MARYLAND
STATE CHILD FATALITY REVIEW TEAM

2005 Annual Report

http://www.fha.state.md.us/mch/html/cfr/

Robert L. Ehrlich, Jr.	Michael S. Steele	S. Anthony McCann
Governor	Lt. Governor	Secretary, DHMH

MARYLAND STATE CHILD FATALITY REVIEW TEAM

Baltimore, Maryland 21201

August 3, 2006

The Honorable Robert L. Ehrlich, Jr.
Governor
State of Maryland
Annapolis, MD 21401-1991

RE: Legislative Report of the State Child Fatality Review Team

Dear Governor Ehrlich:

Pursuant to Senate Bill 464 enacted during the 1999 legislative session, the Maryland State Child Fatality Review Team is pleased to submit the 2005 Annual Report on child deaths in Maryland. The report incorporates information about the work of local teams, training and advocacy efforts to prevent child deaths throughout the state, and also sets forth data relating to child deaths in Maryland. Full CFR reports from local jurisdictions throughout Maryland can be viewed at http://www.fha.state.md.us/mch/html/cfr/.

I hope this information is useful. If you have questions about this report, please contact me at (410) 430-0248 or sdolch@juno.com.

Sincerely,

Sally B. Dolch, M.S.W.
Chairperson

cc: S. Anthony McCann
Michelle A. Gourdine, M.D.
Anne Hubbard
Russell Moy, M.D., M.P.H.
Bonnie S. Birkel, C.R.N.P., M.P.H.

MARYLAND STATE CHILD FATALITY REVIEW TEAM

Baltimore, Maryland 21201

Ms. Sally B. Dolch, M.S.W.
Chairperson

Carolyn Fowler, Ph.D., M.P.H.
Vice-Chairperson

August 3, 2006

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
Annapolis, MD 21401-1991

The Honorable Michael E. Busch
Speaker of the House
H-101 State House
Annapolis, MD 21401-1991

RE: Legislative Report of the State Child Fatality Review Team

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ACKNOWLEDGEMENTS

This Maryland State Child Fatality Review Team (State CFR team) 2005 Annual Report required by Health-General Article, §5-704 (b) (12), is the product of many hands.

We want to acknowledge the volunteer hours contributed by dedicated members of the State CFR team as well as the ongoing support from the Department of Health and Mental Hygiene State CFR team advisors and staff at the Center for Maternal and Child Health who assisted in the preparation and distribution of materials to the members.

The 2005 Annual Report includes:

- State CFR team membership and accomplishments.
- A summary of findings from the 2002-2004 Maryland Child Death Report prepared by the Department of Health and Mental Hygiene's Center for Maternal and Child Health.
- Reports from Maryland jurisdictions discussing local efforts and findings from local child fatality reviews conducted in 2005.
- Recommendations for the State CFR team from local CFR teams.

We welcome the input of readers of this report towards efforts to eliminate preventable child deaths. To contact us or for more information use http://www.fha.state.md.us/mch/html/cfr/ .

Sally B. Dolch, M.S.W.
Chairperson
sdolch@juno.com

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INTRODUCTION

The purpose of the Maryland State Child Fatality Review Team established by Senate Bill 464-1999 is to prevent child deaths by:

1. Developing an understanding of the causes and incidence of child deaths;

2. Developing plans for and implementing changes within the agencies represented on the State CFR team to prevent child deaths;

3. Advising the Governor, the General Assembly, and the public on changes to law, policy, and practice to prevent child deaths.

BACKGROUND

Child Fatality Review (CFR) is a systematic, multi-agency, multi-disciplinary review of unexpected child deaths within a jurisdiction. 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.

Child Fatality Review was established by the Maryland legislature in 1999. The 25 member Maryland State Child Fatality Review Team met for the first time in November the same year. Membership is comprised of the Secretaries (or their designees) of 12 State offices or departments, two pediatricians, and 11 members of the general public with interest and expertise in child safety and welfare who are appointed by the Governor. Current membership is presented on page 7 of this report. The State team meets at least four times a year to address 13 statutorily prescribed duties. One of the meetings is used for the purpose of presenting a conference for education and training on a variety of topics.

In Maryland, besides the State Child Fatality Review Team, local jurisdictions convene regular meetings to review unexpected deaths of child residents living within their geographic borders. The local Child Fatality Review teams concentrate on issues specific to the deaths that may be impacted by changes in systems, policies, or practices at the local level.

