Massachusetts
Child Fatality Review

Annual Report

Fiscal Year 2023

About the Child Fatality Review Program

The Massachusetts Child Fatality Review (CFR) program convenes a multidisciplinary group of state agency representatives, health care experts, and law enforcement officers who analyze birth and death records, medical records, social service files, autopsy reports, and police records. The program comprises 11 local teams—one in each of the Commonwealth's judicial districts—and the State Team with 16 seats. The local teams conduct individual fatality review of child fatalities that aim to understand the circumstances and causes of child deaths. For team membership, see Appendix A. State Team and Local Team Membership. When a review identifies an opportunity to improve policy or practice, the local team issues a recommendation to the State Team. The State Team reviews these recommendations and gathers evidence from outside experts. The State Team then works with its members to change policies and practices under their purview when appropriate, and issues recommendations for consideration by the Governor and state legislature.

Preface

The loss of a child is devastating to families and can have a profound impact on communities. Since 2001, the Massachusetts Child Fatality Review (CFR) program has worked to learn from such deaths and find ways to protect the health and safety of children in the future. The CFR program convenes multidisciplinary teams of practitioners and government officials to conduct comprehensive reviews of the circumstances surrounding child deaths. Those reviews help identify changes in policy and practice that can prevent similar deaths.

This Fiscal Year 2023 (FY23) Annual Report of the State CFR Team describes program findings and activities from July 1, 2022 through June 30, 2023 and is released in compliance with the program's authorizing statute (M.G.L. Chapter 38 § 2A). This report and the activities of the State Team would not be possible without collaboration between the Office of the Chief Medical Examiner (OCME), The Office of the Child Advocate (OCA), and the Department of Public Health (DPH). Through this collaboration, the CFR program is developing more timely reports with deeper explorations of the causes and prevention of child fatalities.

The State Team is immensely grateful to the local teams who carry out the psychologically taxing review of individual child fatalities. Child fatality review is not an easy task; without exception, local teams conduct professional, thorough, and thoughtful reviews that are foundational to the State Team's work.

Finally, the State Team would like to thank the many partners who helped gather data and inform discussions about child fatality, including DPH's Injury Surveillance Program, Dr. Sadiqa Kendi and Fatemeh Naghiloo at Boston Medical Center, and Laura Rios-Ruggiero and Bex Reno at John Snow Inc.

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Executive Summary

Massachusetts (MA) is a national leader in safeguarding the health and wellbeing of children, as demonstrated by low child and infant mortality rates. Public health data for 2022 are not yet available as of the writing of this report. However, national literature points to increasing child and infant fatalities primarily due to deaths involving firearms, motor vehicles, and medical events like sepsis and pregnancy complications.[1] Previous analysis from the CFR program demonstrates that despite low child and infant fatality rates overall, deep disparities exist along geographic, race/ethnicity, and gender lines. For the CFR program to succeed in preventing fatalities, these disparities must be explored and addressed systematically.

With the aim of understanding the needs of the CFR program and improving systematic reviews, the OCA conducted State and Local Team needs assessments in 2017 and 2018. The assessments identified the need to standardize practices across the Local Teams and clarify the role and functions of the State Team. Since that time, CFR staff worked to draft Local Team Guidelines and improve the function of the State Team, including a year-long in-depth exploration of disparities and Social Determinants of Health.[2] In FY23, program staff brought that work to the Local Teams by developing and launching a 12-month community of practice (CoP). The CoP gathered Local Team leaders and coordinators to explore key topics-- including principals of racial equity, self-care, best practices in record collection, protecting confidentiality, facilitating fatality reviews, and identifying and documenting root causes of fatalities-- in an action oriented and equitable way.

To further support Local Teams in identifying needs and trends that can inform their fatality reviews, support staff at DPH generated data profiles that explore jurisdiction specific Social Determinants of Health alongside infant and child fatality data. The data profiles are meant to help Local Teams identify disproportionality in fatalities and understand which Social Determinants of Health may have contributed to a fatality. The data profiles can be found in Appendix C.

The CoP culminated in the final draft of the first ever Local CFR Team Guidelines, which was approved by the State Team at the beginning of FY24. See Appendix D. for the final guidelines. The guidelines are intended to provide basic operating standards to enhance consistency of local reviews across the Commonwealth. They also provide frameworks and principles that support Local Team members in moving beyond the review of immediate facts of the fatality to a broader review of the societal forces that may affect the risks and opportunities surrounding a fatality.

While conducting the CoP, Local Teams continued to meet, review child fatalities, and generate recommendations and problem statements for consideration by the State Team.[3] The State Team focused on operating the CoP and establishing the Local CFR Team Guidelines (Appendix D.). As a result, the State Team is not issuing new prevention recommendations this year. This focus was necessary to improve the CFR Program throughout the state and will result in improved processes and

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[1] https://jamanetwork.com/journals/jama/article-abstract/2802602; https://blogs.cdc.gov/nchs/2023/11/01/7479/#:~:text=A%20new%20Vital%20Statistics%20Rapid,rate%20since%202001%20to%202002.

[2] See the FY22 CFR Annual Report for more information.

[3] The CFR statute calls on local teams to submit action-oriented recommendations, however, the state team encourages local teams to describe problems identified during case reviews to the state team in lieu of a recommendation if no recommendation is identified.

recommendations in the future. The State Team reaffirms their support of the previously issued recommendations, which are listed in Appendix B.

The State of Child Fatalities

In March of 2023, the Journal of The American Medical Association published an article titled "The New Crisis of Increasing All-Cause Mortality in US Children and Adolescents."[4] According to the article, in 2021, the national rate of child fatalities increased. This is a concerning reversal of a three-decade trend of decreasing child morality nationally, as is primarily driven by deaths involving firearms and motor vehicles. As described in the FY22 CFR report, Massachusetts did see a slight increase in child fatalities from 390 in 2020 to 397 in 2021. While 2022 fatality data were not yet available at the time this report was written, additional data will be provided in the FY24 CFR Annual Report.

Massachusetts continues to experience low rates of infant and child fatalities compared to other U.S. States, a testament to the strong child and family service provider network in the Commonwealth. Still, the FY22 CFR annual report highlights that rates of mortality vary substantially across geographic regions and identities.[5] Boys, children of color, and children and infants living in urban centers are all at higher risk of fatality. The scale of inequities in child deaths is particularly marked for infants. These inequities are not rooted in biological or genetic differences between races and ethnicities, nor are they inherent to other aspects of a child's or infant's race or ethnicity. Rather, they are linked to social determinants of health, including factors like socioeconomic status and access to health care. For the CFR program to succeed in preventing fatalities, these disparities must be explored and addressed systematically.

Program Activities

State Team

The State Team met a total of four times in FY23. Those meetings focused on program transitions, updates about the CFR CoP, and development of the Local Team Guidelines—a set of standard practices, foundational frameworks, and expectations that Local Teams are expected to follow when conducting fatality reviews.

Local Teams

In FY23, eight of the 11 Local Teams met a total of 22 times and reviewed 71 fatalities. Three teams did not meet in FY23. Those meetings resulted in six prevention recommendations and two continuous quality improvement recommendations. The State Team is currently analyzing those recommendations with the support of subject matter experts to generate recommendations for the legislature and other audiences.

Training and Technical Assistance to Local Teams

In 2017, the OCA conducted a Local Teams Needs Assessment and followed up with an State Team Needs Assessment in 2018. These assessments identified the need to standardize practices across the Local Teams to ensure the Commonwealth had a consistent approach to analyzing fatalities. From 2019 through 2021, CFR program staff worked to draft Local Team Guidelines and refine the State Team's

[4] https://jamanetwork.com/journals/jama/article-abstract/2802602
[5] For more information, see the FY22 CFR Annual Report

approach to their work, including defining and refining a database and recommendation review process. Following a year-long State Team focus on equity and Social Determinants of Health in FY22, CFR program staff were ready to bring the concepts and draft guidelines to the Local Teams.

As such, DPH and the OCA, with support of subcontractor JSI Research & Training Institute, Inc. (JSI), developed and facilitated a Community of Practice of Massachusetts CFR Local Teams (CFR CoP). During the CoP planning process, program staff were also approached by Dr. Sadiqa Kendi, an expert in pediatric injury prevention with a focus on health equity, who is the Division Chief of the Pediatric Emergency Medicine Division at Boston Medical Center and Boston University School of Medicine. Dr. Kendi sought funding from Johns Hopkins University to carry out the Pediatric Injury Equity Review (PIER) project, in collaboration with three Local Teams, and the findings of which were woven into the CoP.

DPH, OCA, and JSI convened the CFR CoP over 12 sessions from July 2022 through June 2023. The purpose of the CFR CoP was to improve consistency, efficacy, and inclusion of equity across Local Teams' case review processes. Participants in the CFR CoP engaged in mutual learning and best practices sharing; received technical assistance (TA) for implementing the forthcoming Massachusetts CFR Local Team Guidelines and instruction on how to think through problem statement definition; refined their understanding and enhancement of CFR processes; and honed skills in self-care practices.

The CFR CoP was designed with an explicit aim to accomplish 10 goals:

1. Increase application of an equity and multi-level social-ecological model lens to case review processes.
2. Increase advancement of health and racial equity through Local Team recommendation development.
3. Increase the ability of Local Teams to integrate prevention frameworks and social and structural determinants of health into recommendation development.
4. Enhance the understanding and ability of Local Teams to implement the forthcoming Massachusetts CFR Guidelines.
5. Improve communication and networking between Local Teams.
6. Improve communication between Local Teams and the State Team.
7. Improve self-care practices among Local Team members.
8. Increase proportion of Local Teams' child fatality cases that are reviewed.
9. Enhance CFR processes for Local Teams – making processes easier and improving the quality of review findings
10. Refine Massachusetts CFR Guidelines.

Each session focused on a different topic (Table 1). Expert faculty Sadiqa Kendi facilitated two of the 12 sessions. Sessions were well attended with the majority of the Local CFR Teams represented throughout the CoP.

Additionally, to help Local Teams understand disparities and the Social Determinants of Health that contribute to them, the CFR program designed 12 infographics, one for reach Local Team jurisdiction and one for the entire state, that contain team-specific data about fatality rates, trends and inequities in infants ages 0 to 12 months and children ages one through 17 years old. Those infographics can be found in Appendix C. of this report.

Table 1. CoP Topics by Month

Month	Topic
July	Introduction & Orientation to the CoP
August	Laying the Foundation: Developing Shared Norms & Selecting Fatalities
September	Self & Team Care
October	Exploring Your Positionality & Getting to Know Your Community
November	Best Practices in Record Collection
December	Protecting Confidentiality
January	Facilitating fatality reviews
February	Protecting Confidentiality
March	Unpacking a Fatality
April	Reflecting on CoP Learnings & Remaining Needs
May	Conducting Reviews, Time Management, and Fatality Volume
June	Celebration of Learning & Next Steps

Evaluation Findings

For continuous quality improvement purposes, and to measure the impact of the CoP, several evaluations were conducted over the course of the CoP. Baseline data related to Local Team knowledge, attitude and practice were assessed in an application that the Team completed before the start of the CoP. These same questions were asked at the midpoint and end of the CoP.

Brief surveys were also disseminated following each session to assess participant's satisfaction with, and knowledge learned, or skills gained during the session.

On average, post-session survey respondents were satisfied (4.3 out of scale 1=not at all satisfied to 5=very satisfied) with CoP sessions. Participants expressed learning the following during the sessions:

- Meeting facilitation, technical skills
- Understanding health and racial equity in the CFR context
- Case selection and prioritization best practices
- Benefits of themed reviews
- Team and self-care practices
- Gathering, analyzing, and applying community data to CFR
- Obtaining and retaining records
- Options for sharing files for virtual CFR meetings
- How to apply the injury equity framework matrix during local review of cases
- Social-ecological model

Additionally, participants shared what they saw as the biggest benefits to the CoP, including:

- Ability to meet and learn from other teams
- Support clearly being provided by leaders as a resource
- The content covered a wide range of topics/issues Local Teams face
- The environment was comfortable to share/collaborate with others
- The input from other Local Teams

When assessing changes in knowledge, attitude, and practices, the following three items saw the largest increase in respondents saying they agree or strongly agree compared to baseline. These point to the success of the CoP in meeting goals 3, 5 and 6.

- Someone on our Local Team knows who to reach out to if they have a question for another Local Team (39% increase from baseline).
- Our Local Team utilizes prevention frameworks to develop recommendations.
- Our Local Team feels up to date with the goings on of the State CFR Team.

The following two statements showed a decrease in the percentage of respondents stating that they agreed or strongly agreed. This is the opposite of what the CoP administrators wanted, though these data may indicate a greater understanding of the health equity principles and a better understand of how to apply principles of equity to a fatality review.

- During fatality reviews, our Local Team discusses the conditions in which each child lived (for example, housing, education, economic status, etc.) (17% decrease from baseline).
- During fatality reviews, our Local Team discusses the identities (race/ethnicity, gender, sex, etc.) of each child- (6% decrease from baseline).

Outcomes

As a result of participation in the CoP, participants identified the following practices that they have or plan to stop doing, start doing, and continue doing (Table 2).

Table 2. Practices participants identified that they have or will stop doing, start doing, and continue doing because of their participation in the CoP.

