MARYLAND
STATE CHILD FATALITY REVIEW TEAM
Baltimore, Maryland 21201

Richard Lichenstein, MD
Chairperson

August 1, 2013

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: Health-General Article, §5-704(b)(12), Annotated Code of Maryland
2013 Legislative Report of the State Child Fatality Review Team

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

Pursuant to Senate Bill 464, Chapter 355 of the Acts of 1999, the Maryland State Child Fatality Review Team submits this 2013 report on its progress and accomplishments in calendar year 2012. 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, MD
Chairperson

cc: Marie Grant, JD
Laura Herrera, MD, MPH
Michelle Spencer, MS
Ilise Marrazzo, RN, BSN, MPH
Sarah Albert, MSAR #7575

MARYLAND STATE CHILD FATALITY REVIEW TEAM

2013 Annual Legislative Report

Health-General Article, §5-704(b)(12)

`        `

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 2012 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. Local CFR teams are given written 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 2012 are covered in this report.

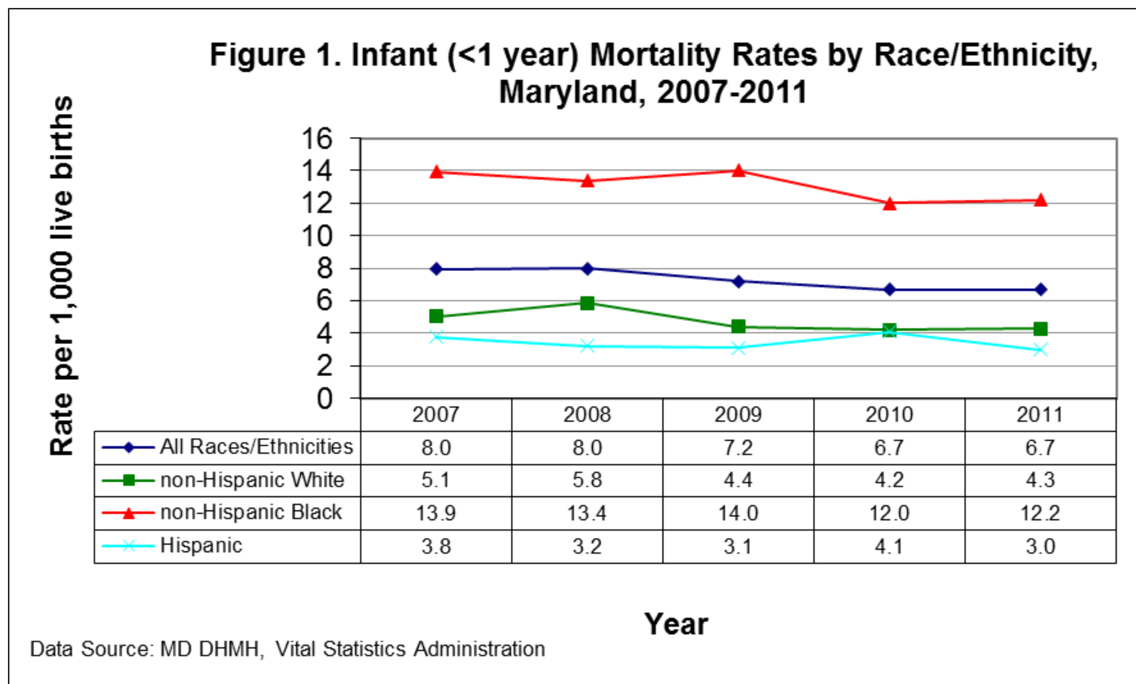
Other teams in Maryland have similar charges to prevent child injury and death. These include the State Council on Child Abuse and Neglect (SCCAN) and the Citizen Review Board for Children (CRBC); both of these organizations examine policies and practices for protecting children. There is collaboration 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 and share resource information.

Summary of Maryland Child Deaths

Reflecting Deaths Occurring 2007-2011

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 cases of unintentional injury deaths, homicides and suicides, and occasional deaths due to natural causes.

