MARYLAND STATE CHILD FATALITY REVIEW TEAM

2014 Annual Legislative Report

Health-General Article, § 5-704(b)(12)

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Martin O'Malley Governor	Anthony G. Brown Lt. Governor	Joshua M. Sharfstein, MD Secretary, Department of Health and Mental Hygiene

http://phpa.dhmh.maryland.gov/mch/SitePages/cfr-home.aspx

Overview of Maryland Child Fatality Review

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 incidents of child fatality, 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 2013 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 (see Appendix C for 2013 Agenda). The State CFR Team is housed within the Department of Health and Mental Hygiene (DHMH) for budgetary and administrative purposes.

The State CFR Team oversees the efforts of local CFR Teams that operate in each jurisdiction. Local CFR teams are given notice of unexpected resident child deaths each month by the Office of the Chief Medical Examiner (OCME), and are required to review each of these deaths. The manner of these deaths is determined to be either natural, homicide, suicide, accidental, or undetermined. Local teams then make recommendations for local level systems changes in statute, policy, or practice, and work to implement these recommendations. Activities of these teams in calendar year 2013 are covered in this report.

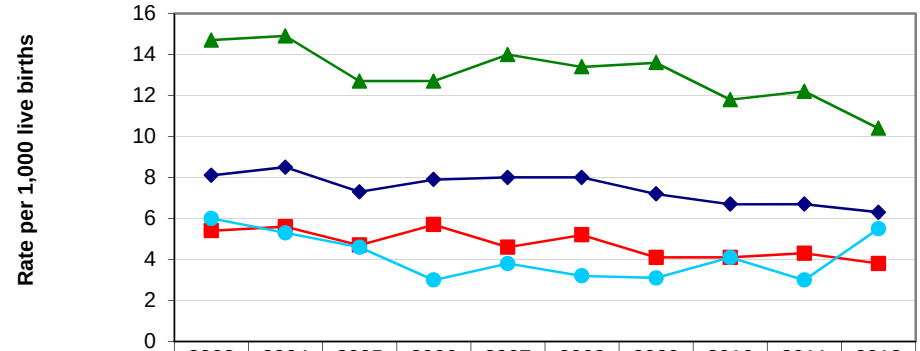
Other teams in Maryland have similar charges to prevent child injury and death. These include the State Council on Child Abuse and Neglect (SCCAN) and the Citizen Review Board for Children (CRBC); both of these organizations examine policies and practices for protecting children. There is collaboration between the State CFR Team, SCCAN, and CRBC as they are considered "sister" teams under Maryland law. Also, the Morbidity, Mortality, and Quality Review Committee (MMQRC), which was established by legislation in 2008 and is also housed within DHMH, is charged with conducting confidential and anonymous reviews of morbidity and mortality associated with pregnancy, childbirth, infancy, and early childhood. The MMQRC provides another opportunity for review and dissemination of information and recommendations developed through the CFR process. In addition to state level collaboration, there are also local collaborative efforts. Local Fetal and Infant Mortality Review (FIMR) teams operate in every jurisdiction, and local FIMR and CFR Teams often collaborate.

Summary of Maryland Child Deaths

Childhood deaths are a major public health concern and many of these deaths are preventable. Surveillance of childhood deaths is important because it helps to measure the magnitude of the problem, and to assess the causes and the population groups most affected. These data are crucial for identifying trends and targeting interventions to reduce childhood mortality. The CFR process reviews a subset of child deaths representing unexpected child deaths referred by the OCME. This subset includes cases of unintentional injury deaths, homicides and suicides, and occasional deaths due to natural causes.

The Child Death Report, most recently published in 2014 with information on deaths occurring in 2012, reviews all deaths in children under the age of 18. In 2012, there were 458 infant deaths (under 1 year of age) and 237 deaths among children aged 1-17. Infant deaths are usually analyzed separately from deaths among children aged 1-17. The three leading causes of infant deaths in 2012 were: (1) disorders related to preterm birth or low birth weight (27.7%); (2) congenital abnormalities (15.3%); and (3) Sudden Infant Death Syndrome (SIDS) (10.3%). The infant mortality rate was essentially unchanged from 2003 to 2007, but has declined by 21% over the last five years to 6.3 per 1,000 live births in 2012 (Figure 1).

