MARYLAND
STATE CHILD FATALITY REVIEW TEAM
Baltimore, Maryland 21201

Richard Lichenstein, MD
Chairperson

September 5, 2012

The Honorable Martin O'Malley
Governor
State of Maryland
Annapolis, MD 21401-1991

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: 2011 Legislative Report of the State Child Fatality Review Team

Dear Governor O'Malley, President Miller, and Speaker Busch:

Pursuant to Health-General Article, §5-704(b)(12), Annotated Code of Maryland, the Maryland State Child Fatality Review Team submits this 2011 report on its progress and accomplishments. The report also sets forth data relating to child deaths in Maryland.

I hope this information is useful. If you have questions about this report, please contact me at (410) 328-2079 or rlichenstein@peds.umaryland.edu.

Sincerely,

Richard Lichenstein, M.D.
Chairperson

Enclosure

cc: Marie Grant, J.D.
Frances B. Phillips, R.N., M.H.A.
Donna Gugel, M.H.S.
Bonnie S. Birkel, C.R.N.P., M.P.H.
Sarah Albert, MSAR #7575

MARYLAND STATE CHILD FATALITY REVIEW TEAM

2011 Annual Legislative Report

Health-General Article, §5-704(b)(12)

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

http://fha.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 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 2011 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 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, which operate in each jurisdiction. It is the responsibility of the local teams to conduct reviews of unexpected deaths of child residents that are investigated by the Office of the Chief Medical Examiner (OCME). The manner of these deaths is determined to be either natural, homicide, suicide, accidental, or undetermined. The local teams are given written notice of resident child deaths each month by the OCME and are required to review these deaths. Local teams then make recommendations for systems changes at the local level through changes in the law, policy, or practice, and work to implement these recommendations.

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 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. Local FIMR and CFR teams often collaborate and share resource information.

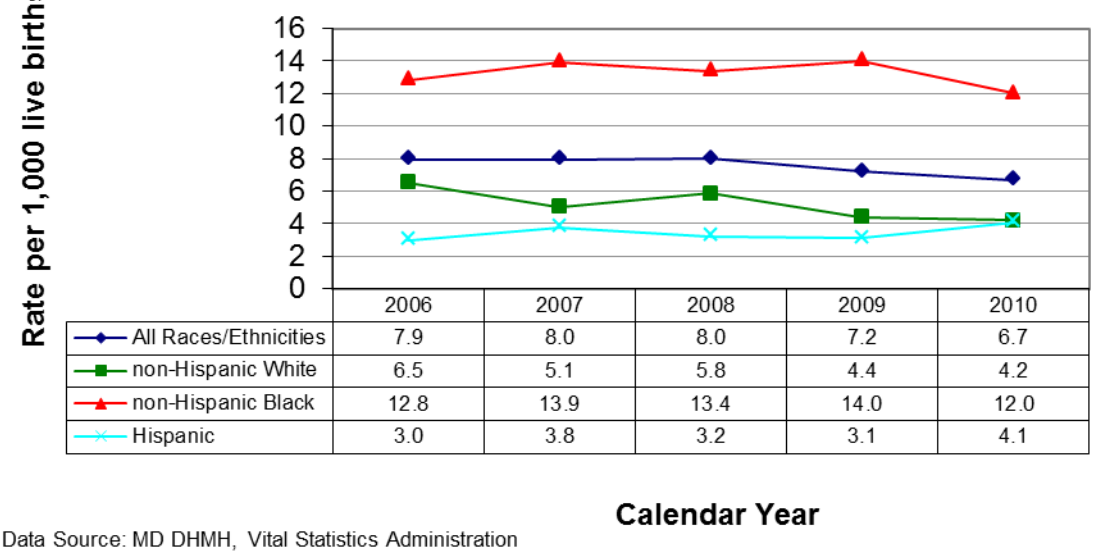
Summary of the Maryland Child Death Report 2011

Reflecting Deaths Occurring 2006-2010

Childhood deaths are a major public health problem 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 the majority of cases of unintentional injury deaths, homicides and suicides, and occasional deaths due to natural causes.

The Child Death Report reviews all deaths in children under the age of 18. In 2010, there were 496 infant deaths (under 1 year of age) and 237 deaths among children ages 1-17. Deaths to infants are usually analyzed separately from deaths among children ages 1-17. The three leading causes of death for infants in 2010 were: (1) disorders related to preterm birth or low birth weight (25.8%); (2) congenital abnormalities (16.1%); and (3) newborn affected by maternal complications of pregnancy (9.5%). The infant mortality rate declined by 15% over the last five years to 6.7 per 1,000 live births in 2010 (Fig. 1).

