attendance records from a virtual platform and assess whether meetings are conforming with membership requirements.

Local Coordinators should also keep a record of Local Team participants for their own coordination purposes. If a statutorily mandated agency is chronically absent, the Local Team should follow up with the state team coordinator or the state team member of the same agency to find a resolution.

[30] National Center for Fatality Review and Prevention. Planning for Remote Fatality Reviews. Accessed here: https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/Planning-For-Remote-Fatality-Reviews.pdf

Sample Confidentiality Statement & Sign-In Sheet[31]

The purpose of a Child Fatality Review Team is to conduct a thorough examination of each child fatality and near-fatality in the _____ judicial district by the district's Local Child Fatality Review Team.

In order to ensure a coordinated response that fully addresses all systemic concerns surrounding child fatalities and near-fatalities, all relevant data, including historical information concerning the deceased child and their family, must be shared at team reviews. Much of this information is protected from disclosure by law, including medical and child abuse/neglect information. Therefore, team reviews are closed to the public as confidential information cannot be lawfully discussed unless the public is excluded.

In no case should any team member or designee disclose any information regarding the cases review, team's findings, or decisions outside the team, other than pursuant to team confidentiality guidelines. State Team members will be notified of confidentiality breaches and may consider taking appropriate action. Any agency team member may make a public statement about the general purpose or nature of the child death review process, as long as it is not identified with a specific case. The undersigned agree to abide by the terms of this confidentiality agreement.

Name	**Agency (note guest if you are not a regular members)**	**Email**	**Signature**

Facilitation

When Local Team Leaders and Coordinators bring team members together, it is important to keep in mind that each member comes to the review with their individual experiences and perspectives. Moreover, these individuals likely do not interact regularly with each other outside of the CFR review process. Therefore, it is important to:

- assure everyone knows everyone else in the room
- take time to build team rapport
- make space for questions about the process and proceedings

ensure all team members understand the frameworks that underpin the CFR Program especially as it relates to prevention

- lay ground rules to ensure all the diverse voices at the table are heard equitably

[31] National Child Fatality Review and Prevention. Program Manual. Page 142. Retrieved from: https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/ProgramManual.pdf

- ensure that power (e.g., in decision-making) is shared equally among all members

The NCFRP guide for Effective Facilitation for Fatality Review provides guidance on these items such as establishing ground rules by developing a team charter and soliciting input from all members by asking open-ended questions. Additional resources on these topics include What Team Building Is, and How to Achieve It and Power Dynamics: The Hidden Element to Effective Meetings. These are also best practice for sustainability of your Local Team in the case of turnover.

Case presentation will depend on the capacity of the Local Team. Ideally, a summary of the records provided, and contextual information should be presented by the team coordinator. If teams are reviewing the case materials individually in lieu of a presentation, sufficient time should be provided for team members to read a review. Local Team Members should have access to the records collected during the case review, even if a presentation is provided. Local Team Coordinators must share what records were collected as part of the planning for the review.

Before diving into a discussion of a case, make sure the team feels comfortable proceeding. They may need additional information or records to understand the root cause of an issue or need more time to finish reviewing materials. It may take a couple of meetings before a local team feels ready to make an assertation about how future deaths could be prevented by various changes in laws, policies, and services. Ask the team to consider whether the team has sufficient information, records, or expertise to fully understand the case. If it does not have sufficient information to conduct a thorough review or develop an actionable problem statement (see Case Materials for Reviews on the types of materials and records that should be available), the Local Team can table the review and revisit it when appropriate materials are available. Be sure to communicate with team members and ad hoc members if a case is reviewed again at a future meeting.

If review of a case raises concerns about abuse or neglect not previously identified by the Office of the Chief Medical Examiner, immediately table the case, and share concerns, questions, and findings with the OCME.

When facilitating a discussion about a case, ensure that health and racial equity are centered throughout the entire process. To do so, Local Teams must consider how the child's intersectional identities might have exposed them to distinct risk factors at the individual and relationship levels of the Social-Ecological Model, and also through social and structural determinants of health. Additionally, Local Teams must consider how power and privilege might have impacted a child fatality. Considering these factors together can ensure that Local Teams are not only able to take a more holistic approach in case reviews, but also in identifying problem statements that are ripe for action.

