MARYLAND
STATE CHILD FATALITY REVIEW TEAM

Child Deaths in Maryland

2002 Annual Report

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

Robert L. Ehrlich, Jr.	Michael S. Steele	Nelson A. Sabatini
Governor	Lt. Govenor	Secretary, DHMH

MARYLAND STATE CHILD FATALITY REVIEW TEAM

BALTIMORE, MARYLAND 21201

MS. SALLY B. DOLCH, MSW
Community Program Solutions
Chairperson

Major Thomas Bowers
Maryland State Police
Vice Chairperson

The Honorable Robert 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 submits this 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) 430-0248 or sdolch@juno.com.

Sincerely,

Sally B. Dolch, MSW
Chairperson

cc: Nelson J. Sabatini
Ms. Arlene H. Stephenson
Pamela Owens, Esq.
Russell Moy, M.D., M.P.H.
Bonnie Birkel, C.R.N.P., M.P.H.

Enclosure

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The Honorable Thomas V. Mike Miller
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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Robert L. Ehrlich, Jr.	Michael S. Steele	Nelson A. Sabatini
Governor	Lt. Govenor	Secretary, DHMH

Acknowledgements

This *Maryland State Child Fatality Review Team (State Team) 2002 Annual Report* required by Health-General Article 5-704 (b) (12) is the product of many hands.

We would like to acknowledge the volunteer hours contributed by dedicated members of the State Team and the ongoing support from Department of Health and Mental Hygiene State Team advisors and staff at the Center for Maternal and Child Health who assist in the preparation and distribution of materials to the members.

Framed by the Vision, Mission and Guiding Principles of the State Child Fatality Review Team, the *2002 Annual Report* includes:

- State team membership and accomplishments.
- Reports from twenty-three jurisdictions highlighting findings from 342 local child fatality reviews and jurisdictional recommendations to the State Team.
- *Child Death Report – 2002* prepared by the Department of Health and Mental Hygiene's Center for Maternal and Child Health, as a stand alone appendix.

As we work to "eliminate preventable child fatalities," we welcome the interest and input of all readers of this report. Please make use of our web site http://www.fha.state.md.us/mch/html/cfr/ or contact us for more information.

Sincerely,

Sally B. Dolch, MSW
Community Program Solutions
Chairperson
sdolch@juno.com

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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 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 includes 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 children in 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.

INTRODUCTION

The purpose of the Maryland State Child Fatality Review Team (State 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 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.

BACKGROUND

The twenty-five member Maryland State Child Fatality Review Team met for the first time in November 1999. Membership is comprised of the secretaries or their designees of twelve state offices or departments, two pediatricians, and eleven members of the general public with interest or expertise in child safety and welfare who are appointed by the Governor. Current membership is presented in Appendix A. The State Team meets at least quarterly to address 13 statutorily prescribed duties.

Child Fatality Review (CFR) is a systematic, multi-agency, multi-disciplinary review of all unexpected child deaths within a jurisdiction. This review process, which began in Los Angeles County 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.

Detecting and preventing child abuse and neglect remain a central focus of CFR and the Department of Social Services. 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 adequacy of services provided in order to prevent child deaths.

In 2002 the representatives from the State Team attended the Southeast Regional Child Death Conference and a seminal meeting of Northeastern State Child Fatality Review Coordinators in order to network with other states and bring to Maryland state of the art strategies and practices in Child Death Review and advocacy for prevention.

The State Team has 13 statutorily prescribed duties that guide its work. Early in 2001 the new Chairperson, Sally Dolch, and Vice Chairperson, Major Tom

Bowers, established quarterly Executive Committee meetings with the chairpersons of the four working committees in order to maximize the accomplishments of the State Team and minimize obstacles to communication and distance. The four chairpersons: Ed Kilkullen, Data; Eileen McInerney, Public Relations; Joel Todd, Policy & Guidelines; and Anntinette Williams, Training; and officers met in January, May, July, August and October with State advisors and the Center for Maternal and Child Health staff to share information, review objectives, make assignments, and set meeting agendas.

During calendar year 2002, the State Team met on March 12, 2002, June 11, 2002, and September 17, 2002. The meeting scheduled for December 5, 2002, was cancelled because of a snow storm.