Detecting and preventing child abuse and neglect remain an important focus of CFR, the Department of Health and Mental Hygiene and the Department of Human Resources. Whatever the cause and manner of death, the majority of childhood deaths raise questions about the general child health system and warrant thorough systematic investigation. 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.

During calendar year 2005, the State CFR team conducted their annual all-day training conference on November 15. The quarterly meetings were held on March 15, May 17, and September 20. Besides the training conference, experts in the field of child fatality spoke at two of the three quarterly meetings.

THIRTEEN STATUTORY DUTIES OF THE STATE CFR TEAM

Health-General Article, §5-704 (b), sets forth the State CFR team's duties as follows:

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, 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 team.

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.

VISION, MISSION, AND GUIDING PRINCIPLES

Vision: We envision a Maryland where preventable child fatalities are eliminated.

Mission: We will review child fatalities to understand the circumstances around those fatalities and to recommend strategies to prevent future child fatalities.

Guiding Principles:

1. We will work cooperatively with other state and local Child Fatality Review systems.

2. We base our recommendations on findings from Child Fatality Reviews.

3. Our understanding of child fatalities is based on both quantitative and qualitative information from Child Fatality Reviews and observations.

4. Child Fatality Review teams include representatives of different community interests.

5. Child Fatality Review is both multi-disciplinary and multi-agency.

6. Support of and advocacy for local Child Fatality Review is a priority function of the State Child Fatality Review Team.

7. The State Child Fatality Review Team builds on the work of the local teams in their efforts to ensure the protection of the children of Maryland.

8. Reviews are conducted with respect for the child and family and for those who served them.

9. To facilitate the sharing of information openly and honestly, confidentiality is adhered to in all reviews.

2005 State Child Fatality Review Team Members

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

(1) THE ATTORNEY GENERAL – Eileen McInerney, J.D., designee
(2) THE CHIEF MEDICAL EXAMINER – David Fowler, M.D.
(3) THE SECRETARY OF HUMAN RESOURCES – Fran Pellerin, designee
(4) THE SECRETARY OF HEALTH AND MENTAL HYGIENE – Maureen Edwards, M.D., M.P.H., designee
(5) THE STATE SUPERINTENDENT OF SCHOOLS – Richard Steinke, designee
(6) THE SECRETARY OF JUVENILE SERVICES – Anne Fox, R.N., B.S., designee
(7) THE SPECIAL SECRETARY FOR CHILDREN, YOUTH AND FAMILITES – Twilah Shipley, J.D., designee
(8) THE SECRETARY OF THE STATE POLICE – Lt. Doug Wehland, designee
(9) THE PRESIDENT OF THE STATE'S ATTORNEY'S ASSOCIATION – Jonathan G. Newell, J.D. designee
(10) THE CHIEF OF THE DIVISION OF VITAL RECORDS – Hal Sommers, M.A., designee
(11) A REPRESENTATIVE OF THE STATE SIDS INFORMATION AND COUNSELING PROGAM, Donna Becker, RN, MSN, 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 AMERCAN ACADEMY OF PEDIATRICS –
Nerita Estampador-Ulep, M.D., FAAP
Richard Lichenstein, M.D., 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 PROFRESSIONALS, AND ATTORNEYS WHO REPRESENT CHILDREN –
Sally Dolch, MSW, Chairperson
Susan Daddio, MSW, Citizen Advocate for Children
Carolyn Fowler, Ph.D, M.P.H.,Vice-Chair, Citizen Advocate for Children
Patricia Kirby, Ph.D., Citizen Advocate for Children
Dorothy Marge, Ph.D., Citizen Advocate for Children
Pierre Mooney, MSW, Citizen Advocate for Children
Albert Rolle, M.D., FACS, Citizen Advocate for Children
John Rusinko, LCSW-C, Citizen Advocate for Children
Anntinette Williams, LICSW, Citizen Advocate for Children

SUMMARY OF THE REPORT ON CHILD DEATHS
MARYLAND, 2002-2004

Childhood deaths are a major public health problem and many of these are preventable fatalities. Surveillance of childhood deaths is one of the most important components of child death prevention. It helps to determine the magnitude of child mortality, the leading causes of death, and the population groups most affected. In addition, this data is crucial for evaluating the effectiveness of program activities and for identifying trends and problems that need further investigation.

The report focuses on deaths of children aged 1-17 years. Child Fatality Review focuses on sudden and unexpected deaths; however the majority of infant deaths do not fall into this category. The three leading causes of infant death in 2004 were disorders related to short gestation and low birth weight, congenital malformations, and sudden infant death syndrome. The Fetal and Infant Mortality Review Program examines infant deaths in Maryland, yet due to limited resources, this program has been unable to issue a report. Therefore, important and relevant aspects of death in infancy are included here.