The Child Death Report, which was last published in 2011, reviews all deaths in children under the age of 18. In 2011, there were 493 infant deaths (under 1 year of age) and 239 deaths among children ages 1-17. Infant deaths are usually analyzed separately from deaths among children aged 1-17. The three leading causes of death for infants in 2011 were: (1) disorders related to preterm birth or low birth weight (25.6%); (2) congenital abnormalities (14.4%); and (3) Sudden Infant Death Syndrome (SIDS) (10.1%). The infant mortality rate declined by 16.0% over the last five years to 6.7 per 1,000 live births in 2011 (Fig. 1).



	2007	2008	2009	2010	2011
All Races/Ethnicities	8.0	8.0	7.2	6.7	6.7
non-Hispanic White	5.1	5.8	4.4	4.2	4.3
non-Hispanic Black	13.9	13.4	14.0	12.0	12.2
Hispanic	3.8	3.2	3.1	4.1	3.0

There were substantial racial disparities in infant mortality rates in 2011. The infant mortality rate for non-Hispanic Blacks (12.2 per 1,000 live births) was four times higher than the rate for Hispanics (3.0) and nearly three times higher than the rate for non-Hispanic Whites (4.3).

In 2011, the child death rate (1-17 years of age) was 18.8 per 100,000 population (Figure 2); this rate has declined by 34.0% since 2007. In 2011, the child death rate was 17.4 for non-Hispanic Whites, 26.3 for non-Hispanic Blacks, and 11.8 for Hispanics per 100,000 population.

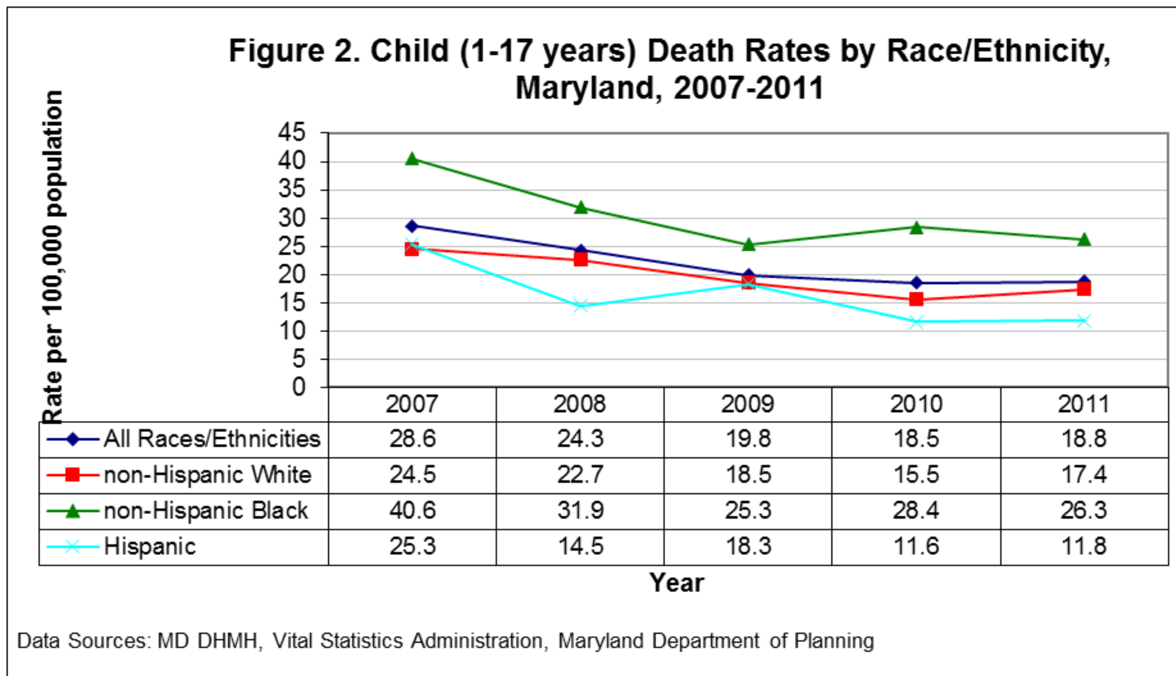


Table 1 shows the leading causes of death by age group. Among children aged 1-17 in the years 2009-2011, the three leading causes of death were: (1) unintentional injuries; (2) homicide; and (3) malignant neoplasms (Note: data are aggregated over a three year period to provide more stability).

