

# **MARYLAND STATE CHILD FATALITY REVIEW TEAM**

## **2010 Annual Legislative Report**

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Governor

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[http://fha.maryland.gov/mch/cfr\\_home.cfm](http://fha.maryland.gov/mch/cfr_home.cfm)

## **Overview of the Maryland State Child Fatality Review Team**

Child Fatality Review is a systematic, multi-agency, multi-disciplinary review of unexpected child deaths. This review process, which began in Los Angeles in 1978 as a mechanism to identify fatal child abuse and neglect, has grown into a national system to examine child fatalities within the context of prevention.

The purpose of the Maryland State Child Fatality Review (CFR) Team is to prevent child deaths by: (1) understanding the causes and incidence of child deaths; (2) implementing changes within the agencies represented on the State CFR Team to prevent child deaths; and (3) advising the Governor, the General Assembly, and the public on changes to law, policy, and practice to prevent child deaths. The State CFR Team envisions the elimination of preventable child fatalities by successfully using the Child Fatality Review process to understand the circumstances around fatalities that occur, and to recommend strategies for prevention of future fatalities.

Child Fatality Review was established in Maryland statute in 1999. The 25 member State CFR Team is comprised of the Secretaries (or their designees) and representatives of 12 State agencies or offices, two pediatricians, and 11 members of the general public with interest and expertise in child safety and welfare who are appointed by the Governor (see Appendix A for 2010 State CFR Team member list). The State CFR Team meets at least four times a year to address 13 statutorily-prescribed duties (see Appendix B for State CFR Team duties). One of the quarterly meetings is an all-day training on select topics to enhance knowledge on child fatality issues.

The State CFR Team is considered part of the Department of Health and Mental Hygiene (DHMH) for budgetary and administrative purposes. In addition to the State CFR Team, each jurisdiction has a local CFR team. These local CFR teams convene regular meetings to review unexpected deaths of child residents living within their geographic borders. The teams concentrate on issues specific to each area, reviewing deaths in order to make recommendations for systems, policy, or practice changes on the local level.

Detecting and preventing child abuse and neglect remains an important focus of CFR, DHMH, and the Department of Human Resources (DHR). The overarching benefit of CFR is an examination of the system of service delivery and an evaluation of the adequacy of services provided in order to prevent child deaths.

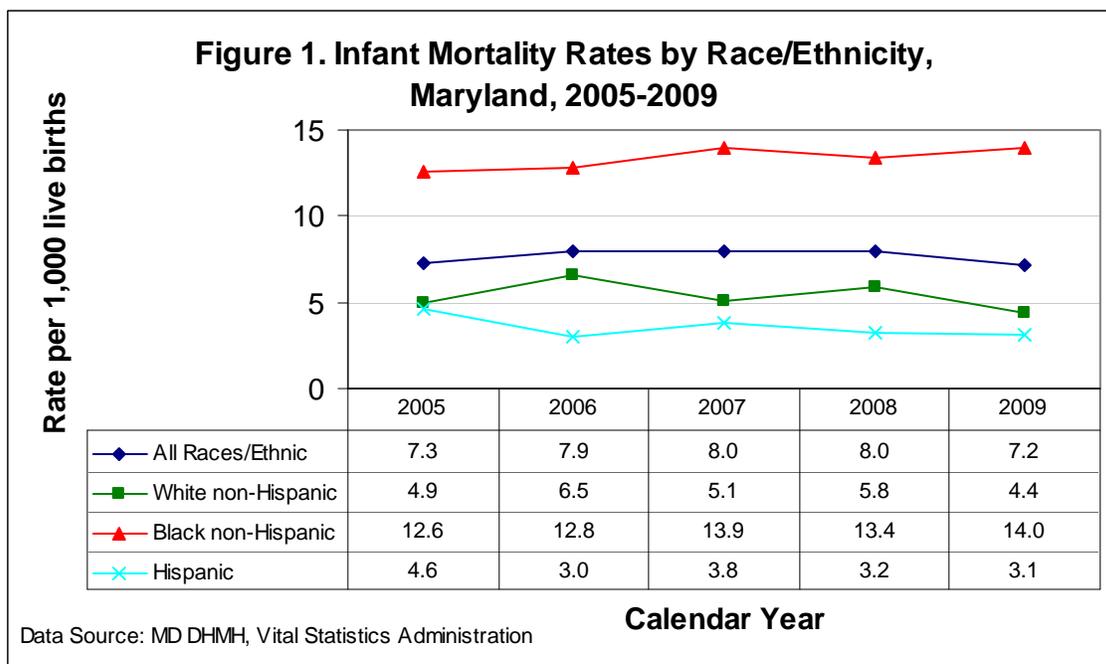
Other teams in Maryland have similar charges to prevent child injury and death, including the State Council on Child Abuse and Neglect (SCCAN) and the Citizen Review Board for Children (CRBC); both of these organizations examine policies and practices for protecting children. There is a close collaboration between the State CFR Team, SCCAN, and CRBC as they are “sister” teams under Maryland law. The State Morbidity, Mortality, and Quality Review Committee (MMQRC), which was established by House Bill 535 (2008), and is housed within DHMH, is charged with conducting confidential and anonymous case reviews of morbidity and mortality associated with pregnancy, childbirth, infancy, and early childhood. Based on information from local morbidity and mortality review teams, the MMQRC is charged with developing and implementing interventions to improve the system of care for pregnancy, childbirth, infancy, and early childhood. In addition to State level collaboration, there are also local collaborative efforts. Local Fetal and Infant Mortality Review (FIMR) teams operate in every jurisdiction. FIMR teams are supported by DHMH in their review of cases of death in infants under one year. Local FIMR and CFR teams often work together closely.