In 2004, there were 1006 deaths of infants and children under the age of 18 years in Maryland. The overall gradual decrease in the infant morality rate in the past decade has been interrupted by increases in two consecutive years in recent times. From a rate of 7.6 per 1,000 live births in 2002, the infant mortality rate rose to 8.1 in 2003 and again to 8.5 per 1,000 live births in 2004, for a total increase of 12% since 2002. There has also been an overall decline in the number and rate of child deaths in the State over the past decade. However, the rate rose from 25.6 per 100,000 population in 2003 to 28.4 per 100,000 population in 2004.

Among older children, injuries were the leading cause of death in children aged 1-17 years, with unintentional injuries accounting for most of the injury-related deaths (60%) in 2002-2004. Homicide and suicide (intentional injuries) represented 29.4% and 7.9% respectively of all fatal injuries. (Table is at the top of next page.)

TABLE 1. NUMBER OF INJURY RELATED DEATHS, 1-17 YEARS MARYLAND, 2002-2004

Type of Injury	2002-2004	% of Total
Unintentional	**349**	**60.0**
Transport	**254**	
-MVA	237	**40.7**
-Other*	17	
Non-Transport	**95**	
-Falls	2	
-Drowning	33	
-Fire	31	
-Poisoning	7	
-Other	22	
Homicide	**171**	**29.4**
-Firearm	100	
-Other	71	
Suicide	**46**	**7.9**
-Firearm	15	
-Other	31	
Legal intervention	**1**	**0.2**
Undetermined Intent	**15**	**2.6**

Source: Analysis of data from Vital Statistics Administration, DHMH
All numbers are rounded to the nearest tenth decimal and may result in a total other than 100%
*Pedestrians, bicyclists, skateboarders, etcetera

Of the unintentional injuries, motor-vehicle related injuries were the leading cause of death to children, causing 237 deaths between 2002 and 2004. Sixty percent of these deaths occurred among boys and 40% were among girls. White and African-American youth died from motor vehicle accidents at the rates of 5.6 and 5.9 per 100,000 population respectively. Older children bore the brunt of the cases, dying at the rate of 18.8 per 100,000 population in the 15-17 year age group.

Violence among young people is a significant public health problem in the U.S. There were 193 homicides in 2002-2004 among infants and children aged birth to 17 years. The numbers of homicide deaths among African-American and white children were 151 and 39 respectively, representing rates of 11.0 per 100,000 for African-American children and 1.6 per 100,000 for white children. The greatest number of homicides occurred in the oldest children and most often involved the use of firearms. Adolescents ages 15-17 years were victims of homicide at a rate of 15.7 per 100,000 population. The homicide rate for infants (under one year of age) was higher than for any age group up until age 15 years; 24 infants were victims of homicide, representing a rate of 10.7 per 100,000. Males died at a significantly higher rate from homicide than females, dying at 6.6 and 2.3 per 100,000 population respectively.

Suicide among young people is also a significant public health problem in the U.S., and it is the third leading cause of death among youth. Suicide is generally a complication of mental health problems, but a mental health disorder is often not the lone cause. Other risk factors may have an effect. Of the 46 children aged 10-17 years who committed suicide between 2002 and 2004, 33 were males and 13 were females, representing rates of 3.3 and 1.4 per 100,000 population respectively. Ten African-American children committed suicide, a rate of 1.5 per 100,000. Among white children, 33 committed suicide, representing a rate of 2.8 per 100,000 population. Older children (15-17 years) committed suicide at a much higher rate (4.0 per 100,000) than younger children (1.5 per 100,000 among 10-14 year olds).

For children ages 1-17 years, the average mortality rate declined by 12.7% between 1995-1999 and 2000-2004. Statistically significant declines occurred, however, only in Baltimore City, Baltimore County, and Prince Georges County. Changes in the sociodemographic characteristics of the population may also have contributed to changes in child deaths rates.

Local Child Fatality Review teams in Maryland jurisdictions review unexpected deaths in infants and children under eighteen. Each jurisdiction submits an annual report detailing how many CFR meetings were held the previous year and how many cases were reviewed. Teams include data on the number of confirmed and suspected cases of child abuse and neglect among the cases they review. They also include data on the number of cases in which there was a previous history of involvement with either Child Protective Services (CPS) for abuse or neglect, or the juvenile justice system.