ACCOMPLISHMENTS

The State Child Fatality Review Team has thirteen statutory duties. The Team's activities and accomplishments are noted below for each area of responsibility:

(1) *"UNDERTAKE ANNUAL STATISTICAL STUDIES OF THE INCIDENCE AND CAUSES OF CHILD FATALITIES IN THE STATE, INCLUDING AN ANALYSIS OF COMMUNITY AND PRIVATE AGENCY INVOLVEMENT WITH THE DECEDENTS AND THEIR FAMILIES BEFORE AND AFTER THE DEATH."*

In 2001, there were 938 deaths in infants and children under the age of 18 throughout the State of Maryland. The age of 18 is selected as the upper limit for the review since it is the age specified in the enabling legislation for the Child Fatality Review Team. Of these child deaths 587 occurred in the first year of life and 351 subsequently. All deaths are reported to the Department of Health and Mental Hygiene, Vital Statistics Administration and are delineated in annual reports produced by the Administration. Child deaths which are considered sudden and unexpected are studied by the Office of the Chief Medical Examiner (OCME). These cases and information concerning the circumstances of death are referred to local Child Fatality Review (CFR) Teams throughout the State. Medical Examiner cases account for approximately one-third of all child deaths and a significantly higher proportion of those over one year of age. Local Fetal and Infant Mortality Review (FIMR) Teams receive notification of deaths of their residents less than one year of age from the Vital Statistics Administration. This facilitates review through the FIMR process. Details of the demographic characteristics and causes of child deaths in Maryland are found in the Child Death Report at the conclusion of this Team Report. (Appendix B)

Data concerning the involvement of agencies with the affected children and their families is noted at the State and local review. The

inclusion of this information in a database maintained by the Office of the Chief Medical Examiner will allow analysis of the statewide system of care in these cases beginning in 2003.

(2) *"REVIEW REPORTS FROM LOCAL TEAMS."*

Local teams reviewed 342 cases during 2002. At the end of the year, each local CFR team was asked to report on their efforts and activities. These reports can be found in Appendix C.

(3) *"PROVIDE TRAINING AND WRITTEN MATERIALS TO THE LOCAL TEAMS TO ASSIST THEM IN CARRYING OUT THEIR DUTIES, INCLUDING MODEL PROTOCOLS FOR THE OPERATION OF LOCAL TEAMS."*

The State Child Fatality Review Team along with the Center for Maternal and Child Health and MedChi, the State Medical Society, planned and organized a Statewide training for local CFR Teams. This training was planned for December 5, 2002. Due to a serious winter storm the training was cancelled. The training was rescheduled for March of 2003. The agenda for that training and some of the materials developed for that training are in Appendix D.

(4) "*IN COOPERATION WITH 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 JURISDICTIONS."*

One of the first actions taken by the State Child Fatality Review Team was the development of "Guidelines for Local Case Review". These guidelines were developed using best practices already identified by the Child Fatality Review Teams in Arizona, Michigan and Pennsylvania. During the past year, these guidelines were modified slightly and were posted on the web site for Child Fatality Review in Maryland (http://www.fha.state.md.us/mch/html/cfr/.)

(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"*

The State Child Fatality Review Team through the data subcommittee and the Office of the Chief Medical Examiner (OCME) have developed a protocol for the collection of data regarding child deaths. It is expected that during 2003, this capacity will expand to include data input

and retrieval in an online system managed at the OCME. Local Child Fatality Review Teams will be able to report the results of their review as well as gather OCME data from the online system.

(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 APROPRIATE 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."*

Appendix C contains information provided by the local teams for CFR activities during 2002. This information includes recommendations for changes to policy or regulation especially at the local level as well as recommendations to local and State agencies. These individual reports include recommendations to the State CFR Team which are presented in a single document as Appendix E.

(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."*

The training that was planned for the local teams (Appendix C) was planned by members of the training subcommittee and the Executive Committee. Cross agency training was built into the process. Gaps in knowledge and service were addressed especially as they related to newly available information. This training was rescheduled for March of 2003.

In April of 2002, the Governor's Conference on Child Abuse and Neglect presented a workshop on Child Fatality Review. Sally Dolch, Chair of the State Team and Dr. David Fowler, the Chief Medical Examiner and a member of the State Team presented information on the Child Fatality Review process in Maryland.

In the Spring of 2002, Sally Dolch, Chair of the State CFR Team and others representing the State team attended a Child Fatality Review Conference for the Southeastern Regional Area and a first ever meeting of the CFR coordinators from the Northeastern states. The Conference provided an opportunity to investigate the activities of nearby states with regards to Child Fatality Review and opportunities for Maryland to improve its own process.