# Summary of the Maryland Child Death Report 2010

2005-2009

Childhood deaths are a major public health problem and many of these deaths are preventable. Surveillance of childhood deaths is critical as it helps to measure the magnitude of the problem, and to assess the causes of death and the population groups most affected. Data are crucial in identifying trends and targeting interventions to reduce childhood mortality.

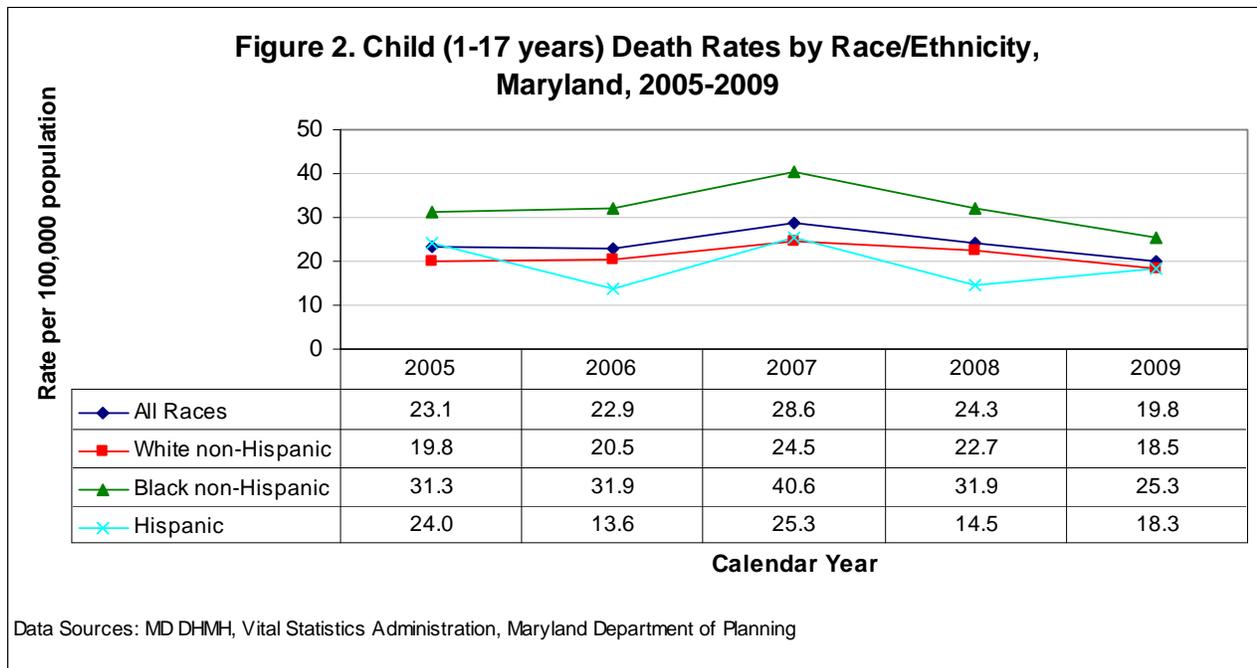
The Child Death Report focuses on deaths in children under the age of 18. In 2009, there were 541 infant (< 1 year of age) deaths and 253 deaths of children ages 1-17. Deaths to infants are usually analyzed separately from deaths to children 1-17 years of age. The three leading causes of death for infants for 2009 were: (1) disorders related to preterm birth or low birth weight (25.0%), (2) congenital abnormalities (15.9%), and (3) sudden infant death syndrome (11.3%). The infant mortality rate declined to 7.2 per 1,000 live births in 2009 (Figure 1).



There were substantial disparities in infant mortality rates between racial groups in 2009. The infant mortality rate for Black non-Hispanics (14.0 per 1,000 live births) was over three times as high as the rate for White non-Hispanics (4.4 per 1,000 live births), and more than four times the rate for Hispanics (3.1 per 1,000 live births).