Figure 1. Infant Mortality Rates by Race/Ethnicity, Maryland, 2006-2010



	2006	2007	2008	2009	2010
All Races/Ethnicities	7.9	8.0	8.0	7.2	6.7
non-Hispanic White	6.5	5.1	5.8	4.4	4.2
non-Hispanic Black	12.8	13.9	13.4	14.0	12.0
Hispanic	3.0	3.8	3.2	3.1	4.1

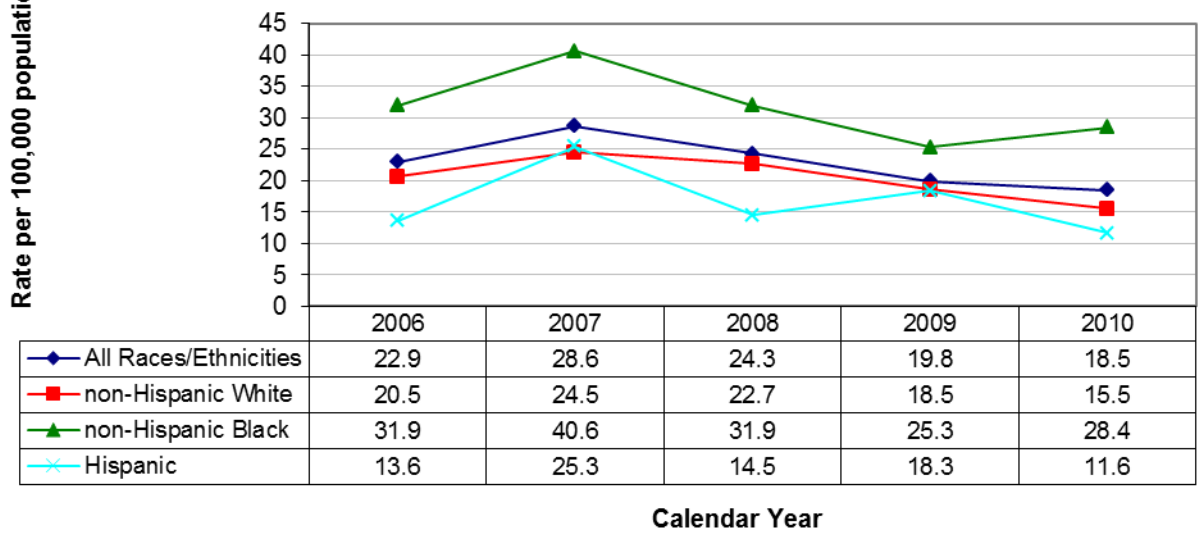
Data Source: MD DHMH, Vital Statistics Administration

There were substantial racial disparities in infant mortality rates in 2010. The infant mortality rate for non-Hispanic Blacks (12.0 per 1,000 live births) was nearly three times higher than the rate for non-Hispanic Whites (4.2) and Hispanics (4.1).

Infant mortality data for 2011 are available at http://dhmh.maryland.gov/vsa/Documents/imrep11.pdf. Further analysis of these data is pending release of the final 2011 Vital Statistics Administration (VSA) Annual Report.

In 2010, the child death rate (1-17 years of age) was 18.5 per 100,000 population (Figure 2). The child death rate has declined by thirty-five percent since 2007. In 2010, the child death rate for non-Hispanic Whites was 15.5 per 100,000 population compared to 28.4 per 100,000 population for non-Hispanic Blacks. The child death rate for Hispanics in 2010 was 11.6 per 100,000 population. Among children aged 1-17 in the years 2008-2010, the three leading causes of death were: (1) unintentional injuries; (2) homicide; and (3) malignant neoplasms (Note: data are aggregated over a three year period to provide more stability).

Figure 2. Child (1-17 years) Death Rates by Race/Ethnicity, Maryland, 2006-2010



	2006	2007	2008	2009	2010
All Races/Ethnicities	22.9	28.6	24.3	19.8	18.5
non-Hispanic White	20.5	24.5	22.7	18.5	15.5
non-Hispanic Black	31.9	40.6	31.9	25.3	28.4
Hispanic	13.6	25.3	14.5	18.3	11.6

Data Sources: MD DHMH, Vital Statistics Administration, Maryland Department of Planning

Table 1 shows the leading causes of death by age group. For the injury related deaths, 29.8% were due to motor vehicle collisions (Tables 2, 3). Sixty-four percent of motor vehicle deaths occurred in males. The greatest proportion of motor vehicle related injury deaths occurred in children aged 15 to 17 years (53.8%). The rates for motor vehicle related deaths among children 1-17 years by race and ethnicity were 3.7 for non-Hispanic Whites, 2.9 for non-Hispanic Blacks and 1.6 for Hispanics, per 100,000 population.