Figure 1. Infant Mortality Rates, by Race and Ethnicity Maryland, 2003-2012



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
All Races	8.1	8.5	7.3	7.9	8.0	8.0	7.2	6.7	6.7	6.3
White, NH	5.4	5.6	4.7	5.7	4.6	5.2	4.1	4.1	4.3	3.8
Black, NH	14.7	14.9	12.7	12.7	14.0	13.4	13.6	11.8	12.2	10.4
Hispanic	6.0	5.3	4.6	3.0	3.8	3.2	3.1	4.1	3.0	5.5

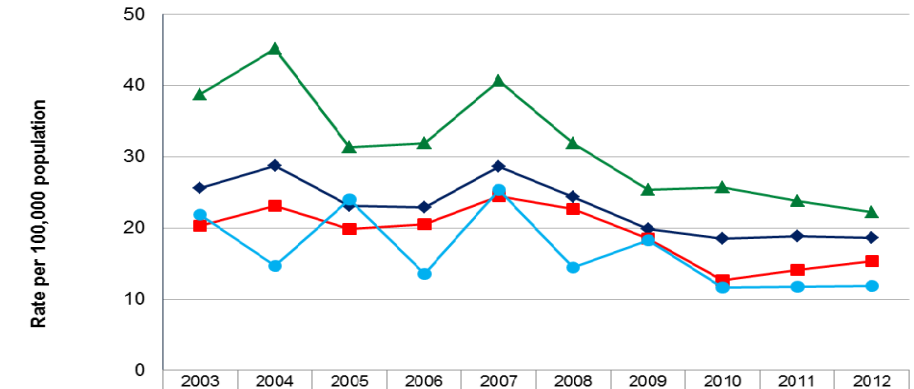
Year

Data Source: MD DHMH, Vital Statistics Administration

There were substantial racial disparities in infant mortality rates in 2012. Despite a 28% reduction in the infant mortality rate for non-Hispanic Blacks over the past 5 years, the non-Hispanic Black infant mortality rate (10.4 per 1,000 live births) was 2.7 times higher than the rate for non-Hispanic Whites (3.8 per 1,000 live births). The infant mortality rate for Hispanics increased in 2012. This may be a single year increase but will be monitored to determine whether it is a changing trend.

In 2012, the child death rate (1-17 years of age) was 18.6 per 100,000 population (Figure 2); this rate has declined by 23% since 2008. In 2012, the child death rate was 22.2 per 100,000 population for non-Hispanic Blacks, 15.3 for non-Hispanic Whites, and 11.9 for Hispanics. Over the past five years, the child death rate has decreased by 30% among non-Hispanic Blacks, by 33% among non-Hispanic Whites, and by 18% among Hispanics.

Figure 2. Child (1-17 years) Death Rates by Race/Ethnicity, Maryland, 2003-2012



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
All Races/Eth.	25.6	28.7	23.1	22.9	28.6	24.3	19.8	18.5	18.8	18.6
White, NH	20.3	23.1	19.8	20.5	24.5	22.7	18.5	12.6	14.1	15.3
Black, NH	38.7	45.2	31.3	31.9	40.6	31.9	25.3	25.7	23.8	22.2
Hispanic	21.9	14.7	24	13.6	25.3	14.5	18.3	11.6	11.8	11.9