Among injury-related deaths during the period 2009-2011, 29.0% were due to motor vehicle collisions (Tables 2, 3). Sixty-one percent of motor vehicle deaths occurred in males. The greatest proportion of motor vehicle-related injury deaths occurred in children aged 15-17 years (52.0%). The rates for motor vehicle-related deaths among children 1-17 years by race were 3.1 for non-Hispanic Whites and 2.9 for non-Hispanic Blacks per 100,000 population. There were less than five motor vehicle-related deaths reported among Hispanic children during this time period, so rates were not computed due to instability.

Children's death by homicide continues to be a significant public health problem in Maryland. In the period 2009-2011, there were 12 homicides of infants under one year, and 93 among children aged 1-17 years. The rate of homicides among children aged 0-17 is substantially higher among non-Hispanic Blacks, at 6.3 per 100,000 population, compared to 1.0 for non-Hispanic Whites. There were less than five homicides reported among Hispanic children during this time period, so rates were not computed due to instability. Fifty-seven percent of the homicides of children aged 0-17 involved firearms. The age group with the highest homicide rate was that of children between 15-17 years (8.3 per 100,000 population), followed by infants (5.4 per 100,000). Seventy-one percent of the child victims of homicide (aged 0-17 years) were male.

There were 48 suicides among children under 18 years of age during the period from 2009-2011. The rate of suicide was highest among those aged 15-17 years (4.8 per 100,000 population). Suicides occurred less frequently among younger children aged 10-14 years (1.1 per 100,000 population). Among children aged 10-17, 89.6% of suicides were committed by males. The suicide rates were similar between

non-Hispanic White children (3.1 per 100,000 population) and non-Hispanic Black children (2.7 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.

Table 1. Leading Causes of Death by Age Group, Maryland, 2009-2011

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	38	40	43	69
	% of Deaths in Age Group	20.2%	32.3%	27.2%	26.6%
2	**Cause of Death**	Congenital Malformations	Malignant Neoplasms	Malignant Neoplasms	Homicide
	# of Deaths	26	21	17	59
	% of Deaths in Age Group	13.8%	16.9%	10.8%	22.8%
3	**Cause of Death**	Homicide	Diseases of the Nervous System	Diseases of the Nervous System	Suicide
	# of Deaths	19	10	13	34
	% of Deaths in Age Group	10.1%	8.1%	8.2%	13.1%
4	**Cause of Death**	Diseases of the Respiratory System	Infectious Diseases	Homicide	Malignant Neoplasms
	# of Deaths	13	9	12	27
	% of Deaths in Age Group	6.9%	7.3%	7.6%	10.4%
5	**Cause of Death**	Malignant Neoplasms	Congenital Malformations	Suicide	Diseases of the Circulatory System
	# of Deaths	13	8	12	13
	% of Deaths in Age Group	6.9%	6.5%	7.6%	5.0%

* Data Source: MD DHMH, Vital Statistics Administration

Table 2. Child (1-17 years) Injury-Related Deaths by Type of Injury and Sex, Maryland, 2009-2011

Type of Injury	Male	Female	Total Deaths	% of Total Injury Deaths
Motor Vehicle Collision	61	39	100	29.0%
Homicide	71	22	93	27.0%
Suicide	43	5	48	13.9%
Other Non-Transport Injury	13	12	25	7.2%
Drowning	18	5	23	6.7%
Fire	7	10	17	4.9%
Undetermined Intent	12	2	14	4.1%
Other Transport Injury	6	4	10	2.9%
Poisoning	4	4	8	2.3%
Falls	7	0	7	2.0%