Children's death by homicide continues to be a significant public health problem in Maryland. In the period 2008 through 2010, there were 16 homicides of infants under one year and 115 homicides among children aged 1-17 years. The rate of homicides among children aged 0-17 is substantially higher among non-Hispanic Blacks, at 7.5 per 100,000 population, compared to 1.4 for non-Hispanic Whites and 1.4 for Hispanics. Fifty-six percent of the homicides of children aged 0-17 involved firearms. The age group with the highest homicide rate was that of children between 15 to 17 years (9.4 per 100,000 population). The group with the next highest rate was that of infants (7.2 per 100,000). Seventy-one percent of the child victims of homicide (aged 0-17 years) were male.

There were 45 suicides among children under 18 years during the period from 2008 to 2010. The rate of suicide was greatest among those aged 15 to 17 years (4.7 per 100,000 population). Suicides occurred less frequently among younger children aged 10 to 14 years (0.9 per 100,000 population). Among children aged 10 to 17, 77.3% of suicides were committed by males. The suicide rates were similar between non-Hispanic

White children (2.9 per 100,000 population) and non-Hispanic Black children (2.2 per 100,000 population). There were less than 5 suicides reported among Hispanic and Asian children during this time period, so rates were not computed due to instability.

Table 1. Leading Causes of Death by Age Group, Maryland, 2008-2010

Rank	Age Group				
		1-4 years	**5-9 years**	**10-14 years**	**15-17 years**
1	**Cause of Death**	Unintentional Injury	Unintentional Injury	Unintentional Injury	Unintentional Injury
	# of Deaths	51	43	41	80
	% of Deaths in Age Group	23.9%	33.3%	24.1%	28.1%
2	**Cause of Death**	Congenital Malformations	Malignant Neoplasms	Malignant Neoplasms	Homicide
	# of Deaths	25	18	24	68
	% of Deaths in Age Group	11.7%	14.0%	14.1%	23.9%
3	**Cause of Death**	Homicide	Diseases of the Respiratory System	Homicide	Suicide
	# of Deaths	24	10	18	34
	% of Deaths in Age Group	11.3%	7.8%	10.6%	11.9%
4	**Cause of Death**	Diseases of the Respiratory System	Diseases of the Nervous System	Diseases of the Respiratory System	Malignant Neoplasms
	# of Deaths	19	9	15	25
	% of Deaths in Age Group	8.9%	7.0%	8.8%	8.8%
5	**Cause of Death**	Infectious Diseases	Infectious Diseases	Suicide	Diseases of the Circulatory System
	# of Deaths	15	9	10	18
	% of Deaths in Age Group	7.0%	7.0%	5.9%	6.3%

* Data Source: MD DHMH, Vital Statistics Administration

Table 2. Child (1-17 years) Injury Related Deaths by Type of Injury and Sex, Maryland, 2008-2010				
Type of Injury	**Male**	**Female**	**Total Deaths**	**% of Total Injury Deaths**
Motor Vehicle Collision	75	42	117	29.8%
Homicide	87	28	115	29.3%
Suicide	35	10	45	11.5%
Other Non-Transport Injury	17	10	27	6.9%
Drowning	22	4	26	6.6%
Fire	10	11	21	5.3%
Undetermined Intent	15	3	18	4.6%
Other Transport Injury	8	5	13	3.3%
Falls	6	2	8	2.0%
Poisoning	1	2	3	0.8%

* Data Source: MD DHMH, Vital Statistics Administration

Table 3. Child (1-17 years) Injury Related Deaths by Type of Injury and Race/Ethnicity, Maryland, 2008-2010					
Type of Injury	**non-Hisp White**	**non-Hisp Black**	**Hispanic**	**Other**	**Total Deaths**
Motor Vehicle Collision	69	35	6	7	117
Homicide by Firearm	12	59	1	1	73
Homicide by other Means	13	25	4	0	42
Suicide by other Means	15	12	2	2	31
Other Non-Transport Injury	12	11	2	2	27
Drowning	18	6	1	1	26
Fire	6	14	1	0	21
Undetermined Intent	11	5	2	0	18
Suicide by Firearm	12	2	0	0	14
Other Transport Injury	8	5	0	0	13
Falls	1	5	1	1	8
Poisoning	3	0	0	0	3

* Data Source: MD DHMH, Vital Statistics Administration

2011 State CFR Team Activities

Summary of 2011 Case Reviews by Local CFR Teams

Each local CFR team is provided information by the OCME about cases of unexpected child death occurring in the team's jurisdiction. Local CFR teams are to meet at least quarterly to review these cases and develop recommendations for local interventions to prevent future child deaths. In 2011, a total of 206 cases were referred by the OCME for review and 66 child fatality review team meetings were held across the state.