Stop	**Start**	**Continue**
• Playing 911 recordings • Holding onto old medical records • Procrastinating • Sharing graphic content when not necessary in order to reduce vicarious trauma	• Inviting experts to meetings - representatives of schools (teens) • Holding CFR meetings • Introductions at CFR meetings • Providing a list of records • Holding meetings virtually • Reorient in a meeting to some concepts in Guidelines • Holding themed meetings where cause and manner of death was similar • Moving diversity of thought and experience to the forefront • Focus more on all aspects of the child's community • Utilizing the injury equity matrix	• Renewal of confidentiality with new members & guests • Discussions of whether to share autopsy photos or not • Introductions at CFR meetings • Fatality summary (emailing 1-2 weeks before meeting) • Refine time management when collecting records/creating reviews

Participants also shared examples of implementing these changes in real time during the CoP timeframe. For example, one participant shared that they began using a "graphic content warning" when working with a grand jury and preparing teams for sensitive information. This includes providing a

written or verbal warning that the information, images, or other content the facilitator was about to share were graphic. Participants also shared that they incorporated records collection best practices when preparing for a next fatality review session, began practicing self-care and boundaries (like not logging onto e-mail during days off), and emphasizing self-care on teams.

Participants were also provided with an opportunity to review and provide feedback on the Local Team Guidelines. They recommended the following changes, which were incorporated into the final Guidelines.

- Conduct reviews based on jurisdiction of the event that led to a fatality rather than residence of the child who experienced the event
- Share best practices among Local Teams in applying frameworks, protecting confidentiality, and practicing self-care
- Share best practices among Local Teams for planning and facilitating a review meeting

Next Steps

At the end of the CoP, participants expressed the need and desire for continued support and connection beyond the CoP. The following recommendations are based on feedback from participants and other developments in the Massachusetts Child Fatality Review process.

1. Engage DA Offices through tailored technical assistance
2. Continually enhance the Local Team Guidelines based on findings and experiences of the Local Teams
3. Facilitate quarterly virtual convenings of Local Team CFR Leaders and Coordinators
4. Disseminate newsletters to the Local Teams
5. Distribute resources, including an example list of experts to share with the Local Teams so they know who they can request connections to for particular topics
6. Host annual in-person convening of CFR Local Teams
7. Create orientation/training curriculum that's matched with technical assistance support for new CFR staff based on materials developed during the CoP
8. Host a Teams channel for all CFR staff to access resources/information

In FY23, key staff for the Child Fatality Review Program moved from DPH to the OCA. With this move comes more flexibility for generating content, convening stakeholders, and growing the program. As such, the State Team is confident in their ability to respond appropriately to the feedback provided by CoP participants. The FY24 work plan includes: an in-person meeting of both the Local Team Coordinators and Leaders as well as the State Team and subject matter experts; quarterly meet ups of the Local Teams; establishing a dedicated website and resource sharing platform; as well as creating orientation materials for new State and Local Team members.

Conclusions

The Massachusetts State CFR Program continued to evolve in FY23. The program focused their efforts and energy on supporting Local Teams in improving the consistency and quality of reviews and developing action-oriented recommendations. These efforts resulted in 12 infographics and the first official review guidelines for the Local Teams. In FY24, the program hopes to build on these advancements by providing space for Local Teams to share with and learn from one another, continuing surveillance of infant and child fatalities, and diving deeply into the recommendations generated by

Local Teams to generate action-oriented recommendations that will not only prevent child fatalities but that will address the drastic disparities in rates of child fatalities in geographic regions and identities.

References

Child Fatality Review Program, FY22 Annual Report

Pediatric Injury Equity Framework, https://masspier.americanhealth.jhu.edu/

Woolf SH, Wolf ER, Rivara FP. The New Crisis of Increasing All-Cause Mortality in US Children and Adolescents. *JAMA.* 2023;329(12):975–976. doi:10.1001/jama.2023.3517 https://jamanetwork.com/journals/jama/article-abstract/2802602 Accessed 9/8/2023

Appendix A. State Membership and Local Team Leadership

State Team Membership

Dr. Mindy Hull
Chief Medical Examiner, Co-Chair

Kelley Cunningham
Designee of the Commissioner of the Department of Public Health, Co-Chair

Jeff Bourgeois
Designee of the Attorney General

Karla Canniff
Designee of the Commissioner of the Department of Children and Families

Margie Gilberti
Designee of the Commissioner of the Department of Early Education and Care

Katharine Folger
Representative of the Massachusetts District Attorneys Association

Janet George
Designee of the Commissioner of the Department of Developmental Services

Anne Gilligan
Designee of the Commissioner of the Department of Elementary and Secondary Education

Shari King
Director of the Massachusetts Center for Unexpected Infant and Child Death

Karine Martirosyan
Designee of the Commissioner of the Department of Youth Services

Capt. Mario Monzon
Designee of the Colonel of the Massachusetts State Police

Maria Mossaides
Director of the Office of the Child Advocate

Dr. Nandini Talwar
Designee of the Commissioner of the Department of Mental Health

Chief John Paciorek, Jr.
Designee of the Massachusetts Chiefs of Police Association

Dr. Celeste Wilson
Representative of the Massachusetts chapter of the American Academy of Pediatrics with experience in child abuse and neglect

Alex Levie
Representative of the Massachusetts Health & Hospital Association

The team position for Chief Justice of the Juvenile Division of the Trial Court or designee is vacant. The CFR statute also allows for attendance to State Team meetings by other individuals with information relevant to fatalities under review

Local Team Leadership

Berkshires
Timothy Shugrue, District Attorney
Team Leader: Stephanie Ilberg,
Assistant District Attorney

Bristol
Thomas Quinn, District Attorney
Team Leaders: Andrea Baldwin,
Assistant District Attorney;
Dennis Collins,
Assistant District Attorney

Cape and Islands
Michael O'Keefe, District Attorney
Team Leader: Sharon Thibeault,
Assistant District Attorney

Essex
Paul Tucker, District Attorney
Team Leader: Kate MacDougall,
Assistant District Attorney

Hampden
Anthony Gulluni, District Attorney
Team Leader: Eileen Sears,
Assistant District Attorney

Middlesex
Marian Ryan, District Attorney
Team Leader: Katharine Folger,
Assistant District Attorney

Norfolk
Michael Morrissey, District Attorney
Team Leader: Lisa Beatty,
Assistant District Attorney

Northwestern
David Sullivan, District Attorney
Team Leader: Lori Odierna,
Assistant District Attorney

Plymouth
Timothy Cruz, District Attorney
Team Leader: Elizabeth Mello,
Assistant District Attorney

Suffolk
Kevin Hayden, District Attorney
Team Leader: Gladys Sorto
Children's Advocacy Center of Suffolk County

Worcester
Joseph Early, District Attorney
Team Leader: Courtney Sans,
Assistant District Attorney

Appendix B. Previously issued Recommendations

Issued in the FY2022 Annual Report

Recommendation	Updates and Information
Develop guidance to support municipalities and communities in the establishment of community schools and expansion of availability of and resources for school-based health centers.	In January 2021, DESE released Massachusetts Family, School, and Community Partnership Fundamentals 2.0. These guidelines as a strong first step to establish more Community schools.
Expand programs that support the deployment of active and passive cooling technologies—including in residences, rental properties, and schools—with an emphasis on growing heat pump use in environmental justice communities.	The following relevant bills are under consideration in the 2023-2024 legislative session: An Act promoting the adoption of renewable energy for heating, cooling and hot water An Act relative to access to air conditioning and relief from oppressive heat
Require the use of integrated pest management as standard practice by licensed pesticide applicators and subsidize the provision of such services to residents in environmental justice communities.	The following relevant bills are under consideration in the 2023-2024 legislative session: An Act relative to the pesticide board Relevant Legislation includes: M.G.L. Part I Title XIX Ch. 132B Section 6E
Study the feasibility of a program that pairs home safety assessments with subsidized home modifications to mitigate injury risk among children.	No updates at this time. However, on March 17, 2023: Medicare clarified that it does cover home safety assessments. No such clarification is available for Medicaid.
Create a statewide Fetal and Infant Mortality Review program to examine the circumstances surrounding individual fetal and infant deaths and to make recommendations that would prevent similar deaths in the future.	The following relevant bills are under consideration in the 2023-2024 legislative session: An Act relative to conducting fetal and infant mortality review (House) An Act relative to conducting fetal and infant mortality review (Senate)

Issued in the FY2021 Annual Report

Recommendation	Updates, and Information
Massachusetts policymakers petition the FDA to reconsider the inclusion of corn masa in their fortification requirements, and work to create incentives for corn masa manufacturers to fortify their products, for food manufacturers to use fortified corn masa in their products, and for retailers to stock products that contain fortified corn masa.	No updates at this time. However, the Center for Science in the Public Interest released *Food Companies Thwarting Success of FDA Fortification Policy, Report Finds*, in February of 2023.
Massachusetts policymakers implement an ethical and equitable primary seat belt law, alongside updated, linguistically appropriate, culturally responsive, and accessible education campaigns about the importance of seat belt use geared towards audiences with the lowest seat belt use rates and highest unbelted crash rates, and improved access to car seats and installation services.	Robust discussions took place on Beacon Hill during the 2021-2022 legislative session regarding primary seat belt laws, however, no bill passed. The following relevant bills are under consideration in the 2023-2024 legislative session: An Act establishing a primary seat belt law (House) An Act establishing a primary seat belt law (Senate)

Issued in the FY2020 Annual Report

Recommendation	Updates, and Information
The State Team continues its support for legislation moving the responsibility for administrating the CFR program from OCME to OCA, with OCA and DPH representatives becoming designated co-chairs of the State Team.	The following relevant bills are under consideration in the 2023-2024 legislative session: An Act relative to child fatality review (Senate) An Act relative to child fatality review (House)
The Commonwealth should study the feasibility of requiring that public and semi-public swimming pools have emergency service activation systems or call boxes within the pool's fence perimeter and in a form that complies with ADA accessibility guidelines.	105 CMR 435.00 Minimum Standards for Swimming pools (State Sanitary Code: Chapter V) was updated in June 2023, and now require semi-public and public swimming pools to have an Emergency Phone available, as described in section 435.25.
The Commonwealth should work with providers to increase cell phone coverage in underserved areas, particularly along roadways.	The 2023 Strategic Highway Safety Plan from the Department of Transportation reiterates this need on page 38. While the legislature is considering some bills related to the expansion of broadband internet, no relevant bills related to cellular coverage were filed at the time of the writing of this report.

In order to practice, licensed mental health clinicians and social workers should be required to have continued education/training on suicidality, screening for suicide risk, and suicide prevention strategies.	No updates at this time. Relevant regulations include: 262 CMR 2.00: Requirements for licensure as a mental health counselor 258 CMR 9.00: Social Worker Licensure Statutes include: MGL c. 112, § 163 to 172 MGL c. 13, § 88 through 90
Commonwealth executive branch agencies should collect gender identity in their data sets.	The Juvenile Justice Policy and Data Board (pg. 76), the Human Rights Campaign, and the National LGBTQIA+ Health Education Center have all released similar recommendations. The following relevant bills are under consideration in the 2023-2024 legislative session: An Act improving juvenile justice data collection
In order to better coordinate care for children across state providers, all EOHHS agencies should use a standard confidential information sharing mechanism for client fatality records.	While no relevant bills were filed at the time of the writing of this report, the Juvenile Justice Policy and Data Board studied Administrative Data Centers and found that it would be feasible to establish one in Massachusetts. Learn More: 2022 JJPAD Annual Report, page 16
Adults operating a motorboat or other motorized personal watercraft in Massachusetts should be required to take a boating safety course.	The following relevant bills are under consideration in the 2023-2024 legislative session: An Act relative to boater safety to be known as the David Hanson Act (House) An Act relative to boater safety to be known as the David Hanson Act (Senate) Relevant Legislation: Massachusetts General Law, Chapter 90B

Appendix C. State and Local Team Profiles

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MASSACHUSETTS DATA PROFILE

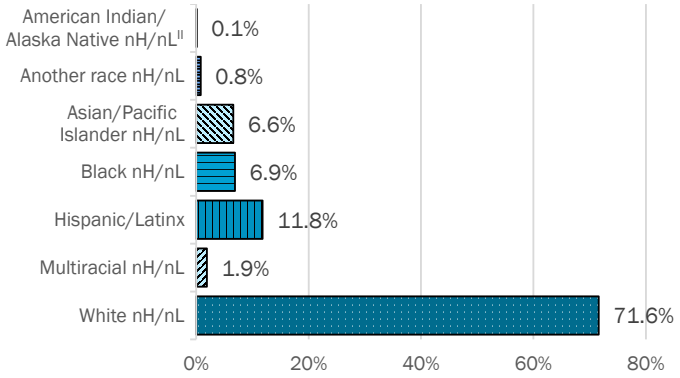
Statewide information about social determinants of health and child fatalities

State Demographics [I]

~7,029,920
Total population in 2020

~1,366,190 (17% of total population)
Population under the age of 18 in 2020

Population by Race & Ethnicity



Education & Income [III,IV]

$81,215
Median household income

$55,429 - $103,291
Hampden Norfolk
Range across judicial districts

13.2%
Percent of children living in poverty

24.1%
Percent of adult population with a college degree

4.8%
Unemployment rate

Resources

The resources below can help Child Fatality Review teams better understand how social determinants of health in their communities affect child fatality rates. The Child Fatality Review Program epidemiologists can provide you with technical assistance in navigating these and other data sources. Please contact us at mdph-isp@mass.gov for more information.