In 2009, the child death rate (1-17 years of age) decreased to 19.8 per 100,000 population (Figure 2). That same year, the child death rate for White non-Hispanics was 18.5 per 100,000 population compared to 25.3 per 100,000 population for Black non-Hispanics. The child death rate for Hispanics in 2009 was 18.3 per 100,000 population. Among children ages 1-17, the three leading causes of death during the period from 2007-2009 were: (1) unintentional injuries, (2) homicide, and (3) malignant neoplasms (note: data are aggregated over a three year period to provide more stability). Table 1 shows the leading causes of death by age group. For the injury-related deaths, 34.1 percent were due to motor vehicle collisions (Tables 2 and 3). Sixty-four percent of motor vehicle deaths occurred in males. The greatest proportion of motor vehicle-

related injury deaths occurred in children ages 15-17 (54.3%). The rates for motor vehicle related deaths by race and ethnicity per 100,000 population were: 4.6 for White non-Hispanics, 4.1 for Black non-Hispanics, and 3.1 for Hispanics.



Childhood death by homicide continues to be a significant public health problem in Maryland. In the period from 2007-2009, there were 13 homicides of infants and 141 homicides among children ages 1-17. The rate of homicides among children ages 0-17 is substantially higher among Black non-Hispanics, at 8.1 per 100,000 population, compared to 3.7 per 100,000 population for Hispanics, and 1.7 per 100,000 population for White non-Hispanics. Fifty-seven percent of the homicides of children ages 0-17 involved firearms. The age group with the highest homicide rate was that of children 15-17 years of age (11.6 per 100,000 population). The group with the next highest rate was that of infants (5.6 per 100,000 population). Seventy-five percent of the child victims of homicide (ages 0-17 years) were male.

There were 49 suicides among children over the period from 2007-2009. The rate of suicide was greatest among those ages 15-17 years (5.2 per 100,000 population). Suicides occurred less frequently among younger children ages 10-14 years (0.9 per 100,000 population). Among children ages 10-17, 68.8 percent of suicides were committed by males. The suicide rates were slightly higher among White non-Hispanic children (3.4 per 100,000 population) compared to Black non-Hispanic children (2.0 per 100,000 population). There were less than five suicides reported among Hispanic and Asian children during this period, so rates were not computed due to instability.

**Table 1. Causes of Death by Age Group, Maryland, 2007-2009**

Rank	Age Group				
		1-4 years	5-9 years	10-14 years	15-17 years
1	<b>Cause of Death</b>	Unintentional Injury	Unintentional Injury	Unintentional Injury	Unintentional Injury
	<b># of Deaths</b>	59	42	52	109
	<b>% of Deaths in Age Group</b>	23.4%	30.7%	26.5%	32.0%
2	<b>Cause of Death</b>	Homicide	Diseases of the Respiratory System	Malignant Neoplasms	Homicide
	<b># of Deaths</b>	31	13	24	84
	<b>% of Deaths in Age Group</b>	12.3%	9.5%	12.2%	24.6%
3	<b>Cause of Death</b>	Congenital Malformations	Malignant Neoplasms	Homicide	Suicide
	<b># of Deaths</b>	31	12	19	38
	<b>% of Deaths in Age Group</b>	12.3%	8.8%	9.7%	11.1%
4	<b>Cause of Death</b>	Diseases of the Respiratory System	Diseases of the Nervous System	Diseases of the Respiratory System	Malignant Neoplasms
	<b># of Deaths</b>	21	11	16	22
	<b>% of Deaths in Age Group</b>	8.3%	8.0%	8.2%	6.5%
5	<b>Cause of Death</b>	Infectious Diseases	Diseases of the Circulatory System	Diseases of the Nervous System	Diseases of the Circulatory System
	<b># of Deaths</b>	18	10	15	20
	<b>% of Deaths in Age Group</b>	7.1%	7.3%	7.7%	5.9%
	<b>All Other Causes of Death</b>				
	<b># of Deaths</b>	92	49	70	68
	<b>% of Deaths in Age Group</b>	36.5%	35.8%	35.7%	20.0%
	<b>Total # of Deaths in Age Group</b>	252	137	196	341

Data Source: MD DHMH, Vital Statistics Administration

**Table 2. Child (1-17 years) Injury-Related Deaths by Type of Injury and Gender, Maryland, 2007-2009**

<b>Type of Injury</b>	<b>Male</b>	<b>Female</b>	<b>Total Deaths</b>	<b>% of Total Injury Deaths</b>
Motor Vehicle Collision	103	59	162	34.1%
Homicide	109	32	141	29.7%
Suicide	34	15	49	10.3%
Fire	19	10	29	6.1%
Drowning	21	5	26	5.5%
Other Non-Transport Injury	14	8	22	4.6%
Undetermined Intent	17	5	22	4.6%
Other Transport Injury	9	4	13	2.7%
Falls	6	3	9	1.9%
Poisoning	0	1	1	0.2%
Legal Intervention	1	0	1	0.2%
<b>Total</b>			<b>475</b>	