In November, the National Child Fatality Review Training program held its first meeting in Philadelphia in association with the annual American Public Health Association meeting. Andy Hannon from the Center for Maternal and Child Health attended this meeting for the State CFR Team. In the future, this training program is expected to offer training sessions that will benefit members of the State Team and the local teams.

(8) "*EXAMINE CONFIDENTIALITY AND ACCESS TO INFORMATION LAWS, REGULATIONS, AND POLICIES FOR AGENCIES WITH RESPONSIBILITIES FOR CHILDREN, INCLUDING HEALTH, PUBLIC WELFARE, EDUCATION, SOCIAL SERVICES, MENTAL HEALTH, AND LAW ENFORCEMENT AGENCIES AND 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."*

This issue of confidentiality is frequently raised as a concern with regard to sharing information with other review teams, with other agencies and with agencies or hospitals sharing information with the team. This has become a sensitive and unresolved issue especially with regard to the requirements of HIPPA. The State Child Fatality Review Team expects to address this issue more fully in the upcoming year.

(9) "*EXAMINE THE POLICIES AND PROCEDURES OF 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. S5106A(B);

(II) THE CHILD PROTECTION STANDARDS SET FORTH IN 42 U.S.C. S5106A (B); AND

(III) ANY OTHER CRITERIA THAT THE STATE TEAM CONSIDERS IMPORTANT TO ENSURE THE PROTECTION OF CHILDREN"

When a child dies, one of the greatest concerns is the safety of children in a similar circumstance or within the same family or household. One way of protecting these children is to include at the Child Fatality Review Team meeting a representative from the local Department of Social Services. This representative should have sufficient knowledge and experience to determine if neglect or abuse should be suspected. They should be able to determine if the family of the child who died was previously known to child protective services. And they, along with other

team members, should be able to determine if other children in the family or the neighborhood could be potential victims of abuse or neglect.

Of the 342 cases that the local Child Fatality Review Teams examined in 2002, there were 15 fatal cases in which child abuse or neglect was thought by the local team to be substantiated and an additional 31 cases in which teams felt that abuse or neglect may have contributed to the death. Designation of child abuse or neglect as causative or contributory to death is not uniformly applied. The State Team and agencies have not to date agreed upon definitions of these attributes, allowing for uniformity in determination. This will be addressed in 2003.

(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."

In 2002, the State Child Fatality Review Team undertook a number if activities that would be generally described as "educating the public" about the incidence and causes of child death and the prevention of these deaths. As mentioned already two members of the State Team presented a workshop on Child Fatality Review at the Governor's Conference on Child Abuse and Neglect.

The web site for the Center for Maternal and Child Health (CMCH) posted the Child Fatality Reports for 2000 and 2001, the CFR Brochure and the "Guidelines for Local Case Review."

The Center for Maternal and Child Health, the State Child Fatality Review Team, and Maryland Public Television (MPT) sponsored and presented "Day Into Night", a video about adolescent depression and preventing suicide. This video was created by DRADA (Depression and Related Affective Disorders Association) and Johns Hopkins University.

The Center for Maternal and Child Health continued its support and collaboration with The Center for Infant and Child Loss at the University of Maryland. This collaboration includes risk reduction activities including "Back to Sleep" and safe bedding campaigns.

Finally, the Baltimore City CFR Team held a press conference expressing concern about the increasing numbers of SIDS (Sudden Infant Death Syndrome) and SUDI (Sudden Unexpected Death of an Infant) in their jurisdiction. They also expressed concern about co-sleeping and drug or alcohol impairment as co-factors in the cases of SUDI.

(11) "*RECOMMEND TO THE SECRETARY ANY REGULATIONS NECESSARY FOR ITS OWN OPERATION AND THE OPERATION OF THE LOCAL TEAMS."*

The State Child Fatality Review Team recommends the allocation of funding for a dedicated staff person to coordinate the responsibilities of the State team and a budget to cover the costs of annual training, including facility, materials and presenters and other printed literature as may be necessary to meet the responsibilities outlined in law.

(12) "*PROVIDE THE GOVERNOR, THE PUBLIC, AND THE GENERAL ASSEMBLY, WITH ANNUAL WRITTEN REPORTS, WHICH SHALL INLCUDE THE STATE TEAM'S FINDINGS AND RECOMMENDATIONS*."