Questions to Consider During a Case Review

To ensure health and racial equity are centered in the review process, the following questions should be asked of each case:

- What led to this child's death? Per the Social-Ecological Model:
    - What individual-level factors contributed to the child's death? (biology, behavior)
    - What relationship-level factors contributed to the child's death? (family and friends)

    - What community-level factors contributed to the child's death? (Municipality and community groups)
    - What societal-level factors contributed to the child's death? (laws, policies and practices)
- What were the child's intersectional identities?
    - Did those intersectional identities expose them to risk?
    - Did those intersectional identities expose them to risk factors through social and structural determinants of health?
- Did any social and structural determinants of health play a role in the child's death?
    - Built environment and neighborhood
    - Education access and quality
    - Employment and economic stability
    - Housing
    - Social environment
    - Violence
    - Access to nutritious foods and physical activity opportunities
    - Air and water quality
    - Language and literacy skills
    - Health care access and quality
- Did power or privilege play a role in the child's death?
    - Was anything denied to the child or the child's family simply because of the groups they belong to, rather than because of anything they have done or failed to do?
    - Did the child or child's family have access to resources and decision-makers, the ability to influence others, and/or the ability to define reality for themselves and others in a way that affected the case?
- What are the major contributing factors to this death?

Reviewing Potentially Traumatizing Material

To protect the mental and physical health of Local Team Members, Local Team Leaders and Coordinators should adequately prepare and support Local Team Members when reviewing potentially traumatizing materials.

Traumatizing materials can include but are not limited to graphic images of the deceased individual or scene, 911 or other recordings related to the fatality, medical records with images or explicit descriptions, descriptions of caregiver or family responses, and eyewitness or other personal testimonials.

Before opening, playing, or otherwise sharing any potentially traumatizing materials, the person facilitating the case review should:

- Warn the members about the content and nature of the materials,
- Provide a justification about why the materials are critical to the identification of an actionable problem statement
- Provide an opportunity for Local Team Members to opt out of the content
- Provide information about crisis support and mental health services that are available to Local Team Members (see the Resources to Learn More about Self-Care section of these guidelines)

Sample Agenda

[Local Team] Child Fatality Review Team Meeting
[date] [Time]
Agenda:

- Welcome and Introductions (20 Min)
- Reminder of CFR key principals: (5 minutes)
    - Confidentiality
    - Equity
    - Knowledge of the Community
    - Prevention
    - Trauma Responsive and Informed
- Questions and concerns about the cases we are about to review (5 minutes)
    - Is there enough information and time to review the cases set forth in today's agenda?
- Suicide: Cases 1&2 (1 hour) Presentation & Discussion
    - [Name]
    - [Name]
- SUID: Cases 3-7 (15 minutes) Presentation & Discussion
    - [Name]
    - [Name]
- Group Reflections and Recap

Questions for Consideration:

- Does the Team have sufficient information to conduct the review?
- Did the Child's intersectional identities expose them to risk factors?
- What about the child's biology or behavior (individual level), family or friends (relationship level), municipality or community, or laws, policies and practices influenced the death?
- Did any social and structural determinants of health play a role in the child's death?
- Was anything denied to the child or the child's family simply because of the groups they belong to, rather than because of anything they have done or failed to do?
- What are the major contributing factors to this death?

Records Reviewed: The following records were reviewed in the development of the case summaries

Jane Doe (DoD 2/28/2022) (DoB: 2/24/2022)

- Death Certificate [Number]
- Autopsy
- Maternal Medical Records
- DCF Case Records
- Emergency Services Records & 911 Recording
- Interviews with:
    - Maternal grandfather
- First Responder

John Smith (DoD 2/24/2022) (DoB: 3/18/2006)

- Death Certificate [Number]
- Autopsy **Contains Graphic Images**
- Toxicology Report
- Emergency Services Records & 911 Recording
- Crash Report and Scene Reconstruction Report
- SUD Treatment Records
- Interviews with:
    - None

Developing Actionable, Data-Informed Problem Statements

Based on the comprehensive discussion and analysis of selected cases, Local Teams are responsible for developing and submitting actionable, data-informed problem statements to the State Team for research and consideration.