Data Source: MD DHMH, Vital Statistics Administration

**Table 3. Child (1-17 years) Injury-Related Deaths by Type of Injury and Race/Ethnicity, Maryland, 2007-2009**

<b>Type of Injury</b>	<b>White non-Hispanic</b>	<b>Black non-Hispanic</b>	<b>Hispanic</b>	<b>Other</b>	<b>Total Deaths</b>
Motor Vehicle Collision	92	51	11	8	162
Homicide by Firearm	16	67	3	1	87
Homicide by other Means	15	28	11	0	54
Suicide by other Means	19	11	2	2	34
Fire	7	20	2	0	29
Drowning	16	8	1	1	26
Other Non-Transport Injury	11	9	2	0	22
Undetermined Intent	15	5	2	0	22
Suicide by Firearm	14	1	0	0	15
Other Transport Injury	9	4	0	0	13
Falls	1	4	2	2	9
Poisoning	1	0	0	1	2
Legal Intervention	0	0	0	1	1

Data Source: MD DHMH, Vital Statistics Administration

## **2010 State CFR Team Activities**

### **Training and Education**

One of the statutory duties of the State CFR Team is to provide educational and training activities to assist local CFR teams in carrying out their duties. Each year, the State CFR Team collects reports from the local CFR teams (see Appendix C for a Summary of Local CFR Team Case Reviews). In these reports, the local teams describe their activities in the previous year, their training needs, and their recommendations for State CFR Team action (see Appendix D for Local CFR Team Recommendations). State CFR Team members review these local reports and respond by providing technical assistance, training, and education specifically addressing the needs described by local CFR teams.

Topics of special interest are covered in-depth at the State CFR Team quarterly meetings, and at the annual training meeting held each year. Presentations are made by expert members of the State CFR Team, and by invited guests.

At the 2010 State CFR Annual Meeting, prevention of infant deaths, traffic safety interventions, and suicide prevention were highlighted. Staff from the Baltimore City “B’More for Healthy Babies” Infant Sleep Campaign made a presentation which included a review of the steps required to establish an effective safe sleep program. Baltimore County Police shared information about their new program which uses data to pinpoint areas of high crime so that resources can be directed to those areas; the goal of this program is to reduce all forms of crime, and especially violent crime. Baltimore Crisis Response, Inc., shared their experience with the logistics and operations of a crisis intervention/suicide hotline run by Baltimore City. This annual CRF meeting was well attended by local CFR team leaders as well as other interested parties from across the State (see Appendix E for the State CFR Team Annual Meeting Agenda).

At all State annual training events, local CFR team members are encouraged to network with colleagues from other local CFR teams in jurisdictions with similar demographics. Examples include those with a predominantly rural or urban population, or a high death rate due to a particular cause, such as homicides or automobile-related deaths. Because similar regions often share risk profiles, they can benefit from the sharing of resources and best practices in prevention topics. Some local teams have expressed an interest in more frequent opportunities to network with each other.

### **Newsletter**

The quarterly State CFR Team newsletter is an excellent source for the latest information on child fatality topics. The newsletter is edited by State CFR Team members Laurel Moody, RN, MS and Donna Mazyck, RN, BSN. The newsletter provides regular updates for local team members regarding legislation, training opportunities, pediatric injury information, useful Web links, meeting dates, and State CFR Team membership changes.

Pediatric risk topics that were addressed in the newsletter in 2010 include: risks associated with leaving children in hot cars, the importance of bike helmets, fire and carbon monoxide safety, drowning prevention, and railway injury prevention. Several newsletters contained articles spotlighting the agencies represented on the State CFR Team. The quarterly newsletters can be viewed at:  
[http://fha.maryland.gov/mch/cfr\\_home.cfm](http://fha.maryland.gov/mch/cfr_home.cfm).

## **Child Death Review Case Reporting System**

The National Center for Child Death Review (NCCDR) provides an Internet-based standardized case reporting tool for use by states with child death review programs through funding provided by the U.S. Department of Health and Human Services', Health Resources Services Administration (HRSA), Maternal and Child Health Bureau. The NCCDR Child Death Review (CDR) Case Reporting System allows local and state users to enter, access, download, and analyze case data, as well as to generate standardized reports. With data use agreements between states, teams are able to compare their data with that of other states, as well as with national figures. The NCCDR offers free training to State and local CFR teams to ensure proper use of the system.

When House Bill 705/Senate Bill 862 (2009) (Child Fatality Review – Child Death Review Case Reporting System) was enacted, Maryland became eligible to participate in the CDR Case Reporting System. The legislation amended the existing child fatality review statute by authorizing State CFR team members and staff to provide a broad range of de-identified information to the NCCDR according to a data use agreement. The enactment of this legislation and the promulgation of related regulations under COMAR 10.11.05 (Child Death Review Case Reporting System) meant that comprehensive training for team members could proceed and the case reporting system could be fully implemented in Maryland.