- PHIT Community Reports
- Child Opportunity Index & Map
- U.S. Census Facts
- Metropolitan Area Planning Council Data Common
- Massachusetts Data Hub

I. Population estimates developed by the University of Massachusetts Donahue Institute (UMDI) in partnership with the Massachusetts Department of Public Health, Bureau of Environmental Health.
II. nH/nL = non-Hispanic/non-Latinx. Hispanic/Latinx refers to the ethnic background of people of Cuban, Mexican, Puerto Rican, or other Spanish or South or Central American culture or origin regardless of race. The terms Hispanic and Latinx are not necessarily interchangeable and include people from many ethnic, national, racial, and linguistic groups. Latinx is a gender-neutral term referring to people of Latin American ancestry.
III. American Community Survey (ACS), 5-Year Estimates, 2015-2019
IV. Metropolitan Area Planning Council Data Common: https://datacommon.mapc.org/browser/

Infant Fatalities (2016-2020)[V] All rates are per 100,000 population	
Number of fatalities	1,348 (2016: 277; 2020: 263)
Fatality rate	376.4
Inequities by race/ethnicity	The infant death rate for Black non-Hispanic/non-Latinx (nH/nL) infants was highest, followed by the rates for Hispanic/Latinx, White nH/nL, and Asian/Pacific Islander (API) nH/nL infants. The Black nH/nL infant death rate was almost 3 times the White nH/nL infant death rate. The Hispanic/Latinx infant death rate was 1.5 times the White nH/nL infants'.
Inequities by sex	The male infant death rate (407.5) was 1.2 times the female infant death rate (341.9).
Leading causes of death	• Short gestation/low birthweight • Congenital malformations • Sudden infant death syndrome (SIDS) • Pregnancy complications
Leading causes of death by sex and race/ethnicity	For SIDS, male infants had a death rate (34.5) that was 1.5 times the rate for female infants (22.3). Short gestation/low birthweight was highest among male Black nH/nL and male Hispanic/Latinx infants, whose death rates were 4.4 and 2.3 times the rate for male White nH/nL infants. The male Black nH/nL infant SIDS rate was 2.2 times the rate for male White nH/nL infants. For congenital malformations, the Black nH/nL female infant death rate was 1.4 times the rate for Black nH/nL male infant deaths.

See next page for data on fatalities among children ages 1-17.

V. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020

Child Fatalities, Ages 1-17 (2016-2020)[VI] All rates are per 100, 000 population	
Number of fatalities	802 (2016: 179; 2020: 127)
Fatality rate	12.2
Inequities by race/ethnicity	The death rate for American Indian/Alaska Native nH/nL children was highest, followed by rates for Black nH/nL, API nH/nL, Hispanic, and White nH/nL children. The American Indian/Alaska Native nH/nL child death rate was more than 5 times the White nH/nL child death rate. The Black nH/nL child death rate was twice the rate for White nH/nL children.
Inequities by sex	The male child death rate (14.4) was 1.5 times the female child death rate (9.9).
Age	The 15-17 age group had the highest death rate (21.3) followed by the 1-4 age group (13.6). Most unintentional injuries, suicides, and homicides occurred among children in the 15-17 age group.
Leading causes of death	• Unintentional injuries • Cancer • Suicide • Homicide Unintentional injuries and cancer were the top causes for children ages 1-14. Unintentional injuries and suicide were the top causes for children ages 15-17.
Leading causes of death by sex and race/ethnicity	Rates of unintentional injuries were higher among male children for all age groups compared to female children. Suicide and homicide rates were also higher among male children ages 15-17 compared to females. Among male children ages 1-17, unintentional injuries were twice as frequent among Black nH/nL children compared to White nH/nL children. Among children ages 15-17, the homicide rate was 17.4 times as high for male Black nH/nL children and 8.3 times as high for male Hispanic/Latinx children compared to male White nH/nL children. Cancer and suicide rates among female API nH/nL children were more than 3 times the rate for female White nH/nL children. Cancer and suicide rates among female Hispanic/Latinx children were 1.5 times the rate for female White nH/nL children.

VI. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020

BERKSHIRE DISTRICT DATA PROFILE

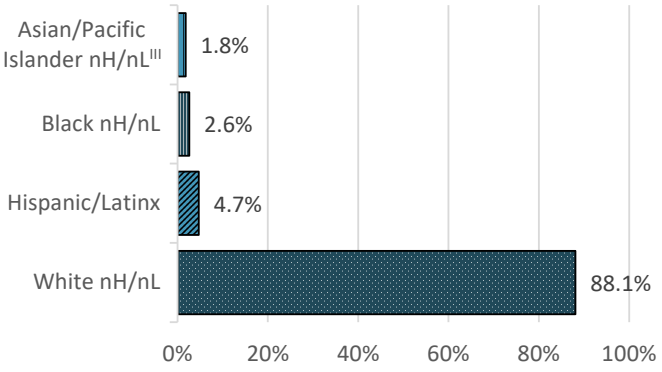
District-specific information about social determinants of health and child fatalities

District Demographics [I]

~129,030
Total population in 2020

~22,260
Population under the age of 18 in 2020
(17% of total population)

Population by Race & Ethnicity[II]



Education & Income [IV,V]

$59,230
Median household income

$39,411 - $106,406
North Adams — Alford
Range across municipalities

15.1%
Percent of children living in poverty

18.7%
Percent of adult population (over age 25) with a college degree

4.8%
Unemployment rate

Resources

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- PHIT Community Reports
- Child Opportunity Index & Map
- Metropolitan Area Planning Council Data Common
- Massachusetts Data Hub
- County History at Britannica.com
- U.S. Census County Facts
- County Education Data at Town Charts
- 2022 County Health Rankings National Findings Report

I. Population estimates developed by the University of Massachusetts Donahue Institute (UMDI) in partnership with the Massachusetts Department of Public Health, Bureau of Environmental Health.
II. Total does not add up to 100%. Population data included here reflects the race and ethnicity categories in the death data shown below.
III. nH/nL = non-Hispanic/non-Latinx. Hispanic/Latinx refers to the ethnic background of people of Cuban, Mexican, Puerto Rican, or other Spanish or South or Central American culture or origin regardless of race. The terms Hispanic and Latinx are not necessarily interchangeable and include people from many ethnic, national, racial, and linguistic groups. Latinx is a gender-neutral term referring to people of Latin American ancestry.
IV. American Community Survey (ACS), 5-Year Estimates, 2015-2019
V. Metropolitan Area Planning Council Data Common: https://datacommon.mapc.org/browser/

Infant Fatalities (2016-2020)[VI, VII] All rates are per 100,000 population	
Number of fatalities	24
Fatality rate	472.9
Inequities by race/ethnicity	The infant death rate for Black non-Hispanic/non-Latinx (nH/nL) infants was highest, followed by the rate for White nH/nL infants. The Black nH/nL infant death rate was 4.2 times the rate for White nH/nL infants.
Inequities by sex	The male infant death rate (562.0) was 1.5 times the female infant death rate (374.1).
Leading causes of death	• Respiratory distress • Short gestation / low birthweight • Sudden Infant Death Syndrome (SIDS)
Leading causes by sex and race/ethnicity[VIII]	Respiratory distress and short gestation/low birthweight were the top causes of death for male infants. Ill-defined/unknown causes of mortality and SIDS were the top causes for female infants. The top cause for Black nH/nL infants was short gestation/low birthweight. For White nH/nL infants, top causes were ill-defined/unknown causes of mortality, respiratory distress, and SIDS.

See next page for data on fatalities among children ages 1-17.

VI. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020
VII. Where death rates for white infants and children are compared with death rates for various other races and ethnicities, the white group represents a population that has not been subject to structural racism and the resulting inequities in social, economic, or environmental factors that contribute to infant and child deaths. The use of white infants and children as a comparison group does not indicate that such a group represents a standard or ideal to which other racial and ethnic groups should be compared.
VIII. The data for leading causes of death by sex and race and ethnicity were only included when there was sufficient data (counts of five and above).

Child Fatalities, Ages 1-17 (2016-2020)[VI, VII] All rates are per 100, 000 population	
Number of fatalities	18
Fatality rate	17.3
Inequities by race/ethnicity	Most deaths were among White nH/nL children.
Inequities by sex	The male child death rate (24.7) was 2.5 times the female child death rate (9.7).
Age	The 15-17 and 1-4 age groups had the highest death rates, followed by the 5-9 age group. About half of all unintentional injuries occurred among the 15-17 age group. All suicides occurred among the 15-17 age group. All homicides occurred among children who were less than 10 years old.
Leading causes of death	• Unintentional injuries • Homicide • Suicide • Cancer
Leading causes by sex and race/ethnicity[VIII]	Unintentional injuries, cancer, and homicide were the top causes of death for male children. Unintentional injuries, homicide, and suicide were the top causes of death for White nH/nL children.

VI. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020
VII. Where death rates for white infants and children are compared with death rates for various other races and ethnicities, the white group represents a population that has not been subject to structural racism and the resulting inequities in social, economic, or environmental factors that contribute to infant and child deaths. The use of white infants and children as a comparison group does not indicate that such a group represents a standard or ideal to which other racial and ethnic groups should be compared.
VIII. The data for leading causes of death by sex and race and ethnicity were only included when there was sufficient data (counts of five and above).

BRISTOL DISTRICT DATA PROFILE

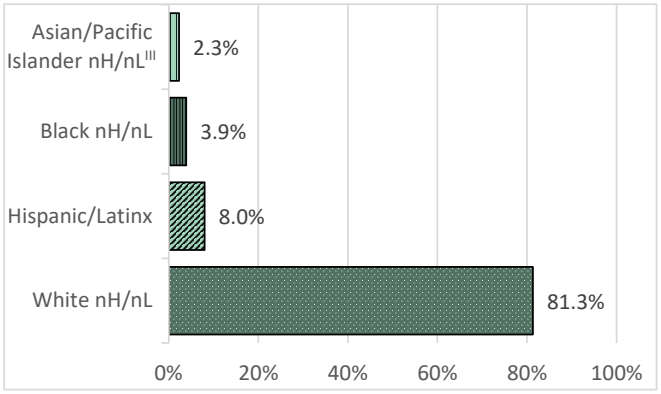
District-specific information about social determinants of health and child fatalities

District Demographics [I]

~579,200
Total population in 2020

~117,300
Population under the age of 18 in 2020
(20% of total population)

Population by Race & Ethnicity[II]



Education & Income [IV,V]

$69,095
Median household income

$41,585 - $114,720
Fall River — Mansfield
Range across municipalities

16.7%
Percent of children living in poverty

18.3%
Percent of adult population (over age 25) with a college degree

5.4%
Unemployment rate

Resources

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- PHIT Community Reports
- Child Opportunity Index & Map
- Metropolitan Area Planning Council Data Common
- Massachusetts Data Hub
- County History at Britannica.com
- U.S. Census County Facts
- County Education Data at Town Charts
- 2022 County Health Rankings National Findings Report

I. Population estimates developed by the University of Massachusetts Donahue Institute (UMDI) in partnership with the Massachusetts Department of Public Health, Bureau of Environmental Health.
II. Total does not add up to 100%. Population data included here reflects the race and ethnicity categories in the death data shown below.
III. nH/nL = non-Hispanic/non-Latinx. Hispanic/Latinx refers to the ethnic background of people of Cuban, Mexican, Puerto Rican, or other Spanish or South or Central American culture or origin regardless of race. The terms Hispanic and Latinx are not necessarily interchangeable and include people from many ethnic, national, racial, and linguistic groups. Latinx is a gender-neutral term referring to people of Latin American ancestry.
IV. American Community Survey (ACS), 5-Year Estimates, 2015-2019
V. Metropolitan Area Planning Council Data Common: https://datacommon.mapc.org/browser/

Infant Fatalities (2016-2020)[VI, VII] All rates are per 100,000 population	
Number of fatalities	114
Fatality rate	394.6 (2016: 315.2; 2020: 682.2)
Inequities by race/ethnicity	The infant death rate for Hispanic/Latinx infants was highest, followed by Black non-Hispanic/non-Latinx (nH/nL) and White nH/nL infants.
Inequities by sex	The male infant death rate (439.1) was 1.3 times the female infant death rate (349.2).
Leading causes of death	• Congenital malformations • Short gestation/low birthweight • Sudden Infant Death Syndrome (SIDS) • Pregnancy complications
Leading causes by sex and race/ethnicity[VIII]	For congenital malformations, the male infant death rate was 2.5 times the female infant death rate. Congenital malformation and short gestation/low birthweight death rates among Hispanic/Latinx infants were 1.3 and 1.4 times the White nH/nL infant death rates respectively. The Black nH/nL male infant death rate was 1.3 times the Hispanic/Latinx male infant death rate, and 1.2 times the White nH/nL male infants death rate.

See next page for data on fatalities among children ages 1-17.

VI. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020
VII. Where death rates for white infants and children are compared with death rates for various other races and ethnicities, the white group represents a population that has not been subject to structural racism and the resulting inequities in social, economic, or environmental factors that contribute to infant and child deaths. The use of white infants and children as a comparison group does not indicate that such a group represents a standard or ideal to which other racial and ethnic groups should be compared.
VIII. The data for leading causes of death by sex and race and ethnicity were only included when there was sufficient data (counts of five and above).