Before developing problem statements, Local Team Members should familiarize themselves with the foundational principles laid out in these guidelines. Actionable, data-informed problem statements address who, what, why, and the extent of the issues contributing to child fatalities and near-fatalities. More effective statements supersede individual knowledge to focus on policy, practices, regulations, and laws as described in the Spectrum of Prevention (see foundational frameworks). They also take into consideration health and racial equity. Good problem statements identify concrete issues that, if addressed, will reduce the likelihood of similar deaths and near-fatalities from occurring, and take into consideration inequities that are already apparent in fatality data. To assure equity is considered in development of the problem statement, take the following steps while refining the problem statement:

- Vet the problem statement with a diverse set of stakeholders who are familiar with the problem
- Discuss who would benefit most from addressing the problem and whether or not it could reduce or increase inequities
- If a problem is related to a specific marginalized community, discuss whether or not addressing the problem will help build power or disempower the community

Local and State Team members can build their understanding of equity by reviewing materials such as:

- National Center Guidance Report: Improving Racial Equity in Fatality Review
- Colorado Fatality Prevention System Equity Learning Series

The State CFR Coordinator can provide technical assistance and advice on developing actionable problem statements before submitting the Death Case Review Reporting Form.

Once submitted, the State CFR Coordinator or State Team may have questions about the statement. When this occurs, the State CFR Coordinator will contact the Local Team's Leader and Coordinator to inform them of the State Team's requests. This is part of the process by which the State Team explores the Local Team problem statements. Once a clearer understanding of the problem is established, the State Team convenes experts to further explore the issue and develop a recommendation. The recommendation is then presented through an annual report which is submitted to the governor and legislature for consideration.

Submitting Death Case Review Reporting Forms

After a review, the Local Team Leader, coordinator, or both completes the Local Child Fatality Review Team Death Case Review Reporting Form (See Case Review Reporting Form). This form asks for the following information:

- The dates of review of the case
- State File Number or Death Certificate Number
- If a 51A was filed
- Race, Sex, and age of the child
- Whether the child was Hispanic
- Date of birth and death of the child
- Official cause of death of the child as listed on the death certificate
- Factors related to the death
- Case review quality assurance and improvement feedback, and
- The problem statement resulting from the review

Using the "Case Review quality assurance and improvement feedback" field, Local Team can provide feedback and needs regarding the CFR process. This field captures information that is not related to the prevention of child fatalities and near-fatalities and is important to address to assure the CFR Program functions effectively.

There is space on the case review form to include more than one problem statement, if necessary.

Case review forms should be submitted via e-mail to the State CFR epidemiologist and coordinator.

Following receipt of the case review form, the state CFR epidemiologist enters the information into the CFR database, maintained by the Department of Public Health. Problem statements and feedback are shared with State Team Members, reviewed by state team members who represent the agencies receiving the problem statements, and presented for consideration during quarterly State Team meetings. During those meetings, the State Team reviews additional data, literature, and input from subject matter experts related to the problem statement in an effort to develop recommendations. The state team then publishes their findings and recommendations in an annual report, which is submitted to the Governor and Legislature.

Appendices

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Appendix A. Local Child Fatality Review Team Death Case Review Reporting Form

Case Information

Please complete one form for each case reviewed

Local Team:				
Date(s) of Review of this case:	/ /	/ /	/ /	
	MM DD YYYY	MM DD YYYY	MM DD YYYY	
SFN (State File Number) / Death Cert. No:		**51a Filed?** Yes / No		
Race:	Sex:	Age:	**Hispanic**: Yes / No	
Date of Birth:	/ /	Date of Death:	/ /	
	MM DD YYYY		MM DD YYYY	
Official Cause of Death (From Death Certificate):				
For accidents, suicides, homicides, and deaths of undetermined intent, please also provide how the injury occurred (Use what is in on death certificate, with additional details gathered by team if appropriate):				
Official Manner of Death (From death certificate):	☐ Natural ☐ Suicide ☐ Undetermined ☐ Unknown ☐ Accident ☐ Homicide ☐ Pending			
Factors related to death For more information, see Social-Ecological Model in the CFR Guidelines	☐ Individual ☐ Relationship ☐ Community ☐ Societal			

Case Review Quality Assurance and Improvement Feedback

Please complete this field if the team was unable to complete a review or generate a recommendation(s)

Description & Suggestion for Improvement The reason a review could not be completed, or recommendation could not be generated, and potential solutions to the challenge	

Problem Statement

Please complete this section for each recommendation generated by the review. If additional fields are necessary complete an additional form, filling in the State File Number in the case information section.