Data Sources: Deaths: MD DHMH, Vital Statistics Administration

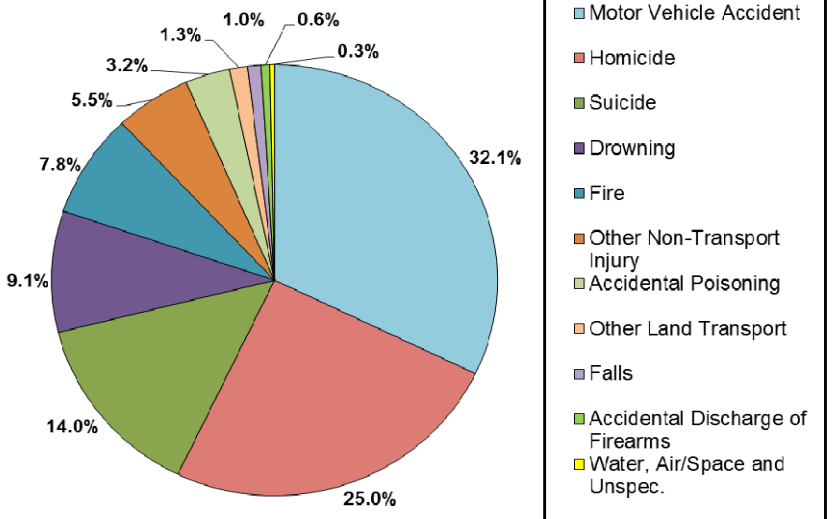
Table 1 shows the leading causes of child death by age group. Among all children aged 1-17, the three leading causes of death in 2010-2012 were: (1) unintentional injuries; (2) malignant neoplasms; and (3) homicide (note: data are aggregated over a three year period to provide more stability).

Table 1. Leading Causes of Death among Children by Age Group, Maryland, 2010-2012.

		Age Group			
Rank		**1-4 years**	**5-9 years**	**10-14 years**	**15-17**
1	**Cause of Death**	Unintentional Injury	Unintentional Injury	Unintentional Injury	Unintentional Injury
	# of Deaths	43	39	36	70
	% of Deaths in Age Group	21.8%	31.7%	25.7%	27.7%
2	**Cause of Death**	Malignant Neoplasms	Malignant Neoplasms	Malignant Neoplasms	Homicide
	# of Deaths	17	20	23	48
	% of Deaths in Age Group	8.6%	16.3%	16.4%	19.0%
3	**Cause of Death**	Homicide	Homicide	Suicide	Suicide
	# of Deaths	16	3	11	31
	% of Deaths in Age Group	8.1%	2.4%	7.9%	12.3%
4	**Cause of Death**	Diseases of the Heart	Diseases of the Heart	Homicide	Malignant Neoplasms
	# of Deaths	6	3	10	23
	% of Deaths in Age Group	3.0%	2.4%	7.1%	9.1%
5	**Cause of Death**	Influenza and Pneumonia	Chronic Lower Respiratory Diseases	Diseases of the Heart	Diseases of the Heart
	# of Deaths	5	3	7	10
	% of Deaths in Age Group	2.5%	2.4%	5.0%	4.0%

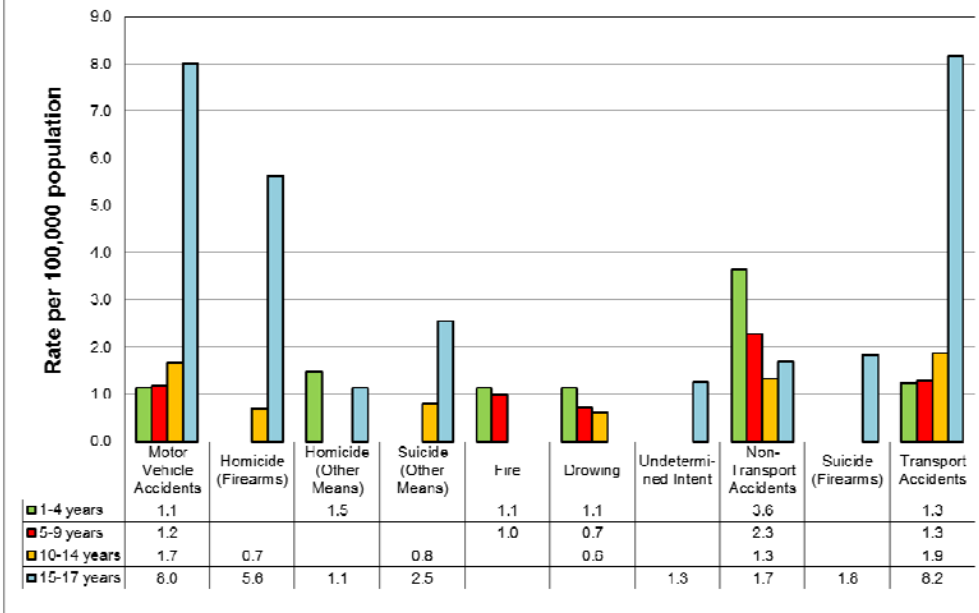
Among injury-related deaths during the period 2010-2012, 32% were due to motor vehicle collisions, 25% homicide, and 14% suicide (Figure 3). The highest rates of motor vehicle and other transport-related deaths were among children aged 15-17 years (Figure 4).