Local teams are developing the capability to report these cases to the State CFR Team through an 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 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, House Bill 705/Senate Bill 862, Chapters 108/107 (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 have been provided training in CDRCRS use and have been implementing the system. The majority of local teams are currently entering case review data into the internet-based system, although at this time, reporting in CDRCRS is incomplete. Of the 206 cases referred to local CFR teams by the OCME in 2011, 141 cases were entered into CDRCRS. This represents a data entry completion rate of 68% of referred cases (Table 4).

Of all the cases reviewed in 2011, abuse or neglect was "confirmed" in 20 of them, which means there was a finding of "indicated" abuse or neglect by CPS or police investigation. In an additional 13 cases, a team felt that abuse or neglect may have contributed to the death.

Table 4.

Percent of OCME* Referred Child (<18 years) Deaths Reviewed and Entered into the National Maternal and Child Health Center for Child Death Review Case Reporting System for Deaths Occurring in 2011, by Jurisdiction, Maryland, 2011

2011

	# of Cases Referred by OCME	# of Referred Cases Reviewed and Entered into NCCDR System	% of Referred Cases Reviewed and Entered into NCCDR System
Allegany	2	2	100
Anne Arundel	20	20	100
Baltimore	22	22	100
Baltimore City	53	44	83
Calvert	3	2	67
Caroline	1	0	0
Carroll	5	3	60
Cecil	10	3	30
Charles	7	0	0
Dorchester	0	N/A	N/A
Frederick	9	7	78
Garrett	0	N/A	N/A
Harford	8	0	0
Howard	7	5	71
Kent	1	1	100
Montgomery	10	3	30
Prince George's	31	21	68
Queen Anne's	2	2	100
Saint Mary's	3	1	33
Somerset	0	N/A	N/A
Talbot	3	0	0
Washington	5	2	40
Wicomico	2	1	50
Worcester	2	2	100
Total	206	141	68

*Office of the Chief Medical Examiner
Data Sources: MD DHMH, National Center for Child Death Review (NCCDR) Database, OCME

Summary of Local CFR Team Activities

Through case reviews at team meetings, local CFR teams developed a variety of recommendations for preventing child deaths. As a result, a number of activities were undertaken by local CFR teams and their respective local health departments during 2011.

- Safe Sleep Activities - Fourteen counties conducted safe sleep activities, making it one of the most frequently addressed issues. Activities included community education events, distribution of educational materials to pregnant women and new mothers, and distribution of free portable cribs to needy families to provide a safe infant sleep environment. Particularly innovative ideas included distribution of safe sleep messages in church bulletins, barber shops, beauty shops, and elementary schools (Baltimore City); notification of the Chairman of Pediatrics at the hospital of birth when an infant died due to unsafe sleep environment; and providing a slide show to promote safe sleep in local movies theaters (Baltimore County).

- Community, Provider, and CFR Team Education - Ten counties conducted community, provider, or CFR Team education. These included CFR team members presenting at local and statewide conferences, inviting speakers for local agencies and programs to address the CFR team, providing technical assistance to local hospitals regarding car seat safety information, providing resources on "tip-over" hazards of television sets to local health departments and home visiting programs, and distributing posters and other materials and hosting discussions on the dangers of leaving children in hot cars, the dangers of window cords, underage drinking, and suicide prevention. One notable activity was an effort by the local CFR coordinator to visit thrift and re-sale shops to screen for infant cribs and other infant items recalled by the Consumer Product Safety Commission, and to alert shopkeepers that it is illegal to resell these items (Harford County).

Training and Education

The State CFR Team provides educational and training activities to assist local CFR teams in carrying out their duties. Each year, the State CFR Team receives an annual report from each local CFR team describing their activities in the previous year and their training needs. State CFR Team members provide technical assistance, training, and education specifically aimed at addressing the needs described by local CFR teams. A training meeting is held each year by the State CFR Team for local CFR coordinators. Presentations are made by experts on the State Team and by invited guests who are experts in their field. At the 2011 State CFR Annual Meeting, topics included suicide prevention, violent death trend analysis, teen driver issues, and safe sleep (see Appendix C for the State CFR Team 2011 Annual Meeting Agenda).

At all State annual training events, opportunities are provided for local CFR team members to network with colleagues from other local CFR teams. Local team members are encouraged to share resources and best practices. Local CFR teams also sponsor conferences in their own areas. Such conferences are usually open to all CFR coordinators throughout the state.