In 2005, 75 local CFR meetings were conducted across the State and a total of 267 child deaths were reviewed. In 30 cases abuse or neglect was confirmed, either by CPS or a police investigation. In 13 cases team members subjectively felt that abuse or neglect may have contributed to the death. In seven cases there was a previous history of child abuse, as determined by CPS, and in 16 cases there was a previous history of neglect. In a total of 16 cases there was a history of involvement with the Department of Juvenile Justice. The summary of local CFR case review meetings and findings can be found on page 23 of this report, and CFR reports from local jurisdictions throughout Maryland can be viewed at http://www.fha.state.md.us/mch/html/cfr/. Data that describes the extent, distribution, and risk factors of childhood deaths is vital to policy makers, health professionals, and communities to enable them to make decisions about allocation of resources and institution of effective strategies to prevent future child fatalities, and to monitor progress.

ACTIVITIES OF THE STATE CFR TEAM

Leadership

The State Child Fatality Review Team is led by elected members Sally B. Dolch, LCSW-C and Carolyn Fowler, PhD, who serve as Co-Chairs. In addition, during the year State team leaders led ad hoc sub-committees to address State CFR team goals, visited local CFR team meetings, and presented at State and local trainings and conferences.

Meetings

The State CFR team convened four daylong sessions in 2005. As in past years, the last meeting of the year was conducted as an all-day training conference for local and State CFR team members. Minutes from the three State CFR team quarterly meetings are located at http://www.fha.state.md.us/mch/html/cfr/ .

Presentations to the State CFR Team

During quarterly State CFR team meetings, topics of special interest are covered in depth, either by State team member experts or invited guests who have special expertise. The following were special topics/invited speakers at the 2005 State team quarterly meetings:

"Teen Motor Deaths"
Guest speakers:

Tim Kerns, Data Base Engineer, Project Director, Crash Outcomes Data Evaluation System (CODES), University of Maryland, National Study Center for Trauma and EMS

Peter Moe, Young Driver Coordinator, Maryland State Highway Administration

"The Maryland Poison Center"
Guest Speakers:

Bruce D. Anderson, PharmD, ABAT
Director of Operations, The Maryland Poison Center,
University of Maryland School of Pharmacy, Baltimore, Maryland

Angel Bivens, R.Ph., MBA, CSPI
Public Education Coordinator, The Maryland Poison Center
University of Maryland School of Pharmacy, Baltimore, Maryland

Annual Training Conference

The 2005 Annual State CFR Training Conference was held on November 15, in Columbia, Maryland. The annual conference typically focuses on the needs of the local Child Fatality Review teams, which convene regularly to review fatality cases in each Maryland county.

The keynote speaker for the 2005 Conference was Teri Covington, Director of the National Maternal and Child Health Center for Child Death Review. Ms. Covington is a well-known expert in the field of child fatality prevention. Her keynote address was entitled, "Translating Review Findings to Action: Overview and Best Practice Guidelines."

The training conference covered a wide array of topics, among them data reporting, strategies to devise effective injury and death prevention programs, and practice sessions to help local CFR teams learn to develop recommendations tailored to the economic and demographic characteristics of their region. Other conference highlights included an update on State Child Fatality Review efforts and a panel of legal experts addressing local CFR team questions, as well as an overview of practice guidelines for translating review findings into action.

At all annual training conferences local CFR team leaders are encouraged to meet with other local CFR team leaders of jurisdictions with similar characteristics. Examples include those with a predominantly rural or urban population or a high death rate in a particular area such as automobile deaths or suicides. Because similar regions often share similar risk profiles, they can benefit from joint communication, efforts, and campaigns.

Coordination with Related Councils, Task Forces, and Programs

In 2005 the State team continued to work to build greater coordination with local CFR teams. Since 2004, State team members have been attending local team meetings to understand the issues and concerns the local teams confront and to determine how the State team can better meet the needs of the local teams.

Child Death Data Dissemination

The Office of the Chief Medical Examiner (OCME) collects data related to the death of children under its auspices. Maryland State Child Fatality Review is concerned with child fatalities under 18 and until the summer of 2005, local CFR teams were informed of these deaths through the efforts of staff at the Maryland Department of Human Resources. Administrative staff for the State CFR team at the Department of Health and Mental Hygiene (DHMH) assumed this responsibility during 2005 and now distributes monthly Maryland child fatality information to local CFR leaders and to the health officers of each local health department in the State.

At the same time, the OCME has streamlined the overall data dissemination system by computerizing a referral form that carries the necessary demographic and medical data, eliminating the need for a handwritten form that was used previously. This shortens the time it takes for the local jurisdictions to get information on the child deaths, so case reviews can take place in a more timely fashion. Staff at the OCME have been very helpful in improving the system of child death notification to local jurisdictions.