Figure 3. Percent of Child (1-17 yrs) Injury Deaths by Type of Injury, Maryland, 2010-2012



Data Source: MD DHMH, Vital Statistics Administration

Figure 4. Child (1-17) Injury Death Rates by Injury Type and Age Group, Maryland, 2010-2012



	Motor Vehicle Accidents	Homicide (Firearms)	Homicide (Other Means)	Suicide (Other Means)	Fire	Drowning	Undetermined Intent	Non-Transport Accidents	Suicide (Firearms)	Transport Accidents
1-4 years	1.1		1.5		1.1	1.1		3.6		1.3
5-9 years	1.2				1.0	0.7		2.3		1.3
10-14 years	1.7	0.7		0.8		0.6		1.3		1.9
15-17 years	8.0	5.6	1.1	2.5			1.3	1.7	1.8	8.2

Data Source: MD DHMH, Vital Statistics Administration
* Note: Rates based on <5 events in the numerator are not displayed.

Children's death by homicide continues to be a significant public health problem in Maryland. From 2010-2012, there were 93 homicides of infants and children in the State. The rate of homicide by firearm was greatest among children aged 15-17 years (Figure 4 and Table 2). There were no homicides by firearm among infants under one year. However, when calculated as a rate per 100,000 population, the highest rate of homicide in any age group is among infants (Table 2). The rate of homicides among children aged 0-17 is substantially higher among non-Hispanic Blacks, at 5.9 per 100,000 population, compared to 0.8 for non-Hispanic Whites (Table 3). There were less than five homicides reported among Hispanic children during this time period, so rates were not computed due to instability. Sixty-nine percent of the child victims of homicide (aged 0-17 years) were male.

Table 2. Child (0-17 years) Deaths Due to Homicide by Age Group, Maryland, 2010-2012

	By Firearm		By Other Means		Total	
Age Group	# of Deaths	Rate per 100,000	# of Deaths	Rate per 100,000	# of Deaths	Rate per 100,000
<1 year	0		16	7.4	16	7.4
1-4 years	3		13	1.5	16	1.8
5-9 years	2		1		3	
10-14 years	8	0.7	2		10	0.9
15-17 years	40	5.6	8	1.1	48	6.8

Data Source: MD DHMH, Vital Statistics Administration

Rates based on <5 events in the numerator are not displayed

Table 3. Child (0-17 years) Deaths Due to Homicide by Race/Ethnicity, Maryland, 2010-2012

	By Firearm		By Other Means		Total	
Race/Ethnicity	# of Deaths	Rate per 100,000	# of Deaths	Rate per 100,000	# of Deaths	Rate per 100,000
White, Non-Hispanic	6	0.3	9	0.5	15	0.8
Black, Non-Hispanic	47	3.6	29	2.2	76	5.9
Hispanic	0		0		0	
All Races/Ethnicities	53	1.4	40	1.0	93	2.4