Child Fatalities, Ages 1-17 (2016-2020)[VI,VII]

All rates are per 100, 000 population

Number of fatalities	79
Fatality rate	14.1 (2016: 15.3; 2020: 12.5)
Inequities by race/ethnicity	The death rate was highest for Asian/Pacific Islander (API) nH/nL children, followed by Black nH/nL, Hispanic/Latinx, and White nH/nL children. The API nH/nL child death rate was almost 3 times the White nH/nL child death rate. The Black nH/nL child death rate was almost twice the White nH/nL child death rate.
Inequities by sex	The male child death rate (16.5) was 1.4 times the female child death rate (11.6).
Age	The 15-17 age group had the highest death rate (28.9), followed by the 10-14 age group (12.7) and the 1-4 year age group (11.4). About 40% of unintentional injury-related deaths, more than half of cancer deaths, and two-thirds of suicide deaths occurred among the 15-17 age group.
Leading causes of death	• Unintentional injuries • Cancer • Suicide • Ill-defined conditions-signs and symptoms • Homicides
Leading causes by sex and race/ethnicity[VIII]	Unintentional injuries, suicide, and homicide were the top causes of death for male children. Cancer, unintentional injuries, suicide, and Ill-defined conditions-signs and symptoms were among the top causes of death for female children. Unintentional injury, cancer, and suicide were the top causes of death for White nH/nL children. Hispanic/Latinx and White nH/nL male children ages 1-17 had comparable death rates.

VI. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020

VII. Where death rates for white infants and children are compared with death rates for various other races and ethnicities, the white group represents a population that has not been subject to structural racism and the resulting inequities in social, economic, or environmental factors that contribute to infant and child deaths. The use of white infants and children as a comparison group does not indicate that such a group represents a standard or ideal to which other racial and ethnic groups should be compared.

VIII. The data for leading causes of death by sex and race and ethnicity were only included when there was sufficient data (counts of five and above).

CAPE & ISLANDS DISTRICT DATA PROFILE*

District-specific information about social determinants of health and child fatalities

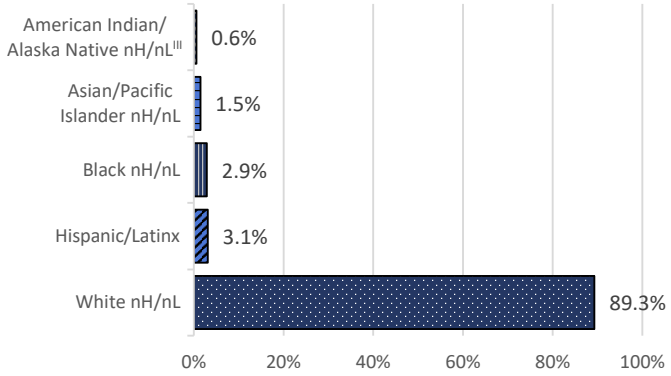
District Demographics [I]

~264,000
Total population in 2020

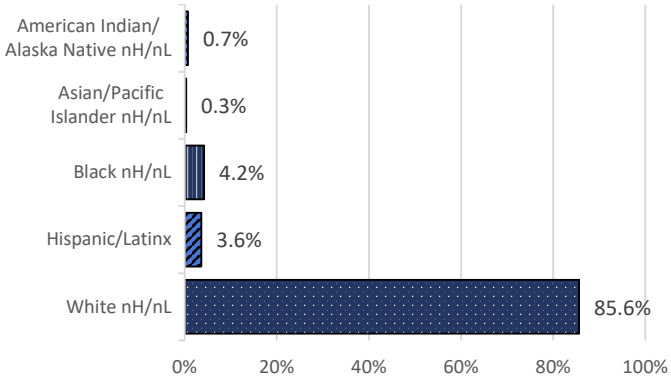
~38,700
Population under the age of 18 in 2020
(14.3 - 16.2% of total population)

Population by Race & Ethnicity[III]

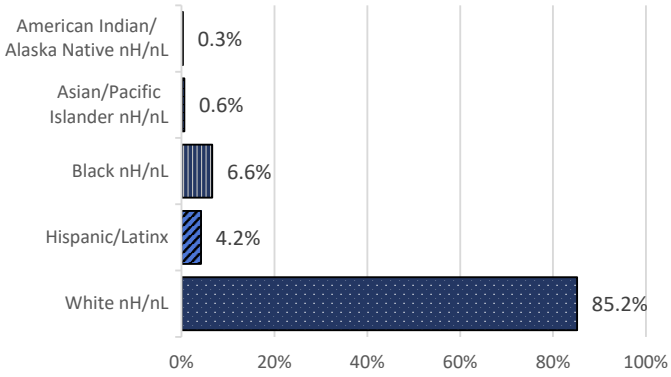
Barnstable



Dukes



Nantucket



Education & Income [IV,V]

Median household income:

Barnstable: $74,336
Dukes: $71,811
Nantucket: $107,717

Range across municipalities:

Barnstable:
$50,741 - $95,600
Provincetown — Sandwich

Dukes:
$50,301 - $126,250
Tisbury — Gosnold

Percent of children living in poverty:

Barnstable: 8.5%
Dukes: 8.3%
Nantucket: 11.9%

Percent of adult population (over age 25) with a college degree:

Barnstable: 24.9%
Dukes: 26.4%
Nantucket: 31.3%

Unemployment rate:

Barnstable: 4.1%
Dukes: 3.4%
Nantucket: 2.9%

* District includes Barnstable, Dukes, and Nantucket counties combined.

Infant Fatalities (2016-2020)[VI,VII] All rates are per 100,000 population	
Number of fatalities	30
Fatality rate	333.0
Inequities by race/ethnicity	The highest rates of infant deaths were found among Black non-Hispanic/non-Latinx (nH/nL) infants, followed by White nH/nL infants. The Black nH infant death rate was 3.9 times the rate for White nH/nL infants.
Inequities by sex	Infant death rates were similar between male and female infants.
Leading causes of death	• Congenital malformations • Short gestation/low birthweight • Sudden Infant Death Syndrome (SIDS)
Leading causes by sex and race/ethnicity[VIII]	SIDS, short gestation/low birth weight, and congenital malformations were the top causes of death for male infants. Among female infants, congenital malformations and short gestation/low birthweight were the top causes of death. Among Black nH/nL infants the top causes of death were congenital malformations, pregnancy complications, and short gestation/low birthweight. Among White nH/nL infants the top causes of death were SIDS, congenital malformations, and short gestation/low birthweight.

See next page for data on fatalities among children ages 1-17.

Child Fatalities, Ages 1-17 (2016-2020)[VI,VII] All rates are per 100, 000 population	
Number of fatalities	22
Fatality rate	12.1
Inequities by race/ethnicity	About half the number of deaths were among White nH/nL children. However, the death rate for children of color (American Indian/Alaska Native nH/nL, Asian/Pacific Islander nH/nL, Black nH/nL, and Hispanic/Latinx) was 4.8 times the rate for the White nH/nL children.
Inequities by sex	The male child death rate was 2.6 times the female child death rate. Most of the unintentional injury deaths occurred among male children.
Age	The 1-4 age group had the highest death rate (22.7) followed by the 15-17 age group (16.1). About 38% of all unintentional injuries occurred in the 15-17 age group.
Leading causes of death	• Unintentional injuries • Cancer • Suicide
Leading causes by sex and race/ethnicity[VIII]	Unintentional injuries and cancer were the top causes of death for male children.

See next page resources and endnotes.

Resources

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- **County History at Britannica.com:**
  - Barnstable County
  - Dukes County: Martha's Vineyard and the Elizabeth Islands
  - Nantucket County
- **U.S. Census County Facts:**
  - Barnstable County
  - Dukes County
  - Nantucket County
- **City/Town-Specific Websites:**
  - Barnstable County
  - Dukes County
  - Nantucket County
- **County Education Data at Town Charts:**
  - Barnstable County
  - Dukes County
  - Nantucket County
- PHIT Community Reports
- Child Opportunity Index & Map
- Metropolitan Area Planning Council Data Common
- Massachusetts Data Hub
- 2022 County Health Rankings National Findings Report

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III. nH/nL = non-Hispanic/non-Latinx. Hispanic/Latinx refers to the ethnic background of people of Cuban, Mexican, Puerto Rican, or other Spanish or South or Central American culture or origin regardless of race. The terms Hispanic and Latinx are not necessarily interchangeable and include people from many ethnic, national, racial, and linguistic groups. Latinx is a gender-neutral term referring to people of Latin American ancestry.
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V. Metropolitan Area Planning Council Data Common: https://datacommon.mapc.org/browser/
VI. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020
VII. Where death rates for white infants and children are compared with death rates for various other races and ethnicities, the white group represents a population that has not been subject to structural racism and the resulting inequities in social, economic, or environmental factors that contribute to infant and child deaths. The use of white infants and children as a comparison group does not indicate that such a group represents a standard or ideal to which other racial and ethnic groups should be compared.
VIII. The data for leading causes of death by sex and race and ethnicity were only included when there was sufficient data (counts of five and above).

ESSEX DISTRICT DATA PROFILE

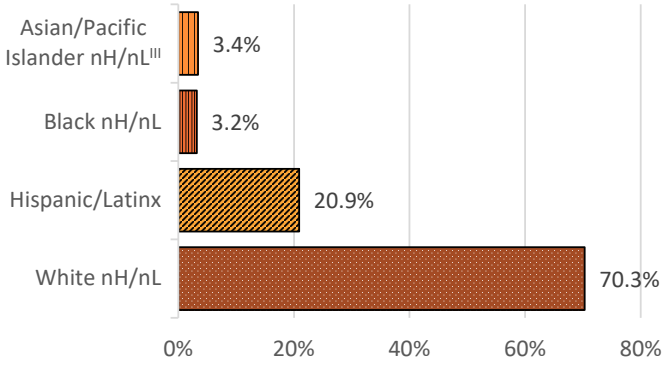
District-specific information about social determinants of health and child fatalities

District Demographics [I]

~809,830
Total population in 2020

~169,000
Population under the age of 18 in 2020
(21% of total population)

Population by Race & Ethnicity[II]



Education & Income [IV,V]

$79,263
Median household income

$41,583 - $174,340
Lawrence Boxford
Range across municipalities

14%
Percent of children living in poverty

23.7%
Percent of adult population (over age 25) with a college degree

4.9%
Unemployment rate

Resources

The resources below can help Child Fatality Review teams better understand how social determinants of health in their communities affect child fatality rates. The Child Fatality Review Program epidemiologists can provide you with technical assistance in navigating these and other data sources. Please contact us at mdph-isp@mass.gov for more information.

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- Child Opportunity Index & Map
- Metropolitan Area Planning Council Data Common
- Massachusetts Data Hub
- County History at Britannica.com
- U.S. Census County Facts
- County Education Data at Town Charts
- 2022 County Health Rankings National Findings Report

I. Population estimates developed by the University of Massachusetts Donahue Institute (UMDI) in partnership with the Massachusetts Department of Public Health, Bureau of Environmental Health.
II. Total does not add up to 100%. Population data included here reflects the race and ethnicity categories in the death data shown below.
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IV. American Community Survey (ACS), 5-Year Estimates, 2015-2019
V. Metropolitan Area Planning Council Data Common: https://datacommon.mapc.org/browser/

Infant Fatalities (2016-2020)[VI,VII] All rates are per 100,000 population	
Number of fatalities	165 2016: 32; 2020: 20
Fatality rate	571.1
Inequities by race/ ethnicity	The infant death rate for Black non-Hispanic/non-Latinx (nH/nL) infants was highest, followed by Hispanic/Latinx, and White nH/nL infants. The Black nH/nL infant death rate was about 4.4 times the White nH/nL infant death rate and almost 2 times the Hispanic/Latinx infant death rate. The Hispanic/Latinx infant death rate was about 2.3 times the White nH/nL infant death rate.
Inequities by sex	The male infant death rate (428.0) was 1.4 times the female infant death rate (311.3).
Leading causes of death	• Short gestation/low birthweight • Congenital malformations • Complications of placenta • Pregnancy complications • Ill-defined and unknown cause of mortality
Leading causes by sex and race/ ethnicity	Male infants had a rate of congenital malformation-related death (96.1) that was 1.5 times the rate for female infants (65.1). The Black nH/nL infant death rate resulting from short gestation/low birthweight was 15.8 times the rate for White nH/nL infants. For congenital malformations, the Hispanic/Latinx infant death rate was 2.6 times the White nH/nL infant death rate. The male Black nH/nL infant death rate was 5.2 times the rate for male White nH/nL infants and 2.2 times the rate for male Hispanic/Latinx infants. The male Black nH/nL infant death rate was almost twice the female Black nH/nL infant rate. The female Black nH/nL infant death rate was 3.5 times and the female Hispanic/Latinx infant death rate was 2.3 times female White nH/nL infant rate.

VI. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020

VII. Where death rates for white infants and children are compared with death rates for various other races and ethnicities, the white group represents a population that has not been subject to structural racism and the resulting inequities in social, economic, or environmental factors that contribute to infant and child deaths. The use of white infants and children as a comparison group does not indicate that such a group represents a standard or ideal to which other racial and ethnic groups should be compared.

VIII. The data for leading causes of death by sex and race and ethnicity were only included when there was sufficient data (counts of five and above).