What does the Local Team think the underlying problem is that if addressed, will prevent similar deaths in the future?	
Agencies affected by the recommendation be as specific as possible, name state or local agencies as relevant	
Factors related to the recommendation See Social-Ecological Model in the CFR Guidelines	☐ Individual ☐ Relationship ☐ Community ☐ Societal

Appendix B. Sample Letters

Medical Record Request Letter

[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 Local Child Fatality Review Team is established in every county in the Commonwealth charged with examining child fatalities and near-fatalities to better understand their causes and to prevent similar deaths in the future (see copy of law attached). The local district attorney has the broad statutory authority to collect all records and information relevant to the cause of death of a child, or near-fatality of a child, under review by the Local Team, including records and information relevant to the child and immediate family (M.G.L. c. 38 §2A(c)). 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
- providers of social services

The statute states that at the request of the local district attorney a provider of medical or social services or another governmental agency shall send the Local 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) , please note that HIPAA allows for disclosures required by law, without the need for an individual authorization, 45 CFR §164.512(a). Listed below are the child's information and records identified as needed for the Child Fatality Review Local Team's case review.

A: Child's Information

- Child Name:
- Date of Birth:
- Date of Death:

B. Records for the review:

- 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, [Team Leader/Coordinator's Name] at (***) ***-****.

Thank you for your assistance.

[NAME]

[Anywhere County District Attorney]

Sample School Records Letter to Caregivers

[ANYWHERE COUNTY DISTRICT ATTORNEY'S OFFICE]
[DATE]
[NAME OF PARENT/CAREGIVER]
[ADDRESS]

RE: Local Child Fatality Review Team Records Request

Dear [parent/caregiver name]:

On behalf of the Office of [DA] I express our sincere condolences for the loss of your child. The [District Name] Local Child Fatality Review (CFR) Team, a Team that is established through the laws of Massachusetts,[32] is exploring the circumstances surrounding your child's death to find ways to prevent tragedies like this in the future. I am writing to request that you have the Keeper of Records at [Name of School] provide the [District Name] CFR Team with a certified copy of any and all school records of your [child] [name of child], including but not limited to: Individualized Education Plan (IEP) records, records of services provided under section 504 of the Rehabilitation Act of 1973, guidance counselor records, neuropsychology testing and evaluation reports, disciplinary records, and any other school records in their custody or control.

The CFR team was created to review deaths and near-fatalities occurring among children in [District Name] District Attorney's jurisdiction. The purpose of our team is to decrease the incidence of preventable child deaths and near-fatalities by coordinating the collection of information, reviewing that information among an interdisciplinary team of experts that are bound by strict confidentiality, and submitting recommendations or problem statements to the statewide CFR Team on changes in law, policy, or practice which may prevent child deaths in the future. Although the District Attorney chairs their districts CFR team, it is not the purpose of the meetings to gather information for criminal investigation and no information gathered by the CFR Team can be used for anything other than the purposes of the CFR Team.

Team meetings are closed to the public and team members and meeting attendees are prohibited from disclosing any information relating to the team's business. Also, information, documents, and records of the of a Local Team are not subject to subpoena, discovery, or introduction into evidence in a court proceeding, unless such material is available from another source.

The CFR Team will be reviewing medical, mental health, and other records if they are relevant to the death or near-fatality of the child under review. We do not, however, have access to school records without your express authorization. We have found that school records have been very helpful in guiding the Team's work and assisting us in making actionable recommendations that will improve safety for children in our state. Please have the school's Keeper of Records email the requested records

[32]M.G.L. c. 38 §2A

to [email address] or fax them to (***) ***-****). If the records are too voluminous to email or fax, please ask the school to send them to my attention as soon as possible at the address listed below.