To help local CFR leaders prepare to use the CDR Case Reporting System, Teri Covington, MPH, Director of the NCCDR, provided an all-day training in September 2009. The official initiation of the CDR Case Reporting System occurred in Maryland in January of 2010. At that time, local CFR leaders became responsible for entry of their case review data into the system, and began to transition away from paper-based case review reporting. The data collected by the CDR Case Reporting System is more standardized and comprehensive than what was previously collected, and requires more team preparation prior to case review meetings, and more focused participation by members to address questions, yielding a richer description of recommendations for the cases presented. Because of the significant change in data collection and recording demands, local teams have required a period of adjustment to this new system.

## **Near Fatalities**

Official case reviews are performed exclusively on child fatalities, not near fatalities, although the CFR statute permits review of near fatalities. In 2007, the State CFR Team developed the following definition of near fatality to facilitate review:

**“A child requiring professional health care for a life-threatening event or a serious or critical condition as a result of a potentially preventable injury or illness.”**

Formal review of all near fatality cases by CFR teams would be optimal. However, in order for this to occur, a system of official notification about such cases would first need to be developed. Under the current structure of the notification system, each month the Office of the Chief Medical Examiner (OCME) sends information on recent child fatalities to the CFR leader in each jurisdiction. Receipt of this notification from the OCME initiates the local CFR team's review process. However, because the OCME only has information on deaths and not on near fatalities, another system of notification will need to be developed before the local CFR teams can uniformly review near fatalities. Near fatality notification will most likely be accomplished through an arrangement with local hospitals, but the exact process is yet to be determined.

## **Collaboration Efforts**

Health-General Article §5-704(c) promotes coordination between the three “sister” teams via the statute which states, “The State Team shall coordinate its activities under this section with the State Citizen Review Board for Children (SCRBC), local citizen review panels, and the State Council on Child Abuse and Neglect (SCCAN) in order to avoid unnecessary duplication of effort.” In 2010, collaboration with the “sister” teams was enhanced when the directors of SCCAN and SCRBC were guest speakers at a State CFR Team quarterly meeting. They each described the purpose and operation of their respective teams and spoke of the impact each team has on promoting the well being of children in Maryland. The meeting provided an opportunity for all State CFR Team members to learn more about SCCAN and SCRBC, as well as to initiate planning for future interactions.

## **State CFR Team Future Activities**

A primary focus of the State CFR Team in 2011 will continue to be growth in the use of the Internet-based reporting system described in this report, and examination of the data now available through electronic reporting, which has greatly simplified the process for examining trends in child fatality and the effect of interventions. Over time, the new Internet-based reporting system will significantly improve each team’s ability to analyze child deaths in its locale, and will help the State CFR Team to more efficiently coordinate efforts based on analysis of data trends.

The State CFR Team will continue to focus on safe sleep, working with the Maryland Center for Infant and Child Loss to offer more safe sleep training for health care professionals, as well as enhancing education and awareness for the general public. This effort also includes promoting the Center’s grief and bereavement trainings, which are an essential component in addressing the needs of families who have suffered a loss.

The State CFR Team will also use and actively promote a safe sleep DVD developed by Baltimore City’s B’More for Healthy Babies Initiative. B’More for Healthy Babies is a collaboration sponsored by the Office of the Mayor, Baltimore City Health Department, Family League of Baltimore, and CareFirst Blue Cross/BlueShield. The DVD, entitled, “Sleep Safe: Alone. Back. Crib. No Exceptions,” uses testimonials from three mothers who describe how their infants died in unsafe sleeping environments. The DVD includes a discussion guide on how to use the video as a teaching tool. Reception to the video as a teaching tool has been positive, and given the continued high rates of infant sleep-related deaths, dissemination of this DVD to local jurisdictions which have identified safe-sleeping practices as a key issue will continue.

In 2009 the State CFR Team worked with the Anne Arundel County CFR Team to begin a pilot program for suicide prevention through analysis of psychiatric visit data in hospital emergency departments. The Anne Arundel County CFR Team planned for collaboration among local agencies and hospitals to better understand trends and risk factors, and to aid in the development of community-based interventions on suicide prevention. The project was postponed in 2010 because of staffing challenges; however, the Anne Arundel County CFR team is interested in resuming this effort in the future.

The State CFR Team has proposed exploring how to improve communications with the local CFR teams via an Internet-based portal. This portal and list serve would be used to disseminate information about successful community efforts on child fatality prevention, and would create a medium for dialogue with the potential to benefit all CFR teams in the State.