Child Fatalities, Ages 1-17 (2016-2020)[VI,VII] All rates are per 100, 000 population	
Number of fatalities	90 2016: 20; 2020: 13
Fatality rate	10.6
Inequities by race/ ethnicity	The death rate for Black nH/nL children was highest, followed by the rates for Hispanic/Latinx and White nH/nL children. Hispanic/Latinx and White nH/nL children had similar death rates.
Inequities by sex	The male child death rate (10.9) was slightly higher than the female child death rate (9.8).
Age	The 1-4 age group (14.2) and 15-17 age group (14.0) had the highest death rates. Unintentional injuries and cancer were among the top causes of death for all age groups. About 36% of unintentional injuries occurred in the 15-17 age group. About 40% of cancer-related deaths occurred in the 10-14 age group. Suicides mainly occurred in the 15-17 age group.
Leading causes of death	• Unintentional injuries • Cancer • Suicide • Ill-defined conditions-signs and symptoms
Leading causes by sex and race/ ethnicity	The unintentional injury-related death rate among male children was 1.7 times the rate for female children. Unintentional injury was the top cause of death for White nH/nL and Black nH/nL children and the second highest for Hispanic/Latinx children. Cancer was the top cause for Hispanic/Latinx children. Most suicides occurred among White nH/nL children. Hispanic/Latinx children's cancer-related death rate was 1.8 times White nH/nL children's death rate. White nH/nL children had the highest death rate for unintentional injuries. Most of the unintentional injuries occurred among male White nH/nL children.

VI. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020
VII. Where death rates for white infants and children are compared with death rates for various other races and ethnicities, the white group represents a population that has not been subject to structural racism and the resulting inequities in social, economic, or environmental factors that contribute to infant and child deaths. The use of white infants and children as a comparison group does not indicate that such a group represents a standard or ideal to which other racial and ethnic groups should be compared.
VIII. The data for leading causes of death by sex and race and ethnicity were only included when there was sufficient data (counts of five and above).

HAMPDEN DATA PROFILE

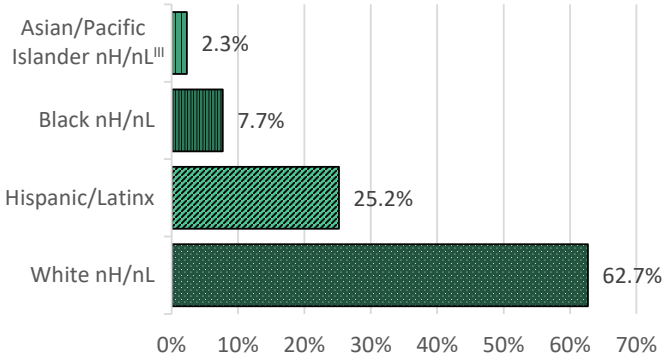
District-specific information about social determinants of health and child fatalities

District Demographics [I]

~465,800
Total population in 2020

~98,390
Population under the age of 18 in 2020
(21.1% of total population)

Population by Race & Ethnicity [II]



Education & Income [IV,V]

$55,429
Median household income

$36,730 - $114,271
Springfield Longmeadow
Range across municipalities

25.1%
Percent of children living in poverty

16.5%
Percent of adult population (over age 25) with a college degree

5.8%
Unemployment rate

Resources

The resources below can help Child Fatality Review teams better understand how social determinants of health in their communities affect child fatality rates. The Child Fatality Review Program epidemiologists can provide you with technical assistance in navigating these and other data sources. Please contact us at mdph-isp@mass.gov for more information.

- PHIT Community Reports
- Child Opportunity Index & Map
- Metropolitan Area Planning Council Data Common
- Massachusetts Data Hub
- History from Britannica.com
- U.S. Census Facts - Essex County
- Education Data at Town Charts
- 2022 County Health Rankings National Findings Report

I. Population estimates developed by the University of Massachusetts Donahue Institute (UMDI) in partnership with the Massachusetts Department of Public Health, Bureau of Environmental Health.
II. Total does not add up to 100%. Population data included here reflects the race and ethnicity categories in the death data shown below.
III. nH/nL = non-Hispanic/non-Latinx. Hispanic/Latinx refers to the ethnic background of people of Cuban, Mexican, Puerto Rican, or other Spanish or South or Central American culture or origin regardless of race. The terms Hispanic and Latinx are not necessarily interchangeable and include people from many ethnic, national, racial, and linguistic groups. Latinx is a gender-neutral term referring to people of Latin American ancestry.
IV. American Community Survey (ACS), 5-Year Estimates, 2015-2019
V. Metropolitan Area Planning Council Data Common: https://datacommon.mapc.org/browser/

Infant Fatalities (2016-2020)[VI,VII]

All rates are per 100,000 population

Number of fatalities	129 2016: 19; 2020: 29
Fatality rate	515.7
Inequities by race/ ethnicity	The infant death rate was highest among Asian/Pacific Islander (API) non-Hispanic/non-Latinx (nH/nL) infants, followed by Black nH/nL infants, Hispanic/ Latinx infants, and White nH/nL infants. The API nH/nL infant death rate was 4.7 times the White nH/nL infant death rate and 2.3 times the Hispanic infant death rate. The Black nH/nL infant death rate was 4 times the rate for White nH/nL infants and 2 times the rate for Hispanic/Latinx infants. The Hispanic/Latinx infant death rate was 2 times White nH/nL infant death rate.
Inequities by sex	The female infant death rate (523.9) was slightly higher than the male infant death rate (492.3).
Leading causes of death	• Congenital malformations • Short gestation/low birthweight • Sudden Infant Death Syndrome (SIDS) • Pregnancy complications
Leading causes by sex and race/ ethnicity	The female infant death rate from congenital malformations was 1.8 times the rate for male infants. The male infant death rate from short gestation/low birth weight and SIDS was 1.3 times the rate for female infants. Short gestation/low birthweight was the leading cause of death among Hispanic/ Latinx Infants. The Hispanic/Latinx infant death rate due to congenital malformations was twice the rate for White nH/nL infants. The male Black nH/nL infant death rate was 7 times the rate for male White nH/ nL infants and 2.7 times the rate for male Hispanic/Latinx infants. The male Hispanic/Latinx infant death rate was 2.6 times the rate for male White nH/nL infants.

VI. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020

VII. Where death rates for white infants and children are compared with death rates for various other races and ethnicities, the white group represents a population that has not been subject to structural racism and the resulting inequities in social, economic, or environmental factors that contribute to infant and child deaths. The use of white infants and children as a comparison group does not indicate that such a group represents a standard or ideal to which other racial and ethnic groups should be compared.

VIII. The data for leading causes of death by sex and race and ethnicity were only included when there was sufficient data (counts of five and above).

Child Fatalities, Ages 1-17 (2016-2020)[VI,VII] All rates are per 100, 000 population	
Number of fatalities	74 2016: 15; 2020: 12
Fatality rate	15.3
Inequities by race/ ethnicity	The death rate for Black nH/nL children was highest–more than twice the rate for White nH/nL children–followed by Hispanic/Latinx and White nH/nL children.
Inequities by sex	The male child death rate (19.4) was 1.7 times the female child death rate (11.1).
Age	The 15-17 age group had the highest death rate (30.4) followed by 1-4 age group (19.1). About 50% of unintentional injury deaths occurred among the 15-17 age group, followed by about 20% in the 10-14 age group. About 80% of suicides and homicides occurred in the 15-17 age group.
Leading causes of death	• Unintentional injuries • Cancer • Suicide • Homicide
Leading causes by sex and race/ ethnicity	The unintentional injury-related death rate among male children was 2.3 times the rate for female children. Unintentional injury was among the top causes of death for Black nH/nL, Hispanic, and White nH/nL children. Among Hispanic/Latinx and White nH/nL children these deaths occurred mainly in the 15-17 age group. For Black nH/nL children, such deaths were distributed among all the age groups. The unintentional injury-related death rate among Black nH/nL children was 2.7 times the White nH/nL child death rate, and 2.3 times the Hispanic/Latinx child death rate. Cancer and suicide were among the top causes of death for White nH/nL children.

VI. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020

VII. Where death rates for white infants and children are compared with death rates for various other races and ethnicities, the white group represents a population that has not been subject to structural racism and the resulting inequities in social, economic, or environmental factors that contribute to infant and child deaths. The use of white infants and children as a comparison group does not indicate that such a group represents a standard or ideal to which other racial and ethnic groups should be compared.

VIII. The data for leading causes of death by sex and race and ethnicity were only included when there was sufficient data (counts of five and above).

MIDDLESEX DATA PROFILE

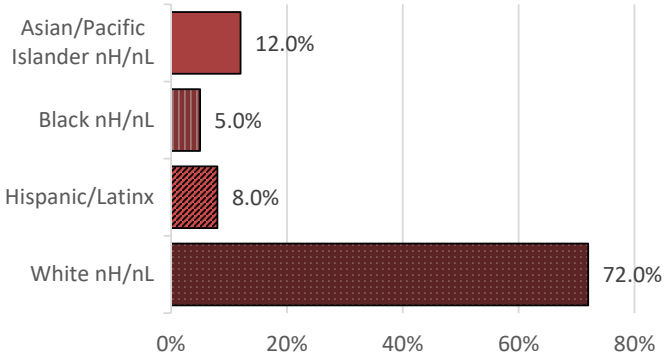
District-specific information about social determinants of health and child fatalities

District Demographics [I]

~1,632,000
Total population in 2020

~318,000
Population under the age of 18 in 2020
(20% of total population)

Population by Race & Ethnicity



Education & Income [III,IV]

$102,600
Median household income

$51,987 - $181,667
Lowell Weston
Range across municipalities

8%
Percent of children living in poverty

27.5%
Percent of adult population (over age 25) with a college degree

3.8%
Unemployment rate

Resources

The resources below can help Child Fatality Review teams better understand how social determinants of health in their communities affect child fatality rates. The Child Fatality Review Program epidemiologists can provide you with technical assistance in navigating these and other data sources. Please contact us at mdph-isp@mass.gov for more information.

- PHIT Community Reports
- Child Opportunity Index & Map
- Metropolitan Area Planning Council Data Common
- Massachusetts Data Hub
- History from Britannica.com
- U.S. Census Facts - Middlesex County
- Education Data at Town Charts
- 2022 County Health Rankings National Findings Report

I. Population estimates developed by the University of Massachusetts Donahue Institute (UMDI) in partnership with the Massachusetts Department of Public Health, Bureau of Environmental Health.
II. nH/nL = non-Hispanic/non-Latinx. Hispanic/Latinx refers to the ethnic background of people of Cuban, Mexican, Puerto Rican, or other Spanish or South or Central American culture or origin regardless of race. The terms Hispanic and Latinx are not necessarily interchangeable and include people from many ethnic, national, racial, and linguistic groups. Latinx is a gender-neutral term referring to people of Latin American ancestry.
III. American Community Survey (ACS), 5-Year Estimates, 2015-2019
IV. Metropolitan Area Planning Council Data Common: https://datacommon.mapc.org/browser/

Infant Fatalities (2016-2020)[V] All rates are per 100,000 population	
Number of fatalities	244
Fatality rate	277.8
Inequities by race/ethnicity	The infant death rate for Black non-Hispanic/non-Latinx (nH/nL) infants was highest, followed by the rate for Hispanic/Latinx infants. White nH/nL and Asian/Pacific Islander (API) nH/nL infants had similar death rates. The Black nH/nL infant death rate was more than twice the rates for White nH/nL, API nH/nL, and Hispanic/Latinx infants.
Inequities by sex	The male infant death rate (306.1) was 1.2 times the female infant death rate (247.9).
Leading causes of death	• Congenital malformations • Short gestation / low birthweight • Sudden infant death syndrome (SIDS) • Complications of placenta • Pregnancy complications
Leading causes by sex and race/ethnicity	The male infant death rates for short gestation/low birthweight and SIDS were 2.5 and 1.4 times the female infant death rates for those causes respectively. However, female infant death rate due to complications of the placenta was 1.6 times the male infant death rate. The female API nH/nL infant death rate was 1.3 times the rate for male API nH/nL infants. The male Black nH/nL infant death rate from short gestation/low birthweight was 6 times the rate for male White nH/nL infants.

See next page for data on fatalities among children ages 1-17.

V. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020

Child Fatalities, Ages 1-17 (2016-2020)[V] All rates are per 100, 000 population	
Number of fatalities	162
Fatality rate	10.5
Inequities by race/ethnicity	The death rate for Black nH/nL children was highest, followed by API nH/nL children. White nH/nL and Hispanic/Latinx children had the same death rates. The Black nH/nL child death rate was 2.1 times and the API nH/nL child death rate was 1.2 times the rates for White nH/nL and Hispanic/Latinx children.
Inequities by sex	The male child death rate (12.9) was 1.6 times the female child death rate (8.1).
Age	The 15-17 age group had the highest death rate (19.7) followed by the 1-4 age group (11.3). Cancer deaths were distributed across all age groups. Cancer was the top cause of death in the 5-9 and 10-14 age groups. Unintentional injuries occurred predominantly in children in the 1-4 and 15-17 age groups. Homicides also occurred in these two age groups. Suicide deaths mainly occurred in the 15-17 age group and was the top cause in this age group. Congenital malformations mainly occurred in 1-4 and 5-9 age groups.
Leading causes	• Cancer • Unintentional injuries • Suicide • Congenital malformations • Homicide
Leading causes by sex and race/ethnicity	The female API nH/nL child death rate was 1.6 times the male API nH/nL child death rate Cancer was the top cause of death for API nH/nL and White nH/nL children, while unintentional injuries was the top cause of death for Hispanic/Latinx children. The cancer death rate among API nH/nL children was 1.7 times the rate for White nH/nL children. The female API nH/nL child death rate was 2.2 times the female White nH/nL child death rate and 2.5 times the female Hispanic/Latinx child death rate.

V. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020

NORFOLK DATA PROFILE

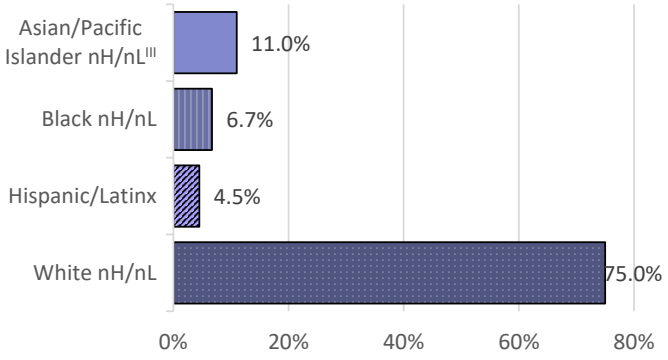
District-specific information about social determinants of health and child fatalities

District Demographics [I]

~726,000
Total population in 2020

~148,650
Population under the age of 18 in 2020
(20% of total population)

Population by Race & Ethnicity [II]



Education & Income [IV,V]

$103,291
Median household income

$69,868 - $224,784
Avon Dover
Range across municipalities

6%
Percent of children living in poverty

28.6%
Percent of adult population (over age 25) with a college degree

4.2%
Unemployment rate

Resources

The resources below can help Child Fatality Review teams better understand how social determinants of health in their communities affect child fatality rates. The Child Fatality Review Program epidemiologists can provide you with technical assistance in navigating these and other data sources. Please contact us at mdph-isp@mass.gov for more information.

- PHIT Community Reports
- Child Opportunity Index & Map
- Metropolitan Area Planning Council Data Common
- Massachusetts Data Hub
- History from Britannica.com
- U.S. Census Facts - Norfolk County
- Education Data at Town Charts
- Norfolk County Website
- 2022 County Health Rankings National Findings Report

I. Population estimates developed by the University of Massachusetts Donahue Institute (UMDI) in partnership with the Massachusetts Department of Public Health, Bureau of Environmental Health.
II. Total does not add up to 100%. Population data included here reflects the race and ethnicity categories in the death data shown below.
III. nH/nL = non-Hispanic/non-Latinx. Hispanic/Latinx refers to the ethnic background of people of Cuban, Mexican, Puerto Rican, or other Spanish or South or Central American culture or origin regardless of race. The terms Hispanic and Latinx are not necessarily interchangeable and include people from many ethnic, national, racial, and linguistic groups. Latinx is a gender-neutral term referring to people of Latin American ancestry.
IV. American Community Survey (ACS), 5-Year Estimates, 2015-2019
V. Metropolitan Area Planning Council Data Common: https://datacommon.mapc.org/browser/

Infant Fatalities (2016-2020)[VI,VII] All rates are per 100,000 population	
Number of fatalities	103
Fatality rate	282.8
Inequities by race/ethnicity	The infant death rate for Black non-Hispanic (nH/nL) infants was highest, followed by Hispanic, White nH/nL, and Asian/Pacific Islander (API) nH/nL infants. The Black nH/nL infant death rate was about 4 times White nH/nL infant death rate.
Inequities by sex	The male infant death rate (299.9) was 1.1 times the female infant death rate (264.1).
Leading causes of death	• Congenital malformations • Short gestation / low birthweight • Complications of placenta • Sudden infant death syndrome (SIDS)
Leading causes by sex and race/ethnicity[VIII]	For congenital malformations, female infants had a death rate (86.1) about 1.6 times the rate for male infants (52.6). Among Black nH/nL infants, congenital malformations was the leading cause of death at a rate 11.3 times that among White nH/nL infants. The next highest death rate for Black nH/nL infants was due to short gestation/low birthweight with a death rate 5.4 times the White nH/nL infant death rate.

See next page for data on fatalities among children ages 1-17.

VI. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020
VII. Where death rates for white infants and children are compared with death rates for various other races and ethnicities, the white group represents a population that has not been subject to structural racism and the resulting inequities in social, economic, or environmental factors that contribute to infant and child deaths. The use of white infants and children as a comparison group does not indicate that such a group represents a standard or ideal to which other racial and ethnic groups should be compared.
VIII. The data for leading causes of death by sex and race and ethnicity were only included when there was sufficient data (counts of five and above).

Child Fatalities, Ages 1-17 (2016-2020)[VI,VII] All rates are per 100, 000 population	
Number of fatalities	62
Fatality rate	8.7
Inequities by race/ethnicity	The death rate for Black nH/nL children was highest, followed by Hispanic, API nH/nL, and White nH/nL children. The Black nH/nL child death rate was almost 3.5 times White nH/nL child death rate.
Inequities by sex	The male child death rate (9.9) was 1.3 times the female child death rate (7.4).
Age	The 15-17 age group had the highest death rate (18.4), followed by the 1-4 age group (8.2). Most unintentional injuries and suicides occurred among children in the 15-17 age group.
Leading causes	• Unintentional injuries • Suicide • Cancer • Heart disease
Leading causes by sex and race/ethnicity[VIII]	Unintentional injury was the top cause of death for male Black nH/nL children and male White nH/nL children. The male Black nH/nL children death rate was 4.3 times male White nH/nL children death rate.

VI. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020

VII. Where death rates for white infants and children are compared with death rates for various other races and ethnicities, the white group represents a population that has not been subject to structural racism and the resulting inequities in social, economic, or environmental factors that contribute to infant and child deaths. The use of white infants and children as a comparison group does not indicate that such a group represents a standard or ideal to which other racial and ethnic groups should be compared.

VIII. The data for leading causes of death by sex and race and ethnicity were only included when there was sufficient data (counts of five and above).

NORTHWESTERN DISTRICT* DATA PROFILE

District-specific information about social determinants of health and child fatalities

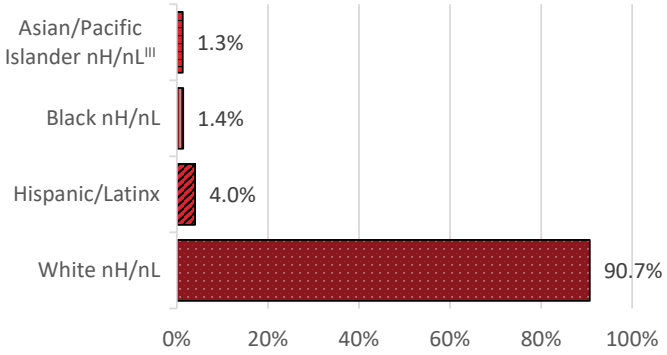
District Demographics [I]

~264,000
Total population in 2020

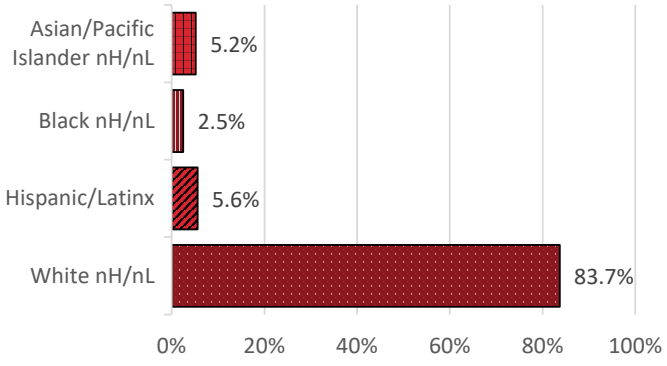
~38,700
Population under the age of 18 in 2020
(14.3 - 16.2% of total population)

Population by Race & Ethnicity [II]

Franklin



Hampshire



Education & Income [IV,V]

Median household income:
Franklin: $60,950
Hampshire: $70,876

Range across municipalities:
Franklin:
$26,458 - $97,188
Monroe — Conway

Hampshire:
$51,878 - $95,978
Amherst — Granby

Percent of children living in poverty:
Franklin: 11.6%
Hampshire: 11%

Percent of adult population (over age 25) with a college degree:
Franklin: 20.4%
Hampshire: 23.9%

Unemployment rate:
Franklin: 4.9%
Hampshire: 5.5%

See next page for data on fatalities among infants.

Infant Fatalities (2016-2020)[VI,VII] All rates are per 100,000 population	
Number of fatalities	43
Fatality rate	537.7
Inequities by race/ethnicity	The death rate for Hispanic/Latinx infants was highest, followed by White non-Hispanic/non-Latinx (nH/nL) infants. The Hispanic/Latinx infant death rate was 2.9 times the White nH/nL infant death rate.
Inequities by sex	The female infant death rate (568.1) was slightly higher than the male infant death rate (509.2).
Leading causes of death	• Congenital malformations • Sudden Infant Death Syndrome (SIDS) • Pregnancy complications
Leading causes by sex and race/ethnicity [VIII]	Congenital malformations and SIDS were the top two causes of death for both male and female infants. The top cause of death for Hispanic/Latinx infants was congenital malformations while the top cause of death for White nH/nL infants was SIDS followed by congenital malformations. The Hispanic/Latinx infant death rate from congenital malformations was 7 times the White nH/nL infant death rate. The death rate for female White nH/nL infants was 1.8 times the rate for male White nH/nL infants. The male Hispanic/Latinx infant death rate was 5 times the rate for male White nH/nL infants.

See next page for data on fatalities among children ages 1-17.

Child Fatalities, Ages 1-17 (2016-2020)[VI,VII] All rates are per 100, 000 population	
Number of fatalities	30
Fatality rate	17.1
Inequities by race/ethnicity	Most of the child deaths were among White nH/nL children. The death rate among children of color (Asian/Pacific Islander nH/nL, Black nH/nL, Hispanic/Latinx) was 1.8 times the rate for White nH/nL children.
Inequities by sex	The male child death rate (20.1) was 1.4 times the female child death rate (14.0). Closer to 60% of all unintentional injury-related deaths occurred among male children.
Age	The 15-17 age group had the highest death rate followed by 1-4 age group. 41% of the unintentional injury deaths occurred among children in the 5-9 age groups. Most suicides occurred among the 15-17 age group.
Leading causes	• Unintentional injuries • Suicide
Leading causes by sex and race/ethnicity [VIII]	Most unintentional injury deaths occurred among White nH/nL children. Male White nH/nL children had a death rate 1.5 times the rate for female White nH/nL children.

Resources

The resources below can help Child Fatality Review teams better understand how social determinants of health in their communities affect child fatality rates. The Child Fatality Review Program epidemiologists can provide you with technical assistance in navigating these and other data sources. Please contact us at mdph-isp@mass.gov for more information.

- **County History at Britannica.com:**
  - Franklin County
  - Hampshire County
- **U.S. Census County Facts:**
  - Franklin County
  - Hampshire County
- **County Education Data at Town Charts:**
  - Franklin County
  - Hampshire County
- PHIT Community Reports
- Child Opportunity Index & Map
- Metropolitan Area Planning Council Data Common
- Massachusetts Data Hub
- 2022 County Health Rankings National Findings Report

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* District includes Hampshire and Franklin Counties combined

I. Population estimates developed by the University of Massachusetts Donahue Institute (UMDI) in partnership with the Massachusetts Department of Public Health, Bureau of Environmental Health.
II. Total does not add up to 100%. Population data included here reflects the race and ethnicity categories in the death data shown below.
III. nH/nL = non-Hispanic/non-Latinx. Hispanic/Latinx refers to the ethnic background of people of Cuban, Mexican, Puerto Rican, or other Spanish or South or Central American culture or origin regardless of race. The terms Hispanic and Latinx are not necessarily interchangeable and include people from many ethnic, national, racial, and linguistic groups. Latinx is a gender-neutral term referring to people of Latin American ancestry.
IV. American Community Survey (ACS), 5-Year Estimates, 2015-2019
V. Metropolitan Area Planning Council Data Common: https://datacommon.mapc.org/browser/ TEST
VI. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020
VII. Where death rates for white infants and children are compared with death rates for various other races and ethnicities, the white group represents a population that has not been subject to structural racism and the resulting inequities in social, economic, or environmental factors that contribute to infant and child deaths. The use of white infants and children as a comparison group does not indicate that such a group represents a standard or ideal to which other racial and ethnic groups should be compared.
VIII. The data for leading causes of death by sex and race and ethnicity were only included when there was sufficient data (counts of five and above).

PLYMOUTH DATA PROFILE

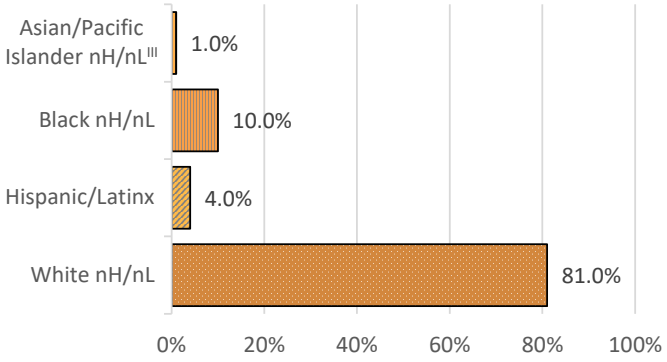
District-specific information about social determinants of health and child fatalities

District Demographics [I]

~ 530,800
Total population in 2020

~111,300
Population under the age of 18 in 2020
(21% of total population)

Population by Race & Ethnicity[II]



Education & Income [IV,V]

$89,489
Median household income

$55,140 - $151,306
Brockton Norwell
Range across municipalities

9.3%
Percent of children living in poverty

23.7%
Percent of adult population (over age 25) with a college degree

5%
Unemployment rate

Resources

The resources below can help Child Fatality Review teams better understand how social determinants of health in their communities affect child fatality rates. The Child Fatality Review Program epidemiologists can provide you with technical assistance in navigating these and other data sources. Please contact us at mdph-isp@mass.gov for more information.