Thank you for your attention to this matter. If you have any questions, or need additional information to process this request, please do not hesitate to contact me at (***) ***-****). We grieve with you for the loss of your child and assure you that the CFR Team treats all deaths and near-fatalities with the seriousness and confidentiality that they deserve.

Sincerely,

[NAME]

Coordinator, [District Name] District Local Child Fatality Review Team

For grief counseling support and resources, please reach out to The Massachusetts Center for Unexpected Infant and Child Death

T (617) 414 – 7437
E magriefcenter@bmc.org

Appendix C. Sample Case Summaries

REDACTED

Summary 1: SUID

Summary 2: Transportation-Related Fatality

Appendix B. Equity Key Terms Defined

Discrimination: "the unjust or prejudicial treatment of different categories of people or things, especially on the grounds of race, age, or sex."[33]

Disparity: Differences in status or outcomes between groups of people.[34]

Equity: Providing all people with fair opportunities to attain their full potential to the extent possible.[35]

Equality: Equal treatment that may or may not result in equitable outcomes.[36]

Equity lens: The lens through which you view conditions and circumstances to assess who experiences benefits and who experiences burdens as the result of a policy, program, or practice.[37]

Health equity: When every person has the opportunity to attain their full health potential, and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." (CDC) In other words, "health equity means that every person has an opportunity to achieve optimal health regardless of the color of their skin, level of education, gender identity, sexual orientation, the job they have, the neighborhood they live in, whether or not they have a disability." "Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."[38]

Inequity: A difference or disparity between people or groups that is systemic, avoidable, and unjust.[39]

Interpersonal discrimination: "encounters between individuals. in which one person acts in an adversely discriminatory way toward another person".[40]

Intersectionality: The interaction between gender, race, and other categories of difference in individual lives, social practices, institutional arrangements, and cultural ideologies and the outcomes of these interactions in terms of power.[41]

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[33] Lexico Dictionaries. (n.d.). Discrimination English definition and meaning. Lexico Dictionaries | English. https://www.lexico.com/en/definition/discrimination

[34] CommonHealth ACTION adapted from Virginia Department of Health, 2012; retrieved from: https://www.aamc.org/media/25731/download

[35] CommonHealth ACTION, adapted from Braveman and Gruskin, 2003; retrieved from: https://www.aamc.org/media/25731/download

[36] Xavier University, n.d.; retrieved from: https://www.aamc.org/media/25731/download

[37] CommonHealth ACTION. Living Glossary of Terms, retrieved from: https://www.aamc.org/media/25731/download

[38] CDC's Practitioner's Guide for Advancing Health Equity

[39] CommonHealth ACTION. Living Glossary of Terms, retrieved from: https://www.aamc.org/media/25731/download

[40] Krieger, Nancy, "Discrimination and Health Inequities," in Berkman, Lisa F., Ichiro Kawachi and M. Maria Glymour (eds.), Social Epidemiology, Oxford University Press, 2014, p. 63–125.

[41] Davis, 2008; CommonHealth ACTION. Living Glossary of Terms, retrieved from: https://www.aamc.org/media/25731/download

-Isms: Systems of privilege and oppression based on social identities, including but not limited to race (racism), sex (sexism), class (classism), age (ageism), ability (ableism), and sexual identity (heterosexism).[42]

Marginalization: "the process through which persons are peripheralized based on their identities, associations, experiences, and environment"[43]

Oppression: The systemic targeting or marginalization of one group by a more powerful group for the social, economic, and political benefit of the more powerful group.[44]

Power: Access to resources and to decision-makers as well as the ability to influence others and to define reality for yourself and potentially for others.[45]

Privilege: When one group has something of value that is denied to others simply because of the groups they belong to, rather than because of anything they have done or failed to do. Dominant group members may be unaware of their privilege or take it for granted.[46]

Race: Race is socially constructed way of grouping people, based on skin color and other apparent physical differences, which has no genetic or scientific basis. This social construct was created and used to justify social and economic oppression of people of color by white people. An important thing to note is that while race is a social construct with no genetic or scientific basis, it has real social meaning.[47]

Racial equity: "a process of eliminating racial disparities and improving outcomes for everyone. It is the intentional and continual practice of changing policies, practices, systems, and structures by prioritizing measurable change in the lives of people of color."[48]

Racism: 1) A belief that race is the primary determinant of human traits and capacities, and that racial differences produce an inherent superiority of a particular race.[49] 2) Racism = Race prejudice + the misuse of power in systems and institutions.[50]

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[42] CommonHealth ACTION, adapted from Xavier University, n.d.; CommonHealth ACTION. Living Glossary of Terms, retrieved from: https://www.aamc.org/media/25731/download

[43] Hall JM, & Carlson K (2016). Marginalization: A revisitation with integration of scholarship on globalization, intersectionality, privilege, microaggressions, and implicit biases. Advances in Nursing Science, 39(3), 200–215.