A goal for the State CFR Team in 2011 is to work with media (television, radio, print, and Internet) to disseminate messages on child injury prevention, timed for when injuries are most prevalent among children. The State CFR Team believes that injury prevention messages can be delivered more efficiently to the

general population using media, and have the potential to make a positive impact on reducing infant and child deaths.

Training and education on child fatality and injury prevention, and the process of child fatality review itself will continue, despite the ongoing challenge of limited resources. Efforts to find more resources for Maryland CFR in general will persist. Maryland is fortunate to have close partnerships with other State and local agencies, as well as area non-profits; these groups work cooperatively to provide education and training on infant and child safety to health care professionals and the general public.

Currently, there are no federal or State funds appropriated specifically for child fatality review in Maryland. However, a comprehensive Statewide or regional approach is necessary for the State and local CFR teams to achieve meaningful and significant long-term changes in the frequency of child fatalities. The death of a single child is a tragedy; the State and local CFR teams will continue to work to understand why unexpected child deaths occur, and how their numbers can be reduced.

## **Appendix A: 2010 State Child Fatality Review Team Members**

HEALTH-GENERAL ARTICLE, §5-703(A), ANNOTATED CODE OF MARYLAND, PROVIDES THAT THE STATE TEAM SHALL BE A MULTIDISCIPLINARY AND MULTIAGENCY REVIEW TEAM, COMPOSED OF AT LEAST 25 MEMBERS, INCLUDING:

- (1) THE ATTORNEY GENERAL – Amanda Scott, JD, designee
- (2) THE CHIEF MEDICAL EXAMINER – Ling Li, MD, designee
- (3) THE SECRETARY OF HUMAN RESOURCES – Vernice McKee, LGSW, designee
- (4) THE SECRETARY OF HEALTH AND MENTAL HYGIENE – Marsha Smith, MD, MPH, designee
- (5) THE STATE SUPERINTENDENT OF SCHOOLS – Donna Mazyck, RN, BSN, designee
- (6) THE SECRETARY OF JUVENILE SERVICES – Jenny Maehr, MD, designee
- (7) THE SPECIAL SECRETARY FOR CHILDREN, YOUTH, AND FAMILIES –  
\* Permanent Vacancy due to the sunset of the Office for Children, Youth, and Families in 2005.
- (8) THE SECRETARY OF THE STATE POLICE – Lt. Joseph Gamble, designee
- (9) THE PRESIDENT OF THE STATE’S ATTORNEYS’ ASSOCIATION – Julie Drake, JD, designee
- (10) THE CHIEF OF THE DIVISION OF VITAL RECORDS – Hal Sommers, MA, designee
- (11) A REPRESENTATIVE OF THE STATE SIDS INFORMATION AND COUNSELING PROGRAM - LaToya Bates, LCSW-C, Director, Center for Infant and Child Loss
- (12) THE DIRECTOR OF THE ALCOHOL AND DRUG ABUSE ADMINISTRATION – David Putsche, designee
- (13) TWO PEDIATRICIANS WITH EXPERIENCE IN DIAGNOSING AND TREATING INJURIES AND CHILD ABUSE AND NEGLECT, APPOINTED BY THE GOVERNOR FROM A LIST SUBMITTED BY THE STATE CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS -  
Nerita Estampador-Ulep, MD, FAAP  
Richard Lichenstein, MD, FAAP
- (14) ELEVEN MEMBERS OF THE GENERAL PUBLIC WITH INTEREST OR EXPERTISE IN CHILD SAFETY OR WELFARE, APPOINTED BY THE GOVERNOR, INCLUDING CHILD ADVOCATES, CASA VOLUNTEERS, HEALTH AND MENTAL HEALTH PROFESSIONALS, AND ATTORNEYS WHO REPRESENT CHILDREN –  
Akin Akintola, MD, Citizen Advocate for Children  
Mary C. Gentile, LCSW-C, Citizen Advocate for Children  
Roger Lerner, JD, Citizen Advocate for Children  
Laurel Moody, RN, MS, Citizen Advocate for Children  
Anntinette Williams, LICSW, Citizen Advocate for Children  
(Six pending general public vacancies)

## **Appendix B: The 13 Duties of the State Child Fatality Review Team**

Health-General Article, §5-704 (b), sets forth the State CFR Team's 13 duties. To achieve its purpose the State Team shall:

- 1) Undertake annual statistical studies of the incidence and causes of child fatalities in the State, including an analysis of community and public and private agency involvement with the decedents and their families before and after the deaths.
- 2) Review reports from local teams.
- 3) Provide training and written materials to the local teams established under §5-705 of this subtitle to assist them in carrying out their duties, including model protocols for the operation of local teams.
- 4) In cooperation with the local teams, develop a protocol for child fatality investigations, including procedures for local health departments, law enforcement agencies, local medical examiners, and local departments of social services, using best practices from other states and jurisdictions.
- 5) Develop a protocol for the collection of data regarding child deaths and provide training to local teams and county health departments on the use of the protocol.
- 6) Undertake a study of the operations of local teams, including the State and local laws, regulations, and policies of the agencies represented on the local teams, recommend appropriate changes to any regulation or policy needed to prevent child deaths, and include proposals for changes to State and local laws in the annual report required by paragraph (12) of this subsection.
- 7) Consider local and Statewide training needs, including cross-agency training and service gaps, and make recommendations to member agencies to develop and deliver these training needs.
- 8) Examine confidentiality and access to information laws, regulations, and policies for agencies with responsibility for children, including health, public welfare, education, social services, mental health, and law enforcement agencies, recommend appropriate changes to any regulations and policies that impede the exchange of information necessary to protect children from preventable deaths, and include proposals for changes to statutes in the annual report required by paragraph (12) of this subsection.
- 9) Examine the policies and procedures of the State and local agencies and specific cases that the State team considers necessary to perform its duties under this section, in order to evaluate the extent to which State and local agencies are effectively discharging their child protection responsibilities in accordance with:
  - i) The State plan under 42 U.S.C. §5106a(b);
  - ii) The child protection standards set forth in 42 U.S.C. §5106a (b); and
  - iii) Any other criteria that the State Team considers important to ensure the protection of children.
- 10) Educate the public regarding the incidence and causes of child deaths, the public role in preventing child deaths, and specific steps the public can undertake to prevent child deaths.
- 11) Recommend to the Secretary any regulations necessary for its own operation and the operation of the local teams.
- 12) Provide the Governor, the public, and subject to §2-1246 of the State Government Article, the General Assembly with annual written reports, which shall include the State Team's findings and recommendations.
- 13) In consultation with local teams:
  - i) Define "near fatality;" and
  - ii) Develop procedures and protocols that local teams and the State Team may use to review cases of near fatality.

## Appendix C: Summary of Local CFR Team Case Reviews

<b><u>2010 Summary of Local Case Review Meetings and Findings, Maryland Jurisdictions</u></b>	
Questions	Total
1. Number of CFR meetings held in 2010.	70
2. How many cases were reviewed at your local CFR team meetings in 2010, regardless of year of death? (Number should include cases from the OCME, Vital Statistics and other sources).	249
3. a. How many of the reviewed cases were entered in the NCCDR database but not completed? (The case review is complete if there will be no more meetings on the case). b. How many of the reviewed cases were entered in the NCCDR database as “Completed?”	a. 18 b. 192
4. Were all Medical Examiner cases reviewed by the team? If not, please explain.	Yes 10 No 12 N/A 2 (No deaths)
5. Of all the cases reviewed by the team in 2010, in how many was abuse or neglect <u>confirmed</u> ; e.g., there was a finding of “indicated abuse” or “indicated neglect” by CPS or a positive police investigation?	19
6. Not including those children counted in number 5 above; in how many cases did the team <i>subjectively</i> feel abuse or neglect may have <u>contributed</u> to the death?	25
7. Of all the cases reviewed in 2010, in how many was there a <u>previous</u> history of child abuse, as determined by CPS?	4
8. How many had a <u>previous</u> history of child neglect, as determined by CPS?	7
9. How many had a history of involvement with the Department of Juvenile Services (formerly Department of Juvenile Justice)?	19

## **Appendix D: Local CFR Team Recommendations**

### **2010 LCFR'S Recommendations for State CFR Team by Topic Area**

#### **Administrative (1 county)**

1. Finalize the State CFR Policy and Procedure Manual. (Cecil)

#### **Advocacy/Publicity (3 counties)**

1. Continue "Buckle-Up" campaign. Emphasize need for backseat passenger restraints. (Caroline)
2. Safety Around Maryland Waters Campaign (is not just for beaches). (Caroline)
3. Regulation of golf carts. (Caroline)
4. Establish Statewide drop-off sites for unused medications. (Caroline)
5. Suicide education for students and school staff. (Frederick)
6. Firearm safety. (Frederick)
7. Update school health curriculums at State level. (Frederick)
8. The team recommends a State-wide initiative to increase public awareness about safe sleep practices. (Wicomico)

#### **ATVs/Mopeds (no counties requested this topic)**

#### **Autopsy/Forensics (no counties requested this topic)**

#### **Communication/Feedback (3 counties)**

1. Provide more information on CFR activities around the State. (Anne Arundel)
2. Request the State CFR Team to continue to highlight local team efforts/accomplishments for State-wide sharing of resources. (Baltimore County)
3. Request that State CFR provide feedback to local teams regarding identified areas needed to strengthen Statewide child death/information collection. (Baltimore County)
4. Continue to share successful programs campaigns from other jurisdictions as a result of CFR recommendations. (Somerset)