* Data Source: MD DHMH, Vital Statistics Administration

Table 3. Child (1-17 years) Injury-Related Deaths by Type of Injury and Race/Ethnicity, Maryland, 2009-2011					
Type of Injury	**non-Hisp White**	**non-Hisp Black**	**Hispanic**	**non-Hisp Other Race**	**Total Deaths**
Motor Vehicle Collision	56	35	4	5	100
Homicide by Firearm	9	50	1	0	60
Homicide by other Means	7	22	2	2	33
Suicide by other Means	13	13	3	1	30
Other Non-Transport Injury	12	8	2	3	25
Drowning	13	9	0	1	23
Suicide by Firearm	15	3	0	0	18
Fire	4	11	2	0	17
Undetermined Intent	7	5	2	0	14
Other Transport Injury	7	3	0	0	10
Poisoning	4	4	0	0	8
Falls	2	4	1	0	7

* Data Source: MD DHMH, Vital Statistics Administration

2012 State CFR Team Activities

Summary of 2012 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 meet at least quarterly to review these cases and develop recommendations for local interventions to prevent future child deaths. In 2012, a total of 194 cases were referred by the OCME for review, and 71 child fatality review team meetings were held across the state.

Local CFR 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 (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 at this time, reporting of case information into CDRCRS is incomplete and not always timely. Of the 194 cases referred to local CFR teams by the OCME in 2012, 160 cases had at least partial information entered into CDRCRS. This represents a data entry completion rate of 82.0% of referred cases (Table 4).

Local CFR teams report that out of all cases reviewed in 2012, abuse or neglect was “confirmed” in 22 of them, which means there was a finding of “indicated” abuse or neglect by Child Protective Services (CPS) or police investigation. Six cases had a history of child abuse while 13 had a history of neglect. Fourteen cases had a history of involvement with the Department of Juvenile Justice.

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 2012, 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	19	19	100
Baltimore	22	22	100
Baltimore City	49	25	51
Calvert	4	1	25
Caroline	5	4	80
Carroll	5	4	80
Cecil	5	4	80
Charles	5	5	100
Dorchester	0	n/a	n/a
Frederick	1	1	100
Garrett	0	n/a	n/a
Harford	12	10	83
Howard	9	9	100
Kent	0	n/a	n/a
Montgomery	19	18	95
Prince George's	20	20	100
Queen Anne's	1	1	100
Saint Mary's	1	0	0
Somerset	0	n/a	n/a
Talbot	2	2	100
Washington	6	6	100
Wicomico	5	5	100
Worcester	1	1	100
Total	194	160	82

*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 2012.

- **Safe Sleep Activities** – Thirteen counties conducted approximately 31 safe sleep activities, making it one of the most frequently addressed issues by local CFR teams. One jurisdiction (Baltimore City) saw a decrease in sleep-related deaths for the third year in a row.

    - Anne Arundel County received a grant from the Lothian Ruritans and the South County Baby Food Pantry to provide free portable cribs to needy families.
    - Baltimore City provided safe sleep training to public health home visiting staff and demonstrated innovative programs with the development of two new safe sleep videos, one targeting fathers and another targeting the Spanish speaking population. This same team developed a Safe Sleep public service announcement in collaboration with a Baltimore Ravens player.
    - Baltimore County trained workers from the Department of Social Services in safe infant sleep, and worked to establish a requirement that all funded methadone clinics in the county provide safe sleep training to clients.
    - Howard County's Safe Sleep campaign included a media release, a YouTube video, and a presentation to a high school teen parenting program.
    - Worcester County developed a comprehensive Safe Sleep Campaign consisting of 11 events, from a newspaper article to training sessions with WIC clients and others.

- **Community, Provider, and Local CFR Team Education** – Eleven counties conducted community, provider, or local CFR team education. Activities included development of programs or materials, in-service trainings, conferences, and distribution of information to targeted populations.

    - Anne Arundel County collaborated with the fire department to develop and distribute a checklist on county requirements for residential pools.
    - The Baltimore County local CFR team leaders collaborated with the school system and the fire department to establish a requirement that all high school students be trained in CPR.
    - Caroline County promoted newspaper coverage of community actions and responses following a drowning.
    - Cecil County conducted a daylong conference on "Investigation and Response to the Death of a Child or Infant," including guidelines on Sudden Unexplained Infant Death (SUID).
    - The Frederick County local CFR team gave a presentation to medical personnel at the local hospital on the identification of child abuse.
    - Howard County collaborated with the school system and other partners to work on establishing a Mental Health Task Force to address the emotional needs of students.
    - The Montgomery County local CFR team distributed brochures on toddler bathtub safety to child care centers.
    - After two gun-related deaths, Wicomico County provided public messages on gun safety via an electronic board, Twitter and Facebook.