[44] OpenSource Leadership Strategies, n.d.; CommonHealth ACTION. Living Glossary of Terms, retrieved from: https://www.aamc.org/media/25731/download

[45] OpenSource Leadership Strategies, n.d.; CommonHealth ACTION. Living Glossary of Terms, retrieved from: https://www.aamc.org/media/25731/download

[46] McIntosh, 2000; CommonHealth ACTION. Living Glossary of Terms, retrieved from: https://www.aamc.org/media/25731/download

[47] Boston Public Health Commission

[48] Race Forward. What is Racial Equity? Understanding Key Concepts Related to Race. Retrieved from: https://www.raceforward.org/about/what-is-racial-equity-key-concepts#:~:text=Racial%20equity%20is%20a%20process,lives%20of%20people%20of%20color.

[49] Merriam-Webster; CommonHealth ACTION. Living Glossary of Terms, retrieved from: https://www.aamc.org/media/25731/download

[50] The People's Institute for Survival and Beyond, n.d.; CommonHealth ACTION. Living Glossary of Terms, retrieved from: https://www.aamc.org/media/25731/download

Social and structural determinants: "The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors."[51]

Social justice: "Social justice is the view that everyone deserves equal economic, political and social rights and opportunities."[52]

[51] Commission on Social Determinants of Health, Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. 2008, World Health Organization: Geneva

[52] Workers, N. A. (2008). NASW Code of Ethics (Guide to the Everyday Professional Conduct of Social Workers). Washington, DC: NASW.

Appendix D. References and Resources

Equity

National Center Guidance Report: Improving Racial Equity in Fatality Review
Colorado Fatality Prevention System Equity Learning Series

General CFR Resources

NCFRP's *A Program Manual for Child Death Review*
Race Forward. What is Racial Equity? Understanding Key Concepts Related to Race. Retrieved from: https://www.raceforward.org/about/what-is-racial-equity-key-concepts#:~:text=Racial%20equity%20is%20a%20process,lives%20of%20people%20of%20color.
NCFRP Webinar Series: https://ncfrp.org/center-resources/archived-webinars/

Grief

The Massachusetts Center for Unexpected Infant and Child Death

Laws Relevant to CFR

FERPA
Massachusetts General Law (M.G.L.) Chapter 38, Section 2A

Meeting Facilitation, Sustainability & Team Building

emotions wheel
two-word check-in
NCFRP's Planning for Remote Fatality Reviews
NCFRP guide for Effective Facilitation for Fatality Review
What Team Building Is, and How to Achieve It
Power Dynamics: The Hidden Element to Effective Meetings.
Developing a team charter

Prevention Frameworks and Resources

Prevention Institute's The Spectrum of Prevention
Contra Costa Health Services' The Spectrum of Prevention

Self-Care & Trauma Informed Resources

Take 5 Breathing
30 Meditation Exercises and Activities to Practice Today
11 Chair Yoga Poses to Try
Emotional Wellness Toolkit
Beyond the Cliff,
Drowning in Empathy: The Cost of Vicarious Trauma
The Edge of Compassion
Trauma Stewardship Institutes
Tiny Survival Guide,
Map for Managing One's Day,
Gratitude Log

Social and Structural Determinants of Health

Centers for Disease Control and Prevention. About Social Determinants of Health (SDOH). Retrieved from: https://www.cdc.gov/socialdeterminants/about.html

U.S. Department of Health and Human Services. Healthy People 2030: Social Determinants of Health. Retrieved from: https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Social-ecological Model

Centers for Disease Control and Prevention. The Social-Ecological Model: A Framework for Prevention. January 2022