Data Source: MD DHMH, Vital Statistics Administration

Rates based on <5 events in the numerator are not displayed

There were 42 suicides among children under 18 years of age during the period from 2010-2012. The rate of suicide was highest among those aged 15-17 years (4.4 per 100,000 population). Suicides occurred less frequently among younger children aged 10-14 years (1.0 per 100,000 population). Among children aged 10-17, 88% of suicides were committed by males. The suicide rates were similar between non-Hispanic White children (2.7 per 100,000 population) and non-Hispanic Black children (2.2 per 100,000 population). There were less than five suicides reported among Hispanic children during this time period, so rates were not computed due to instability.

2013 State CFR Team Activities

Summary of 2013 Case Reviews by Local CFR Teams

Each local CFR Team is provided information by the OCME about cases of unexpected child deaths occurring in the team's jurisdiction. Local CFR Teams meet at least quarterly to review these cases and develop recommendations for local interventions to prevent future child deaths. In 2013, a total of 185 cases were referred by the OCME for review, and 74 child fatality review team meetings were held across the State.

Local CFR Teams continue to improve their reporting of Maryland child fatality data to a national internet-based data collection system. The National Center for the Review and Prevention of Child Death (NCRPCD) 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 (HHS) Health Resources Services Administration (HRSA), Maternal and Child Health Bureau. The NCRPCD Child Death Review Case Reporting System allows local and state users to enter, access, download, and analyze de-identified 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 data. The NCRPCD offers free training to state and local CFR Teams to ensure proper use of the system.

In 2009, Maryland House Bill 705/Senate Bill 862 (Child Fatality Review – Child Death Review Case Reporting System) and related regulations under COMAR 10.11.05 (Child Death Review Case Reporting System) enabled Maryland to participate in this internet-based reporting system. The Child Death Review Case Reporting System (CDRCRS) was launched in Maryland in January of 2010. Local CFR Teams were provided training in CDRCRS use. All local teams are currently entering case review data into the internet-based system, although data entry is not complete. The State CFR Team continues to work with local teams to improve reporting. Of the 185 cases referred to local CFR Teams by the OCME in 2013, 121 cases had at least partial information entered into the CDRCRS. This represents a data entry completion rate of 65% of referred cases (Table 4). In several jurisdictions, cases are still under investigation and CFR reviews are not complete. Final entry of completed case reviews will be tracked with those local teams. The DHMH Office of Surveillance and Quality Initiatives, which provides funding to all jurisdictions for CFR and FIMR activities, has made entry of data on all CFR cases a required performance measure for funding starting in fiscal year 2015.

Local CFR Teams report that of all cases reviewed in 2013, abuse or neglect was "confirmed" in 15 (8%), which means there was a finding of "indicated" abuse or neglect by Child Protective Services (CPS) or police investigation. Two cases had a prior history of child abuse while 15 had a history of neglect. Six cases had a history of involvement with the Department of Juvenile Justice.

Table 4. Number and Percent of OCME* Referred Child (<18 years) Deaths Occurring in 2013 Reviewed and Entered into the Child Death Review Case Reporting System by Jurisdiction, Maryland

	# of Cases Referred by OCME	# of Cases Reviewed and Entered into National Center for Child Death Review System	% of Referred Cases Reviewed and Entered into National Center for Child Death Review
Allegany	3	3	100
Anne Arundel	12	11	92
Baltimore	19	19	100
Baltimore City	40	8	20
Calvert	1	0	0
Caroline	2	2	100
Carroll	3	3	100
Cecil	3	0	0
Charles	9	0	0
Dorchester	3	3	100
Frederick	11	10	91
Garrett	2	0	0
Harford	13	10	77
Howard	6	1	17
Kent	1	1	100
Montgomery	15	15	100
Prince George's	27	22	81
Queen Anne's	0	0	N/A
Saint Mary's	1	1	100
Somerset	0	0	N/A
Talbot	1	1	100
Washington	7	7	100
Wicomico	3	0	0
Worcester	3	3	100
Total	185	120	65

*Office of the Chief Medical Examiner

Summary of Local CFR Team Activities

With information gleaned from case reviews at team meetings, local CFR Teams developed a variety of recommendations and innovative approaches to prevent child deaths. As a result, a number of activities were undertaken by local teams and their respective health departments during 2013.