Training and Education

The State CFR Team provides educational and training activities to assist local CFR teams in carrying out their duties. Every year, the State CFR Team receives an annual report from each local CFR team describing their activities during the previous year and their training needs. State CFR Team members provide technical assistance, training, and education aimed at addressing the needs described by local CFR teams. The State CFR Team holds annual meetings for local CFR team coordinators. Presentations are made by State Team member experts and by invited guests who are experts in their field. At the 2012 State CFR Annual Meeting, a mock case review was conducted by leaders of one local CFR team; the agenda for this meeting is included in this report as Appendix C. Other meeting topics included death scene investigation, the uses and benefits of the electronic data entry system, and an overview of the operation of the OCME in relation to CFR. Local team members network and share resources and best practices. Local CFR teams sponsor conferences in their own areas, which are often open to the other CFR coordinators.

Team Communication

In 2012, a listserv tool was developed 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, thus expanding communication between CFR team members.

Newsletter

The State CFR Team newsletter continues to be a very popular source of information with both state and local CFR leaders, providing information on child fatality topics, and the activities of teams throughout the state. The newsletter is edited by State CFR Team member Laurel Moody, RN, MS. Updates are provided for local team members regarding legislation, training opportunities, pediatric injury information, internet links, meeting dates, State CFR Team membership changes, webinars, and more.

Motor vehicle crashes and occupant safety were the main newsletter topics in 2012, with discussion of available educational programs and recommendations for prevention. 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

While 2012 saw expansion in the use of the internet-based data reporting system by local CFR teams, some teams struggle to keep data entry current. These teams were contacted by the chair of the State Team, and encouraged both to review cases thoroughly and enter data in a more timely fashion. The State Team continues to assist local teams, and to convey how a better understanding of the causes and circumstances of child deaths via data collection will, over time, improve the ability of teams to develop meaningful prevention recommendations. The data system will improve each team’s ability to understand local child deaths, and the analysis of data trends will help the State CFR Team better coordinate prevention efforts.

Safe Sleep

The State CFR Team will continue efforts to prevent sleep-related deaths. Collaboration is ongoing with the University of Maryland's Center for Infant and Child Loss (CICL), which offers safe sleep training to the general public and professionals. DHMH is providing support to CICL to develop a safe sleep DVD in English and Spanish. The DVD will be available for distribution by local and State CFR Team members.

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: 2012 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 – Betty Stemley, JD, designee

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

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

(4) The Secretary of Health and Mental Hygiene – vacant

(5) The State Superintendent of Schools – Lynne Muller, PhD, 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 State Police – Lt. Joseph Gamble, designee

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

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

Six 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

Maryland State Child Fatality Review Team Annual Meeting
Wednesday, November 28, 2012
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

9:15	**Registration Begins**
10:00	**Welcome** Richard Lichenstein, MD Chair, The Maryland State Child Fatality Review Team
10:15	**Mock CFR Case Review Meeting** Baltimore County Local Child Fatality Review Team Leaders Scott Krugman, MD, CFR Chair Colleen Freemen, RN, MS, CFR Coordinator State CFR Team Members **(Audience participation for recommendations and action planning)**
11:15	**Maryland's CFR Database: What's In It – Why It's Important** Lee Hurt, DrPH, MS DHMH MCH Epidemiologist
12:00	**Introduction of Attendees – Know Your CFR Neighbor**
12:15	**Lunch**
1:00	**Death Scene Investigation** Lt. Joe Gamble, Commander, Maryland State Police Homicide Unit **The OCME and CFR** Dwayne Brown, Investigator, Office of the Chief Medical Examiner
2:45	**Wrap-up** Joan Patterson, LCSW-C Coordinator, The Maryland State Child Fatality Review Team