The State Child Fatality Review Team has completed annual reports for 1999-2000 and 2001. These are both posted on the CMCH web site to ensure public access.

(13) "*IN CONSULTATION WITH LOCAL TEAMS:*

(I) DEFINE "NEAR FATALITY;" AND

(II) DEVELOP PROCEDURES AND PROTOCOLS THAT LOCAL TEAMS AND THE STATE MAY USE TO REVIEW CASES OF NEAR FATALITY."

"Near fatality" is defined by the Child Abuse Prevention and Treatment Act as "an act that, as certified by a physician, places the child in serious or critical condition." This definition must be further developed for use in the State and by local jurisdictions. Several local teams have reviewed non-fatal cases which they determined could have resulted in death. In jurisdictions with lesser number of deaths, reviewing "near fatalities" helps maintain the experience of the team at the same time identifying opportunities for the improvement of services for children and families. A proxy measure for severe childhood injury may be admission to a critical care unit for greater than 24 hours following an injury. The Health Services Cost Review Commission (HSCRC) database reveals 160 admissions in 2001 in children under 18 years which met this criteria. Discharge of a child under 18 years from an acute care hospital following an admission for an injury to a sub-acute or chronic care facility provides another potential operational definition of "near fatality." The HSCRC database contains approximately 97 cases that met this definition. Review of cases of "near fatality" would require not only defining cases but developing a method of identifying cases and an approach to review. The State Team will constitute an Ad Hoc Sub-Committee to work with local teams and other experts to clarify this issue in 2003.

COORDINATION

The State Child Fatality Review Team is required to coordinate its activities with the State Citizens Review Board for Children, Local Citizens Review Panels and the State Council on Child Abuse and Neglect in order to avoid unnecessary duplication of effort. Three strategies were undertaken to ensure this coordination:

1. The chairperson coordinated by phone and through correspondence with chairpersons of the State Board and Council and their staff.

2. The Medical Examiner and the Chairperson of the State Team presented a workshop about “The “State Child Fatality Review Team at the April 2002 Ninth Annual Maryland Conference on Child Abuse & Neglect.

3. State Council on Child Abuse and Neglect Chairperson, Carolyn Billingsley presented to the State Team in 2002.

CHILD FATALITY REVIEW – Report Of Maryland Jurisdictions

Every year a survey of local jurisdictions is conducted to assess the status of CFR at the local level. Reports from December 2002 are presented in Appendix C. All but one jurisdiction has a CFR team. This jurisdiction uses its multi-disciplinary team to review child deaths. Of note is the number of cases reviewed involving child abuse and neglect: ten out of 24 jurisdictions reviewed at least one case in which child abuse and neglect was thought to be causative or possibly contributory for a total of 46 cases. Child Fatality Review Team Reports from Maryland jurisdictions are included in Appendix C.

CHALLENGES AND GOALS

The State Child Fatality Review Team will be addressing the following priorities in 2003:

* Implement the computerized uniform data collection system for use by Child Fatality Review Teams in all counties.

* Examine, in depth, factors which may contribute to the disproportionate burden of child deaths in the African American community.

* Collaborate, as required by law, with state and local panels reviewing child abuse and neglect to identify deaths and potential deaths associated with preventable abuse and neglect.

* Develop, in consultation with local teams, policy recommendations to reduce child deaths in Maryland.

* Examine confidentiality and access to information laws.

* Define near fatality and develop protocols for review of these situations.

* Provide training for Local Child Fatality Review Teams.

Appendix

Appendix A

State Child Fatality Review Team
Membership 2002

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 MEMBGERS, INCLUDING:

(1) *THE ATTORNEY GENERAL* - Eileen McInerney, designee

(2) *THE CHIEF MEDICAL EXAMINER* - David Fowler,MD

(3) *THE SECRETARY OF HUMAN RESOURCES* - Tom Grazio, designee

(4) *THE SECRETARY OF HEALTH AND MENTAL HYGIENE* - Carol Garvey,MD, designee

(5) *THE STATE SUPERINTENDENT OF SCHOOLS* - Richard Steinke, designee

(6) *THE SECRETARY OF JUVENILE JUSTICE* - Lee Towers, designee

(7) *THE SPECIAL SECRETARY FOR CHILDREN, YOUTH AND FAMILIES* - Donna Behrens, designee