- **Safe Sleep Activities** – Fourteen jurisdictions conducted safe sleep activities, including:
    - Anne Arundel County CFR Team collaborated with their Fetal and Infant Mortality Review Team (FIMR) in community outreach programs and distribution of Pack N' Play portable cribs via the Health Department.

- Baltimore County's CFR Team Chair presented at a Centers for Disease Control and Prevention conference on linking CFR and safe sleep efforts. The CFR Team provided safe sleep materials to local pediatricians, and funded safe sleep messages at local movie theaters.
- Cecil County CFR Team combined safe sleep and anti-smoking efforts in a campaign distributing educational materials, bottle bags, and infant t-shirts.
- Dorchester County CFR Team members presented safe sleep information on a local radio program.
- Harford County CFR Team provided "Share Your Room, Not Your Bed" brochures for hospital newborn discharge materials.
- Howard County CFR Team held a "Crib Bumper Buyback," providing gift cards or coupons in exchange for crib bumpers, the sale of which is now banned in Maryland.
- Somerset County CFR Team provided safe sleep information through reproductive health programs.

- **Community, Provider, and Local CFR Team Education** – Ten counties provided community, provider, or local CFR Team education. Activities included development of programs, campaigns, or materials, in-service trainings, school outreach, inter-agency collaboration, and distribution of information to targeted populations. Team activities included:

  - Anne Arundel County CFR Team was active in youth suicide prevention efforts, including placing emergency phone numbers on the back of student school IDs.
  - Baltimore County CFR Team, working with the school system, began developing resources on traffic safety for students and families.
  - Frederick County CFR Team began developing a mental health screening tool for students.
  - Harford County CFR Team developed a mental health brochure for teens at higher risk of suicide, (i.e. those arrested, suspended, or having suffered a loss).
  - Howard County CFR Team supported the "Just One Minute" campaign alerting the community to the dangers of leaving children unattended in cars.
  - Montgomery County CFR Team formed a workgroup to develop a teen suicide prevention plan and met with school board staff to recommend earlier implementation (7^{th} grade vs 9^{th} grade). They also worked with the county Department of Licensing and Regulatory Services to disseminate Summer Pool Safety materials to all local pool operators.

Training and Education

The State CFR Team provides technical assistance, training, and education to address the needs expressed by the local CFR Teams. The State CFR Team receives an annual report from each local CFR Team describing their activities during the previous year and their training needs. The State CFR Team holds an annual meeting for local CFR Team coordinators. Presentations are made by State Team member experts and by invited guests who are experts in their field. The 2013 State CFR Annual Meeting included a presentation on the Prescription Drug Monitoring Program (PDMP) established through the Maryland Department of Health and Mental Hygiene. The PDMP is designed to address the increasing dangers of prescription drug abuse by reducing the misuse, abuse, and diversion of prescription drugs. Other topics included a presentation about the Baltimore City Child Protection Team (BCCPT), which uses a collaborative, multidisciplinary approach to evaluate and address child maltreatment; a legislative update on the 2014 Maryland General Assembly session; a review of issues related to the national database; and an overview by local CFR Team Leaders on their team's efforts, successes, and challenges.

Team Communication

Since 2012, a listserv tool has been available through DHMH to disseminate topical information to local and State CFR Team members. The listserv also allows members to post questions and receive input from other listserv members. Postings are sent out at least monthly.

Newsletter

The State CFR Team newsletter continues to be a source of information for both state and local CFR leaders, providing information on child fatality topics and activities throughout the state. The newsletter is edited by State CFR Team member Laurel Moody, RN, MS. It includes updates regarding legislation, training opportunities, pediatric injury information, online resources, meeting dates, and State CFR Team membership changes.