Computerized Data System to Assist Local CFR Case Review

2005 saw the completion of a new computerized data system that will eventually allow local CFR teams to receive information from the OCME and then complete and transmit their completed case review forms via computer after each case review meeting. With a grant from DHMH, the OCME enlisted the help of faculty and students at Towson University Department of Computer and Information Sciences to develop a sophisticated data collection instrument. This instrument incorporated the form already in use by Maryland CFR teams and the data tool used by the National Child Death Review to ensure that Maryland's data collection system fits the national standard. Where the death is that of an infant, a separate infant death protocol form will be included. Narrative fields are included in the new tool as well and will enhance the ability to look for death trends. Steps remaining to be completed before the system can become fully functional and implemented are final testing and subsequent modifications.

Newsletter

2005 saw the creation of a State CFR monthly newsletter, written and compiled by State team Chair, Sally B. Dolch. The Communication Subcommittee had recommended the State team publish a newsletter as a way of improving communication and increasing the reach and ability of the State team to provide information and education. The newsletter will focus on a special topic each month and will contain a calendar of upcoming conferences and trainings which might be helpful to local and State team members. Copies of the newsletter can be viewed at http://www.fha.state.md.us/mch/html/cfr/ under "What's New."

Relevant Legislation Passed in 2005

During the 2005 session of the Maryland General Assembly, a number of bills were introduced related to reducing childhood injuries and deaths. Throughout the legislative season, State team member Maureen Edwards, MD, MPH, designee of the Secretary of the DHMH, and the Medical Director of the Center for Maternal and Child Health, Maryland DHMH, kept the State CFR team updated on the content and progress of the proposed bills.

The following relevant legislation was passed in 2005:

The Child Abuse and Neglect Centers of Excellence Initiative was established in the DHMH by Senate Bill 782. The Secretary of DHMH appointed an expert panel designated by statute. The overall goal of the Initiative is to improve the protection of children in the State by recruiting local physicians to develop clinical expertise in the diagnosis and treatment of child abuse and neglect, and by developing and guiding the practice of multidisciplinary teams to improve the assessment and treatment of children who are the subject of a child abuse or neglect investigation, or child in need of assistance investigation. The Initiative will also work to facilitate the prosecution of criminal child abuse and neglect and will provide expert consultation and training to local multidisciplinary teams in the diagnosis and treatment of child abuse and neglect and sexual abuse through teleconferencing and on-site services.

Among the duties of the Center for Excellence faculty will be to assist local and regional jurisdictions in developing standards and protocols for the composition and operation of local or regional Centers of Excellence and the provision of financial support to part-time local and regional expert clinic staff for the diagnosis and treatment of child abuse and neglect.

FUTURE ACTIVITIES

The work of the State CFR team will continue with the following goals and priorities:

- Continue to meet quarterly to address the concerns and issues that affect the safety, health, and viability of children in the State of Maryland.
- Continue to advocate for the legal and administrative opportunities that will protect the children in the State of Maryland.
- Continue to propose funding opportunities and to search for funds to support the activities of local and State CFR.
- Collaborate with other citizen review panels that have similar goals and priorities.
- Continue to prepare the annual Child Death Report.
- Encourage local teams and State partners to support and work with local private efforts to support the families and communities where children have died.
- Review local CFR team reports to look for trends and information to plan for CFR training, consultation, and the sharing of written materials and Web site information that will help them to better understand the potential of their activities as a review team.
- Encourage sharing of best practices information as it applies to CFR.
- Collaborate with other State agencies to encourage the training and understanding of the potential for CFR.
- Continue to develop an understanding of the issues of confidentiality and sharing of confidential information to better serve the children of Maryland.
- Continue to collaborate with State and local agencies in an effort to evaluate the extent of their effort to protect the children of Maryland.
- Continue to provide the Governor, the public and the General Assembly with annual reports that shall include the State team's findings and recommendations.
- Continue to educate the public about the incidence of child deaths and the efforts each individual and community could make to prevent child deaths.
- Continue to work with the National Center for Child Death Review in order to share and benefit from other state and local teams from around the country and to disseminate information and issue specific reports that they send to us.
- Continue to develop and expand the monthly newsletter.

- Continue to develop and improve the CFR Web site, http://www.fha.state.md.us/mch/html/cfr/ .