(8) *THE SECRETARY OF THE STATE POLICE* - Thomas Bowers, designee, **Vice Chairperson**

(9) *THE PRESIDENT OF THE STATE'S ATTORNEY'S ASSOCIATION*, Joel Todd, designee

(10) *THE CHIEF OF THE DIVISION OF VITAL RECORDS* - Geneva Sparks, designee

(11) *A REPRESENTATIVEOF THE STATE SIDS INFORMATION AND COUNSELING PROGRAM,* Donna Becker, Director, Center for Infant & Child Loss

(12) *THE DIRECTOR OF THE ALCOHOL AND DRUG ABUSE AD*MINISTRATION – David Putsche, designee

(13) *TWO PEDIATRICIANS WITH EXPERIENCE IN DIAGNOSING AND TREATING INJURIES AND CHILD ABUSE AND NEGLECT, APPOINTED BY THE GOVERNOR FROM A LIST SUBMITTED BY THE STATE CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS -*
Nerita Ulep Estampador, MD

Scott Krugman, MD

(14) *ELEVEN MEMBERS OF THE GENERAL PUBLIC WITH INTEREST OR EXPERTISE IN CHILD SAFETY AND WELFARE, APPOINTED BY THE GOVERNOR, INCLUDING CHILD ADVOCATES, CASA VOLUNTEERS, HEALTH AND MENTAL HEALTH PROFESSIONALS, AND ATTORNEYS WHO REPRESENT CHILDREN -*
Sally Dolch, MSW, Community Program Solutions, **Chairperson**

Jennifer Bodine, Citizen Advocate for Children

Carolyn Fowler, Baltimore County Health Department

Edward Kilcullen, Maryland CASA Association

Pierre Mooney, Citizen Advocate for Children

Barbara Roque, Allegany College of Maryland

Anntinette Williams, LICSW, Citizen Advocate for Children

APPENDIX B

SEE "CHILD DEATH REPORT 2002" ON THE CFR WEBSITE

APPENDIX C

LOCAL CHILD FATALITY TEAM REPORTS*

THIS REPORT IS CURRENTLY NOT AVAILABLE ELECTRONICALLY.

*** NOTE: SOME LOCAL REPORTS WERE EDITED TO REMOVE INFORMATION THAT MAY HAVE IDENTIFIED THE FAMILY OF THE CHILD WHO DIED.**

APPENDIX D

Child Fatality Review in Maryland

March 6, 2003

8:30 AM	Registration and Coffee
9:00 AM	**Welcome & Why Child Fatality Review in Maryland ?** Sally B. Dolch, M.S.W Chairperson, State Child Fatality Review Team
	What have we learned so far? Maureen Edwards, M.D., M.P.H. Medical Director Center for Maternal and Child Health
9:30 AM	**Forensic Investigations** David Fowler, M.D. Chief Medical Examiner Lt. Douglas Wehland Commander of Maryland State Police Homicide Unit
10:30 AM	Break
10:40 AM	**Ask the Medical Examiner and Law Enforcement** David Fowler, M.D., Chief Medical Examiner Lt. Douglas Wehland, Maryland State Police
11:15 AM	**Panel Discussion: Challenges for Local Child Fatality Review** Laura Chase, Montgomery County Rose Johnson, R.N., Wicomico County Nancy Luginbill, R.N., St. Mary's County Dawn Zulauf, R.N., Baltimore County
12:15 PM	Lunch Provided
1:00 PM	**Panel Discussion: Infant Safety** Scott Krugman, M.D. Beverly Byron, R.N. Carolyn Fowler, Ph.D.
2:00	**Call to Action!**
2:30	Adjourn

The State Child Fatality Review Team invites you to join us
for our quarterly meeting at 2:45PM.

The State CFR Team wishes to acknowledge the assistance and support received from the Center for Maternal and Child Health and from MedChi, the State Medical Society.