- PHIT Community Reports
- Child Opportunity Index & Map
- Metropolitan Area Planning Council Data Common
- Massachusetts Data Hub
- History from Britannica.com
- U.S. Census Facts - Norfolk County
- Education Data at Town Charts
- Plymouth County Website
- 2022 County Health Rankings National Findings Report

I. Population estimates developed by the University of Massachusetts Donahue Institute (UMDI) in partnership with the Massachusetts Department of Public Health, Bureau of Environmental Health.
II. Total does not add up to 100%. Population data included here reflects the race and ethnicity categories in the death data shown below.
III. nH/nL = non-Hispanic/non-Latinx. Hispanic/Latinx refers to the ethnic background of people of Cuban, Mexican, Puerto Rican, or other Spanish or South or Central American culture or origin regardless of race. The terms Hispanic and Latinx are not necessarily interchangeable and include people from many ethnic, national, racial, and linguistic groups. Latinx is a gender-neutral term referring to people of Latin American ancestry.
IV. American Community Survey (ACS), 5-Year Estimates, 2015-2019
V. Metropolitan Area Planning Council Data Common: https://datacommon.mapc.org/browser/

Infant Fatalities (2016-2020)[VI,VII] All rates are per 100,000 population	
Number of fatalities	87
Fatality rate	344.6 2016: 379.1; 2020: 367.6
Inequities by race/ethnicity	The infant death rate for Black non-Hispanic/Latinx (nH/nL) infants was highest, followed by Hispanic/Latinx and White nH/nL infants The Black nH/nL infant death rate was 2.7 times the White nH/nL infant death rate and 1.9 times the Hispanic/Latinx infant death rate.
Inequities by sex	The male infant death rate (415.5) was 1.6 times the female infant death rate (261.2).
Leading causes of death	• Short gestation / low birthweight • Congenital malformations • Pregnancy complications • Complications of placenta
Leading causes by sex and race/ethnicity [VIII]	The male infant death rate resulting from short gestation/low birthweight was 1.8 times the female infant death rate. The Black nH/nL infant death rate due to short gestation/low birthweight was 2.2 times the White nH/nL infant death rate.

See next page for data on fatalities among children ages 1-17.

VI. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020
VII. Where death rates for white infants and children are compared with death rates for various other races and ethnicities, the white group represents a population that has not been subject to structural racism and the resulting inequities in social, economic, or environmental factors that contribute to infant and child deaths. The use of white infants and children as a comparison group does not indicate that such a group represents a standard or ideal to which other racial and ethnic groups should be compared.
VIII. The data for leading causes of death by sex and race and ethnicity were only included when there was sufficient data (counts of five and above).

Child Fatalities, Ages 1-17 (2016-2020)[VI,VII] All rates are per 100, 000 population	
Number of fatalities	58
Fatality rate	10.7 2016: 16.5; 2020: 8.5
Inequities by race/ethnicity	The death rate for Black nH/nL children was highest, followed by White nH/nL children. The Black nH/nL child death rate was twice as high as White nH/nL child death rate.
Inequities by sex	The male child death rate (11.9) was 1.3 times the female child death rate (9.5).
Age	The 15-17 age group had the highest death rate (17.8). Unintentional injury deaths mainly occurred in the 15-17 age group, followed by the 10-14 age group. Homicide was the leading cause of death in the 5-9 year age group.
Leading causes	• Unintentional injuries • Cancer • Homicide • Ill-defined conditions signs and symptoms
Leading causes by sex and race/ethnicity [VIII]	The unintentional injury-related death rate among Black nH/nL children was 5.6 times the White nH/nL child death rate. Unintentional injuries were the top cause of death among male children. Unintentional injuries were also the top cause among Black nH/nL children. Among White nH/nL children unintentional injuries and cancer were among the top causes of death.

VI. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020

VII. Where death rates for white infants and children are compared with death rates for various other races and ethnicities, the white group represents a population that has not been subject to structural racism and the resulting inequities in social, economic, or environmental factors that contribute to infant and child deaths. The use of white infants and children as a comparison group does not indicate that such a group represents a standard or ideal to which other racial and ethnic groups should be compared.

VIII. The data for leading causes of death by sex and race and ethnicity were only included when there was sufficient data (counts of five and above).

SUFFOLK DATA PROFILE

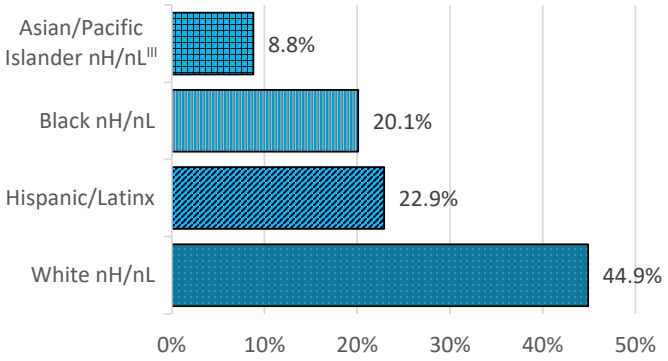
District-specific information about social determinants of health and child fatalities

District Demographics [I]

~798,000
Total population in 2020

~127,650
Population under the age of 18 in 2020
(16% of total population)

Population by Race & Ethnicity [II]



Education & Income [IV,V]

$69,669
Median household income

$53,280 - $68,322
Chelsea Winthrop
Range across municipalities

26%
Percent of children living in poverty

25.3%
Percent of adult population (over age 25) with a college degree

6.4%
Unemployment rate

Resources

The resources below can help Child Fatality Review teams better understand how social determinants of health in their communities affect child fatality rates. The Child Fatality Review Program epidemiologists can provide you with technical assistance in navigating these and other data sources. Please contact us at mdph-isp@mass.gov for more information.

- PHIT Community Reports
- Child Opportunity Index & Map
- Metropolitan Area Planning Council Data Common
- Massachusetts Data Hub
- History from Britannica.com
- U.S. Census Facts - Suffolk County
- Education Data at Town Charts
- 2022 County Health Rankings National Findings Report

I. Population estimates developed by the University of Massachusetts Donahue Institute (UMDI) in partnership with the Massachusetts Department of Public Health, Bureau of Environmental Health.
II. Total does not add up to 100%. Population data included here reflects the race and ethnicity categories in the death data shown below.
III. nH/nL = non-Hispanic/non-Latinx. Hispanic/Latinx refers to the ethnic background of people of Cuban, Mexican, Puerto Rican, or other Spanish or South or Central American culture or origin regardless of race. The terms Hispanic and Latinx are not necessarily interchangeable and include people from many ethnic, national, racial, and linguistic groups. Latinx is a gender-neutral term referring to people of Latin American ancestry.
IV. American Community Survey (ACS), 5-Year Estimates, 2015-2019
V. Metropolitan Area Planning Council Data Common: https://datacommon.mapc.org/browser/

Infant Fatalities (2016-2020)[VI,VII]

All rates are per 100,000 population

Number of fatalities	207 2016: 50; 2020: 35
Fatality rate	463.7
Inequities by race/ethnicity	The infant death rate for Black non-Hispanic/non-Latinx (nH/nL) infants was highest, followed by the rates for Hispanic/Latinx, Asian/Pacific Islander (API) nH/nL, and White nH/nL infants. The Black nH/nL infant death rate was about 4 times the White nH/nL infant death rate, 2 times the Hispanic infant death rate, and 2.8 times the API nH/nL infant death rate. The Hispanic/Latinx infant death rate was about 2 times the White nH/nL death rate. The API nH/nL infant death rate was about 1.4 times the rate for White nH/nL infants.
Inequities by sex	The male infant death rate (506.9) was 1.2 times the female infant death rate (418.3).
Leading causes of death	• Short gestation/low birthweight • Congenital malformations • Pregnancy complications • Sudden Infant Death Syndrome (SIDS) • Complications of placenta
Leading causes by sex and race/ethnicity [VIII]	The male infant death rate for short gestation/low birthweight (104.9) and pregnancy complications (56.8) were 1.2 and 1.4 times the rates for female infants respectively (87.3 and 41.4) Short gestation/low birthweight was the leading cause of death among Black nH/nL infants at a rate 8.1 times the rate for White nH/nL infants, and 2 times the rate for Hispanic/Latinx infants. The next highest cause-specific death rate for Black nH/nL infants was for congenital malformations, and was 2.5 times the rate for White nH/nL infants and 1.6 times the rate for Hispanic/Latinx infants.

See next page for data on fatalities among children ages 1-17.

VI. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020

VII. Where death rates for white infants and children are compared with death rates for various other races and ethnicities, the white group represents a population that has not been subject to structural racism and the resulting inequities in social, economic, or environmental factors that contribute to infant and child deaths. The use of white infants and children as a comparison group does not indicate that such a group represents a standard or ideal to which other racial and ethnic groups should be compared.

VIII. The data for leading causes of death by sex and race and ethnicity were only included when there was sufficient

Child Fatalities, Ages 1-17 (2016-2020)[VI,VII] All rates are per 100, 000 population	
Number of fatalities	100 2016:29; 2020:14
Fatality rate	16.1
Inequities by race/ethnicity	The child death rate for API nH/nL children was highest, followed by the rate for Black nH/nL children. Hispanic/Latinx and White nH/nL children had similar child death rates. The API nH/nL child death rate was 1.3 times the White nH/nL and Hispanic/Latinx child death rates.
Inequities by sex	The male child death rate (20.8) was 1.8 times the female child death rate (11.4).
Age	The 15-17 age group had the highest death rate (29.1), followed by the 1-4 age group (20.8). Cancer deaths were distributed across all age groups. Homicides mainly occurred in the 15-17 age group. Unintentional injuries occurred predominantly in the 5-9 and 15-17 age groups.
Leading causes	• Cancer • Homicide • Unintentional injuries • Congenital malformations
Leading causes by sex and race/ethnicity [VIII]	90% of homicides occurred among male children. The cancer death rate among male children was 1.5 times the rate for female children. Cancer was the top cause of death for Hispanic, White nH/nL, and API nH/nL children. Homicide was the top cause for Black nH/nL children and second highest cause for Hispanic/Latinx children. The majority of homicide deaths occurred in the 15-17 age group.

VI. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020

VII. Where death rates for white infants and children are compared with death rates for various other races and ethnicities, the white group represents a population that has not been subject to structural racism and the resulting inequities in social, economic, or environmental factors that contribute to infant and child deaths. The use of white infants and children as a comparison group does not indicate that such a group represents a standard or ideal to which other racial and ethnic groups should be compared.

VIII. The data for leading causes of death by sex and race and ethnicity were only included when there was sufficient

WORCESTER DATA PROFILE

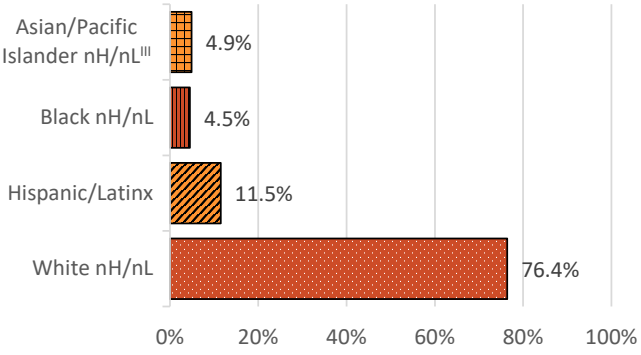
District-specific information about social determinants of health and child fatalities

District Demographics [I]

~862,100
Total population in 2020

~178,530
Population under the age of 18 in 2020
(21% of total population)

Population by Race & Ethnicity [II]



Education & Income [IV,V]

$74,679
Median household income

$46,407 - $155,093
Worcester Bolton
Range across municipalities

12.3%
Percent of children living in poverty

22.0%
Percent of adult population (over age 25) with a college degree

5%
Unemployment rate

Resources

The resources below can help Child Fatality Review teams better understand how social determinants of health in their communities affect child fatality rates. The Child Fatality Review Program epidemiologists can provide you with technical assistance in navigating these and other data sources. Please contact us at mdph-isp@mass.gov for more information.