APPENDICES

Appendix A

LOCAL CFR TEAM ANNUAL REPORTS: SUMMARY OF CASE REVIEW MEETINGS AND FINDINGS

Summary of Case Review Meetings and Findings – Maryland Jurisdictions* Local Jurisdiction Reports available at http://www.fha.state.md.us/mch/html/cfr/ (Question numbers match to question numbers in Part B of the Jurisdiction reports) *Three counties not included due either to no deaths or no case reviews	
	Total
1. Total Number of CFR meetings held in 2005.	75
2. Were all Medical Examiner cases reviewed by the team?	Yes 18 No 3
3. Total number of cases reviewed at local CFR team meetings in 2005, regardless of year of death.	267
4. Of all the cases reviewed by all teams in 2005, in how many was abuse or neglect confirmed; e.g., there was a finding of "indicated abuse" or "indicated neglect" by CPS or a positive police investigation?	30
5. Not including those children counted in number 4 above; what is the total number of cases that teams *subjectively* felt abuse or neglect may have contributed to the death?	13
6. Of the total cases reviewed in 2005, in how many was there a previous history of child abuse, as determined by CPS?	7
7. How many had a previous history of child neglect, as determined by CPS?	16
8. How many had a history of involvement with the Department of Juvenile Services (formerly Dept. of Juvenile Justice)?	16

Appendix B

The 2005 Recommendations of Local CFR Teams to the State CFR Team

1. Allegany County

Interest would be greater if cases were fresher. It would help to receive the information for review sooner.

Training Need/Interest: SIDS, SUDI, and/or Safe Sleep expert to speak at a case review meeting. Due to distance, members would be agreeable to training opportunities offered in the area.

2. Anne Arundel

1. Methadone treatment programs should provide periodic face-to face counseling and a written child safety awareness handout (similar to the attached used by Anne Arundel) to all patients with take-home medication privileges.
2. A written child safety awareness handout should be provided by the pharmacist whenever Methadone is dispensed.
3. Public agency home visitors (e.g. Social Services workers) should visually inspect Methadone lock boxes on every home visit. We commend Anne Arundel County Social Services for this practice.
4. Pool fencing regulations should be expanded to mandate fences around above-ground pools.
5. Restart Maryland "Back to Sleep" public information campaign.

Training Need/Interest: None at this time.

3. Baltimore City

Out of concern over the severe choking hazard posed by gummi bears and jellybeans, the team recommends that the State CFR team send a letter to the State Restaurant Association. The letter should request that the State Restaurant Association warn restaurants that foods such as gummi bears or jellybeans pose a choking hazard and should not be available to young children.

Training Need/Interest: An update on State CFR team activities

4. Baltimore County

Please provide a list of all local CFR team coordinators so we can contact each other easily – especially if we have cases of mutual interest.

Training Need/Interest: The annual training conference is always helpful.

5. Calvert County

None

Training Need/Interest: None at this time.

6. Caroline County
All Terrain Vehicle safety awareness campaign

Training Need/Interest: Clarification of team roles of review and recommendation.

7. Carroll County
1. Need for Statewide standards and consistency when licensing foster homes.
2. Need for Department of Social Services to be involved when an outside county or city licenses foster care homes in other jurisdictions.

Training Need/Interest: Would like someone from State to give overview of trends explanation of how medical examiners office works, etc., at a case review meeting.

8. Cecil County
None at this time.

Training Need/Interest: None at this time.

9. Charles County
1. Broader state education on co-sleeping.
2. Importance of crib environment for newborns.

Training Need/Interest: None at this time.

10. Dorchester County
No Report.

11. Frederick County
None.
Training Need/Interest: None at this time.

12. Garrett County
None.
Training Need/Interest: None at this time.

13. Harford County
1. Obtain Statewide data regarding methadone maintenance "take home" doses and poisoning/overdose/fatality incidents involving children. For "take home" doses, consider the addition of a strong flavoring such as peppermint to deter children.
2. Explore the possibility of creating a computerized system of notification from OCME to local CFR (for case identification as well as for final autopsy results).
Training Need/Interest: None at this time.

14. Howard
None this year.

Training Need/Interest: Not events but rather literature reviews on preventable causes of child fatalities (that could be discussed during local CFR team meetings) would be helpful.

15. Kent County
None.
Training Need/Interests: None at this time.

16. Montgomery
1. Would appreciate a Statewide action plan on the issue of infant unsafe sleeping practices, as it is a recurring theme.
2. It would be helpful to standardize the criteria for coding alcohol related deaths.

Training Need/Interests: Pediatric forensic updates.