THE MARYLAND STATE CHILD FATALITY REVIEW TEAM

PRESENTS

PREVENTING CHILD FATALITY THROUGH
FORENSIC INVESTIGATION AND ADVOCAC
A TRAINING OPPORTUNITY
FOR LOCAL CHILD FATALITY REVIEW TEAMS

WHO: UP TO THREE MEMBERS OF EACH LOCAL CHILD FATALITY REVIEW TEAM

WHEN: THURSDAY, DECEMBER 5, 2002, 8:30AM TO 2:30PM followed by the quarterly meeting of the State Child Fatality Review Team

WHERE: MEDCHI, The MARYLAND STATE MEDICAL SOCIETY
1211 CATHEDRAL STREET, BALTIMORE, MARYLAND 21201
DIRECTIONS AND PARKING INFORMATION ENCLOSED

AGENDA: Why child fatality review in MD? What have we learned so far?

Forensic Investigation

Challenges for Local CFR Teams

Infant Safety

Call to Action!

Submit Registrations by November 22 to Maternal and Child Health Programs, MedChi, The Maryland State Medical Society, 1211 Cathedral Street, Baltimore, Maryland, 21201 or fax to 410-547-0915 or 410-649-4131

For additional information call Andy Hannon at the Center for Maternal and Child Health, 410-767-6716 or e-mail at hannona@dhmh.state.md.us

Child Fatality Review
Resource List

March 6, 2003

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.silentmarch.org (Americans Against Violence, "Protect Kids – Regulate Guns", "Guns Know No Borders")
5. www.acy.org (Advocates for Children and Youth)
6. www.acy.org/relatedlinks.shtml (Web sites related to children's issues)
7. www.acy.org/md-can.htm (Maryland Children's Action Network)
8. www.acy.org/advocacy_tools.shtml (Advocacy tools. Working with elected officials)
9. www.aids-alliance.org/home/ (Click on "print" for publications on the subject)
10. www.baltimorecity.gov/government/mocyf/mission.html (Youth Violence Reduction Initiative)
11. www.firemarshal.state.md.us (Fire Safety Issues.)
12. www.firemarshal.state.md.us/links.htm (Fire Safety Issues and related links.)
13. www.nfpa.org/riskwatch (National Fire Protection Association)
14. www.nfpa.org/riskwatch/kids.html (Risk Watch: Make Time for Safety
15. www.nfpa.org/riskwatch/about.html (Overview of the Risk Watch program.)
16. www.nfpa.org/riskwatch/teacher.html (Teacher's tools to use in the Risk Watch program.)
17. www.infography.com (Search on Farm Safety)
18. www.fs4jk.org (Kids safety messages, games, coloring book, crossword puzzles etc.)
19. 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)
20. http://www.cdc.gov/health/default.htm (A list of Health Topics A-Z)
21. http://www.bam.gov/ (A CDC web site for kids and people who work with kids. The topics are wide ranging. There is a section on safety for different sports.)
22. www.calib.com/nccanch/pubs/factsheets/fatality.cfm (Child Fatality Fact Sheet)
23. www.calib.com/nccanch/pubs/index.cfm (National Clearinghouse on Child Abuse and Neglect.)
24. www.calib.com/nccanch/pubs/factsheets/canstats.cfm (Summary of key findings from CY 2000.)
25. www.calib.com/nccanch/stats/index.cfm (Related links.)
26. http://mova.missouri.org/childab.htm (Missouri Victims Assistance Network, Child Abuse Victims Resources. Click on Child Abuse Prevention Network.)
27. www.child-abuse.com (Click on ICAN-NCFR Child Fatality Review)
28. www.marylandcasa.org (Maryland CASA Programs, Maryland Facts. FAQs
29. www.nationalcasa.org (Services and health tips)
30. www.agnr.umd.edu/MCE/Publications/index.cfm (Maryland Cooperative Extension Service)
31. http://safety.coafes.umn.edu/ (University of Minnesota, Farm Safety and Health Information Clearinghouse
32. www.connectforkids.org (Click of "Topics A-Z. Click on "Health". Click on "Safety and Injuries". Explore other aspects of this web site.)
33. www.cpsc.gov/indexmain.html (Consumer Product Safety Commission. Kids and kids safety, "Sprocket Man" Comic Book – Bike Safety. "10 Smart moves to bicycle safety." "Kids Speak Out on Bike Helmets".
34. www.nichd.nih.gov/sids/ (SIDS Back To Sleep Campaign)
35. www.nichd.nih.gov/publications/pubskey.cfm?from=sids (Ordering information for SIDS material in Spanish and English).
36. www.nichd.nih.gov/strategicplan/cells/SIDS_Syndrome.pdf (Targeting Sudden Infant Death Syndrome (SIDS): A Strategic Plan—June 2001, 40 pages).
37. www.mdpublichealth.org/mch (Click on Child Fatality Review)
38. www.infantandchildloss.org (The Center for Infant and Child Loss)
39. www.drada.org/ (Depression and Related Affective Disorders Association)
40. http://www.suicidehotlines.com/maryland.html (Suicide hotlines in Maryland)
41. http://www.mentalhealth.org/suicideprevention/stateprograms/Maryland.asp
42. http://www.familytreemd.org (Child Abuse information for Maryland)
43. http://www.childwelfare.net/CFR/ (Child Fatality Review in Georgia)
44. http://www.hs.state.az.us/cfhs/azcf/ (Child Fatality Review in Arizona)