- PHIT Community Reports
- Child Opportunity Index & Map
- Metropolitan Area Planning Council Data Common
- Massachusetts Data Hub
- History from Britannica.com
- U.S. Census Facts - Worcester County
- Education Data at Town Charts
- 2022 County Health Rankings National Findings Report

I. Population estimates developed by the University of Massachusetts Donahue Institute (UMDI) in partnership with the Massachusetts Department of Public Health, Bureau of Environmental Health.
II. Total does not add up to 100%. Population data included here reflects the race and ethnicity categories in the death data shown below.
III. nH/nL = non-Hispanic/non-Latinx. Hispanic/Latinx refers to the ethnic background of people of Cuban, Mexican, Puerto Rican, or other Spanish or South or Central American culture or origin regardless of race. The terms Hispanic and Latinx are not necessarily interchangeable and include people from many ethnic, national, racial, and linguistic groups. Latinx is a gender-neutral term referring to people of Latin American ancestry.
IV. American Community Survey (ACS), 5-Year Estimates, 2015-2019
V. Metropolitan Area Planning Council Data Common: https://datacommon.mapc.org/browser/

Infant Fatalities (2016-2020)[VI,VII]

All rates are per 100,000 population

Number of fatalities	202
Fatality rate	465.0 2016: 553.2; 2020: 404.9
Inequities by race/ethnicity	The infant death rate for Black non-Hispanic/Latinx (nH/nL) infants was highest, followed by Hispanic/Latinx, White nH/nL, and Asian/Pacific Islander (API) nH/nL infants. The Black nH/nL infant death rate was 2.0 times the rates for Hispanic/Latinx infants and White nH/nL infants, and 3.2 times the rate for API nH/nL infants.
Inequities by sex	The male infant death rate (482.7) was slightly higher than the female infant death rate (446.1).
Leading causes of death	• Short gestation / low birthweight • Congenital malformations • Sudden Infant Death Syndrome (SIDS) • Pregnancy complications • Ill-defined and unknown cause of mortality
Leading causes by sex and race/ethnicity[VIII]	The female infant death rate resulting from short gestation/low birthweight was 1.6 times male infant death rate. The female Hispanic/Latinx infant death rate resulting from short gestation/low birthweight was twice the male Hispanic/Latinx infant death rate. The short gestation/low birthweight-related death rate for Black nH/nL infants was 3.5 times the rate for White nH/nL infants and 2.8 times the rate for Hispanic/Latinx infants.

See next page for data on fatalities among children ages 1-17.

VI. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020

VII. Where death rates for white infants and children are compared with death rates for various other races and ethnicities, the white group represents a population that has not been subject to structural racism and the resulting inequities in social, economic, or environmental factors that contribute to infant and child deaths. The use of white infants and children as a comparison group does not indicate that such a group represents a standard or ideal to which other racial and ethnic groups should be compared.

VIII. The data for leading causes of death by sex and race and ethnicity were only included when there was sufficient

Child Fatalities, Ages 1-17 (2016-2020)[VI,VII]

All rates are per 100, 000 population

Number of fatalities	113
Fatality rate	13.3 2016: 10.6; 2020: 8.8
Inequities by race/ethnicity	The child death rate for Black nH/nL children was highest, followed by rates for API nH/nL, Hispanic/Latinx, and White nH/nL children. The Black nH/nL child death rate was 1.9 times the Hispanic/Latinx child death rate and 2.1 times as high as the White nH/nL child death rate. API nH/nL children had a death rate 1.6 times as high as Hispanic/Latinx children and 1.8 times as high as White nH/nL children.
Inequities by sex	The male child death rate (14.3) was 1.2 times the female child death rate (12.3).
Age	The 15-17 age group had the highest death rate (21.5), followed by the 1-4 age group (12.5). More than half of all unintentional injury deaths occurred in the 15-17 age group. About80% of all Suicide deaths occurred in the 15-17age group. Cancer was the leading cause of death among children in the 5-9 and 10-14 age groups. Ill-defined condition-related deaths occurred primarily in the 1-4 age group.
Leading causes	• Unintentional injuries • Cancer • Suicide • Ill-defined conditions signs and symptoms
Leading causes by sex and race/ethnicity[VIII]	For unintentional injury-related deaths, the Hispanic/Latinx child death rate was 2.4 times the rate for White nH/nL children; the male Hispanic/Latinx children's death rate was 3.7 times male White nH/nL children's. Unintentional injuries were the top cause of death among male children, while cancer was the top cause of death for female children. The suicide-related death rate was similar among male children, for whom it was the fourth leading cause, and female children, for whom it was the second leading cause. Unintentional injuries were the top cause of death among White nH/nL and Hispanic/Latinx children. Suicide was the second leading cause of death among Hispanic/Latinx children and third leading cause of death among White nH/nL children. Cancer was the second leading cause of death for White nH/nL children.

VI. Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2020

VII. Where death rates for white infants and children are compared with death rates for various other races and ethnicities, the white group represents a population that has not been subject to structural racism and the resulting inequities in social, economic, or environmental factors that contribute to infant and child deaths. The use of white infants and children as a comparison group does not indicate that such a group represents a standard or ideal to which other racial and ethnic groups should be compared.

VIII. The data for leading causes of death by sex and race and ethnicity were only included when there was sufficient

Appendix D. Local Team Guidelines

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CHILD FATALITY REVIEW LOCAL TEAM GUIDELINES

Massachusetts

Approved 7/12/2023

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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.

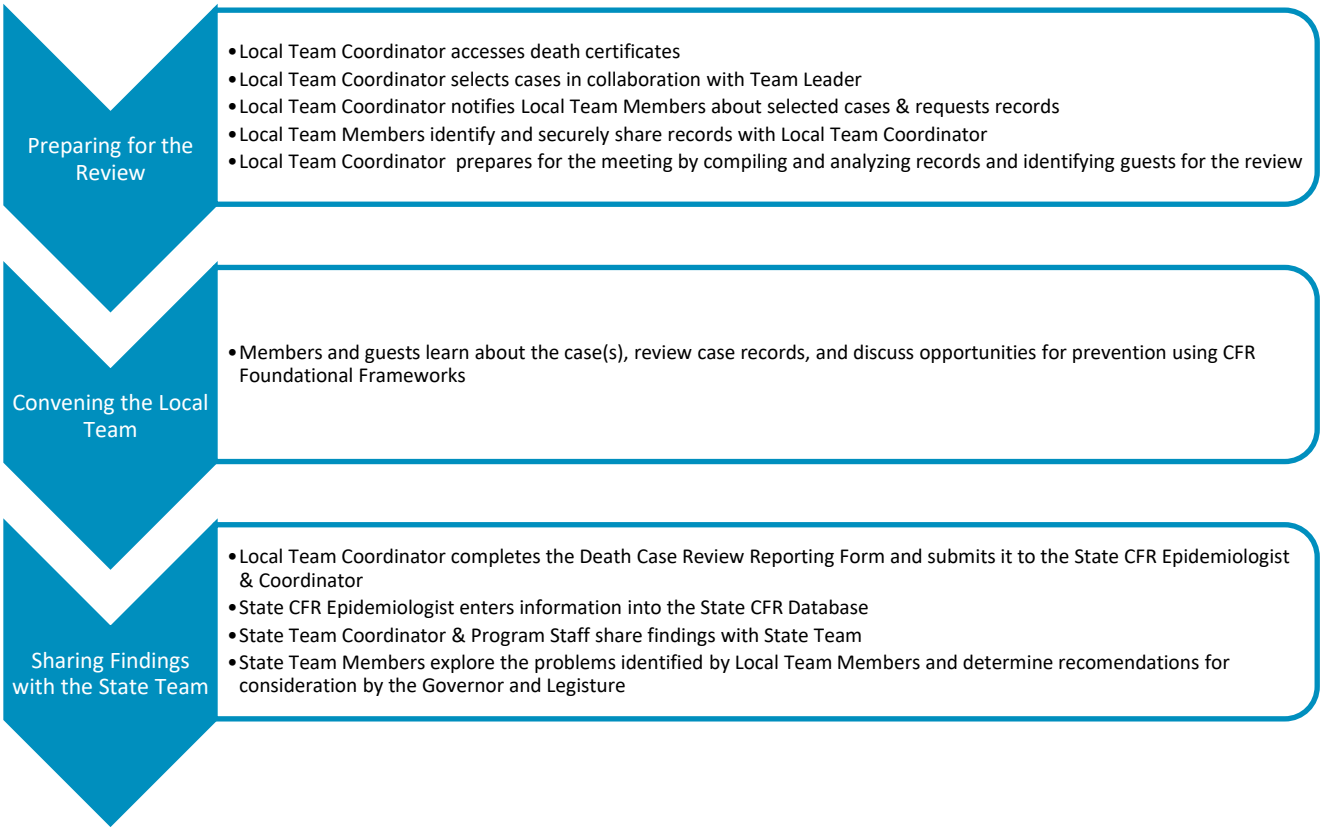
This set of guidelines has some sample letters in the appendix that may be of particular help to Local Teams.

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

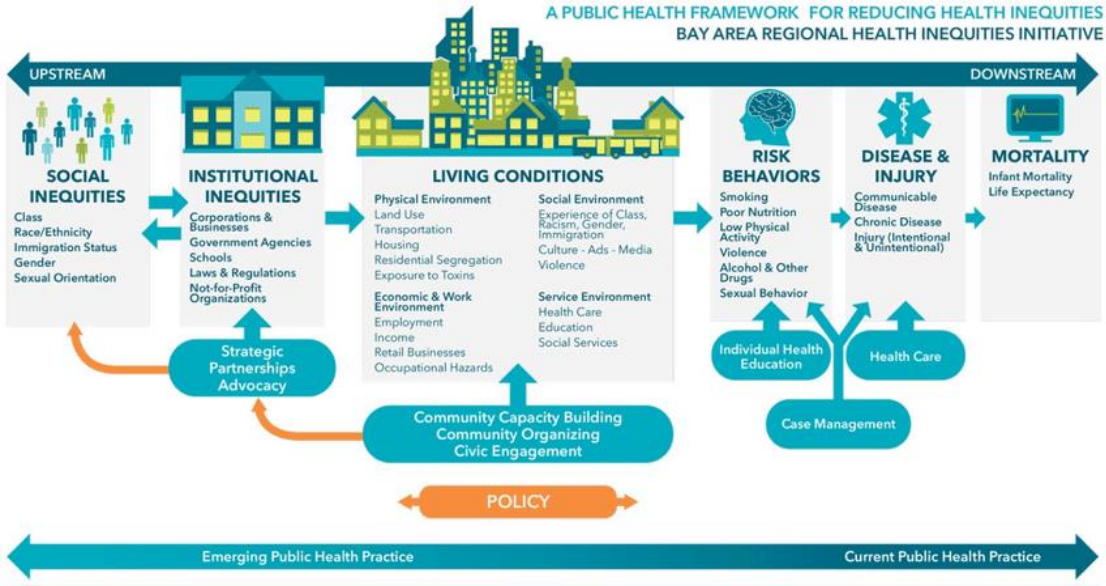
- Discrimination and Social Inequities
- Public Policy, Wealth, and Resource Distribution
- Heath and Insurance Systems
- Licensing and Permitting Systems
- Screening and Referral Systems

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.

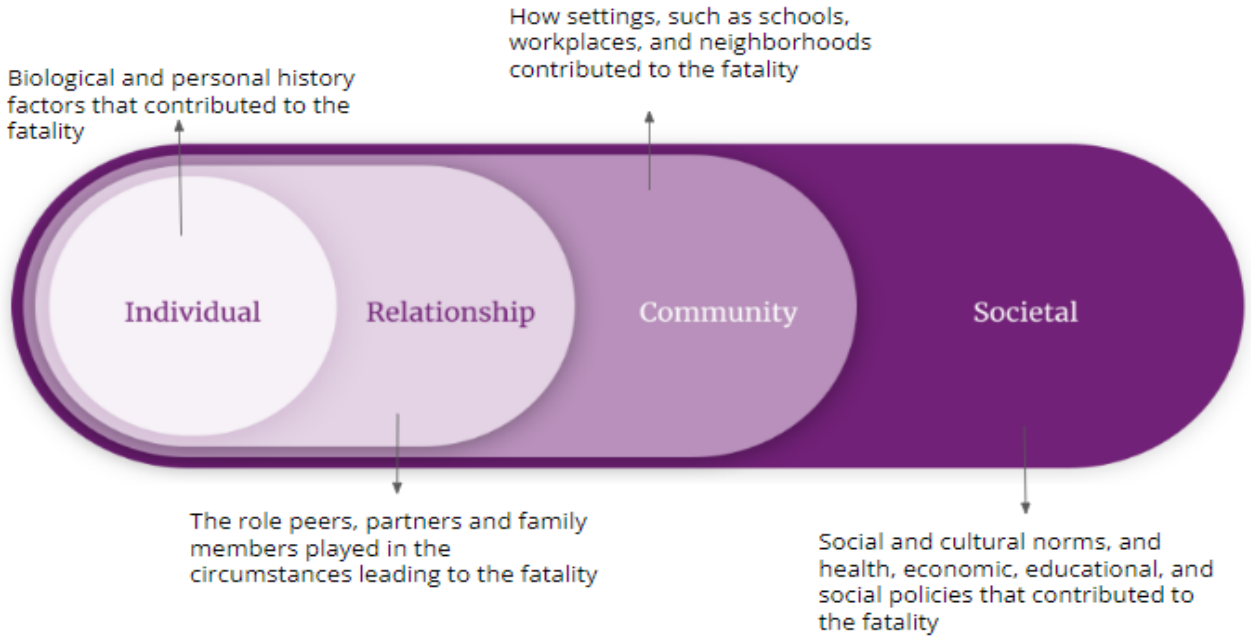
3. **Investigate the community's history and context, including long-standing policies, cultural norms, and values.** There is an array of sources that can provide detailed insights into local history that may shape the factors contributing to a fatality or near fatality:
    - Local libraries sections 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: / / MM DD YYYY		Date of Death: / / 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