17. Prince George's County
1. Establish a database system that compiles information for local CFR teams.
2. Explore funding resources for local teams.
3. Revision of current reporting forms used by the local teams.
4. Increase the number of trainings offered to local teams.

Training Need/Interests:
   a. Grant writing and other funding resources for local CFR teams.
   b. Networking opportunities with other local teams to discuss accomplishments and issues.
   c. Data tabulation and analysis.

18. Queen Anne's County
None at this time.
Training Need/Interest: Annual Update.

19. St. Mary's County
None
Training Need/Interest: None at this time.

20. Somerset County
None
Training Need/Interest: Use of standard worksheet during actual case reviews would be helpful.

21. Talbot County
Educate about the dangers of ATVs, the dangers of truck blind spots, and advise parents that their new drivers are often challenged by peers to become involved in dangerous driving, to show off or defy authority. Encourage parents to urge their children to avoid this behavior and remember blind spots.
Training Need/Interest: State CFR team meeting is adequate.

22. Washington County
Statewide education on teen suicide.
Curriculum included in school and home safety.
Safety regulations on ATVs and other adult equipment used by children.
Laws regarding use of helmets/license for scooters/mopeds.

Training Need/Interest: How to educate children in middle/high schools regarding reaching out to some one they trust with issues of drugs, depression, and suicide.

23. Wicomico County
None at this time.
Training Need/Interest: As identified in CY 2004 report, the team would like training on how to move from the review process to community collaboration.

24. Worcester
None.
Training Need/Interest: None at this time.

Appendix C

Tally of 2005 Local CFR Team Recommendations to State CFR Team by Topic

Administrative/Data Related (3) jurisdictions had suggestions on these topics)

1. Would like case information sooner.
2. Would like a list of all local CFR team leaders to be available, to facilitate contacting one another.
3. Revise current Case Reporting forms used by local teams.
4. Explore funding resources for local teams.
5. Establish a database system that compiles information for local CFR teams.

Advocacy (1)

In response to a case of a 17 month-old who choked on gummi bears and/or jellybeans, the team recommends that the State CFR team send a letter to the State Restaurant Association. The letter should request that the State Restaurant Association warn restaurants that foods such as gummi bears or jellybeans pose a choking hazard and should not be available to young children.

Alcohol and Drug Related (3)

1. Methadone treatment programs should provide periodic face-to-face counseling and a written child safety awareness handout (similar to one used by Anne Arundel) to all patients with take-home medication privileges.

2. Whenever Methadone is dispensed, a written child safety awareness handout should be provided by the pharmacist.

3. Public agency home visitors (e.g. Social Services workers) should visually inspect Methadone lock boxes on every home visit. We commend Anne Arundel County Social Services for this practice.

4. Obtain Statewide data regarding methadone maintenance "take home" doses and poisoning/overdose/fatality incidents involving children. For "take home" doses, consider the addition of a strong flavoring such as peppermint to deter children.

5. It would be helpful to standardize the criteria for coding alcohol related deaths.

ATV's/Mopeds/Trucks/Teens (3)

1. ATV safety awareness campaign.
2. Educate about the dangers of ATVs, the dangers of truck blind spots, and advise parents that their new drivers are often challenged by peers to become involved in dangerous driving, to show off or defy authority. Encourage parents to urge their children to avoid this behavior and remember blind spots.
3. Safety regulations on ATVs and other adult equipment used by children.
4. Laws regarding use of helmets/licenses for scooters/mopeds.

Safe Sleeping (5)

1. Restart the Maryland "Back to Sleep" education campaign**.**
2. A Statewide action plan on the issue of infant unsafe sleep.
3. Broader state education on co-sleeping.
4. Importance of crib environment for newborn.
5. Safe sleep/SIDS expert to speak at a CFR case review meeting.

Suicide (1)

Statewide education on teen suicide.

Training (1)

Increase the number of trainings offered to local CFR teams.

Water Safety (1)

Pool fencing regulations should be expanded to mandate fences around aboveground pools.