Newsletter

The quarterly State CFR Team newsletter provides information on child fatality topics and teams. The newsletter is edited by State CFR Team member Laurel Moody, RN, MS. The newsletter provides updates for local team members regarding legislation, training opportunities, pediatric injury information, internet links, meeting dates, State CFR Team membership changes, and more.

Drowning was a main newsletter topic in 2011, with discussion of statistics and recommendations for prevention. Other articles included a review of the Citizen's Review Board for Children, which makes recommendations to improve Maryland's Child Welfare System, and a review of Maryland law regarding drivers and school buses. The quarterly newsletter is available at http://fha.dhmh.maryland.gov/mch/SitePages/cfr-home.aspx.

Future State CFR Team Activities

Child Death Review Case Reporting System

A primary focus of the State CFR Team in 2012 will be expansion of the internet-based reporting system described in this report, as well as examination of data available through the system. The data collected by the CDRCRS are more comprehensive than data previously collected. Once all local teams are using the enhanced reporting system, a more complete and comprehensive understanding of child fatality in the State will be possible. Better understanding of the causes and circumstances of child deaths will help teams develop meaningful recommendations for preventing deaths. The data system will improve each team's ability to analyze local child deaths, and will help the State CFR Team to more efficiently coordinate efforts based on analysis of data trends.

Near Fatalities

Official case reviews are required to be performed on child fatalities, although the CFR statute permits review of near fatalities. The State CFR Team defines a near fatality as:

> **"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, allowing review of contributing factors and development of prevention strategies before a fatality occurs. However, in order for this to occur, a system of official notification about such cases would need to be developed. Under the current system, the OCME sends monthly 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. Since the OCME only has information on deaths and not on near fatalities, another system of notification would need to be developed before the local CFR teams can review near fatalities. Near fatality notification will require an arrangement with local hospitals, but an exact process is yet to be determined. The State CFR Team will begin to look into development of a mechanism to address near fatalities.

Safe Sleep

The State CFR Team will continue efforts aimed at preventing sleep-related deaths, working with Maryland's Center for Infant and Child Loss (CICL) to offer safe sleep training to the general public and

professionals. This effort includes promoting CICL's grief and bereavement services, whereby families are contacted by the CICL soon after the death of an infant or child.

The State CFR Team will also continue to 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, the Family League of Baltimore, and CareFirst Blue Cross/BlueShield. Dissemination of this DVD will continue to local jurisdictions which have identified safe-sleep practices as a key issue.

Media

Another goal for the State CFR Team in 2012 is to develop opportunities to disseminate messages on child safety and injury prevention through the media (television, radio, print, internet, and social media). Messaging should be timed with incident prevalence, such as promoting drowning prevention messages as summer approaches.

A comprehensive regional and statewide approach is necessary for the State and local CFR teams to achieve meaningful and significant 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 their numbers can be reduced.

Appendix A: 2011 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 - TBA
(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 - Richard Lichenstein, MD, FAAP , Allen Walker, 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

AGENDA
Maryland State Child Fatality Review Team Annual Meeting
Wednesday, November 16, 2011
Location: Maryland Department of Transportation
7201 Corporate Center Dr., Hanover, Maryland 21076
410-865-1142

8:45 – 9:30	**Registration**
9:30 – 9:45	**Welcome & Introductions** Richard Lichenstein, MD Chair, Maryland State Child Fatality Review Team
9:45 – 11:00	**Rob Schmidt, LCPC, NCC** Talbot County Public Schools "The Yellow Ribbon Suicide Prevention Program"
11:00 – 11:45	**Tom Manion, MA** Maryland Department of Health and Mental Hygiene "An Analysis of Violent Death Trends Using the Maryland Violent Death Reporting System"
11:45 – 12:00	**Introduction of Attendees – Know Your Neighbor**
12:00 – 1:00	**Lunch & Lunchtime Discussion** **12:30** Review of New AAP Safe Sleep Guidelines Dr. Jinlene Chan, Deputy Health Officer Anne Arundel County Health Department
1:00 – 1:30	**Lee Hurt, MS, MPH** Staff Epidemiologist Maryland Department of Health and Mental Hygiene "Violent Deaths in the NCRPCD Database"
1:30 – 2:45	**Jackie Abendschoen-Milani, Certified Prevention Specialist** **Joe Lloyd, Crash Reconstructionist** University of Maryland Medical Center Shock Trauma "Teen Driver Issues/Distracted Drivers"
2:45 - 3:00	**Wrap-up** Joan Patterson, LCSW-C Coordinator, Maryland State Child Fatality Review Team