#### **Data Systems Reporting and/ or Training on Electronic System (1 county)**

1. Make a recommendation to the NCCDR to add "SUDI" as a cause of death in the CDR database. Currently only SIDS is listed as a cause of death and most AA sleep related deaths are SUDI. (Anne Arundel)
2. There is duplication of infant deaths reviewed between CFR and FIMR. It would be good if the CDR database could extract information from the FIMR database BASINET for infant cases. (Anne Arundel)

#### **Firearms (1 county)**

1. Firearm safety. (Frederick)

#### **Funding (1 county)**

1. DHMH reinstate and fund (Statewide) local health departments, MCH home visitation programs such as Healthy Start, which provided in-home family assessment by nurses. Once needs were identified, families would receive in-home health education and referral to resources for pregnant women and for parents of infants and children. (Harford)

### **MVA/Teen Driving (1 county)**

1. The State CFR Team may seek to promote public education and outreach re: adolescent motor vehicle trauma and mortality. (Howard)

### **Newsletter (1 county)**

1. Continue the State newsletter. (Anne Arundel)

### **Safe Sleep (2 counties)**

1. Cases where Boppy pillows are found at the scene of a SIDS death should be looked at more closely to determine if the Boppy pillow is a contributing factor. (Allegany)
2. Other Safe Sleep recommendations are listed here under "Advocacy." (Wicomico)

### **Schools (1 county)**

1. Update school health curriculums at the State level. (Frederick)

### **Suicide (1 county)**

1. Suicide education for students and school staff. (Frederick)

### **Training and/or Technical Assistance Requests (9 counties)**

1. Provide resources as to how to take the CFR team prevention recommendations in the CDR database and put them into action plans. (Anne Arundel)
2. Provide written guidance regarding sharing of CFR and FIMR information within a jurisdiction. (Anne Arundel)
3. Provide feedback on LCFR recommendations that are sent to SCFRT. (Anne Arundel)
4. Additional mock reviews with a focus on recommendations for different manner and causes of death. (Anne Arundel)
5. Continue training on the electronic data system. (Baltimore County)
6. Training on risky behaviors gaining popularity with youth that have potential for injury or death (autoerotic asphyxia, for instance). (Caroline)
7. Funding to implement CFR recommendations. (Caroline)
8. Funding for continuing education. (Caroline)
9. It will be good when the annual report information can be obtained from the NCCDR system. (Frederick)
10. Continue the State CFR annual training. (Harford)
11. In-service about how to move CFR recommendations to an action agenda. (Montgomery)
12. We would like assistance in recruiting a new representative from the OCME as the retirement of Dr. Margolis has left a gap in the review process. (Montgomery)
13. It would be helpful to have a review of the CFR Guidelines for our new members. (Montgomery)
14. The annual conference could highlight teams that have made recommendations and show how they are implemented within their communities. (Prince George's)
15. Continued support from the State CFR Team. (Prince George's)
16. Any prevention-related trainings as they relate to preventable child deaths. (Somerset)
17. Any guidance on how to assure that the representatives from response agencies do not feel their performance is under scrutiny when reviewing a case, to avoid the withholding of information. (Worcester)

## **Appendix E: State CFR Team Annual Meeting Agenda**

### **Agenda**

#### **Maryland State Child Fatality Review Team Annual Meeting Tuesday, November 16, 2010**

Location: Maryland Department of Transportation  
7201 Corporate Center Dr., Hanover, Maryland  
410-865-1142

- 8:30 – 9:30**                    **Registration**
- 9:30 – 10:00**                **Welcome & Introductions**  
Richard Lichenstein, MD  
Chair, The Maryland State Child Fatality Review Team  
Introduction of Attendees
- 10:00 – 11:30**              **B'More for Healthy Babies Infant Sleep Campaign  
Establishing an Effective Safe Sleep Program**  
Baltimore City Health Department, B'More for Healthy Babies Program and the  
Center for Infant and Child Loss  
LaToya Bates, LCSW-C, The Center for Infant and Child Loss  
Stephanie Regenold, MD, MPH, Baltimore City Health Department  
Rebecca Dineen, MS, Baltimore City Health Department  
Gena O'Keefe, MD, Family League of Baltimore City
- 11:30 – 12:00**              **Lunch (Brief break)**
- 12:00 – 1:15**                **Lunchtime Discussion: The CFR Data System**  
CFR Data System and Local CFR Feedback
- 1:15 – 2:00**                **Data Driven Approaches to Crime and Traffic Safety (DDACTS):  
Using data to target problem areas and develop solutions**  
Ernie Lehr, Baltimore County Police Department
- 2:00 – 2:45**                **Logistics and Operation of a Crisis Intervention Program  
and Suicide Hotline: Assessing Emergencies and Providing Support**  
Edgar Wiggins, Baltimore Crisis Response Inc.
- 2:45**                         **Wrap-up**  
Joan Patterson, LCSW-C  
Coordinator, The State Child Fatality Review Team