45. http://www.tdprs.state.tx.us/child_protection/about_child_abuse/cfrt.asp (Child Fatality Review in Texas)
46. http://www.cdphe.state.co.us/pp/cfrc/cfrchom.asp (Child Fatality Review in Colorado)
47. http://www.dss.state.mo.us/stat/mcfrp.htm (Child Fatality Review in Missouri)
48. http://www.vdh.state.va.us/medexam/fatality.htm (Child Fatality Review in Virginia)
49. http://www.keepingkidsalive.org/ (Child Fatality Review in Michigan)
50. http://www.ohd.hr.state.or.us/ipe/stat.htm (Child Fatality Review in Oregon)
51. http://www.sonoma.edu/cihs/html/CATTA/childfatal.htm (Child Fatality Review in California)

Note: If you would like an e-mail version of this page, e-mail me at hannona@dhmh.state.md.us and I'll send it to you as an attachment. That way you should be able to just click on the site to visit and search.

Appendix E

Local Child Fatality Review

Recommendations to the State Child Fatality Review Team

Allegany County:

- Crisis team involvement for staff and youth at a school where a young person may die.
- Continue efforts of awareness of road conditions in driver's education classes.
- School safety committee is going to look into increasing CPR training of school staffs.
- Family Preservation services to be provided in needed family class.
- Increased awareness of availability and encourage attendance at parenting classes.

Anne Arundel County:

- The Department of Health and Mental Hygiene's Genetics Program should be providing state-wide public service announcements about the importance of Sickle-cell screening and education. Information on where to obtain these services should be included in the announcements.

- The center for Infant and Child Loss should resume its public awareness campaign for the "Back To Sleep" program and include information in hospital newborn discharge packets.
- The Maryland Department of Education should include safe sleeping of infants and young children and the "Back To Sleep" program in their health curriculum.

Baltimore City:

- State legislature should consider mandating that individuals immediately report deaths to law enforcement agencies
- In order to prevent fires in homes, agencies that have contact with families in their homes should include on their checklist verification of the presence and working condition of smoke detectors, and advise families accordingly.

Baltimore County:

- The Team appreciates the participation of members of the Office of the Chief Medical Examiner, but suggests that it would be helpful to have even closer cooperation with the OCME in complex cases. We suggest a discussion with the OCME about how best to achieve this because we cannot impose an unrealistic burden on the office.

Calvert County:

- Autopsy reports need to be more accessible to Child Fatality Team chairman.
- Child Fatality Review should be a funded mandate.

Caroline County:

- Opportunities for counties to receive additional training and share successes would be helpful.
- Guidelines for reviewing a case that is being prosecuted.
- Merging information from a regional FIMR into individual county CFR reporting and data collection.
- Assistance obtaining police records, assisting MSP Central records to understand CFR teams role.

Carroll County:

- It would be interesting to have a "regional" meeting with counties similar to ours (e.g., Harford, Howard, Frederick), and to combine statistics for this group of counties. This might help in identifying trends, as we feel that Carroll County does not have enough cases (29 in 5 years) to draw conclusions.
- The team would be interested in hearing if the Child Fatality Review process has resulted in any changes in mortality rates, either statewide or in a particular area of the state.

Cecil County:

- Cecil County has requested assistance from the State Team to take the lead in determining the types of data needed in order to provide consistent recording of child death statistics. At this time, Cecil County will be following the lead of Montgomery County and using ACCESS data systems.

Charles County:

- Hard to review cases with incomplete data.

Dorchester County:

- No recommendations for the State Team.

Frederick County:

- No recommendations for the State Team.

Garrett County:

- No recommendations specified for the State team.