Gun issues and opioid dependence and overdose were the main newsletter topics in 2013, with other topics including cyber bullying and the "5 to Drive" campaign, which emphasizes five practices for safe driving. The newsletter is available at http://phpa.dhmh.maryland.gov/mch/SitePages/cfr-home.aspx.

Future State CFR Team Activities

Child Death Review Case Reporting System

At the 2013 Annual Meeting, State CFR Team Chair, Richard Lichenstein, MD, emphasized the importance of data collection and analysis to CFR efforts. Some teams are still not meeting expectations for data entry into the CDRCRS database. These teams will be provided additional training or technical assistance to improve reporting and monitored for future compliance. With improved statewide data reporting, the CDRCRS database will become a valuable tool in understanding the causes and circumstances of child deaths in the State and developing meaningful prevention recommendations.

Safe Sleep

The State CFR Team will continue efforts to prevent SIDS and sleep-related deaths, the third leading cause of infant death in Maryland. Collaboration is ongoing with the University of Maryland's Center for Infant and Child Loss (CICL), which offers safe sleep training to the public and professionals. DHMH is providing support to the CICL to develop a safe sleep DVD, emphasizing the danger of co-sleeping, which is a factor in many sleep-related deaths. The DVD will be available for distribution by local and State CFR Team members in late 2014.

A comprehensive regional and statewide approach is necessary for the State and local CFR Teams to bring about long-term changes in the incidence 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 the number of these deaths can be reduced.

Appendix A: 2013 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) Attorney General – Betty Stemley, JD, designee

(2) Chief Medical Examiner – Ling Li, MD, designee

(3) Secretary of Human Resources – Vernice McKee, LGSW, designee

(4) Secretary of Health and Mental Hygiene – Ilise Marrazzo, RN, BSN, MPH, designee

(5) State Superintendent of Schools – Lynne Muller, PhD, designee

(6) Secretary of Juvenile Services – Jenny Maehr, MD, designee

(7) Special Secretary for Children, Youth and Families – permanent vacancy due to the sunset of the Office for Children, Youth, and Families in 2005.

(8) Secretary of State Police – Lt. Joseph Gamble, designee

(9) President of the State's Attorneys' Association – Ernest Reitz, JD, designee

(10) 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) 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 –

Richard Lichenstein, MD, FAAP
Wendy Lane, MD, MPH, 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 –

Tim C. Allen
Mary C. Gentile, LCSW-C
Roger Lerner, JD
Laurel Moody, RN, MS
John Rusinko, MSW
Anntinette Williams, LICSW

Five 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

AGENDA
The Maryland State Child Fatality Review Team Annual Meeting
Wednesday, November 20, 2013

Location: Howard County Department of Fire and Rescue
James N. Robey Public Safety Training Center
2200 Scott Wheeler Drive, Marriottsville, MD, 21104
410-313-1361

9:00	**Registration Begins**
10:00	**Welcome** Richard Lichenstein, MD Chair, The Maryland State Child Fatality Review Team
10:10	**The DHMH Prescription Drug Monitoring Program (PDMP)** Michael Baier, DHMH
11:00	**The Baltimore Citywide Child Protection Team: A Multidisciplinary Approach** Ernest Reitz, Esq., Assistant State's Attorney, State Team Member Mitchell Goldstein, MD, JHH, Baltimore Citywide Child Protection Team Wendy Lane, MD, MPH, UMMC, Baltimore Citywide Child Protection Team
12:00	**Lunch**
12:30	**Luncheon Speaker** Marie Grant, Director of Legislative Affairs Legislative Update
1:15	**NCPRCD Version 3 Data System** Richard Lichenstein, MD
1:45	**Local CFR Leaders Sharing/Presentations**
3:15	**Wrap-up** Joan Patterson, LCSW-C Coordinator, Maryland State Child Fatality Review Team