Appendix D

Agenda
2005 Maryland State Child Fatality Review Team Annual Training Conference
Tuesday, November 15

Wilde Lake Interfaith Center
10431 Twin Rivers Road
Columbia, Maryland 21044

8:00 – 9:00	**Registration**
9:00 – 9:45	**Greetings and Update: State CFR in Maryland** State CFR Team Chairperson, Sally B. Dolch
9:45 – 10:15	**National CFR Overview** Teri Covington Director, National Child Death Review Center (NCDRC)
10:15 – 10:30	**Break**
10:30 – 12:00	**Translating Review Findings to Action: Overview and Best Practice Guidelines** Teri Covington and Carolyn Fowler, State CFR Team Co-Chair
12:00 - 1:00	**Lunch** (Provided)
1:00 - 2:00	**Legal Issues in CFR: Panel Presentation by Attorneys** -John Cox, Assistant State's Attorney, Violent Crimes, Baltimore County -Eileen Mc Inerney, Office of the Attorney General and State CFR Team Member -Christi Megna, Department of Health and Mental Hygiene, FHA, Director of Legislative and Regulatory Affairs -Jonathan Newell, State's Attorney's Association and State CFR Team Member
2:00 - 2:15	**Break**
2:15 - 4:00	**Translating Findings to Action and Getting to Best Practices** Teri Covington, Carolyn Fowler, Sara Rich (NCDRC)
4:00	**Adjourn**

Appendix E
Child Fatality Review
Resource List

1. www.aap.org (American Academy of Pediatrics)
2. www.medem.com (Search Child Fatality)
3. www.seatcheck.org (Safety Seats—1-866-seat-check)
4. www.acy.org (Advocates for Children and Youth)
5. www.acy.org/relatedlinks.shtml (Web sites related to children's issues)
6. www.acy.org/advocacy_tools.shtml (Advocacy tools and working with elected officials)
7. www.firemarshal.state.md.us (Fire Safety Issues.)
8. www.nfpa.org/riskwatch (National Fire Protection Association)
9. www.nfpa.org/riskwatch/about.html (Overview of the Risk Watch program.)
10. www.nfpa.org/riskwatch/teacher.html (Teacher's tools to use in the Risk Watch Program.)
11. www.infography.com (Search on Farm Safety)
12. www.fs4jk.org (Kids safety messages, games, coloring book, crossword puzzles etc.)
13. http://www.cdc.gov/ncipc/duip/duip.htm (National Center for Injury Prevention Control, Division of Unintended Injury—includes a State Injury Prevention Profile for Maryland)
14. http://www.cdc.gov/health/default.htm (A list of health topics A-Z)
15. http://www.bam.gov/ (A CDC Web site for kids and people who work with kids. The topics are wide ranging, including a section on safety for different sports.)
16. http://mova.missouri.org/childab.htm (Missouri Victims Assistance Network, Child Abuse Victims Resources. Click on Child Abuse Prevention Network.)
17. www.child-abuse.com (Click on ICAN-NCFR Child Fatality Review)
18. www.nationalcasa.org (Services and health tips)
19. www.agnr.umd.edu/MCE/Publications/index.cfm (Maryland Cooperative Extension Service)
20. http://safety.coafes.umn.edu/ (University of Minnesota, Farm Safety and Health Information Clearinghouse)
21. www.connectforkids.org (Click of "Topics A-Z. Click on "Health". Click on "Safety and Injuries". Explore other aspects of this Web site.)
22. www.nichd.nih.gov/sids/ (SIDS Back To Sleep Campaign)
23. www.nichd.nih.gov/publications/pubskey.cfm?from=sids (Ordering information for SIDS material in Spanish and English)
24. www.nichd.nih.gov/strategicplan/cells/SIDS_Syndrome.pdf (Targeting Sudden Infant Death Syndrome (SIDS): A Strategic Plan—June 2001, 40 pages)
25. www.mdpublichealth.org/mch (Click on Child Fatality Review)
26. www.infantandchildloss.org (The Center for Infant and Child Loss)
27. www.drada.org/ (Depression and Related Affective Disorders Association)
28. http://www.suicidehotlines.com/maryland.html (Suicide hotlines in Maryland)
29. http://www.mentalhealth.org/suicideprevention/stateprograms/Maryland.asp
30. http://www.familytreemd.org (Child Abuse information for Maryland)
31. http://www.childwelfare.net/CFR/ (Child Fatality Review in Georgia)
32. http://www.hs.state.az.us/cfhs/azcf/ (Child Fatality Review in Arizona)

33. http://www.tdprs.state.tx.us/child_protection/about_child_abuse/cfrt.asp (Child Fatality Review in Texas)
34. http://www.cdphe.state.co.us/pp/cfrc/cfrchom.asp (Child Fatality Review in Colorado)
35. http://www.dss.state.mo.gov (Child Fatality Review in Missouri)
36. http://www.keepingkidsalive.org/ (Child Fatality Review in Michigan)

Note: If you would like an e-mail version of this page, e-mail jpatterson@dhmh.state.md.us and it will be sent to you as an attachment so addresses can be opened.