Harford County:

- Encourage trauma centers to cooperate with local CFR medical record requests.
- Obtain information regarding elevator safety compliance in Maryland.
- The local CFR Team would like to know how HIPPA will impact the FIMR/CFR ability to obtain medical records without consent.

Howard County:

- Establish guidelines that restrict the number of passengers in an adolescent's car.
- Establish guidelines for enhanced drivers' education programs.
- Establish guidelines for one parent to care for children when the other parent wants his/her rights terminated.

Kent County:

- No recommendations for the State Team

Montgomery County:

General Recommendations (From "2001 Montgomery County Child Fatality Report.)

- Encourage vigilant supervision of children
- Address cultural issues pertaining to child safety

Motor Vehicle Related Injuries

- Support safety legislation in the 2002 Maryland General Assembly
- Consider merits of legislation that address inattention while driving
- Identify and correct road hazards and *high risk* roadways to make design changes, such as adding rumble strips

Impaired Driving

- Support county programs, such as *Drawing the Line*, and police alcohol enforcement efforts to reduce incidence of impaired driving, especially among teens
- Revitalize Mothers Against Drunk Driving (MADD)

- Support promising new approaches to reduce underage drinking, such as geographically targeted, server training programs
- Support legislation to hold impaired drivers accountable for their actions

Occupant Restraints

- Maintain and expand child passenger safety programs
- Focus attention on booster seat and safety belt use by children and adolescents through a public awareness campaign, education and enforcement
- Consider dedicating state Medicaid funds to provide child safety seats to eligible families
- Support legislation mandating booster seat use up to and including eight years or eighty pounds

Young Drivers

- Encourage parents/guardians to provide more supervision of young drivers than currently required by law
- Encourage school policies such as on-campus lunch, which will reduce the need for student driving
- Discourage young drivers from transporting passengers

Pedestrians

- Support measures to increase the safety of pedestrians, including:
    1. Expanding *Walk Your Child to School Day* to alert the community to needed changes along school routes
    2. Increasing the number of red light cameras
    3. Improving the timing of walk lights
    4. Implementing the Maryland Pedestrian Safety Fund to facilitate local jurisdiction pedestrian programs
    5. Supporting legislation to toughen laws related to greater pedestrian safety
    6. Enforcing jaywalking laws

Bicycle Safety

- Support bicycle safety programs and safety fairs that include education regarding helmet use and rules of the road
- Design/implement an age-appropriate bike safety program for young adolescents
- Support road design and bicycle trails that enable safe cycling

Accidental deaths

- Support home safety program
- Encourage parents and caregivers of young children to install window guards on all windows (ensuring that such guards can be opened in the event of fire)

Recommendations

- Support programs for families who have children with chronic illness
- Support community efforts to reduce the incidence of asthma attacks and to ensure proper management
- Ensure that all children have access to health care and available resources are utilized
- Encourage anticipatory guidance to alert parents of age-appropriate risks to children
- Encourage that all families with a chronically ill child have telephone access to emergency response (replicate cell phone distribution program similar to the one established for domestic violence

SIDS

- Expand a *Safe Sleeping* awareness campaign
- Provide needy families with access to affordable cribs that meet current safety standards

Homicide

- Promote safe gun storage for firearms and ammunition
- Support public awareness of the danger of children left unattended in motor vehicles
- Alert the public on how and when to report suspected abuse or neglect

Suicide

- Identify early symptoms of depression
- Treat adolescents promptly
- Encourage safe firearms storage
- Encourage parents to be cognizant of changes in their children

Prince George's County:

- The local team feels that the State team should allocate the appropriate funds for team members. We have a large number of cases in Prince George's County and it takes a lot of time and effort to review the cases. The local team feels that all information from the State should be disseminated to local jurisdictions via E-mail and all forms to be completed can be done via e-mail.

Queen Anne's County:

- No recommendations for the State Team.

St. Mary's County:

- No recommendations for the State Team.

Somerset County:

- No recommendations at this time.

Talbot County:

- Include training needs of local team.

Washington County:

- More autopsies performed in child deaths on a regular basis.
- More access to genetic counseling.
- Gun Safety campaign.

Wicomico County:

- The team has identified a need for further training on child abuse and childcare regulations and standard methods of investigating child deaths.

Worcester County:

- No recommendations were formulated as a result of individual case reviews. However, the Worcester County Team anticipates the state definition of near-fatality which will be a resource in determining future cases for review.